COUNTERPOINT

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The End of the Insurer Controlled Defense: *Babcock & Wilcox v. American Nuclear Insurers*

By Nicholas A. Cummins, Bennett, Bricklin & Saltzburg LLC, Philadelphia, PA

The rights of an insurance carrier to defend its insured under a reservation of rights letter, and to control the defense and settlement of the pending claim, are among the most fundamental tenets of Pennsylvania insurance law. This paradigm has long allowed insurers and insureds to cooperate in the defense of third party liability claims, even in cases involving disputed coverage issues. In *Babcock & Wilcox Co. v. American Nuclear Insurers*[1], the Superior Court recently upended this practice, holding that in all cases where an insurer issues a reservation of rights letter, the insured is entitled to reject the reserved defense, defend (or not defend) the claim as it sees fit, and then seek reimbursement from the insurance carrier for the resulting adverse judgment or reasonable, non-collusive settlement, as well as defense costs. The issue is now before the Pennsylvania Supreme Court[2]. Its decision could work a fundamental alteration in the way third party liability claims are handled and defended in Pennsylvania.

A. The *Babcock* Saga – Overview of the Suit and Opinions

Babcock's unique ruling may have been motivated by its unusual facts. *Babcock* is a declaratory judgment action arising from an underlying mass tort claim filed in 1994. In the underlying tort suit, several residents in the area surrounding nuclear processing facilities operated by Babcock & Wilcox and B&W Nuclear Environmental Services (collectively, "B&W") claimed that exposure to radiation from the facilities caused a variety of serious injuries. B&W's insurers, American Nuclear Insurers and Mutual Atomic Energy Liability Underwriters (collectively, "ANI"), assumed B&W's defense subject to a reservation of rights. The coverage issues expanded as the litigation continued, but ANI generally reserved the right to disclaim coverage to the extent the losses fell outside of the "nuclear energy hazard" or the policy period. Later, ANI also reserved the right to disclaim for an alleged breach of the policies' cooperation clauses stemming from B&W and Babcock's refusal to proceed with joint counsel. By the time the underlying suit resolved, however, that issue was apparently moot, as an appellate court had ruled in B&W's favor on the question of separate counsel.

As the years passed, the tort suit grew to encompass more than three hundred claimants. In 1998, a test

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Tincher v. Omegaflex, Inc: *Paradigm Shift or "More of the Same?"*

By Bill Ricci, Esquire, Ricci Tyrrell Johnson & Grey, PLLC, Philadelphia, PA

On March 16, 2013 The Pennsylvania Supreme Court granted allocator in *Tincher v. OmegaFlex, Inc.,* 64 A. 3d 626 (Pa. 2013). This is actually the second time the Pennsylvania Supreme Court expressly pledged to answer the following question, once and for all: "whether this court should replace the strict liability analysis of sec. 402A of the Second Restatement with the analysis of the Third Restatement . . . [and] whether, if the court were to adopt the Third Restatement, that holding should be applied prospectively or retroactively." In fact, this description of the issue for the court's decision may to some degree be misleading to those not familiar with Pennsylvania product liability law.

Beginning in 1978, The Pennsylvania Supreme Court has crafted its own version of Section 402A of the Restatement (Second) of Torts; namely, *Azzarello v. Black Brothers Co., 480 Pa. 547, 391 A.2d 1020 (1978). Azzarello* and its progeny have

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Phone: 800-734-0737 FAX: 800-734-0732
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trial by eight claimants yielded a total verdict of more than thirty five million dollars. The test trial was ultimately reversed due to issues with the science relied upon by plaintiffs' experts to link the claimed injuries with the nuclear facilities. Nonetheless, the test trial result suggested the theoretical potential for more than one billion dollars in total exposure, if plaintiffs could prove their claims. ANI, for its part, incurred more than forty million dollars in defense costs[3]. Between the two, Babcock and B&W had three hundred twenty million dollars in insurance coverage available to them, which was eroded by defense costs.

Ostensibly in recognition of the significant weaknesses in their claims, the plaintiffs offered to settle all claims against B&W for the comparatively modest total sum of eighty million dollars. ANI rejected this offer, believing that plaintiffs had little chance of success on the merits. B&W, believing the settlement to be favorable, asked ANI to withdraw its reservations of rights if it intended to reject the settlement and continue to defend the claim. ANI refused. Without ANI's consent, B&W then unilaterally accepted the plaintiffs' settlement offer, paying the eighty million dollar settlement out of pocket, and bringing the underlying suit to an end.

