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Contacts:

Matthew M. Haar
717.257.7508
mhaar@saul.com

Joseph C. Monahan
215.972.7826
jmonahan@saul.com

Amy L. Piccola
215.972.8405
apiccola@saul.com

Matthew J. Antonelli
202.295.6608
mantonelli@saul.com

A.J. Kornblith
202.295.6619
akornblith@saul.com

Patrick F. Nugent
215.972.7134
pnugent@saul.com

Meghan Talbot
215.972.1970
mtalbot@saul.com

Saul Ewing LLP

Insurance Practice

The Bad Faith Sentinel

Standing guard on developments in the law of insurance bad faith around the country

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Southern District of New York: It is Unlawful for an Insurer to Withhold Payment When Some Portion on an Insured's Entitlement is Undisputed

***Lexington Ins. Co. v. MGA Entm't*, No. 12-cv-3677 (SAS), 2014 WL 3955205 (S.D.N.Y. Aug. 12, 2014).**

The Southern District of New York denies an insurer's motion to dismiss an insured's claim that the insurer breached its duty of good faith and fair dealing by withholding all payment of defense costs where the insurer's obligation was divisible into undisputed and disputed portions.

On July 10, 2013, the Southern District of New York ruled that National Union Fire Insurance Company of Pittsburgh, Pennsylvania ("National Union") had a contractual duty to defend MGA Entertainment, Inc. ("MGA") in connection with a copyright infringement brought by Bernard Belair against MGA (the "*Belair* action"). The ruling entitled MGA to recover attorneys' fees incurred in connection with its defense in the *Belair* action. Because MGA had settled with its attorneys for an amount less than originally billed, National Union's exact obligation to MGA remained in dispute. On June 10, 2014, the court found that National Union was obligated to pay MGA a total of $2.4 million, plus pre-judgment interest.

Before the court ruled on National Union's exact obligation, it permitted MGA to file an amended answer. In its amended answer, MGA included a new counterclaim, alleging that National Union breached its duty of good faith and fair dealing by unreasonably delaying its recovery following the court's July 10, 2013 ruling on entitlement to a defense. MGA argued that while National Union's exact obligation was in dispute, it was unreasonable for National Union to withhold payment of undisputed amounts, including the amounts that it had actually paid to its attorneys in the *Belair* action. National Union filed a motion to dismiss, arguing that MGA had failed to state a claim upon which relief could be granted. National Union argued that because a question remained as to whether it was liable to MGA for the total amounts billed, or only for the amounts MGA actually paid, it was reasonable for it to withhold all payment to MGA.

Because this case was a diversity action, California law applied to the parties' insurance policy. The court began its analysis by noting that under California law, all insurance policies contain an implied duty of good

faith and fair dealing that is violated when an insurer unreasonably withholds payment of a claim. The court reasoned that in order for National Union to prevail on its motion to dismiss, it had to establish that, as a matter of law: 1) California law does not recognize a distinction between undisputed and disputed insurance obligations; or 2) MGA had not adduced "plausible" evidence of an undisputed obligation by National Union. Because it concluded that National Union's arguments as to both issues failed, the court denied the motion to dismiss.

First, the court reasoned that under established California law, it is unlawful for an insurer to continue to withhold all payment once some portion of an insured's entitlement is undisputed. Insurers can therefore be liable for bad faith by refusing to pay the undisputed portion of an obligation, even where the full value of the insured's entitlement remains unclear.

Next, National Union argued that MGA had not produced sufficient evidence of the undisputed portion of the obligation. National Union noted that it had repeatedly requested documentation from MGA proving its payment to its attorneys, but that MGA had only supplied internal company spreadsheets. The court rejected National Union's argument, reasoning that for the purposes of a motion to dismiss, it had to accept all of MGA's factual allegations as true. MGA's allegations, viewed in the aggregate and taken as true, made it "plausible" to infer that National Union acted in bad faith. Accordingly, National Union's motion to dismiss was denied.

The court emphasized that under California law, an insurer is not permitted to withhold payment from an insured if it is clear that payment was due. The question of whether the undisputed amount owed to MGA by National Union was "clear" at the time National Union withheld payment is a factual issue that is preserved for trial.

Eastern District of Pennsylvania: State Farm Cannot Refuse Appraisal of Superstorm Sandy Damage

***Currie v. State Farm Fire & Cas. Co.*, No. CIV.A. 13-6713, 2014 WL 4081051 (E.D. Pa. Aug. 19, 2014).**

After Superstorm Sandy damaged the insureds' house, they and their insurer came to markedly different assessments of the scope and extent of the loss. The insureds asked for an appraisal, but the insurer refused, claiming there was a dispute about whether certain damages were covered. Concluding that this dispute was limited to the extent of loss, the court denied the insurer's motion for summary judgment on the bad faith claim.

