LIABILITY INSURANCE: HOW INSURANCE IS WRITTEN AND WHY YOU NEED TO KNOW—A GENERAL OVERVIEW OF LIABILITY POLICIES

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Liability insurance provides an insured valuable protection in the event of a claim or suit. As defense costs can often be staggering, the right to a defense may be more valuable to an insured than the right to indemnity. Insurance companies write and price policies by attempting to predict the risk of a claim occurring and the amount a claim may be worth in both defense and indemnity costs. If the risk of a particular type of claim is too great and/or too costly, an insurance company may refuse to insure such risk by inserting an exclusion into a policy. This paper discusses general information regarding standard liability insurance contracts, the responsibilities of both insurer and insured, and provides an overview of common coverage disputes, including the duty to defend versus the duty to indemnify and bad faith claims.

A. THE INSURANCE CONTRACT

Two main types of liability policies exist: Occurrence based and claims made. The primary difference between these two types of policies is how they are triggered. In the former, a policy will be applicable if the occurrence or injury takes place during the policy period regardless of when the claim is made.[1] However, in a claims made policy, the important date is when a claim is first made and reported, regardless of when the conduct giving rise to the claim occurred.

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1 Occurrence is generally defined as: "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."

Most liability insurance policies are written on forms used by the industry at large, but some companies use their own forms. Either way, they follow the same basic format. A policy will contain a declarations page, a provision stating the grant of coverage, provisions outlining the duties and obligations of both insured and insurer, exclusions and definitions for terms used in the policy. Below we discuss common policy provisions.

The declarations page of a policy generally provides the following important information: the named insured, the policy period, the policy limits, the policy number, any applicable deductible or self-insured retention and a list of forms comprising the policy. Endorsements may be issued which vary or add to the terms of the main policy provisions. Policies define certain terms and will often designate defined terms by bolding them or placing them in quotation marks.

The wording of the coverage grant may vary slightly depending on the company issuing the policy and the type of policy. We offer you the following examples from an occurrence-based policy and a claims made policy:

> OCCURRENCE:
>
> a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies.
>
> b. This insurance applies to "bodily injury" and "property damage" only if: (1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory"; and (2) The "bodily injury" or "property damage" occurs during the policy period.
>
> CLAIMS MADE:
>
> We will pay those sums that the Insured becomes legally obligated to pay as "damages" because of a "wrongful act" (regardless of whether or not such allegations prove to be groundless, false or fraudulent) arising out of the discharge of duties by or on behalf of the Named Insured as shown in the Declarations provided always that:

a. The "claim," on account of such "wrongful act," is first made against the Insured and reported to us during the policy period, in compliance with SECTION VII-CONDITIONS - Item A., or any applicable reporting period under SECTION VI-EXTENDED REPORTING PERIODS;

b. Such "wrongful act" took place in the "coverage territory"; and

c. As of the inception date of this policy, no Insured had any knowledge of any circumstance likely to result in or give rise to a "claim" nor could have reasonably foreseen that a "claim" might be made.

For purposes of paragraph 1a. of SECTION I -COVERAGE A. Insuring Agreement, if, during the policy period of any applicable reporting period under SECTION VI - EXTENDED REPORTING PERIODS, the Insured gives written notice to us, in accordance with SECTION VII - CONDITIONS - Item A., of a "wrongful act" likely to result in a "claim," then any "claim" that may subsequently be made against an insured arising out of such "wrongful act" shall be deemed to have been made during the policy period or any applicable reporting period hereunder.

Most primary policies contain a duty to defend clause. If a policy contains a duty to defend provision, it often will look like this:

We will have the right and duty to defend any "suit" seeking those damages. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result.

Common policy conditions include the following:

2. Duties In The Event Of Occurrence, Claim Or Suit.

a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:

(1) How, when and where the "occurrence" or offense took place;

(2) The names and addresses of any injured persons and witnesses; and

(3) The nature and location of any injury or damage arising out of the "occurrence" or offense.

b. If a claim is made or "suit" is brought against any insured, you must:

(1) Immediately record the specifics of the claim or "suit" and the date received; and

(2) Notify us as soon as practicable.