In the resulting declaratory judgment action against ANI, B&W sought reimbursement for its settlement payment, contending that the settlement was reasonable under the circumstances. In response, ANI conceded that the policies otherwise covered the settlements, but asserted that B&W was not entitled to reimbursement because it breached the policies' consent to settle clauses. Those clauses authorized ANI to direct and approve any settlement of the claim, and barred B&W from making any payment to the plaintiffs, except at its own expense[4]. Since ANI's consent to settle clauses were clear and unambiguous, the trial court initially resolved the issue by holding that B&W could not recover unless B&W proved that ANI acted in "bad faith" under the *Cowden v. Aetna*[5] standard. To meet this burden, B&W would have been required to prove by clear and convincing evidence that ANI did not have a good possibility of winning the suit on its merits, and unreasonably refused the plaintiffs' settlement offer[6]. On further consideration, however, the trial court reversed course. Instead, it held that B&W was entitled to reimbursement so long as the settlement was reasonable and non-collusive under the circumstances[7]. Effectively, the trial court barred ANI from arguing that it was entitled to refuse the offer because it was likely to win the case on its merits. Instead, the jury was asked only to determine whether the dollar amount of the settlement was reasonable.

The trial court reached its conclusion by looking to a separate line of Pennsylvania cases[8], holding that when the insurer issues an outright *denial* of coverage, it has breached the insurance policy and may be liable for any reasonable settlement covered by the policy. Those cases reasoned that when the insurer has refused to provide any coverage, it has no right to demand control over the settlement. The trial court, while recognizing that the claim was not one which was likely to exceed the coverage limits, focused its reasoning on ANI's pending reservation of rights. It found little practical distinction between the scenario where the insurer issues an outright denial of coverage, and the one in which the insurer issues a reservation of rights. It reasoned that in both cases, the insurer was seeking to dictate the terms of a settlement with one hand, while repudiating (or potentially repudiating) coverage with the other. Finding a reservation of rights to be the functional equivalent of a coverage denial, the trial court held that B&W could recover so long as the verdict was reasonable and non-collusive. A jury agreed that the settlement was reasonable, and the issue was appealed to the Superior Court.

The majority Superior Court opinion reversed and remanded, but did so only after creating a new rule in Pennsylvania governing the handling of insurance claims defended under a reservation of rights. It did so in an attempt to avoid what it saw as two competing interests at play when a reservation of rights is issued.

On one hand, the Superior Court recognized that an insurance policy is a contract, and that unambiguous terms in an insurance contract are to be enforced as written, absent a material breach of the contract by the insurer. Since no party disputed the clarity of the consent to settle clauses, the majority was troubled by the trial court's decision to effectively treat the issuance of a reservation of rights letter as a breach of the insurance policy. Finding that the issuance of a reservation of rights did not constitute

a breach, the majority disagreed with the trial court's decision to impose a reasonable settlement standard simply because a reservation of rights was issued[9]. Such a rule disregarded basic concepts of contract interpretation.

On the other hand, the majority was also troubled by the fact that a reservation of rights creates an inherent conflict of interest which incentivizes an insurer to elevate its own interests above that of its insured. The majority observed that an insurer defending under a reservation of rights is given two chances to avoid liability for the claim. Where an insurer believes it has a meritorious coverage defense, the court reasoned that the insurer may be motivated to turn down an otherwise reasonable settlement, secure in the knowledge that, if it loses on liability, it may still escape liability under its coverage defense. In so doing, the insurer may be denying the insured the opportunity to settle the potentially uncovered claim for far less than the resulting verdict at trial. As such, the issuance of a reservation of rights, the majority reasoned, allowed the insurer to control the defense and settlement of a claim in such a way as to expose the insured to greater potential liability on a claim that ultimately would not be covered by the policy. This, the majority concluded, created a conflict of interest between the insurer and insured, which militated against the insurer's right to control the defense and settlement when a reservation of rights has been issued[10]. The majority went on to reject as "too cavalier," the use of the *Cowden* bad faith standard to resolve and prevent the abuse of this conflict of interest by the insurer.

To balance the need to enforce the contract as written with the conflict of interest between the insurer and insured, the majority adopted a hybrid rule[11]. The majority held that any time an insurer issues a reservation of rights, the insured may either accept or reject the defense. If the insured accepts the defense, the insurer is entitled to assert and rely upon its consent to settle clause. If the insured settles the claim directly, the insurer is only liable for the settlement if it acted in bad faith under *Cowden* (which would constitute a material breach of the policy). Conversely, if the insured rejects the defense, it may control the defense and settlement of the claim directly and at its own expense. If coverage is later found, the insurer is then liable for any reasonable, non-collusive settlement, along with the insured's defense costs[12]. The majority therefore remanded the case with instructions to apply the bad faith standard, assuming B&W had accepted ANI's defense (which it had)[13].

B&W appealed this ruling, and the Supreme Court of Pennsylvania granted *allocator*. Briefs have been filed, and oral argument is expected to be scheduled in the coming months.

B. A Post-*Babcock* World – The Practical Implications of *Babcock*

Most insurance claim handlers in Pennsylvania would be surprised to learn that the issuance of a reservation of rights letter permits the insured to walk away from the proffered defense, defend as it sees fit, and then present the carrier with the bill. They would be even more surprised to learn that this result would follow from even a relatively innocuous reservation, such as one reserving the right to disclaim to the extent a verdict is in excess of the policy limits. In essence, almost every litigated third party claim has the potential to fall within *Babcock*. Some of the practical problems with such an arrangement are immediately apparent.

