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INSURANCE COVERAGE ISSUES: OVERVIEW AND UPDATE

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COVERAGE ISSUES IN UM/UIM CLAIMS¹

I. INTRODUCTION

Uninsured Motorist (“UM”) and Underinsured Motorist (“UIM”) claims constitute a substantial amount of auto insurance claims in Pennsylvania today. Moreover, because the law relating to them is often complicated, uncertain and inconsistent, and continually changing, they give rise to more extra-contractual, bad faith litigation than any other type of insurance claim. Therefore, it is critical that claim representatives have a good, basic understanding of UM/UIM law. Although this pamphlet is not an exhaustive review of the law, it is intended to provide basic information about UM/UIM coverage and claims and recent case law concerning the subject, and to stimulate discussion about potential problems regarding UM/UIM coverage and claims.

II. GENERAL LEGAL PRINCIPLES

There are four (4) dominant legal principles applied commonly in UM/UIM cases.

One, policy provisions which violate public policy or the mandates of the Motor Vehicle Financial Responsibility Law (“MVFRL”) are invalid. *E.g.*, Richmond v. Prudential, 856 A.2d 1260 (Pa. Super. 2004) (policy’s definition of insured, which limited insureds to certain categories of people while occupying “cars” (as distinguished from “motor vehicles,” which includes motorcycles, trucks, buses, taxicabs) is invalid).

Two, clear and unambiguous policy terms will be enforced (unless they violate public policy and/or the MVFRL). Progressive Northern Ins. Co. v. Schneck, 813 A.2d 828 (Pa. 2002).

Three, a provision of an insurance policy is ambiguous if it is reasonably susceptible of different interpretations. Cordero v. Potomac Ins. Co., 794 A.2d 897 (Pa. Super. 2002).

Four, any ambiguity in an insurance policy will be construed against the insurer, in favor of the insured. Cordero, *supra*.

III. BASICS OF UM/UIM IN PENNSYLVANIA

A. WHAT IS UM/UIM COVERAGE?

UM/UIM coverage is insurance against the risk that the insured may be injured as a result of the negligence of a motorist who does not have any insurance or does not have sufficient insurance to fully compensate the insured for his injuries.

If a motorist who negligently causes an accident (the “tortfeasor”) does not have any insurance, then the injured party may be entitled to UM benefits pursuant to policies under which he qualifies as an “insured.” This UM coverage pays damages for the harm caused by the tortfeasor. In a sense, it takes the place of liability insurance for the uninsured motorist. In exchange for making this payment, the UM carrier has a “subrogation” right against the uninsured motorist, which means that the UM carrier “steps into the shoes” of its insured and

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may attempt to recover payment from the tortfeasor, since he is really responsible for the damages.

A driver is “uninsured” if he has no coverage, if his insurer denies coverage or if he is unidentified. However, in regard to unidentified or “phantom” drivers, the accident must be reported *to the police*, and the claimant must notify the insurer within 30 days or as soon as practicable, that he has a legal action arising out of the accident. 75 Pa. C.S. §1702 (definitions—insured motor vehicle). If the claimant fails to report the accident to the police, then the insurer does not need to show prejudice in order to deny coverage. State Farm v. Foster, 889 A.2d 78 (Pa. 2005).

UIM coverage is similar, except that it applies whenever the tortfeasor has some liability coverage of his own, but not enough coverage to fully compensate the injured party. Again, the UIM carrier receives a subrogation right against the tortfeasor in exchange for making a payment.

B. WHO IS AN INSURED

An “insured” is defined in the Motor Vehicle Financial Responsibility Law (“MVFL”) as including: an individual named as the insured in the policy; the spouse and relatives residing in the named insured’s household; and any minors in the custody of such insureds. 75 Pa. C.S.A. §7102 (relating to definitions). A typical policy provides that an occupant of the insured vehicle is also an “insured” or “covered person” for purposes of UM/UIM coverage.

“Class one” insureds include the named insureds, their resident family members and minors in the custody of such insureds. Class one insureds generally have a right to “stack” the limits on the vehicles covered under the policy (explained further below). A person who is insured only because he was an occupant of a vehicle involved in an accident is a “class two” insured. Generally, a class two insured cannot stack limits under the policy covering that vehicle.

In regard to business auto policies, there may be an issue as to whether anyone qualifies as a “class one” insured. If the policy names only a corporation (as distinguished from individuals, sole proprietorships and partnerships) as “the named insured,” does that include the corporation’s principals or shareholders, officers and directors? That is an unsettled question of law, although most courts have held that, where only a corporation is named, corporate officers and their resident relatives do not qualify as “class one” insureds. Insurance Co. of Evanston v. Bowers, 758 A.2d 213 (Pa. Super. 2000) (there are no “class one” insureds for UM/UIM coverage under a corporate policy); Nationwide Mut. Fire Ins. Co. v. Salkin, 163 F.Supp.2d 512 (E.D. Pa. 2001) (same); United States Fidelity & Guaranty Co. v. Tierney Associates, Inc., 213 F.Supp.2d 468 (M.D. Pa. 2002); Hunyady v. Aetna Life & Cas., 578 A.2d 1312 (1990), *aff’d*, 530 Pa. 25, 606 A.2d 897 (1992); Caron v. Reliance Ins. Co., 703 A.2d 63 (Pa. Superior Ct. 1997), *appeal denied*, 727 A.2d 126 (Pa. 1998); LaCourse v. Firemen’s Ins.Co., 1986 U.S. Dist. LEXIS 23771 (E.D. Pa, June 30, 1986), *aff’d*, 822 F.2d 53 (3d Cir. 1987); Canto v. Harleysville, 20 Phila. 293, 1990 Phila. Cty. Rptr. LEXIS 11 (Feb. 23, 1990), *aff’d per curiam*, 588 A.2d 556 (1990), *appeal denied*, 593 A.2d 837 (1991). However, several federal trial court decisions have gone the other way, ruling or suggesting that officers of corporations may qualify as class one insureds. Transguard Ins. Co. v. Hinchey, 2006 U.S. Dist. LEXIS 34529 (M.D. Pa., May 30, 2006); Ober v. Aetna Cas. & Sur. Co., 766 F. Supp. 342 (W.D. Pa. 1990) and Lehman v. Nationwide Mut. Ins. Co., 1990 U.S. Dist. LEXIS 7756 (E.D. Pa., June 21, 1990).

In Continental Cas. Co. v. ProMachine, 2007 Pa.Super. 18 (Pa.Super. 2007), the Pennsylvania Superior Court found that where policy declarations include a partnership and also name the individual partners trading as the partnership, the individuals qualify as named insureds for UIM coverage; that a non-scheduled motorcycle qualifies as a covered auto as an owned auto by the individual; and that the household exclusion does not apply. However, the partner can obtain UIM coverage only if he was acting in his capacity as a partner at the time of the accident.

Pro Machine is a Pennsylvania partnership, registered as a fictitious name. One partner owned a motorcycle, titled in his name, which he used to make customer calls on behalf of Pro Machine. The partners obtained a commercial insurance policy for the partnership from Continental. After the policy was issued, the motorcycle owner was seriously injured. He collected the other driver's policy limits and recovered UIM benefits under his motorcycle policy. He then filed a claim with Continental for additional UIM coverage. Continental denied coverage, claiming that owner was not a "Named Insured" under the Policy and that the motorcycle was not a "covered motor vehicle" pursuant to the UIM "household" exclusion. Continental filed a motion for summary judgment in its declaratory judgment action, which was granted by the Trial Court.

The Superior Court found a trial issue of fact and overturned the Trial Court decision. The policy declarations were issued to the partnership and individuals trading as the partnership. "Covered autos" under the UIM coverage form includes autos "you" own. An insured under the form included "you" and if an individual, any family member. The Court found that a partnership is made up of individuals, and is not recognized as an entity like a corporation and is not separate from its partners. In this context, the Court found the declarations not ambiguous, and includes the individuals in their capacity as partners of the partnership. This gives meaning to the reference to family members in the UIM form. The Court also found that the motorcycle is a covered auto, and that the household exclusion does not apply. However, the Court found that coverage only applies if the partner was driving the motorcycle on partnership business at the time of the accident and remanded the case to the Trial Court.

C. THE "IMPORTANT NOTICE"

75 Pa. C.S. §1791 requires insurers to provide an applicant with an "IMPORTANT NOTICE," in a particular form mandated by the statute, which includes some basic information regarding available coverages. For many years, courts held generally that an applicant's selections (e.g., request for lower limits, discussed in Section IV below), were invalid in the absence of proof that they were made "knowingly and intelligently." An insurer could satisfy that requirement by proving that the Notice was given or by other proof of the applicant's knowledge. Courts held that in the absence of such proof, an applicant's election of lesser coverage was invalid, and the policy would be "reformed" to provide greater coverage. However, more recently, courts generally have held that there is no "remedy" for failure to give the notice and there is no requirement to prove that the selections were "knowing and intelligent," so long as they were executed in accordance with the other statutory requirements. See Allstate Ins. Co. v. DeMichele, 2005 Pa. Super. 382 (Pa. Super., Nov. 14, 2005); Nationwide v. Heintz, 804 A.2d 1209 (Pa. Super. 2002); and *citations therein*.

D. LIMITS

Unless UM/UIM coverage has been rejected (see below) or lower limits have been requested properly, UM/UIM coverage must be provided in an amount equal to the liability coverage limit in the policy. 75 Pa.C.S. §1734.

75 Pa. C.S. §1734 states only that “[a] named insured may request in writing the issuance of [UM and/or UIM coverages] in amounts equal to or less than the limits of liability for bodily injury.” Oddly, when one considers the specificity of other sections of the MVFRL, this section does not specify the language, print, form or mechanism to be used, nor even whether the request must be signed by a named insured to be valid. Any writing that reflects the insured’s choice of lower coverage is sufficient. See, e.g., Employers Fire Ins. Co. v. Alvarado, 2005 U.S. Dist. LEXIS 1109 (M.D.Pa., June 25, 2005) (application is sufficient) *and citations therein*. The statute’s lack of specificity raises many possible issues. What if the insured checks a box to indicate the desired limit? A federal district court has held that a form with lower limits “checked” by an agent, initialed by the named insured, and signed elsewhere by the named insured is valid. State Farm v. Ciccarella, 2002 U.S. Dist. LEXIS 7698 (E.D. Pa., May 1, 2002). What if it is not signed? What if the insured’s agent checks the box and/or signs a form, while sitting across a table from the insured, indicating the insured’s informed decision? In MIC Prop. & Cas. Ins. Corp. v. Crawford, 2001 U.S. Dist. LEXIS 24212 (E.D. Pa., Oct. 26, 2001), the Court pointed out that the statute requires only a “request in writing,” not a signature; and the court held that, at least in that case, a written request by an authorized agent of the insured was sufficient. See also, Transguard v. Hinchey, 2006 U.S. Dist. LEXIS 34529 (M.D. Pa., May 30, 2006) (whether request was valid depends on whether broker who made written request acted as agent of insurer or else agent of insured).

In Lewis v. Erie Ins. Exch., 793 A.2d 143 (Pa. 2002), the Pennsylvania Supreme Court held that an election of lower limits is valid even though the insurer’s forms for rejecting UM/UIM coverage were invalid (because they were printed on the same page), specifically rejecting the suggestion in National Union Fire Ins. Co. v. Irex Corp., 713 A.2d 1145 (Pa. Super. 1998), that all elections were invalid if the rejection forms were invalid.

One recent case is Blood v. Old Guard Ins. Co., 894 A.2d 795 (Pa. Super. 2006), where Plaintiff, the defendant’s insured’s son, sought review of the decision of the Court of Common Pleas of Crawford County, which granted summary judgment in favor of the defendant insurer in the son’s declaratory judgment action seeking a determination of the underinsured motorist coverage (UIM) limits provided in the policy.

The Plaintiff was a passenger in a vehicle and suffered serious injuries as the result of the accident. The driver’s liability insurer paid the plaintiff the limits of the driver’s policy with the insurer. The insurer then paid the son money representing a limit on the coverage for three stacked vehicles owned by the insureds. The son subsequently filed a declaratory judgment action, seeking a determination of the UIM policy limits provided in the policy.

The trial court granted the insurer’s motion for summary judgment, but the Superior Court reversed. The “Pennsylvania Auto Insurance Coverage Selection Form” signed by the insurers contained an explicit option for selecting lower UIM benefits. No such selection was made, nor was that option crossed off or rendered inoperative. Thus, the statutory presumption of UIM policy limits equivalent to the bodily injury liability limits was in effect under 75 Pa. C.S. § 1731(C.1). The insurer, as the drafter of the document, was in a position to make it clear whether the insureds were choosing a lower UIM coverage limit. Having failed to protect itself, the court was not empowered to reform the contract to reflect the insurer’s contention. Therefore, the Superior Court reversed the judgment and remanded to the trial court.

In State Farm v. Hughes, 438 F.Supp. 2d 526 (E.D. Pa. 2006), the insurer brought a declaratory judgment action against defendant insureds, asking for a declaration that automobile insurance policies issued to the insureds provided underinsured motorist (UIM)

coverage with limits of \$25,000 per person and \$50,000 per occurrence. The parties consented to the jurisdiction of a magistrate judge and filed cross-motions for summary judgment. The applications for the policies at issue requested bodily injury coverage limits of \$50,000 per person and \$100,000 per occurrence and uninsured motorist (UM)/UIM limits of \$25,000 and \$50,000. In 1990, following amendment of the Pennsylvania Motor Vehicle Financial Responsibility Law (MVFRL), 75 Pa. Cons. Stat. § 1701 et seq., one of the insureds signed a form electing to retain the policies' UM/UIM limits. The insureds later increased the bodily injury limits to \$100,000 and \$300,000, and they claimed that under the MVFRL they were entitled to \$100,000 in UIM coverage when one of the insureds was injured in an accident. The court found that the applications and the 1990 election forms satisfied the requirement under 75 Pa. Cons. Stat. § 1734 that a request in writing be made in order to reduce UIM coverage below the bodily injury coverage limits pursuant to 75 Pa. Cons. Stat. § 1731. The lower UIM coverage limits remained in effect when the insureds increased the bodily injury coverage limits, as the MVFRL did not require a new written request for reduced UM/UIM coverage to be made. The insurer's summary judgment motion was granted, and the insureds' summary judgment motion was denied. The policies were declared to have UIM coverage limits of \$25,000 and \$50,000, and it was further declared that the insurer had satisfied its obligations to the insureds.

In Hartford Ins. C. v. O'Mara, 907 a.2d 589 (Pa.Super. 2006), the Insureds brought an action in Philadelphia for uninsured motorist (UM) and underinsured motorist coverage (UIM). Insureds were covered under a policy with a limit of \$100,000 per person and \$300,000 per accident on the liability portion of their policy, and elected to reduce their UM and UIM coverage to \$15,000 per person and \$30,000 per accident by making a selection on their policy application form. Following an accident, insureds made a claim for UM benefits under the policy. Insurer paid \$45,000 (\$15,000 stacked for three vehicles) in UM benefits. Insureds contested the validity of their selection for reduced UM/UIM benefits. A panel of arbitrators in Philadelphia County concluded that the form did not provide enough evidence that the insureds knowingly and intelligently reduced benefits pursuant to 75 Pa.C.S.A. § 1734, and reformed the policy to reflect full UM/UIM coverage. Insurer filed a petition in the Court of Common Pleas of Philadelphia County to vacate the arbitrators' award, which the Court denied. The Superior Court concluded that because the arbitrators' award was based on the legal conclusion that portions of the policy did not comply with statute, the trial court erred in declining to review the arbitrators' decision. The Superior Court further concluded that the 75 Pa.C.S.A. § 1745 does not dictate specific language about a reduction in UM/UIM benefits, but rather needs only convey an insured's wishes to purchase UM/UIM coverage in amounts less than or equal to the policy limits for bodily injury.

E. REJECTION OF COVERAGE

The requirements for valid rejections of UM and UIM coverage are set forth in 75 Pa.C.S. §1731 (relating to availability, scope and amount of coverage), which provides in pertinent part:

* * * * *

(b) Uninsured motorist coverage. . . . *The named insured shall be informed that he may reject uninsured motorist coverage by signing the following written rejection form:*

REJECTION OF UNINSURED MOTORIST PROTECTION

By signing this waiver I am rejecting uninsured motorist coverage under this policy, for myself and all relatives residing in

my household. Uninsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have any insurance to pay for losses and damages. I knowingly and voluntarily reject this coverage.

.....
Signature of *First Named Insured*

.....
Date

* * * * *

(c) Underinsured motorist coverage. . . . *The named insured* shall be informed that he *may reject* underinsured motorist coverage by signing the following written rejection form:

REJECTION OF UNDERINSURED MOTORIST PROTECTION

By signing this waiver I am rejecting underinsured motorist coverage under this policy, for myself and all relatives residing in my household. Underinsured coverage protects me and relatives living in my household for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages. I knowingly and voluntarily reject this coverage.

.....
Signature of *First Named Insured*

.....
Date

(c.1) Form of waiver.—Insurers shall print the rejection forms required by subsections (b) and (c) on separate sheets in prominent type and location. *The forms must be signed by the first named insured and dated to be valid. . . .* Any rejection form that does not specifically comply with this section is void. If the insurer fails to produce a valid rejection form, uninsured or underinsured coverage, or both, as the case may be, under that policy shall be equal to the bodily injury liability limits. . . .

* * * * *

75 Pa.C.S. §1731 (italics added).

According to this statute, the forms must use the exact statutory language “on separate sheets in prominent type and location.” They must be signed by the first-named insured. They must be dated. Although the statute does not state specifically whether they must be dated by the named insured, that certainly is the better, safer practice. However, a federal trial court has held that a rejection dated by the insurer (or agent) is valid. State Farm Fire & Casualty Co. v. Rey, 1995 U.S. Dist. LEXIS 5282 (E.D. Pa., April 21, 1995).

Courts have held that any deviation from those requirements renders the rejection invalid, even if the insured knowingly and intelligently chose to reject the coverage. For example, in Lucas v. Progressive Cas. Ins. Co., 680 A.2d 873 (1996), *appeal denied*, 693 A.2d 589 (1997), the Court held that, even though the insureds knowingly rejected UM coverage, and even though the rejection forms used the precise statutory language, the rejections were void, and the insureds were entitled to UM coverage equal to their liability limits, because the form included rejection of UM coverage and rejection of UIM coverage on the same sheet. (However, in fact, some courts have held that some deviations *are* tolerated. (See VII below.))

But forms containing rejections of UM and UIM coverages on the same sheet with other selections do not necessarily make *other* selections invalid. For example, in Lewis v. Erie Insurance Exchange, 793 A.2d 143 (Pa. 2002), the insured executed a reduction of UM/UIM limits on a form which also provided for the waiver of UM/UIM coverages altogether. After the insured's son was injured in a car accident, the insured argued that his request for lower limits was invalid, because on the same form was a rejection of both UM and UIM coverages. The Supreme Court rejected this argument, holding that the technical and remedial provisions of section 1731(c.1) are only available when an insurer attempts to enforce an outright waiver of UM/UIM coverage, not when it is attempting to enforce some other selection. Therefore, the Court upheld the insured's request for lower limits.

Similarly, the Supreme Court in Winslow–Quattlebaum V. Maryland Cas. Co., 752 A.2d 878 (Pa. 2000), reversed the Superior Court, holding that there is no requirement that rejections of UM/UIM be alone on pages separate from rejections of stacking and all other elections or writings. Rather, the MVFRL requires only that rejections of UM and rejections of UIM be separate from one another.

Although the statute is inconsistent (*e.g.*, it states that “the named insured” may reject by signing the form but also that it must be signed by the “first” named insured), and there is some room for argument about whether the signature of any named insured is sufficient, a great deal of litigation may be avoided by ensuring that the form in fact is signed by the named insured whose name appears first on the declarations sheet.

In American International Ins. Co. v. Vaxmonsky, 2006 Pa.Super. 373 (Pa. Super. 2006), the Superior Court voids UIM rejection form which omits the word “all” from statutorily proscribed language. Vaxmonsky signed a UIM rejection form in 1993 and did not pay premiums for UIM coverage for successive policy years. Vaxmonsky was injured in an auto accident in 2001, and American denied the claim, citing the signature on the UIM rejection form. In the subsequent declaratory judgment action, the trial court found the UIM form to be invalid because it did not match the language of section 1731(c) of the MVFRL exactly, thus entitling Vaxmonsky \$400,000 of coverage.

