RECENT DEVELOPMENTS AND TRENDS IN PENNSYLVANIA INSURANCE BAD FAITH LITIGATION

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I. INTRODUCTION

We are setting forth developments and trends in insurer bad faith law as reflected in Pennsylvania's state and federal judicial opinions from January 2003 through July 21, 2005. Necessarily, some discussion of earlier case law is also set forth, however, the large number of cases dealing with bad faith claims during this 2½ year period reflects the consolidation of the law in some areas; its clarification in other areas; and ongoing developments in this burgeoning field of litigation in areas that remain needful of further clarification.

Among others, we see the following issues, determinations and trends in the cases, as will be described in greater detail below:

- To what extent can the insurer's conduct of the bad faith litigation itself be subject to claims under 42 Pa. C.S. § 8371 (the "Bad Faith Statute")? On June 28, 2005, Pennsylvania's Supreme Court granted the petition for allowance of appeal in Hollock v. Erie Ins. Exch. One of the questions expressly stated to be at issue on this appeal is: "Whether conduct of a party during a bad faith action under 42 Pa. C.S. § 8371 is admissible to support a finding of punitive damages?"
- How have Pennsylvania's state and federal courts applied State Farm Mut. Ins. Co. v. Campbell, 538 U.S. 408 (2003), and the jurisprudence embodied in that case, in evaluating and determining punitive damages under the Bad Faith Statute? In granting the appeal in Hollock, the Supreme Court is also going to address the issue of "[w]hat scope of review should an appellate court apply when reviewing a punitive damages award?"
- What constitutes a sufficient nexus between the claims raised by a plaintiff-insured and events involving other, non-party or out-of-state, insureds and/or the insurer's broad practices and procedures, permitting discovery of that information and/or presentation as evidence at trial? Conversely, what events or practices lack the connection to the specific harm caused to the insured such that they are beyond the pale of discovery and admissibility?

- What classes of defendants have been excluded *per se* from application of the Bad Faith Statute because they are not "insurers" within the meaning of the statute?
- How independent is the Bad Faith Statute from the cause of action for breach of the insurance contract?
- Claims under the Bad Faith Statute may go to a jury in federal court, but not in state court.
- Both the United States Court of Appeals for the Third Circuit and the Superior Court have found that the Bad Faith Statute is subject to a two-year statute of limitations.
- Until the Supreme Court rules otherwise, what types of discovery or testimonial abuses during bad faith actions may be treated as additional acts of bad faith and then included in the bad faith action?
- ERISA preempts the Bad Faith Statute.
- Are Bad Faith Statute claims subject to mandatory arbitration clauses pursuant to the Federal Arbitration Act or must they be tried by a judge?

II. THE STATUTE AND GENERAL STATEMENT OF CONTRACTUAL BAD FAITH

The Bad Faith Statute, 42 Pa. C.S. § 8371, provides:

> 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 percent.
>
> (2) Award punitive damages against the insurer.
>
> (3) Assess court costs and attorney's fees against the insured.

This is not the sole basis for bad faith insurance actions in Pennsylvania. While this statute provides for exemplary damages in cases of bad faith, along with super-interest awards and fee shifting, Pennsylvania case law separately provides a common law basis for actions that permit compensatory damage recoveries. This is a cause of action under a contract theory for breach of the contractual duty to act in good faith, which also brings with it the concept of a breach of fiduciary duty. See, e.g., The Birth Ctr. v. The St. Paul Companies, Inc., 567 Pa. 386, 787 A.2d 376 (2001).[1] Further, under Cowden v. Aetna, 389 Pa. 459, 134 A.2d 223 (1957), the carrier's contractual right to control the litigation and settlement of the insured's case creates a contract-based fiduciary duty and a good faith obligation that may require settlement in certain excess verdict situations. The breach of this obligation can result in a damage award for the entire excess verdict, independent of policy limits. In The Birth Center, even after the

[1]The Court noted that it was not deciding whether the Bad Faith Statute created an additional cause of action or created an additional remedy. Id. at 387 n.14. The Court's holding states: "Where an insurer acts in bad faith, by unreasonably refusing to settle a claim, it breaches its contractual duty to act in good faith and its fiduciary duty to its insured. Therefore, the insurer is liable for the known and/or foreseeable compensatory damages of its insured that reasonably flow from the insurer's bad faith conduct." Id. at 389.

carrier voluntarily paid the excess verdict, the insured was permitted to pursue additional forms of contract damages. The Birth Center, 787 A.2d at 385.[2]

Applying the Supreme Court's decision in The Birth Center, the Third Circuit reiterated that Pennsylvania recognizes an independent contract claim for the breach of the obligation to act in good faith. Haugh v. Allstate Ins. Co., 322 F.3d 227, 236 (3d Cir. 2003). This is significant because such an action is subject to a four-year statute of limitations, rather than two years for section 8371.

In SEPTA v. Holmes, 835 A.2d 851 (Pa. Commw. 2003), appeal denied, 577 Pa. 738, 848 A.2d 930 (2004), the Commonwealth Court stated that there is no common law tort for insurer bad faith, while recognizing the possibility of an express or implied contractual duty of good faith and fair dealing. In that case, however, there was no contract between SEPTA and the public that could create any rights against it as an insurer.

In Corch Constr. Co. v. Assurance Co. of America, 64 Pa. D.&C. 4th 496 (C.C.P. Luzerne 2003), the court stated that: "An insured is entitled to recover compensatory damages based upon a contract cause of action because of an insurer's bad faith conduct." Id. at 518 (citing The Birth Center). These damages included the coverage payment due for the collapse of a wall, and also included foreseeable compensatory damages. The carrier knew it was insuring a single construction project, and that the failure to pay on the policy effectively would put the insured out of business. Thus, compensatory damages for losses associated with a project loan were foreseeable, as were costs for tenant concessions, lost past rent and lost future rent. The total of the foregoing damages exceeded $1.6 Million.

[2]In that case, the jury awarded compensatory damages for losses to the insured's business, reputation and credit, even where the carrier paid the full policy amount and the excess verdict in the underlying action prior to the bad faith verdict. Id. at 381.

III. CASE LAW

A. Section 8371 as an Independent Claim

The case law is not consistent, or at least not clear, on the issue of whether a successful breach of contract defense on the merits precludes the possibility of a bad faith claim. Put another way, must there be some breach of the insurance contract as a predicate to a successful bad faith claim? There is a distinct issue of whether the bad faith claim can proceed if the breach of contract claim failed for a technical or procedural reason, e.g., missing the contractual period of limitations; or was somehow not pursued because, e.g., the matter settled or payment was finally made without the need to pursue the full legal course.

Schubert v. Am. Indep. Ins. Co., No. 02-6917, 2003 U.S. Dist. LEXIS 10769 (E.D. Pa. Jun. 24, 2003). The District Court found that section 8371 was an independent cause of action and not a damage enhancement mechanism for existing bad faith theories. Id. at *10 (citing state and federal cases). Further, the District Court stated that "[c]ourts have … held that a statutory claim under § 8371 can be maintained even before a contract claim has fully developed, and that a statutory claim can be successful even if the underlying breach of contract claim fails." Id. at *11 (citing Doylestown Elec. Supply Co. v. Maryland Cas. Ins. Co., 942 F. Supp. 1018, 1020 (E.D. Pa. 1996) and March v. Paradise Mut. Ins. Co., [646 A.2d 1254] (Pa. Super. 1994), appeal denied, 540 Pa. 613, 656 A.2d 118 (1995)).

However, Doylestown Elec. was distinguished in Frog, Switch & Mfg. Co. v. Travelers Ins. Co., 193 F.3d 742, 751 n. 9 (3d Cir. 1999). The Third Circuit stated that where there was a substantive finding of no duty to defend, there was good cause to refuse a defense. In Pizzini v. Am. Int'l Specialty Lines Ins. Co., No. 03-1959, 107 Fed. Appx. 266, 2004 U.S. App. LEXIS 14246 (3d Cir. Jul. 12, 2004), the Court stated: "Finally, appellants argue that even though the District Court held their assigned policy claims invalid, a statutory bad faith claim should not be precluded. We do not agree. Having already found that appellants can enforce no right under either policy, they lack the predicate action needed to pursue a 42 P.S. § 8371 bad faith claim … This being the

case, appellants' bad faith claim is not sustainable." Id. at *7 (citing Polselli v. Nationwide Mut. Fire Ins. Co., 126 F.3d 524, 530 (3d Cir. 1997)).[3]

Both Doylestown Elec. and March involved dismissal of contract claims based on contractual statute of limitations, not on the actual failure of the claims on the merits. But see Rutkowski v. Allstate Ins. Co., 69 Pa. D.&C. 4th 10, 12 n.1 (C.C.P. Lackawanna 2004) (Nealon, J.) ("Since the success of a bad faith claim is not dependent upon the resolution of the underlying contract claim, see March v. Paradise Mutual Insurance Co., 435 Pa. Super. 597, 601-602, 646 A.2d 1254, 1256 (1994), appeal denied, 540 Pa. 613, 656 A.2d 118 (1995), a plaintiff may succeed on a bad faith claim even if she is unsuccessful with the underlying contract claim. Doylestown Electrical Supply Co. v. Maryland Casualty Ins. Co., 942 F. Supp. 1018, 1020 (E.D. Pa. 1996). Thus, a bad faith trial may proceed regardless of the outcome or existence of a contract claim. See Frederick & Emily's Inc. v. Westfield Group, 2004 U.S. Dist. LEXIS 17274, 2004 WL 1925007, *3 (E.D. Pa. 2004).").

In Shadduck v. Christopher J. Kaclik, Inc., 713 A.2d 635, 638 (Pa. Super. 1998), the Superior Court analyzed Nealy v. State Farm Mut. Auto. Ins., 695 A.2d 790, 793-94 (Pa. Super. 1997), appeal denied, 553 Pa. 690, 717 A.2d 1028 (1998), a case cited for the proposition that the underlying breach of insurance contract claim and the bad faith claim are two separate and independent causes of action. In Nealy, the Superior Court had ruled that the section 8371 claim was distinct from the breach of contract claim, and

[3]The District Court had stated in Pizzini: "The defendants also move for summary judgment on the plaintiffs' statutory claim of bad faith … for refusing to indemnify …. The plaintiffs maintain that their claim under § 8371 is still a viable claim. The plaintiffs are incorrect. Like their claim of bad faith sounding in contract, the plaintiffs' bad faith claim under § 8371 was contingent on the success of their underlying breach of contract claim …. 'Bad faith claims cannot survive a determination that there was no duty to defend, because the court's determination that there was no potential coverage means that the insurer had good cause to refuse to defend.' … It follows that an insurer with no duty to defend or indemnify its insured could not have acted in bad faith in violation of § 8371." Pizzini v. Am. Int'l Specialty Lines Ins. Co., 249 F. Supp. 2d 569, 570-571 (E.D. Pa. 2003) (citations omitted).

could not be arbitrated since it had a statutory basis requiring adjudication by a judge. The Superior Court in Shadduck explained:

> Upon review, this Court held that, due to the unique nature of section 8371 bad faith claims, original jurisdiction thereover lies solely in our courts of common pleas. In explaining our rationale, we noted that, because the behavior giving rise to such causes of action occur after the behavior originally complained of, bad faith claims "are distinct from the underlying contractual insurance claims from which the dispute arose." Id. at 792. More specifically, we elaborated as follows:
>
> A § 8371 bad faith claim, however, is initiated based upon behavior of the insurance company occurring subsequent to the negligent or intentional behavior of a third party that spawned the contractual suit. Thus, because *the behavior complained of is temporally and factually distinct* from any behavior that would impact upon the outcome of the damages and liability disposition of the contract claim, we see no reason to expand upon the panels' jurisdiction. Id. at 794 (emphasis added [by Superior Court]).

Id. at 638.

In Schindler v. Berkshire Life Ins. Co., No. 98-5049, 1999 U.S. Dist. LEXIS 10414 at *1 n.1 (E.D. Pa. Jul. 9, 1999), the District Court observed:

> Plaintiff's argument that Count One - breach of contract - must be adjudicated as a predicate to bad faith is rejected. Bad faith claims necessarily are based on an underlying contractual cause of action. See Polselli v. Nationwide Mut. Fire Ins. Co., 126 F.3d 524, 529-30 (3d Cir. 1997). However, bad faith claims, while arising from the insurance contract, are separate and independent and may be actionable even when the contract claim is barred by technical defenses, settled, or otherwise not litigated. Id., at 530.

Monarch, Inc. v. St. Paul Prop. and Liab. Ins. Co., No. 03-CV-0054, 2004 U.S. Dist LEXIS 14803 (E.D. Pa. Jul. 30, 2004). The District Court stated that "[b]ad faith may exist even if no breach of contract occurred." Id. at *13. See discussion of this case under bad faith conduct during the course of litigation.

B. Who can Sue and be Sued

In Brown v. Progressive Ins. Co., 860 A.2d 493 (Pa. Super. 2004), the Superior Court addressed the issue of who is an insurer against whom a bad faith action may be brought, where both Progressive and an affiliated entity, Mountain Laurel Assurance Co. were named as defendants. The Court stated:

> [I]t is undisputed that both Progressive and Mountain Laurel are "insurers."
>
> Unfortunately, that does not answer the more relevant question, which is: how should courts decide which of the two related insurance companies is the "insurer" for purposes of the Bad Faith Statute? This question appears to be one of first impression among Pennsylvania state courts.
>
> There is no simple rule for determining who is the insurer for purposes of the Bad Faith Statute. The question is necessarily one of fact, to be determined both by examining the policy documents themselves, and by considering the actions of the company involved. Thus, we look at two factors: (1) the extent to which the company was identified as the insurer on the policy documents; and (2) the extent to which the company acted as an insurer. See, Lockhart v. Federal Ins. Co., 1998 U.S. Dist. LEXIS 4046 (E.D. Pa. March 30, 1998). This second factor is significantly more important than the first factor, because it focuses on the true actions of the parties rather than the vagaries of corporate structure and ownership.

Id. at 498-99.

In its analysis of the first factor, the Court observed that "wherever Mountain Laurel is listed, Progressive is also listed, at least as prominently (if not more so)." Id. at 499. The Court determined that this, "combined with a total lack of guidance in the policy itself as to who is the insurer, supports the trial court's finding that Progressive was an appropriate party to this action." Id.

As for the second factor, the Court noted:

> Progressive handled the medical payments and lost wages claim, approved the third party settlement, waived its subrogation rights, and handled all aspects of the UIM claim. In this respect, the record overwhelmingly establishes that Progressive was Brown's insurer. To hold

> otherwise would create a situation where insurers are judged not on their actions, but on their corporate structures.

Id. at 500. The Court also acknowledged the concept of a "de facto" insurer, where an insurer not listed in the contract could still be held liable under an alter ego or agency theory. The Court proceeded, however, to overturn the trial court's finding of bad faith against Progressive.

Digregorio v. Keystone Health Plan East, 840 A.2d 361 (Pa. Super. 2003). "Pennsylvania specifically exempts HMOs … from statutory bad faith claims under 42 Pa. C.S. § 8371." Id. at 370 (citing 40 P.S. § 1560). In light of this statute, the Court was not inclined "to mold a common law right of action in bad faith based solely on … Dercoli v. Pennsylvania National Mutual Insurance Co., 520 Pa. 471, 554 A.2d 906 (1989), that insurance companies owe their insureds a duty of fair dealing. Since the insured in that case did not assert a claim for punitive damages, Dercoli is not dispositive." Id. at 370 n.2.

SEPTA v. Holmes, 835 A.2d 851 (Pa. Commw. 2003), appeal denied, 577 Pa. 738, 848 A.2d 930 (2004). SEPTA, even though a self-insurer, is not an insurer subject to 42 Pa. C.S. § 8371. The statute "only applies to insurance companies that have assumed the liability of others by the issuance of an insurance policy, and it has no application to a self-insured." Id. at 854. Further, there is no exception to sovereign immunity. The court also found that there could be no breach of contract of the covenant of good faith and fair dealing absent a contract. Id. at 859.

Silverman v. Rutgers Cas. Ins. Co., June Term 2003, No. 363, 2005 Phila. Ct. Com. Pl. LEXIS 130 (Mar. 31, 2005) (Jones, J.). Section "8371 does not extend to claims raised by medical providers for treatment provided to persons injured in motor vehicle accidents." Id. at *10. There are no direct contractual relations between the medical providers and the insurance carriers, and the Motor Vehicle Financial Responsibility Law ("MVFRL") elsewhere defines rights and obligations between insurers and treating physicians.

Kvaerner U.S. Inc. v. OneBeacon Ins. Co., April Term 2003, No. 940, 2003 Phila. Ct. Com. Pl. LEXIS 45 (Sept. 29, 2003) (Sheppard, J.). "Bad faith claims against insurance agents, claims representatives, peer review physicians have been found to be impermissible under § 8371." Id. at *6 (citation omitted). In that case, a third party claims administrator was not an insurer under section 8371 and was not subject to such a claim. Id.

Powell v. Crawford & Co., No. 03-2182, 2003 U.S. Dist. LEXIS 20207 (E.D. Pa. Oct. 30 2003). An adjuster is not an insurer for section 8371 purposes and there is no statutory cause of action against adjusters.

Margaret Auto Body, Inc. v. Universal Underwriters Group, July Term 2002, No. 1750, 2003 Phila. Ct. Com. Pl. LEXIS 52 (Jan. 10, 2003) (Jones, J.). Investigators hired by an insurer, even if the insurer's agents acting under the insurer's exclusive control and direction, are not subject to liability under section 8371.

Hebrew School Condo. Ass'n v. Distefano, May Term 2004, No. 1886, 2004 Phila. Ct. Com. Pl. LEXIS 71 (Oct. 21, 2004) (Cohen, J.). Plaintiffs, a condominium association and individual unit owners, brought a bad faith claim against an insurance carrier for allegedly failing to provide coverage under the policy. The carrier, however, filed preliminary objections asserting that the individual unit owners could not assert claims for bad faith since they were not named insureds under the property policy. Id. at **6-7. The Court held that "[o]nly the insured under a contract of insurance can bring a cause of action for bad faith." Id. (citing 42 Pa. C.S. §8371). Accordingly, the Court dismissed the individual plaintiffs' bad faith claims against the carrier.

Chau v. RCA Ins. Group, January Term 2003, No. 692, 2004 Phila. Ct. Com. Pl. LEXIS 23 (Mar. 23, 2004) (Sheppard, J.). Claim was brought against a carrier and the carrier's agent. The Court stated that 42 Pa. C.S. §8371 only applies to the conduct of an insurer toward an insured. Id. at **2-3. While the Court acknowledged that the term "insurer" was not defined under the statute, insurers generally "'issue[] policies, collect[] premiums and in exchange assume[] certain risks and contractual obligations.'" Id. at *3 (citing Ihnat v. Pover, 35 Pa. D.&C. 4th 120 (C.C.P. Allegheny 1997) (Wettick, J.)).

Therefore, the agent could not be deemed an insurer under the act, and was not subject to a bad faith claim thereunder. Id. at **3-4.

Davin v. Davin, 842 A.2d 469 (Pa. Super. 2004). A life insurance policy holder was ordered to pay his first wife proceeds from his policy to settle marital debt. The order provided that he could designate the beneficiary for the remainder policy amount, and that any failure to comply with the terms of the order would result in his default on the policy, the entire policy amount then being payable to his first wife. He designated his second wife as an "irrevocable beneficiary" to the policy in violation of the previous court order, but then allowed the policy to lapse so that the premium amounts were being paid from the cash value of the policy. The first wife asserted a bad faith claim against the insurance company for its failure to disclose, upon her inquiry, the fact that payments were not being made to the policy. The second wife also asserted a bad faith claim for the insurance company's failure to disclose the first wife's interest in the policy.

The Superior Court determined that the lower court had not erred in concluding that the second wife had no standing to sue the insurance company, and she was not an intended third party beneficiary within the meaning of the statute where her designation as "irrevocable beneficiary" was in violation of a court order.