First, *Babcock* completely ignores the fact that many reservations of rights letters are "soft" reservations, and instead treats all reservations of rights as if they may result in no coverage for the insured. "Soft" reservations are those that address coverage issues suggested by the complaint, but which are not likely to ripen into actual coverage disputes between the parties. For example, in liability cases involving water damage to property, insurers will frequently accept coverage for water damage, but issue a reservation of rights with respect to any damage caused by mold, which is typically excluded from a general liability policy. In most cases, mold never becomes an issue. Instead, the only claim presented is one for covered water damage, which is ultimately settled by the insurer without any conflict with the insured[14]. While *Babcock* was intended to address conflicts of interest, its rule applies equally to these "soft" reservations, despite the fact that there is no actual conflict of interest between insurer and insured.

By creating a rule that applies to all reservations of rights, regardless of the "strength" of the reservation, *Babcock* forces insurer and insured into adversarial positions from the moment the suit is filed. Under *Babcock*, an insurer faced with a water damage claim now must choose between reserving its rights in the off-chance mold becomes an issue, but potentially giving up control of the defense and the right to settle the claim, or proceeding without the reservation, and risking liability for a mold claim should one develop. *Babcock* transforms what would have otherwise been a run-of-the-mill, inconsequential coverage reservation into a potentially significant legal decision fraught with negative consequences for the insurer that chooses incorrectly. Moreover, the decision must be made at the outset of the suit, where both insurers and insureds generally have little information on the claim, and are poorly situated to predict how it may develop. Indeed, *Babcock*'s underlying tort suit is a prime example of this problem. It seems exceedingly unlikely that when the tort suit was first filed by five claimants in 1994, ANI or B&W suspected it would become the three-hundred plaintiff, one billion dollar exposure claim it was twenty years later. *Babcock* forces the insurer to make irrevocable coverage decisions at a time when it is least equipped to do so, and punishes the insurer that guesses wrong with liability for an uncovered claim, or the fruits of a poorly mounted defense conducted by its lay insured. By forcing the insurer to make such decisions from the moment the suit is filed, *Babcock* immediately sets the insurer and

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insured at odds, and upsets what would otherwise normally be a cooperative relationship. Worse, it does so even in cases where no conflict of interest actually exists.

Second, the *Babcock* rule discourages an insurer from defending a questionably covered claim under a "hard" reservation of rights. Insurers are frequently faced with claims that likely are not covered by the policy, but the outcome of a declaratory judgment action on the question is not absolutely guaranteed. In those situations, the general practice is to assume the defense under a "hard" reservation of rights. Insurers who do so reason that by assuming the defense of the claim, they are able to control defense costs and ensure that the suit is properly defended. All of this inures to the insurer's benefit if it is later determined that the claim is covered. *Babcock* removes this incentive. Now, an insurer faced with a tenuously covered claim must choose between issuing a reservation of rights and losing control of the defense, or waiving its coverage defenses and being forced to cover a claim that is likely to fall outside of the policy. Thus, *Babcock* deprives insurers of their primary incentive to assume the defense of questionably covered claims - control of the defense. In so doing, *Babcock* is likely to lead to insurers issuing denials in cases where they may otherwise have defended under a "hard" reservation of rights. Such an outcome injures insurers and insureds alike.

Third, by permitting an insured who rejects a defense to nonetheless seek reimbursement for its legal costs and any "reasonable" resulting settlement, *Babcock* subjects the insurer to greatly increased liability, while simultaneously making it difficult for the insurer to later show that the settlement was unreasonable. For *Babcock* permits the insured to conduct the defense in any manner it sees fit. This scenario not only opens the door for the insured to retain competent, but overpriced, counsel, but also permits the insured to retain no counsel at all and defend the suit *pro se*. Where the insured retains unreasonably priced legal counsel, the insurer faces greatly increased defense costs. On the other hand, where the insured retains no counsel at all, the insurer is faced with a potentially exorbitant judgment or settlement, possibly in a claim that otherwise could have been disposed of on motion practice, had it been handled by a competent attorney. Moreover, if the poorly defended insured enters into a settlement, the question of whether that settlement was reasonable becomes difficult, if not impossible, to resolve. This is because a settlement that might seem emminently reasonable when viewed in light of a poorly conducted defense, which did not seek key discovery or raise vital defenses, might seem patently unreasonable if it had been handled by a competent and thorough attorney. It is both unworkable and unfair to force an insurer to litigate the reasonableness of a settlement, when it must rely upon the facts and defenses developed through a potentially inept attorney overseen by a lay insured.

Perhaps less obviously, *Babcock* also creates a potential cottage industry for unscrupulous attorneys, based entirely on the recovery of exorbitant legal fees from insurers. While at first blush it may seem that very few insureds will have the financial wherewithal to fund their own defense, *Babcock* does not require that the insured actually issue payment for his or her defense costs. It is not hard to imagine attorneys seeking out insureds who have received "soft" reservations of rights letters, and offering to defend the insureds on a contingent arrangement. The insured would not be required to pay the attorney any money for his services. Instead, the attorney would present the insurance carrier with a bill for his or her services, if it is later determined that the claim is covered. Since soft reservations are issued in cases where there is no doubt that the thrust of the claim is covered, and the insurer is only seeking to protect itself from unlikely eventualities suggested by the complaint (i.e. mold), such an attorney could proceed virtually assured that an insurance carrier will ultimately be required to pick up the tab.