American appealed, arguing that the omission of a single word (“all”) from the phrase “all losses and damages” does not invalidate the rejection if the insuring knowingly waived his right to coverage. American contended that the 1731(c) form is irrelevant to 1731(c.1)'s requirement of specific compliance. The Superior Court rejected this argument and also rejected American's reliance on cases involving declining stacking coverage. The court noted that the Pennsylvania Supreme Court has emphasized that valid rejections of UIM coverage (as opposed to reduction of coverage) must use the specific statutory language. The court held that American made the UIM form more ambiguous, however slightly, by restricting the scope of coverage from “all underinsured losses and damages”, to simply “underinsured losses and damages.” By deleting this “expansive and clarifying” word, American failed to include all of the required statutory language. The court also gave deference to the Insurance Department's own interpretation,

which requires the exact statutory language. The court reached their holding even though Vaxmonsky did not allege unawareness, paid lower premiums, and despite the UIM rejection form stating “NO UNDERINSURED MOTORISTS BODILY INJURY COVERAGE IS PROVIDED BY THIS POLICY.”

F. STACKING

1. What is “stacking”?

“Stacking” means adding up limits of coverage on vehicles. For example, if two (2) vehicles are insured under a policy with UM/UIM limits of \$100,000, stacking the coverage would yield a total limit of \$200,000.

“Inter-policy stacking” occurs when an insured recovers the UM or UIM limit on one policy (e.g., the UM/UIM limit on the policy applicable to the occupied vehicle) plus the limit of coverage under another policy (e.g., a resident relative’s policy). For example, an insured may recover the \$100,000 UIM limit on the occupied vehicle plus a \$50,000 UIM limit on a family member’s vehicle.

“Intra-policy stacking” occurs when more than one vehicle is covered by a particular policy and the insured may be entitled to benefits up to the amount of the sum of the limits on each of those vehicles. For example, if each of three vehicles are covered for \$100,000 UM/UIM, then the coverage may be stacked for an effective limit of \$300,000.

The MVFRL requires that stacking be permitted unless rejected properly. (See below.) However, intra-policy stacking is only required for class one insureds. (The typical policy provides that only named insureds, resident relatives, and minors in their custody, can stack the limits applicable to the vehicles covered by the policy.)

Stacking claims have generated a great deal of litigation. Two of the more important stacking issues concern rejection of stacking and whether and to what extent stacking applies under commercial policies.

2. Rejection of stacking

75 Pa. C.S. §1738, which prescribes the forms to be used for rejection of stacking, provides in pertinent part:

* * * * *

(b) Waiver. . . . *a named insured may waive coverage providing stacking of uninsured or underinsured coverages in which case the limits of coverage available under the policy for an insured shall be the stated limits for the motor vehicle as to which the injured person is an insured.*

(c) More than one vehicle.—*Each named insured purchasing uninsured or underinsured motorist coverage for more than one vehicle under a policy shall be provided the opportunity to waive the stacked limits of coverage and instead purchase coverage as described in subsection (b). The premiums for an insured who exercises such waiver shall be reduced to reflect the different cost of such coverage.*

(d) Forms.—

(1) *The named insured* shall be informed that he may exercise the waiver of the stacked limits of uninsured motorist coverage by signing the following written rejection form:

UNINSURED COVERAGE LIMITS

By signing this waiver, I am rejecting stacked limits of uninsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

.....
Signature of *First Named Insured*

.....
Date

(2) *The named insured* shall be informed that he may exercise the waiver of the stacked limits of underinsured motorist coverage by signing the following written rejection form:

UNDERINSURED COVERAGE LIMITS

By signing this waiver, I am rejecting stacked limits of underinsured motorist coverage under the policy for myself and members of my household under which the limits of coverage available would be the sum of limits for each motor vehicle insured under the policy. Instead, the limits of coverage that I am purchasing shall be reduced to the limits stated in the policy. I knowingly and voluntarily reject the stacked limits of coverage. I understand that my premiums will be reduced if I reject this coverage.

.....
Signature of *First Named Insured*

.....
Date

(e) Signature and date.—The forms described in subsection (d) must be signed by the *first named insured* and dated to be valid. Any rejection form that does not comply with this section is void.

According to the statute, the exact language must be used. The forms must be signed by the first named insured and dated. Again, the statute is inconsistent as to whether “a” named insured, or “each” named insured, or “the” named insured, or only “the first named insured” can reject stacking by signing the form; but litigation can be avoided by ensuring that it is signed by the “first” named insured.

Unlike the section of the MVFRL that deals with complete rejection of UM/UIM coverage, this section does not specify that the rejection of stacking forms must be printed “on separate sheets and in prominent type and location.” Although some courts have suggested that any deviation from the statutory forms renders them invalid, some deviations are tolerated, as discussed below.

A rejection of stacking, when executed in connection with a single-vehicle policy, applies to both intra-policy stacking (stacking of coverage on vehicles insured under the same policy) and inter-policy stacking (if the policy limits such stacking). In regard to inter-policy stacking, the typical non-stacked policy provides that, at the second level of priority (i.e. where the claim is made not by virtue of occupancy on the covered vehicle but rather based on the claimant’s status as a named insured or family member), the maximum amount recoverable is the amount by which the highest limit on any one vehicle at the second priority exceeds the limit at the first priority. Such non-stacking provisions are valid. Generette v. Donegal Mut. Ins. Co., 884 A.2d 266 (Pa. Super. 2005) (other insurance provision valid, even if it reduced limit to zero).

However, in Craley v. State Farm Fire & Casualty Company, No. 162 MAP 2004, 2006 Pa. LEXIS 540 (Pa. 2006), the Pennsylvania Supreme Court, while confirming the validity of a rejection of stacking form in an inter-policy stacking case, when the form was executed in connection with a single vehicle policy, suggested that the standard statutory rejection form may not be effective to waive inter-policy stacking in connection with a multi-vehicle policy.

Craley and Generette do put to rest the notion, which had been adopted by several courts, that an insured could not waive stacking at all if the policy covered only one vehicle at the time the form was executed.

In Sackett v. Nationwide Mutual Insurance Company, No. 8 WAP 2006, 2007 Pa. LEXIS 835 (April 17, 2007), the Pennsylvania Supreme Court holds that insureds are entitled to stack the UM/UIM coverages on all vehicles, despite an otherwise valid rejection of stacking, if the first named insured did not sign a new rejection form upon the addition of vehicles that increases the number of vehicles under the policy.

Victor Sackett obtained an insurance policy from Nationwide on his two vehicles. He executed a proper UM/UIM rejection of stacking form. Two years later, he acquired a third vehicle, which was added to the policy. He did not request any other changes in his policy. Ten days later, he was injured in a motor vehicle accident. Nationwide paid the \$100,000 UIM limit. Sackett asserted that he was entitled to stack coverage (for an additional \$200,000), because he did not execute another rejection of stacking when the third vehicle was added. The trial court and the Superior Court ruled in favor of Nationwide, holding that a valid rejection of stacking remained effective after additional vehicles were added to the policy.

The Supreme Court reversed the Superior Court’s ruling, on the grounds that a new rejection of stacking must be executed whenever the number of vehicles insured under a policy is increased. Furthermore, the Supreme Court held that, where no new rejection of stacking form is executed, the insured is entitled to stack coverage on all vehicles insured under the

policy, including vehicles that were covered under the policy when the old rejection of stacking was executed.

This shocking decision—which is certain to result in payment of millions of dollars of benefits for stacked coverage that was rejected, and a corresponding increase in the cost of insurance—not only requires insurers to obtain new rejection of stacking forms in the future, but it also means that insureds will have the right to stacked coverage on all existing non-stacked policies on which the number of vehicles increased at any time since 1990. Furthermore, it raises other difficult issues for underwriters and claims personnel. It does not address “newly acquired” vehicles, which of course increase the number of vehicles and which are automatically covered under many policies for a certain period of time even without notice to the insurer. Moreover, although the Court, at least in non-binding dicta, indicates that new forms are not required if UM/UIM coverage had been rejected entirely, it leaves open the question of whether a selection of UM/UIM limits, lower than the liability limits, remains valid after the number of vehicles covered under a policy is increased.

This decision has the potential to have an enormous impact on claims. Consider the following common scenario. John Doe, trading as Doe Electric, obtains auto coverage for his 2 vehicles, some 15 years ago, and executes proper forms to select liability limits of \$500,000, and UM/UIM limits of \$35,000, and to reject stacking. Over the years, as his business prospers, he adds 4 more vehicles, but no new forms are executed. As a result of Sackett, he is now entitled to at least \$210,000 (\$35,000 X 6) in UM/UIM coverage, and perhaps as much as \$3,000,000 (\$500,000 X 6), depending on how the courts rule on the selection of limits issue. In light of such potential consequences, insurers are well-advised to implement carefully-planned agency and underwriting procedures to deal with the addition of vehicles in the future (such as: issuing separate policies or obtaining new selection and rejection forms; “defaulting” policies to maximum coverage and charging adequate premiums in the event forms are not executed promptly; and eliminating or carefully restricting newly acquired auto coverage). Insurers also should implement a remedial program to identify and obtain proper forms for existing policies where the number of vehicles have increased since their inception.

The decision is shocking, in part, because it is contrary to the pertinent statutory provisions, prior case law and common sense. The Court disregards the statutory provision, that if proper notice of available coverages is provided at the time of the original application, “no other . . . rejection shall be required” (75 Pa.C.S. §1791), and based its decision primarily on two concepts which are, to say the least, of questionable validity: (1) when an insured increases the number of vehicles by adding a vehicle to the policy, he is “purchasing” coverage, and the statute provides that each insured “purchasing uninsured or underinsured motorist coverage” shall be provided the opportunity to waive stacked coverage; and (2) an insured cannot knowingly reject the right to coverage up to the “sum” of the limits (i.e. stacking) until that sum is known. By that same logic, one should expect insureds’ attorneys to argue in the future that, in cases where a policy has valid “lower” limits of UM/UIM coverage, the addition of a vehicle involves “issuance of coverages,” so insureds are entitled to UM/UIM limits equal to their liability limits, in the absence of a new, written request for “the issuance of coverages . . . less than the limits of liability.” 75 Pa. C.S. §1734 (relating to request for lower limits).

On June 27, 2007, the Supreme Court of Pennsylvania, on the Court’s own initiative, issued an order inviting the Insurance Commissioner to submit an amicus curiae (“friend of the court”) brief regarding whether the Court should reconsider the recent decision in Sackett v. Nationwide. That unusual development is a strong sign that the Court will reconsider the Court’s prior decision—an extremely rare procedural step.

On April 30, 2007, Nationwide applied for reargument, basically on the grounds that the Court was mistaken or uninformed as to the enormous impact of the decision. Reargument of a Supreme Court decision is rarely granted—reportedly, it has been allowed only a handful of times throughout the Court’s 285 year history. PDI, the Insurance Federation and PaTLA have asked the Court for permission to file briefs. The recent order inviting the insurance Commissioner to file a brief is, at the least, an indication that the Court is giving serious consideration to reconsideration—at best it is an indication that the Court will give the issue a fresh look, in light of better information, as to its impact.

3. Commercial stacking

The extent to which stacking is permitted or required under commercial or business policies is unsettled. In Lastooka v. Aetna Ins. Co., 552 A.2d 254 (1988), the court held that the claimant could stack personal use vehicles on a business auto policy but not “the corporate fleet vehicles.” However, in Groff v. Continental Ins. Co., 741 F. Supp. 541 (Ed. Pa. 1990) and Werkman v. Erie Ins. Exch., 629 A.2d 1042 (1993), the courts suggested that stacking of business vehicles is permitted, particularly if the policy makes no distinction between personal use and business use vehicles. Some insurers are addressing this issue by providing clearly in their policies that stacking is not permitted with respect to business use vehicles.

In Transguard Ins. Co. of Am., Inc. ,v. Hinchey, 433 F.Supp.2d 450 (M.D.Pa. 2006), the plaintiff insurer sought declaratory judgment against defendants, a corporate officer and his spouse, providing that defendants were not entitled to stack underinsured motorist (UIM) policies pursuant to 75 Pa. C.S. § 1738 and not entitled to underinsured motorist benefits equal to the \$1,000,000 dollar liability limits pursuant to 75 Pa. C.S. § 1734. The parties filed cross-motions for summary judgment under Fed. R. Civ. P. 56. The officer was involved in an automobile accident while he was driving a corporate vehicle. The officer notified the insurer that he intended to pursue an UIM motorist claim. The court found that the defendants were entitled to summary judgment on the issue of stacking the UIM fleet policy under 75 Pa. C.S. § 1738. The officer was driving a covered vehicle at the time of the accident; the corporation was the named insured; and defendants were the named individuals on the first party benefits endorsement. Thus, the reasonable expectation of the insurer and the corporation was that defendants were covered while using a covered vehicle. However, the court found that summary judgment was inappropriate on the issue of UIM benefits under 75 Pa. C.S. § 1734. Defendants claimed that they were entitled to UIM benefits equal to the policy’s limit. The insurer argued that an insurance agent was the corporation’s agent who requested lower limits of UIM coverage, and defendants argued that the request for lower limits had to be from the named insured, not an agent. A hearing was required to determine the effect of the agency issue on the UIM benefits. The court denied the insurer’s motion for summary judgment. The court granted defendants’ motion for summary judgment on the issue of stacking but denied it on the issue of UIM benefits.

G. DEFECTIVE FORMS: FORGERIES AND DEVIATIONS FROM STATUTORY REJECTION FORMS

On rare occasions, insurers produce signed forms but claimants contend the signature is forged. A federal court has held that the burden is on the claimant to prove the forgery “by clear, direct, precise and convincing evidence.” Jackson v. Allstate Ins. Co., No. 05-CV-1480 (E.D. Pa. July 12, 2006), slip op. at 6 (*quoting* Carlson v. Sherwood, 206 A.2d 19, 20 (Pa. 1965)).

As noted above, although some courts have held that any deviation from the statutory rejection forms renders the form invalid, in fact some deviations are tolerated. Putting aside the issue of whether there is any “rhyme or reason” to the statutory requirements and Court rulings, it appears that the rules that have evolved to date may be summarized fairly as follows:

1. A rejection of UM coverage cannot be on the same page as a rejection of UIM coverage, but other selections and additional language (such as rejections of stacking) can be on the same page with a rejection of coverage (see, e.g., Quattlebaum, *supra*).

2. Rejections are invalid if they omit any of the language set forth in the form as required by statute, but the inclusion of *additional* language may be acceptable, especially if it improves the form.

In Allstate v. Seelye, 846 A.2d 1286 (Pa. Super. 2004), *appeal denied*, the Superior Court held that a rejection of UM stacking form was valid even though it was entitled “REJECTION OF STACKED UNINSURED COVERAGE LIMITS,” rather than simply “UNINSURED COVERAGE LIMITS” as the statutory form is entitled. The Court reasoned that Allstate’s form “merely adds three words, and those words actually make clearer that the named insured is rejecting stacked benefits,” and the Insurance Department, which had published an identical form, should be afforded deference in the matter. In Vosk v. Encompass, 851 A.2d 162 (Pa. Super. 2004), the Superior Court applied the same holding to an UIM rejection form.²

In Unitrin Auto & Home Ins. Co. v. Hester, 2005 U.S. Dist. LEXIS 21870 (M.D. Pa., Sept. 22, 2005), the Court followed Seelye and Vosk in upholding a rejection of UIM coverage form that added “clarifying” language to the text of the statutory form. However, the Court also offered the following good advice:

Although we find for [Unitrin] today, we take pause to mention that we believe the better practice for [Unitrin] and its fellow insurance companies is *not* to supplement the required language of § 1731. Efforts to achieve clarity regarding UIM waivers are better suited perhaps in the form of a cover letter or in a dialogue between the insured and an insurance carrier representative. Surely by utilizing only the exact language provided for in the statute, [Unitrin] and other insurance carriers doing business in Pennsylvania will reduce their exposure to future litigation on this issue.

Deviations in the nature of *omissions* of statutory language probably do render the form void. For example, in Scott v. Continental, 65 Pa. D.&C. 4th 24 (Lycoming C.P. 2004), the Court refused to dismiss plaintiff’s complaint that Continental’s rejection form was invalid because it omitted the following bracketed language from the statutory form:

² In Vosk, the Superior Court also indicated its agreement with the trial court that the statutory provision that “[a] rejection form that does not comply with this section is void” applies not to the substance of the form but only with respect to the requirement that it be signed by the first named insured. However, it is doubtful that other courts will notice or follow that rather cavalier suggestion.

By signing this waiver I am rejecting underinsured motorist coverage under this policy, for myself and all relatives residing in my household [. Underinsured motorist coverage protects me and relatives living in my household] for losses and damages suffered if injury is caused by the negligence of a driver who does not have enough insurance to pay for all losses and damages.

Therefore, it appears that courts remain willing to deem forms invalid if they omit language from the statutory forms, regardless of whether the omission changes the clear meaning and import of the form.

H. POLICY CHANGES AND NEED FOR NEW FORMS

The law is somewhat unsettled as to whether new selection and rejection forms must be executed when certain policy changes are made. Issues that arise include:

1. whether rejections of UM/UIM and rejections of stacking of UM/UIM remain in effect when policy changes are made;
2. if there was no prior request for lower limits, whether UM/UIM limits will automatically equal liability limits when liability limits are raised; and
3. in cases subject to federal jurisdiction, whether a valid request for lower limits remains in effect even if liability limits are subsequently changed, but, in state court cases, the old request may be invalid, depending on the form used to change limits.

In Smith v. Hartford, 849 A.2d 277 (Pa. Super. 2004), *appeal denied*, 867 A.2d 524 (Pa. 2005), the Superior Court held that a rejection of UM/UIM coverage remained effective after the policy was changed to increase liability limits.

In Generette v. Donegal, 884 A.2d 266 (Pa. Super. 2005), the Superior Court, *en banc*, held that a rejection of stacking, executed when the policy covered only one vehicle, is valid and precludes or limits interpolicy stacking.

In Sackett v. Nationwide, 880 A.2d 1243 (Pa. Super. 2005), the Court held that a new rejection of stacking form is not required when vehicles are added to the policy. (In that case, there were two covered vehicles when the rejection was signed and a third vehicle was added later.)

In Rupert v. Liberty Mutual, 291 F.3d 243 (3d Cir. 2002), a federal Court of Appeals held that a rejection of stacking executed by the first named insured remains valid even after a different person becomes the named insured.

In Cebula v. Royal & SunAlliance Ins. Co., 158 F. Supp. 2d 455 (M.D. Pa. 2001), a federal trial court held that if there was no prior or subsequent written request for lower limits, then UM/UIM limits increase automatically to equal liability limits when those liability limits are raised.

In Nationwide Mut. Ins. Co. v. Buffetta, 230 F.3d 634 (3d Cir. 2000), the United States Court of Appeals for the Third Circuit held that an election of lower limits by a named insured is

effective with respect to someone who subsequently becomes a named insured but who never elected lower limits herself. While the decision is specifically limited to the particular facts of that case (claimant was insured as the spouse of the named insured from the inception of the policy and subsequently “took over” the policy after divorce), it suggests that new election forms are not required after the initial application (e.g., where someone is added as a named insured after marriage).

In a very well-reasoned opinion, Nationwide v. Merdjanian, 2005 U.S. Dist. LEXIS 3493 (E.D. Pa., Mar. 4, 2005), a federal trial court held that, where the named insured elected lower UM/UIM limits than liability limits, that election remained effective even after the liability limits were changed (increased) subsequently. The federal court disagreed specifically with the Superior Court panel decision in Blood v. Old Guard Insurance Company.

