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Pennsylvania Supreme Court Sets Forth Elements of Statutory Bad Faith Claim

In a case of first impression, the Supreme Court of Pennsylvania has explained the elements of a bad faith insurance claim under Pennsylvania's bad faith statute.

The Case

In March 1992, while working for the U.S. Postal Service, the plaintiff purchased a cancer insurance policy as a supplement to her primary employer-based health insurance.

More than a decade later, the plaintiff was diagnosed with ovarian cancer. She believed that she was eligible for waiver-of-premium status under her cancer insurance policy on the basis that she was unable to work, and thus, disabled since her admission into the hospital in February 2003. Plaintiff submitted the waiver of premium forms and the required physician statement to her insurer. The physician statement, however, mistakenly stated that her disability started in April 2003, rather than February. Believing that her premiums had been waived, plaintiff stopped paying premiums. Plaintiff continued to submit claims over the next two years.

In 2005, the insurer performed an audit and determined that plaintiff's policy had lapsed due to non-payment of premiums in May 2003. The insurer paid for plaintiff's treatment in 2004 and 2005, but refused to pay for her continued treatment.

Plaintiff disputed the insurer's position and presented her case as to why she was entitled to a premium waiver. She provided authorizations permitting the insurer to contact her employer and others concerning the actual date of her disability. The insurer, however, maintained its position based on the information in the physician's statement.

The plaintiff sued, alleging breach of contract and bad faith pursuant to the Pennsylvania bad faith statute. The two claims were bifurcated. After a bench trial on the bad faith claim, the trial judge noted that the insurer was "sloppy and even negligent" in its handling of the claim, but concluded that plaintiff had failed to demonstrate that the insurer lacked a reasonable basis for denying benefits under the policy because plaintiff did not prove that the insurer had acted out of "some motive or self-interest or ill will."

A Pennsylvania appeals court vacated the trial court's judgment as to the plaintiff's bad faith claim, and the dispute reached the Pennsylvania Supreme Court.

The Pennsylvania Supreme Court's Decision

The court affirmed.

In its decision, the court noted that this was the first time it was considering the elements of a bad faith insurance claim brought under Pennsylvania's bad faith statute (42 Pa.C.S. § 8371).

It then ruled that, to recover in a bad faith action, a plaintiff had to present "clear and convincing evidence" that the insurer: (1) did not have a reasonable basis for denying benefits under the policy; and (2) knew of or recklessly disregarded its lack of a reasonable basis.

The court also held that proof of an insurance company's motive of self-interest or ill-will was not a prerequisite to prevailing in a bad faith claim under the Pennsylvania statute. The court said that such evidence was probative of the second prong of the two-prong test, but that evidence of the insurer's knowledge or recklessness as to its lack of a reasonable basis in denying policy benefits was "sufficient."

In this case, the court explained, the parties generally agreed on the first prong of the two-prong test for bad faith under Pennsylvania's bad faith law: whether the insurer had a reasonable basis for denying benefits. The court also pointed out that there was agreement that, under the second prong of the test, mere negligence was insufficient for a finding of bad faith.

The court resolved the parties' primary point of contention, relating to the relevance of an insurance company's subjective motivation under the second prong of the test, by ruling that proof of a motive of self-interest or ill-will was not required to prove bad faith.

According to the court, an "ill-will level of culpability" would limit recovery in any bad faith claim to the "most egregious instances only" where the plaintiff uncovered some sort of "smoking gun" evidence indicating personal animus toward the insured. The court concluded that requiring ill-will could "functionally write bad faith" under the statute "out of the law altogether."

The court remanded the case back to the trial court to consider if the test it adopted has been met.

The case is *Rancosky v. Washington Nat'l Ins. Co.*, No. 28 WAP 2016 (Pa. Sept. 28, 2017).

Cancellation Notice That Did Not Follow Letter of the Law Was Ineffective, Nevada Supreme Court Says

The Nevada Supreme Court has ruled that a cancellation notice sent by an insurer to the policyholder that did not strictly comply with the requirements of Nevada law was ineffective.

The Case

After O.P.H. of Las Vegas, Inc., defaulted on its obligation to pay a premium on a business owner protector policy for the pancake restaurant it operated, its insurer sent O.P.H. a cancellation notice. The notice stated that the insurer would cancel the policy on August 16, 2012 if it did not receive payment by August 15, 2012.

The notice, however, did not specifically inform O.P.H. of its right under Nevada law to request

and receive within six days additional information about the reasons for the policy's cancellation.

A fire destroyed O.P.H.'s restaurant, and it submitted a claim to its insurer. The insurer denied coverage, stating that the policy had been cancelled for failure to pay the premium effective one day before the fire.

O.P.H. sued its insurer, arguing that its policy had not been validly cancelled because the notice the insurer sent was inadequate.