On October 29, 2012, Robert and Kathleen Currie's house in Langhorne, Pennsylvania was struck by a tree during Superstorm Sandy, causing damage to the roof and other parts of the home. The Curries had a homeowner's insurance policy with State Farm Fire and Casualty Company ("State Farm"), and they promptly notified State Farm of the claim. A State Farm adjuster and a roofer contacted by the Curries subsequently inspected the damage. During the inspection, the roofer told the Curries that he thought replacing the roof would cost more than $100,000.

On November 19, 2012, however, the Curries received an estimate and check from State Farm for little more than $50,000. This prompted the Curries to hire their own experts, who inspected the property and estimated the total damage at more than $360,000. State Farm hired an engineer to conduct a second inspection, after which it sent the Curries a second check for an additional $9,500 on May 27, 2013.

The Curries' policy provided that if the insured and insurer failed to agree on the amount of the loss, either party could demand that the loss be set by appraisal. In June 2013, the Curries sent to State Farm two written demands for appraisal. State Farm rejected these demands on July 2, 2013, stating, "This claim involves certain items for which State Farm has not admitted liability [including] sanding and refinishing of the wood

floors. Since the dispute goes beyond the amount of loss, appraisal is not an appropriate method of resolution."

In October 2013, the Curries filed an action in Pennsylvania state court against State Farm for bad faith and breach of contract, which State Farm removed to federal court. The Curries alleged that State Farm acted in bad faith when, among other things, it denied their demands for appraisal. In June 2014, State Farm moved for summary judgment on the bad faith claim, arguing that there existed a "coverage dispute" that made an appraisal inappropriate because the parties did not agree on which items of damage were caused by the storm.

The U.S. District Court for the Eastern District of Pennsylvania noted that well-established Pennsylvania law encourages the resolution of insurance disputes by appraisal, and that appraisal is appropriate when two conditions are met: 1) the insurer has admitted liability for the loss; and 2) the only dispute is over the dollar amount of the loss. As to this second condition, the court stated that when the parties merely disagree over the extent of damage or whether a covered peril is the cause of certain damage, that dispute is one regarding the amount of loss and thus appropriate for resolution by appraisal. The court observed that, as a practical matter, differing assessments of loss often boil down to disagreements by the assessors over the cause of damage or scope of necessary repairs. If State Farm could avoid the appraisal remedy by labeling this state of affairs a "coverage dispute" rather than an extent of loss issue, it would render the policy's appraisal provision "useless."

The court stated that the parties' disagreement concerned whether Superstorm Sandy damaged the Curries' floors and the scope of repairs needed to their roof. It concluded that it was "disingenuous of State Farm to characterize this disagreement as a coverage issue in order to avoid appraisal, especially in light of the fact that Pennsylvania law encourages the settlement of disputes regarding the amount of loss by appraisal." Therefore, the court denied State Farm's motion for summary judgment on the bad faith claim regarding the refusal to go to appraisal.

The Curries also alleged that State Farm acted in bad faith in its dealings with the roofer they initially hired, but the court held that the Curries failed to present evidence for that claim. The court thus granted summary judgment for State Farm on that specific portion of the bad faith claim.

Eastern District of Pennsylvania Denies Bad Faith Claim in Homeowner's Policy Dispute

***White v. Metro. Direct Prop. and Cas. Ins. Co.*, Civ. A. No. 13-434 (E.D. Pa. July 29, 2014).**

Eastern District of Pennsylvania enters summary judgment for the insurer on statutory bad faith claim in coverage dispute under homeowner's policy.

This case involved a coverage dispute under a homeowner's policy following the collapse of a wall in the plaintiffs' home. Plaintiffs alleged that the collapse resulted from excessive rainfall during a storm in March 2011. As part of the investigation of the plaintiffs' claim, the insurer, Metropolitan Direct Property and Casualty Insurance Company ("Metropolitan"), hired a professional engineer to assess the cause of the collapse. The engineer concluded that the collapse was not caused by the single storm event in March 2011, but instead resulted from long-term and on-going water infiltration attributable to poor maintenance. In fact, one year earlier, the plaintiffs' home had sustained water damage, but the plaintiffs did not fix the damage. Plaintiffs also retained an engineer, who determined that the cause of the collapse was attributable to the type of brick used to construct the home and not to poor maintenance. Metropolitan determined that the plaintiffs' claim was not a covered collapse under the terms of the policy and denied coverage for their claim.