You must see to it that we receive written notice of the claim or "suit" as soon as practicable.

c. You and any other involved insured must:

(1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or "suit";

(2) Authorize us to obtain records and other information;

(3) Cooperate with us in the investigation, settlement or defense of the claim or "suit"; and

(4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply.

d. No insureds will, except at their own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without out consent.

3. Legal Action Against Us

No person or organization has a right under this Coverage Part:

a. To join us as a party or otherwise bring us into a "suit" asking for damages from an insured; or

b. To sue us on this Coverage part unless all of its terms have been fully complied with.

A person or organization may sue us to recover on an agreed settlement or on a final judgment against an insured obtained after an actual trial; but we will not be liable for damages that are not payable under the terms of this Coverage part of that are in excess of the applicable limit of insurance. An agreed settlement means a settlement and release of liability signed by us, the insured and the claimant or the claimant's legal representative.

Policies contain many exclusions, often including exclusions for damage to the insured's own work or product, damage from contractual liability or pollution, and damage or injury that is expected or intended.

B. THE INSURANCE COMPANY'S RESPONSIBILITIES

An insurer's responsibilities to its insureds are defined by the contract, statutes and regulations. Case law further refines an insurer's duties.

In Pennsylvania, regulations provide insurers with mandates regarding how to handle a claim and the time within which they should perform certain functions. The Unfair Insurance Practices Act, 40 P.S. § 1171.1 *et seq.*, [hereinafter UIPA] prohibits unfair methods of competition and unfair or deceptive acts or practices in the insurance business. Section 1171.5 defines unfair methods of competition and unfair or deceptive acts and practices. While some of the prohibited acts are unfair or deceptive any time they occur, other acts are considered unfair practices only "if committed or performed with such frequency as to indicate a business practice." 40 P.S. § 1171.5(a)(10).

No private cause of action exists under the UIPA. Romano v. Nationwide Mut. Fire Ins. Co., 435 Pa. Super. 545, 646 A.2d 1228, 1232 (1994); Strutz v. State Farm Mut. Ins. Co., 415 Pa. Super. 371, 609 A.2d 569, 571 (1992) ("Appellants' final argument, that the Unfair Insurance Practices Act, 40 P.S. §1171.1 *et seq.* allows a civil claim against an insurer by a private plaintiff for the insurer's failure to deal in good faith, is likewise without merit."); Moy v. Schreiber Deed Security Co., 392 Pa. Super. 195, 572 A.2d 758, 760-61 (1990) (holding that the provisions of the Unfair Insurance Practices Act may be enforced only by the Insurance Commissioner, and finding that the court was without jurisdiction to hear a private claim). Federal courts have

similarly held that no private party may enforce the provisions of the UIPA. Sabo v. Metropolitan Life Ins. Co., 137 F.3d 185, 192 (3d Cir. 1998) (By judicial precedent, the Pennsylvania Insurance Commissioner alone may seek to enforce the UIPA); Smith v. Nationwide Mut. Fire Ins. Co., 935 F. Supp. 616, 620 (W.D. Pa. 1996) (citing numerous cases in which courts have held that there is no private cause of action under the UIPA).

Regulations adopted to enforce the UIPA can be found at 31 Pa. Code § 146.1 et seq. These regulations include a section detailing the standards for prompt investigation of claims, § 146.6; standards for prompt, fair and equitable settlements, § 146.7; and standards for prompt, fair and equitable settlements applicable to automobile insurance, § 146.8.

The primary duties of the insurer defined by the contract are the duty to defend and the duty to indemnify. These duties will be discussed in detail in section F below.