A trial court ruled in favor of the insurer, and the case reached the Nevada Supreme Court.

The Nevada Supreme Court's Decision

The court reversed.

In its decision, the court ruled that an insurer's cancellation notice was ineffective if it did not include an "express statement of a policyholder's right to request additional information about the reasons for a policy's cancellation."

According to the court, the Nevada law required "strict compliance" by insurers seeking to cancel a policy, and without an express statement of a policyholder's right to request additional information about the reasons for a policy's cancellation, the cancellation notice was ineffective – even if the notice provided a toll-free number the policyholder could call with billing inquiries or advised that the policyholder could contact its broker.

Because the insurer's notice to O.P.H. did not contain the required information, the court concluded, the policy was in effect at the time of O.P.H.'s loss.

The case is *O.P.H. of Las Vegas v. Oregon Mutual Ins. Co.*, No. 68543 (Nev. Sept. 14, 2017).

Contributory Trademark Infringement Claim Was Not "Advertising Injury," Georgia Federal Court Decides

The U.S. District Court for the Northern District of Georgia has ruled that a claim for contributory trademark infringement against owners of a discount mall based on the alleged sale of counterfeit merchandise by the mall's tenants did not fall within the scope of "advertising injury" under the mall owners' insurance policies.

The Case

The owners of a discount mall were sued for contributory trademark infringement under the federal Lanham Act based on the alleged sale of counterfeit Ray-Ban and Oakley sunglasses by some of the mall's tenants.

Their insurer went to court, seeking a declaration that the trademark infringement claims were not within the coverage provided by the advertising injury provisions of the owners' commercial general liability ("CGL") insurance policies.

The insurer moved for summary judgment.

The District Court's Decision

In a case of first impression in Georgia, the district court granted the insurer's motion.

In its decision, the district court found that it was "clear" from the provisions of the policies as a whole that the contributory trademark infringement claim brought against the mall owners was not "advertising injury" covered under the policies because it did not arise out of any *advertisement* by the mall owners of *their* goods and services.

The district court explained that the policies defined advertising injury as including an injury resulting from trade dress infringement, but expressly excluded from coverage injury resulting from trademark infringement. Therefore, the district court said, it could not construe the claim for trademark infringement against the mall owners as falling within the policies' definition of advertising injury for "infringing upon another's copyright, trade dress, or slogan."

The district court also rejected the mall owners' contention that a reference in the policies to "advertising idea" encompassed the concept of a trademark, ruling that an interpretation of the undefined term "advertising idea" as including a trademark would render the policies' exclusion for trademark infringement "meaningless."

In any event, the district court said that even if trademarks came within the scope of an "advertising idea," to fall under the coverage provisions of the policies, the injury for which coverage was sought had to be caused by the advertising itself. The district court then pointed out that the complaint against the mall owners contained no allegation that they or their vendors had engaged in any advertising or that there was any causal connection between any advertising and the alleged injury.

Accordingly, the district court concluded that the insurer had no duty to defend or indemnify the mall owners with respect to the contributory trademark infringement claim that had been filed against them.

The case is *Allstate Ins. Co. v. Airport Mini Mall, LLC*, No. 1:15-cv-3086-AT (N.D. Ga. Sept. 26, 2017).

Pollution Exclusion Precluded Coverage for Alleged Groundwater Contamination, Illinois District Court Rules

A federal district court in Illinois has ruled that the pollution exclusion in commercial general liability insurance policies precluded coverage for assertions by two state agencies that groundwater at two sites formerly operated by the insured were contaminated. **Read more…**

The Case

After state environmental agencies in Illinois and California asserted that they found groundwater contamination at two sites formerly operated by Varlen Corp., the company sued its commercial general liability insurance carrier.

The insurer moved for summary judgment, citing its policies' pollution exclusion.

Relying on an expert opinion, Varlen contended that the policies' pollution exclusion did not apply because there had been "sudden and accidental releases" of plating fluid containing hexavalent chromium into the soil at one site and because its diesel refueling and chlorinated solvent operations likely had resulted in "sudden and accidental releases" into the soil at the other site.

The insurer countered that the opinion testimony that the contamination at the two sites had resulted from sudden and accidental spills had to be excluded under Rule 702 of the Federal Rules of Evidence and the U.S. Supreme Court's decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc*.

The District Court's Decision

The district court granted the insurer's motion.

In its decision, the district court first found that Varlen's expert's report was inadmissible to prove that the contamination found by the state agencies had been the result of sudden and accidental releases. The expert described how long it took for contaminants to reach groundwater, but did not sufficiently demonstrate how he determined that pollutants were discharged suddenly and accidentally. The court noted that the rate of migration has nothing to do with *how* the contaminants began migrating. The expert also based his conclusion that the releases were sudden and accidental on the size of the plume. The court found the expert's opinion was speculative; he jumped from the amount of contaminants to an opinion about when and under what circumstances they were released. The court determined that the expert had not demonstrated that his opinions resulted from a reliable methodology.