This creates the perverse scenario where the defense attorney's only interest is in driving up the defense costs at rates far above those an insurer would otherwise pay for competent counsel. This attorney would turn over every stone, file every conceivable motion, and depose every person even tangentially related to the underlying suit, regardless of whether such work was actually necessary. All the while, the defense attorney has little incentive to provide a good defense for his or her client. So long as the resulting judgment or settlement is within the insurer's policy limits, neither the insured nor the attorney have anything to fear. Indeed, it is not difficult to imagine arrangements between unscrupulous plaintiffs and defense attorneys, in which the defense attorney does nothing but drive up costs, with no vested interest in the actual result of the case, and then agrees to settle the case at the absolute upper limit of what may be considered reasonable by a jury. The end result is a whole industry of attorneys who do nothing but litigate for the sake of incurring costs, with little if any care for the ultimate outcome so long as it is not in excess of the policy limits. Such a result drives up both litigation expenses and claim payments.

Finally, *Babcock* opens the door for insureds to refuse a defense and quickly settle a claim for reasons entirely divorced from the merits of the litigation. For example, a corporate insured may prefer not to litigate a frivolous claim for fear of bad publicity, or the revelation of embarrassing information in discovery. Such an insured may use the issuance of a soft reservation of rights as an opportunity to settle the suit quietly, at the insurer's unwarranted expense. Likewise, *Babcock* substantially increases the risk of collusive settlements. It is not inconceivable that a plaintiff could approach an insured with an offer to share in the settlement

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proceeds, if the insured would simply agree to a settlement that the insurer would not otherwise accept. Indeed, such a result would seem to be a very real danger in family-member-versus-family-member, or friend-versus-friend suits. While *Babcock*, by its terms, would invalidate a collusive settlement, collusion may be difficult, if not impossible, to prove. In fact, given the threat of a bad faith suit, many insurers would likely be hesitant to accuse their insureds of collusion unless clear proof was at hand without taking additional discovery. Thus, while *Babcock* forbids collusion, it makes collusion significantly easier to accomplish. In sum, *Babcock* is premised on the assumption that both insurer and insured have equal interests in defending a lawsuit. In the real world, this is not always the case.

The quandary faced by insurance carriers in a post-*Babcock* world is clear. Every claim presented now puts the insurer in the position of choosing between unlimited liability, or the potential loss of the ability to control defense costs and the amount of the ultimate settlement. Either choice is guaranteed to expose the carrier to increased costs, either through the assumption of liability not covered by the policy, or the burden of unchecked legal fees, verdicts and settlements resulting from poorly defended claims. Such a result is bad, both for insurers and insureds. When an insurer faces increased costs, increased premiums for insureds inevitably follow. Likewise, when the insurer is forced to choose between defending a questionably covered suit, and accepting liability for a claim that the policy likely will not cover, insurers will undoubtedly issue denials where they may otherwise have defended pre-*Babcock*. Thus, *Babcock* increases premiums for insureds, while simultaneously reducing the frequency with which insureds actually realize a benefit from the premium payment. In a post-*Babcock* world, insurers and insureds suffer alike.

C. A Break from Settled Precedent - Legal Reasons to Reject *Babcock*

Aside from the public policy reasons discussed above, *Babcock* is simply an unnecessary and unjustified departure from settled insurance contract law that has faithfully served the Commonwealth for the last half century.

Pennsylvania has long treated an insurance contract as just that – a contract. While it is strictly construed in favor of the insured, the courts of the Commonwealth have always enforced the clearly drafted terms of the contract as written. Barring unconscionability or the violation of public policy, it is only in the presence of a material breach of the contract that the courts have been willing to free one party or the other from their obligations under the agreement. *Babcock* paid lip service to this settled principle, agreed that the issuance of a reservation of rights letter did not constitute a breach of the contract, but then went on to strip the insurer of its rights to control the defense and settlement in all cases where the insurer issues a reservation.

The majority rationalized its decision by claiming to find a middle ground to resolve what it perceived as the intractable conflict of interests that arise when a reservation of rights is issued. In so doing, however, the majority essentially ignores the fact that *Cowden's* bad faith standard has provided the solution to this problem for the last fifty years. *Cowden* arose in the context of an insurer's decision to proceed to trial on a liability defense, notwithstanding the possibility that an adverse verdict could result in a verdict in excess of the policy limits. *Cowden* directly confronted the conflict of interest presented in *Babcock*, expressing its concern that the insurer has the power to place its interests above the insured, by choosing to gamble the insured's money on the outside chance of a defense verdict, secure in the knowledge that its exposure could never exceed the policy limits[15]. *Cowden* resolved this dilemma by holding the insurer to a duty to act in good faith, giving appropriate consideration to the interests of its insured, and requiring that the insurer reject a settlement offer only when it does so reasonably, based on a good faith belief that it will succeed on the merits at trial. Other than calling it "too cavalier," *Babcock* fails to explain why the *Cowden* standard is any less effective when the potential uncovered exposure arises from a coverage reservation, as opposed to a verdict in excess of the policy limits. The conflicts of interest are the same, the risks are the same, and the rule should be the same.

