~~UNDER SEAL~~ - Seal Removed per 5/25/17 Order. (CS)

IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE
TWENTIETH JUDICIAL DISTRICT, DAVIDSON COUNTY

VAUGHAN REGIONAL MEDICAL CENTER, LLC, RALEIGH GENERAL HOSPITAL, LLC, LIFEPOINT RC, INC., HSCGP, LLC, PRHC-ALABAMA, LLC, LIFEPOINT HEALTH, INC., and LIFEPOINT WV HOLDINGS, INC.,	)	
Plaintiffs,	)	
VS.	)	**NO. 16-238-BC**
STEADFAST INSURANCE COMPANY,	)	
Defendant.	)	

FILED
2017 APR 25 AM 9:42
CLERK & MASTER
DAVIDSON CO. CHANCERY CT.
D.C. & M.

MEMORANDUM AND ORDER: (1) DENYING DEFENDANT'S SUMMARY JUDGMENT ON COUNT ONE; (2) GRANTING DEFENDANT'S SUMMARY JUDGMENT ON COUNT TWO; (3) GRANTING PLAINTIFFS' RULE 56.07 MOTION; (4) GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION TO COMPEL; AND (5) SETTING 5/12/17 DEADLINE TO FILE POSITION STATEMENT ON TIMING OF MEDIATION

This lawsuit was filed by hospitals, medical centers, and a parent company who are all named insureds under a Healthcare Umbrella Liability Policy (the "Policy") issued by the Defendant. The Complaint contains two counts. In Count One, the Plaintiffs seek a declaration of coverage under the Policy. In Count Two, the Plaintiffs seek recovery from the Defendant for anticipatory breach of contract. The issues in the lawsuit stem from

lawsuits filed against the Plaintiffs arising out of allegedly unnecessary cardiac procedures performed on numerous patients by Dr. Seydi Aksut in Alabama and Dr. Kenneth Glaser in West Virginia.

The case is presently before the Court on these three motions:

— Defendant Steadfast Insurance Company's Motion for Summary Judgment (filed January 20, 2017) on the self-insurance retention issue and anticipatory breach;

— Motion of Plaintiffs Pursuant to Rule 56.07 of the Tennessee Rules of Civil Procedure (filed January 27, 2017); and

— Plaintiffs' Motion to Compel Defendant's Responses to Discovery (filed March 3, 2017).

Oral argument on the motions was conducted on March 27, 2017, and the motions were taken under advisement.

After considering the law, the record and argument of Counsel, it is ORDERED that Plaintiffs' Rule 56.07 motion is granted, and Defendant's motion to enter summary judgment on Count One, that its Policy construction prevails, is denied without prejudice to reassert after the Plaintiffs have obtained discovery. This ruling is based upon the Court's conclusion that Plaintiffs' application of grammatical rules, and meaning derived from word choice and placement does not lead to an absurd or strained construction, and that the Plaintiffs have demonstrated a reasonable construction of the Policy different from the Defendant's

construction, thereby establishing an ambiguity. Because an ambiguity has been shown, the Plaintiffs are entitled to discovery on facts extrinsic to the Policy text.

As to Defendant's Motion for Summary Judgment on Count Two of the Complaint, the motion is granted, and it is ORDERED that Count Two of the Complaint is dismissed with prejudice. Neither the allegations of the Complaint nor the summary judgment record demonstrate the essential element of an anticipatory breach: a total and unqualified refusal to pay.

With respect to Plaintiffs' Motion to Compel, some of it is ruled upon, and some of the ruling is held in abeyance. The detailed rulings are provided at the conclusion of this Memorandum.

Additionally, the case is approaching the point where it should be mediated. The initial ruling of law herein tells the parties that the time and expense of discovery must be undertaken in this case. Proceeding with mediation before more discovery is exchanged and discovery motions proceed is cost effective, but the issue is whether timing mediation in that way will be sufficiently informed to be meaningful and productive. Accordingly, by May 12, 2017, each side shall file a statement of their position on whether the case should be referred to mediation before proceeding with any additional discovery and discovery motions including those covered at the conclusion of this Memorandum. The Court will then issue an order on the timing of mediation.