But in Blood v. Old Guard Insurance Company, 2006 Pa. Super. 44 (March 2, 2006), Superior Court *en banc* held that where the insured changes liability limits, a prior request for lower UM/UIM limits is no longer effective, if the insurer used a change form which also allows insureds to select lower UM/UIM limits but insured leaves that section blank. The Old Guard policy issued to the Bloods provided for \$500,000, in liability coverage and \$35,000, in UM/UIM coverage, in accordance with a valid request for UM/UIM limits lower than liability limits. The Bloods requested a *reduction* in liability limits from \$500,000, to \$300,000, among other changes. The form used for requesting the reduction in liability limits included a section of options for selection of limits of UM/UIM coverage, which was left blank. A panel of the Superior Court held that the prior request for lower limits was ineffective. The Superior Court *en banc* agreed. Therefore, the effective limit of UIM coverage would be \$900,000, rather than \$105,000.

The Blood decision further complicates the handling of policy changes. The Plaintiff’s Bar will argue that this case stands for the proposition that whenever there are changes to a policy, especially changes in liability limits, prior requests for lower limits are rendered invalid. But that is too broad a reading. Rather, the decision is fact specific and turned on the method and form used by the insurer. Indeed, the Superior Court suggested the following ways in which insurers could avoid the sort of consequences (\$795,000, increase in limits) suffered by Old Guard in Blood: use a form dedicated solely to modification of the coverage to be changed (e.g., liability limits); include a statement in the form that only completed sections will have effect on the policy; and/or have the agents cross off inapplicable sections of the form (presumably, *before* the form is signed).

In light of all that, in regard to future practices with respect to changes, the methods suggested by the Superior Court may be sufficient, but the safest course of action would be to equalize liability and UM/UIM limits automatically (together with appropriate premium changes) whenever liability limits are changed—unless the insured specifically indicates on a form or other writing that the insured requests lower UM/UIM limits. As to fact scenarios similar to Blood, the best course of action will depend on whether there is federal jurisdiction or not. In cases subject to federal jurisdiction, insurers should take the position that prior requests remain valid. (Usually, there will be federal jurisdiction where there is more than \$75,000, at stake and the parties are “citizens” of different states (typically, where the claimant lives in Pennsylvania and the insurer is incorporated and has its principal place of business outside of Pennsylvania)). Other insurers should not take that position, unless they are ready, willing and able to appeal all the way to the Supreme Court of Pennsylvania.

In Nationwide Mut. Ins. Co. v. Merdjanian, 2006 U.S. App. LEXIS (3d Cir. 2006), the Third Circuit Court of Appeals holds that an insurer need not obtain from its insured a new

signed reduction of benefits form for UM/UIM benefits when there are subsequent changes to the policy -- namely, an increase in bodily injury liability limits.

The insured purchased a personal automobile insurance policy from Nationwide in 1990. The policy provided bodily injury liability limits of \$25,000/\$50,000. During the application process, the insured signed a form, in which he selected UM/UIM coverage in the amount of \$15,000/\$30,000. Eight years later, the insured increased his bodily injury liability coverage from \$25,000/\$50,000 to \$100,000/\$300,000. The insured did not change the amount of his UM/UIM coverage at that time, although he was given the opportunity to do so. The insured's wife was killed, and his two sons injured, when an uninsured motorist struck one of the vehicles covered under the Nationwide policy. The insured and his two sons made a claim to Nationwide for UM benefits, claiming that the amount of UM/UIM benefits available under the policy was \$100,000/\$300,000 (stacked times 3 vehicles). Nationwide disagreed and commenced a declaratory judgment action against the insured. Both parties moved for summary judgment. The District Court granted summary judgment in favor of Nationwide, holding that the UM/UIM coverage under the policy was limited to \$15,000/\$30,000 (stacked). The insured took an appeal.

On appeal, the insured argued that while he signed a reduction of coverage form for UM/UIM benefits at the inception of the policy, his subsequent alteration of the policy, whereby he increased his bodily injury liability coverage to \$100,000/\$300,000, triggered an obligation on the part of Nationwide to obtain a new signed confirmation that he wished to continue to have UM/UIM benefits lower than his bodily injury liability limit. Citing the minimal requirements of Section 1734 (relating to selections of lower limits) and other pertinent provisions of the Motor Vehicle Financial Responsibility Law (MVFRL), the Court ruled that, "[n]othing in the statute requires an insurer to obtain a new writing under 1734 each time an insured chooses to increase liability coverage or otherwise alter the policy." Importantly, the Court held further that even if new forms were required, when there are subsequent changes to the policy, the MVFRL contains no penalty (or remedy) for violation of 1734's requirement that requests for reduction be in writing. For these reasons, the decision of the District Court was affirmed.

I. EXHAUSTION

Although most policies provide that an insured must "exhaust" or recover the limits of all available liability coverage, before he is eligible for UIM benefits, such provisions have been held invalid in two major respects. First, they have been held invalid in regard to non-motor vehicle tortfeasors. Kester v. Erie Ins. Exch., 582 A.2d 17 (1990), *appeal denied*, 527 Pa. 624, 592 A.2d 45 (1991) (exhaustion requirement is invalid as to a claim against PennDOT for negligent maintenance of a highway). Second, it has been held that the claimant does not have to actually recover the motor vehicle tortfeasor's full liability limits; rather, he may proceed with a UIM claim even if he has not recovered the full limits, but he must give the UIM carrier credit for the full amount of the available limits of liability coverage. Boyle v. Erie Ins. Co., 656 A.2d 941 (1995), *appeal denied*, 668 A.2d 1120 (1995); Harper v. Washington Ins. Co., 753 A.2d 282 (Pa. Superior Ct. 2000). As an example, if a tortfeasor has \$100,000 in liability coverage, the claimant does not have to actually recover those limits but he can only recover UIM benefits to the extent that his damages are determined to be in excess of \$100,000.

Of course, the practice of allowing claimants to proceed with UIM claims prior to resolution of the third-party liability claim(s) is rife with potential problems, including the risk of inconsistent adjudications. Indeed, that risk materialized in Krakower v. Nationwide Mut. Ins. Co., 790 A.2d 1039 (Pa. Super. 2001), where arbitrators rendered an award in favor of claimants in a UIM claim but a jury subsequently reached a verdict in favor of the alleged

tortfeasor. Incredibly, a Superior Court panel held that such a result was acceptable and necessary to further the goal of expedient resolution of UIM claims. However, as discussed below, the Superior Court has held that exhaustion of primary UM/UIM coverage may be required before excess UM/UIM coverage is available.

J. WORKERS' COMPENSATION

Generally, the Workers' Compensation Act provides that a workers' compensation claim is an employee's exclusive remedy against an employer for injuries sustained while working. 77 P.S. § 481(a). That is, the employer is "immune from suit." Furthermore, an employee is immune from liability in regard to injuries to co-workers, except for intentional wrongs. 77 P.S. § 72 (liability of fellow employee). Generally, an employee is allowed to recover UM/UIM benefits if injured while working, even under a policy issued to the employer. City of Meadville v. WCAB (Kightlinger), 810 A.2d 703 (Pa. Cmwlth. 2002), *appeal denied*, 852 A.2d 313 (Pa. 2004). Generally, an entity that is self-insured must provide UM benefits (though not UIM benefits) up to \$15,000/\$30,000. 75 Pa. C.S. § 1787 (self-insurance). However, an employee is not entitled to UM benefits from his employer, if his employer is self-insured for that coverage under the MVFRL. Hackenberg v. Southeastern Pennsylvania Transportation Authority, 586 A.2d 879 (Pa. 1991); Safe Auto v. School Dist. of Phila., 872 A.2d 247 (Pa. Cmwlth. 2005).

A workers' compensation carrier has no subrogation lien against an employee's UM/UIM recovery under the employee's own motor vehicle insurance policy; but there is a lien against an employee's UM/UIM recovery under an employer's policy or a policy issued to an unrelated third party. American Red Cross v. WSAB (Romano), 745 A.2d 78 (Pa. Commw. 2000) (no WC subrogation against recovery under employee's own UM policy), *aff'd per curiam*, 766 A.2d 328 (Pa. 2001); City of Meadville v. WCAB (Kightlinger), *supra* (WC carrier can subrogate against UM/UIM claim under employer's policy); Schwaab v. WCAB (Schmidt Baking Co.), 832 A.2d 1164 (Pa. Commw. Ct. 2003) (valid WC subrogation lien against UM recovery under employer's policy); Hannigan v. WCAB (O'Brien Ultra Service Station), 860 A.2d 632 (Pa. Commw. Ct. 2004) (WC carrier can subrogate against UM claim under third party's policy on occupied car). It remains to be seen whether a WC carrier can subrogate against a policy purchased by the employee's resident relative ("family member").

It is unsettled whether an employee has a right to recover UM/UIM benefits where the accident was caused by a co-employee. State courts have held or suggested that the employee has no right to such benefits, because he is not legally entitled to recover damages from the (uninsured or underinsured) co-employee (who is immune from suit). Love v. Nationwide Mutual Ins. Co., 42 Pa. D&C 4th 394 (Cambria C.P., 1999); see also Gardner v. Erie Ins. Co., 772 A.2d 1041, 1047 (Pa. 1999) (*dicta*, noting that many jurisdictions preclude UM/UIM benefits where tortfeasor is immune). But some federal trial courts have held to the contrary. Holland v. GEICO, 2001 U.S. Dist. LEXIS 24194 (E.D. Pa., Dec. 5, 2001), *aff'd per curiam*, 62 Fed. Appx. 415 (2002).³

K. SUBROGATION/CONSENT TO SETTLE

A typical UM/UIM coverage form provides that the UM/UIM carrier has subrogation rights against the uninsured or underinsured driver—that all the claimant's rights against the tortfeasor are transferred to the UM/UIM carrier when UM/UIM payments are made—and that, therefore,

³ In Nationwide v. Chiao, 374 F.Supp.2d 432 (M.D. Pa. 2005), the trial court held that a co-employee could recover UM/UIM, but a panel of the Court of Appeals reversed, 2-1, in a non-precedential opinion. Nationwide v. Chiao, No. 05-3488 (3d Cir., June 29, 2006).

the claimant cannot settle with the tortfeasor and thereby extinguish those rights without the carrier's consent.

1. Insurer must show "prejudice"

Unfortunately, the Pennsylvania Supreme Court has declined, so far, to answer the question of whether an insurer must prove "prejudice" in order to deny a claim based on lack of consent. On May 10, 2001, the Pennsylvania Supreme Court changed its mind and refused to hear the appeal in Nationwide Mut. Ins. Co. v. Lehman, 743 A.2d 933 (Pa. Super. 1999), *reargument denied* (Jan. 26, 2000), *appeal granted*, 2000 Pa. LEXIS 2032 (Pa., Aug. 22, 2000), *appeal dismissed as improvidently granted*, 772 A.2d 413 (Pa. 2001), where a three (3) judge panel of the Superior Court held that an insurer cannot deny UM/UIM benefits based on the claimant's settlement/release of the tortfeasor without the insurer's consent, unless the insurer can demonstrate that "its interests were actually prejudiced by the settlement." The panel suggested that an insurer is not prejudiced if the circumstances "render subrogation impracticable," summarily dismissing the insurer's argument that even if the tortfeasor was presently insolvent, she had sufficient earning capacity to satisfy a judgment against her. Unfortunately, the panel gave little or no guidance as to how to determine whether subrogation was "impracticable" or whether the insurer was "actually prejudiced." Moreover, since the Superior Court refused rehearing *en banc*, and the Supreme Court decided not to hear the appeal, there was no further review of the panel's decision, an opinion which is contrary to the long-standing common law rule that preservation of subrogation rights is a *quid pro quo* for entitlement to benefits.

In Cerankowski v. State Farm Mut. Auto. Ins. Co., 783 A.2d 343, 348 (Pa. Super. 2001), *app. denied*, 2002 Pa. LEXIS 364 (Pa., Mar. 4, 2002), a different Superior Court panel, following Lehman, also held that "an insurer must demonstrate prejudice before it can invoke a 'consent to settle' clause to prevent its payment of underinsured motorist coverage. . . ."

Although there is still some authority for the proposition that an insurer is not required to prove that it was actually prejudiced where its subrogation rights are impaired by a settlement without its consent,⁴ Lehman and Cerankowski suggest a strong trend against enforcement of consent to settle provisions in the absence of proof of actual prejudice.

In a recent case, American States Insurance Co. v. Braheem, 2007 Pa.Super. 23 (Pa.Super. 2007), the Superior Court holds that UIM insurer must demonstrate actual prejudice related to destruction of subrogation rights against non-automobile tortfeasors to preclude or limit recovery. After Michael Braheem died in a single vehicle accident, his Estate brought claims against the driver of the vehicle and also made claim to Braheem's own insurer for UIM benefits. After collecting the full limits of coverage from both policies and after the passage of two years, the Estate brought a claim for \$900,000 in UIM benefits from another applicable policy. Both Braheem and the vehicle driver were intoxicated at the time of the accident. By the time notice of a claim was received by American States, the statute of limitations had run on its potential right of subrogation against two dram shops.

In summary judgment proceedings, the trial court ruled in favor of American States holding that the failure to give notice of claims and settlement, regardless of prejudice to the insurer, barred the UIM claim. The Estate appealed.

⁴ See, e.g., Fisher v. USAA Casualty Ins. Co., 973 F.2d 1103 (3d Cir. 1992).

The Superior Court reversed. The main issue on appeal concerned the two dram shop claims, how prejudice could be proven and how an arbitration panel should proceed. This Opinion requires the UIM insurer to prove not only that a subrogation claim existed against a viable, financially responsible target, but also, the insurer must prove in arbitration (if such a provision exists in the policy) that the subrogation target has sufficient resources to satisfy the entire UIM claim. The arbitration panel is charged with the task of determining the merit and value of the subrogation claim and the total value of the UIM claim. The panel is then to reduce the UIM claim by the value of the lost subrogation claim. If the UIM claim has greater value than the subrogation claim or the resources available to the subrogation target, the UIM claimant collects the difference.

2. There is no “30 day rule”

It practically has become gospel among lawyers and insurers that when a UIM demand is made, then the insurer has thirty (30) days to either consent to settlement with the tortfeasor or else it must “front” the underlying limits in order to preserve its subrogation rights, based on a misunderstanding of Daley-Sand v. West Am. Ins. Co., 564 A.2d 965 (Pa. Super. 1989). In Nationwide v. Lehman, *supra*, a Superior Court panel recognized that that is not a rule of law at all. Rather, an insurer is allowed a reasonable time to make this determination. In Daley-Sand, the Superior Court held merely that, where the insurer had already had over eighteen (18) months to make its decision, the trial court was justified in allowing it only thirty (30) more days to take action.

3. No prejudice required where insured fails to get excess UM/UIM insurer’s consent to settle with primary UM/UIM insurer for less than primary limits

In Nationwide Ins. Co. v. Schneider, 2005 Pa. Super. 325 (Pa. Super. 2005), the Superior Court held that where an UIM claimant settles for less than the policy limit of a first-in-priority UIM policy, a policy requirement in a secondary policy requiring exhaustion will be given effect to deny coverage.

Schneider, a police officer, was rear-ended while driving a police car, insured by Granite. He obtained the \$15,000 tortfeasor limit, and settled his UIM claim under the Granite policy for \$750,000 out of the \$1 million limit. He then submitted an UIM claim to Nationwide, his personal insurer. Nationwide denied coverage, and filed a declaratory judgment action, and the trial court agreed that there was no coverage. Schneider appealed.

Despite the offer of a credit by Schneider of \$1,015,000, the Superior Court upheld a Nationwide exhaustion provision stating that “no payment will be made until the limits of all other auto liability insurance and bonds that apply have been exhausted by payments.” Prior cases held that liability coverage does not have to be exhausted if the UIM carrier is given “credit” for the full liability limit. Such a structure protects both the insurer from the “gap” created from low settlements and the insured from a delay in the receipt of actual benefits. However, the Superior Court held here that those concerns were not applicable in Schneider, as the primary-excess matrix is different, and direct benefits are not unjustifiably withheld.

L. PRIORITIES AND CONTRIBUTION

In many UM/UIM cases, there will be multiple policies which apply or arguably apply. Section 1733 of the MVFRL deals with the issue of priority of recovery. It provides as follows:

§ 1733. Priority of recovery.

(a) General rule – Where multiple policies apply, payment shall be made in the following order of priority:

(1) A policy covering a motor vehicle occupied by the injured person at the time of the accident.

(2) A policy covering a motor vehicle not involved in the accident with respect to which the injured person is an insured.

(b) Multiple sources of equal priority – The insurer against whom a claim is asserted first under the priorities set forth in Subsection (a) shall process and pay the claim as if wholly responsible. The insurer is thereafter entitled to recover contribution pro rata from any other insurer for benefits paid and the costs of processing the claim.

In situations where there are multiple sources of equal priority, subsection (b) of section 1733 comes into play. This subsection requires that the carrier against whom a claim is first asserted shall process and “pay the claim as if wholly responsible.” The apparent reason for the inclusion of this language is to speed the payment of claims and simplify the claims process for the insured.

But what happens if that insurer’s limits are insufficient to cover the claim? Must the carrier pay more than its limits of liability and then proceed against the other carrier for *pro rata* contribution? That is but one example of many potential issues that are not addressed clearly by the statute and have not been answered by our courts.

Note that the policy may limit the amount that can be recovered in the event that more than one policy applies. (See the discussion of “stacking” above.)

M. COMMON EXCLUSIONS AND SET OFFS

The most common exclusions and set-offs relating to UM/UIM coverage are discussed below.

1. Family car/household/owned auto/regular use

A typical policy excludes UM/UIM coverage for injuries sustained while occupying or when struck by a vehicle which is owned by or available for the regular use of the claimant or his resident relatives, if that vehicle is not insured under that policy. Such provisions are commonly referred to as the family car, household, other owned auto or regular use exclusions. Such exclusions have been upheld by most courts in most circumstances, but their validity is still challenged in certain circumstances.

When applied to a claimant who actually owned the vehicle he occupied when injured, this type of exclusion has been upheld by every federal court and every state appellate court that has considered it. *See, for examples, Eichelman v. Nationwide Ins.*, 711 A.2d 1006 (Pa. 1998) (exclusion upheld where claimant sought UIM benefits under parent’s policy when injured while using his own vehicle for which he had waived UIM coverage); Royal Ins. Co. of Am. v.

Beauchamp, 2002 U.S. Dist. LEXIS 7239 (E.D. Pa., April 25, 2002) (exclusion upheld where claimant injured using own vehicle, which was insured for UIM, and sought additional coverage under relative's policy); Rudloff v. Nationwide Mut. Ins. Co., 806 A.2d 1270 (Pa. Super. 2002), *app. den.*, 818 A.2d 505 (Pa. 2003) (same); Old Guard Ins. Co. v. Houck, 801 A.2d 559 (Pa. Super. 2002), *app. den.*, 818 A.2d 505 (Pa. 2003) (exclusion upheld where claimant injured on own motorcycle which she insured (including UM/UIM) under a different policy).

In Alderson v. Nationwide Mut. Ins. Co., 2005 Pa. Super. LEXIS 3448 (Pa. Super., Sept. 19, 2005), the Superior Court held that where plaintiff was injured while operating his motorcycle, insured by Nationwide, he could not collect UIM benefits under other Nationwide policies covering other household vehicles. The Court rejected the insured's argument that the household vehicle exclusion was invalid in that case on the grounds that Nationwide had full knowledge of the motorcycle. (Plaintiffs have argued in many cases—focusing on language from several appellate opinions—that the exclusion is valid only as it applies to risks “unknown” to the insurer.)

For a considerable period of time, it appeared that all appellate decisions could be reconciled on the following grounds: if the claimant himself selected the coverage that preceded the potential UM/UIM coverage, then the exclusion is valid (e.g., Eichelman); but if the claimant had no control over that preceding coverage, then the exclusion cannot be enforced (e.g., Prudential v. Gisler, 764 A.2d 1111 (Pa. Super. 2000), *appeal denied*, 782 A.2d 548 (Pa. 2001) (officer in police car)). (A minority of state trial courts, however, had invalidated the provision even as applied to the owner of the occupied vehicle. Prudential v. O'Donnell, 52 Pa. D.&C.4th 117 (Phila. C.P. 2001); Nationwide v. Catalfu, 47 Pa. D.&C. 4th 282 (Erie C.P. 2000).)