In addition to providing a workable, established framework for resolving conflicts of interest between insurer and insured, *Cowden* is also intellectually consistent with Pennsylvania contract law, in that it strips the insurer of its rights only when it has acted in "bad faith," which is a material breach of the implied duty of good faith present in every contract. When such a breach occurs, the law readily permits the insured to be relieved of its contractual obligations. Furthermore, the *Cowden* standard avoids imposing a bright line rule in which all reservations strip the insurer of its rights, regardless of the circumstances. The *Cowden* standard permits a case-by-case analysis, which sets aside the contract only when the insurer actually abuses the conflict of interest. Such a case-by-case analysis works to avoid the evils discussed above, which arise from the application of the *Babcock* rule to "hard" and "soft" reservations alike, even when there is no actual conflict of interest.

Simply stated, the *Cowden* standard presented an established solution to the problems perceived by the Superior Court majority, which the courts have successfully applied for nearly sixty years. The Superior Court should have held unequivocally that B&W's breach of the consent to settle clause voided B&W's right to coverage, unless ANI had acted in bad faith under *Cowden*. By instead endowing the insured with the right to accept or reject a reserved defense, and then conditioning the application of the *Cowden* standard on the insured's choice on that issue,

the Superior Court needlessly broke from basic legal principles, upending all aspects of the relationship between insurer and insured in the process. Indeed, given that the question of an insurer's right to control the defense in the presence of a reservation of rights was not at issue at any point in the case, one must wonder why the Superior Court chose to go quite so far out on this particular limb. The Superior Court's unnecessary decision to establish a new legal standard in *Babcock* is fraught with risks - — some apparently unconsidered, many unknown and all with the potential for much mischief.

ENDNOTES

[1] 76 A.3d 1 (Pa. Super. 2013).

[2] 2 WAP 2014

[3] ANI's Supreme Court Brief at 13.

[4] The consent to settle clauses gave ANI the right to make any settlement of the claim that it deemed expedient, and prohibited B&W from "mak[ing] any payment, assum[ing] any obligation or incur[ring] any expense," "except at [their] own cost." ANI's Supreme Court Brief at 4.

[5] *Cowden v. Aetna Cas. Ins. Co.*, 389 Pa. 459, 134 A.2d 223 (1957), and its progeny, generally hold that an insurer may only be liable for a verdict in excess of the insured's policy limits if the insurer acted in "bad faith" in unreasonably refusing an offer of settlement. *Cowden* held that to act in "good faith," "the decision to expose the insured to personal pecuniary loss must be based on a bona fide belief by the insurer, predicated upon all circumstances of the case, that it has a good possibility of winning the suit." *Id*. at 478, 134 A.2d at 228. "Good faith requires that the chance of a finding of nonliability be real and substantial and that the decision to litigate be made honestly." *Id*.

[6] *Babcock*, 76 A.3d at 6.

[7] *Babcock*, 76 A.3d at 7.

[8] *Alfiero v. Berks Mut. Leasing Co.*, 347 Pa. Super. 86, 500 A.2d 169 (1985).

[9] *Babcock*, 76 A.3d at 11-13.

[10] *Babcock*, 76 A.3d at 14-17.

[11] The majority found that adopting either the "reasonable settlement" standard espoused by the trial court, or the "bad faith" standard advanced by ANI, "tilted the playing field too far" in favor either the insurer or insured. *Babcock*, 76 A.3d at 17.

[12] "[W]hen an insurer tenders a defense subject to a reservation, the insured may choose either of two options. It may accept the defense, in which event it remains unqualifiedly bound to the terms of the consent to settlement provision…. Should the insured choose this option, the insurer retains full control of the litigation…. In that event, the insured's sole protection against any injuries arising from the insurer's conduct of the defense lies in the bad faith standard articulate in *Cowden*. Alternatively, the insured may decline the insurer's tender of a qualified defense and furnish its own defense, either *pro se* or through independent counsel retained at the insured's expense. In this event, the insured retains full control of its defense, including the option of settling the underlying claim under terms it believes best. Should the insured select this path, and should coverage be found, the insured may recover from the insurer the insured's defense costs and the cost of settlement, to the extent that those costs are deemed fair, reasonable and non-collusive." *Babcock*, 76 A.3d at 22.

[13] The Superior Court's dissent contended that settled Pennsylvania insurance law required that the contract be enforced as written absent a material breach of the contract under the *Cowden* standard. It argued that the majority had improperly adopted new tenets of law in contravention of settled Supreme Court precedent. *Babcock*, 76 A.3d at 23-24 (Olsen, J., dissenting).

[14] Even when mold becomes an issue, it typically only affects a small portion of the claimed damages, the majority being covered by the policy. Even in those circumstances, however, it is not unusual for the insurer to settle the claim in full, without any contribution from the insured.