Osborne v. Neville, 65 D.&C. 4th 225 (C.C.P. Lackawanna 2004)(Nealon, J.). In this medical malpractice case, the plaintiff was awarded damages in excess of the payments available through the Pennsylvania Property & Casualty Insurance Guaranty Association (PPCIGA) statute and the Medical Professional Liability Catastrophe Loss (CAT) Fund. The plaintiff sought to recover the full amount of the award, above the amounts paid by PPCIGA and CAT, from the physician personally. The Court held that nothing in either statute insulated a medical provider from personal liability from unpaid judgment amounts. In so holding, the Court noted that because PPCIGA and CAT are not "insurers" for the purposes of 42 Pa. C.S. § 8371, there can be no liability for bad faith conduct if not provided for separately by statute.

C. Subject Matter Outside the Scope of the Bad Faith Statute

UPMC Health Sys. v. Metropolitan Life Ins. Co., 391 F.3d 497 (3d Cir. 2004). Act by insurer that allegedly violated the UIPA resulting in greater premiums is not actionable under section 8371. The essence of a bad faith claim has to be based on an unreasonable and intentional or reckless denial of benefits. Purported misconduct in generating an unfairly high premium is not a denial of benefits, even if it violates the UIPA.

The Brickman Group, Ltd. v. CGU Ins. Co., 865 A.2d 918 (Pa. Super. 2004). Case involved dispute over premiums and renewal of policy. The Court observed that it had previously stated that section 8371 was aimed at bad faith denials of coverage, and added that it could look to other cases construing the statute and the bad faith law, generally, the statute's plain language and other statutes on the same or similar subjects, including the Unfair Insurance Practices Act ("UIPA"). These principles permitted a limited extension to consider the insurer's litigation conduct after a claim for coverage had been made in evaluating bad faith. The Trial Court had ruled that section 8371 did not apply to issues concerning premiums and renewals, and the insureds tried to transform the issue into one of coverage by claiming the misconduct was an anticipatory breach. The Superior Court rejected that later effort and affirmed.

American Empire Surplus Lines Ins. Co. v. Ardsley Group, No. 04-518, 2004 U.S. Dist. LEXIS 26134 (E.D. Pa. Jan. 3, 2005). Dispute over policy cancellation cannot be the basis of a section 8371 claim.

Echevarria v. Unitrin Direct Ins. Co., No. 02-8384, 2003 U.S. Dist. LEXIS 4680 (E.D. Pa. Mar. 17, 2003). Claim for wrongful cancellation of an insurance policy cannot form the basis of a section 8371 action. The court relied upon the reasoning in Berks Mut. Leasing Corp. v. Travelers Prop. Cas., No. 01-6784, 2002 U.S. Dist. LEXIS 23749 at *18 (E.D. Pa. Dec. 9, 2002). Also citing to Berks Mut., the Third Circuit did not reach the issue of whether section 8371 claims can go to causes other than denial of claims. Brayman Constr. Corp. v. Home Ins. Co., 319 F.3d 622, 627 n.4 (3d Cir. 2003).

Ferrick Constr. Co. v. One Beacon Ins. Co., April Term 2004, No. 3858, 2004 Phila. Ct. Com. Pl. LEXIS 70 (C.C.P. Phila. Dec. 27, 2004) (Jones, J.). Section 8371 does not apply to surety bonds.

Wise v. American Gen. Life Ins. Co., 2005 U.S. Dist. LEXIS 4540 (E.D. Pa. Mar. 22, 2005). The decedent's life insurance policy was not to take effect until it was accepted and the first premium had been paid. Decedent died the same day he received the policy, and the insurer refused to accept payment of the first premium from his wife after his date of death. In deciding in favor of the insurer, the District Court stressed that the purpose of section 8371 is to allow bad faith claims "to cover the actions of insurance companies in the denial of benefits under an *existing contract*; there is no indication that it was intended to extend to an insurer's actions in the solicitation of customers or to regulate the insurance industry more generally." Id. at *17 (emphasis added).

Schleinkofer v. Nat'l Cas. Co., 339 F. Supp. 2d 683 (W.D. Pa. 2004). Plaintiff was injured in an automobile accident and brought claims for auto insurance medical benefits and first party wage loss benefits. After these benefits were denied by the insurer, the insured brought bad faith claims under §8371 for (1) wage loss and (2) medical benefits. The Court found that the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. § 1701, et. seq., preempted the medical benefits claim, but did not preempt the wage loss claim.

The Court determined that 75 Pa. C.S. § 1797 and section 8371 were not reconcilable because: (1) the two provisions contained different measures of calculating damages; and (2) section 1797 sets out procedures and remedies "with specificity." Schleinkofer, 339 F. Supp. 2d. at 687. Thus, section 1797 was the plaintiff's exclusive remedy for auto insurance medical benefits. However, the language of 75 Pa. C.S. § 1716 had been previously held to recognize remedies under other sections. In addition, the court noted a distinction in the requisite level of intent, in that section 1716 requires only "unreasonable" conduct, which section 8371 requires subjective "bad faith." Id. at 688. Thus, the plaintiff was not barred from asserting claims under both section 1716 and section 8371.

D. Ripeness

Allstate Ins. Co. v. Kenney, No. 02-2387, 2003 U.S. Dist. LEXIS 18250 (E.D. Pa. Oct. 8, 2003). The carrier brought a declaratory judgment action seeking a declaration that the policy did not provide coverage for the claims in the underlying action, and the insureds filed a counterclaim for bad faith. The insurer had provided a defense in the underlying action, subject to a reservation of rights, and had not yet disclaimed coverage. The underlying action was stayed pending the declaratory judgment action.[4]

The District Court defined the issues: "In this case, the [insureds] assert that they are harmed because the state court action has been stayed and [the carrier] is not behaving as the [insureds] would have them do. However, implicit in [the insureds'] claim is that the State Court has rendered no judgment against them and that they have a disagreement with counsel whom [the carrier] has provided regarding strategy in the state court action. Thus, the issue presented is whether the actions of which the [insureds] complain are ripe for our review." Id. at *7.

The Court stated: "Under the facts pled by the [insureds] in their counterclaims, it is undisputed both that [the carrier] has provided the [insureds] with counsel and that the state action is in suspense by agreement of the parties. In their breach-of-contract

[4]The District Court opinion states "counsel whom Allstate provided … in the state court action agreed to stay the state court action while Allstate sought the within declaratory judgment." Id. at *4. This would appear to invoke considerations of the Rules of Professional Conduct in light of the fact that this could create certain advantages and/or disadvantages between the insurer and the insured on coverage. See the chapter in this text on the Rules of Professional Conduct. The District Court's background recitation also included: "Counsel whom [the carrier] provided to the [insureds] in the state court action led [the insured] to believe that if she filed no response to the federal [declaratory judgment] action, then she would likely survive the state court action because she would be judgment-proof without Allstate's insurance coverage. Moreover, counsel informed [the insured] that the [the underlying plaintiffs] would dismiss the state action if she did not have insurance coverage. An entry of default was entered in the federal action … However … counsel for the [insured] defendants entered their appearance in the federal action. By agreement of counsel, the entry of default was lifted … The underlying state court action has remained in suspense … [The carrier] has refused to engage in settlement negotiations regarding the state action while the within action is pending." Id. at **4-5.

counterclaim, the [insureds] aver that [the carrier] has a duty to defend them and to indemnify them from damages resulting from the state court action. However, they fail to plead how [the carrier] has breached its duty to defend the state court action." Id. at **8-9.

The District Court would not speculate if the carrier would have later refused to defend or indemnify absent the declaratory judgment action. "However, Allstate has provided counsel for the [insureds], and no damages have resulted from the state court action. We do not know, and decline to speculate, whether [the carrier] would have refused to defend or indemnify the [the insureds] in the state action in the absence of a ruling by this court that they are not legally obligated to do so. Accordingly, their breach-of- contract claim is not ripe for our consideration." Id. at *9.

Turning to the issue of bad faith:

> because [the carrier] has provided counsel and no adverse judgment has been entered upon which [the carrier] has refused to indemnify the [the insureds], plaintiff-on-the-counterclaim cannot show under the facts pled in their counterclaims that [the carrier] denied benefits under the insurance contract. Because as of this time, [the carrier] has not denied benefits under the insurance policy to the [insured] defendants, we conclude that the parties are not adverse.
>
> This issue would be ripe for our review if [the carrier] had already failed to defend or indemnify the [the insureds] in the state court action. However, by our separate Order and Opinion of this date granting the [carrier's] motion for summary judgment,[5] we determined that [the carrier], as a matter of fact and law, is not under an obligation to do so. Therefore, [the carrier] has not breached any of the [insureds'] legal or contractual rights.
>
> [W]e conclude that the [insured] defendants have not suffered actual and concrete harm, [and] that they have

[5]That same day, in a separate opinion, the District Court granted the insurer's summary judgment motion finding no coverage or duty to defend. Allstate Ins. Co. v. Kenney, No. 02-CV-02387, 2003 U.S. Dist. LEXIS 18251 (E.D. Pa. Oct. 8, 2003).

failed to state a claim upon which relief may be granted.

….

E. Statute of Limitations

Haugh v. Allstate Ins. Co., 322 F.3d 227 (3d Cir. 2003). The statute of limitations for section 8371 claim is two years. The Court pointed out that there was authority for the position that the cause of action based on a bad faith refusal to settle does not accrue until the excess judgment in the underlying case becomes final. Id. at 231 n.6. The discovery rule would apply on the issue of when the insured knew or should have known that carrier declined to settle for a policy limits demand. Id. at 231. A snap demand by injured parties' lawyer to settle the case for policy limits early, which the insurer claimed the plaintiff made knowing that insurer would not settle, was no defense to a bad faith claim or avoidance of the discovery rule, since nothing prevented settlement other than internal determinations and policies; rather than some external objective rule or force. Id. at 222. Following the Supreme Court's decision in The Birth Center case, the Third Circuit held that Pennsylvania recognizes an independent contract claim for the breach of the obligation to act in good faith. Id. at 236. This is significant because such an action is subject to a four-year statute of limitations, rather than two years for section 8371.

Ash v. Continental Ins. Co., 861 A.2d 979 (Pa. Super. 2004); Allen v. Gen. Accident Ins. Co. of America, 868 A.2d 594 (Pa. Super. 2005). The Superior Court has likewise applied a two-year statute of limitations.

Simon Wrecking Co. v. AIU Ins. Co., 350 F. Supp. 2d 624 (E.D. Pa. 2004). The question of when the statute of limitations begins to run on a bad faith claim was at issue. The insured received a potentially responsible party (PRP) letter from the Environmental Protection Agency (EPA) in November 1996. Id. at 628-29. In February 1997, the insured notified its liability carriers, AIU, Liberty Mutual and CNA. In October 1997, both AIU and Liberty Mutual wrote letters to the insured denying coverage. Id. at 629.

By 1999, other entities that were recipients of PRP letters had entered into a consent decree with the EPA permitting the potentially responsible parties to file suit against the non-settling parties, including the insured. On July 30, 2002, the insured notified AIU, Liberty Mutual and CNA of a pending lawsuit against it and requested that

it be defended. Suit was formally filed on December 9, 2002 against the insured as a non-settling party.

Later in December 2002, CNA sent a reservation of rights letter, and did not defend the insured. On February 24, 2003, CNA sent a letter to the insured requesting additional information before it could make a determination as to whether the claim was covered. On May 21, 2003, the insured filed a complaint for, inter alia, bad faith denial of coverage against AIU, Liberty Mutual and CNA. Id. at 630.

AIU, Liberty Mutual and CNA filed motions for summary judgment arguing that the statute of limitations started running when they each responded to the insured's letter in 1997. The insured argued that the carrier's refusal to defend in response to its July 30, 2002 letter constituted new and distinct acts of bad faith. The insurers countered by arguing that any response, or lack thereof, to the insured's July 30, 2002 letter was simply a continuing denial of coverage, and as such did not constitute separate acts of bad faith. Id. at 631.

The Court agreed that the initial denial triggered the two-year statute of limitations, and that subsequent acts would not be treated as new acts of bad faith. The Court then held that AIU's and Liberty Mutual's initial denial letters of October 1997 were based on the denial of coverage due to the type of pollution and the applicability of the pollution exclusion, and not merely a denial of a defense due to the PRP letter. Therefore, the court held that the statute of limitations as to the insured's bad faith claim against AIU and Liberty Mutual began to run in October 1997. Thus, the claims were time-barred. Id. at 633. The Court did not grant CNA's motion for summary judgment since it found that CNA's letter did not actually deny coverage to the insured. Thus, the Court held that "[w]ithout a denial of benefits, there was no act of bad faith" which would trigger the statute. Id. at 632.

F. Right to a Jury Trial in Section 8371 Claims

Mishoe v. Erie Ins. Co., 573 Pa. 267, 824 A.2d 1153 (2003). Pennsylvania's Supreme Court holds that there is no right to a jury trial in a bad faith action brought under 42 Pa. C.S. § 8731. Under the Federal Constitution, however, the United States

Court of Appeals for the Third Circuit has held that the Seventh Amendment requires a jury trial on punitive damages, and so on section 8371 claims. W. V. Realty Inc. v. Northern Ins. Co., 334 F.3d 306, 309 n.1 (3d Cir. 2003). Thus, the parties should be aware that if they seek to remove a case to federal court, the bad faith issue will go to the jury along with all other issues, while that same claim must be ruled upon by a Judge in an action in Pennsylvania's State Courts.

G. Decisions on the Existence of Bad Faith

1. Failure to Investigate; Failure to Perform Legal Research; Reliance on Untrustworthy Expert Report; Unreasonable Interpretation of Policy Provisions; Misrepresentations of Facts or Policy Provisions

Corch Constr. Co. v. Assurance Co. of America, 64 Pa. D.&C. 4th 496 (C.C.P. Luzerne 2003). Plaintiffs, contractor and its principal (who had an excellent credit history and considerable experience) purchased a business risk insurance policy for a particular construction project. The project foundation failed because of a subcontractor's poor workmanship and poor materials which led to a partial collapse. The contractor, via its agent, repeatedly made reports to the carrier, with delays in response on the carrier's end. The carrier's business risk department referred the matter to the liability department, but no real action was taken on the claim.

The Court stated it was obvious that the claim was covered as a partial collapse. Yet no action was taken and the project remained shut down. The carrier finally retained an expert who addressed the source of the failure as workmanship and material. He then gratuitously brought up a complete collapse, which was not genuinely an issue, while conspicuously failing to discuss a partial collapse, which was at issue and should have been covered. In addition, the insurer's personnel claim to have researched the state of the law on collapse in making their decision, which the court found to be incredible. Instead, the court found that there had been no legal research by the adjustors or supervisor, nor consultation with counsel. Further, the carrier had investigative photographs showing the partial collapse taken, but somehow came to be missing from the file and could not be located.

The Court found that:

(1) There was no evidence supporting the denial of the claim.

(2) The expert report was a transparent effort to support the denial, which the carrier either knew was unreasonable or recklessly disregarded the fact that it was unreasonable. Reliance upon the dubious expert report was in and of itself bad faith.

(3) The failure to make an adequate investigation could amount to bad faith.

(4) The failure to perform any legal research can also amount to bad faith. The carrier in this case failed to perform any legal research, which was especially egregious not only because the employees lied, but because on the facts there clearly was coverage under the applicable law.

(5) An unreasonable interpretation of the policy provisions can support bad faith.

(6) "[A] blatant misrepresentation of the facts or policy provisions will support a bad faith claim."

(7) The Court was also troubled that photographs evidencing the state of the collapse, and so the key coverage issue, went missing from the file and were not found. Id. at 517.

The Court accepted the opinions of plaintiff's expert, described below in the discussion on experts, to support the finding of bad faith. This included the expert's opinion that the carrier's personnel had formed "*a mindset of denial throughout the claim which is contrary to the requirements to be looking for coverage and to live up to its covenant of good faith* …" Id. at 517 (emphasis added).

Wiener v. Banner Life Ins. Co., No. 02-1351, 2003 U.S. Dist. LEXIS 4957 (E.D. Pa. Feb. 28, 2003). In a case involving a claim on a life insurance policy and alleged delays in payment, the insured widow made a bad faith claim that the carrier allegedly "lacked any reasonable basis for its prolonged and improper post-loss investigation into the medical history of the deceased, and that Defendant unjustifiably delayed in paying Plaintiff's claim in order to receive the benefit of the time value of the money." Id. at *18. "[A] delay in payment of a claim may, under appropriate circumstances, constitute bad faith. To constitute a claim of bad faith delay, Plaintiffs must allege that, at the time,

(1) Defendant had no reasonable basis for the delay of coverage and that (2) Defendant delayed coverage with knowledge or reckless disregard for the unreasonableness of his action." Id. at *20 (citations omitted).

On the overall question of the insurer's reasonableness, "[C]ourts apply an objective analysis to the reasonableness prong, questioning whether there is any possible reasonable basis for the insurer's conduct and not whether the insurer's conduct was actually motivated by a reasonable purpose." The court cited to Livornese v. Medical Protective Co., 219 F. Supp. 2d 645, 648 (E.D. Pa. 2002) to support this proposition, and then quoted: "'As a matter of law, if some reasonable basis did exist, that insurer cannot have acted in bad faith, under Section 8371.'"[6] Id. at *20.

The Court observed that the carrier had a right to investigate claims. The Court found that the carrier had a right to investigate the deceased's medical history over a ten-year period to determine if there had been some fraud in the insurance application. While 4 months may have been somewhat long, it was not so unreasonable to constitute bad faith. The Court cited two prior cases where 11 and 13 month periods did not constitute bad faith investigations.

Mark 1 Restoration SVC v. Assurance Co. of America, 112 Fed. Appx. 153, 2004 U.S. App. LEXIS 21305 (3d Cir. Oct. 13, 2004). The insured restoration company was hired to deodorize a skunk-infested home, which resulted in it being named as a third-party defendant in a homeowner's action. The insured filed suit against the insurance company, alleging it acted in bad faith when it refused to defend the suit by failing to properly investigate the claim. Among other things, the Third Circuit affirmed the trial court's holding that bad faith did not arise because an insurer is not required to investigate claims beyond those being made within the four corners of the complaint filed against the insured.

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[6]After Wiener was decided, Livornese was subsequently reversed on appeal because the District Court erred in finding a reasonable basis for the insurer's decision in a statute, when the policy language itself required a different result. Livornese v. The Medical Protective Co., Nos. 03-2116/03-2143/03-2410, 2005 U.S. App. LEXIS 10785 (3d Cir. Jun. 9, 2005).

2. Tying Settlement Offer to Release of Potential Bad Faith Claim

Hayes v. Harleysville Mut. Ins. Co., 841 A.2d 121, 127-128 (Pa. Super. 2003), appeal denied, 870 A.2d 322 (Pa. 2005). The insured and insurer were in dispute over whether the insured had selected a lower level of underinsured motorist coverage. The carrier first offered the full amount of the policy under its version of the facts, and then later offered to make full payment under the insured's view of the policy. In making the second offer, however, the carrier also demanded that the insured release any bad faith claim as well as ceasing its arbitration claim. The insured refused and won the arbitration in the full amount he was seeking. He then brought a bad faith claim.

The insured's counsel had asked for the original selection form to get a fix on what his client had in fact requested for UIM coverage. The carrier had taken a misleading position about the insured's agreement to the lower rate, saying that such a form did not exist, and that it only had later forms; purportedly supporting the existence of an earlier consent to lower coverage. Only on the day of the arbitration did the insurer produce the insured's original selection form, which had not been signed by the insured himself, a requirement if there was to be UIM coverage at a reduced rate.

The insurer's own counsel did not learn of the document until that time as well, and recommended that the insurer pay the insured in full, independent of any other claims the insured might have. Counsel also wrote of potential bad faith exposure. The insurer ultimately agreed to offer the full amount, but only on the condition of receiving a release on the bad faith claim. It had earlier received a bad faith letter from the insured's counsel.