C. THE INSURED'S RESPONSIBILITIES

The insurance policy contains certain conditions which the insured must follow. Common conditions include the duty to give timely notice of a claim or suit and the duty to cooperate. In Pennsylvania, if an insured provides late notice or fails to cooperate, an insurer will only be relieved of its obligations under the contract if it suffers prejudice from the late notice or failure to cooperate. In Pennsylvania, a late notice defense requires the insurer to establish that notice was untimely and that untimely notice prejudiced the insurer. Brakeman v. Potomac Ins. Co., 371 A.2d 193 (Pa. 1977); Metal Bank of Am. v. Ins. Co. of N.A., 520 A.2d 493 (Pa. Super. 1987), appeal denied, 536 A.2d 1332 (Pa. 1987). Prejudice may be established by showing that the insurer lost opportunities. The Pennsylvania Superior Court found both primary and excess insurers to have been prejudiced as a matter of law where an insured had

conducted its own defense of complex environmental claims for two years, notifying its insurers only when it sought their help in funding a negotiated settlement. Metal Bank of America, Inc. v. Insurance Co. of North America, 360 Pa. Super. 350, 520 A.2d 493 (1987), appeal denied, 517 Pa. 607, 536 A.2d 1332 (1987). There, the facts underlying the claims were complex and dated; the insurers had lost opportunities to investigate and control the defense, including such decisions as whether other defendants should be joined. See also Hyde Athletic Industries, Inc. v. Continental Cas. Co., 969 F. Supp. 289, 300 (E.D. Pa. 1997)(accepting late notice defense as alternative to pollution exclusion defense where insurers notified after trial was already underway).

Notice after entry of default judgment constitutes prejudice. Hargrove v. CNA Ins. Group, 323 A.2d 785, 787 (Pa. Super. 1974) (noting "if the evidence demonstrates that the insureds failed to forward suit papers, prejudice to the insurer is clearly established by the fact that a default judgment was taken against its insureds") (citing Flagg v. Puleio, 150 A.2d 400 (Pa. Super. 1959)); Stetzer v. Ohio Cas. Ins. Co., 18 Pa. D.&C.4th 145 (Schuylkill Cty. 1993) (holding insurer prejudiced by notice after default judgment); Champion v. Chandler, 1999 U.S. Dist. LEXIS 15824 (E.D. Pa. 1999) (holding insured and driver failed to comply with cooperation clause where they did not provide suit papers or respond to Nationwide's request for information after underlying plaintiff notified Nationwide and prejudice was established by the default judgment as a matter of law because the insurer "was denied an adequate opportunity to take control of a case for which it is now being asked to be accountable"). However, if the insurer would have denied coverage even if timely notified, prejudice will not be established. Strickler v. Huffine, 618 A.2d 430 (Pa. Super. 1992), appeal denied, 637 A.2d 290 (Pa. 1993) (coverage denied before default judgment entered and former claims manager testified that Royal

"would have refused to participate in Mr. Huffine's defense had timely notice been received regarding the Fayette County action."); UTI Corp. v. Fireman's Fund Ins. Co., 896 F. Supp. 362 (D.N.J. 1995) (applying PA law) (no prejudice from late notice because insurer would have denied coverage even if given timely notice); Safeguard Scientifics, Inc. v. Liberty Mutual Ins. Co., 766 F. Supp. 324, 332 (E.D. Pa. 1991) ("Liberty Mutual has not shown that its actions would have been any different had the plaintiffs notified Liberty Mutual of the Barnes lawsuit immediately. Because Liberty Mutual has failed to show that 'timely notice would have put [it] in a more favorable position,' relieving it of its obligations under the policy would be 'unduly severe and inequitable.' Brakeman, 472 Pa. at 76, 371 A.2d at 198."), aff'd in part and rev'd in part w/o opinion, 961 F.2d 209 (3d Cir. 1992).

An insurer does not necessarily need to be notified by the insured in order for the insured to be protected from a late notice defense. In Philadelphia Elec. Co. v. Aetna Cas. & Sur. Co., 484 A.2d 768 (Pa. Super. 1984), PECO was named as an insured on a policy purchased by a contractor. PECO was sued by a worker injured when he hit a PECO line. PECO did not notify the insurer because it was not aware of the policy, but did join the contractor as an additional defendant. The contractor then notified Aetna and sought a defense for itself, giving a detailed account, including the involvement of PECO. PECO later became aware of the policy and sought a defense which Aetna denied because PECO failed to give timely notice of the accident. The provision provided: "Notice of Accident -- when an accident occurs written notice shall be given by or on behalf of the insured to the company or any of its authorized agents as soon as practicable." The court held: "We believe the parties intended the phrase 'or on behalf of the insured' to mean that notice of the accident from 'any reliable source' is all that was required to trigger Aetna's responsibility under the policy." Id. at 771 (footnote omitted). The court further