Further, the above rulings necessitate revision of the January 25, 2017 Updated Rule 16 Order, particularly with respect to the April 28, 2017 completion of fact discovery. It is therefore ORDERED that the deadlines in January 25, 2017 Order are suspended until after the May 12, 2017 filings by Counsel on mediation, after which the Court will contact Counsel to revise the Rule 16 deadlines.

Lastly, with respect to this Memorandum and Order being placed under seal, removal of the seal will occur on May 12, 2017, unless prior to that date Counsel file an objection and identify content which needs to be redacted and placed under seal. By May 12, 2017, Counsel will have had an opportunity to review the Memorandum and Order for any confidential information to be redacted.

The facts, law and analysis on which these rulings are based are as follows.

Pertinent Policy Provisions and Contextual Facts

In the interest of issuing a prompt ruling, the following synopsis of the underlying claims from which the coverage dispute devolves and identification of pertinent Policy provisions are essentially quoted verbatim from pages 2-6 of Defendant's January 20, 2017 *Memorandum* in support of its motion for summary judgment.

The undisputed facts are that around November, 2014, LifePoint provided notice to former patients of cardiologist Dr. Seydi Aksut that he had allegedly performed medically unnecessary cardiac procedures at certain LifePoint hospitals or facilities located in Alabama.

Dr. Aksut performed medical procedures at Vaughan Regional Medical Center. Multiple patients of Dr. Aksut filed individual lawsuits against certain of the LifePoint facilities (collectively the "Alabama Lawsuits"). Each of the Alabama Lawsuits generally allege that various patients of Dr. Aksut were injured by unnecessary cardiac procedures, including unnecessary stent placements. At the time the Complaint was filed in this coverage action 27 lawsuits had been filed against the LifePoint Hospitals in Alabama.

Around January, 2015, LifePoint provided notice to former patients of cardiologist Dr. Kenneth Glaser that he had allegedly performed medically unnecessary cardiac procedures at certain LifePoint's hospitals or facilities located in West Virginia. Dr. Glaser was employed by Raleigh General Hospital during the relevant time period. Multiple patients of Dr. Glaser filed individual lawsuits in West Virginia against Raleigh General Hospital, LifePoint, LifePoint Health, and LifePoint WV. Each of the West Virginia Lawsuits generally allege that various patients of Dr. Glaser were injured by unnecessary cardiac procedures. At the time the Complaint was filed in this coverage action 87 patients had filed lawsuits in West Virginia. The Alabama Lawsuits and the West Virginia Lawsuits are collectively referred to as the "Cardiac Lawsuits."

The Plaintiffs provided notice of the various Cardiac Lawsuits to the Defendant.

On February 11, 2016, the Defendant issued a coverage position letter in which the Defendant acknowledged potential coverage under Coverage A of the Policy for the allegations asserted in the Cardiac Lawsuits, subject to the Policy's $5 million retention, per

Medical Incident, and subject to any exclusions and defenses. The Defendant also notified the Plaintiffs that each patient's claim (along with any family members' loss of consortium claim) constituted a separate Medical Incident per the definition in the Policy and was subject to a separate $5 million underlying, self-insured limit of liability. This meant that the Plaintiffs needed to satisfy the retention for each individual lawsuit submitted as a claim under the Policy before coverage would be triggered for any particular Cardiac Lawsuit.

The Plaintiffs then filed this Complaint on March 10, 2016, alleging generally that all of the Alabama Lawsuits constitute one Medical Incident subject to a single $5 million retention, and that all of the West Virginia Lawsuits constitute a separate single Medical Incident subject to a second single $5 million retention. It is the Plaintiffs' contention that only one $5 million retention should be paid for all of the lawsuits filed in Alabama and that a second retention should be paid for all of the lawsuits filed in West Virginia.

Insurance coverage for the foregoing lawsuits is asserted by the Plaintiffs under Policy No. HPC 9172481 issued to the Plaintiffs by the Defendant for the period of April 1, 2014 to April 1, 2015 (the "Policy"). The Policy provides a "Specific Loss Limit" of $25 million and a "Health Care Professional Liability Aggregate Limit" of $25 million. (*Id.*) Insuring Agreement A (Health Care Professional Liability Insurance) provides that:

> Under Coverage A, we will pay on behalf of the insured those sums that the insured becomes legally obligated to pay as damages because of injury caused by a medical incident to which this insurance applies. We will pay only such damages that are in excess of the Retained Limit . . . or that are in excess of the applicable underlying limit, whichever is greater. (*Id.* at Section I, Insuring Agreement (A), p. 268).