The Superior Court upheld the finding that the carrier acted in bad faith by failing to reform the policy and pay the full amount demanded. The Court found that the carrier had misrepresented that the original form did not exist. It only produced that form on the day of arbitration to its own counsel and the insured, when the document must have been in the file throughout the handling of the whole claim. It did not make a reasonable effort to locate this document, which the insured's counsel had requested, and made low settlement offers before producing the form. Id. at 127.

A key issue raised was whether it was bad faith to try and settle the case by seeking a release for both the underlying insurance contract claim and a bad faith claim. In that case, the carrier actually knew that the insured was entitled to the full sum he had requested, offered to pay that sum, but further demanded a release of the UIM claim and any potential bad faith claim. The insured refused the release and the carrier refused to pay the claim. This constituted bad faith conduct. Id. at 127-28.

Kubrick v. Allstate Ins. Co., No. 01-6541, 2004 U.S. Dist. LEXIS 358 (E.D. Pa. Jan. 7, 2004), aff'd, Kubrick v. Allstate Ins. Co., 121 Fed. Appx. 447, 2005 U.S. App. LEXIS 1440 (3d Cir. Jan. 28, 2005). In contrast to Hayes, the carrier had made efforts to locate a sign-down agreement which it believed existed and supported a lower coverage amount, and could not do so. The parties agreed to settle the insurance contract claims for $600,000 (the claimants believing there was a $900,000 potential if the case went to arbitration), and, despite the efforts and explanations of their own counsel, the plaintiffs repeatedly refused to sign off on the basis that they did not want to release their bad faith claim. However, the carrier was not seeking such a general release, as pointed out by plaintiffs' own counsel. Id. at **15-19, 48-49.

The District Court stated that "[w]here, as here, there are substantial unresolved questions as to the insurer's liability, making an offer for less than the policy limits cannot constitute bad faith. Id. at *46 (citation omitted). This was a first party claim. The court further stated that "it is not bad faith for an insurer to seek a release when settling a disputed claim." Id. at *48. As stated above, the evidence showed that the carrier clearly was not seeking a general release that would cover a potential bad faith claim.

3. Discovery Conduct During the Bad Faith Action

W. V. Realty Inc. v. Northern Ins. Co., 334 F.3d 306, 313-314 (3d Cir. 2003). "Pure" discovery violations during bad faith litigation cannot be the basis for further bad faith claims; but conduct during trial that goes beyond such violations and reflects a broader attempt to evade the insurer's obligations may be subject to section 8371. The Third Circuit discussed a number of cases where both circumstances were at issue. Id.

4. Failure to Pay Delay Damages and Post Judgment Interest

Livornese v. The Medical Protective Co., Nos. 03-2116/03-2143/03-2410, 2005 U.S. App. LEXIS 10785 (3d Cir. Jun. 9, 2005). Plaintiff's bad faith claim against an insurer who tendered policy limits during litigation but failed to pay any delay damages or post judgment interest was permitted to continue pursuit of a bad faith claim where the policy permitted collection of such delay damages and post judgment interest, independent of any statutory requirement.

5. Disability Claims and Surveillance

Alexander v. Provident Life & Accident Ins. Co., No. 00-1405, 2003 U.S. Dist. LEXIS 4498 (M.D. Pa. Jan. 2, 2003). A disability insurer denied coverage and obtained surveillance video and its own medical reports indicating there was no disability. Despite this, the insured argued other evidence that purportedly showed bad faith. The District Court found that the insurer was not liable, and that the standard was not perfection in decision making. Quoting from Judge Vanaskie in Krisa v. Equitable Life Assurance Society, 113 F. Supp. 2d. 694, 703 (M.D. Pa. 2000): "in order to survive bad-faith claims, an insurance company's procedures must be reasonable, but they need not be perfect: 'For an insurance company to show that it had a reasonable basis, an insurance company is not required to demonstrate its investigation yielded the correct conclusion or even that its conclusion more likely than not was accurate. The insurance company also is not required to show the process by which it reached its conclusion was flawless or that the investigatory methods it employed eliminated possibilities at odds with its conclusion. Rather an insurance company simply must show it conducted a review or investigation sufficiently thorough to yield a reasonable foundation for its action.'" Id. at *12.

6. Conduct Prior to Formation of Insurance Contract

Altimari v. John Hancock Variable Life Ins. Co., 247 F. Supp. 2d 637 (E.D. Pa. 2003). "Although plaintiff argues that this action arises under an insurance policy because defendants refuse to pay the proceeds of a life insurance policy, 42 Pa. Cons. Stat. § 8371 does not apply to conduct which occurs prior to formation of an insurance contract. See Weisblatt v. 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.") In this case, there was no insurance policy; therefore, [the carrier's] refusal to pay insurance proceeds does not violate section 8371." Id. at 649.

7. Excess Verdict Risks and Settlement/ *Cowden* Bad Faith

Haugh v. Allstate Ins. Co., 322 F.3d 227 (3d Cir. 2003). "An insurer does not comply with the good faith standard when it refuses to settle merely because it believes that its insured is not liable for the claim asserted." Id. at 237. Acting with "sincerity" is insufficient in itself to satisfy a good faith standard. Id. (quoting The Birth Center, 727 A.2d at 1156). Even assuming the carrier conducted a reasonable investigation *and* there was a reasonable basis for concluding that the insured was not liable, this alone is not enough to show good faith as a matter of law; rather "there were other factors that [the carrier] was *required to assess before refusing to settle within policy limits*." Id. at 237 (emphasis added).

In determining whether to settle, "an insurer acting in good faith must consider 'all of the factors bearing upon the advisability of a settlement for the protection of the insured.'" Id. at 237-238 (citations omitted). These include:

(1) Risk of liability;

(2) Considering the anticipated range of an adverse verdict;

(3) "the strengths and weaknesses of all of the evidence to be presented on either side so far as known";

(4) "the history of the particular geographic area in cases of a similar nature" and

(5) "the relative appearance, persuasiveness, and likely appeal of the claimant, the insured, and the witnesses at trial."

Id. at 238 (citations omitted).[7]

[7]An interesting consideration may arise when ethical rules might limit what an attorney can tell the carrier, which could conceivably weigh in on these factors. See the Rules of Professional Conduct concerning providing information to the insurer. Thus, e.g., if the insured tells defense counsel that the act at issue was not negligent, but rather the insured

The Third Circuit also stated that "[b]ecause an insured contractually surrenders responsibility to its insurance company for defense of the underlying claim, the duty of good faith and fair dealing requires that the insurer reasonably inform the insured of significant developments bearing on the settlement of claims against the insured." Id. at 238 (citation omitted). The insured in this case was not informed about the offer to settle for policy limits. The Third Circuit noted that the Pennsylvania Supreme Court would likely not require an insurer to "continually" inform the insured of "all" developments. Id. at 238 n.17. The carrier's own policy manual, however, also required its adjusters to keep the insured abreast of the settlement negotiations when an excess verdict was possible. The failure to notify the insured of the settlement negotiations also occurred before the carrier informed the insured that the insured could retain private counsel.

Thus, the failure to consider all factors, the failure to inform the insured of the settlement demand, and evidence that there may have been an unsatisfactory investigation on liability could each be used before the jury to determine bad faith. Id. at 239.

Schubert v. Am. Indep. Ins. Co., No. 02-6917, 2003 U.S. Dist. LEXIS 10769 (E.D. Pa. Jun. 24, 2003). The insured was a driver who injured two other persons, a husband and wife. His policy limit was $15,000. The injured parties' counsel sent the carrier the wife's medical records and asked about settlement. The carrier asked for an IME. The same counsel sent more records, demanded the $15,000 to settle and refused an IME as unreasonable. The carrier refused to settle at $15,000 and the offer expired. The carrier never informed the insured about these events.

The following events occurred: "The [injured parties] filed suit against [the insured] in the Court of Common Pleas of Lancaster County. During discovery, an IME of [the wife] was performed. After receiving the results of the IME, the Defendant offered [plaintiff's counsel] the $ 15,000 policy limit. That offer was rejected. The case proceeded to trial and … a non-jury verdict was rendered in favor of [the wife] in the

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intended to harm the underlying plaintiff -- a fact at trial that could clearly affect the case's outcome -- an ethical issue is raised as to whether the attorney can relay this confidential information under R.P.C. 1.6, 1.7 and 1.8 if it could cause the insured's coverage to fall into question.

amount of $2,505,755 and in favor of [the husband] in the amount of $100,000 for loss of consortium." Id. at **2-3. The insured filed for bankruptcy and the bankruptcy trustee brought a section 8371 claim against the carrier.

The District Court first clarified the law concerning the basis of an action for an excess verdict bad faith claim:

> The right to bring an excess-verdict bad faith case against an insurance company was established by Cowden v. Aetna, 389 Pa. 459, 134 A.2d 223 (1957). Cowden found that "an insurer against public liability for personal injury may be liable for the entire amount of the judgment secured by a third party against the insured regardless of any limitation in the policy, if the insurer's handling of the claim, including a failure to accept a proffered settlement, was done in such a manner as to evidence bad faith on the part of the insurer in the discharge of its *contractual duty*." Id. at 468 (emphasis added [by District Court]). This rule is founded upon the nature of a liability insurance contract. Id. at 469. Specifically, that such contracts vest the insurer with control over litigation that can expose the insured to personal liability. Id. Cowden thus established an implied duty to act in good faith during the defense of an insured. n2 See Diamond v. Penn Mut. Fire Ins. Co., 247 Pa. Super. 534, 552, 372 A.2d 1218 (1977)(finding implied duty of good faith in an insurance contract). Thus, an excess-verdict bad faith claim is in the nature of a breach of contract. The Birth Ctr. v. The St. Paul Cos., 567 Pa. 386, 402, 787 A.2d 376 at nt. 12 (citing Johnson v. Beane, 541 Pa. 449, 458, 664 A.2d 96 (1995)(Cappy, J., concurring)); Haugh v. Allstate Ins. Co., 322 F.3d 227, 236-7 (3d Cir. 2003).

Id. at **5-6.

"[A]n insurer must act with due care when handling an insured's litigation. Included within this duty is the obligation to act reasonably when deciding whether or not to accept a settlement offer. Reasonableness has traditionally been the standard governing an insurer's decision whether to settle." Id. at *6 (citations omitted).

The Court rejected the argument that the failure to inform the insured of the original settlement negotiations was in itself bad faith. "While the failure to inform an

insured of an offer to settle may be evidence of whether the Defendant had the insured's interests in mind, it does not constitute bad faith *per se*. See Haugh, 322 F.3d at 232 (noting that failure to advise insured of offer to settle could constitute evidence of bad faith)." Id. at **8-9. The Court also found that there was no proximate causal connection between the failure to inform the insured and the rejection of the settlement offer. Id. at *9.

The District Court then went on to examine the claims under section 8371. The court found that "acting with bad faith when deciding whether or not to settle should be treated the same as the mishandling of any other claim under any other insurance contract." Id. at *13. The matter could not be decided on summary judgment, and would be left to the jury to determine whether the refusal to settle for $15,000 was unreasonable, and if so, whether the insurer knew or recklessly disregarded that fact. The failure to inform the insured about the settlement demand was deemed of no practical consequence, in the bad faith context, because the only material issue was the refusal to settle; thus, if the refusal was reasonable, failing to inform the insured would be inconsequential, and if done in bad faith, then that would be decisive in itself. Id. at**15-16.

8. "Deems Expedient" Settlements

Transcon. Ins. Co. v. Century Steel Erectors, Inc., 318 F. Supp. 2d 276 (W.D. Pa. 2004). There was an insurance contract with a "deems expedient" clause ("carrier had 'the right to investigate and settle these claims, proceedings or suits'"). This empowered the carrier to settle a case, even against an insured's wishes, for a variety of reasons -- including likelihood of success, cost of defense, and nuisance value. This clause precluded a bad faith claim where there was a settlement *within the policy limits*. Id. at 278 (citing Caplan v. Fellheimer Eichen Braverman & Kaskey, 68 F.3d 828 (3d Cir. 1995)). This is so even if underlying claim was baseless.

9. Length of Investigation and Delay in Payment, Insured's Conduct[8]

Kubrick v. Allstate Ins. Co., 121 Fed. Appx. 447, 2005 U.S. App. LEXIS 1440 (3d Cir. Jan. 28, 2005). The Third Circuit determined that the insured had failed to make

[8]See also Section III.G.1.

out a bad faith claim when the insurer "reasonably believed in 1989, based on then-existing Pennsylvania law, that Appellants' UIM claim was not ripe and indeed may never have ripened based on the litigation then pending...." Id. at 448. This was in spite of an eight-year lapse between when the insured filed its claim and when the insurer undertook its factual investigation, and a ten-year lapse between filing and the eventual resolution of the claim.

In the lower Court's decision, Kubrick v. Allstate Ins. Co., No. 01-6541, 2004 U.S. Dist. LEXIS 358 (E.D. Pa. Jan. 7, 2004), in contrast to Hayes, supra, the carrier had made efforts to locate a sign-down agreement which it believed existed and supported a lower coverage amount, and could not do so. In addition to the change in the law, the court also observed delays engendered by the plaintiffs themselves, and obstreperous conduct by the claimants. For example, the parties agreed to settle the insurance contract claims for $600,000 (the claimants believing there was a $900,000 potential if the case went to arbitration), and the plaintiffs repeatedly refused to sign off on the basis that they did not want to release their bad faith claim. However, the carrier was not seeking such a release, and even plaintiff's counsel recognized this fact.

The Court also noted that the carrier believed that there was a sign-down, and the carrier was being forced to make a payment beyond what would have been required had it not lost this document, resulting in a huge windfall. Id. at *14 n.4. There were also significant and real factual issues that the insurer was investigating, which were not evidence of bad faith (as to the identity of the driver in a fatal auto accident, and where the deceased actually resided at the time of death, two facts which were critical and difficult to develop in light of the case's age). Id. at **40-42. This was not a case where the carrier "knew that it had no basis to deny a claimant," the District Court observing that courts will look to the degree of such knowledge in weighing bad faith. Id. at *39. Further, while there was an admitted delay in the investigation, the plaintiffs came "forward with no evidence that the delay was occasioned by [the carrier's] ill will, frivolous conduct, dishonest purpose or unreasonable self-interest." Id. at *44.

10. Ambiguous Contract Terms

McCrink v. Peoples Benefit Life Ins. Co., No. 04-1068, 2005 U.S. Dist. LEXIS 5072 (E.D. Pa. Mar. 29, 2005). The insurance contract contained a coverage exception for "operating" a motorcycle. The insured died when his motorcycle pulled him into traffic. The Court noted that (1) the term "operating" was ambiguous as applied to the insured's conduct; (2) case law did not agree as to the meaning; (3) the insurer reopened the investigation after receiving a letter from Plaintiff's counsel (resulting in a finding of a reasonable investigation); and (4) the insurer ultimately adopted one of many dictionary definitions of "operate." Although the insurer's notion of "operating" was not adopted by the court, it was reasonable, and the insurer's investigation proceeded reasonably given its definition of "operating." Thus, the insurer could not be found to have acted unreasonably and thus was entitled to summary judgment on the bad faith claim Id. at **32-49.

Hollingsworth v. State Farm, No. 04-3733, 2005 U.S. Dist. LEXIS 3694, (E.D. Pa. March 9, 2005). The insureds suffered an initial loss to rental property due to vandalism. The insureds submitted an estimated repair cost of $31,643.61. Id. at **1-2. The insurer, however, estimated total costs to be approximately $6,000.00. Id. at *4. While the parties were negotiating the actual amount of the loss, a second act of vandalism occurred while the initial claim was still pending. The insurer denied coverage for the second loss asserting that since the vandalism had occurred while the dwelling had been vacant for more than thirty consecutive days prior to the loss, it was excluded under the policy. Id. at *5.

The term "vacant" was not affirmatively defined. The carrier assumed that the term "vacant" should be defined in accordance with its usual meaning. Id. at *14. The insureds stated that the term "vacant" should not be interpreted to preclude coverage given the facts of the case. The insureds noted that the parties were still negotiating the insureds' claim for the initial loss, and as such no repairs to the property had yet been performed at the time of the second loss. Id. at **15-16. Therefore, plaintiffs argued that

it would be "unreasonable to require them to occupy a dwelling rendered inhabitable by a prior, unresolved loss in order to prevent defendant from denying coverage for future losses under the Vandalism Exclusion." Id. at *16. The insureds were arguing that the term "vacant" must be interpreted "by considering not only the fact of the vacancy, … but also the cause of the vacancy." Id.

Ultimately, the Court concluded that the term "vacant" was ambiguous and as such, strictly interpreted in favor of the insured. Id. at 21. Thus, the Court concluded that, as a matter of law, "where the Property has been rendered uninhabitable by an insured loss, the vacancy clause in the Vandalism Exclusion is suspended until Defendant elects to either pay the loss or repair the damage caused by the loss." Id. at **21-22. In addition, the Court noted that had the carrier intended for its interpretation to prevail, it could have expressly stated in the policy's Vandalism Exclusion includes any "vacancy which results from an insured loss that has rendered the Property uninhabitable." Id. at *21.

The insureds argued that the carrier acted in bad faith by offering to settle the initial loss for only $6,000. Id. at *24. The Court stated that the carrier's initial settlement offer of $6,000 was nothing more than an initial "starting point for negotiation." Id. at *24 (citing Segall v. Liberty Mut. Ins. Co., No. 99-6400, 2000 U.S. Dist. LEXIS 16382, No. 99-6400 (E.D. Pa. Nov. 9, 2000). The insureds argued that the carriers interpretation of the term "vacant" was unreasonable. Id. at 24. Nevertheless, the Court noted that no bad faith can be found where the carrier's interpretation of the policy is reasonable albeit incorrect. Id. at *25 (citing Bostick v. ITT Hartford Group, Inc., 56 F. Supp. 2d 580, 587 (E.D. Pa. 1999)).

Roth v. Old Guard Ins. Co., 850 A.2d 651 (Pa. Super. 2004). The insured made a first party claim with regard to fire damage. A release was executed by the insured for the losses incurred. The insurer honored the claims for property damage, but refused to pay the claims for lost rental income. The Court reviewed the release and concluded that there was no evidence of mutual mistake and, therefore, the insurer was not required to pay for rental loss. The actions taken by the insurer after the signing of the release, in

denying the claims for rental income, did not arise to bad faith. The Court found that the refusal to pay the lost rental income was not frivolous, unfounded or the product of ill will.

Atlantic Cas. Ins. Co. v. Epstein, No. 03-6506, 2004 U.S. Dist. LEXIS 18725 (E.D. Pa. Sept. 15, 2004). An oil tank located on the insured property leaked heating oil, which allegedly caused harm on property adjacent to the insured. The insurer denied coverage, alleging that heating oil was a pollutant under the insurance policy, and filed a declaratory judgment to determine coverage. The insured counterclaimed, which included a count for bad faith refusal to defend and indemnify the underlying action. The court found that the plain meaning of the insurance policy did not include heating oil or a petroleum product as an exclusion under the policy. Other definitions in other Pennsylvania statutes of a pollutant did not include petroleum products. Therefore, the Court held that there was a sufficient ambiguity in the policy to afford coverage. The Court denied the insured's bad faith claim, however, since the interpretation of the insurer of the pollution exclusion clause was not wholly unreasonable or a reckless interpretation.

F. P. Woll & Co. v. Valiant Ins. Co., No. 99-0456, 2004 U.S. Dist. LEXIS 4377 (E.D. Pa. March 11, 2004). The insurer paid the insured for a fire loss under a commercial policy for the company's loss of business income, its extra expenses, and for the loss of the building. The insured filed a breach of contract and bad faith action against the insurer seeking additional payments under the policy for the procurement of a replacement facility, including construction costs, architectural fees, environmental testing costs and legal fees under the policy's "extra expenses" language. The Court found that the insured failed to meet its burden of showing that the insurer's interpretation of the "extra expenses" policy language was unreasonable.