But in Burstein v. Prudential Prop. & Cas. Ins. Co., 801 A.2d 516 (Pa. 2002), the Pennsylvania Supreme Court held a “regular use” exclusion valid, even though the insured did not own the vehicle or select the coverage on it. In that case, the Bursteins were injured in a company car provided to Mrs. Burstein by her employer. Unbeknownst to Mrs. Burstein, the employer had rejected UM/UIM coverage. The insurer of the Bursteins' own vehicles denied their UIM claim based on an UM/UIM exclusion for bodily injury sustained while occupying any vehicle “regularly used” by the named insured or resident relative. The Supreme Court held that exclusion valid, rejecting arguments that it violated public policy. In the course of the opinion, the Court also rejected the argument that Mrs. Burstein had no choice regarding coverage, indicating that her choices were: (1) take her chances; (2) arrange for adequate UM/UIM coverage on the company car; or (3) refuse the company car. The Burstein decision seems so broad that it is difficult to conceive of a situation where those exclusions would not be valid. Even Gisler, *supra*, where the exclusion was held invalid as applied to an officer riding in his police cruiser, seems to have been decided wrongly, in light of Burstein.

Finally, in Prudential v. Colbert, 813 A.2d 747 (Pa. 2002), in response to a question certified by the United States Court of Appeals for the Third Circuit, the state Supreme Court held squarely that household exclusions are generally valid. (However, the plaintiffs' bar, as expected, continues to challenge household exclusions frequently, arguing that each case must be decided in its unique factual context.)

2. Government vehicle

Most policies exclude UIM coverage for injuries caused by a vehicle owned by the government. Such an exclusion is based on the concept that the amount of damages recoverable in such a case are limited by statute, not by liability insurance limits. However, the state Supreme Court has held that the government vehicle exclusion is invalid, because it

conflicts with the MVFRL's definition of an underinsured motor vehicle. Kmonk-Sullivan v. State Farm Mut. Auto. Ins. Co., 788 A.2d 955 (Pa. 2001).

3. Nonpermissive user

Most policies exclude coverage for persons using a vehicle without permission. This exclusion applies not only to the driver but also to passengers. It has been upheld consistently. Nationwide Mutual Ins. Co. v. Cummings, 652 A.2d 1338 (1994), *appeal denied*, 540 Pa. 650, 659 A.2d 988 (1995); Allstate Ins. Co. v. Davis, 977 F.Supp. 705 (E.D. Pa. 1997); Gift v. Nationwide Ins. Co., 1998 U.S. Dist. LEXIS 4563 (E.D. April 9, 1998).

The wording of this exclusion may be important. Some exclusions deny coverage for persons using the vehicle without the actual permission of the owner. In such cases, coverage may be denied even if the claimant did not know that permission was lacking. Other policies deny coverage only if the claimant did not have "a reasonable belief" that there was permission. In such cases, a more complicated factual issue exists as to whether there was such a reasonable belief.

4. Dual recovery/set-off

Of course, most policies that have UM coverage also include UIM coverage and liability. Most policies include provisions that exclude or limit recovery under more than one of those coverages. Some policies provide that if a person recovers under one of those coverages, then she cannot recover under another coverage. Some policies provide that any recovery under one part of the policy reduces the limit of coverage available under another coverage.

There is a statutory exclusion of UIM coverage where the insured recovers damages under the UM coverage. 75 Pa.C.S. §1731(d) (relating to limitation on recovery). A federal district court has held that that statutory provision is valid and applies to UM claims that follow UIM claims as well. State Farm v. Kosick, 2006 U.S. Dist. LEXIS 21090 (W.D. Pa., April 10, 2006). However, the validity of dual recovery exclusions and set-offs in regard to liability coverage is unsettled.

In Nationwide v. Cosenza, 258 F.3d 197 (3d Cir. 2001), the Third Circuit Court of Appeals held that a **dual recovery exclusion** which provided that a claimant cannot recover under both the policy's liability coverage and its UIM coverage, is invalid in multiple tortfeasor cases. Cosenza involved a two (2) vehicle accident. Mr. Cosenza and his mother, Ms. Dezii, were passengers in a vehicle operated by Mrs. Cosenza when it collided with a vehicle driven by Angela Nicolucci. Mr. Cosenza and Ms. Dezii settled their liability claims, receiving funds from both Nicolucci's insurer and from Nationwide's liability coverage on the Cosenza vehicle. Nationwide denied their claims for UIM benefits pursuant to the dual recovery exclusion. In very foreboding language, the Court of Appeals held that, while the exclusion is valid in single tortfeasor cases, it was invalid in such multiple tortfeasor cases because they did not involve an attempt to convert cheap UIM coverage into expensive liability coverage and because denying benefits would defeat the reasonable expectations of the policyholder. The Court of Appeals asserted that UIM exclusions are valid only where insureds are attempting to convert inexpensive UIM coverage into liability insurance and that public policy requires liberal interpretation of the Motor Vehicle Financial Responsibility Law in order to effectuate its policy of ensuring compensation to motor vehicle accident victims—completely ignoring the many non-conversion situations where exclusions have been upheld as well as the Supreme Court's repeated rejection of the old public policy of maximum restoration in favor of the MVFRL's current cost containment purposes. See, e.g., Eichelman, *supra*.

However, in Bowersox v. Progressive Cas. Ins. Co., 781 A.2d 1236 (Pa. Super. 2001), the Superior Court upheld a policy's liability payment **set-off** provisions, with the net result that the claimant was entitled to no UIM recovery. (In Bowersox, the decedent was a passenger in a car operated by Heather Lyons, when it was involved in an accident with two (2) other cars, one operated by her brother, Joel Lyons, and the other operated by Matthew Lytle, who were jointly at fault for the accident. The Lyons' vehicles were insured under a single Progressive Insurance policy. The Bowersox estate recovered the policy limits on both tortfeasors' vehicles. Progressive refused to pay UIM benefits under the coverage on the vehicle occupied by Bowersox, pursuant to a set-off provision which reduced the UIM coverage by the amount of any liability payment made under the same policy.) The Superior Court stated that precedent required it to uphold the provision, which had the effect of reducing the \$50,000 UIM limit by the full amount of the \$50,000 liability payment, but also stated that "we feel compelled to highlight the harshness of this result."

In Tannenbaum v. Nationwide Ins. Co., 2007 PA Super 54 (Pa. Super. 2007), the Pennsylvania Superior Court holds that recovery under personal disability policies, which are policies paid for by the UIM claimant, are not duplicate payments under the MVFRL. The insured was permanently disabled in an automobile accident. He sought UIM coverage under his Nationwide policy, which claim was arbitrated. Nationwide asserted that payment of individual and group disability policies constituted duplicate recovery under section 1722 of the MVFRL. The arbitrators set off these payments, leaving a net amount payable by Nationwide. The Court of Common Pleas of Bucks County vacated the award. The Superior Court affirmed the trial court order. The Court characterized Nationwide as arguing that recovery of any benefit payments was duplicative, other than UIM recovery. The Court stated that Nationwide confused double recovery with recovery of excess benefits, which the MVFRL allows. The Court refused to distinguish prior cases involving types of personally paid insurance. Thus, where personal policies are both separate from UIM or UM coverage, and paid for exclusively by the claimant either directly, or through payroll deductions which result in lower wages, payments received from these coverages do not duplicate benefits under the MVFRL, as they are fundamentally different from those benefits.

In Pennsylvania National Mutual Casualty Company v. Black, No. 109 MAP 2005 (Pa. 2007), the Pennsylvania Supreme Court upholds the validity of a standard set-off provision in an underinsured motorist ("UIM") endorsement, which reduces the amount recoverable as UIM benefits by the amount paid (or payable) under the liability coverage of the same policy to the same person for the same accident. Eric Black was a passenger in a car driven by John Myers. Mr. Myers pulled out from a stop sign and his car collided with a car driven by Todd Jamison on the intersecting through highway. Mr. Myers and Mr. Black were killed and Mr. Jamison was injured. The Black Estate made third-party claims against the Myers Estate, Mr. Jamison and PennDOT. The Myers Estate made claims against Mr. Jamison and PennDOT. Mr. Jamison made claims against the Myers Estate and PennDOT.

Penn National, as the liability insurer of Mr. Myers, offered its \$100,000 policy limit to the Black Estate and Mr. Jamison, who agreed to split the fund, with \$99,000 going to the Black Estate and \$1,000 to Mr. Jamison. The Myers policy with Penn National included UIM coverage with a \$100,000 limit, stacked on three vehicles. The Myers Estate agreed to waive any claim to coverage on the occupied vehicle and settled with Penn National for the \$200,000 UIM coverage on the other two vehicles. (The Decedents were cousins). The Black Estate then refused to go forward with the \$99,000 liability settlement, in an effort to avoid the effect of a set-off provision in the Penn National UIM endorsement, which stated: "The limit of liability under this coverage is reduced by any amount paid to the same person for the same accident

under Part A [liability coverage] or Part C [uninsured motorist coverage].” The Black Estate then demanded the full \$100,000 limit of UIM coverage on the occupied vehicle.

Penn National, represented by Thomas, Thomas & Hafer, LLP, responded that it would treat the \$99,000 liability offer as a constructive liability payment, for purposes of the set-off provision, and tendered a check for \$1,000, which it contended was the remaining balance of UIM coverage. The Black Estate refused Penn National’s tender (and accused Penn National of bad faith for relying on an inapplicable and invalid policy provision). Penn National brought a declaratory judgment action. The Black Estate contended that the set-off provision was inapplicable for several reasons, including the arguments (1) that the Estate, the Decedent’s mother and the Decedent’s father were not the “same person”; and (2) that the set-off provision was invalid as violative of the Motor Vehicle Financial Responsibility Law (“MVFRL”) and public policy.

The Trial Court determined all issues in favor of Penn National and held that the set-off provision was applicable and valid. The Superior Court reversed, holding that the set-off provision was invalid as against public policy, although the Superior Court agreed with the Trial Court on all other issues. The Pennsylvania Supreme Court agreed to hear an appeal from Penn National on the public policy issue and refused to hear the Black Estate’s appeal on the other issues.

The Supreme Court reversed the Superior Court’s reversal of the Trial Court, holding that the set-off provision is valid and enforceable. The Supreme Court’s validation of the set-off provision not only upholds an important standard policy term, but also, and perhaps more importantly, continues a strong trend in favor of restrictions on UM/UIM coverage. The Court states or reiterates several important principles:

- The Court will not invalidate UM/UIM limitations, if they are not directly contrary to clear statutory requirements, on grounds that they are against public policy generally or that the MVFRL is a “remedial” statute that must be “construed liberally to compensate victims.”
- The MVFRL does not mandate UM/UIM coverage, but rather requires that insurers offer coverage, and insurers comply by offering coverage subject to exclusions and set-offs that are not prohibited.
- Although making UM/UIM coverage available is one purpose of the MVFRL, cost containment is an “increasingly significant” purpose.
- Limitations on coverage reduce the cost of insurance, which is favored, not prohibited, by public policy.

Perhaps most importantly, the Court, in a footnote, suggests that insurers may not be required to offer or include UM/UIM coverage for guest passengers. One of Penn National’s arguments was that the MVFRL, which defines “insured” as named insureds and their resident relatives, does not require UM/UIM coverage for guest passengers, so all restrictions on such coverage are per se valid. In footnote 18, the Court said that “it is not clear whether the MVFRL mandates the offer of underinsured motorist coverage for guest passengers. . . .” However, the Court noted that the statutory rejection forms, required to be presented to policyholders, describe UIM coverage as protecting “me and relatives living in my household.” The Court goes on: “This statement makes no reference to guest passengers. Absent any statement by the legislature requiring a minimum of underinsured motorist coverage to guest passengers or forbidding set-off provisions and in the absence of a previous expression of a clear public policy

against such provisions, we are unwilling to declare the unambiguous set-off provision in this policy void as against public policy.”

5. Excluded driver

An endorsement which clearly excludes coverage for all claims arising from an accident that occurs while a vehicle is operated by an excluded driver is valid and bars UM/UIM claims. Progressive Northern Ins. Co. v. Schneck, 813 A.2d 828 (Pa. 2002).

N. ARBITRATION

In the past, most policies have provided that disputed UM/UIM claims must be decided by arbitration. That process usually involves three arbitrators. The claimant and the insurer each appoint an arbitrator and then those two arbitrators agree on a third, or “neutral,” arbitrator. The claim is then heard by the arbitrators and decided by a majority vote. Arbitration decisions are usually final and cannot be appealed to the courts, with certain exceptions.

Years ago, most policies provided simply that if there is a disagreement as to whether the insured is entitled to damages or as to the amount of damages, then the dispute must be decided by arbitration. Under such a provision *all* issues would be decided exclusively by arbitration, even coverage questions. Brennan v. General Accident, 574 A.2d 580 (1990). However, more recently, many insurers provided in their policies that certain issues, usually involving coverage, are not subject to arbitration but rather must be resolved in court. Such provisions appear to be valid. See, e.g., Troebs v. Nationwide Insurance Co., 1998 U.S. Dist. LEXIS 13246 (E.D. Pa., Aug. 25, 1998).

There are several types of arbitration, depending on the specific policy provision. If the policy states specifically that arbitration is governed by the Arbitration Act of 1927 (as distinguished from the Uniform Arbitration Act of 1980), then the arbitration award may be appealed based on errors of law. Otherwise, an arbitration award may be appealed only in certain, very narrow grounds, such as fraud or corruption. See CIGNA Ins. Co. v. Squires, 628 A.2d 899 (Pa.Super.1993); *appeal denied*, 644 A.2d 161 (1994); Uniform Arbitration Act, 42 Pa.C.S. §§7301 *et seq.*; 42 Pa.C.S. §§7341, *et seq.* (relating to common law arbitration).

Generally, it had been the practice of the Insurance Department to require that some form of arbitration provision be included in UM and UIM policy forms. However, in late 2005, the Supreme Court of Pennsylvania held that the Department does not have the authority to require the inclusion of policy provisions for mandatory arbitration. Ins. Fed'n of Pa., Inc. v. Dep't of Ins., 889 A.2d 550 (Pa. 2005). It is anticipated that most insurers will delete arbitration entirely from their policies or else limit it substantially. Of course the parties are always free to agree to arbitrate a particular UM/UIM claim anyway.

O. DEMANDS FOR ADVANCE PAYMENT OF “UNDISPUTED AMOUNTS”

Claimants often demand that insurers pay the “undisputed amount” in advance of settlement or arbitration of an UM/UIM claim. When, if ever, is an insured required to do so?

Although it appears that insurers rarely will be required to make such advance payments, the law on this issue is unclear and unsettled. Based on the few reported decisions on the issue, it is conceivable that a court would rule that, in certain circumstances, an insurer must tender an “undisputed amount” in an UM/UIM case, if requested.

It appears that the only reported appellate decisions on this issue are Williams v. Nationwide Mut. Ins. Co., 750 A.2d 881 (Pa. Super. 2000) and Keefe v. Prudential Prop. & Cas. Ins. Co., 203 F.3d 218 (3d Cir. 2000). In both of those UM/UIM cases, the courts held, based on the particular facts presented, that insurers were *not* liable for breach of contract or bad faith for failing to offer undisputed amounts. However, the courts implied that an insurer may have an obligation to pay an “undisputed amount” if (1) the insured requests a “partial final assessment” and partial payment and (2) “the insurance company conducted, or the insured requested but was denied, a separate assessment of some part of her claim (*i.e.*, that there was an undisputed amount).” Keefe, 203 F.3d at 226.

Unfortunately, those decisions offer little more guidance as to when payment of an “undisputed amount” is required. What is an “undisputed amount”? The Williams court stated that neither the amount reserved by the insurance company nor the amount offered in settlement by the insurance company is necessarily an “undisputed amount.” A concurring opinion in Williams suggests one situation where such a payment may be required:

If a widow were to make a claim for UM benefits under a policy insuring her husband, and the only dispute between the parties was whether the policy was subject to stacking, the failure of the insurer to pay the amount not in dispute upon demand of the insured would, in my opinion, constitute bad faith.

Williams, 750 A.2d at 889 n. 1 (McEwen, P.J., concurring) The Williams court *suggested* that there is no “undisputed amount” unless the parties agree that there is an “undisputed amount.” What is a “partial final assessment”? The Keefe court *suggested* that it *could* include a situation where the insurer has completed its evaluation of one or more distinct injuries in a multiple injury case. (This seems to make little sense, because, typically, even if an insurer did a separate assessment of a distinct injury (which would be rare), an insurer cannot know the actual (undisputed) value of a pain and suffering claim until it is resolved—indeed it is not unusual for an insurer to *overestimate* the value of a claim.)

Another interesting decision is Perschau v. USF Ins. Co., 1999 U.S. Dist. LEXIS 3334 (E.D. Pa., March 22, 1999), a first-party property insurance case in which the court held that the insurer was not liable for failing to offer an “undisputed amount.” In that case, the court, discussing the infamous PolSELLI v. Nationwide case, suggested that an insurer may be required to offer an “undisputed amount” if there is an undisputed amount, the insured had some special need for it (*e.g.*, in PolSELLI the plaintiff needed additional living expense payments to avoid eviction from her temporary housing), and the insurer has a standard practice of making such undisputed payments.

If this strikes the reader as a lot of lawyer’s gobbledygook, then that is not surprising—it does seem to be a lot of vague, inconsistent nonsense. But that is practically all the guidance we have from our courts.

In conclusion, although there is no crystal clear authority for the proposition that an insurer must offer to pay an undisputed amount in an UM/UIM case, insurers should consider making an advance payment, especially if (a) the insured has a special, urgent need for funds, (b) the insured requests such a payment and (c) there really is an undisputed amount (examples: clear liability, wrongful death, and the only issue is whether claimant can stack a \$15,000 policy; clear liability, catastrophic loss, request for modest advance needed to pay for medical expenses). Provided that the insurer makes it clear that the advance is exceptional and that it is not the insurer’s general policy to make such payments, there is little harm in making

such a payment. The benefit of making such payment is, of course, good will, demonstration of good faith, and avoidance of possible bad faith litigation (whether meritorious or not).

P. STATUTE OF LIMITATIONS

Although it is clear that UM/UIM claims are governed by the four (4) year statute of limitations applicable to contracts, the law with respect to several related issues is unsettled and uncertain.

Although much of the case law is conflicting, unclear or outdated, the basic principle seems to be that the statutory period of limitation begins to run when the claimant knew or should have known that he has a claim and could proceed with it. In the case of UM, that occurs as soon as the claimant knows or should know that the tortfeasor has no insurance. Seary v. Prudential Prop. & Cas. Ins., 543 A.2d 1166 (Pa. Super. 1988). In the case of a UIM claim, the courts used to hold that the statutory period of limitation does not begin to run until the UIM carrier consents to the underlying settlement and/or the underlying limits are exhausted, on the grounds that the UIM claim could not proceed before that. Wheeler v. Nationwide, 749 F.Supp. 660 (E.D. Pa. 1990); Smith v. United States Fidelity & Guaranty Co., 40 D&C 4th 381 (Lycoming C.P. 1998). However, that specific reasoning may no longer be valid, since some courts have held that neither consent nor exhaustion is necessarily required for a UIM claim to go forward. Nationwide v. Lehman, 743 A.2d 933 (Pa. Super. 1999) (lack of consent does not bar claim in absence of prejudice to insurer), *app. dismissed*, 772 A.2d 413 (Pa. 2001); Cerankowski v. State Farm, 783 A.2d 343 (Pa. Super. 2001) (same); Harper v. Washington Ins. Co., 753 A.2d 282 (Pa. Super. 2000) (exhaustion is not required).

The courts should hold that the statutory period of limitation with respect to UIM claims begins to run when the claimant knows or should know that the liability limits are insufficient. There is a good argument that that occurs, at the latest, when the claimant knows the extent of his injuries and knows the amount of liability coverage available.

One might pose the following question to a court considering this issue: would the court have granted a petition to compel arbitration if it had been filed more than four (4) years earlier? One could argue that, if the answer is yes, then the statutory period of limitation has expired.