The underlying limit applicable to Coverage A is $5 million for each medical incident which is set forth in the Schedule of Underlying Self Insurance applicable to Professional Liability. (*Id.* at p. 263). The Policy, as amended by Endorsement No. 10, defines Medical Incident in pertinent part as:

> 1. An actual or alleged act, error or omission in furnishing or failing to furnish professional medical services, or a series of related actual or alleged acts, errors or omissions in furnishing or failing to furnish professional medical services to a patient;
>
> 2. A single actual or alleged act, error or omission resulting in a series of related injuries from furnishing or failing to furnish professional medical services to more than one patient. However, this sub-paragraph does not apply to:
>
> a. Service by any persons, as members of a formal accreditation, standards review, peer review, credentialing or similar board or committee of the named insured, or the administrative acts of a person charged with executing the directives of such board or committee; or
>
> b. Service by any person at your request in supervising. teaching or proctoring others . . . .
>
> Bodily injury, property damage, or personal and advertising injury sustained by any person while at your premises (including while entering or leaving your premises) for the purpose of receiving professional medical services. (*Id.* at *Definitions, Section V.X.,* and *Endorsement No. 10,* pp. 282, 317).

As defined in the Policy, Professional Medical Services means the rendering or failing to render:

> 1. Medical, surgical, dental, x-ray, or nursing service or treatment, or the furnishing of food or beverage in connection therewith;
> 2. Any health or therapeutic service, treatment, advice or instruction;

3. Any counseling service, social service, or other such treatment;
4. The furnishing or dispensing of pharmacotherapeutic agents, including chemical and biologic products or medical, dental or surgical appliances or equipment;
5. The postmortem handling of human bodies, including autopsies, organ donation or other procedures relating to the postmortem handling of human bodies;
6. Service by any persons, as members of a formal accreditation, standards review, peer review, credentialing, or similar board or committee of the named insured, or the administrative acts of a person charged with executing the directives of such board or committee;
7. Service by any person at your request in supervising, teaching or proctoring others; or
8. Services in connection with clinical trials. (*Id.* at *Definitions, Section V.HH.*, p. 284).

As defined in the Policy, self insured retention means:

> [A]ny amounts listed on the Schedule of Underlying Self Insurance, forming a part of this policy. It is the amount the insured must pay, including underlying expenses, for each claim before we will pay claims for which insurance is provided under the applicable coverage, subject to the terms and conditions of this policy. (*Id.* at *Definitions, Section V.KK.*, p. 285).

Summary Judgment Analysis

Defendant's Motion

Defendant's motion for summary judgment has two parts. The first part of the motion seeks a determination that there is no ambiguity and that from the four corners of the Policy the self-insured retention the Plaintiffs are required to pay for a "Medical Incident" before coverage is triggered is the construction asserted by the Defendant.

The Defendant's construction requires the Plaintiffs to pay the $5 million self-insured retention for each individual lawsuit before coverage is triggered.

The Plaintiffs' construction of the Policy is that all the Alabama lawsuits constitute one medical incident and all the West Virginia lawsuits constitute one medical incident, thus requiring payment of only one $5 million self-insured retention for each group of lawsuits before coverage is triggered.[1]

As well explained by the Defendant in its *Memorandum of Law in Support of Defendant Steadfast Insurance Company's Motion for Summary Judgment*, January 20, 2017 at pages 1-2:

> Steadfast has acknowledged potential coverage under the relevant policy subject to any self insured retention, exclusions or defenses. Steadfast contends that each cardiac procedure or procedures performed on a single patient represents a separate Medical Incident as that term is defined in the Steadfast policy. Consequently, each lawsuit filed against the Plaintiffs is subject to a separate $5 million self-insured retention before coverage under the $25 million policy would be triggered. The Plaintiffs seek to batch the claims into two Medical Incidents—one in Alabama and one in West Virginia—such that LifePoint would only be obligated to meet a $5 million self-insured retention obligation for each group of lawsuits before coverage is triggered. They claim that all of the cardiac procedures in Alabama performed by Dr. Askut represent one Medical Incident and all of the cardiac procedures performed by Dr. Glaser in West Virginia represent a second Medical Incident.