[15] *Cowden*, 389 Pa. 469, 134 A.2d at 227-28.

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strayed far from the original purpose of Pennsylvania product liability law – to allow recovery for unsafe products without requiring proof of negligence on the part of product suppliers. The *Azzarello* approach meant that juries would no longer hear a defective condition defined as one that rendered a product "unreasonably dangerous." Rather, juries would hear an instruction one Justice has described as "minimalistic" and "lacking essential guidance concerning the nature of the central concept of product defect." *Phillips v. Crickett Lighters, 576 Pa. 644, 841 A.2d 1000 (2003) (Saylor, J. concurring)*.

In the ensuing years since *Azzarello*, the Pennsylvania Supreme Court has consistently segregated a manufacturer's conduct in designing a product from the product itself. As currently applied, Pennsylvania product liability law represents a clear departure from generally accepted principles of strict liability, relying instead on poorly instructed juries to evaluate the safety of a design without being permitted to engage in the risk/utility balancing at the core of any claim of defective design (such evaluation being left to the trial judge in his or her role as so-called "social policy gatekeeper").

Under the Third Restatement, sellers are liable for injury resulting from the sale of products that are "defective." A product is defective if "the foreseeable risks" it poses "could have been reduced or avoided by the adoption of a reasonable alternative design," and if "the omission of the alternative design renders the product not reasonably safe."

Members of the Pennsylvania Supreme Court have long been calling for judicial reform in the product liability arena. *See, e.g.*, *Bugosh v. I.U. North America, Inc., 942 A.2d 897 (Pa. 2008); Phillips v. Crickett Lighters, 841 A.2d 1000 (Pa. 2003)*. In 2008, The Supreme Court previously granted allocator on the question whether to adopt the analysis of the Third Restatement, see *Bugosh v. I.U. North America, Inc., supra,* but then changed its mind and dismissed that appeal as having been "improvidently granted," *Bugosh v. I.U. North America, Inc., 971 A. 2d 1228 (Pa. 2009)*.

Since 2009, the United States Court of Appeals for the Third Circuit has predicted that the Pennsylvania Supreme Court would ultimately adopt the Third Restatement and abandon the "antiquated" and "unworkable" *"Azzarello* - tinged" version of Restatement (Second) sec. 402A, and thus directed federal courts sitting in diversity cases to do the same. See *Covell v. Bell Sports, Inc., 651 F.3d 357 (3d Cir. 2011); Berrier v. Simplicity Manufacturing, Inc., 563 F.3d 38 (3d Cir. 2009), cert. denied, 558 U.S. 1011, 130 S. Ct. 553, 175 L.Ed.2d 383 (2009)*. This is remarkable, as the Pennsylvania Supreme Court

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continued to call for the application of *Azzarello* in the wake of the *Bugosh* "retreat." See., e.g., *Reott v. Asia Trend, Inc., 55 A.3d 1088 (Pa. 2012)*. Certain members of the plaintiffs' bar bemoaned the "demise of the *Erie* doctrine."

Equally remarkable has been the rift among federal district court judges in diversity-based product liability cases involving the application of Pennsylvania law: certain judges refuse to apply the Third Restatement, reasoning that the *Azzarello* / 402A "pure" strict liability approach remains the law unless and until the Pennsylvania Supreme Court expressly says otherwise. Other judges follow the Third Circuit prescription and apply the Third Restatement.

The Pennsylvania Supreme Court held oral argument in *Tincher* on October 15, 2013. To the great surprise of the numerous plaintiffs' bar *amici curiae* present, Tincher's counsel conceded a *consensus* that *Azzarello* should be overruled, and that the "real concern" was that the Third Restatement "proof of alternative feasible safer design" requirement would be too onerous for plaintiffs and would discourage the filing of meritorious claims. Per Justice Max Baer's comments during the argument, he and Justices McCaffrey and Todd apparently share that concern. The solution, argued Tincher's attorney, was to return to 402A of the Restatement (Second) as applied historically, *without* the *Azzarello* trappings.

The Pennsylvania Association for Justice (also *amicus curiae* in *Tincher*) quickly filed an urgent request for reargument, insisting that *Azzarello* is a critical bastion of justice for injured plaintiffs in Pennsylvania, and decried Tincher's counsel's arguments as the "ranting" of a lawyer representing the interests of a subrogating insurance company. That request was summarily denied by the court.

A decision by the Pennsylvania Supreme Court in *Tincher* appears imminent. Possible outcomes include: *Azzarello* and progeny will be left intact in *all* product cases; the Restatement (Second) will be applicable to all product cases, *without* the trappings of *Azzarello*; *Azzarello* and progeny will be applicable to manufacturing defect cases only; the Restatement (Second) *sans* Azzarello will be applicable to design and warnings cases only; the Third Restatement will be applicable to *all* product cases; the Third Restatement will be applicable to design and warnings cases only; majority and/or plurality decisions on various issues; an equally divided court on key issues leaving current law intact (if fewer than all justices participate in the decision); retroactive applicability or applicability to cases which "accrue" after a given date.