However, it should be noted that, in Motorist Mut. Ins. Co. v. Durney, 2005 U.S. Dist. LEXIS 33752 (E.D. Pa., Dec. 16, 2005), a federal trial court held that the statutory period of limitations does not begin to run in an UIM (and, presumably, UM) case until there is a "disagreement" between the insured and the insurer, such as a denial of coverage or a refusal to pay the amount demanded. The court agreed with the insured's argument that the policy provides for arbitration " 'only when the parties manifest a disagreement about the amount owed,' " so the period of limitation does not begin to run until then. Another Eastern District Judge agreed with the Durney decision in State Farm v. Rosenthal, No. 05-CV-1156 (E.D. Pa., Jan. 20, 2006), holding that the statutory period of limitation did not begin in that case until the insurer refused to arbitrate, rejecting the argument that it begins to run when claimant knows or should know that he has a claim in excess of the third-party liability limits.

Other courts should not follow Motorist v. Durney and State Farm v. Rosenthal as case law, as their rationale is questionable, and those rulings would lead to absurd results. *E.g.*, under Motorist v. Durney and State Farm v. Rosenthal, a claimant could wait twenty (20) years or more before notifying an insurer of a claim, but the statutory period of limitation would not begin to run until the claim was denied.

The Rosenthal Court suggested that its holding would not allow an insured to delay his claim unreasonably, because an insurer can compel arbitration or deny the claim if prejudiced by late notice, but that defeats the purposes of statutes of limitations and burden of proof. It would require the insurer to commence an action to resolve a claim that the claimant has neglected or chosen not to pursue. It makes it the defendant's burden to commence actions to resolve *potential* claims. And, as a practical matter, insurers will be able to prove "prejudice" to the satisfaction of the courts only on the rarest occasions. That defeats the purpose of statutes of limitations, which presume prejudice after passage of a certain period of time and thereby provide some predictability and finality in the parties' affairs.

In short, the law relating to commencement of the statutory period of limitation for UM/UIM claims is very uncertain and unsettled at this time.

In any event, the case law suggests that the statutory period of limitation is not tolled merely by a demand for arbitration. Rather, the statute is not tolled until the claimant brings some action in court (e.g., a petition for appointment of arbitrators). Walker v. Providence Ins., 1998 U.S. Dist. LEXIS 4852 (E.D. Pa., April 2, 1998); Buhl v. Allstate, 46 Pa. D&C 4th 219 (Chester C.P. 2000); Messa v. State Farm, 24 Pa. D&C 4th 476 (Mont. C.P. 1993), *rev'd on other grounds*, 641 A.2d 1162 (Pa. Super. 1994).

COVERAGE ISSUES IN BAD FAITH CLAIMS⁵

I. TEXT OF THE "BAD FAITH" STATUTE

§8371. Actions on insurance policies.

In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:

1. Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
2. Award punitive damages against the insurer.
3. Assess court costs and attorney fees against the insurer.

42 Pa.C.S. §8371, enacted 1990.

II. PURPOSE AND SCOPE OF THE "BAD FAITH" STATUTE

The purpose of Section 8371 is to provide a statutory remedy to an insured when an insurer acts in "bad faith" towards the insured in an action arising under an insurance policy. Gen. Accident Ins. Co. v. Fed. Kern Ins. Co., 452 Pa. Super. 581, 682 A.2d 819 (1996). There is no common law *tort* cause of action for bad faith in Pennsylvania. D'Ambrosio v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 494 Pa. 501, 431 A.2d 966 (1981).⁶

"Bad faith" is not defined in the statute but has been identified by the courts of Pennsylvania as a "frivolous or unfounded refusal to pay proceeds of a policy." Terletsky v. Prudential Prop. and Cas. Ins. Co., 437 Pa. Super. 108, 649 A.2d 680 (1994). To state a statutory "bad faith" claim, a plaintiff must present clear and convincing evidence that (1) an insurer denied benefits under a policy without any reasonable basis to do so and (2) the insurer knowingly or recklessly disregarded its lack of reasonable basis for denying the claim.

Subsequent to Terletsky, the Pennsylvania Superior Court adopted the definition of "bad faith" from Black's Law Dictionary as applicable to "bad faith" in the context of 42 Pa.C.S. 8371. Said definition reads:

"Bad Faith" on the part of an insurer is any frivolous or unfounded refusal to pay proceeds of a policy; it is not necessary that such refusal be fraudulent. For purposes of an action against an insurer for failure to pay a claim, such conduct imports a dishonest purpose and means a breach of a known duty (i.e. good faith and fair dealing), through some motive of self-interest or ill will; mere negligence or bad judgment is not bad faith.

O'Donnell v. Allstate Ins. Co., 1999 Pa. Super. 161, 734 A.2d 901 (1999)(internal quote from Black's Law Dictionary 139 (6th ed. 1990).

Since O'Donnell, there has been a challenge by insured as to whether "motive of self-interest or ill will" is a third element required for a bad faith claim. The Western District Court of

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⁶ Please see discussion in Section on recent trend of courts to recognize a *contractual* common law remedy for the bad faith conduct of insurers.

Pennsylvania predicted that the Supreme Court of Pennsylvania will rule consistently with the Superior Court concerning the level of culpability that needs to be associated with a finding of bad faith which is that the "motive of self interest or ill will" is not a third element required to establish bad faith, but it is probative of the second element identified in Terletsky, i.e. that the insurer knew or recklessly disregarded its lack of reasonable basis in denying the claim." Employers Mutual Casualty Company v. James Loos et al., 476 F.Supp. 2d 478 (W.D. Pa. 2007); See also Barry v. Ohio Casualty Group, 2007 U.S. Dist. LEXIS 2684 *23-24 (W.D. Pa. 2007).

With respect to the requisite level of culpability associated with a finding of bad faith, it is settled that mere negligent conduct, however harmful to the interests of the insured, is not enough. Pure negligence has been recognized by Pennsylvania courts to be categorically below the threshold for a showing of bad faith.⁷

If a complaint fails to contain sufficient allegations that an insurer possessed the requisite wrongful state of mind, i.e. that it knew or recklessly disregarded the lack of reasonable basis for denying coverage, the complaint will fail and is subject to dismissal. Kojeszewski v. Infinity Insurance Co., 2006 U.S. Dist. LEXIS 79306 (Mem. Op. M.D. Pa. Oct. 2006).

III. "BAD FAITH" CASE UPDATE

"Bad faith" litigation continues to grow by number of suits and variety of theories. There have been a number of decisions handed down by the Courts of the Commonwealth of Pennsylvania, both state and federal, in the last year which have impacted this area of the law and should be known to those lawyers who practice in the bad faith arena. A snap shot of the "bad faith" decisions issued in the last year (July 2006 – July 2007) follows.

A. PARTIES TO A "BAD FAITH" SUIT

1. Who may be sued for "bad faith"?

Statutory bad faith actions can only be brought against an "insurer". While the Judicial Code does not define "insurer", the Insurance Department Act of 1921, as amended, 40 P.S. 221.3, does offer a definition of "insurer" as "any person who is doing, has done, purports to do, or is licensed to do any insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization or conservation by any insurance commissioner." Brown v. Progressive, 2004 Pa. Super. 346, 860 A.2d 493 (2004). Neither self-insured entities nor insurer-affiliated corporate entities which do not act as *de facto* insurers, but rather administrators, qualify as insurers for purposes of Section 8371.

In Lindsey v. Chase Home Fin. L.L.C., 2006 U.S. Dist. LEXIS 61893 (M.D. Pa. August 2006), the plaintiff-insured filed a civil action including a statutory bad faith count, arising out of an alleged improper denial of a flood claim. The plaintiff included Chase Home as a party defendant to the "bad faith" count on the basis that Chase withheld money from a monthly mortgage payment of the insured, which in turn would be used to purchase and pay premiums for a disaster mortgage protection policy. Chase cancelled the policy without notifying the insured, a flood occurred and insured was refused payment by the insurer which was Ace. The

⁷ Furthermore, to the extent that an insured includes a count for negligence based upon allegations that an insurer negligently performed its obligations under an insurance policy, the same is subject to dismissal pursuant to the gist of the action doctrine which precludes recasting ordinary breach of contract claims into tort claims based purely on social policy. Kojeszewski v. Infinity Insurance Co., 2006 U.S. Dist. LEXIS 79306 (Mem. Op. M.D. Pa. Oct. 2006).

Court held no bad faith can exist against Chase because it was not a licensed insurer but rather a mortgage company.

In cases where there are related entities and a dispute as to which entity was the insurer and therefore subject to a “bad faith” suit, the question is one of fact. When faced with this issue, the court looks at two factors: (1) the extent to which the company was identified as the insurer in the policy documents and (2) the extent to which the company acted as an insurer – the second factor being the more important. Barry v. Ohio Casualty Group, 2007 U.S. Dist. LEXIS 2684 (W.D. Pa. 2007), relying on Brown v. Progressive, *supra*; See also, Estakhrian v. Continental General Insurance Co., 2006 U.S. Dist. LEXIS 95607 (E.D. Pa. Dec. 2006)(The court dismissed Ceres Group, a non-insurance holding company, which owned a subsidiary, CGI, from claims of breach of insurance contract and bad faith filed by an insured of CGI. Ceres was not referenced in the insurance contract, was not involved with underwriting or primary investigations, and correspondence to the insured indicated CGI was the insurer. Two of Ceres’ employees were involved with CGI’s follow up investigations of plaintiff’s claim, but the Court found this involvement was not so extensive to make Ceres a “de facto insurer” under Section 8371).

Also, note the courts interpret the term “insurer” in Section 8371 literally, limiting such actions to insurance companies, disallowing bad faith claims against individual insurance agents and claims adjusters. Ihnat v. Prover, et al., 35 Pa. D & C 4th 120 (Allegheny County 1997); Cardine v. Ohio Life Ins. Co., CCP Fayette County (1996); Dresdiner v. State Farm Mut. Auto Ins. Co., 1995 U.S. Dist. LEXIS 11213 (E.D. Pa. 1995).

2. Who may sue for “bad faith”?

The only party who has standing to pursue a “bad faith” action is an insured, and in limited circumstances, an intended third party beneficiary to the policy. See Freedom Medical Supply, Inc. v. Nationwide Mut. Ins. Co., 2004 Phila. Ct. Com. Pl. LEXIS 35 (Decided April 23, 2004) and Davin v. Davin and Principal Financial Group d/b/a Principal Life Ins. Co., 842 A.2d 469 (Pa. Super. 2004).

To bring a bad faith suit, the plaintiff does not have to be the named insured, or even a payor of the premium on the policy, but has to qualify as an insured on the subject policy. Klinger v. State Farm, 895 F. Supp. 709 (M.D. Pa. 1995).

To bring a bad faith suit as an intended third party beneficiary, there must be a recognition of the beneficiary's right as appropriate to effectuate the intention of the parties, and the performance must satisfy an obligation of the promisee to pay money to the beneficiary or the circumstances indicate that the promisee intends to give the beneficiary the benefit of the promised performance. Davin, *supra*.

B. FORUM FOR BAD FAITH LITIGATION

Bad Faith cases are litigated in both state and federal courts, and there is often a contest as to which forum is appropriate.

There is a trend for insurers to remove these actions to federal court based on diversity of citizenship pursuant to 28 U.S.C. §1332. There is likewise a trend for the insured to move for remand in those instances. Remand is often requested based on a difference in opinion regarding the amount in controversy. In Jenkins v. Texas International Life Insurance, 2007 U.S. Dist. LEXIS 14238 (W.D. Pa. Feb. 2007), on a second motion for remand filed on behalf of an insured who had filed a bad faith action, the Court granted the same, observing that the insured filed a declaration before the District Court, limiting her relief to less than the \$75,000

threshold. The insurer argued that insured's refusal to sign a "stipulation" saying the same created federal jurisdiction. The Court held that the refusal to sign the stipulation did not create federal jurisdiction, but that the insurer could argue against recovery beyond \$75,000 in the state court action, relying on insured's declaration. See *also*, Knauer v. Farmers Insurance Co., 2007 U.S. Dist. LEXIS 14233 (M.D. Pa. 2007)(the District Court granted insured's motion for remand in a bad faith case where there were no unpaid contract damages [underlying arbitration award was paid by insurer], and "a naked claim for punitive damages, which this case presents, is not computable for purposes of determining the amount in controversy." Jenkins, citing Casey v. Nationwide, No. 3:02-1324 (M.D. Pa. 2002). The Court declared that the punitive damage claim stands alone, as a statutory right, unrelated to compensatory damages. As there was no suggested relationship between the amount awarded at arbitration and amount of punitive damages, remand was granted.

There has also been an attempt by an insured to challenge diversity of citizenship, arguing that the citizenship of a policyholder should be imputed to the insurer where there is an action brought by a third party claimant pursuant to an assignment of rights under the policy. Campbell v. State Farm Mutual Automobile Insurance Co., 2006 U.S. Dist. LEXIS 92336. This action for declaratory judgment and bad faith was brought in state court by a claimant who had obtained a judgment against a State Farm insured in a third party suit and secured an assignment from said insured. Claimant filed suit for a declaration that liability coverage was in effect at the time of accident and sought damages for bad faith for the coverage denial. State Farm removed the action based on diversity of citizenship pursuant to 28 U.S.C. §1332. The claimant sought remand, arguing that this is a direct action against an insurer pursuant to Section 1332(c)(1), and thus the citizenship of the insured must be imputed to the insurer for diversity purposes, and since the claimant and State Farm insured are both Pennsylvania residents, remand is appropriate. State Farm countered submitting that Section 1332(c)(1) is not applicable because claimant does not and cannot have a direct action against State Farm, another's insurer, under state law. Rather, this suit can be characterized as claimant bringing the driver's claims against State Farm, and an insured's suit against his own insurer is not a "direct action" under Section 1332(c)(1). Thus, the court held citizenship of its insured is not imputed on State Farm and the motion to remand was without merit.

C. COMMON THEORIES OF "BAD FAITH"

Theories of "Bad faith" vary from a charge of unreasonable denial of benefits because of unreasonable policy construction or inadequate investigation, unreasonably compelling litigation by under-evaluating a claim and making unfair offers of settlement, failure to communicate with the insured, and refusal to settle a claim that could have been settled within policy limits resulting in actual damage to the insured. An overview of recent cases, addressing the most common theories follows.

1. Unreasonable Construction of Coverage

In order to recover on a claim of bad faith, a plaintiff must show by clear and convincing evidence (1) that the defendant did not have a reasonable basis for denying benefits under the policy and (2) that the defendant knew or recklessly disregarded its lack of reasonable basis in denying the claim. However, a claim for bad faith is defeated if the defendant shows that it had a reasonable basis for denying the claim, whether the insurance company adopted a reasonable construction of the policy or an adequate investigation led to a reasonable basis for denial. The presence of bad faith in Pennsylvania does not turn on the legal correctness of the denial of an insured's claim. If so, the need for an independent analysis of an insured's bad faith claim would disappear, as a Section 8371 case would turn specifically on the underlying coverage determination. Section 8371 is only to be applied to claims which are denied on an

unreasonable basis. Employers Mutual Casualty Company v. James Loos et al., 476 F.Supp. 2d 478 (W.D. Pa. 2007)(Court concluded despite finding of coverage, insurer's denial at issue was not bad faith); See *also*, T.H.E. Insurance Co. v. Charles Boyer Children's Trust, 455 F.Supp.2d 284 (M.D. Pa. 2006)(This bad faith claim failed along with a breach of contract claim where plaintiff insurance company properly denied coverage where it was excluded by the policy. The insurance company was granted summary judgment because the mud and water damage at issue was specifically excluded by the surface water exclusion in the policy. Since coverage was unambiguously barred, the court dismissed the bad faith claim).

2. Inadequate Investigation

Several recent cases alleging bad faith have been based on claims of inadequate or unfair investigation. A description of circumstances where the courts have concluded that bad faith may or may not lie for inadequate or improper investigation follows:

a. Examples of conduct which courts found may be bad faith

In Scarpato v. Allstate Insurance Co., 2007 U.S. Dist. LEXIS 4585 (E.D. Pa. Jan. 2007), the complaint alleged that Allstate denied insured's claim "without conducting a reasonable investigation based upon all available information and asserted policy defenses without a reasonable basis in fact." The suit stemmed from a denial of a fire loss claim. The Insured averred he fully informed Allstate's agents that the property was commercial in nature; but only after the loss, learned that his agent placed the property on a homeowners rather than commercial property policy. Allstate refused coverage because the Insured did not reside in the property. The Insured filed suit for breach of contract and bad faith against Allstate and negligence against his agent. Allstate filed a Motion for Judgment on the Pleadings, seeking a declaration of coverage based on the face of the policy and admissions by the Insured that he did not reside in the property, and dismissal of bad faith count with a finding that no coverage was available. The Court denied the Motion on the basis that Allstate could be estopped from relying on any defect in the policy if the same was caused by the agent, and further that allegation that the claim was unreasonably investigated before denied could support a bad faith finding.

In Trunzo v. Allstate Insurance Co., 2006 U.S. Dist. LEXIS 87051 (W.D. Pa. Sept. 2006), the Court denied Allstate's summary judgment motion on plaintiff's bad faith claim based on improper and inadequate investigation. Plaintiff's counsel testified that he advised an Allstate representative that the basis for denying coverage was compromised by new information. Specifically, the subject denial was a denial of liability coverage on the basis that claimant was not an insured because she was operating a non-owned auto and was not a resident relative of the named policyholder. This denial was based on an initial statement taken by Allstate of the policyholder who denied claimant was a resident relative. Plaintiff's counsel spoke separately to the policyholder at which time policyholder relayed that his statement to Allstate was false and created out of fear related to his immigration status. Plaintiff's counsel informed Allstate of this information, but Allstate refused to do any further investigation and maintained the denial. In denying summary judgment, the Court held that "if evidence arises that discredits the insurer's reasonable basis, the insurer's duty of good faith and fair dealing requires it to reconsider its position and act accordingly."

b. Examples of conduct which courts found not to be bad faith

In Wedemeyer v. U.S. Life Insurance Company in the City of New York, et al., 2007 U.S. Dist. LEXIS 15742 (E.D. Pa March 2007), the plaintiff contends that defendant insurance company's investigation into her claim and the decision to stop paying long term disability

benefits after more than three years of paying them was wrongful and unreasonable. Plaintiff alleges that she was only partially recovered cognitively and totally disabled by her physical injuries. Plaintiff brought a claim for breach of contract, bad faith, and for violation of the Unfair Trade Practices and Consumer Protection Law (“UTPCPL”). The court held that an insurance company makes an adequate investigation where it considered multiple medical reports and medical review files, including two reports by independent consultants and two reports from IMEs done by independent doctors. Additionally, plaintiff’s physician declined to respond to the insurance company’s conclusion with any information other than an almost two-year-old report. The court noted that in reviewing a claim, an insurance company is not required to give greater weight to opinions of treating medical providers over any other available evidence. Such an investigation was deemed satisfactory in determining that plaintiff was no longer disabled within the meaning of the policy. Thus, the defendant conducted a thorough investigation and had a reasonable basis for determining plaintiff’s benefits.

In Estakhrian v. Continental General Insurance Co., 2006 U.S. Dist. LEXIS 95607 (Mem. Op. E.D. Pa. Dec. 2006), the Court granted summary judgment to the insurer on plaintiff-insured’s bad faith claim based on a theory of inadequate or improper investigation into the medical claim. The Court acknowledged evidence that the insurer did not request additional information from a treating physician relevant to its position; however, declared that where there is an uncertainty as to diagnosis of a material medical claim, an insurer’s failure to review all medical records or to follow up for additional information is not in itself bad faith. “Even assuming, *arguendo*, that Defendant doing things differently would have improved the handling of the claim from Plaintiff’s standpoint, that Defendant’s action *could have been* improved does not mean that its unimproved actions arose to bad faith.” *Id.* at *28.

In Smith v. Westfield Insurance Co., 2007 U.S. Dist. LEXIS 43996 (Mem.Op. E.D. Pa. June 2007), Plaintiffs made a bad faith and breach of contract claim based on defendant’s denial of plaintiffs’ homeowner’s insurance claim for water penetrating the interior of plaintiffs’ house. Three years after plaintiffs noticed water coming into the house they finally notified defendant by submitting a claim which was denied. The court granted defendant summary judgment on the bad faith claim, premised in large part on a theory of inadequate or improper investigation. The Court found that the defendant promptly investigated both inside and outside the house, took plaintiffs’ statements, and received an expert report prepared on behalf of plaintiffs. Defendant’s investigation was deemed thorough and that the same provided a reasonable basis for the coverage position. Thus, even if the coverage determination turns out to be incorrect, that does not denote the presence of a dishonest purpose or reckless disregard for the truth to state a claim for bad faith.