Plaintiffs filed a complaint in Pennsylvania state court alleging breach of contract and statutory bad faith under 42 Pa. C.S.A. § 8371.[1] Metropolitan removed the case to federal district court, and later moved for summary judgment on the plaintiffs' claims, arguing that the homeowner's policy excluded coverage for collapse caused by weather, and in any event, that the collapse was not caused by a single rain event but rather by long-term water infiltration behind the collapsed wall. The homeowner's policy provided coverage only for "sudden and accidental direct physical loss or damage to the property," except as excluded in other relevant provisions of the policy. Metropolitan also argued that the plaintiffs could not establish evidence of bad faith because the record demonstrated that the plaintiffs were not entitled to coverage and Metropolitan had adjusted their claim in a timely manner, provided them over $17,000 in temporary housing, corresponded with them regularly, and based the coverage denial on an engineering analysis.

The court analyzed the terms of the homeowner's policy in ruling on Metropolitan's motion for summary judgment on the plaintiffs' breach of contract claim. The policy excluded coverage for collapses caused (or caused in part) by weather conditions and defective, faulty, or unsound design, specifications, workmanship, or construction. Thus, under either of the plaintiffs' theories regarding the cause of the collapse – severe weather or construction defects – the policy unambiguously excluded coverage for their loss. The court, therefore, entered summary judgment in Metropolitan's favor on the plaintiffs' breach of contract claim.

In support of their bad faith claim, Plaintiffs argued that Metropolitan wrongfully withheld payment under the policy without a reasonable basis. To establish a bad faith claim under 42 Pa. C.S.A. § 8371, a plaintiff must establish that the insurer (1) lacked a reasonable basis for denying benefits and (2) knew or recklessly disregarded its lack of a reasonable basis. The court noted, "[i]n the insurance context, bad faith denotes a 'frivolous or unfounded' refusal to pay policy proceeds, which imports a dishonest purpose and a breach of a known duty, such as good faith and fair dealing." The court then explained that "to defeat a motion for summary judgment, a plaintiff must show that a jury could find by 'the stringent level of clear and convincing evidence,' that the insurer lacked a reasonable basis for its handling of the claim and that it recklessly disregarded its unreasonableness." Having already determined that Metropolitan's denial of benefits "was not only reasonable, but correct under the Policy language," the court ruled that the plaintiffs could not demonstrate that Metropolitan lacked a reasonable basis for denying their claim and entered summary judgment for Metropolitan on the plaintiffs' bad faith claim.

1. Plaintiffs also alleged a claim for common law fraud in their complaint, which was dismissed with prejudice following Metropolitan's motion for partial judgment on the pleadings.

Eleventh Circuit: Florida Law Does Not Equate Mere Negligence with Bad Faith

***Kincaid v. Allstate Prop. and Cas. Ins. Co.*, No. 2:13-cv-014030, 2014 WL 3733758 (11th Cir. Jul. 30, 2014).**

The Eleventh Circuit holds that under Florida law, negligence does not equate to bad faith, and under the specific facts of the case, one possible negligent mistake was insufficient to find bad faith where the insurer otherwise consistently acted with due regard for the interest of the insured.

In an unpublished per curiam opinion, the Court of Appeals for the Eleventh Circuit affirmed the grant of summary judgment in favor of defendant-appellee Allstate Property and Casualty Insurance Company ("Allstate"). The underlying action arose from an April 2006 accident in which plaintiff Joshua Kincaid drove his automobile out of a parking lot and into the path of Deon Vanzyl's motorcycle. As a result, Vanzyl was placed in an intensive care unit, and he remains partially paralyzed. Kincaid was legally impaired by alcohol and received a DUI charge for the accident, and admitted that the accident was his fault.

At the time of the accident, Kincaid insured under a policy issued by Allstate with $100,000 in bodily injury liability coverage. Within one month, Allstate had investigated the claim and mailed Vanzyl a check and release for the full $100,000 bodily injury policy limits, while contacting Kincaid's family and attorney to tell them that although Allstate would try to settle Vanzyl's claim, the claim could exceed the policy limits.

Over the next four months, Allstate contacted Vanzyl's attorney 31 times attempting to negotiate a settlement. The attorney only responded three times and refused to discuss settlement each time. On October 13, 2006, Allstate's adjuster received a letter from Vanzyl's attorney proposing a settlement that must be concluded by October 20, 2006. The letter proposed a settlement for Vanzyl's property injury, but did not mention any settlement for personal injury. In fact, Vanzyl's attorney specifically noted that he had returned Allstate's $100,000 check for Vanzyl's bodily injuries, and did not request a replacement.