[1]The Defendant's motion for summary judgment pertains only to the issue of whether the Plaintiffs must meet the retention for each individual lawsuit. The Defendant's motion does not seek summary judgment on the parties' differences as to Policy exceptions and defenses.

The second part of Defendant's motion for summary judgment is that the undisputed facts establish that the Plaintiffs have failed to establish the essential element of an unequivocal refusal to proceed on trial on their claim of anticipatory repudiation.

Contract Construction of Medical Incident Coverage Text—Count One of the Complaint

The Defendant asserts that there is no need to engage in the time and expense of discovery on facts extrinsic to the text of the Policy to decide the coverage dispute. That is because the Defendant's position is that the term "Medical Incident" is clearly defined in the Policy and is ascertainable as a matter of law from the four corners of the Policy document that each of the cardiac lawsuits constitutes a separate Medical Incident subject to a $5 million retention for each lawsuit before coverage is triggered for any one lawsuit, and, therefore, summary judgment should enter in favor of the Defendant.

2. Steadfast's Motion for Summary Judgment presents a question of contract interpretation that is appropriate for determination by this Court as a matter of law, and completion of additional discovery is not necessary for Plaintiffs to oppose Steadfast's motion.

3. The additional time Plaintiffs seek to conduct the requested discovery would produce inadmissible evidence that would not assist the court in reviewing Steadfast's Motion for Summary Judgment. The motion presents a narrow legal issue regarding the policy's coverage: whether each cardiac procedure or procedures performed on a single patient represents a separate "Medical Incident" as that term is defined in the Steadfast policy.

4. Where, as here, the language of a written instrument is unambiguous, Tennessee law provides that the parties' intent. and therefore the meaning of the contract, should be derived from the provisions in the

insurance policy itself without resort to extrinsic evidence. The parties' subjective intentions at the time of contract formation are irrelevant. Nor is it necessary, in the absence of a judicial determination that the contractual language is ambiguous, to seek an expert opinion regarding the interpretation of a defined term in the insurance policy.

5. If the Court determines now that the policy term "Medical Incident" is unambiguous, this would save the parties time and money in conducting unnecessary discovery and would be judicially expeditious for this court.

6. There is no harm to Plaintiffs in having the court rule on this motion now. If the court determines the language is ambiguous, discovery may proceed as currently scheduled and Plaintiffs will have an opportunity to introduce other evidence at a later motion or at trial.

Defendant Steadfast Insurance Company's Memorandum in Opposition to Plaintiffs' Rule 56.07 Motion, February 6, 2017, at 2.

The Plaintiffs' position is that the summary judgment record establishes, at a minimum, that the Plaintiffs' construction of the Policy is as reasonable or more compelling than the Defendant's construction, therefore requiring that summary judgment be denied, and that discovery proceed on evidence extrinsic to the Policy text.

In analyzing Defendant's motion, the Court is required to adhere to the following law:

"A cardinal rule of contractual interpretation is to ascertain and give effect to the intent of the parties." *Allmand,* 292 S.W.3d at 630; *see also West,* 459 S.W.3d at 41-42; *Allstate Ins. Co.*, 195 S.W.3d at 611. The parties' intent is determined by considering the "plain meaning of the words" used in the contract. *Allmand,* 292 S.W.3d at 630; *Allstate Ins. Co.*, 195 S.W.3d at 611. If the words used are clear, unambiguous, and not susceptible to more than one reasonable interpretation, courts are to rely on the literal language used in the contract to determine the parties' intent. *Allmand,* 292 S.W.3d at 630; *Allstate*

> *Ins. Co.,* 195 S.W.3d at 611; *see also Planters Gin Co. v. Fed. Compress & Warehouse Co., Inc.,* 78 S.W.3d 885, 889-90 (Tenn. 2002) (explaining parties' intent is based on usual, natural, and ordinary meaning of words used in contract). A court will not look beyond the four corners of the document to determine the parties' intent when the contract is unambiguous. *Williams v. Larry Stoves and Lincoln Mercury, Inc.,* No. M2014-00004-COA-R3-CV, 2014 WL 5308634, at *4 (Tenn. Ct. App. Oct. 15, 2014); *West,* 459 S.W.3d at 42. A contract is not ambiguous if its meaning is clear and it is not subject to more than one interpretation. *Allstate Ins. Co.*, 195 S.W.3d at 611.