In Totty v. Chubb Corp., 455 F. Supp. 2d 376 (W.D.Pa. Aug. 2006), plaintiff sued Chubb seeking to recover under a homeowner’s insurance policy for alleged structural damage to her property caused by vibrations from construction equipment used by the city to resurface her street and claiming that defendants acted in bad faith in violation of 42 Pa.C.S.A. § 8371. The court granted summary judgment on the bad faith claim based on the fact that after receiving the insured’s claim, the insurer employed an expert, which determined that the property damage was related to foundation settlement. Thereafter, when the insured provided the insurer with evidence that vibrations from the road equipment densified the soil, causing the house to “settle,” the insurer employed two additional experts, both of whom rejected the insured’s new theory of causation. The insured did not argue that she was entitled to coverage under any of the theories of the insurer’s experts. Thus, the Court found that the insurer continued to have a reasonable basis to deny the insured’s claim. “Even if the expert incorrectly assessed the cause of damage, this is not evidence that his conclusions were unreasonable or that Defendant acted unreasonably in relying upon them.”

3. Compelling Litigation by Unreasonable Offer

Bad faith may be found if the insurer compels the insured to engage in litigation in order to obtain benefits owed by making unreasonably low offers.

In Barry v. Ohio Casualty Group, 2007 U.S. Dist. LEXIS 2684, the insured presented a stacked uninsured motorist benefits claim for \$75,000 that was ultimately settled for that amount with an exception carved in the release to allow for a related bad faith action. One of the insured's bad faith theories was that the insurer "low balled" her claim, particularly by making the initial offer below the value created by Colossus used by the claims representative to evaluate the value of injuries; and by increasing the offer with no new information. The Court denied the insurer's summary judgment concluding that a jury could find that insurer acted in bad faith with respect to its offering unreasonably low offers during negotiations of the underlying UIM claim.

See also, Zappile v. Amex Assurance Company, 2007 Pa.Super. 171 (June 8, 2007). In this case, the Superior Court reversed trial court judgment of bad faith. Plaintiff-insured filed a bad faith action, stemming from unreasonable offer and resultant delay in resolution of UIM claim. The UIM arbitration took place two years after demand by insured was made and three years after the date of loss. The demand for settlement was the policy limit of \$150,000, but the maximum offer made by Amex was \$32,000. The arbitration award was \$95,000 for injured claimant and \$10,000 for spouse. The Trial Court found Amex acted in bad faith in: failure to make partial payment for wage loss claim; and under-evaluating UIM claim. Amex appealed arguing in part that it was in error to conclude that taking adversarial position in defending against an UIM claim equated to bad faith and error to conclude that Amex owed duty to make partial payments. The Superior Court reversed judgment and made following material conclusions: (1) "[A] UIM claim is not strictly a first party claim and it is 'inherently and unavoidably adversarial'; (2) "[W]e are unprepared to say that as a general rule the failure to cut out certain portions of a general damage claim, especially where the insurance contract makes no representation that such a procedure be followed constitutes bad faith"; and (3) an insurer has the right to investigate all parts of a claim and the fact that an arbitration hearing could have taken place earlier than it did does not alone warrant a finding of bad faith. In reversing the bad faith judgment, the Court explained relative to issue one that while it is apparent the insurer undervalued the UIM claim, it is not apparent it did so out of ill will or without reasonable basis. The Court further explained relative to issue two that it did not accept the notion that a partial payment is legally required, and assuming arguendo it is, there is an indication that a prerequisite for such payment is a formal demand for the same which was not present in this case. Finally, the Court explained relative to issue three that "delay" in arbitrating a UIM claim attributable to time needed to explore injuries sustained in a subsequent incident is not bad faith delay, but rather an exercise of an insurer's right to investigate all aspects of the claim.

See also, Heinlein v. Progressive Northern Ins. Co., 2007 U.S. Dist. LEXIS 51592 (W.D.Pa. 2007), wherein the court stated that the bad faith statute does not require an insurance company to submerge its own interests in favor of those of its insured, and investigating and litigating a claim does not constitute bad faith. The court further noted, relying on the *Condio* decision, that consistent with this concept, underinsured and uninsured motorist claims are "inherently and unavoidably adversarial." However, the court expressly rejected any argument that the fact there is a genuine dispute over the value of a UIM damages claim does not mean that no attempts at settlement need be made, and arbitration is always the appropriate result.

4. Delay

Delay in the investigation or payment of a claim without good reason can amount to a *de facto* denial of a claim without a reasonable basis, and therefore, supportive of a finding of bad faith. With that said, recent cases show a decline in bad faith actions founded on an insurer's alleged delay; and previous litigation has yielded well-settled theories in favor of insurers, consistently concluding delays must be unreasonable to support a finding of bad faith.

In Pittas v. Hartford Life Ins. Co., 2007 U.S. Dist. LEXIS 36165 (W.D. Pa. May 2007), the plaintiff filed a claim for bad faith relating to a claim for benefits under group policy of accident insurance. Plaintiff alleged that Defendant acted in bad faith: 1) in failing to timely obtain records and failing to inform Plaintiff as to reasons for delay in payment; 2) in initially denying benefits based on intoxication; 3) in failing to pay \$ 600 daily benefits rather than \$ 300.00 daily benefits; and 4) in initially denying benefits for Plaintiff's stay at Healthsouth Harmarville. With regard to the first claim of bad faith, Plaintiff alleges that Defendant did not act in a timely manner in obtaining the records after receiving notice of the claim on March 13, 2004. Specifically, Plaintiff asserts that taking over seven months, until November 22, 2004, when it initially denied the claim, is bad faith. The Court, however, opined that the evidence showed efforts by Defendant to obtain the needed reports to complete the proof of loss, and once the report was obtained, Defendant issued its decision within 60 days. The Court held that a delay of seven months after receiving notice of the claim, without more, is not clear and convincing evidence of bad faith. The Court found there was no indication, evidence, or inference of conduct that imports a reckless disregard or bad faith.

See also, Clugston v. Nationwide Mut. Ins. Co., 2006 U.S. Dist. LEXIS 27898 (M.D. Pa. 2006), in which the court denied Nationwide's motion to dismiss the insured's claim of bad faith founded on an alleged delay in processing a claim. The relevant facts revealed that Nationwide did not conduct an evaluation of the damage to insured's automobile until sixteen days after the claim was presented, an evaluation of the automobile's interior was not performed for another three months, and a month after the final evaluation, the automobile still had not been repaired. The court found this evidence was sufficient to state a claim under bad faith and any assertion that Nationwide had a reasonable basis to delay the processing of insured's claim must await the outcome of discovery.

Another very interesting decision in this area involving a theory of delay which failed is Daniel P. Fuss Builders-Contractors, Inc. v. Assurance Co. of America, 2006 U.S. Dist. LEXIS 56742 (E.D.Pa. 2007). In *Fuss*, the insured asserted claims for breach of contract, breach of fiduciary duty, and bad faith pursuant to 42 Pa.C.S.A. § 8371 alleging that the insurers delayed the settlement of a third party claim brought against the plaintiff insured. On a Motion to Dismiss, the Court was asked to determine whether Pennsylvania law recognized a bad faith cause of action against an insurer who ultimately settled a third-party insurance claim within policy limits before an excess verdict had been entered. With respect to actions arising from an insurer's refusal to settle that resulted in the entry of a verdict in excess of the insured's policy limits, numerous federal and state courts have recognized a cause of action for bad faith. The insured analogized its cause of action to these cases. However, the court found that under Pennsylvania law, there was no recognized cause of action against an insurer for delaying settlement of a *third-party* claim. While the insured painted a disturbing picture of improper conduct on the part of the insurers, the Pennsylvania legislature had not yet created a cause of action for the insurers' conduct, nor had the Pennsylvania Supreme Court found that one existed under current law. Accordingly, the instant court held that plaintiff failed to state a claim upon which relief could be granted and dismissed the bad faith claim.

D. COMMON LAW BAD FAITH BREACH OF CONTRACT

There is still no common law tort remedy available in Pennsylvania. Those claims are governed by 42 Pa.C.S.A. § 8371. However, the court in Birth Center v. St. Paul Co. Inc., 567 Pa. 386 (2001), paved the way for an insured in Pennsylvania to bring a common law bad faith breach of contract claim to recover those types of damages available in contract actions generally. *Id.* at 386. Federal courts have very recently jumped on this bandwagon to allow for more recovery.

In Kakule v. Progressive Cas. Ins. Co., 2007 U.S. Dist. LEXIS 44942 (E.D. Pa. June 20, 2007), the plaintiff brought a breach of contract bad faith suit against his insurer relative to an underlying uninsured motorist claim. The UIM claim was tried at an arbitration which resulted in an award in excess of the limit. Defendant paid the limit and plaintiff sought damages consequential to the breach. The Trial Court initially dismissed plaintiff's bad faith breach of contract claim, concluding Pennsylvania did not recognize a common law theory of bad faith. However, the Court reversed this dismissal and held that he too narrowly construed the law, and opined that the Pennsylvania Supreme Court chose to recognize a contractual common law remedy for the bad faith conduct of insurers in Birth Center, just not a common law tort action; and further held that the Birth Center holding applies to first party insurance situations as well as third party insurance claims.

In McPeek v. Travelers Casualty and Surety Co., 2007 U.S. Dist. LEXIS 46628 (Mem. OP. W.D. Pa. June 2007), the insured filed a civil action sounding in statutory and common law bad faith, stemming from an alleged wrongful denial of liability coverage. The insurer challenged the claim of common law bad faith. The Court characterized the breach of contract claim as a common law bad faith claim by way of the contract carrying an implied duty of good faith. The Court further recognized the position taken in DeWalt v. The Ohio Cas. Ins. Co., 2007 U.S. Dist. LEXIS 26901 *28 (Mem. Op, E.D. Pa. April 2007), as the best articulation of a common law bad faith claim, namely that an insured may establish bad faith based on an insurer's negligence or unreasonableness, but such a showing must be by clear and convincing evidence. The Court in DeWalt ruled that there is a contract claim for bad faith and the same requires evidence that an insurer acted negligently or unreasonably in handling the potential settlement of claims against its insured.

In McCrorry v. State Farm Mutual Automobile Insurance Company, 2007 U.S. Dist. LEXIS 20981 (W.D. Pa. March 2007), plaintiff filed an action for breach of an insurance contract and bad faith evolving out of alleged wrongful denial of an uninsured motorist claim. Insurer moved for dismissal of the contract claim. The court held that the contract claim was actionable because a breach of contract claim stemming from the bad faith handling of the insurance claim is viable, even when combined with a claim under Section 8371. The court also recognized that compensatory damages, to return the parties to the position they would have been in but for the breach, are appropriate damages in this type of case; however recognized that counsel fees and costs do not qualify as compensatory damages under the American Rule.

E. CLAIMS OUTSIDE THE PURVIEW OF 8371

While the theory of bad faith need not be the literal act of denying an insured's claim, the essence of the bad faith theory must be the unreasonableness and intentional or reckless denial of benefits. A number of attempts have been made to expand application of the statute have been made but refused by the courts. Of particular note is the recent Pennsylvania Supreme Court case in Toy v. Metropolitan Life Ins. Co. handed down on July 18, 2007 in which the Court affirmed the Superior Court's conclusion that theories of deceptive insurance policy sales

practices do not fall within the purview of Section 8371. There is a recognized limitation to Section 8371 to exclude pre-contract conduct.

1. Manipulative Sales Practices

By the plain text of 42 Pa.C.S. §8371, the statute extends to actions “arising under an insurance policy.” Thus, the statute was intended specifically to cover the actions of insurance companies in the denial of benefits under an *existing* contract.

In Wise v. Am. Gen. Life Ins. Co., 459 F.3d 443 (3rd Cir. Aug. 2006), plaintiff pled bad faith under §8371 based on her insurer’s alleged scheme to collect annual insurance premiums while providing less than a full year of actual coverage. Allegedly, the insurer was predating newly issued insurance policies, without prior notice to potential customers, thereby enabling the company to collect annual premiums for less than a full year of coverage and to increase its own profits. The Court interpreted the phrase “arising under an insurance policy” literally, limiting such actions to a denial of benefits under an existing contract. Accordingly, the Court did not extend Section 8371 to an insurer’s actions in the solicitation of customers and Third Circuit affirmed dismissal of this claim.

In Novinger Group, Inc. v. Hartford Ins., Inc., 2007 U.S. Dist. LEXIS 35779 (Mem. Op. E.D. Pa May 2007), Plaintiffs filed suit alleging, *inter alia*, bad faith because they were “baited and switched” into purchasing policies by a Hartford Salesperson. The Court dismissed the bad faith claim because plaintiffs’ allegations of bad faith relate to alleged misrepresentations and omissions that occurred prior to formation of the insurance contracts. The Court held that because plaintiffs did not allege that Hartford denied them benefits under the policy, plaintiffs have failed to state a claim for insurance bad faith under 42 Pa.C.S.A. § 8371.

In Toy v. Metropolitan Life Ins. Co., (Pa. July 18, 2007), plaintiff alleged that defendants acted in bad faith due to misrepresentations about her life insurance policy, which she believed to be a savings or investment vehicle, that caused her to purchase life insurance she did not want. The Pennsylvania Supreme Court held that they need not go any further than the language of the bad faith statute to ascertain that the legislature did not intend to provide relief to an insured who alleges that his insurer engaged in unfair or deceptive practices in soliciting the purchase of a policy.

2. First Party Medical Claims

The Third Circuit Court of Appeals and Pennsylvania’s District Courts have held for some years that an insured can maintain a bad faith action with regard to denial of first party *wage loss* benefits pursuant to § 8371 because 75 Pa. Cons. Stat. Ann. § 1716 does not provide the exclusive remedy for such a claim, but that 75 Pa. Cons. Stat. Ann § 1797 does provide for the exclusive remedy (including punitive damages) in an auto insurance *medical* benefits claim, which preempts a claim under § 8371. Harris v. Lumberman’s Mut. Cas. Co., 2006 U.S. Dist. LEXIS 2432 (E.D. Pa. 2006). Thus, a count for statutory bad faith stemming from denial of first party medical benefits in most instances may be dismissed.

This position was restated in Cronin v. State Farm Mutual Automobile Insurance Co., 2006 U.S. Dist. LEXIS 82139 (Mem. Op. M.D. Pa. Oct. 2006). In Cronin, the court dismissed the plaintiff’s claim that he was denied medical benefits in bad faith after being injured in a motor vehicle accident. Plaintiff alleged that he was denied first party medical and wage loss benefits in bad faith by Defendant. The Court held that section 1797 of the Pennsylvania Motor Vehicle Financial Responsibility Law (“MVFRL”) provides “the exclusive first party remedy for bad faith

denials by insurance companies with respect to claims arising out of automobile accidents.” The Court held that Section 1797 preempts Pennsylvania’s Bad Faith Statute, 42 Pa.C.S.A. § 8371 insofar as it relates to the refusal to pay medical loss benefits.

Furthermore, in Barry v. Ohio Casualty Group, 2007 U.S. Dist. LEXIS 2684, the Court addressed whether an inconsistent position taken by a first party medical claims unit and underinsured motorist claims unit is prima facie evidence of bad faith, and declared it was not. The insured argued that it was bad faith for its insurer to pay first party medical benefits for years post accident, and then challenge causation between the accident and injuries claimed when adjusting a related underinsured motorist claim. The Court ruled that the insurer’s prior acceptance of its obligation to provide coverage to its insured under first party portions of the policy did not operate as a bar preventing insurer from later raising the issue of causation with respect to UIM benefits. *Id.* at *34. However, it may still be bad faith if the challenge to causation was unreasonable. *Id.* at *35.

However, there is a recognized exception to this rule when the claim for bad faith involves a theory that first party medical benefits were denied pursuant to a peer review process that was abused or implemented improperly, i.e. conspiracy with vendor to secure sham reports to deny benefits and/or use of a peer review report to challenge causation which is beyond the scope of the peer review process. Schwartz v. State Farm Ins. Co., 1996 WL 189839 (E.D. Pa. 1996); Neun v. State Farm Ins. Co., 1996 WL 220980 (E.D. Pa. 1996); DeFazio v. Nationwide, 35 Pa. D & C 4th 221 (Lackawanna Co. 1997); Hice v. Prudential Ins. Co., 34 Pa. D & C 4th 97 (Westmoreland Co. 1997); Olsofsky v. Progressive, 52 Pa. D & C 4th 449 (Lackawanna Co. 2001).

Furthermore, the general rule of preemption recognized by federal courts has not been so quickly applied by state courts. For a time, the Pennsylvania Superior Court decision in Barnum v. State Farm, 430 Pa. Super. 488, rev’d on other grounds, 539 Pa. 673 (1994) was applied as binding authority for this general rule in state courts, but the value of that decision has been disputed because of the reversal, albeit on different and unrelated grounds. Insured argues that the reversal did apply to this issue, and insurers argue the reversal was limited to the issue of exhaustion of remedies and did not change the law that 1797 preempts 8371.

3. Post-Claim Conduct

Pennsylvania courts have yet to extend bad faith claims to post-claim conduct, e.g. post claim underwriting practices including policy rescission and premium increases.

In Am. Home Assur. Co. v. Church of Bible Understanding, 2006 U.S. Dist. LEXIS 63859 (Mem. Op. E.D.Pa. Sept. 2006), in which a missionary was injured in a car accident in the Bahamas, where she had stopped on her way to Haiti to work at an orphanage owned by the church. Following the accident, the missionary filed a worker’s compensation claim with the insurer seeking coverage for her injuries. The insurer denied the claim. In this declaratory judgment action, the insurer maintained that the policy it had issued to the church was subject to rescission because the church made misrepresentations in its application. Specifically, contrary to its representations in the application, the church, during the relevant time period, owned and operated at least one aircraft, and its employees regularly traveled out of the country to orphanages operated by the church in Haiti. The court found that, under these circumstances, the insurer had the right under Pennsylvania law to rescind the policy. As a result, the counterclaim alleging that the insurer’s attempt to terminate the policy was in bad faith did not have merit.

See Coppola v. Travelers Indem. Co., 2007 U.S. Dist. LEXIS 21771 (Mem. Op. E.D. Pa. March 2007). Insured brought an action for benefits denied by his homeowner's insurer. In an Amended Complaint, the insured plead breach of contract, bad faith and concerted tortious action against his insurer. The concerted tortious action count related to an alleged increase in premiums on the policy after the loss and suit was filed and insured's contention that said premium increase was in retaliation to the initiation of the suit for benefits. Insurer moved to dismiss this count based on gist of the action doctrine, arguing that this claim was limited to duties allegedly created by the insurance contract and therefore could not be recast into a tort theory for additional recovery. The Court agreed and dismissed the count for concerted tortious action.

See also Connolly v. Reliastar Life Ins. Co. Inc., 2006 U.S. Dist. LEXIS 83440 (Mem. Op. E.D. Pa. Nov. 2006), the bad faith claim stemmed from a separate action, in which defendant-insurer successfully claimed that plaintiff-insured must reimburse it for receiving excess benefits. Plaintiff asserted that defendant's conduct in collecting that amount was harassing and in bad faith. Plaintiff was paid long-term disability benefits for 24 months pursuant to a policy with defendant. The policy provided that benefits would be reduced by the amount that the beneficiary received from SSDI and "other income" including state teachers' retirement benefits. Thus, plaintiff and defendant entered into a Reimbursement Agreement whereby plaintiff would reimburse defendant for any overpayment of benefits once she received payments of the "other income." Plaintiff refused to reimburse defendant and subsequently defendant had to go through a drawn out process where plaintiff evaded it and made collection difficult. Finally, defendant filed a collection action against plaintiff and the claim was later settled in open court for the full amount that defendant demanded. The *Connolly* court held that plaintiff's bad faith claims failed. Section 8371 claims require an insurance policy. However, plaintiff's allegations related to defendant's efforts to enforce the Reimbursement Agreement, not an insurance policy. The Agreement neither required defendant to investigate any claims nor provide any benefits. Therefore, plaintiff cannot state a bad faith claim based upon defendant's actions in enforcing it.