The district court then noted that Varlen relied exclusively on its expert's deposition and report to create a fact issue on whether the discharges at the two sites had been sudden and accidental under the policies' pollution exclusion. Without that evidence, the district court reasoned, Varlen could not prove an essential element of its case. Accordingly, it concluded that it had to grant the insurer's motion for summary judgment.

The case is *Varlen Corp. v. Liberty Mutual Ins. Co.*, No. 13-cv-05463 (N.D. Ill. Sept. 25, 2017).

"Personal Profit or Advantage" Exclusion Given Broad Reading by Michigan Appellate Court

A Michigan appeals court, affirming a trial court's decision, has broadly interpreted an insurance policy's "personal profit or advantage" exclusion, finding that it precluded coverage of a consent judgment involving violation of a state's securities law.

The Case

After a charter school issued bonds that it was not authorized to issue, several investment funds that had purchased approximately $7 million of the bonds filed a lawsuit. The funds and the defendants reached a consent judgment, and the defendants acknowledged that they had violated part of the Connecticut Uniform Securities Act ("CUSA"). The funds were awarded

significant damages.

The defendants' insurer asked a Michigan court to declare that it was not obligated to indemnify the defendants. Among other things, it relied on its policy's "personal profit or advantage" exclusion.

The trial court granted summary judgment in favor of the insurer, and the dispute reached a Michigan appellate court.

The Appellate Court's Decision

The appellate court affirmed, finding that the personal profit or advantage exclusion served to preclude coverage.

In its decision, the district court found no dispute that the defendants had received a personal profit or advantage from the bond issue. The district court then rejected the argument that the exclusion did not apply because the profit the defendants' had realized had been "merely incidental."

It concluded that the exclusion applied even if the profit the defendants had realized was not itself an illegal act because the exclusion required only a gain to which the insured was "not legally entitled," and the defendants were not legally entitled to the profit they had obtained.

The case is *Employers Mutual Casualty Co. v. Helicon Associates, Inc.*, No. 322215 (Mich. Ct. App. Sept. 7, 2017).

Policy Did Not Cover Electricity Overcharge Suit Against Shopping Mall Owner, Delaware Court Finds

A Delaware court has ruled that an insurance company had no obligation to defend or indemnify its insureds for a lawsuit that alleged that they had engaged in intentional conduct.

The Case

Wave Lengths Hair Salon of Florida, Inc. d/b/a Salon Adrian, a salon located in a shopping mall in Fort Myers, Florida, sued CBL & Associates Properties, Inc., CBL & Associates Limited Partnership, CBL & Associates Management, Inc., and JG Gulf Coast Town Center, LLC, alleging that the defendants had engaged in a scheme "to overcharge small business tenants for electricity at its shopping malls."

Salon Adrian asserted six causes of action: for violation of the federal Racketeer Influenced and Corrupt Organizations ("RICO") Act; unjust enrichment; violation of Florida's Deceptive and Unfair Trade Practices Act ; violation of Florida's Civil Remedies for Criminal Practices Act; breach of contract by charging inflated electricity rates; and breach of the implied covenant of good faith and fair dealing.

The defendants sought coverage for the lawsuit from their insurer under a Contractor's Protective, Professional, and Pollution Liability Insurance Policy.

In response, the insurer asked a Delaware state court to declare whether it had a duty to defend or indemnify the defendants. It argued that each and every claim against the defendants was based on their allegedly intentional, knowing, and wrongful conduct. Its policy, the insurer contended, did not cover such claims, and as a consequence, it had no duty to defend the defendants or to pay any defense costs or damages incurred by the litigation.

The defendants countered that they were entitled to coverage because the lawsuit against them involved alleged negligent acts, errors, or omissions in the rendering of professional services – something explicitly covered by their policy.

The parties moved for judgment on the pleadings.

The Delaware Court's Decision

The court, applying Tennessee law, granted the insurer's motion.

In its decision, the court explained that the policy provided coverage to the defendants for claims arising out of "negligent acts, errors or omissions." In other words, the court continued, to be covered, the defendants' acts had to be negligent, their errors had to be negligent, or their omissions had to be negligent. If not, there was no coverage.

The court then examined the allegations in the complaint against the defendants and found that Salon Adrian had asserted "no theory of recovery" that could reasonably be deemed mere (or any other sort of) negligence. According to the court, Salon Adrian's complaint alleged "no negligent (or even grossly negligent) conduct." Instead, the court said, it was based on a plainly pled theory that the defendants had engaged in a pattern of intentional, knowing, wrongful, fraudulent conduct.