11. Settlement: Negotiations in non-excess situation; Failure to Participate in Settlement

Hollingsworth v. State Farm, No. 04-3733, 2005 U.S. Dist. LEXIS 3694 (E.D. Pa. March 9, 2005). The insureds suffered an initial loss to rental property due to vandalism.

The insureds submitted an estimated repair cost of $31,643.61. Id. at **1-2. The insurer, however, estimated total costs to be approximately $6,000. Id. at *4. The insureds argued that the carrier acted in bad faith by offering to settle the initial loss for only $6,000. Id. at *24. The Court found no bad faith, stating that the carrier's initial settlement offer of $6,000 was nothing more than a "starting point for negotiation." Id. at *24 (citing Segall v. Liberty Mut. Ins. Co., No. 99-6400, 2000 U.S. Dist. LEXIS 16382, No. 99-6400 (E.D. Pa. Nov. 9, 2000)).

Resource America, Inc. v. Certain Underwriting Members of Lloyd's, April Term 2003, No. 2709, 2005 Phila. Ct. Com. Pl. LEXIS 219 (May 5, 2005) (Sheppard, J.). A certified class sued the insured for alleged securities fraud and asserted damages in excess of $100,000,000. Id. at *2, *16. The insurer failed to participate in the underlying settlement and the insured filed a motion for summary judgment asking the court to compel the carrier to contribute $2,000,000 to the settlement. Id. at *2. The carrier argued that the insured breached its duty to cooperate and entered into an unreasonable settlement. After reviewing its previous decision on these issues in Resource America, Inc. v. Certain Underwriting Members of Lloyd's, April Term 2003, No. 2709, 2004 Phila. Ct. Com. Pl. LEXIS 32 (Nov. 12, 2004), the Court again affirmed its prior ruling.

The carrier's excess policy provided that "the Insureds shall not … enter into any settlement … without the prior written consent of the insurer. Id. at *5. The policy also stated: "The Insurer's consent shall not be unreasonably withheld, provided that the Insurer shall be entitled to full information and all particulars it may request in order to reach a decision as to such consent and shall be entitled to effectively associate in the defense and the negotiation of any settlement of any Claim." Id. at *5. The carrier had previously refused to participate in mediating the underlying litigation, and the insured argued that this refusal to participate in the mediation was a breach of its obligation under the policy. The insurer argued that the insured breached the second half of the above-quoted policy language by failing to cooperate in the defense and as such was not required to pay anything towards the settlement. Id. at *6.

The Court stated that in establishing a breach of the duty to cooperate, "the insurer must show that the breach is something more than a mere technical departure from the letter of the policy." Id. at *7. The carrier's evidence in this regard was insufficient, even though it had specifically argued that the insured did not provide it with a settlement recommendation until three weeks prior to the underlying mediation. During the litigation, however, the insured did, on several occasions, provide the carrier with its analysis of the strengths and weaknesses of the claims against the insured. Id. at **9-10.

The carrier also argued against payment because the settlement was unreasonable. The Court stated that "an insurer that withholds its consent to settle must show that it did so in good faith, fairly, and reasonably." Id. at *12. Moreover, the Court stated that the carrier must show that the underlying settlement was prejudicial to show that its consent was reasonably withheld. Id. at *13. The carrier claimed prejudice because the settlement was too high. The settlement offered a two-tiered alternative depending on the outcome of the coverage issue. The class plaintiffs were willing to accept $6,000,000 if the carrier was found not to be required to pay under the insurance policy and $7,000,000 if the court found that the carrier was obligated to proffer the $2,000,000 policy limits. Id. at **14-15.

The Court found that the evidence indicated that the two-tiered settlement was entered into reasonably. Specifically, the Court noted that the underlying class of plaintiffs had claimed more than $100,000,000 in damages; the insured's expert suggested that a $13,500,000 settlement was reasonable; the insured's underlying motion to dismiss had been denied; an impartial mediator recommended $7,000,000 as a reasonable settlement; and, the insured's other insurers agreed to pay their policy limits towards the settlement. Id. at *16. Accordingly, since the Court found that the insurer had not produced any evidence in support of its argument that the two-tiered settlement was prejudicial, the court found that it had no valid ground on which to object to participating in the settlement. Id. at *17.

On the other hand, "an insurer that withholds its consent to settle must show that it did so in good faith, fairly, and reasonably." Id. at *12. An unreasonable refusal to settle

is a breach of both the contractual duty of good faith and the carrier's fiduciary duty. Id. at *13. However, there was no finding of bad faith. "In this case, the court does not find that [the insurer] acted in bad faith in defending this action because it put forth legitimate, albeit not winning, arguments to justify its refusal to consent to the settlement [the insured] entered into with the plaintiff class." Id. at *19.

12. Insurance Applications, Post-Claim Underwriting

Chau v. RCA Ins. Group, January Term 2003, No. 692, 2004 Phila. Ct. Com. Pl. LEXIS 23 (Mar. 23, 2004) (Sheppard, J.). Plaintiffs attempted to assert a bad faith claim against the carrier due to its alleged failure to investigate the responses provided by plaintiffs on their application for insurance. Id. at **5-6. The Court stated that insurers and their agents have "no general obligation to investigate the accuracy of an insurance application." Id. at *6. The Court went on to state that insurers only have a duty to investigate cases where inconsistencies within the application put the insurer on notice that the application itself may be inaccurate or incomplete. Id. The Court did state that section 8371 is not limited to claim denials, but can apply to UIPA violations. Id. at *5.

Northwestern Mut. Life Ins. Co. v. Babayan, No. 03-1622, 2004 U.S. Dist. LEXIS 17155 (E.D. Pa. Aug. 25, 2004). The insured had applied for disability income insurance. In her insurance application, the insured made misrepresentations in her answers to several questions and did not fully disclose her past medical history. When she later asserted a claim against the insurer, the insurer sought rescission of the contract on the grounds that it had been unable to properly assess its risk due to the insured's misrepresentations. The insured then brought a bad faith claim against the insurer for post-claim underwriting and the denial of benefits, also claiming that the insurer did not follow its own policies.

The Court refused to follow a Mississippi case in its holding that post-claim underwriting was "patently unfair" and thus *per se* bad faith. Id. at *44 (citations omitted). While recognizing that Pennsylvania law had not previously addressed the issue of post-claim underwriting, the court noted that "Pennsylvania law imposes no duty on insurers to conduct pre-claim investigation and underwriting." Id. at *43. The Court

determined despite the "scholarship of other jurisdictions… the inescapable conclusion is that no Pennsylvania law forbade [the insurer] from conducting post-claim underwriting." Id. at *50. In addition, the Court found that the insurer had not violated its own policies and, if it had, the insured had not supported her position that failure to follow claim review policies would amount to bad faith.

13. Filing a Declaratory Judgment Action as Bad Faith

Little Souls, Inc. v. State Auto Mut. Ins. Co., No. 03-5722, 2004 U.S. Dist. LEXIS 4569 (E.D. Pa. Mar. 15, 2004). The court held that an insurer's filing of a declaratory judgment action cannot alone sustain an action for bad faith, though a plaintiff may use that as part of its case to prove bad faith.

14. Pre-Investigation Determinations, Instructions not to Examine Damage

Agnew v. State Farm Ins. and Cas. Co., No. 03-3658, 2005 U.S. Dist. LEXIS 1107 (E.D. Pa. January 26, 2005). The insured alleged that the insurer refused to fully pay a loss on his house, which resulted from storm damage and a fallen tree. The insured alleged that the insurer hired certain plumbers and exterior companies to inspect the house, with the intent to deny his claim. The Court denied the motion for summary judgment for the bad faith claim filed by the insurer, because the insured alleged that the insurer instructed the plumbers not to inspect the insured's bathroom because the insurer had previously decided, prior to the inspection, to deny a portion of the claim relating to the bathroom. The Court found that a genuine issue of material fact existed with regard to the bad faith claim and denied summary judgment.

15. Late Notice as Basis for Claim Denial

Nat'l Union Fire Ins. Co. v. Sharon Reg'l Health Sys., 69 Pa. D.&C. 4th 374 (C.C.P. Allegheny 2004) (Wettick, J.). The insurer claimed that it received post-verdict notice of a medical malpractice claim, while the insured claimed that earlier notice was given to an apparent agent or was not required. The claim at issue was possibly subject to both a claims made and occurrence coverage. The insurer issued a reservation of rights and filed a declaratory judgment claim, but asserted in its defense that it never

denied coverage, and only looked to the claims made portion of the policy as applicable. Based on disputed issues of fact as to the forms of coverage and the adequacy of notice, the Court denied the insurer's motion for summary judgment on the issue of bad faith.

Philadelphia Indem. Ins. Co. v. Fed. Ins. Co., No. 02-7247, 2004 U.S. Dist. LEXIS 9686 (E.D. Pa. May 26, 2004). The Court found that a re-insurer which did not receive notice for over a year after the underlying lawsuit was initiated and being defended, could not act in bad faith by reasonably believing that the primary insurer forfeited coverage by failing to adhere to notice provisions, and by incurring defense costs without the re-insurer's approval.

H. Conduct of Bad Faith Litigation as Bad Faith

Hollock v. Erie Ins. Exch., 842 A.2d 409 (Pa. Super. 2004) (en banc), appeal granted, 878 A.2d 864 (Pa. 2005).[9] The scope of a bad faith claim is not limited to the time period before litigation. In this case, the court found that the evidence supported the lower court's finding of bad faith, citing examples out of the trial judge's 169 findings of fact. As background, in terms of pre-bad faith litigation conduct, this included such matters as (1) for over a year the insurer misled insured's counsel into thinking that the amount of coverage was only half of the actual amount of coverage; (2) the reserve amount of $30,000 was arbitrarily set; (3) the insurer failed to reevaluate its claim despite the introduction of several pieces of evidence supporting reevaluation and no evidence to the contrary; (4) the insurer deliberately ignored evidence corroborating the insured's claims; and (5) the insurer used tactical delays in order to place the insured under surveillance and submit the file to its own experts in order to challenge causation of the injury.

In finding for the insured, the Court first addressed the scope of section 8371, holding that evidence of the insurer's conduct after settlement of the claim is allowed.

[9]The Pennsylvania Supreme Court has granted an appeal in Hollock on the following issues: "1) Whether conduct of a party during a bad faith action under 42 Pa. C.S. § 8371 is admissible to support a finding of punitive damages?"; and "2) What scope of review should an appellate court apply when reviewing a punitive damages award?"

The Court, disagreeing with the insurer's interpretation of O'Donnell v. Allstate Ins. Co., 734 A.2d 901 (Pa. Super. 1999) stated that "[n]othing in [O'Donnell] indicates that resolution of the benefits claim should limit the admissibility of new evidence of bad faith to establish a bad faith claim." Hollock, 842 A.2d at 415. The Court distinguished O'Donnell, in that it dealt merely with discovery issues and that plaintiff could have sought a protective order against such discovery. In Hollock, the Court observed the Trial Court's finding that the insurer's activities constituted "an intentional attempt to conceal, hide, or otherwise cover-up the conduct of Erie employees." Id. In addition, because the insurer's behavior related to the good-faith payment of the underlying claim, it was properly characterized as being "based upon a breach of the underlying insurance contract." Id. at 416.

The Court also distinguished Ridgeway v. United States Life Credit Life Ins. Co., 793 A.2d 972 (Pa. Super. 2002), which found conduct after a first bad faith action excluded from section 8371's scope, because that case was brought by a judgment creditor as opposed to being brought by a claimant. Here, the insurer's bad faith actions constituted a breach of the underlying contractual duty to act in good faith. In addition, the Court found that the insurer's employees' testimony at trial did not establish a "reasonable basis" for its actions, because the credibility of the testimony was an issue for the fact-finder.

The en banc panel held the lower Court's legal conclusions were not in error, as they depended upon the credibility of the insurer's testimony. The court distinguished Terletsky v. Prudential Prop. & Cas. Ins. Co., 649 A.2d 680 (Pa. Super. 1994). Terletsky raised genuine questions of unsettled law, whereas the insurer in Hollock had challenged conclusions based purely upon factual questions. Also, the Court refused to overturn the lower Court's finding that the insured had carried her burden of showing bad faith by the "clear and convincing" standard. Hollock, 842 A.2d at 417.

The Trial Court looked at the carrier's conduct "[i]mmediately prior to and during the [bad faith] trial" and found that the carrier "continued to exhibit reckless indifference to the rights of its policyholder…" Hollock v. Erie Ins. Exch., 54 Pa. D.&C. 4th 449, 496

(C.C.P. Luzerne 2002). Among other findings in this regard, the trial judge found a deliberate decision of a Senior Vice President not to review documents so that he could feign ignorance and avoid meaningful responses during his trial testimony; similar behavior by a litigation manager, branch manager and claims examiner to avoid having to respond during their trial testimony; and a failure to make any settlement efforts other than the cost of defense through trial, despite the trial judge's inquiries at a pre-trial conference. Id. at 496-497. The Trial Court found as fact that the conduct of the carrier's representatives showed "a deliberate attempt, both in the deposition and in their trial testimony, to obfuscate the issues at trial…." This, included "evading answers to questions, deliberately failing to review documents and file materials in order to feign ignorance, contradicting their sworn deposition testimony, and providing testimony that defies logic and credibility." Id. at 497. Moreover, the Judge found that certain testimony given was self-contradictory with other sworn testimony and reflected a pattern of dishonesty reaching back to the underlying case Id. at 498.

The Superior Court upheld the statutory damage award for interest, legal fees and costs totaling nearly $279,000. The damages in Hollock included: $80,072 in interest on the time period between the insured's $450,000 settlement demand and the insurer's payment of its $500,000 policy limits; $15,406.09 in attorney's fees and legal costs in the underlying underinsured motorist action; and $183,347.81 in legal fees and costs in the bad faith action. Hollock v. Erie Ins. Exch., 54 Pa. D.&C. 4th 449, 542-543 (C.C.P. Luzerne 2002). The punitive damage award, discussed below, was $2.8 Million dollars; and was in large part the result of multiplying the legal fees and costs associated with the bad faith action itself.

W. V. Realty Inc. v. Northern Ins. Co., 334 F.3d 306 (3d Cir. 2003). While not the circumstances of that case, the Third Circuit recognized that "there are some cases in which the insurer's conduct during the course of litigation is both a violation of discovery rules and a violation of the insurer's duty to the insured." Id. at 315 n.6 (citing O'Donnell v. Allstate Ins. Co., 734 A.2d 901, 909 (Pa. Super. 1999)). This rested on the more general proposition that bad faith conduct "arising in the insurer-insured relationship"

could arise during litigation. Id. Thus, "using litigation in a bad faith effort to evade a duty owed under a policy would be actionable under Section 8371." Id. at 313. The discovery abuse in that case did not arise out of the insurer-insured relationship. The Court did express the view that dishonest conduct during discovery "could potentially violate [the carrier's] fiduciary duty of candor." Id. at 315 n.6.

Monarch, Inc. v. St. Paul Prop. and Liab. Ins. Co., No. 03-CV-0054, 2004 U.S. Dist LEXIS 14803 (E.D. Pa. Jul. 30, 2004). Bad faith conduct may arise during the course of litigation. Id. at *13. In that case, the carrier invoked a contractual two-year period within which the insured had to make repairs as a predicate to collecting under the policy. The carrier did so for the first time in its Answer to the bad faith action, after the adjustment period, and in light of the fact that it continued to negotiate that particular aspect of the claim despite the two-year period having expired. The carrier claimed that it withheld asserting the provision earlier because of the pending negotiations. Id. at *16.

During the adjustment period, the carrier sent two reservation of rights letters. The first included specific reference to the two-year period and both included general reservation of rights language (reserving carrier's "rights and privileges under the terms of the policy and the law, none of which are to be deemed waived, modified or relinquished in any way.'"; and "'the writing of this letter and the continuing of our investigation should not be construed as a waiver of any of our respective rights under the terms and conditions of our policy contracts.'"). Id. at **16-17. The insured offered no evidence to contradict the carrier's evidence that it intended to reserve all of its rights and communicated that fact on more than one occasion, as set forth above. The District Court concluded that "when [the carriers] filed their Answer, they had a good-faith argument that the two-year limitations period applied[; and] their decision to invoke the provision did not constitute bad faith even though they may not ultimately prevail on that interpretation." Id. at **17-18.

I. Punitive Damages

There are important leading cases from the United State Supreme Court, the United States Court of Appeals for the Third Circuit and by an en banc Panel of the

Superior Court that will be discussed at some length because of their central place in bad faith litigation. Moreover, in June 2005, Pennsylvania's Supreme Court granted an appeal to decide two critical issues concerning punitive damages under the Bad Faith Statute.

State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408 (2003). This bad faith case originated in the Utah state court system, and went on appeal to the U.S. Supreme Court on the issue of punitive damages. It is thus of obvious importance for any insurance bad faith claim on the issue of punitive damages, and along with prior Supreme Court jurisprudence, particularly BMW v. Gore, 517 U.S. 559 (1996), provides the touchstone for measuring punitive damages in Pennsylvania's bad faith case law.

The case involved a third party claim for an auto accident. There was one death and one permanent disability as a result of the insured's careless driving. The carrier could have settled for $50,000 ($25,000 policy limit per occurrence). A complete investigation revealed there was no real question on the defendant/insured's liability. The carrier's investigators told it not to take the case to trial. The carrier contested liability and took the case to trial, in a clear excess verdict situation, telling the insured that his assets were safe, that there was no liability with him, that the carrier would represent his interests and that there was no need to procure separate counsel. A jury found the insured 100% liable and returned a verdict for $185,849. Id. at 412-13.

The carrier refused to pay the excess verdict, told the insured that he might want to put "for sale" signs up on his house and refused to post a bond so that insured could appeal. The insured got his own counsel, and during the appeal settled with the injured parties; effectively giving them rights to a bad faith claim against the carrier. Id. at 413. The bad faith trial revealed that the carrier's employees altered company records to make the insured look less culpable, were fully aware of the near certainty the insured would lose the case and would have to pay an excess verdict. Id. at 419.

After the original appeal was exhausted, the carrier did pay the excess verdict. The bad faith case ensued anyway. Claims were made that the decision not to settle was part of a "national scheme to meet corporate fiscal goals by capping payouts on claims

company wide." Id. at 414. Evidence on nationwide operations over a 20 year period were permitted into evidence. A jury awarded $2.6 Million in compensatory damages, and $145 Million in punitive damages, with the Utah Supreme Court later reducing the first number to $1 Million but upholding the full punitive damage award. Id. at 415-16. The Utah Supreme Court relied on the evidence of a nationwide scheme in considering the reprehensible nature of the carrier's conduct, its massive wealth, and because the secretive nature of this scheme would allow only 1 of every 50,000 cases to be punished. This award was also not disproportionate in light of comparable state laws that allowed $10,000 penalties for each act of fraud, loss of license, disgorgement of profits and jail. Id.

The Supreme Court rejected the punitive damage award on due process grounds. It repeated the three guideposts for reviewing punitive damage awards, stated earlier in Gore, which should be reviewed *de novo* by an "exacting" appellate court in assessing the trial court's application of these guidelines to assure a jury's punitive damage award was the result of applied law and not "decisionmaker's caprice." These were: "(1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases." Id. at 418 (citing Gore).

Further, guidance is given as to how to understand and apply the "reprehensibility" factor, which is the cornerstone of the punitive damages award and analysis. As will be discussed in other cases, this analysis includes the important concept of "recidivism," factor 4 below.

> We have instructed courts to determine the reprehensibility of a defendant by considering whether: [1] the harm caused was physical as opposed to economic; [2] the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others; [3] the target of the conduct had financial vulnerability; [4] the conduct involved repeated actions or was an isolated incident; and [5] the harm was the result of intentional malice, trickery, or deceit, or mere accident. The existence of any one of

> these factors weighing in favor of a plaintiff may not be sufficient to sustain a punitive damages award; and the absence of all of them renders any award suspect. It should be presumed a plaintiff has been made whole for his injuries by compensatory damages, so punitive damages should only be awarded if the defendant's culpability, after having paid compensatory damages, is so reprehensible as to warrant the imposition of further sanctions to achieve punishment or deterrence.