6. Preemption of claims

There have been several decisions identifying laws that preempt Section 8371. These include claims made under ERISA, FEGLIA and FEMA.

a. ERISA claims

In Knochel v. Healthassurance Pennsylvania, Inc., 2006 U.S. Dist. LEXIS 81009 (Rpt and Recommendation W.D. Pa. Sept. 2006), plaintiff's state law claims for breach of contract and bad faith were preempted by the Employee Retirement Income Security Act ("ERISA"). Plaintiff was denied insurance coverage under her husband's employer policy for chemotherapy, which defendant claimed was excluded pursuant to a provision which exempts coverage for experimental services. "A claim 'falls within' the scope of ERISA and is completely preempted, if the plaintiff could have brought his claim under ERISA § 502(a)(1)(B), and there is no other independent legal duty that is implicated by a defendant's actions." In *Knochel*, since the terms of the benefit plan are crucial to both the breach of contract and bad faith claims, the court could not say that the legal duty alleged was entirely independent of ERISA. Finally, the "savings clause" in ERISA did not save the state law claims, since Pennsylvania's bad faith statute does not "regulate insurance" within the meaning of ERISA's saving clause.

See also, Viechnicki v. Unumprovident Corp., 2007 U.S. Dist. LEXIS 8959 at *17; Scheibler v. Highmark Blue Shield, 2007 U.S. App. LEXIS 12977 *7 (3rd. Cir. May

2007)(unpublished opinion); Tennenbaum v. Unum Life Ins. Co., 2006 U.S. Dist. Lexis 66623 (E.D. Pa. Sept. 2006).

b. FEGLIA claims

In Fernbaugh v. Metropolitan Life Ins. Co., 2006 U.S. Dist. LEXIS 67765 (Mem. Op. M.D. Pa. Sept. 2006), plaintiff brought a bad faith claim under 42 Pa.C.S.A 8371 for refusal to pay \$98,000 in proceeds on the death of his wife under a Federal Employees' Group Life Insurance policy issued by Metro Life. Metro Life moved to dismiss the case, arguing Federal Employees' Group Life Insurance Act ("FEGLIA"), 5 U.S.C. 8701-8716, preempted the state statute for bad faith. The Court disagreed and ruled that provisions of the policy regarding what types of claims could be pursued were not inconsistent with the bad faith statute and that the claim was not preempted by FEGLIA. However, the Court held that the FEGLIA policy was inconsistent with the bad faith statute with respect to types of damages recoverable, i.e. the Policy did not permit recovery of punitive damages or court costs. Thus, the bad faith claim was allowed to proceed, but only for the recovery of attorney's fees and interest to the extent permitted by FEGLIA.

c. FEMA claims

In Dudick v. Nationwide Mut. Fire Ins. Co., 2007 U.S. Dist. LEXIS 21773 (Mem. Op. E.D. Pa. March 2007), the insured filed suit for breach of contract, bad faith, misrepresentation and Unfair Trade Practices, evolving out of the submission of a flood loss claim. The policy at issue was a Standard Flood Insurance Policy ("SFIP") issued pursuant to the National Flood Insurance Program ("NFIP"), 42 U.S.C. § 4002, et seq. The NFIP is administered by the Federal Emergency Management Agency ("FEMA"), and flood insurance claims are ultimately paid by the United States Treasury. Insurer argued for dismissal of the case as preempted by FEMA. The Court agreed, concluding "Plaintiffs' claims may appear to sound in tort, they are intimately related to - and inextricably intertwined with - the disallowance of their claim for damages. . . State law claims which involve disputes regarding the adjustment and handling of claims are preempted by the National Flood Insurance Act ("NFIA")."

COVERAGE ISSUES IN CONSTRUCTION CLAIMS⁸

I. COVERAGE ISSUES

A. NAMED INSURED

The “named insured” is the insured listed on the declaration pages, and as added by endorsement. In addition, the definition of “Who is An Insured” adds, by definition, other described insureds. Depending on whether the named insured is an individual, a partnership or joint venture, a limited liability company, or some other organization, spouses, other members, executive officers, and shareholders are included as insureds, but only with respect to the operation of the business or with respect to their duties for the business. Employees are also typically considered insureds, by definition, for acts within the scope of their duties, but not for bodily injury or personal injury to co-employees and others. Real estate managers are also described insureds. The definition does contain a catchall limitation at the end which states:

No person or organization is an insured with respect to the conduct of any current or past partnership, joint venture or limited liability company that is not shown as a Named Insured in the Declarations.

One decision in Pennsylvania which addresses the issue of who is considered an insured is as follows.

In Boyertown Mutual Insurance Company v. Skias, 52 Pa. D & C 4th 86 (C. C. P. Berks 2001), a policy was issued to “Chris and Shirley Skias individually and t/a Weld-Rite Shop. Mr. Skias also operated a crane rental business from the same location. Both businesses were sole proprietorships. Mr. Skias rented a cherry picker, and the user fell, sustaining personal injuries. Boyertown denied coverage as being totally unrelated to the welding operations of the insured, which was the underwriting classification used. The named insured was described as “individual”, and the definition of named insured thus extended to “the person so designated but only with respect to the conduct of a business of which he is the sole proprietor“. As this definition referred to “a business”, not “the business”, there was no limitation, and the policy covered both proprietorships. The court rejected Boyertown’s efforts to limit coverage to only the described underwriting classifications.

B. ADDITIONAL INSUREDS

Additional insured endorsement no. CG 20 10 11 85 provides that the named person or organization is now an insured under the definition “Who Is An Insured”, “but only with respect to liability arising out of “your work” for that [additional] insured by or for you [the named insured].”

Endorsement no. CG 20 26 11 85, “Additional Insured – Designated Person or Organization” provides similar language:

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule as an insured but only with respect to liability arising out of your

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operations or premises owned by or rented to you. (emphasis added.)

Pennsylvania courts have considered the effect of limiting language. In Rust Engineering and Construction, Inc. et al. v. American Refractories Co., Inc., et al., 1997 U. S. Dist. LEXIS 19783 (E. D. Pa. 1997), the Court holds that the phrase “arising out of your operations” is unambiguous as a matter of law. The Court broadly interprets that phrase to only require “but for” causation, not “proximate cause.”

In Maryland Casualty Company v. Regis Ins. Co., 1997 U. S. Dist. LEXIS 4359 (E. D. Pa. 1997), the Court holds that the phrase “as the result of” contained in an additional insured endorsement, which was argued by the insurer to be more restrictive than “arising out of”, also only required a “but for” analysis.⁹

In Township of Springfield v. William Ersek, et al., 660 A. 2d 672 (Pa. Cmwlth. Ct. 1995), alloc. denied 675 A. 2d 1254 (1996), an insurer was required to defend and indemnify the additional insured for its own negligence. The Township of Springfield, as lessor, sought indemnity from Ersek, the lessee of a golf pro shop, for injuries sustained by Ersek’s employee who slipped and fell on steps leading to a parking lot. The Township was an additional insured, “but only with respect to liability arising out of the operations performed by the named insured.” Neither the lease agreement nor the employment agreement controlled the legal obligations of the insurer. The policy did not require that Ersek was negligent in causing the injury. The insurer had to defend and indemnify the Township for the Township’s own alleged negligence in the causation of employees’ injuries. “[A]rising out of” has been defined as “causally connected”, not “proximately caused by”: This language requires the insurer to provide a defense and indemnify an additional insured for the additional insured’s negligence which occurred on the covered premises.

In Pennsylvania Turnpike Commission v. The Transcontinental Ins. Co., et al., 1995 U. S. Dist. LEXIS 11089 (E. D. Pa. 1995), two employees of a painting subcontractor were injured while painting a turnpike overpass bridge. The employer was a subcontractor to a prime contractor. The additional insured endorsement issued by the subcontractor’s insurer to the Commission contained the limitation “but only with respect to liability arising out of” work or operations performed by the subcontractor or on the subcontractor’s behalf for the Commission. The insurer argued that the phrases “but for” and “your work” operated to limit the “arising out of” phrase such that coverage existed only with respect to acts or omissions committed by the subcontractor. The complaints in the underlying injury actions alleged that the accident was caused by the Commission’s negligence in designing, implementing and enforcing a traffic control plan for the work site, and did not allege that the accident was caused by the subcontractor’s work. The Court found that the additional insured endorsement was ambiguous as to whether an additional insured was covered for independent acts of negligence. A showing of proximate causation or vicarious liability is required only when an insurance contract contains unambiguous language to that effect. Without such explicit wording, the phrase “arising out of” must be construed to merely require “but for” causation.¹⁰

⁹ The Court also found that a more restrictive phrase requiring the liability to be a result of “an alleged act or omission” of the named insured would extend to any liability sought to be imposed upon the additional insured because of something the named insured was alleged to have done or failed to have done. It did not matter whether the liability sought to be imposed was vicarious liability or not.

¹⁰ This decision is decided under Ohio law, but relies upon Pennsylvania case law.

In City of Philadelphia v. Charter Oak Fire Ins. Co., 6 Pa. D. & C. 3d 304 (C. C. P. 1977), the claimant fell on the sidewalk six feet west of the west entrance steps of the Philadelphia Civil Center after leaving a performance and filed a personal injury suit. The licensor was the City of Philadelphia. The licensee was Shipstads & Johnson Ice Follies, Inc., and the license agreement granted permission to use “all that certain space of the Philadelphia Civic Center . . . and such other parts of that structure as may be permitted by licensor for the purpose incident to the use to be made of the licensed space” The additional insured endorsement provided to the City by Shipstad’s insurer included the City “but only with respect to liability arising out of the ownership, maintenance or use of that part of the premises leased by [the City of Philadelphia] to the named insured [licensee].” The Court held that the claimant’s injury arose out of Shipstad’s use of that part of the premises “leased”.

C. LEGALLY OBLIGATED TO PAY AS DAMAGES

The Commercial General Liability Policy provides coverage for “sums the insured becomes legally obligated to pay as damages because of . . . ‘property damage’ . . . caused by an ‘occurrence,’” defined as “an accident.” Insurers take the position that there is no coverage for the failure to perform work required under a contract, or for the inadequacy of the insured’s work or product itself. Cases hold that this coverage does not apply to liability based solely on breach of contractual duties. However, where there is a claim that the insured accidentally injured other property, there may be coverage, since the insured has a non-contractual duty to use reasonable care not to damage such other property, regardless of the contract. See Redevelopment Auth. v. International Ins. Co., 685 A. 2d 581 (Pa. Super. 1996), appeal denied, 695 A. 2d 787 (Pa. 1987). Pennsylvania cases which address this issue include the following.

In Keystone Filler & Mfg. Co., Inc. v. American Mining Ins. Co., 179 F. Supp. 2d 432 (M. D. Pa. 2002), the court held that tort, as opposed to contract, actions are covered. The tort must be the “gist” of the claim, with the contract collateral. In Snyder Heating v. Pa. Mfrs. Ass’n Ins., 715 A. 2d 483 (Pa. Super. 1998), the court held that a general liability policy is not “a performance bond” applicable to the insured’s “failure to perform a contract or agreement in accordance with its terms.”

D. OCCURRENCE

Most insureds involved in construction projects have commercial general liability policies issued on an “occurrence” form. Another form issued by ISO is on a claims-made basis. An “occurrence” is defined as “an accident, including repeated exposure to substantially the same general harmful conditions.”

On April 5, 2004, the Pennsylvania Supreme Court granted petitions for appeal to determine the appropriate test of whether a claim sounds in tort or contract for liability insurance coverage purposes, and when such circumstances give rise to an “occurrence”. The petitions for appeal which were granted are of the Superior Court decisions of Kvaerner Metals Division, et al., v. Commercial Union Ins. Co. et al., 2003 Pa. Super. 149, 825 A.2d 641 (2003), which was consolidated for appeal with Freestone v. New England Log Homes, Inc., et al., 2003 Pa. Super. 24, 819 A.2d 550 (2003). Freestone subsequently settled.

On October 25, 2006, the Pennsylvania Supreme Court issued its decision in Kvaerner Metals v. Commercial Union Ins. Co., 908 A.2d 888 (Pa. 2006). The Pennsylvania Supreme Court holds that the “accident” required to establish an “occurrence” under liability policies cannot be satisfied by claims based upon faulty workmanship which result solely in damage to the insured’s work product. The court explains that it does not matter that the damage was

unexpected or unintended by the insured. Such claims do not present the degree of fortuity required by the policies and to hold otherwise would turn the policy into a performance bond. The court observes that the Complaint against Kvaerner only alleges “workmanship-related irregularities” to Kvaerner’s own work product (which included subcontractor work). This poor workmanship did not constitute the required “active malfunctioning” causing damage to property other than the insured’s work product. The court also reaffirms that in Pennsylvania, only the factual allegations of the complaint can trigger coverage, not extrinsic evidence outside of the complaint.

The Pennsylvania Supreme Court recognizes a potential for coverage where the complaint alleges that the cause of the property damage is faulty workmanship, but there is damage to property other than the insured’s work product. The court does not directly address the possibility of coverage where a cause of property damage (qualifying as “active malfunctioning”) is alleged to be something other than poor workmanship, even if the damage is confined to the insured’s work product.

Kvaerner was sued for breach of contract and breach of warranty arising out of the design and construction of a coke oven battery. Alleged damage included cracking of battery bricks, subsidence, spalling of walls, and bowing of tie rod housings. The recovery sought was limited to the amount to replace the battery, or the difference in value between the defective battery and the battery that Kvaerner warranted that it would deliver. National Union refused to defend Kvaerner under its CGL policies.

Kvaerner sued National Union, who brought a motion for summary judgment arguing there was no “occurrence” and that the “business risk/work product” exclusions applied. Kvaerner argued that an “occurrence” existed due to an unintended and unexpected event (roof movement caused by heavy rains and early grouting). Kvaerner also argued that the damage arose out of subcontractor work and was covered under completed operations coverage. The trial court ruled in favor of National Union, relying on Redevelopment Auth. of Cambria County v. International Ins. Co., 685 A.2d 581 (Pa. Super. 1996) to hold that damages resulting from a breach of contract can never be classified as “accidental.” The trial court found that damages sought were solely for breach of contract, not damages caused by an “accident”, stating that “[t]he design specifications are duties imposed upon an Insured, not by public policy, but by the Contract”

Kvaerner appealed to the Superior Court, which found triable issues of fact, reversed the trial court’s order, and remanded the case back to the trial court. The Superior Court first held that the trial court erred in holding that National Union did not have a duty to defend or indemnify. The court held that extrinsic evidence outside of the complaint may be considered (here, expert opinions raising the possibility of other causes for the damage, including torrential rains) because the liability policies did not require that a civil complaint be filed to trigger coverage. The extrinsic evidence raised triable issues of fact concerning the causes of the damage to the battery. The court also found that triable issues of fact existed as to the business risk/work product exclusions, namely that coverage was allowed for damages caused by work of subcontractors.

National Union appealed to the Pennsylvania Supreme Court, and the court allowed the appeal to consider three issues: 1) whether extrinsic evidence outside of the complaint can be considered in determining a duty to defend; 2) whether the battery was damaged by an “occurrence”, and 3) whether the business risk/work product exclusions delete coverage. The court first concludes that the Superior Court erred in looking at extrinsic evidence. Coverage can be triggered solely by a determination of whether the factual averments of a complaint

implicates a policy's coverage. Here, a duty to defend only exists if a civil proceeding alleges damages for property damage caused by an "occurrence", or an "accident". The court thus examines whether the damage that is the "impetus" of the suit was caused by an accident.

Based on dictionary definitions, the court notes that the key term in the ordinary definition of "accident" (an undefined term) is "unexpected", which "implies a degree of fortuity that is not present in a claim for faulty workmanship." The Court cites with approval Snyder Heating v. Pennsylvania Manufacturer's Assoc. Ins. Co., 715 A.2d 483 (Pa. Super. 1998) (contractual claims of poor workmanship not covered; general liability policies only provide coverage if the insured work or product "active malfunctions" causing injury or damage to another's property). The court also cites a New Hampshire Supreme Court decision, McAllister v. Peerless Ins. Co., 474 A.2d 1033 (N.H. 1984) (no coverage as only damage alleged was caused by faulty workmanship to the work product itself; thus no fortuity, as required by "accident", due to mere failure of workmanship). Finally, the court cites as "instructive" a recent South Carolina Supreme Court decision, L-J, Inc. v. Bituminous Fire and Mar. Ins. Co., 621 S.E.2d 33 (S.C. 2005), where after roads deteriorated, the insured was sued for breach of contract and negligence. The South Carolina court held that there was no occurrence, even for the claims of negligence, as faulty workmanship was not an accident (stating that it could be if it caused bodily injury or damage to other property, but not in cases where only the insured's work product was damaged).

The Pennsylvania Supreme Court holds that the complaint against Kvaerner only alleged poor workmanship resulting in "workmanship-related irregularities" to the work product itself (including the subcontractor work performed by the insured). As the "accident" required to establish an "occurrence" cannot be satisfied by claims based upon such faulty workmanship, National Union did not have a duty to defend or indemnify Kvaerner. The Court then finds it unnecessary to address the business risk/work product exclusions.

Note that Kvaerner had been consolidated on appeal with Freestone v. New England Log Homes, 819 A.2d 550 (Pa. Super. 2003), and the Supreme Court directed the parties to brief whether the action sounds in contract or tort impacts insurance coverage (and as such, requiring the parties to address the "gist of the action" doctrine). In Freestone, the insured was sued for improperly supplying unseasoned logs for the construction of a log home, which resulted in the shrinking of the logs allowing water intrusion and resultant damage. Three claims were made: breach of contract; breach of warranty, and negligent advice. Judge Klein of the Superior Court concluded that there was no coverage, holding that the gist of the negligent advice claim sounded in contract. However, Freestone settled while on appeal, and in footnote 6 of Kvaerner, the Pennsylvania Supreme Court states: "we see no need to address this issue and shall therefore leave it for another day." As such, the Supreme Court does not specifically embrace a strict view that breach of contract claims can never be an "occurrence", focusing instead on faulty workmanship resulting solely in damage to the insured's work product as not being an "occurrence."

Other prior Pennsylvania cases which address these issues include the following. In Pro Dent Inc. v. Zurich, 2001 U. S. Dist. LEXIS 5672 (E. D. Pa., May 1, 2001), the court held that there was no "occurrence" where gist of complaint was contractual breach based on insured's failure to install suitable plumbing lines, despite "negligence" verdict.

In Lang Tendons, Inc. v. Northern Ins. Co. of New York, 2001 U. S. Dist. LEXIS 2358 (E. D. Pa. 2001), the court distinguishes Snyder, and Redevelopment Agency, infra., as the complaint, which alleged breach of contract, breach of warranty, and negligence arising out of

the improper installation of cable barriers in a parking garage, alleged the negligent performance of duties independent of any contract.

In Jerry Davis, Inc. v. Maryland Ins. Co., 38 F. Supp. 2d 387 (E. D. Pa. 1999), the court held that there was no “occurrence” where gist of claim was contractual breach based on failure to perform suitable electrical work. In American Planned Communities, Inc. v. State Farm Ins. Co., 28 F. Supp. 2d 964 (E. D. Pa. 1998), the court held that there were intentional misrepresentations of zoning in sale of housing which were not an occurrence. In Snyder Heating v. Pa. Mfrs. Ass’n Ins., 715 A.2d 483 (Pa. Super. 1998), the court held that a general liability policy is not “a performance bond” applicable to the insured’s “failure to perform a contract or agreement in accordance with its terms.” In Solcar Equipment Leasing Corp. v. Pennsylvania Mfrs’ Ass’n Ins. Co., 606 A. 2d 522 (Pa. Super. 1992), the court held that there is no coverage for negligent construction, because there was no accidental occurrence, and the insurance contract is “not a performance bond or any type of construction malpractice insurance.” In Redevelopment Auth. v. International Ins. Co., 685 A. 2d 581 (Pa. Super. 1996), appeal denied, 695 A. 2d 787 (Pa. 1987), the court held that the purpose and intent of a general liability policy is to protect the insured from liability for essentially accidental injury rather than coverage for disputes between parties to a contractual undertaking.