Edwards v. Urosite Partners, No. M2016-011610-COA-R3-CV, at *7 (Tenn. Ct. App. Mar. 30, 2017).

Additionally, the law as cited by Counsel provides that mere disagreement between the parties does not create an ambiguity. There must be two reasonable constructions of the text before a court can find ambiguity. *Parker v. Union Planters Corp.*, 203 F. Supp. 2d 888, 900 n.11 (W. D. Tenn. 2002); *Paul v. Insurance Co. of N. Am.*, 675 S.W.2d 481, 484 (Tenn. Ct. App. 1984).

After applying the foregoing law, the Court concludes that the Plaintiffs have established that their competing construction of the Policy is reasonable and therefore an ambiguity exists. In two ways, the Plaintiffs have demonstrated a competing, reasonable construction of the Policy: (1) the granular application of grammatical rules, and word choice and placement in the Policy text in issue and (2) the Policy's acknowledgment and identification of the insureds and risks for which the Policy was issued.

As to the grammatical rules, and word choice and placement, for ease of reference the text of the Policy, as amended by Endorsement No. 10, defining Medical Incident in pertinent part is quoted again:

> 1. An actual or alleged act, error or omission in furnishing or failing to furnish professional medical services, or a series of related actual or alleged acts, errors or omissions in furnishing or failing to furnish professional medical services to a patient;
>
> 2. A single actual or alleged act, error or omission resulting in a series of related injuries from furnishing or failing to furnish professional medical services to more than one patient. However, this sub-paragraph does not apply to:
>
> a. Service by any persons, as members of a formal accreditation, standards review, peer review, credentialing or similar board or committee of the named insured, or the administrative acts of a person charged with executing the directives of such board or committee; or
>
> b. Service by any person at your request in supervising. teaching or proctoring others . . . .
>
> Bodily injury, property damage, or personal and advertising injury sustained by any person while at your premises (including while entering or leaving your premises) for the purpose of receiving professional medical services.

The Court adopts the Plaintiffs' analysis and authorities at pages 9-12; 15-18 of its March 8, 2017 *Plaintiffs' Response in Opposition to Defendant's Motion for Summary Judgment* and concludes that Plaintiffs' application of grammatical rules and meaning derived from word choice and placement are supported by the text. In particular from the above quoted text, the Court concludes that use of the disjunctive word "or" preceded by a

comma; the modifier "to a patient" not followed by a comma placed at the end of the second clause; and that "professional medical services" is repeated in both clauses of subparagraph 1 of submission of Medical Incident all establish a reasonable basis for the Plaintiffs' construction that the first and second clause of subparagraph 1 of the definition of Medical Incident are separate and independent criterion for determining whether a Medical Incident exists under the Policy.

Next, when Plaintiffs' construction of the first and second clause of subparagraph 1 of the definition of Medical Incident is considered in conjunction with the text of subparagraph 2, the resulting construction is that the definition of "Medical Incident" consists of three alternatives:

(a) an actual or alleged act, error or omission in furnishing or failing to furnish **professional medical services**; or

(b) a series of related actual or alleged acts, errors or omissions in furnishing or failing to furnish **professional medical services** to a patient; or

(c) a single actual or alleged act, error or omission resulting in a series of related injuries from furnishing or failing to furnish **professional medical services** to more than one patient.

The Court concludes that solely under a granular grammatical and textual analysis, Plaintiffs' construction of three separate alternatives that can constitute a Medical Incident is a reasonable construction.

The next step required by Tennessee law, however, as asserted by the Defendant, is that meaning derived from granular grammatical, and word choice and placement rules is not appropriate if it results in a strained interpretation. Tennessee law does not mechanically apply cannons of construction, and those can be overcome where the interpretation "would yield an absurd result," or evident sense and meaning require a different construction. *See* authorities cited for this proposition in Defendant's briefing: *In re Estate of Tanner*, 295 S.W.3d 610, 625 n.14 (Tenn. 2009); *see also* discussion in *Cracker Barrel Old County Store v. Cincinnati Ins. Co.*, No. 3:07-CV-00303, 2011 WL 5208369 at *5 (M.D. Tenn. Sept. 21, 2011), aff's sub nom. *Cracker Barrel Old County Store, Inc. v. Cincinnati Ins. Co.*, 499 F. App'x 559 (6th Cir. 2012) (quoting *In re Estate of Tanner*, 295 S.W.3d 610, 625 n.14 (Tenn. 2009)).