In any event, we will soon learn whether the Pennsylvania Supreme Court will restore a negligence-based normalcy to a jury's evaluation of design-based and perhaps other product liability claims.

THE PA SUPREME COURT HAS AGREED TO DECIDE IF THERE IS A DIRECT RIGHT OF WORKERS' COMPENSATION SUBROGATION IN PENNSYLVANIA

By Robert F. Horn, Connorslaw LLP, Exton, PA

On May 29, 2014, the Pennsylvania Supreme Court granted a petition for allowance of appeal in *Liberty Mutual as Subrogee of George Lawrence v. Domtar Paper* ["Domtar"], 77 A.3d 1282 (2013).

Domtar arises from a slip and fall where the workers' compensation carrier proceeded in subrogation against the property owner, because the claimant did not bring his own action. The Superior Court ruled that an action against the third party tortfeasor must be brought by the injured employee, and the carrier does not have the right to bring suit directly against a third party. The issue of appeal as certified by the PA Supreme Court is:

Does section 319 of the Pennsylvania Workers' Compensation Act, 77 P.S Section 671, allow the employer/insurer to step into the shoes of the insured employee against the tortfeasor?

The plain meaning of the statute is at issue. The subject statute states (emphasis added):

> Where the compensable injury is caused in whole or in part by the act or omission of a third party, the **Employer shall be subrogated to the right of the Employee**, his personal representative, his estate or his dependents, against such third party to the extent of the compensation payable under this article by the Employer.

The principle of the *plain meaning rule* operates as a rule of caution: The courts must not change a statute under the guise of interpreting it. If the language of the statute has a "plain meaning," it must be followed. The plain meaning of subrogation is, "the substitution of one person in the place of another with reference to a lawful claim" or, commonly, "the right to step into the shoes of a party who may compensate". *Black's Law Dictionary*.

The certified question was already answered by the Pennsylvania Supreme Court in a recent decision: "Thus, the employer/compensation insurer may step into the shoes of the claimant to recover directly against a third party tortfeasor," *Frazier v. WCAB (Bayada*

Nurses, Inc.), 52 A.3d 241, 248 (2012). The Supreme Court in *Frazier* followed the plain meaning of the statute by interpreting "subrogation" to mean the insurer *may step into the shoes of the claimant*. Unfortunately, the same is not true of Superior Court.

The matter at hand is not the first time the Pennsylvania Superior Court ruled against the subrogation rights of workers' compensation carriers. The Superior Court first discussed denying carriers' rights in *Reliance Ins. Co. v. Richmond Machine*, 455 A.2d 686 (Pa. Super. 1983). The holding of the *Reliance* case is limited and the facts are distinguishable from the matter at hand.

The *Reliance* case was filed after the two-year statute of limitations and the carrier was trying to assert a direct right for contribution and indemnity. The court properly denied that it did not have an independent right of contribution and indemnity and, in fact, its subrogation rights were no greater than the subrogee who was required to file the action within the two-year statute of limitations.

The Superior Court further eroded the subrogation rights in *Whirley Industries, Inc. v. Segel*, 462 A.2d 800 (Pa. Super. 1983), where it opined that the action against a third party tortfeasor must be brought by the injured employee. This created ambiguity since the subrogation action is brought in the name of the injured employee, on behalf of the carrier.

More recently, the Superior Court affirmed the dicta in *Reliance* stating that the carrier does not have a right of subrogation, but only a right of reimbursement in the unpublished Opinion, *Sentry Insurance as Subrogee of Donald J. Rettman v. Van DeCamps, Inc., et al*, 4 A.3d 669 (Pa. Super. 2010, unpublished) followed by the published opinion in *Domtar*. While the result of the Superior Court in *Domtar* is not a surprise, it is contrary to all the rulings of the Pennsylvania Supreme Court on this issue.

The Pennsylvania Supreme Court has always favored protecting the carrier's right to subrogate in the name of the employee. In *Smith v. Yellow Cab Co.*, 135 A. 858 (1927), Smith recovered from a tortfeasor who had notice of a lien. After the tortfeasor refused to compensate the lien holder, the workers' compensation carrier then filed a suit in the name of *Smith* "to the use of" his employer against the tortfeasor. The Supreme Court upheld that the wrongdoer could not escape liability by entering into a settlement with the injured worker, and that "it may fairly be inferred from the language of the workers' compensation statute that the employer may bring suit in order to recover the compensation paid."

In *Scalise v. F.M. Venzie & Co.*, 152 A.90 (1930), an employee was killed in the course of his employment, and his widow filed suit against the responsible parties. The defendants in that action tried to claim that the right no longer belonged to the widow, but rather, to the workers' compensation carrier. The court ruled that the right of action remains with the employee, but that the employer [carrier] may intervene, bring suit in the employee's name if the employee fails to do so, or, be an additional party plaintiff.