E. FORTUITY/KNOWN LOSS DOCTRINE

The known loss doctrine is a common law concept that derives from the fundamental requirement of fortuity in insurance law. The doctrine provides that one may not obtain insurance for a loss that either has already taken place or is in progress. The concept is based on the concept that the purpose of insurance is to protect insureds against unknown risks. State courts are divided as to the scope of the known loss doctrine. Some have construed it quite narrowly, barring coverage only when the insured knew of certainty of damages and liability. Others have refused to find coverage when the insured was substantially aware of a risk of loss. Pennsylvania cases that address this issue include the following.

In Rohm and Haas Co. v. Continental, 781 A. 2d 1172 (Pa. 2001), the court observes that although the known loss doctrine has not been adopted formally in Pennsylvania, the state Supreme Court has hinted strongly that it will be. The Court holds that where a “sophisticated insured,” at the time of the insurance application, knew or should have known of “a likely exposure to losses,” then no coverage is afforded for those losses. In Appalachian Insurance Co. v. Liberty Mutual Insurance Co., 676 F. 2d 56 (C. A. 3d. Cir. 1982), a long-standing rule precludes persons from obtaining insurance against injuries that have already occurred. Otherwise, an insured with knowledge of their own potential liability could obtain occurrence coverage after the fact and yet have the loss be deemed to have occurred during the after-acquired insurance coverage period.

F. PROPERTY DAMAGE

Pennsylvania decisions addressing “property damage” include the following.

In American International Underwriters Corp., et al., v. Zurn Industries, Inc., 771 F. Supp. 690 (W. D. Pa. 1991), the court held that potential property damage exists if the insured’s product is incorporated and becomes part of a larger product, and causes damage to other than the insured’s product or work, with resultant consequential damages. In Imperial Casualty and Ind. Co. v. High Concrete Structures, Inc., 858 F. 2d 128 (C. A. 3rd Cir. 1988), the court held that property damage occurs when a third party incorporates the insured’s product into a new

product having a value in excess of the original product supplied by the insured, and suffers damage to more than only the insured's product.

G. APPLICABLE POLICIES

The insuring agreement of the general liability policy forms provide that the insurance only applies if the "property damage" occurs during the policy period. Analysis and resolution of this "trigger" of coverage issue may depend on whether the facts can be characterized as involving: 1) a single event resulting in immediate injury; 2) a single event resulting in delayed or progressively deteriorating injury; 3) a continuing event resulting in a single or multiple injuries; or 4) numerous separate events causing separate injuries.

Different "triggers" will be applied by various courts depending on the nature of the claim. For example, arguments can be made that claims of personal injury or illness from mold, resulting from alleged construction defects, require special treatment under Pennsylvania law for the "timing of occurrence" purposes. The Pennsylvania Supreme Court has carved out an exception to the "first manifestation" rule for certain toxic tort cases. The decision was designed to protect the insured from coverage denials in toxic tort cases where the disease processes involved had extraordinarily long latency periods. See, J.H. France Refractories Company v. Allstate Insurance Company, 626 A. 2d 502 (Pa. 1993). A subsequent decision by the Superior Court suggests that the multiple-trigger rule is limited to situations where the injuries occasioned by the wrongful conduct lay dormant for unusually extended periods. Consulting Engineers, Inc. v. INA, 710 A. 2d 82 (Pa. Super. 1998). If more than one occurrence is deemed to be present, more than one deductible may apply. See Peco Energy Co. v. Boden, 64 F. 3d 852 (C. A. 3rd Cir. 1995) (where multi-year series of thefts constituted one occurrence, with only one deductible applicable). Pennsylvania cases include the following.

In West American Ins. Co. v. Endel Lindepuu, 128 F. Supp. 2d 220 (E. D. Pa. 2000), the court held that policies in force when injuries arising out of improper installation of windows discovered apply. In Consulting Engineers, Inc. v. INA, 710 A. 2d 82 (Pa. Super. 1998), the court suggests that the multiple-trigger rule is limited to situations where the injuries occasioned by the wrongful conduct lay dormant for unusually extended periods. In J.H. France Refractories Company v. Allstate Insurance Company, 626 A. 2d 502 (Pa. 1993), a "multiple-trigger" approach was adopted in asbestos cases. Every insurer who covered a tortfeasor during any of the stages of development of a plaintiff's asbestos-related disease was bound to indemnify the tortfeasor. The rationale for this approach was found in the fact that "bodily injury" was defined by the policies as "bodily injury, sickness or disease which occurs during the policy period" and "occurrence" was defined as "an accident, including continuous or repeated exposure to conditions, which result in bodily injury." The particular medical evidence led to the conclusion that injury occurred in the asbestos context not only at the time of initial exposure but also up to and including the periods where the disease was progressing and becoming an incapacitating illness.

In Triangle Publications, Inc. v. Liberty Mutual Ins. Co., 703 F. Supp. 367 (E. D. Pa. 1989), in underground toxic waste case, court adopts injury-in-fact trigger, as opposed to manifestation of damage (the aspect of "occurrence" which must take place within the policy period is the "result", that is, the time when the accident or the injurious exposure produces injury). In Great Northern Ins. Co. v. Altemose Construction Co., 1989 U. S. Dist. LEXIS 10728 (E. D. Pa. 1989), in construction case involving roof leaks, the Court holds that the occurrence begins when the injurious effects of the act of negligence manifest themselves such that a reasonable person would be on notice of the injury. The court raises issue of whether there was only one occurrence or multiple occurrences triggering more than one policy. In D'Auria v.

Zurich Insurance Co., 507 A. 2d 857 (Pa. Super. 1986), the court holds that “[a]n occurrence happens when the injurious effects of the negligent act *first manifest themselves* in a way that would put a reasonable person on notice of an injury.” The key phrase in this definition is “first manifest themselves” because the implication that arises from this phrase is that harm which begins at a certain point in time cannot be deemed to “occur” later through accrual of additional damage.

H. OTHER INSURANCE

Courts have considered “other insurance” clauses in policies when determining how those policies relate to each other. Such clauses are considered to make a policy either primary or excess to each other. The other type of clause is known as an “escape” clause, because the insurer attempts to avoid any liability in the event of other insurance. Escape clauses are disfavored and will not be given effect. See Contrans, Inc. et al., v. Ryder Truck Rental, et al., 836 F. 2d 163 (C. A. 3rd Cir. 1987). Other insurance clauses will only be given effect if the court determines that the policies cover the same insurable risk. See Everett Cash Mut. Ins. Co. v. General Acc. Ins. Co., 30 D. & C. 4th 452 (C. C. P. Cumberland 1996), Mission National Ins. Co. v. Hartford Fire Ins. Co., 702 F. Supp. 543 (E. D. Pa. 1989).

I. EXCLUSIONS AND LIMITATIONS

Pennsylvania cases involving interpretation of exclusions include the following. In West Am. Ins. Co. v. Lindepuu, 128 F. Supp. 2d 220 (E. D. Pa. 2000), the court holds that there is no coverage for replacement of doors and windows installed by insured.

In American Int’l Surplus Lines Ins. Co. v. IES Lead Paint Div., 1996 U. S. Dist. LEXIS 3404 (E. D. Pa., Mar. 18, 1996), aff’d, 111 F. 3d 125 (3d Cir. 1997), the court holds that exclusion m. excludes coverage for liability for property damage (which would include loss of use) to “impaired property” or property that has not been physically injured, if it arises out of a deficiency in the insured’s product or work or the insured’s failure to perform an agreement in accordance with its terms. This exclusion applies to both “impaired property” and “property that has not been physically injured.”

In Ryan Homes, Inc., et al. v. The Home Indemnity Company, et al., 647 A. 2d 939 (Pa. Super. 1994), the court holds that defective and deteriorating roof sheathing installed by subcontractor was considered to be part of the general contractor’s work for purposes of applying exclusions.

In Solcar Equipment Leasing Corp. v. Pennsylvania Mfrs’ Ass’n Ins. Co., 606 A. 2d 522 (Pa. Super. 1992), the court holds that the product and work exclusions are unambiguous and preclude coverage. Coverage is excluded for damages claimed for repair, replacement, etc. of the insured’s product or work (but perhaps not damage to other parts of the house that were not part of the insured’s work).

In John J. Curry & Son v. Harleysville Mut. Ins. Co., 11 D. & C. 4th 521 (C. C. P. Carbon 1991), the court holds that damage to carpet and sheet rock installed by insured, caused by failure to perform in a workmanlike manner using suitable materials. In Mazzotta v. Aetna Casualty & Surety Co., 4 D. & C. 4th 283 (C. C. P. Allegheny 1989), the court holds that there is no coverage for costs of removing old paint and repainting walls where paint was supplied and applied by insured. In Standard Venetian Blind Co. v. American Empire Ins. Co., 469 A. 2d 563 (Pa. 1983), the collapse of a portico installed by the insured’s subcontractor was held excluded.

II. WAIVER OF SUBROGATION

In Universal Underwriters Insurance Co. v. A. Richard Kacin, Inc., 2007 Pa. Super. LEXIS 16 (Pa.Super. 2007), a case of first impression, the Superior Court holds waiver of a subrogation provision not invalid, even where the insurer is not party to the contract and there is no evidence that it consented to the provision.

Although the Pennsylvania Superior Court upheld the validity of waiver of subrogation provisions in the case of Penn Avenue Place Assoc., L.P. v. Century Steel Erectors, Inc., 798 A.2d 256 (Pa. Super. 2002), the Court was called upon here to address new issues with respect to these provisions that limit the filing of legal actions.

Kacin and Bassett were the general contractor and subcontractor for construction work performed at Watson Chevrolet Oldsmobile. When a wall fell down allegedly as the result of the contractors' negligence, Watson's commercial property insurer, Universal Underwriters, paid for the repairs and then attempted to bring a subrogation action against the contractors for its losses. First, the Court rejected the argument that the waiver of subrogation provision was in conflict with other contract provisions allowing for contractual remedies, as those provisions could be read to allow for a party to pursue such damages when not covered by property insurance.

Second, and perhaps more importantly, the Court rejected Universal Underwriters' contention that the waiver of subrogation provision could not be enforced, because it did not have notice of or give consent to the provision. Although recognizing that some jurisdictions have reached a different result, the Court agreed with those jurisdictions that determine "the right to subrogation as dependent entirely on the viability of the insured's cause of action against the third-party tortfeasor."

Thus, if the insured waives such a claim, the insurer's ability to bring such a claim is also waived regardless of notice or consent. According to the Court, such a result is not inequitable, as the parties to the contract agreed not to sue each other for damages covered by insurance. In addition, since subrogation is a derivative right, the insurer stands in the shoes of its insured. Finally, insurers can protect themselves from such waiver provisions by inserting exclusions in their policies, charging higher premiums, investigating the insured's contracts to determine if they have already waived subrogation, or obtaining reinsurance to cover such losses. For these reasons, lack of notice or consent did not make the waiver of subrogation provision unenforceable.

ADDITIONAL RECENT COVERAGE CASES

WHO IS AN INSURED:

Progressive N. Ins. Co. v. Universal Underwriters Ins. Co., 898 A.2d 1116 (Pa. Super. 2006) This declaratory judgment action arose out of an automobile accident in which the injured party was operating a vehicle on loan from a car dealership. In the declaratory judgment action, the Court was asked to determine questions regarding liability and physical damage coverage. The two parties to the action, the injured's father's insurer and the car dealership's insurer agreed that the injured was an insured under his father's policy. The dispute arose as to whether the son was an insured for purposes of liability coverage under the dealership's policy. The dealership's policy defined an insured as "[a]ny other person or organization required by law to be an INSURED while using an AUTO covered by this Coverage Part within the scope of YOUR permission." The Court held that the 1990 amendments to the Motor Vehicle Financial Responsibility Law imply that the owner of a vehicle is required to provide coverage to all permissive users of that vehicle. As such, the Court found that both the dealership's policy and the father's policy provided liability and damage coverage.

TIMING OF PAYMENT OF PREMIUM AND NOTICE OF CANCELLATION:

Russock v. AAA Mid-Atlantic Ins. Co., 898 A.2d 636 (Pa. Super. 2006) Plaintiff insured brought action against defendants automobile insurer and bank for declaratory judgment to determine the insured's entitlement to coverage under a policy of automobile insurance. The insurer had issued a policy on a vehicle rented by the insured under which plaintiff insured was a named insured. Premium payments were to be made through an on-line remittance service of defendant-bank pursuant to a written agreement with plaintiff-insured that required payment dates to be scheduled five days prior to the actual payment due date. On June 3, 2003, approximately ten days before the payment due date for renewal on June 13, 2006, plaintiff-insured electronically requested the bank to issue payment to the defendant-insurer through the on-line service. The premium check was issued and mailed from the bank's facility on June 10, 2003 to the insurer's Philadelphia post office box whereupon it was transported to a processing facility in New Jersey, arriving there four days after the due date. On that date a cancellation confirmation was issued to the insured but payment was credited to the insured's policy. Three days later, insured was involved in a motor vehicle accident which was reported to the insurer. Thereafter, the insured received the cancellation notice from the insurer. Following a non-jury trial, the trial court issued a verdict in favor of the insurer and the bank. The plaintiff-insured's Motion for Judgment Notwithstanding the Verdict was denied, and the insured appealed to the Superior Court of Pennsylvania. The Superior Court vacated the judgment in favor of insurer and bank. In so ruling, the Superior Court held that payment of the premium was made when the check was mailed before the end of the policy period, even though the renewal notice required receipt on or before the due date. The Superior Court further concluded that the Notice of Cancellation sent on the day that the premium payment arrived at the insurer's processing facility was ineffective.

ADVERTISING INJURY:

Melrose Hotel Company v. St. Paul Fire and Marine Insurance Company, 432 F.Supp.2d 488 (D.Ct. Pa., 2006) The insured, a hotel, hired a third-party to send faxes advertising insured's hotels. A recipient of one such fax filed a class action suit against the insured, alleging a violation of the Telephone Consumer Protection Act ("TCPA"), 47 U.S.C. §

227. Insured filed a declaratory judgment action, seeking a determination that insurer must defend and indemnify in connection with such litigation. The policy contained an “advertising injury” provision, which included “making known to any person or organization covered material that violated a person’s right to privacy. The court held that the “advertising injury” provision of the policy did not cover the sending of unsolicited faxes because plaintiff’s alleged actions did not fall within the scope of the policy’s coverage for invasions of privacy, as the privacy interests included under the policy involved secrecy, and the privacy interests under the TCPA involved the right to be left alone. The court also held that the “property damage” coverage of the policy was not applicable to the underlying suit. Specifically, the court found that the policy exclusion for “expected or intended” property damage was a grounds for coverage in this case.

PPCIGA AND INSOLVENT INSURER:

Valley Med. Facilities, Inc. v. PPCIGA, 902 A.2d 547 (Pa.Super.2006) In a case involving an underlying medical malpractice action and an insolvent insurer, appellant, the Pennsylvania Property and Casualty Insurance Guaranty Association (PPCIGA), appealed the order of the Court of Common Pleas of Beaver County, which directed the PPCIGA to pay both appellee hospital's excess insurance coverage limits of \$ 300,000 and appellee doctor's primary insurance coverage limits of \$ 200,000. On appeal, the PPCIGA raised the following issue: Was the PPCIGA's \$ 300,000 limit, which was expressly stated in the Pennsylvania Property and Casualty Insurance Guaranty Association Act, 40 Pa. Stat. Ann. §§ 991.1801-991.1820, as "per claimant," instead to be applied "per insured" and "per policy"? The Pennsylvania Superior Court concluded that both the hospital and the doctor were claimants under the Act because both first-party and third-party claimants could possess "covered claims" for purposes of the Act. In addition, a covered claim existed for each policy because the unpaid claims brought by the hospital and the doctor arose out of and were within the coverage of the limits of the insurance policies issued by the insolvent insurer pursuant to 40 Pa. Stat. Ann. § 991.1802. Also, the Superior Court was persuaded to find that the statutory cap was applicable on a per policy basis. Thus, the PPCIGA's total liability under the insolvent insurer's policy limits amounted to \$ 800,000, which included \$ 300,000 for the hospital's primary policy, \$ 300,000 for the hospital's excess policy, and \$ 200,000 for the doctor's primary policy.

“CAR FOR HIRE” EXCLUSION:

Prudential Property and Cas. Ins. Co. v. Sartno, 903 A.2d 1170 (Pa. 2006) Defendant-insurer filed a Declaratory Judgment Action seeking to preclude liability coverage and duty to defend plaintiff in a civil action. Plaintiff was involved in an accident while operating his private vehicle in order to deliver pizzas for his employer. The insurance policy at issue contained a “Cars for Hire” exclusionary provision, which stated: “We will not pay for bodily injury or property damage caused by anyone using a car covered under this part to carry people or property for a fee.” The Court held that this provision was open to at least two reasonable interpretations. First, using a broad interpretation, plaintiff did carry property for a fee because his deliveries occurred during the course of his employment, for which he was paid. Second, using a narrower interpretation, plaintiff did not carry property for a fee because there was no delivery charge for the pizzas. The Court held that because the exclusionary clause was ambiguous, it must be construed in favor of the insured. As such, the Court held the exclusionary clause to be inapplicable to plaintiff.

OTHER INSURANCE:

Allstate Ins. Co. v. Tokio Marine & Nichido Fire Ins. Co., 464 F.Supp.2d 452 (E.D.Pa. 2006) In a declaratory judgment action, the parties sought clarification of coverage

under conflicting insurance policy contract provisions related to an automobile accident. The driver was involved in a motor-vehicle accident while driving a car loaned to her by the dealership. The driver's policy included substitute vehicles as insured autos. The dealership's policy also contained an other insurance clause that sought to make its coverage excess over any other collectible insurance. The parties disputed which policy provided primary coverage and which policy provided excess coverage related to the driver's accident and the resulting personal-injury actions. At the time the driver borrowed the loaner vehicle, she signed a two-page agreement, which attempted to shift primary coverage to driver's personal insurance carrier. By signing the agreement, the driver essentially attempted to strike the driver's personal policy's other-insurance clause and enlarge the driver's insurer's bargained-for obligations to include the provision of full primary coverage of a substitute vehicle. Since the proposed modification was unknown to the driver's insurer, it did not consent to such a change to the policy contract. Because there were two conflicting excess-coverage, other-insurance clauses, the rule of mutual repugnancy applied to render the clauses ineffective. The Court denied both the driver's insurer and the dealership's insurer's motions for summary judgment and found as a matter of law that the policies were co-primary, and that the driver's insurer and the dealership's insurer had to share the loss by equal shares.

OCCURRENCE:

QBE Insurance Corp. v. M&S Landis Corporation t/d/b/a Fat Daddy's, et al., 915 A.2d 1222 (Pa. Super. 2007) Appellant insureds sought review of the judgment of the Court of Common Pleas, Civil Division York County (Pennsylvania), which, in appellee insurer's action, seeking a declaration that it had no duty to defend or indemnify the insureds in a wrongful death action filed against them, granted summary judgment to the insurer and denied the insureds' motion for summary judgment. The wrongful death suit filed against the insureds alleged that the decedent was smothered to death as a result of the insureds' negligent conduct in forcibly evicting him from the insureds' bar. The court held that summary judgment was improperly granted to the insurer in the declaratory judgment action because the allegations in the wrongful death action constituted an "occurrence" under the policy. Although the forceful eviction of the decedent from the bar involved intentional conduct on the part of some of the employees involved, the insureds' legal liability for the decedent's death was derived from the allegations of their negligence, including allegations that the decedent was improperly restrained, that the insureds failed to properly train their staff to evict patrons, and that the insureds did not timely render first aid. Further, the "assault and battery" exclusion under the policy did not excuse the insurer from providing coverage. There was a litany of allegations that the insureds' negligence led directly to the decedent's death; thus, the decedent's bodily injury did not arise from an assault and batter but, rather, arose from the alleged negligence of the insureds. The court reversed the judgment of the trial court and remanded the matter for entry of judgment in favor of the insureds.

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The foregoing is not intended to be a complete or exhaustive review of each and every reported or unreported decision issued by Pennsylvania courts, state and federal, on bad faith issues. Rather, the foregoing is intended as an overview of the recent and significant decisions with respect to issues typically encountered in insurance coverage issues in Pennsylvania.

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