Accordingly, moving from the granular examination of the text of the Policy to a more general view, Defendant contends that Plaintiffs' construction is strained and unreasonable because the Plaintiffs' interpretation of subparagraph 1 of the definition of Medical Incident renders subparagraph 2 of that definition meaningless:

> In other words, according to LifePoint's construction, the first clause of paragraph 1 encompasses **professional medical services** resulting in more than one injury, to multiple patients. LifePoint states that Paragraph 2 of the definition of **Medical Incident** "contemplates a single act resulting in more than one injury from furnishing or failing to furnish professional medical services to more than one patient." *Id.* Although LifePoint asserts that "each of these definitions are exclusive of each other," they are in fact the same and LifePoint fails to explain how this construction would give meaning to the entirety of the definition. Where Paragraph 2 of the definition of Medical Incident already addresses **professional medical services** furnished to "more

than one patient," it does not make sense for this definition to be included in Paragraph 1 above; and as a result, LifePoint has failed to set forth a reasonable alternative construction of the language.

Defendant Steadfast Insurance Company's Reply to Plaintiffs' Opposition to Steadfast's Motion for Summary Judgment, filed March 20, 2017, at 7 [emphasis in original].

In reply, Plaintiffs asserted during oral argument that when subparagraphs 1 and 2 are considered in the context that the Plaintiffs are institutions, not physicians, subparagraph 1 has a broader meaning and is not redundant to subparagraph 2. Guided by *CHS/Community Health Systems, Inc. v. Lexington Insurance Co.*, 2013 WL 6500477 (M.D. Tenn. Dec. 9, 2013), the Plaintiffs argue that the risks for them as insureds are not limited to the medical procedure itself, such as the surgery, performed by the individual physician but are broader and include institutional acts, errors or omissions in providing professional services. The Plaintiffs characterize the allegations in the underlying lawsuits against them as including allegations of negligent hiring and retention, and a strategy by the Plaintiffs of expanding services such as interventional cardiology.

The Defendant's response is that the Policy "contemplated acts by doctors, surgeons, technicians and/or nurses as the basis of a **Medical Incident**." Defendant's *Response*, April 3, 2017, at 4. The Defendant supports this argument with the point that the definition of Medical Incident includes the definition of Professional Medical Services. The latter is defined as:

1. Medical, surgical, dental, X-ray, or nursing service or treatment, or the furnishing of food or beverage in connection therewith;

2. Any health or therapeutic service, treatment, advice or instruction;

3. Any counseling service, social service, or other such treatment;

4. The furnishing or dispensing of pharmacotherapeutic agents, including chemical and biologic products or medical, dental or surgical appliances or equipment;

5. The postmortem handling of human bodies, including autopsies, organ donation or other procedures relating to the postmortem handling of human bodies;

6. Service by any persons, as members of a formal accreditation, standards review, peer review, credentialing, or similar board or committee of the named insured, or the administrative acts of a person charged with executing the directives of such board or committee;

7. Service by any person at your request in supervising, teaching or proctoring others; or

8. Services in connection with clinical trials.

This definition the Defendant characterizes as demonstrating that the Policy pertains to acts by doctors, surgeons, technicians and/or nurses as the basis of a Medical Incident.

The Defendant's further analysis is that management functions such as peer review and credentialing are excepted from the definition of Paragraph 2 of Medical Incident, and that the Policy, at Exclusion P, does not provide institutional coverage. Services rendered by the insured in its capacity as a managed care institution are excluded, in Exclusion P, such as case management, handling and adjusting health care claims, marketing of health services, quality assurance review of professional medical services and utilization review. Defendant's *Response*, April 3, 2017, at 5.

Lastly, the Defendant argues that, "the focus of the underlying lawsuit is on the doctors' acts." The Defendant's characterization is that the "underlying complaints clearly allege that LifePoint and the hospitals are directly liable for the medical procedures performed by Dr. Glaser and Dr. Aksut." April 3, 2017 *Response* at 5.