The court was not persuaded by the defendants' argument that certain claims – including the breach-of-contract claim and the Unfair Trade Practices claim – were covered because they did not require intent, and therefore, could not be based on intentional acts. The court said that it had to focus on what the underlying allegations actually were, "not what they might be." It then ruled that Salon Adrian had alleged "no semblance of negligent conduct" or any claim through which the defendants could be found liable under a negligence theory.

Accordingly, the court concluded that because Salon Adrian alleged only intentional conduct, its complaint against the defendants was not covered by their insurance policy.

The case is *Catlin Specialty Ins. Co. v. CBL & Associates Properties, Inc.*, No. N16C-07-166 PRW CCLD (Del. Super. Ct. Sept. 20, 2017).

Claims Against Pharmacy Were "Related" and Constituted a Single "Claim" Under Its Insurance Policy, Eleventh Circuit Opines

The U.S. Court of Appeals for the Eleventh Circuit has ruled that claims against a pharmacy that repackaged eye medications were all "related" and, therefore, amounted to one "claim" under the pharmacy's insurance policy.

The Case

A number of individuals developed bacterial infections after being injected with eye medications. The pharmacy that had repackaged the medications submitted a claim to its insurer. The insurer filed an action to determine whether the individuals' injuries constituted one claim under the pharmacy's insurance policy, such that a single "claim" limit applied.

The U.S. District Court for the Southern District of Florida granted the insurer's motion for summary judgment, concluding that all of the claims against the pharmacy were "related," and therefore, they all constituted a single claim under the pharmacy's insurance policy.

The dispute reached the U.S. Court of Appeals for the Eleventh Circuit.

The Eleventh Circuit's Decision

The circuit court affirmed.

In its decision, the circuit court explained that the question was not whether there were any differences between the individual claims against the pharmacy, but rather, whether the claims were "logically or causally connected" by "any" common fact or circumstance. If they were, the circuit court said, then the insurance policy required that they all be considered a single "claim" under the policy.

The Eleventh Circuit then ruled that the claims against the pharmacy amounted to one "claim." It pointed out that the pharmacy's owner had used the same procedure to repackage the medications into single use vials and had repeated "the same violations of health and safety regulations, such as failing to turn on the laminar flow hood, every time."

In the circuit court's opinion, in light of the "myriad shared facts, circumstances, and decisions" that connected the claims against the pharmacy, it was "clear" that they arose out of "related acts, errors or omissions." Because they arose out of "related acts, errors or omissions," the Eleventh Circuit agreed with the district court that the policy's $1 million single "claim" limit applied.

The case is *American Casualty Co. of Reading, PA v. Belcher*, No. 17-10848 (11th Cir. Sept. 27, 2017).

Lawsuits Over Three Landfills Were Separate Claims, New Jersey District Court Concludes

A federal district court in New Jersey has ruled that three lawsuits for environmental contamination filed against a waste hauler amounted to separate claims, not one claim, under its primary insurance policies.

The Case

From the late 1950s to approximately 1996, Gus Bittner, Inc., hauled waste from multiple companies and municipalities to landfills throughout New Jersey, including three landfills in

Vorhees, Southampton Township, and Mantua.

After these three landfills closed, Bittner was named as a defendant or third-party defendant in various superfund lawsuits as an alleged transporter of refuse and waste materials.

The insurance company that had issued commercial general liability ("CGL") insurance policies to Bittner paid over $3 million to settle the lawsuits. It subsequently sought contribution from Bittner's excess carrier, contending that its policies had been exhausted, and as a consequence, the excess insurer had defense and indemnity obligations under its excess policies.

In response, Bittner's excess insurer asserted that the CGL policies had not been exhausted because the lawsuits against Bittner amounted to separate claims under the CGL policies. Therefore, it asserted, its excess policies had not been triggered.

Bittner's CGL insurer sued its excess insurer, and the parties moved for summary judgment.

The District Court's Decision

The district court granted the excess insurer's motion, ruling that Bittner's hauling activity at the three landfills were separate occurrences under New Jersey law.

The district court reasoned that Bittner hauled to separate landfills, in separate geographical locations, at separate times over the course of nearly a decade, causing alleged environmental damage "at distinct and discrete locations."

The district court rejected the argument that Bittner's activities in hauling waste to the three landfills, which were "spatially and temporally distinct events," should be reduced to a single occurrence under the applicable CGL policies, noting that the "cause of the harm flowing from Bittner's waste hauling" was "distinct as to each landfill," and concluding that Bittner's hauling activities could "not be rolled into one single occurrence."

The case is *Penn Nat'l Ins. Co. v. Crum & Forster Ins. Co.*, No.: 2:9-cv-4644 (KSH) (CLW) (D.N.J. Sept. 1, 2017).

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