held: "We are convinced that McCloskey's notice of the accident, in combination with the notice Aetna received under the worker's compensation claim, were sufficient to notify Aetna of its responsibility to defend PECO in the personal injury action." Id. at 772 (footnotes omitted). In a footnote, the court cautioned that constructive notice will not be found in all cases; but, indirect notice must be determined by the facts of each individual case. Id. at n.11. Thus, if notice by a named insured does not provide sufficient details to alert the insurance company that an unnamed insured is also involved in the suit, such notice may not be sufficient to protect the unnamed insured from a late notice defense.

D. UMBRELLA POLICIES

Umbrella policies are hybrid policies. They act as excess policies for claims covered by other insurance policies and act as primary policies for claims not covered or intended to be covered by other insurance. Umbrella policies will often contain similar provisions to those found in primary policies, but with slightly different wording and will often have a schedule of underlying insurance.[2] A coverage grant in an umbrella policy may look like this:

> We will pay on behalf of the "Insured" those sums in the excess of the "Retained Limit" which the "Insured" by reason of liability imposed by law, or tort liability assumed by the "Insured" under contract prior to the "Occurrence", shall become legally obligated to pay as damages for 1. "Bodily Injury" or "Property Damage" occurring during the Policy Period stated in Item 2 of the Declarations and caused by an "Occurrence" 2. "Personal Injury" caused by an "Occurrence" committed during the Policy Period or 3. "Advertising Injury" caused by an "Occurrence" committed during the Policy Period.

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2 Pure excess policies will often follow form to an underlying policy, essentially adopting the provisions of a stated primary policy. Sample language:

> To indemnify the Insured for such loss as would have been payable under all of the terms of the Liability Coverages afforded by the underlying policies listed in Item 5 of the Declarations if the limits of liability stated in Item 4 of the Declarations were available under the underlying policies in addition to the limits of liability stated in Item 5 of the Declarations (hereinafter called the "underlying limits"); provided the Company's obligation hereunder shall apply only to loss in excess of such underlying limits.

Retained limit is often defined as follows:

> 1. with respect to any "Occurrence" that is covered by "Underlying Insurance" or "Other Insurance", the total of the applicable limits of "Underlying Insurance" and "Other Insurance"; or 2. with respect to any "Occurrence" that is not covered by "Underlying Insurance" or "Other Insurance", the amount of the Self-Insured Retention stated in Item (4)e of the Declarations.

Umbrella policies generally will not provide for a duty to defend unless or until the underlying primary policy and other insurance has exhausted its limits or is not applicable to the claim:

> We shall have the right and duty to defend any "Claim" or "Suit" seeking damages, or damages and "Covered Pollution Cost or Expense", covered by the terms and conditions of this policy, even if the allegations are groundless, false or fraudulent when: 1. the applicable limits of "Underlying Insurance" and "Other Insurance" have been exhausted by payments; or 2. damages, or damages and "Covered Pollution Cost or Expense", are sought which are not covered by the terms and conditions of "Underlying Insurance" or "Other Insurance."

E. COMMON COVERAGE DISPUTES

Coverage disputes under liability policies fall into two general categories: 1. Does the claim come within the grant of coverage and 2. Is the claim barred from coverage by a policy exclusion. The insured carries the burden of proof in the former, while the insurer has the burden in the latter. Often, a coverage dispute will involve both questions. Within this framework, the ultimate question is generally whether the insurer has or had a duty to defend the insured in an underlying suit and if so whether the insurer has or had a duty to indemnify the insured. A comparison of the duty to defend versus the duty to indemnify will be discussed in section F below.

Common issues regarding coverage include whether an occurrence has taken place; when an occurrence took place; and the number of occurrences. Whether an occurrence has taken

place and when it occurred go to the heart of whether coverage exists in an occurrence-based policy because an occurrence during the policy period is a prerequisite to coverage. Determining whether a single occurrence or multiple occurrences are involved impacts the applicable policy limits, how many deductibles apply and sometimes how many policies are triggered.