In determining coverage, a court is to examine the allegations of the pleadings of the underlying lawsuit. *Travelers Indem. Co. of America v. Moore & Associates, Inc.*, 216 S.W.3d 305 (Tenn. 2007); *St. Paul Fire & Marine Ins. Co. v. Torpow*, 879 S.W.2d 831, 835 (Tenn. 1994).

Attached to the March 10, 2016 *Complaint*, as Exhibits C and E, respectively, are pleadings from the Alabama and West Virginia Lawsuits.

A review of the pleadings of the underlying lawsuits shows that they not only allege wrongdoing based upon the doctors' actions, but there are also allegations of institutional acts and omissions of the Plaintiffs, independent of the actions of the physicians, such as negligent hiring, supervision, retention, quality control, ratification, concealment, delayed notification, conspiracy, and a strategy of expanding profitable service lines and suppressing competition. In particular are paragraphs 8, 14, 15, 17, 20, 23, 27, 28, 29 of an Alabama Complaint, Exhibit C to the Complaint; and paragraphs 10, 11, 12, 15-26 of a West Virginia Complaint, Exhibit E to the Complaint.

These allegations, the Court concludes, aver institutional acts and omissions, independent of the actions of the physicians. Moreover, all of these allegations do not fit

within the credentialing and accreditation excluded in subparagraph 2(a) of Medical Incident, and it is not ascertainable at this time whether they all fit within the Exclusion P items of quality assurance and utilization review because that has not been presented to the Court.

Thus, upon comparing the allegations of the underlying lawsuits to the Policy, the result with respect to summary judgment as a matter of law based on the four corners of the document, is that the Plaintiffs' construction of the definition of Medical Incident is neither unreasonable nor strained when the context of the Policy, that the insureds are institutions, is taken into account. That construction, as stated by the Plaintiffs, is as follows:

> Specifically, subparagraph 1, prong 1 (before the comma and disjunctive "or"), defines a Medical Incident as broadly as possible to mean an act, error or omission in the furnishing of professional medical services. This prong, by its terms, contemplates a single act of furnishing or failing to furnish professional medical services. Importantly, the party injured by the act or omission need neither be a single individual nor a patient. Under prong 2 of subparagraph 1, a medical incident is defined as a series of related acts in furnishing or failing to furnish professional medical services to a [single] patient. Finally, subparagraph 2 contemplates a single act resulting in more than one injury from furnishing or failing to furnish professional medical services to more than one patient. Thus, each of these definitions are exclusive of each other. The adoption of the plain and ordinary meaning of the terms used in the Medical Incident definition does not render any part of the definition superfluous, but rather gives meaning and effect to the entirety of the definition . . . . Importantly, when the Medical Incident definition is given plain and ordinary meaning, LifePoint's claims are appropriately batched under both subparagraph 1, prong 1, and subparagraph 2.

Plaintiffs' Response in Opposition to Defendant's Motion for Summary Judgment, filed March 8, 2017, at p. 26 [emphasis in original].

The Court therefore concludes that the Plaintiffs' application of grammatical rules, and meaning derived from word choice and placement do not lead to an absurd result, and that the Plaintiffs have demonstrated a reasonable construction of the Policy different from the Defendant's construction. The Defendant's Motion for Summary Judgment with respect to Count One of the Complaint is, therefore, denied because an ambiguity has been shown which entitles the Plaintiffs to discovery of facts extrinsic to the Policy text.

Anticipatory Breach—Count Two of the Complaint

With respect to summary judgment on Count Two of the Complaint, it is granted. To state a claim for anticipatory breach of contract under Tennessee law, there must be an allegation of total and unqualified refusal to pay. *Wright v. Wright*, 832 S.W.2d 542, 545 (Tenn. Ct. App. 1991); *UT Med Group, Inc. v. Vogt*, 235 S.W.3d 110, 122 (Tenn. 2007). These essential elements are not averred in the Count Two pleadings. The allegation is that the Defendant has "indicated" it will unequivocally breach the Policy "by not providing coverage" consistent with Plaintiffs' construction of the self-insured retention. *See* ¶¶ 64 and 65 of the Complaint. This is not an averment of total and unqualified refusal to pay which constitutes anticipatory breach.