Id. at 419 (citing Gore).

The Supreme Court did not question the carrier's bad faith as to the insureds, but then scrutinized what it found to be the overbreadth of the award based on the lower courts' reliance upon evidence of the carrier's nationwide conduct. Even if it were true that the carrier harmed people all over the country for two decades, absent those people's presence in the instant action, the court could not address damages as to them. Moreover, some of the conduct at issue was not unlawful in other states. "A State cannot punish a defendant for conduct that may have been lawful where it occurred." Id. at 421 (citing Gore). The Court did state that "[l]awful out-of-state conduct may be probative when it demonstrates the deliberateness and culpability of the defendant's action in the State where it is tortious, but that conduct must have a nexus to the specific harm suffered by the plaintiff." Id. at 422.

This leads to a critical point related to both punitive damages and discovery/admissibility: the "nexus" between the specific plaintiff's claims and the conduct to be punished.[10] "The [Utah] courts awarded punitive damages to punish and deter conduct that bore no relation to the Campbells' harm. *A defendant's dissimilar acts, independent from the acts upon which liability was premised, may not serve as the basis for punitive damages.* A defendant should be punished for the conduct that harmed the plaintiff, not for being an unsavory individual or business." Id. at 422-23 (emphasis added). Other parties' hypothetical claims do not belong in the reprehensibility analysis. Id. at 423.

[10] See also the Saldi decision, referenced throughout the discovery portion of this chapter.

The Supreme Court then turned to the issue of "recidivism." Recidivists can be punished more harshly than those who have done wrong in a single instance, but "the courts must ensure the conduct in question *replicates the prior transgressions*." Id. at 423 (emphasis added). The prior conduct need not be identical. In that case, however, the Utah court apparently relied upon dissimilar first party claims, evidence of the carrier's investigating an employee's personal life and broad policies that allegedly corrupted employees. This conduct was too dissimilar to form a nexus with the claims at issue. Id. at 424.

The Court would not set a bright line for ratios of punitive damages to compensatory damages, but made abundantly clear that single digit ratios are the norm. Id. at 425. An exception could occur with a "'particularly egregious act [resulting] in only a small amount of economic damages.'" Id. (citation omitted). On the other hand, "[t]he converse is also true, however. When compensatory damages are substantial, then a lesser ratio, perhaps only equal to compensatory damages, can reach the outermost limit of the due process guarantee." Id. In either event, "[t]he precise award in any case, of course, must be based upon the facts and circumstances of the defendant's conduct and the harm to the plaintiff." Id.

In Campbell, the factors did not favor an extraordinary punitive damages award. There was a substantial compensatory award (the $1 Million in reduced damages); the harm arose from economic and not physical damages and there were no physical injuries[11]; the excess verdict was paid before the bad faith complaint was filed and so the economic injuries were minimized to the 1½ period of non-payment; and the compensatory damage award for emotional distress was of a type for which punitive damages are awarded (the individuals distress and humiliation), i.e., the compensatory damages already held a punitive element. Id. at 426. The Supreme Court rejected the Utah courts' justifications finding that: a similarly huge award in Texas lacked a nexus; no evidence was presented to support the claim that other Utah consumers, not directly

[11]This is an interesting point as the Court had just immediately observed that the $1,000,000 was compensation for a 1½ years of emotional distress. Id. at 426.

involved in the case, had been similarly victimized; reliance on the defendant's wealth "cannot justify an otherwise unconstitutional punitive damages award[]"; and the fact there might not be another opportunity to punish the carrier for its allegedly broad practices did not warrant punitive damages. Id. at 427.

As to the comparison of the punitive damage award to civil penalties, the Court first noted that reference to criminal penalties should be avoided. This left only the $10,000 civil penalty for fraud, which was "dwarfed by the $145 Million punitive damages award." The Court discounted the Utah Court's attempt to place a value on the loss of the carrier's license, disgorgement and imprisonment because the Utah Court had looked to out-of-state and dissimilar conduct in finding such possibilities applicable. Id. at 428.

Willow Inn, Inc. v. Public Serv. Mut. Ins. Co., 399 F.3d 224 (3d Cir. 2005). The insured sustained property damage as the result of a tornado. In settling the claim, the insurer repeatedly delayed or refused to respond to various estimates and correspondence by its own adjusters, Proof of Loss submissions from the insured, and appraisal requests. In addition, the insurer caused an eight-month delay in appraising the damage, and it failed to pay or acknowledge the insured's request for payment of costs incurred in preparing the Proof of Loss.

Citing Gore and Campbell as guideposts for punitive damages, the Court observed that "punitive damages awards must not be disproportionately excessive to the degree of reprehensibility of the defendant's conduct and the harm that conduct visited upon the plaintiff, and the award must not exceed the state legislature's judgment of the appropriate sanctions of the conduct." Id. at 230. The Court stressed that reprehensibility of insurer's conduct is the most important factor, and agreed with the District Court that three of the United States Supreme Court's five subfactors of reprehensibility applied here: "[1] the financial vulnerability of the plaintiff, [2] that the conduct involved repeated actions by the defendant, and [3] that the harm was intentionally inflicted...." Id. at 232. The insured was a small family-run business, and thus it was financially vulnerable.

In determining punitive reprehensibility of insurer's conduct, one factor is the existence of "repeated conduct." Addressing the existence of "repeated conduct," the court distinguished between "merely a pattern of contemptible conduct within one extended transaction… [and] rather specific instances of similar conduct by the defendant in relation to other parties." Id. at 232. Although repeated conduct generally refers to an insurer's dealings with multiple insureds, in this case, repeated conduct was found solely on the basis of the insurer's dealings with this insured; although this form of repeated conduct would not weigh as heavy as repeated similar instances with other parties. The court determined that the insurer's "conduct in settling and paying Willow Inn's claim was a mix of purposefully indifferent inaction and intentionally dilatory action[,]" where the insurer asked repeatedly for documents that it either already had or did not need, as well as freezing the appraisal process. Id. at 233. The Court cited the "series of actions and inaction" as implying a "concerted effort to lessen [insurer's] expected payment on the claim." Willow Inn, 399 F.3d at 232-33. The Court also noted that the insured's ability to recover at all on its claim was a result of its diligence and patience, rather than any good faith on the part of the insurer.

In determining whether the conduct was intentional, the Court found that the insurer's "conduct in settling and paying Willow Inn's claim was a mix of purposefully indifferent inaction and intentionally dilatory action[,]" and not "mere accident" where the insurer asked repeatedly for documents that it either already had or did not need, as well as freezing the appraisal process. Id. at 233. The Court also noted that the insurer persistently attempted to lowball the insured on the price of construction materials, and it failed to communicate with the insured regarding the claim's status. The Court concluded its reprehensibility analysis by finding punitive damages appropriate.

The Court next addressed the appropriateness of the ratio of punitive damages to harm to the plaintiff, specifically asking, "[w]hat figure comprises the second term of the ratio to compare to the $150,000 punitive damages award?" Here, the breach of contract claim was worth only $2,000; however, the total amount of the claim was $125,000, and the lower Court had awarded the insured roughly $135,000 in costs and attorney's fees.

The Court distinguished as inapposite the case of TXO Prod. Corp. v. Alliance Resources Corp., 509 U.S. 443 (holding in cases of fraud that punitive damages can match the entire amount of the "potential harm," i.e., the claim.). However, the Court, citing Hollock, held that costs and attorney's fees are includable in the second term of the ratio. Id. at 236. The attorney's fees provisions of § 8371 "vindicate the statute's policy by enabling plaintiffs such as [insured] to bring § 8371 actions alleging bad faith delays to secure counsel on a contingency fee." Id. In addition, this section of the statute uses attorney discretion as a filter for meritless bad faith claims. In justifying its decision to include costs and attorney's fees, the Court stressed the insured's entitlement to counsel in defending its claim. Id. at 237.

Last, the Court addressed the third punitive damages guidepost from Gore, "the disparity between the punitive damages award and the civil penalties authorized or imposed in comparable cases." Id. (citing Campbell and Gore). The court disagreed with the District Court in determining that the civil penalty amount here is $5,000 under the Pennsylvania's Unfair Insurance Practice Act, 40 Pa.C.S. § 1171, instead of including the amount of attorney's fees. However, because the court was unsure as to the proper resolution of the civil penalties issue, it was "reluctant to overturn the punitive damages award on this basis alone." Willow Inn, 399 F.3d at 238. In justifying this conclusion, the Court stated that the insurer's "conduct arguably amounted to multiple violations of § 1171, and that the statute provides for escalating civil penalties for repeat violations…." Id. The court ultimately upheld the $150,000 punitive damages award.

Hollock v. Erie Ins. Exch., 842 A.2d 409 (Pa. Super. 2004) (en banc), appeal granted, 878 A.2d 864 (Pa. 2005).[12] Some of the numerous factual findings in this matter are discussed above under section III.H. addressing the carrier's conduct during the bad faith litigation itself as a source of further section 8371 violations. After upholding an

[12]Pennsylvania's Supreme Court has granted an appeal in Hollock on the following issues: "1) Whether conduct of a party during a bad faith action under 42 Pa. C.S. § 8371 is admissible to support a finding of punitive damages."; and "2) What scope of review should an appellate court apply when reviewing a punitive damages award?"

award of nearly $279,000 for statutory interest, attorney's fees and legal costs -- the insurer had tendered its entire policy limit by that point -- the en banc Panel addressed the issue of whether the trial court's award of $2.8 Million in punitive damages was appropriate.

The Court examined the language of section 8371 in introducing the principle that although "a finding of bad faith does not compel an award of punitive damages, it does allow for the award without additional proof, subject to the trial court's discretion." Id. at 419. Thus, the Court rejected the insurer's argument that a further showing beyond simple bad faith must be made before punitive damages may be awarded under § 8371.

The Court first looked to Pennsylvania law in whether to award punitive damages, and then to the United States Supreme Court's jurisprudence to measure whether such an award comported with due process. Citing Pennsylvania law, three factors must be considered in awarding punitive damages: "(1) the character of the act; (2) the nature and extent of the harm; and (3) the wealth of the defendant." Hollock, 842 A.2d at 419 (quoting Comm. Funding Corp. v. Am. Fin. Mortg. Corp., 797 A.2d 269, 290 (Pa. Super. 2002)). In its analysis, the Court deferred to the trial court's findings of fact concerning the insurer's actions, and observed the trial court's finding that the carrier was a "company run amok, whose supervisory personnel sanctioned deceit in the service of a corporate belief that it is acceptable to tell a lie as long as no one really gets hurt." Hollock, 842 A.2d at 420 (citations omitted). Regarding the extent of the insured's harm, "Hollock suffered an invasion of a legitimate health interest to serve Erie's financial goals and was subjected to unwarranted surveillance and unnecessary litigation." Id. (citations omitted). Lastly, the Court determined that a large punitive damages award was necessary to deter such conduct, given the immense wealth of the insurer ($4.8 Billion).

Looking to Gore and Campbell, the Hollock Court considered "(1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties

authorized or imposed in comparable cases." Hollock, 842 A.2d at 420 (quoting Campbell, 532 U.S. at 1520). The Court found that Erie's conduct was "outrageous" and showed repeated "reckless indifference" toward the insured. Hollock, 842 A.2d at 421. It then stressed that Campbell, although suggesting a single-digit ratio as an upper range of punitive damages, did not impose a bright-line ratio. Finally, the Court noted that penalties under the Unfair Insurance Practices Act, 40 P.S. §§ 1171.1-1171.15, could include a $5,000 fine for each offense, and could also lead to the revocation of the insurer's license. In light of these factors, the Court, upholding the award, determined that a 10 to 1 ratio, $2.8 million punitive on $278,825 in underlying damages (chiefly attorney's fees), was constitutional and did not offend due process.

Zimmerman v. Harleysville Mut. Ins. Co., 860 A.2d 167 (Pa. Super 2004). The insureds were successful at trial in a bad faith claim against the insurer for the failure to pay a homeowner's claim for their roof. The insurer alleged that the insureds concealed the bad condition of their roof when they applied for insurance. The insurer also alleged that the insureds knew or should have known that there was a structural problem with the roof. However, it took a professional contractor to ascertain that some of the trusses supporting the roof were separating. The insurer also advanced a loss of progress theory for denying coverage despite the lack of supporting case law. The Appellate Court found that the Trial Court was correct in finding bad faith. The Court followed Hollock, 842 A.2d 409 (see above), in holding that a finding of bad faith can be *per se* justification for an award of punitive damages.

Corch Constr. Co. v. Assurance Co. of America, 64 Pa. D.&C. 4th 496 (C.C.P. Luzerne 2003). See Sections III.G.1., 9. The carrier originally failed to pay a fully covered claim and was also liable for compensatory damages on a breach of contract theory that brought the total over $1.6 Million. The Court applied BMW v. Gore, 517 U.S. 559 (1996) and State Farm Mut. Ins. Co. v. Campbell, 538 U.S. 408 (2003) in determining punitive damages, which were based solely on the defendant's actions or lack thereof. The Court was also clearly disturbed by the fact that a man with decades long history of running a successful business was driven to ruin, both financial and

personal. The Court reiterated the defendant's "mindset of denial" and disregard of the obvious coverage throughout the matter. The carrier had also relied on what the Court clearly believed was an expert report concocted to meet its preordained result and rationale. This was all pre-trial conduct.

The Court also looked to the "reprehensible" and "untruthful" deposition and trial testimony during the bad faith litigation. To what extent trial conduct can be considered will be determined by the Pennsylvania Supreme Court in Hollock v. Erie Ins. Exch., supra.[13] The following comment by the Court must be weighed in that light as well: "The conduct of the defendant and the impact of that conduct which continues even today, almost five years after the bad faith denial, caused a distinct harm separate from the compensatory damages. Unlike the facts in Campbell, supra, the nightmare for the plaintiffs continues." Id. at 522-23. Punitive damages of 1½ times the compensatory damages, totaling $2,460,387 in punitive damages, were imposed.

Rutkowski v. Allstate Ins. Co., 69 Pa. D.&C. 4th 10 (C.C.P. Lackawanna 2004) (Nealon, J.). Plaintiff insured hit a deer while driving and was able to drive home after receiving advice to that effect from a police officer and a mechanic. An unknown oil leak caused engine damage to the vehicle after the accident. The insurer relied on a policy exclusion to deny benefits, under which the insured is under a duty to "protect the auto from further loss." Id. at 39. Although the insurer bears the burden of proving that the exclusion precludes coverage, the insurer offered no basis for questioning the credibility of the insured's story and later denying benefits. The insured was entitled to attorney's fees and punitive damages where insurer did not have a reasonable basis for denying the claim.

The Court determined that the insurer's denial "clearly reflect[s] an unfounded and frivolous refusal that was motivated by [the insurer's] self-interest or ill will." Id. at 40. In so finding, the Court focused on the fact that the insurer (1) failed to provide the insured with appraisals; (2) denied the claim under a collision provision instead of the

[13]Like Corch, Hollock originated with a lengthy opinion on egregious facts from the Court of Common Pleas of Luzerne County.

applicable comprehensive coverage provision; (3) deleted sections of its own Special Investigation Unit report that supported the legitimacy of the claim; (4) made conclusions with no basis in law or fact and against uncontested testimony of insured; and (5) gave no explanation of the denial of benefits.

The Court also recognized that the insurer's "bad faith conduct was clearly outrageous and egregious and displayed a reckless indifference toward the rights and interests" of the insured. Id. at 45. The Court looked to the Campbell factors in calculating punitive damages, stating that "[a] greater ratio [than single-digit] may be accepted where a particularly outrageous act results in only a small amount of economic damages." Id. at 46. However, the Court did not decide the amount of punitive damages to award, as the attorney's fees had yet to be determined.

J. Use of Experts, and Limits on Scope of Testimony

McCrink v. Peoples Benefit Life Ins. Co., No. 04-1068, 2005 U.S. Dist. LEXIS 5072 (E.D. Pa. Mar. 29, 2005). Expert testimony is not required in a bad faith case, and it is "often excluded on the basis that the fact finder possesses the requisite knowledge to assess the reasonableness of an insurer's conduct in denying coverage, and, thus, that expert testimony would not assist the fact finder in performing her duty. …." Id. at **12-13. Such testimony can be relevant when "complex or highly technical" insurance issues are at hand. In that case, the District Court permitted an expert to testify on the bad faith issues, but not on his legal conclusions as to insurance contract construction of the policy at issue. The court emphasized that "the report's ultimate conclusion that defendant acted in bad faith is inadmissible for embracing a legal conclusion." Id. at *12, n. 1.

Kubrick v. Allstate Ins. Co., No. 01-6541, 2004 U.S. Dist. LEXIS 358 (E.D. Pa. Jan. 7, 2004), aff'd, Kubrick v. Allstate Ins. Co., 121 Fed. Appx. 447, 2005 U.S. App. LEXIS 1440 (3d Cir. Jan. 28, 2005). An expert's opinion was not clear and convincing evidence of bad faith where the facts of the case cannot support a conclusion of bad faith. "'When an expert opinion is not supported by sufficient facts to validate it in the eyes of the law, or when indisputable record facts contradict or otherwise render the opinion unreasonable, it cannot support a jury's verdict.'" Id. at *54 (citation omitted). That

expert had not only recited the facts in his report, he concluded that the carrier should have acted differently, resolved the claims years earlier and had "certainly acted in bad faith" at least at certain times. Id. at **51-52. The District Court observed that the expert could not testify on the ultimate issue of bad faith, but did not have to reach the admissibility issue because of the above-stated reasoning demonstrated an inadequate basis for any expert to reach a finding of bad faith on the undisputed facts.

Mora v. Nationwide Mut. Fire Ins. Co., 65 Pa. D.&C. 4th 59 (C.C.P. Lawrence 2003). It is within the Trial Court's sound discretion to admit or exclude expert testimony in actions on insurance policies based on bad faith claims. Plaintiff sought to produce an expert as to the internal machinations of insurance companies. The Trial Court permitted this to aid it, weighing in the fact that there was no jury in the case, thus eliminating the risk of inflammatory or prejudicial materials could have on a jury. The Court ruled that such testimony could assist the trier-of-fact.

Corch Constr. Co. v. Assurance Co. of America, 64 Pa. D.&C. 4th 496 (C.C.P. Luzerne 2003). Plaintiff used an expert to render opinions on insurance practices. The expert identified a series of failures, which the court identified as "concerning the defendant's bad faith conduct…." Id. at 517-518. This included: (1) refusal to accept the claim report from the insured's agent for months; (2) ignoring an investigator's relevant factual observations; (3) ignoring an engineering report of relevant observations; (4) ignoring the insured's sworn statement concerning relevant factual observations; (5) acting without a legal opinion; (6) not reviewing pictures of the factual situation; (7) knowing the evidence supported coverage but denying the claim; (8) having no reasonable basis to deny the claim while ignoring overwhelming evidence supporting coverage; and (9) professing reliance on a report when the actual physical appearance and law dictate a different result, where a post-dated denial letter was written even before receiving the report. Id. at 517-18.

1. The Mindset of Denial

We separately note one factor reported by the expert, which leaps out even from this list. To quote the Court, the expert's opinion included her opinion as to the carrier's

employees: *"forming a mindset of denial throughout the claim which is contrary to the requirements to be looking for coverage and to live up to its covenant of good faith…."* Id. at 517 (emphasis added).

K. Discovery Issues[14]

1. Claims/Training/Procedure Manuals

Mora v. Nationwide Mut. Fire Ins. Co., 65 Pa. D. & C. 4th 59 (C.C.P. Lawrence 2003). Plaintiff sought documents regarding the carrier's settlement procedures. The court looked at Garvey v. Nat'l Grange Mut. Ins. Co., 167 F.R.D. 391 (E.D. Pa. 1996), where the court denied discovery of claims adjustment manuals, but only after "it examined the insurance manuals in camera and 'found no evidence of bad faith in the documents.'" Id. at 68. "So, in essence, what the court said was that when the manual does not manifest a corporate philosophy of bad faith, mere noncompliance with that manual does not indicate that that behavior is bad faith, i.e., noncompliance with acceptable procedure is not in of itself evidence of bad faith." Id.