The Court of Appeals noted that the terms of the demand letter were vague with respect to the proposed release. Despite requesting a "basic mutual general release," the release Vanzyl's attorney attached to the letter only released Allstate and its insureds from property damage claims. It did not release Vanzyl from any claims or release anyone from bodily injury claims. Further, Allstate itself had no "basic mutual general release."

Upon receipt of the letter, Allstate's insurance adjuster was confused about its terms and immediately hired outside counsel. The adjuster requested that outside counsel help her comply with the offer and explained that Allstate wanted to do whatever was necessary so long as its insureds were released from all claims. Although the letter was ambiguous, Allstate understood it as also contemplating settlement of Vanzyl's personal injury claims for the $100,000 bodily injury policy limit. Allstate's outside counsel also found the request for the release confusing and thought it was impossible to ascertain exactly what Vanzyl's attorney was requesting; after multiple unsuccessful attempts to reach Vanzyl's attorney, Allstate's outside counsel sent two releases that he believed complied with the request of Vanzyl's attorney, and included a note stating that the releases were not a material part of the settlement and would consider any proposed changes.

Vanzyl's attorney did not provide a response until three days later, when he returned the settlement checks and advised that Vanzyl would be filing suit because a satisfactory release had not been provided. Upon receiving this clarification, Allstate's counsel drafted the requested release and delivered it to Vanzyl's counsel, who once again rejected the settlement even though it complied with his requests.

Vanzyl filed a personal injury suit against Kincaid, ultimately winning a $16,299,163.88 final judgment. After the verdict, Vanzyl entered into an agreement with Kincaid whereby Kincaid would bring this bad faith suit in exchange for a stay of the execution of the judgment and a possible satisfaction if Kincaid succeeded in this suit. Allstate moved for summary judgment contending that no reasonable jury could find that it acted in bad faith. The District Court for the Southern District of Florida granted Allstate's motion, and Kincaid appealed to the Eleventh Circuit.

The Court of Appeals rejected plaintiff-appellant Kincaid's contention that a reasonable jury could find Allstate was negligent because Allstate did not provide the precise release that Vanzyl's attorney desired. According to Kincaid, this possibility of negligence also meant that a reasonable jury could find that Allstate acted in bad faith. The Court of Appeals noted that Florida law does not support this assumption, and rather that the Florida Supreme Court has specifically stated that the standard for liability in an excess judgment case "is bad faith *rather than* negligence."

The court continued its inquiry by noting that under Florida law, bad faith is present when an insurer fails to act in "good faith and with due regard for the interests of the insured." Negligence could be relevant insofar as negligent claim handling may indicate an insurer who is acting without due regard for the insured. Therefore, the Court of Appeals examined all of the evidence, including evidence of negligence, to determine whether a reasonable jury could find bad faith on the part of Allstate.

The court found that Allstate's failure to draft the release in the manner that Vanzyl's attorney desired was not bad faith, and was at most a negligent mistake (while noting that it was not clear that there was a mistake at all). Further, the court reasoned that it was "hard to imagine how Allstate could be acting in bad faith when it had already offered the full policy limits, aggressively sought to settle the case at every turn, and even continued to argue at all points that it had reached a binding settlement with Vanzyl." In light of the evidentiary record, the Court of Appeals agreed with the District Court's conclusion that no reasonable jury could find that Allstate acted in bad faith.

Baltimore, MD
500 East Pratt St.
Charles O. Monk, II
410.332.8668

Boston, MA
131 Dartmouth St.
Richard D. Gass
617.723.3300

Chesterbrook, PA
1200 Liberty Ridge Dr.
Michael S. Burg
610.251.5750
Nathaniel Metz
610.251.5099

Harrisburg, PA
2 North Second St.
Joel C. Hopkins
717.257.7525

Newark, NJ
One Riverfront Plaza
Stephen B. Genzer
973.286.6712

New York, NY
555 Fifth Ave.,
212.980.7200

Philadelphia, PA
1500 Market St.
Bruce D. Armon
215.972.7985

Pittsburgh, PA
One PPG Place
Charles Kelly
412.209.2532
David R. Berk
412.209.2511

Princeton, NJ
650 College Rd. E
Marc A. Citron
609.452.3105

Washington, DC
1919 Pennsylvania Ave, NW
Mark L. Gruhin
202.342.3444
Andrew F. Palmieri
202.295.6674

Wilmington, DE
222 Delaware Ave.
Wendie C. Stabler
302.421.6865
William E. Manning
302.421.6868