Additionally, the undisputed facts on summary judgment, as established in the affidavit of Attorney Mulligan and paragraphs 41 and 42 of the Complaint, are that the Defendant has not denied coverage. The Defendant acknowledged in its February 11, 2016

position letter that coverage is potentially triggered under the Policy, subject to satisfaction of the applicable retention and any Policy exclusions and defenses. Because the Defendant has expressed a willingness to perform if the self-insured retention for each Medical Incident arising under Coverage A of the Policy is satisfied, there has been no total and unqualified refusal to perform the contract. In so concluding the Court has been guided by the cases, cited by the Defendant, that denial of an insurance claim does not amount to the repudiation of the Policy. *New York Life Insurance Co. v. Viglas*, 297 U.S. 672, 676 (1936). *See also Evanoff v. Standard Fire Insurance Co.*, 534 F3d 516 (6th Cir. 2008).

Accordingly, the Defendant's motion for summary judgment with respect to Count Two is granted, and that portion of the Complaint is dismissed with prejudice.

Plaintiffs' Rule 56.07 Motion for Discovery on Extrinsic Evidence and Motion to Compel

Now that the law of the case is that the Policy text in issue is susceptible to differing reasonable constructions, extrinsic evidence is discoverable to inform and resolve the meaning. Plaintiffs' Rule 56.07 motion to obtain discovery on such extrinsic evidence is, therefore, granted.

The summary judgment ruling also affects Plaintiffs' motion to compel. Until Defendant knew whether extrinsic evidence would be admissible, its objection or withholding such evidence was consistent with its contract construction position. The above ruling on summary judgment provides Counsel more certainty as to the admissible evidence

in this case, and enables them to refine their previous determinations of information calculated to lead to the discovery of admissible evidence. That, in turn, places Counsel in a better position to narrow or eliminate some of the objections to Plaintiffs' discovery and the objections to asserted privileges.

It is therefore ORDERED that the Plaintiffs' motion is granted to compel answers to interrogatories 3 and 5 (to the extent that they have not already been completely supplemented by the Defendant) and requests for production 9-27. The discovery shall be provided by May 26, 2017.

It is additionally ORDERED that the Plaintiffs, by May 5, 2017, shall reword interrogatory 10 now that the Defendant has explained its impression of the information requested in the interrogatory, and the Defendant shall respond by May 26, 2017.

Also, Attorney Mulligan has volunteered to clarify her assertion of privilege descriptions on the privilege log, and this shall be completed by May 26, 2017.

It is ORDERED that production by the Defendant of information on its reserves and how it calculated the premium is denied at this time without prejudice to the Plaintiffs to demonstrate, after the completion of written discovery and before depositions, that the amount of reserves and the premium calculation information is necessary evidence or necessary to lead to information to enable it to prosecute its case.

With respect to Plaintiffs' requests for production 4, 28-29 and 30, and interrogatories 7 and 8, the Court is unable to discern from the briefing and oral argument whether

Defendant's denial of production of information on reserves and calculation of premium precludes Defendant from responding entirely to these items of discovery or only partially. It is therefore ORDERED that the Court holds in abeyance its ruling on Plaintiffs' Motion to Compel responses to requests for production 4, 28-29 and 30, and interrogatories 7 and 8. It is further ORDERED that Counsel shall confer regarding their disputes on this part of Plaintiffs' Motion to Compel. If any issues remain, by June 9, 2017, Plaintiffs shall file an updated Motion to Compel and supporting brief. By June 23, 2017, Defendant shall file opposition. By June 30, 2017, Plaintiff shall reply. Because the oral argument already conducted has informed the Court, it will decide any remaining issues on the Motion to Compel on the papers or by scheduling a telephone conference for any followup questions the Court has.

ELLEN HOBBS LYLE
CHANCELLOR
TENNESSEE BUSINESS COURT
PILOT PROJECT

cc by U.S. Mail, email, or efiling as applicable to:
W. Brantley Phillips, Jr.
John N. Ellison
Luke E. Debevec
Byron R. Trauger
Paul W. Ambrosius
Maureen Mulligan
Catherine M. Scott

MAILED+faxed
4-25-17