The Court then looked at Bonenberger v. Nationwide Mut. Ins. Co., 791 A.2d 378 (Pa. Super. 2002). In that case, the Superior Court "approved the admission of the manual that was defendant's primary guide in 'evaluating, valuing and negotiating claims.'" Id. at 69 (citing Bonenberger, 791 A.2d at 381). To quote the Mora Court in full:

> As an insurance company has a duty "to treat their insureds fairly and provide just compensation," "a company manual, which dictates a certain philosophy in claims handling, may be relevant and useful in evaluating a bad faith claim." … By viewing the manual, both the trial and the Superior Court became privy to the corporate philosophy which did "not encourage reasonable case-by-case evaluation." Id. Only by viewing the manuals can the court discern whether a corporate philosophy or policy was therein manifested encouraging or mandating bad faith responses.

[14] See also Section III.K.6.

> Operating without the benefit of such information could mean excluding something important. Dangers on the other side are less poignant because judges as triers of fact, as stated previously, can be assumed to be better equipped than juries to ignore inflammatory, misleading or prejudicial materials. … As this evidence could disclose defendant's corporate philosophy while there is no danger the court would overvalue such evidence or be confused by it, the court thinks it best to exercise its discretion to allow the manuals to be introduced into evidence.

Id. at 69.

Safeguard Lighting Sys. v. North American Specialty Ins., No. 03-4145, 2004 U.S. Dist. LEXIS 26136 (E.D. Pa. Dec. 30, 2004). Plaintiff requested production of claims handling manuals, which were general outlines of claim handling. The court held that production of all claims handling materials would be "overly broad and unduly burdensome," because the claims handler did not rely entirely upon this information in settling the claim. Id. at *10. However, the court ordered production of "any material which pertains to instructions and procedures for adjusting claims and which was to be given to the adjusters who worked on plaintiffs' claim [and] may be relevant to the action …." Id.

Bell v. Allstate Ins. Co., No.03-4482, 2004 U.S. Dist. LEXIS 10519 (E.D. Pa. June 3, 2004). The insured made a claim after a fire loss to his home, which was rented to a tenant. The insured was unaware of a provision which stated that he was required to be a resident at the time of the fire, and filed a breach of contract and bad faith claim. The court decided a motion to compel filed against the insurer. The insured sought manuals and policies of the insurer to show that either the insurer instructed its agents not to provide materials to the insured, or it was negligent in failing to provide the materials. The discovery with regard to what agents were required to provide to insureds, including claims manuals, policy manuals and policy statements information -- which were already made public -- was discoverable.

Robinson v. Hartford Ins. Co., No. 03-5618, 2004 U.S. Dist. LEXIS 8962 (E.D. Pa. May 11, 2004). This case is discussed below under "Reserves." The Court found that relevant portions of claims manuals that apply to the claim are discoverable.

McCrink v. Peoples Benefit Life Ins. Co., No. 04-1068, 2004 U.S. Dist. LEXIS 23990 (E.D. Pa. Nov. 30, 2004). The insured sought claims, training and procedure manuals, "materials related to the investigation of insurance claims," as well as materials relating to the carrier's "efforts to comply with" the UIPA. Id. at *27. The Court found these requests overbroad and burdensome; however, the Court recognized that "it is well-settled that manuals and other training materials are relevant in bad faith insurance litigation where they contain instructions concerning procedures used by employees in processing claims." Id. at **27-28. Of these, only the portions relevant to processing the claim in question are discoverable "as they may show *inter alia* that agents of an insurance company recklessly disregarded standard interpretations of a particular contractual provision in denying coverage or deliberatively omitted certain investigatory steps." Id. at *28 (citations omitted). The Court limited discovery to the exclusion at issue, but added that it would "not limit production only to those portions of materials sent to employees who directly handled plaintiffs' claim, as the failure to provide interpretative, training, and investigatory manuals to those agents who processed plaintiffs' claim may provide evidence of bad faith." Id. at *29 n.8.

2. Punitive Damages Discovery and Evidence; Repeated Conduct, Reprehensibility and Recidivism; When can Discovery of Claims by Other Insureds or General Practices be Obtained?; Financial Status

Saldi v. Paul Revere Life Ins. Co., 224 F.R.D. 169 (E.D. Pa. 2004). Plaintiff had an individual disability policy with defendants. Plaintiff was paid benefits after developing multiple sclerosis, but a decision was made to cease benefits after 17 months. The insured claimed that a business restructuring turned the carrier from a coverage oriented carrier, into a financial entity that was seeking to reduce payments to insureds to improve its financial circumstances. The defendant carriers allegedly developed a set of nationwide policies and practices to eliminate payable claims through efforts that essentially twisted and/or ignored the actual facts to permit the disabled insureds to be re-classified in such a way that they would lose their payment benefits.

The insured sought to take discovery of the defendant carriers' general business practices, procedures and policies to support the existence of this systemic scheme. The insured was aware of another litigation in the Eastern District of Pennsylvania where the same sort of allegations had been made against the defendants. The carriers filed motions for protective orders, claiming that these other matters were not connected to the specific plaintiff's harm, and that the insured was seeking discovery of the insurers' confidential internal practices. Id. at 173-76.

The District Court looked to the Supreme Court's decision in State Farm Mut. Auto. Ins. Co. v. Campbell, 123 S. Ct. 1513 (2003), on the issue of when acts that appear to go beyond a specific plaintiff's case can be relevant to that specific person's case. The issue is whether there is a "nexus" between those other actions and the individual plaintiff's specific harm. The Court stated that "courts have consistently held that when a bad faith policy or practice of an insurance company is applied to the specific plaintiff, the plaintiff is entitled to discover and ultimately present evidence of that policy or practice at trial in order to prove that the insurer intentionally injured the plaintiff and to show the insurer's reprehensibility and recidivism in order to assist the jury in calculating appropriate punitive damages." Id. at 176 (citing State Farm, 123 S. Ct. at 1523).

"[E]vidence of the lawful out-of-state conduct of the defendant 'may be probative when it demonstrates the deliberateness and culpability of the defendant's action in the State where it is tortious' so long as the 'conduct had a nexus to the specific harm suffered by the plaintiff." Id. at 176 (citing State Farm, 123 S. Ct. at 1523). According to the District Court, the Supreme Court's goal was to protect a defendant's due process rights by not allowing a jury to punish that defendant for dissimilar acts unrelated to the instant plaintiff's harm; not to establish a requirement that plaintiffs show specific types of nexus evidence. Thus, the Supreme Court found that in looking at prior transgressions for evidence of recidivism, the prior conduct must be replicated in the case then before a court. Id. at 177 & n.6. Importantly, alleged bad faith practices that were not applied to the plaintiff are not discoverable. "Such evidence of a general bad faith practice of the Defendants that did not have any relation to the Defendants' actions in the instant case is prohibited by State Farm." Id. at 183 n.18.

The District Court conducted an analysis of plaintiff's discovery requests based on relevance, and whether the benefit outweighed the defendant's burden or expense. The court observed the pendency and adjudication of other similar cases, which was proffered by plaintiff in an effort to show a national pattern and practice; and noted that the burden of discovery on the materials sought is lessened in light of the defendants having gathered it in other litigation. Id. at 178 & n.7. The District Court found that this provided "support for the instant allegations of a pattern and practice of bad faith and supports further investigation into Defendants' internal business practices and policies." Id. The Court did limit the time period for the more general discovery to the time after plaintiff's first claims as adequate to show contemporaneous practices, with some exceptions to information the plaintiff had already obtained in other cases, which could be relevant to explain the development of the defendants' policies. Id. The plaintiff sought the discovery to show that his termination of benefits was a direct result of a national policy, and the court agreed with that argument. Id.

Willow Inn, Inc. v. Public Serv. Mut. Ins. Co., 399 F.3d 224, 232 (3d Cir. 2005). The Third Circuit made clear that the pattern of bad conduct evidence used to

support a finding of reprehensibility under the United States Supreme Court's punitive damage jurisprudence addressed repeated instances of bad conduct against other persons, not repeated instances against the same person; though repeated misconduct against the single plaintiff would have some, though lesser, weight. The Supreme Court has described this multi-person victimization through the same pattern of conduct and practices as showing "recidivism," which can be considered within reprehensibility in awarding punitive damages.

> The District Court noted that the delay in settling and paying Willow Inn's claim "was not the result of one specific event, but, rather, a series of instances in which PSM failed or refused to act on Plaintiff's claim." The District Court considered this conduct to evince reprehensibility because "repeated conduct is more reprehensible than an individual instance of malfeasance." Gore, 517 U.S. at 577. The District Court seems to have misinterpreted this subfactor, at least as it has been applied by the Supreme Court. The "repeated conduct" cited in Gore involved not merely a pattern of contemptible conduct within one extended transaction (i.e., the sale of one automobile to Dr. Gore), but rather specific instances of similar conduct by the defendant in relation to other parties. *In Gore, the behavior the plaintiff argued was recidivistic involved BMW selling repainted cars as "new" to 1,000 people, all but fourteen of whom lived in other states.* The claimed recidivistic behavior did not refer to the series of steps that amounted to the alleged fraud related to Dr. Gore's automobile. Similarly, *in Campbell, the plaintiffs essentially attempted to put State Farm's policy for minimizing claims on trial. The "repeated conduct" alleged in Campbell related to the insurer's nationwide claims handling practices across thousands of claims, not to the series of unreasonable decisions various State Farm employees made in handling the Campbells' specific claim.* (Emphasis added).

McCrink v. Peoples Benefit Life Ins. Co., No. 04-1068, 2004 U.S. Dist. LEXIS 23990 (E.D. Pa. Nov. 30, 2004). Insured permitted to obtain insurer's financial statements for the previous five years, as, even after Campbell, a defendant's wealth

remains one factor in determining punitive damages although it can never justify an award that would exceed constitutional limits. Id. at **31-33.

3. Profitability Analyses

Saldi v. Paul Revere Life Ins. Co., 224 F.R.D. 169 (E.D. Pa. 2004). The background of this case is explained in section III.K.2. above. The insured sought profitability analyses, information on cash flow underwriting, interest rate projections and/or the relationship between the insurer's investment income and premiums charged. Defendants claimed this was privileged, proprietary, and confidential business information; and further, was irrelevant. The Court found that because the insurer had acknowledged profitability issues in its past related to insurance policies like the one plaintiff had obtained, the information goes to the Defendants "state of mind" and is discoverable.

4. Policy Drafting Information

Saldi v. Paul Revere Life Ins. Co., 224 F.R.D. 169 (E.D. Pa. 2004). The background of this case is explained in section III.K.2. above. Plaintiff's claim included allegations and some support that a flaw in the original policies created financial problems for the insurers that caused them to create a nationwide practice of improperly terminating policies to salvage the carriers' financial situation created by these improvidently written policies. The defendants claimed that this was irrelevant because the insured's claim was not related to the form of the policy, e.g., that it had been altered or violated state law or was different than the policy originally presented. The Court found the policy formation relevant to plaintiff's claim and permitted discovery.

5. Documents Relating to the Insurer's Knowledge about Lack of Profitability

Saldi v. Paul Revere Life Ins. Co., 224 F.R.D. 169 (E.D. Pa. 2004). The background of this case is explained in section III.K.2. above. The plaintiff already had a memo from the carrier that referred to the group of policies, that included plaintiff's policy, as the "bad block." Discovery was permitted.

6. Personnel Files; Documents Relating the Carrier's Alleged Bad Faith Plan and Methods used to Execute that Plan against Persons such as Plaintiff

Saldi v. Paul Revere Life Ins. Co., 224 F.R.D. 169 (E.D. Pa. 2004). The background of this case is explained in section III.K.2. above. Plaintiff's central claim was that the carriers had a plan and policy to terminate coverage under the insurance policies of persons like plaintiff to improve the carriers' financial status. The Court stated that this goal in itself could be bad faith. Plaintiff sought information on strategies, policies and procedures for implementing this objective. The Court stated broadly that "any potential information regarding these goals and policies would clearly be relevant to the specific harm to Plaintiff." Id. at 181. Importantly, alleged bad faith practices that were not applied to the plaintiff are not discoverable. "Such evidence of a general bad faith practice of the Defendants that did not have any relation to the Defendants' actions in the instant case is prohibited by State Farm." Id. at 183 n.18. Thus, e.g., a practice of hiring biased doctors to perform IMEs in the carriers' favor lacked a nexus to Saldi's claims since he had no IME. Id.

The Saldi Court permitted discovery of documents and meetings that involved the overall strategy and policies that purportedly victimized the specific plaintiff. The Court would not permit discovery of the more general concept that the carrier was increasing its litigation budget as somehow reflecting that it knew its policies would increase litigation against it; nor would it allow discovery of meetings or strategies concerning rejecting claims under other types of insurance for other underlying problems. Id. at 181-82. The Court also permitted discovery of claims handling procedures that were purportedly designed to improperly limit claims such as plaintiffs. Id. at 182. The Court permitted discovery concerning the existence of "roundtable discussions" as to the denial of the specific plaintiff's claims, and if such existed, then the plaintiff could obtain discovery of the general use and practice of roundtable discussions that occurred in connection with denying other similar claims. Id. at 182-83.

The Court also permitted discovery of any "training, standards and incentive structures" and specific performance and training information concerning individuals

who were involved with the plaintiff's claim. Id. at 183. This is relevant to show the responsibility of the defendants for their employees conduct in connection with the specific plaintiff. Plaintiff was also permitted some discovery of the personnel files, performance reviews and field reviews of those handling the plaintiff's claims and their supervisors. The Court stated that the defendants offered no support for the argument that these files were highly confidential or unduly burdensome to produce. The Court observed that there is a higher standard for relevance when seeking information contained in personnel files, and that alternative means for obtaining the information should be sought in the first instance. Id. at 184. The defendants did not make a showing that such was the case, and the relevant portions of the personnel file were subject to discovery, the court noting an existing confidentiality order was in place as well.

Reports and criteria concerning the evaluation and monitoring of the people handling the plaintiff's case were also discoverable. Id. at 184-85 & n.21. Awards and financial bonus programs were also relevant to defendants state of mind. Id. at 185. The Court likewise permitted the discovery of training materials on the subject matter at issue. Id. at 185-86. The Court also permitted discovery on staffing and retention problems in the office handling plaintiff's claim on the theory that defendants may have known of poor performance and case handling based on staff overload. Id. at 186. The Court permitted discovery of some manuals related to ethics, training, and claims handling, as well as to the development of the unit responsible for quality and training of the claim's handlers, even where an employee may not have used the manual, since the creation of the manual itself goes to the defendant carrier's knowledge. Id. at 189. The plaintiff was also allowed discovery of policies concerning record retention and file documentation. Id.

7. Reserves

Robinson v. Hartford Ins. Co., 2004 U.S. Dist. LEXIS 8962 (E.D. Pa. May 11, 2004). The District Court, citing to the Federal Rules of Civil Procedure, noted that "there are two types of discovery - core discovery, which is broadly discoverable, and discovery of information reasonably calculated to lead to the discovery of admissible

evidence, which requires a showing of good cause for discovery." Id. at *2 n.1 (citing Fed. R. Civ. P. 26(b)). The Court stressed that Hollock does not stand for the proposition that reserve information is generally discoverable. Instead, the Court distinguished Hollock on the basis that there, the insurer refused to increase an offer, and disregarding evidence that was relevant to the value of the claim. In this case "[t]here is no need to discover the reserve in order to establish liability, nor does Plaintiff show cause why this type of discovery should be had." Id. at *2.

Safeguard Lighting Sys. v. North American Specialty Ins., No. 03-4145, 2004 U.S. Dist. LEXIS 26136 (E.D. Pa. Dec. 30, 2004). An insurer cannot claim work product as a viable defense to producing information regarding its reserves unless prepared for litigation. The reserves information in this case was prepared in the ordinary course of business and thus would have been discoverable. However, because of the "tenuous link between reserves and actual liability," the Court held that reserves information was not relevant and, therefore, not discoverable.

Monarch, Inc. v. St. Paul Prop. and Liab. Ins. Co., No. 03-CV-0054, 2004 U.S. Dist LEXIS 14803 (E.D. Pa. Jul. 30, 2004). The plaintiff asserted that the carrier had to make a settlement offer of the full amount set aside in it reserves. The District Court rejected this position. "[E]ven if Plaintiff could prove that Defendants' settlement offers fell short of their reserves, this would not be clear and convincing evidence of bad faith." Id. at *20 (citations omitted).

Maiden Creek T. V. Appliance v. Gen. Cas. Ins. Co., No. 05-667, 2005 U.S. Dist. LEXIS 14693 (E.D. Pa. Jul. 21, 2005). While reserves are typically not discoverable, in that case, the Court found it significant that liability was undisputed and the claim was solely for bad faith. "Thus, the reserve information is 'germane' to defendant's analysis of the value of the insured's claims and is therefore discoverable on the question of bad faith." Id. at *3 (citing North River Ins. Co. v. Greater New York Mut. Ins. Company, 872 F. Supp. 1411, 1412 (E.D. Pa. 1995)). The court also permitted discovery of communications about settlement authority made in the ordinary course of business. Id. at *6.

8. Discovery Concerning Other Cases

First, the parties should begin this analysis with review of the United States Supreme Court's decision in Campbell, which is discussed at length in the punitive damages discussion, section III-I.

W. V. Realty Inc. v. Northern Ins. Co., 334 F.3d 306, 313-314 (3d Cir. 2003). The Trial Court's admission into evidence of other bad faith cases was held contrary to Federal Rule of Evidence 404(b). See Section III.K.13 for a further explanation of this case.

In Saldi, Section III.K.2, the plaintiff sought depositions or affidavits of the insurers' claims handlers or their supervisors as to their handling of other bad faith cases. The court recognized the general proposition that this is not permitted because factual distinctions would create a case within a case scenario on a completely different matter. However, this request sought statements from the employees handling the plaintiff's claim as to their involvement in these other cases. The Court found that their handling in the other cases might lead to the discovery of relevant evidence in the instant case. Saldi, 224 F.R.D. at 191-92.

The plaintiff also sought more general discovery about other bad faith cases to show similar misconduct, corporate policies, recidivism and reprehensibility. The Court permitted discovery of other Pennsylvania bad faith cases during the same time period that the plaintiff sought benefits, where the claims made and denials were similar to plaintiff's circumstances. The Court permitted discovery of "settlements of such cases in which Defendants entered into a non-confidential settlement with value in excess of the present value of contract benefits." Id. at 196. The Court also permitted document discovery relating to "changes in education or procedures that resulted from such a settlement." The Court set up a procedure for dealing with confidential settlements of the same kind, and granted a protective order as to any other type of bad faith claims in other parts of the nation and/or before the date of plaintiff's request for benefits. Id.

McCrink v. Peoples Benefit Life Ins. Co., No. 2:04-cv-01068, 2004 U.S. Dist. LEXIS 23990 (E.D. Pa. Nov. 30, 2004). Discovery of other lawsuits involving interpretation of identical language in exclusion was not permitted. Id. at **21-22.

Sampathachar v. Federal Kemper Life Assurance Co., No. 03-5905, 2004 U.S. Dist LEXIS 23978 (E.D. Pa. Nov. 24, 2004). Plaintiff made a claim on his wife's life insurance policy after she died in the Ganges River on a trip to India. In bringing his bad faith claim, Plaintiff sought discovery of the disposition of other claims made by Indian claimants. The Court held that such interrogatories were irrelevant because "a plaintiff does not have to prove a pattern or practice of prejudice to prevail, but only an unreasonable failure to pay." Id. at *7. In its order, however, the Court stated the carrier did not have to answer these interrogatories "absent a more specific showing of relevance." Id. at *8.