With respect to whether an occurrence has taken place, Pennsylvania courts look to the allegations of the underlying complaint to determine whether an accident is alleged. Toombs N.J. Inc. v. Aetna Cas. & Sur. Co., 591 A.2d 304, 306 (Pa. Super. 1991)(general liability policy does not provide coverage for damages sounding in commercial breach, here damages arising out of a developer's agreement to establish two restaurants). See also Snyder Heating Co., Inc. v. Pennsylvania Mfrs. Ass'n Ins. Co., 715 A.2d 483 (Pa. Super. 1998)(*en banc)*(general liability policy did not provide coverage for insureds' failure to provide adequate maintenance of school district's burners and boilers under the contract); Keystone Filler & Mfg. Co., Inc. v. American Mining Ins. Co., 179 F. Supp.2d 432, 439-40 (M.D. Pa. 2002) (holding that damages sustained by a customer resulting from the insureds' product which did not conform with the customer's requirements did not constitute an "occurrence" within the meaning of the general liability policy where a carbon-based product made from finely ground coal sold by the insured to a customer contained oversized particles damaging the customer's product); Solcar Equip. Leasing Corp. v. Pennsylvania Mfrs. Ass'n Ins. Co., 606 A.2d 522, 524 (Pa. Super. 1992)(finding "no allegations that an 'accident' occurred based on allegations of defective workmanship and materials, this Court affirmed the trial court's decision that "a claim of lack of structural integrity and breach of contract" is not "an unexpected or unanticipated event within the provisions of the policy.").

Under Pennsylvania law, an occurrence takes place when the injurious effects first become apparent or manifest themselves. City of Erie, PA v. Guaranty Nat. Ins. Co., 109 F.3d

156 (3d Cir. 1997); Consulting Engineers, Inc. v. Insurance Co. of N.A., 710 A.2d 82 (Pa. Super. 1998), aff'd, 743 A.2d 911 (Pa. 2000). Although Pennsylvania's courts have not squarely addressed the trigger of coverage for gradually inflicted property damage claims, the Supreme Court adopted a continuous or multiple trigger for progressive disease scenarios. J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502 (Pa. 1993).

With respect to determining the number of occurrences, Pennsylvania follows the cause test. D'Auria v. Zurich Ins. Co., 507 A.2d 857 (Pa. Super. 1986) ("The general rule is that an occurrence is determined by the cause or causes of the resulting injury. '[T]he majority of jurisdictions employes [sic] the 'cause theory'. . . . . Using this analysis, the court asks if '[t]here was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damage.'" (quoting Appalachian Ins. Co. v. Liberty Mut. Ins. Co., 676 F.2d 56 (3d Cir. 1982)).

Disputes often involve multiple insurance policies. One such case involved the interplay between a primary policy's "other insurance" clause and a true umbrella policy. In Chester Carriers, Inc. v. National Union Fire Ins. Co. of Pittsburgh, 767 A.2d 555 (Pa. Super. 2001), a truck owner's insurer paid its limits toward settlement and the dispute over who should pay the remainder was between the operator's primary carrier and the owner's umbrella insurer. The former asserted that its "other insurance" clause made it excess and the latter argued that it issued a true umbrella policy. The Superior Court focused on the *types* of coverage to determine that the primary, despite its "excess" clause, had to pay the balance of the settlement. The Court discussed the purposes and costs of primary vs. umbrella policies, and refused to place a true umbrella in an equal position with a primary policy.

F. INSURERS' DUTY TO DEFEND VS. DUTY TO INDEMNIFY

The courts describe the duty to defend as follows:

> An insurer's duty to defend is distinct from, and broader than, its duty to indemnify an insured. *Aetna Casualty and Surety Co. v. Roe*, 437 Pa. Super. 414, 421, 650 A.2d 94, 98 (1994). An insurer is not obligated to defend all claims asserted against its insured; its duty is determined by the nature of the allegations in the underlying complaint. *Wilson v. Maryland Casualty Co.*, 377 Pa. 588, 594, 105 A.2d 304, 307 (1954); *Elitzky*, 358 Pa. Super. at 368, 517 A.2d at 985. An insurer must defend its insured if the underlying complaint alleges facts which, if true would actually or *potentially* bring the claims within the policy coverage. *Roe*, 437 Pa. Super. at 422, 650 A.2d at 99; *Humphreys v. Niagara Fire Insurance Co.*, 404 Pa. Super. 347, 354, 590 A.2d 1267, 1271, *alloc. denied*, 528 Pa. 637, 598 A.2d 994 (1991).