9. Discovery of Changes in Internal Procedure as a Result of Other Claims

The Saldi Court, Section III.K.2, permitted document discovery relating to "changes in education or procedures that resulted from such a settlement [of another bad faith claim]." Saldi, 224 F.R.D. at 196.

10. Attorney-client Privilege, Work Product Doctrine, Advice-of-Counsel

Safeguard Lighting Sys. v. North American Specialty Ins., No. 03-4145, 2004 U.S. Dist. LEXIS 26136 (E.D. Pa. Dec. 30, 2004). An insurer cannot assert the work product doctrine to prevent a carrier's producing information regarding its reserves unless prepared for litigation. The reserves information in this case was prepared in the ordinary course of business and thus would have been discoverable; however, because of the "tenuous link between reserves and actual liability," the Court held that reserves information was not relevant and, therefore, not discoverable.

In Saldi, Section III.K.2, the plaintiff wanted to depose in-house counsel on the basis that she was involved in the claims handling prior to suit. The defendants claimed her work was in anticipation of litigation and was work product and/or subject to the attorney-client privilege. The burden rested on the parties claiming work product or

privilege and the Court observed that "[c]ommonly, the party asserting the privilege demonstrates a need for the privilege by submitting the papers in question or an affidavit by the attorney or a privilege log." Saldi, 224 F.R.D. at 193 (citation omitted). The Court listed the factors that the party asserting the privilege must prove. It found that the defendants submitted no information to support "bald and conclusory assertions of privilege" on information that was relevant to the handling of the plaintiff's claim, and permitted the discovery. As a matter of practice, the Court reiterated that the burden was on the party asserting the privilege and that they "are the ones that know the exact contents of these requested documents and what attorney-client privilege information they contain" for purposes of explaining how disclosure "will interfere with the attorney-client privilege." Id. at 194 & n.35.

McCrink v. Peoples Benefit Life Ins. Co., No. 2:04-cv-01068, 2004 U.S. Dist. LEXIS 23990 (E.D. Pa. Nov. 30, 2004). The insured sought discovery of information and documents otherwise protected by the attorney-client privilege or attorney work product doctrine. This Court very clearly staked out the principle that the privilege and work product doctrine could only be defeated if the insurer itself raised advice-of-counsel as an affirmative defense or included these matters in a counterclaim. Id. at **4-12. The Court cited cases in support, and at least one case to the contrary,[15] but robustly stated:

> The Third Circuit has declared that a waiver of the attorney-client privilege in the insurance liability context occurs under both federal common law and Pennsylvania law only when the party asserting the privilege takes the affirmative step of "putting his or her attorney's advice in issue in the litigation." Rhone-Poulenc Rorer v. Home Indem. Co., 32 F.3d 851, 863. n1 An attorney's advice is not in issue "merely because it is relevant." Id. at 864. Nor is it in issue "because the attorney's advice might affect the client's state of mind in a relevant manner." Id. Instead, a party takes the affirmative step of placing the advice-of-counsel "in issue" when a client chooses to make the advice-of-counsel an

[15]Jones v. Nationwide Ins. Co., No. 98-2108, 2000 U.S. Dist. LEXIS 18823 (M.D. Pa. Jul. 20, 2000) (Munley, J.); see also Gen. Refractories Co. v. Fireman's Fund Ins. Co., 45 Pa. D.&C. 4th 159 (C.C.P. Phila.) (Bernstein, J.); McAndrew v. Donegal Mut. Ins. Co., 56 Pa. D.&C. 4th 1 (C.C.P. Lackawanna) (Nealon, J.), aff'd w/o opinion, 855 A.2d 144 (Pa. Super. 2004).

> essential element of a claim or defense and "attempts to prove that claim or defense by disclosing or describing an attorney-client communication." Id.

Id. at *6.

That being said, the Court did permit discovery concerning whether or not the carrier had sought legal advice on certain subjects, without permitting any disclosure of that confidential information. In particular, the plaintiff asked if the carrier had pursued legal counsel in interpreting the meaning of a word in an exclusion that the carrier was asserting against the insured. Id. at *16. The Court stated that three interrogatories were "relevant because they request information related to whether defendant failed to seek counsel's advice in interpreting the … exclusion." Id. The Court noted that "the fact of consultation with an attorney is still relevant to plaintiffs' bad faith claim. Indeed, part of plaintiffs' theory of bad faith is that defendant failed both to seek a legal opinion of the definition of 'operation' in the motorcycle exclusion of the insurance policy and to research applicable case law interpreting the term 'operation' prior to denying plaintiffs' claim." Id. at *17 n.4. Among other authorities, in support of granting the motion to compel, the court parenthetically cited Kosierowski v. Allstate Ins. Co., 51 F. Supp. 2d 583, 594 (E.D. Pa. 1999) for the proposition that "recovery of bad faith under Pennsylvania's insurance statutes requires plaintiff to show by clear and convincing evidence that insurer did not have reasonable basis for denying coverage under policy and that insurer knew of or recklessly disregarded its lack of reasonable basis in denying claim." Id. Thus, the insured was permitted to "seek discovery of all information related to defendant's seeking of, or failure to seek, legal advice on the interpretation of the motorcycle exclusion, so long as this information is not privileged." Id.

Further the Court permitted discovery of the identity of any "legal decision, authority, or secondary source" that the carrier "relied upon to determine the meaning of [the key terms in the] exclusion of the insurance policy" during various time periods. Again, the Court found that such "interrogatories do not seek privileged communications between an attorney and client. Nor do they ask defendant to identify its reasoning for interpreting the [policy exclusion language] in a particular way. Instead, they seek the

factual source that defendant relied upon to interpret the policy." "The incorporation of this factual source into communications between defendant's employees and in-house/outside counsel does not trigger the protection of the attorney-client privilege." Moreover, the Court permitted discovery of the source that provided the legal authorities identified. Id. at **17-19.

The Court ruled that documents prepared by employees and counsel after notice of the potential bad faith claim from the insured's lawyer were prepared in anticipation of litigation and were not discoverable as work product. Id. at *22-24. Documents prepared prior to the insured's counsel triggering the work product protection might be covered by the attorney-client privilege, but the Court could not make the determination at that time. Id. at *26.

Maiden Creek T. V. Appliance v. Gen. Cas. Ins. Co., No. 05-667, 2005 U.S. Dist. LEXIS 14693 (E.D. Pa. Jul. 21, 2005). While the "mental impressions of an insurer's non-attorney agents contained in claims files are also at issue and are discoverable," portions of the claim's analyst's investigative reports to his supervisor, which included the advice of outside counsel, were protected by the attorney-client privilege. Id. at **3-5. The insured could not evade the attorney-client privilege and obtain correspondence between the claim's handler and outside counsel by claiming that counsel was acting as an investigator. "An attorney does not step outside of his role as an attorney simply because he conducts some investigation." The Court found it important to observe that the carrier was not asserting an advice-of-counsel defense. Id. at *6. The Court refused to permit discovery of invoices submitted by the attorney and an accountant to the carrier. Id. at *7.

Corch Const. Co. v. Assurance Co. of America, 64 Pa. D.&C. 4th 496, 516-517 (C.C.P. Luzerne 2003). The insurer's personnel claimed to have reviewed the state of the law on the relevant insurance policy issue in making coverage decision; testimony which the Court found to be incredible. Instead the court found that there had been no legal research by the adjusters or supervisor, nor consultation with counsel. The failure to perform any legal research can amount to bad faith. The carrier's failure to have any

legal research performed was especially egregious not only because the employees lied, but because on the facts there clearly was coverage under the applicable law.

11. Board of Directors Meeting

In Saldi, Section III.K.2, the plaintiff sought the minutes of board of director meetings concerning the interrelationships of corporate defendants, to show knowledge attributable to one may be attributable to another. This was permitted. Saldi, 224 F.R.D. at 195.

12. Information Relating to Policy Issuance, Beneficiary Selection and Meaning to Policy Terms; Sales Literature

McCrink v. Peoples Benefit Life Ins. Co., No. 04-1068, 2004 U.S. Dist. LEXIS 23990 (E.D. Pa. Nov. 30, 2004). The Court recognized the relevance of a request for materials both within and outside the claims file to the extent it went to actual issues in the case, which involved interpreting the language of a particular exclusion and the selection of eligible beneficiaries. Among others, "materials, such as sales, marketing pamphlets, booklets, or other correspondence exchanged between the parties concerning the issuance of the policy, may be relevant to the litigation to the extent that these materials contain information concerning or interpreting the … exclusion to the policy." Id. at **30-31.

13. Discovery Violations and Bad Faith

W. V. Realty Inc. v. Northern Ins. Co., 334 F.3d 306, 313-314 (3d Cir. 2003). "Pure" discovery violations during bad faith litigation cannot be the basis for further bad faith claims; but conduct during trial that goes beyond such violations and reflects a broader attempt to evade the insurer's obligations may be subject to section 8371. In this case, the Third Circuit discussed a number of cases where both circumstances are at issue. Id.

In response to document requests for other bad faith cases and claims where co-insurance penalties were applied to blanket insurance coverage, the carrier responded that there were none. Plaintiff's counsel found at least 15 bad faith cases, and the Court found that the carrier was not substantially justified in having failed to disclose this other

litigation against it.[16] Plaintiffs called the carrier's in-house counsel at trial to present these discovery issues to the jury, and the failure to make a genuine effort to locate the other cases. In-house counsel was also questioned about the existence of hundreds of such suits, and handed a sheet that plaintiff's counsel had prepared listing these hundreds of other suits. The compilation was before the jury, but was never moved into evidence. In-house counsel was then directed to read from the District Court's earlier opinion granting sanctions against the carrier. This all become fodder in plaintiffs' closing to attack the carrier's counsel's veracity. The jury also received the District Court's sanctions opinion. Id. at 312-313.

The Third Circuit observed that the plaintiffs' offered no explanation as to why these discovery abuses constituted section 8371 bad faith, or how this litigation conduct was used "to evade an obligation under the policy." Id. at 314. Thus, e.g., plaintiffs did not argue that this was a tactic used to delay payment under the business interruption insurance, which might have been probative of bad faith under the claims pleaded. Id. at 314 & n.5. As the discovery dispute and the Court's opinion on sanctions were not probative of section 8371 bad faith, they should not have been admitted into evidence. Even if it had been relevant, the prejudice outweighed the probative value, especially where other evidence existed on that point. Id. at 315. Further, the admission of other bad faith cases was contrary to Federal Rule of Evidence 404(b). After noting additional errors the Third Circuit required a new trial.

L. Burden of Proof

J. C. Penney Life Ins. Co. v. Pilosi, 393 F.3d 356 (3d Cir. 2004). J.C. Penney issued the insured's life insurance policy. The policy was to pay $100,000 for an accidental death if the insured was traveling in a private vehicle, but $1,000,000 if it was a public conveyance operated by a "common carrier." Id. at 359. The insured died in a casino shuttle plane provided by a company that chartered planes for public use, but tickets for the flight were not available to the general public. The Court held that the

[16]The Court did find the carrier's counsel's failure to obtain the documents inadvertent and excusable. Id. at 312.

insured's beneficiaries did not carry their burden of proving with "clear and convincing evidence" that the insurer acted in bad faith in denying the claim on the basis that the plane was not a "common carrier," although the claim ultimately was decided in favor of the insureds. No bad faith was found despite the fact that: (1) the insurer marketed its life insurance policy as applying broadly when company officials admitted it applied a much narrower definition in practice; and (2) the insurer had taken a contrary position on the definition of "public conveyance" in another case, and took a position contrary to that of its own employee.

Royal Ins. Co. of America v. Laurelton Welding Ser., Inc., No. 02-7781, 2004 U.S. Dist. LEXIS 18287 (E.D. Pa. June 15, 2004). The excess insurer sought a declaratory judgment that it had no duty to defend or indemnify the insured, because the insured had failed to timely notify the insurer of the underlying claim. The insured brought a bad faith claim against the insurer for denying coverage. The Court found that the insured had not failed to act in a timely manner to the prejudice of the insurer. However, the "clear and convincing standard" for bad faith was not met, "[e]ven assuming that [the carrier] had no reasonable basis to deny coverage," and although the senior claims adjuster handling the claim "did not do as thorough a job as she could have done." Id. at *40.

M. Bifurcation and Severance

Frederick & Emily's, Inc. v. Westfield Group, No. 03-6589, 2004 U.S. Dist. LEXIS 17274 (E.D. Pa. Aug. 27, 2004). The carrier sought to sever the contract and bad faith claims, and to stay bad faith discovery pending the outcome of the contract case. The carrier had denied payment for lost income under a business interruption policy. The carrier argued that judicial economy was favored in the event it would win the contract case; that allowing the actions to go on together would expand discovery and reveal trade secrets and proprietary information; that the evidence on bad faith would inflame the jury and prejudice the contract claim; and that the two different burdens of proof would confuse the jury. The carrier argued that the delay would not prejudice the insured because if successful, the insured could get delay damages. Id. at **2-3.

The Court strongly rejected the motion. There was no record that discovery would be unduly expanded or proprietary information revealed. "There [was] a very considerable overlap between [the insured's] discovery requests intended to obtain evidence relevant to both the breach of contract and § 8371 claims." Id. at *4. There was no showing why sensitive information was beyond discovery; rather, it seemed the defendant only wanted to delay that discovery. The Court observed that corporate state of mind evidence was common in commercial litigation. Id. at **5-6. The Court would not sever the bad faith claim on the theory that the bad faith evidence would inflame the jury; observing that it would simply prove one claim. The differing standards of proof argument was rebuffed with the observation that juries commonly have to decide fraud claims along with other causes of action, which similarly have a clear and convincing evidence standard. Id. at **7-8.

The Court observed that if any genuine issue of prejudice and confusion were to arise, this would be better addressed by a request to bifurcate the trial, rather than to sever the cases and stay discovery in one. The Court also cited authority for the proposition that a bad faith case could proceed even if a contract case was unsuccessful, and stated generally: "Perhaps most significant, [the carrier's] very general arguments would compel the severance of virtually every bad faith claim brought together with a claim that an insurance contract was breached. As a practical matter, this would largely nullify § 8371, as few plaintiffs would have the resources to prosecute the bad faith claims only after they had successfully prosecuted their breach of contract claims. Perhaps this is why [the carrier] has offered almost no federal authority to support its request for severance." Id. at *9.

The District Court did recognize the possibility of situations where severance may be warranted in bad faith cases. This may include a situation where the prompt determination of a much simpler claim could resolve a more complex case; or where "'bad faith' claims themselves appear to have been brought in bad faith --whether artificially to inflate potential damages, to injure a defendant unnecessarily, or for any

other vexatious reason -- severance could well be warranted. Such determinations necessarily are made on a case by case basis." Id. at *10.

N. UIM

Hayes v. Harleysville Mut. Ins. Co., 841 A.2d 121 (Pa. Super. 2003), appeal denied, 870 A.2d 322 (Pa. 2005). See Section III.G.2.

O. Advice-of-Counsel Defense

See section III.K.10. addressing this issue under Discovery.

P. External Statutory Criteria Used to Measure Bad Faith

1. Unfair Insurance Practices Act ("UIPA")

Creswell v. Nat'l Mut. Cas. Ins. Co., 820 A.2d 172 (Pa. Super. 2003). The Unfair Insurance Practices Act does not create a private cause of action; however, the Superior Court has held that conduct that would violate the UIPA "may also be considered when determining whether an insurer acted in 'bad faith' under 42 Pa. C.S.A. § 8371." Id. at 180 n.4. (citations omitted). In that case, the plaintiff could not meet it burden of proof.

UPMC Health Sys. v. Metropolitan Life Ins. Co., 391 F.3d 497 (3d Cir. 2004). Act by insurer that allegedly violated the UIPA resulting in greater premiums is not actionable under section 8371. The essence of a bad faith claim has to be based on an unreasonable and intentional or reckless denial of benefits. Purported misconduct in generating an unfairly high premium is not a denial of benefits, even if it violates the UIPA.

2. Health Care Services Malpractice Act

Lloyd v. Pennsylvania Medical Prof'l Liab. Catastrophic Loss Fund, 573 Pa. 114, 821 A.2d 1230 (Pa. 2003). In a medical malpractice action, the CAT fund denied coverage because it had received late payments from the doctor and employing hospital. There was a $4 Million judgment and in "'return for a release of his personal liability, [the doctor] tendered his primary insurance limits and assigned … any and all rights he may have against the CAT Fund...." The Commonwealth Court would not permit a bad faith claim because the CAT Fund had denied coverage based on valid regulations promulgated pursuant to the Health Care Services Malpractice Act. The Supreme Court

found that regulation valid. It denied the bad faith claims as moot "because the CAT Fund cannot be deemed to have acted in bad faith for acting pursuant to a valid regulation." Id. at 1237. The purported improper motives of the CAT Fund were "of no moment because the CAT Fund has no obligation, or authority, to deviate from its duly enacted, valid regulations." Id. at 1237. See also Livornese v. The Medical Protective Co., Nos. 03-2116/03-2143/03-2410, 2005 U.S. App. LEXIS 10785 at *20 (3d Cir. Jun. 9, 2005).

Q. ERISA and Bad Faith Claims

Barber v. UNUM Life Ins. Co. of America, 383 F.3d 134 (3d Cir. 2004). In that case, an employee obtained long term disability benefits under an ERISA governed benefits plan. The employee filed suit when the benefits were terminated, including a bad faith claim under section 8371. The Third Circuit found that the state statutory claim was preempted by ERISA, and that the Bad Faith Statute did not regulate insurance. See also Gilbertson v. UNUM Life Ins. Co. of America, No. 03-5732, 2005 U.S. Dist. LEXIS 12240 (E.D. Pa. Jun. 21, 2005) (rejecting plaintiff's attempt to skirt Barber and to have the court act contrary to Third Circuit precedent directly on point); Broadnax v. Life Ins. Co. of North America, No. 03-3204, 2005 U.S. Dist LEXIS 11884 (E.D. Pa. Jun. 17, 2005).

R. Arbitrability

Brayman Constr. Corp. v. Home Ins. Co., 319 F.3d 622 (3d Cir. 2003). The Third Circuit ruled that claims under section 8371 must be arbitrated. Even though the Superior Court ruled in Nealy v. State Farm Mut. Auto. Ins., 695 A.2d 790, 793-94 (Pa. Super. 1997), appeal denied, 553 Pa. 690, 717 A.2d 1028 (1998), that the statute requires that only a judge hear the case and that an arbitration panel lacked jurisdiction, the Third Circuit found that this holding was in direct conflict with the Federal Arbitration Act. Id. at 627-628. The Third Circuit noted that the Superior Court had only look to Pennsylvania's Arbitration Act.

D&H Distributing Co., Inc. V. Nat'l Union Fire Ins. Co., 817 A.2d 1164 (Pa. Super. 2003), appeal granted, 574 Pa. 760, 831 A.2d 599 (2003). Where an arbitration

clause stated that either party may make written demand upon the other for arbitration, the Court found the clause mandatory if demand was made, even after a party filed a complaint.[17] The issue of whether the bad faith claim was pre-empted by the Federal Arbitration Act was not decided on appeal; rather, the case was remanded to consider that issue; however, the Supreme Court has granted the petition for allowance of appeal in this case.

The clarity guiding cases brought within the Third Circuit, stands in contrast to the current ambiguity in Pennsylvania's state courts. Thus, a party seeking enforcement of an arbitration provision should fine success in federal court, though not necessarily in state court.

S. Attorney's Fees

Corch Constr. Co. v. Assurance Co. of America, 64 Pa. D.&C. 4th 496 (C.C.P. Luzerne 2003). One set of attorneys' submission for payment of their attorney's fees along with a list of time and work done was not proper and would not be considered by the court. While recognizing that, under section 8371, "the court may award attorneys' fees and expenses where bad faith is found," none were awarded. Id. at 523. "The calculation of reasonable attorneys' fees for bad faith by an insurer for handling a claim should begin with the actual number of hours spent in pursuing the claim multiplied by a reasonable rate. The court finds that no testimony was presented during the course of trial to substantiate an award of attorneys' fees and/or costs. The court finds that absent a request to present evidence relative to attorneys' fees and costs, and not having presented any evidence relative to same, no attorneys' fees or costs may be granted." The lesson is obvious.