Board of Education v. Nat. Union Fire Ins., 709 A.2d 910, 913 (Pa. Super. 1998) (emphasis in original).

On the other hand, the duty to indemnify is based on actual coverage rather than potential coverage. See, e.g., Diamond State Ins. Co. v. Ranger Ins. Co., 47 F. Supp. 2d 579, 584 (E.D. Pa. 1999)("The duty to indemnify is more limited than an insurer's duty to defend and 'arises only when the insured is determined to be liable for damages within the coverage of the policy.'")(citation omitted). Stated another way, in relationship to the duty to defend: "The duty to defend also carries with it a conditional obligation to indemnify in the event the insured is held liable for a claim covered by the policy." General Acc. Ins. Co. of Am. v. Allen, 692 A.2d 1089, 1095 (Pa. 1997) (citation omitted).

To determine the existence of a duty to defend, the policy must be compared to the underlying complaint for any potential of coverage. Scopel v. Donegal Mut. Ins. Co., 698 A.2d 602, 605 (Pa. Super. 1997). If there is no duty to defend, there is no duty to indemnify. Id. at 605 ("if [insurer] had no duty to defend [its insured] on the merits of the underlying action, it

could not later be required to indemnify [its insured] or his assignees, against the subsequent $100,000 consent judgment which, by settlement, ended the underlying suit"). Furthermore, it is the facts alleged, and not labels or theories, which control. Mutual Benefit Ins. Co. v. Haver, 725 A.2d 743, 745 (Pa. 1999); Scopel, 698 A.2d at 605.

Policy interpretation in Pennsylvania requires the court to look to the language of the policy and give effect to its plain meaning:

> [T]he task of interpreting [an insurance] contract is generally performed by a court rather than by a jury. The goal of that task is, of course, to ascertain the intent of the parties as manifested by the language of the written instrument. Where a provision of a policy is ambiguous, the policy provision is to be construed in favor of the insured and against the insurer, the drafter of the agreement. Where, however, the language of the contract is clear and unambiguous, a court is required to give effect to that language.

Madison Const. Co. v. Harleysville Mut. Ins. Co., 735 A.2d 100, 106 (Pa. 1999)(quoting Gene & Harvey Builders v. Pennsylvania Mfrs. Ass'n., 517 A.2d 910, 913 (Pa. 1986)(quoting Standard Venetian Blind Co. v. American Empire Ins. Co., 469 A.2d 563, 566 (Pa. 1983))) (emphasis added).

In Madison, the Supreme Court affirmed a decision in favor of an insurance company in a declaratory judgment action. There, the insured sought coverage for a suit filed against it which alleged that the insured's negligence in failing to safely maintain a construction site, failing to properly ventilate the work area, failing to warn and failing to properly barricade a hole resulted in the underlying plaintiff becoming overcome by fumes and sustaining injuries when he fell into a hole. The insurance company denied coverage based on the policy's pollution exclusion: "'Bodily injury' . . . arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants." Id. at 102. After determining that the fume-causing agent was a pollutant within the meaning of the policy, the court rejected the insured's argument

that the negligence alleged, such as failure to warn, does not arise out of the insured's use of the pollutant. The court found that the underlying plaintiff's injuries arose out of the release of the fumes because

> [a]ll of the plaintiff's claims of negligence, however, rest upon the fundamental averment that "while [plaintiff] attempted to set up an exhaust fan for the fumes emanating from the curing agent, he suddenly and without warning *was overcome by the fumes,* causing him to become dizzy and pass-out [sic] . . . ."

Id. at 109 (quoting underlying complaint)(emphasis in original). Thus, the insurer did not have the duty to defend or indemnify the insured in the underlying suit.

G. BAD FAITH

Pennsylvania allows for recovery for bad faith in a dispute involving an insurance policy only under 42 Pa.C.S.A.§ 8371. The statute does not define bad faith, but courts have adopted the following definition:

> 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.

Polselli v. Nationwide Mutual Fire Ins. Co., 23 F.3d 747, 751 (3d Cir. 1994); Terletsky v. Prudential Property and Casualty Ins. Co., 649 A.2d 680, 688 (Pa. Super. 1994), appeal denied 659 A.2d 560 (Pa. 1995) (both citing Black's Law Dictionary (6th ed. 1990) and other citations omitted).

It is often said that recovery for bad faith requires that the insured show (1) that the insurer did not have a reasonable basis for denying the insured's claim and (2) that the insurer knew or recklessly disregarded its lack of reasonable basis in denying the claim. MGA Ins. Co.

v. Bakos, 699 A.2d 751 (Pa. Super. 1997); Terletsky, supra. In MGA, the insurer appealed the denial of its Petition to Vacate and/or Modify Arbitration Award and the trial court's order granting attorney fees. The Superior Court noted that the insured's response to the Petition merely requested confirmation of the award with interest and attorney fees, but did not allege that the defendant had no reasonable basis for denying benefits or knew or recklessly disregarded its lack of reasonable basis for denial. This failure, coupled with the trial court's failure to state the basis of his finding that the petition was frivolous, led the Superior Court to hold that the record did not support a finding of bad faith and the trial court erred in awarding attorney fees. Id. at 755.

In Terletsky v. Prudential Property and Casualty Ins. Co., 649 A.2d 680 (Pa. Super. 1994), appeal denied 659 A.2d 560 (Pa. 1995), the insureds brought a bad faith action against their uninsured motorist carrier which delayed in paying in full an arbitration award in favor of the insureds. The insurer delayed based on its belief that the law did not allow the insureds to stack their coverage. At the time of the insurer's actions, Pennsylvania law was unsettled on the issue. The Superior Court reversed the finding of bad faith, holding that the insurer had a reasonable basis for its actions.

Under this definition, a bad faith claim should not stand where the contract claim has failed on its merits because obviously if an insurer does not act in bad faith by relying on case law that is in flux, then an insurer cannot be found to have acted in bad faith in refusing to pay when no coverage is available as a matter of law. See, e.g., Cresswell v. Nat'l Mut. Cas. Ins. Co., 820 A.2d 172, 179 (Pa. Super. 2003) (holding that since insurer had no duty to provide coverage, "it is impossible for Appellants to demonstrate that Appellee USF&G lacked a reasonable basis for denying Appellants coverage" and summary judgment was properly granted

in favor of the insurer on the insured's bad faith claim); Morrison v. Mountain Laurel Assur. Co., 748 A.2d 689 (Pa. Super. 2000) (if no coverage, no bad faith in failing to provide coverage); First Philson Bank, N.A. v. Hartford Fire Ins. Co., 727 A.2d 584, 590-91 (Pa. Super. 1999) (court assumed that failure on the contract claim made bad faith claim moot), appeal denied, 747 A.2d 901 (Pa. 1999); Zawierucha v. Contributionship Ins. Co., 740 A.2d 738 (Pa. Super. 1999) (affirming trial court decision where insured sued for breach of contract and bad faith but trial court granted summary judgment only in an amount which affirmed the insurer's interpretation of the policy, thus finding no bad faith sub silentio), appeal denied, 757 A.2d 934 (Pa. 2000); Feldman v. Home Ins. Co., 34 Phila. 392 (C.P. 1997) (granting summary judgment in favor of insurer on both contract and bad faith claims where insurer owed no coverage because of specific firm exclusion); Fasanya v. Allstate Indemnity co., 2000 U.S. Dist. LEXIS 18689 at *12 (E.D. Pa. 2000) ("The absence of a duty to provide coverage during a lapse precludes a finding of bad faith."); Continental Ins. Co. v. Alperin, Inc, 1998 U.S. Dist. LEXIS 5929 at 29-30 (E.D. Pa. 1998) ("Here, the insurer had no contractual obligation to provide coverage. Because the defendants' breach of contract and promissory estoppel claims fail on the merits, there is no cognizable bad faith claim."), aff'd w/o opinion 1999 U.S. App. LEXIS 13521 (3d Cir. 1999).