Regis Ins. Co. v. Wood, 852 A.2d 347 (Pa. Super. 2004). The insured's success in defeating a declaratory judgment action brought by the carrier seeking to disclaim coverage and the duty to defend, in itself, is not sufficient for an award of attorney's fees. There still must be a showing of bad faith by the carrier. The insurer refused to defend

[17]But cf. Messick v. Progressive Ins. Co., No. 04-3424, 2005 U.S. Dist. LEXIS 13100 (E.D. Pa. Jun. 30, 2005).

the insured in an underlying tort action by a claimant involved in a bar fight. The insurer's position was that a recent change to the commercial liability insurance company excluded assault and battery liability coverage. The Court found that there was a legitimate question as to whether the insurer adequately notified the insured of the new policy exclusion and, therefore, denied the insured's claim for bad faith. Thereafter, the insured sought attorney's fees and costs under the Pennsylvania Declaratory Judgment Act, since it was denied attorney's fees under the Bad Faith Statute. The Court found that the standard for awarding attorney's fees under the Declaratory Judgment Act was the same as under the Bad Faith Statute. It concluded that in only the limited circumstances of an insurer's unreasonable and bad faith refusal to defend and indemnify would an award of attorney's fees be required.

Precision Door Co. v. Meridian Mut. Ins. Co., 353 F.Supp. 2d 543 (E.D. Pa. 2005). The District Court followed Kelmo Enterprises, Inc. v. Commercial Union Ins. Co., 285 Pa. Super. 13, 426 A.2d 680, 683 (1981) for the proposition "'that an insured who is compelled to bring a declaratory judgment action to establish his insurer's duty to defend an action brought by a third party may recover his attorney's fees incurred in the declaratory judgment action if the insurer has, in bad faith, refused to defend the action brought by the third party.'" Precision Door also cited Regis Ins. Co. v. Wood, supra. The District Court could not rule on the issue because evidence of reliance on an inapplicable policy exclusion did "not conclusively demonstrate bad faith, unless such reliance was undisputedly unreasonable or malicious." Id. at 557 n.12.

T. Compensatory Damages

Corch Constr. Co. v. Assurance Co. of America, 64 Pa. D.&C. 4th 496 (C.C.P. Luzerne 2003). "An insured is entitled to recover compensatory damages based upon a contract cause of action because of an insurer's bad faith conduct." Id. at 518 (citing The Birth Center). These damages included the coverage payment due for the collapse of a wall; and the following foreseeable compensatory damages: costs associated with a loan which were foreseeable to the carrier that knew it was insuring a single construction project; costs for tenant concessions; and lost past and future rent. These totaled over

$1.6 Million. The Court found that had the insurance money been timely paid, the job could have been corrected and the project successfully completed. The plaintiff had done all it could to mitigate and had no further means to obtain the additional funds to do the work.

U. Pleading

Mezzacappa v. State Farm Ins. Co., No. 04-5249, 2004 U.S. Dist. LEXIS 25441 (E.D. Pa. Dec. 14, 2004). A claim was sufficiently stated under the notice pleading standard. The complaint averred that the insurer "unreasonably refused to pay for the structural collapse and water damages to her home"; that "she suffered damages to her home between December 2003 and April 2004, and promptly filed claims with [the carrier]"; that, "after an investigation, [the carrier] denied [the insured's] claims"; and that the "denial was unreasonable, lacked sufficient basis and violated the terms of the insurance contract." This pleading was sufficient. While the complaint did not set out all of the detailed facts that would be needed to prove bad faith, the Federal Rules do not require that the complaint do so. "Discovery may reveal evidence from which a reasonable jury could conclude that [the carrier] acted in bad faith." Id. at *4.

Orrison v. Farmers New Century Ins. Co., No. 04-1003, 2004 U.S. Dist. LEXIS 10698 (E.D. Pa. June 9, 2004). The insureds filed a claim after their home was damaged and water seeped into it. The insurer paid the claim and hired a contractor to replace the roof. The insureds filed a second claim after they discovered mold underneath the roof and other sides of the home, allegedly caused by the improper installation of the new roof. As a result, the insured filed a claim under the Bad Faith Statute, and the insurer filed a motion to dismiss. The Court, in partially denying the motion to dismiss, found that the complaint specifically alleged that the insurer did not have a reasonable basis to deny the insureds' claims, and the insurer acted knowingly and/or recklessly in denying the claim.

V. Diversity Jurisdiction/Amount in Controversy

Barnes v. State Farm Mut. Auto. Ins. Co., No. 04-6874, 2004 U.S. Dist. LEXIS 7200 at *2 n.1 (E.D. Pa. Apr. 7, 2004). In calculating federal jurisdictional amount in a

section 8371 diversity case, the Court will include attorney's fees, costs and punitive damages in the calculation. Even after permitting jurisdictional discovery, the case was remanded. Where attorney's fees, costs and punitive made up the bulk of the $75,000 minimum, the Court must look to these claims with a heightened scrutiny. Further, it is the removing defendant's burden to show the sum is met to a legal certainty. Interestingly, in this case, the carrier was arguing that the claim was worth more than $75,000 and the Court found that the proof was insufficient, leaving the Court to guess at the sum.

O'Toole v. State Farm Fire and Cas. Co., No. 03-5442, 2004 U.S. Dist. LEXIS 9426 (E.D. Pa. May 20, 2004). The insured's complaint included a bad faith claim, among others. The Court remanded for lack of diversity jurisdiction where no individual claim in the insured's complaint was in excess of $50,000.

W. Assignment of Bad Faith Claims

Haugh v. Allstate Ins. Co., 322 F.3d 227 (3d Cir. 2003). The insured can assert breach of contract, breach of fiduciary duty and section 8371 claims against the insurer. The Court observed that the Pennsylvania Superior Court has held that third parties cannot bring claims against carriers without an assignment, and the Court tested the existence of an assignment in that case.

Allen v. Gen. Accident Ins. Co. of America, 868 A.2d 594 (Pa. Super. 2005). In a child abuse case resulting in a damage award, the abuser's conduct was intentional and the insurer had no duty to defend the lawsuit against the abuser. The judgment against his wife, however, was covered, as she was merely negligent in failing to prevent the abuse. In addressing the matter of assignability, the court stated:

> We begin with the observation that an insurance company is liable in the form of a judgment in excess of policy limits where the insurance company's negligence in investigating a claim or unreasonable refusal of an offer of settlement results in damages to the insured. This cause of action for "bad faith" on the part of the insurance company is assignable by the insured to third parties. Brown v. Candelora, 708 A.2d 104, 107 (Pa. Super. 1998) (third party may, through written assignment, stand in shoes of

> insured and bad faith claim against insurance company in place of insured).
>
> Conversely, we held in Brown v. Candelora … that a judgment-creditor of an insured may not, absent a written assignment of rights from the insured, pursue a "bad faith" suit *via* a garnishment action against an insurer who refuses to indemnify an insured in order to obtain a judgment award in excess of the insured's policy limits. Rather, a judgment-creditor in a garnishment action may attach only the liquidated "property" held by the insurer for the insured, *i.e.*, the applicable limits of the coverages provided by the policy insuring against the loss. This is because only those debts that are certain and not subject to a contingency are attachable in a garnishment proceeding. An unliquidated claim for "bad faith" against an insurance company is "property subject to a contingency" and, therefore, is not attachable in garnishment proceedings.

Allen, 868 A.2d at 599.

X. Reverse Bad Faith

Scalia v. Erie Ins. Exch., 878 A.2d 114 (Pa. Super. 2005). The insureds had filed a claim for loss incurred when their house burned down. In its decision to award attorney's fees to the insurer under 42 Pa. C.S. § 2503, the Trial Court found that the insureds had committed insurance fraud and the insurer thus had not breached its contract. The insureds appealed, claiming the trial court abused its discretion in awarding attorney's fees. The Superior Court found that the Trial Court did not abuse its wide discretion, because the Trial Judge was able to consider the wife/insured's guilty plea to insurance fraud as an admission of fraudulent filing. Additionally, the only grounds for finding no breach of contract on the insurer's part (arson or misrepresentation) would also have supported an award of attorney's fees.

IV. TIPS FOR AVOIDING AND DEFENDING BAD FAITH CLAIMS

A. 16 Tips for Avoiding Bad Faith Claims

1. Communication. All persons working on handling the claim should be clearly and fully communicating with each other. Any reports prepared by one person, whether by or for a decision-maker or investigator, should be shared with other persons involved in adjusting the claim so that all decisions are fully informed and based on the same pool of information.

2. Be aware of the "mindset of denial." Do not fall into a way of thinking and a course of conduct that seems to stretch conclusions and unduly favor results that always work to limit or deny a claim, while wholly ignoring equally plausible or more plausible alternatives that might favor coverage. In connection with this, be aware that if there has been a misstatement, misunderstanding or mis-judgment, do not compound that by failing to correct a clear problem, or by attempting to support or conceal a position that is known to be incorrect. If the claims handler or manager has omitted facts in writing to the insured or preparing an internal report, review the document and its conclusions to determine whether the subsequent inclusion of that information would alter the conclusion in the report or the letter.

3. Be aware that even a sincere belief that there is a legitimate defense that could prevail in the case is not by itself a sufficient basis to refuse to settle a case. Other factors such as the chance of an excess verdict, the potential range of an adverse result, the strengths and weaknesses of both sides' evidence, the history of verdicts in similar cases in the same geographic region and the relative appearance and persuasiveness of all witnesses must be considered.

4. The insurer must reasonably inform the insured of significant developments bearing on claims, at least in excess verdict situations, because of the insurer's duty of good faith and fair dealing.

5. Where payment is going to, or should be, made under the policy, do not make the settlement of any dispute with the insured over that payment contingent on a

release of potential bad faith claims. If less than the full sum due has been offered to an insured, and the insurer later determines that the policy actually requires payment of a greater sum, or the policy limits, be extremely cautious about taking any position other than making the payment known to be due. Once the obligation is clear, it is virtually certain that the payment must be made without delay or condition.

6. Respond promptly to any claims made by the insured, the insured's agent or the insurer's agent when receiving the report of a claim against the insured.

7. If the insured has provided reports or statements to the insurer, whether factual or expert, the insurer should give these full consideration and evaluation. In making a decision on coverage or defense, consider and evaluate all the evidence and information received from all sources.

8. Be aware that at least some courts will permit discovery as to whether the carrier sought legal advice; and that action, or lack thereof, is in itself potentially probative on bad faith. This is so even if the contents of that advice may not be discoverable or admissible, and even if the advice-of-counsel defense is not in issue. Thus, at least in an area where the law is not clear, always consider obtaining a legal opinion before making a decision on coverage and/or defense.

9. Any person handling or managing a claim should beware of uncritically relying, or baldly claiming reliance, upon an opinion or report without making their own critical analysis. A legal opinion or expert report that is inadequate or contrary to facts or law known to the claims handlers or managers will not likely be a legitimate source of a defense to bad faith claims handling.

10. Be aware of the insurer's own policies and procedures and adhere to them in claims handling and management.

11. Be aware that everything that claims personnel write or say may someday be made known broadly and publicly, and approach statements and conclusions about the claim, coverage and defense with that perspective. It is prudent to assume that anything and everything in writing, whether activity log, email, calendar entry, etc., will ultimately be discoverable.

12. Be aware that even communications with in-house or outside counsel or attorney work product as to the merits of coverage may become known if the advice-of-counsel defense is asserted. Even if advice-of-counsel is not asserted, be aware that there is some Pennsylvania case law that permits anything going to the state of the adjuster's mind to be made the subject of discovery, even attorney work product. On this broader view see Jones v. Nationwide Ins. Co., No. 98-2108, 2000 U.S. Dist. LEXIS 18823 (M.D. Pa. Jul. 20, 2000) (Munley, J.); Gen. Refractories Co. v. Fireman's Fund Ins. Co., 45 Pa. D.&C. 4th 159 (C.C.P. Phila.) (Bernstein, J.); McAndrew v. Donegal Mut. Ins. Co., 56 Pa. D.&C. 4th 1 (C.C.P. Lackawanna) (Nealon, J.), aff'd w/o opinion, 855 A.2d 144 (Pa. Super. 2004).[18]

13. Be aware that the oversight and conduct of declaratory judgment/bad faith litigation may itself become the subject of bad faith litigation.

14. Insurer witnesses should not attempt to avoid answers at deposition or trial by choosing to forego a review of the relevant file prior to testimony so that they can claim ignorance or no recollection during the time of testimony. (This conduct was found particularly egregious by the Hollock trial judge).

15. A snap policy limits demand from an underlying plaintiff's counsel, or the insured's counsel in a first party case, cannot simply be ignored as premature, as the Third Circuit holds that even if counsel made the demand solely for strategic reasons, the decision not to settle can be evaluated as part of a bad faith case.

[18]These cases are challenged in Michael A. Hamilton and Sara Anderson Frey, Traditional Rights in Modern Day Litigation: Upholding the Attorney-Client Privilege and Work Product Doctrine in Actions Brought Under Pennsylvania's Bad Faith Statute, 73 Pa. Bar Assn. Quarterly 47 (April 2002). See also, e.g., Saltern v. Nor-Car Fed. Credit Union, No. 02-2175, 2003 U.S. Dist. LEXIS 7679 at *4 (E.D. Pa. Apr. 16, 2003) (citing Jones, but then stating that Third Circuit precedent provides that "advice is not placed in issue merely because it is relevant … A waiver can be found only where a client has made the decision and taken an affirmative step in the litigation to place the advice of attorney in issue … This occurs where the client attempts to prove a claim or defense by *disclosing* or *describing* an attorney-client communication.") (emphasis added).

16. Be aware of Pennsylvania's Unfair Insurance Practices Act, as the Courts may look there for guidance on bad faith, including, e.g., as to such issues as timely investigation of the claims, follow up reporting and settlement practices.

B. 17 Tips for Defending Bad Faith Claims

1. While you are an advocate, you still need to be honest and objective in advising the insurer about the risks presented in each case, both as to past conduct that is the subject of litigation and the manner and objectives of the bad faith litigation itself. Obtain and learn the entire file as early as you can in making such an evaluation, along with speaking to the claims personnel. When you speak with the insurer's claims personnel be respectful and neither accusatory nor obsequious. If there was or is a conflict, e.g., between the claims adjuster and a supervisor, avoid taking sides and focus on trying to evaluate the facts coming from each individual as simply being aspects of one single case.

2. To the extent possible, learn the history of outcomes in bad faith cases in the jurisdiction in which the case is litigated, and the history of the judge before whom the case is being litigated, especially in any state court litigation where the judge will be the only trier-of-fact on section 8371 claims. Consider research in legal newspapers, published verdict reports and reported cases, along with finding out what other lawyers know.

3. Be aware that, unless and until the Supreme Court of Pennsylvania rules otherwise, conduct of the bad faith litigation itself can be the subject of further bad faith litigation. This certainly can implicate conduct in which you are directly involved, and the testimony of the insurer's personnel during depositions or at trial.

4. Be aware that even though some discovery disputes can leach into bad faith claims, not all discovery disputes can be the basis for a threat of section 8371 bad faith conduct if they are "pure" discovery disputes.

5. Be aware of the parameters for defining the kinds of documents and information that are and are not discoverable. Think of the effect it may have on the judge when objecting to discovery requests that have been consistently held to be non-objectionable. As discovery disputes in bad faith cases are almost inevitable, study the case law on what has and has not been permitted, so that you can pick your fights based upon a likelihood of success as well as the concern over the degree of sensitivity of the

information that is at issue. Beware of making arguments that something should not be produced because it is proprietary and/or a trade secret where: (a) there is no law actually supporting that position; and/or (b) the courts have typically handled the production of such materials with a confidentiality order.

6. Be aware of the benefits and detriments of asserting the advice-of-counsel defense, and that even when not asserted, there are some decisions permitting discovery of counsel's advice under the theory that such advice goes to the claims' handler's state of mind. Know the case law going both ways on this subject.

7. If the possibility of being in state or federal court is in the carrier's hands, e.g., by a right to remove a state court action, go over the options very carefully, and make sure the carrier is fully aware that section 8371 claims can go to a jury in federal cases, but can only be tried by a judge in state cases. If you can anticipate the likely issues in the case, you should also investigate whether the Third Circuit and/or Federal District Court cases, on the one hand, and the state intermediate appellate or Common Pleas courts, on the other hand, reach different conclusions on the same issues, e.g., arbitrability. The Supreme Court of Pennsylvania should be the final word on most issues in any forum, though not in all cases, e.g., ERISA, Federal Arbitration Act and the right to a jury under the Federal Constitution.

8. Evaluate whether you should seek a bifurcation of the coverage and bad faith issues at trial, e.g., to keep the more inflammatory bad faith evidence away from the jury deciding the basic contract coverage issue; and be aware of the distinction between bifurcation and severance (the later being more extreme and less likely). There is also the issue of "trifurcation", i.e., separate trials on basic coverage, bad faith and damages.

9. Be aware of whether and within what parameters you can use experts; and be aware if the other side's expert is offering opinions on matters beyond what is permissible.

10. Be aware of the distinctions in bad faith theories that can be pursued under the Supreme Court's Cowden decision on failures to settle in excess situations, and under contract theories for breach of the covenant of good faith and fair dealing that may allow

compensatory damages (The Birth Center), as well as the punitive damages, fees shifting and super-interest claim/remedy under 42 Pa. C.S. § 8371.

11. Be aware of the nuances in the case law generally asserting that section 8371 claims are "independent" of the breach of insurance contract claims, and closely scrutinize any argument that under this principle an insured could lose on the merits of a claim that the carrier had no coverage duty, e.g., because of an exclusion, but can still be subject to a bad faith claim for failures to defend or settle a case.

12. In a case where the defendant is not a classic insurance company, but is in a related insurance industry, do not assume that this person or entity is subject to section 8371. The same basic review should be done when a complaint is filed that is not related to the denial of a claim, but is rather, e.g., related to premiums or policy cancellation.

13. Be aware of the pattern and practice issue in taking discovery, and whether pattern and practice discovery outside specific facts of case is permissible because there is a nexus between a broad practice and the specific harm alleged; or, whether it is impermissible because the harm is not connected to the pattern, but it is merely an attempt to show the insurer is a bad actor.

14. Be aware of instances where the UIPA has and has not been permitted to be used as a reference point for bring section 8371 bad faith claims.

15. During the course of litigation do regular research updates on bad faith case law. There is a high volume of decisions on the subject each year, and even when there is no dramatic new development like Hollock, Campbell or The Birth Center, there may be trial court or intermediate appellate court opinions that apply old law to new factual settings, or simply to a set of factual settings similar to those present in your case.

16. Do not underestimate the value and guidance given in the decisions of the Courts of Common Pleas of Pennsylvania. For example, the trial court's extremely thorough decision in Hollock v. Erie Ins. Exch., 54 Pa. D.&C. 4th 449 (C.C.P. Luzerne 2002), gives a detailed sense of what can constitute bad faith conduct. In addition, if you have a case in the Philadelphia Court of Common Pleas' Commerce Case Management

Program, the Program judges have decided numerous bad faith cases which should be reviewed before litigating in that forum.[19]

17. In a property damage case, be aware of whether an appraisal provision exists that would allow the insurer to take the matter to an appraisal where each party can pick their own damage appraiser, who then mutually select an umpire to decide the proper amount. Invoking this process promptly, if available under policy, may avoid claims of bad faith.

[19]Some of these cases are being reported on Lexis, but all the Commerce Court Opinions are posted on its web site, http://courts.phila.gov/common-pleas/trial/civil/commerce-program.html.

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