In recent years the Pennsylvania Supreme Court has made two significant pronouncements on the law of insurance bad faith. First, in Birth Center v. St. Paul Companies, Inc., 787 A.2d 376 (Pa. 2001), the Supreme Court held that compensatory damages can be awarded in a bad faith action:

> The insured's liability for an excess verdict is a type of compensatory damage for which this court has allowed recovery. Therefore, when an insurer breaches its insurance contract by a bad faith refusal to settle a case, it is appropriate to require it to pay other damages that it knew or should have known the insured would incur because of the bad faith conduct.

Id. at 388-89. Second, in Mishoe v. Erie Ins. Co., 824 A.2d 1153 (Pa. 2003), the Supreme Court held that no right to a jury trial exists in a statutory bad faith action.

Despite its existence for ten years, some issues under the bad faith statute remain unsettled and subject to debate:

- Pre-contract conduct and conduct not involving denial of claim: Compare Weisblatt v. The Minnesota Mut. Life Ins. Co., 4 F. Supp.2d 371, 385 n.20 (E.D. Pa. 1998) ("because plaintiff's claims do not 'arise under an insurance policy' – but rather address conduct prior to formation of the insurance contract—she may not avail herself of the additional remedies provided in § 8371"); Seiss v. Sherman, 49 Pa. D.&C.4th 367 (Butler Cty. 2000) (holding that bad faith claim cannot be premised on pre-contract misrepresentations); and Berks Mut. Leasing Corp. v. Travelers Prop. Cas., 2002 U.S. Dist. LEXIS 23749 (E.D. Pa. 2002) (bad faith limited to cause of action arising out of denial of a claim or benefit; no bad faith claim for refusal to renew policy); with Ihnat v. Pover, 35 Pa. D. & C.4th 120 (Allegheny County, 1997) (allowing a bad faith case based on a premium dispute involving pre-contract conduct to go forward).
- Statute of Limitations: The appellate courts of Pennsylvania have avoided ruling on the correct limitations period to apply to statutory bad faith claims and the other courts have been split in their analysis. Last year, the Superior Court ruled that the two-year statute of limitations applied to an insurance bad faith action, but then withdrew the opinion. Trujillo v. State Farm Mut. Auto. Ins. Co., 2002 PA Super 280, 2002 Pa. Super. LEXIS 2599 (2002), opinion withdrawn Sept. 4, 2002. Some trial court and federal court opinions have applied the two-year

statute of limitations. See Susich v. Prudential Prop. & Cas. Ins. Co., 35 Pa. D. & C.4th 178 (Beaver Cty. 1998) (holding 2-year statute of limitations applies to bad faith under 42 Pa. C.S. §§ 5524(5) (claim of bad faith is a statutory action for a civil penalty) and (7) (conduct complained of sounds in trespass and involves intentional wrongdoing and negligence); Haugh v. Allstate Ins. Co., 2003 U.S. App. LEXIS 3721 (3d Cir. Feb. 28, 2003) (holding that a two-year statute of limitations applies to an action under 42 Pa. C.S. § 8371); Lochbaum v. USF&G Co., 136 F. Supp.2d 386 (W.D. Pa. 2000) (applying 2 year statute of limitations to bad faith claim because it creates a tort obligation), aff'd. w/o opin., 265 F.3d 1055 (3d. Cir. 2001), cert. denied, 534 U.S. 1066 (2001); Nelson v. State Farm Mut. Auto. Ins. Co., 988 F. Supp. 527 (E.D. Pa. 1997) (applying two year statute of limitations to bad faith action). But, other courts have applied the six year catch-all statute of limitations. See Hospital Shared Servs. v. CIGNA Ins. Co., 41 Pa. D.&C.4th 148 (Alleg. Cty. 1998) (applying a six-year statute of limitations); Kosierowski v. Allstate Ins. Co., 51 F. Supp.2d 583 (E.D. Pa. 1999) (applying six-year limitation period); Woody v. State Farm Fire & Cas. Co., 965 F. Supp. 691 (E.D. Pa. 1997) (applying six year limitation period).