In addition, the Supreme Court favored subrogation in several other decisions, most recently in *Frazier v. WCAB (Bayada Nurses, Inc.*, 52 A.3d 241, 248 (2012). In *Frazier*, the Pennsylvania Supreme Court decided the superiority between subrogation immunity under the Tort Claims Act versus the workers' compensation right of subrogation. Although the court decided that the Tort Claims Act immunity was superior, the court authored strong wording about the rights of subrogation. It noted that the right of subrogation exists both in subrogation *and* reimbursement and, further, analyzed the public policy in favor of subrogation to keep workers' compensation costs down in order to save jobs in the Commonwealth.

Further, the court explicitly upheld *Scalise* and opined that the carrier may step into the shoes of the claimant to recover directly against a third party tortfeasor.

> Fn. 10: While not directly implicated by this case, we note that normally in subrogation, the right of action lies in the injured employee, and the action for subrogation against the third party tortfeasor is brought in the employee's name. Nonetheless, an employer … is not to be denied his right of suit [in subrogation] because the employee does not sue [the third party tortfeasor], but may institute the action in the latter's name.
>
> ***Scalise v. F.M. Venzie & Co.***, 301 Pa. 315, 152 A.90, 92 (1930), as quoted by *Frazier Id.*, 248. (emphasis added)

In summary, the right to subrogation for an employer/insurer is not based on a right of the claimant to maintain a suit against the third party, but is an absolute right granted by the Workers' Compensation Act. If the carrier's right of subrogation was based on the claimant's sole right to bring a suit, than it would be a right of reimbursement and not a right of subrogation. Further, the purpose of subrogation is defeated when defendants are allowed to escape liability and the employer is forced to pay for the negligence of the defendant.

PENNSYLVANIA EMPLOYMENT LAW UPDATE

By Lee C. Durivage, Esquire, Marshall Dennehey Warner Coleman & Goggin, Philadelphia, PA

Third Circuit finds that plaintiff's termination following her failure to execute an offer letter and non-compete agreement was insufficient to sustain an FMLA claim.

O'Donnell v. Passport Health Communications, Inc., 2014 U.S. App. LEXIS 5793 (3d. Cir. 3/28/14)

The plaintiff was informed that her position would be eliminated, and she began interviewing for a new position with the company. Eventually, the plaintiff was offered a new position and informed that she needed to execute an offer letter and non-compete agreement for that new position. However, the plaintiff was continuing to negotiate an increased salary and did not execute the documents as requested. The plaintiff then requested (and was granted) approximately two weeks of leave under the FMLA for anxiety-related issues. While the plaintiff was on leave, the company again requested that she provide the executed documents and informed her that, if she did not provide the executed documents by a certain date, the company would revoke the offer and proceed with the termination of her employment. The plaintiff never provided the executed offer letter or non-compete agreement, and her employment was terminated as a result. Following her termination, the plaintiff filed a lawsuit, alleging that the company interfered with her rights under the FMLA by requiring her to perform work-related tasks while on leave and terminated her employment in retaliation for exercising her rights under the FMLA. In upholding the dismissal of her claims, the Third Circuit expressly noted that "[t]here is no evidence that [the company's] requirement that she sign the forms or the consequences for failing to do so arose because she took leave," particularly because she "knew that she needed to sign the forms well before she invoked her FMLA rights." Moreover, the Third Circuit further noted the company's "*[d]e minimus* contacts did not require [plaintiff] to perform work to benefit the company and did not materially interfere with her leave," as there "is no right in the FMLA to be 'left alone,' and be completely absolved of responding to the employer's discrete inquiries."

Third Circuit upholds court's dismissal of plaintiff's race discrimination claim, finding that a single utterance of the phrase "you people" fails to establish a race discrimination claim.

Miller v. Thomas Jefferson Univ. Hosp., 2014 U.S. App. LEXIS 8130 (3d. Cir. 4/30/14)

The Third Circuit upheld the dismissal of a plaintiff's claims of race discrimination following her dismissal from a nurse anesthetist program. The plaintiff received a failing grade and was dismissed from the program based upon poor performance, including her failure to follow doctors' instructions, her failure to perform procedures property, and concerns "from some of her supervisors that she might kill a patient." Following her dismissal from the program, the plaintiff alleged that she was discriminated against on the basis of her race, including her allegation that a supervisor used the phrase "you people" during the time when she was in the program. In rejecting her claim, the Third Circuit noted that, "[w]e have previously expressed skepticism that use of this phrase alone is 'so revealing of discriminatory animus that it would enable a fact finder to conclude that a discriminatory attitude was, more likely than not, a motivating factor in the decision'" and "[w]e continue to find it unlikely that a single utterance of the phrase 'you people' suffices to establish a claim of racial discrimination." In particular, the Third Circuit found that the plaintiff largely conceded that she made the mistakes that were the subject of her performance evaluations and, as a result, that she was unable to establish that her dismissal was a pretext for discrimination.

An employer's alleged failure to strictly adhere to its progressive discipline policy was insufficient to defeat summary judgment.

George v. Lehigh Valley Health Network, 2014 U.S. Dist. LEXIS 51690 (E.D. Pa. 4/15/14)

The plaintiff alleged gender discrimination following the termination of his employment as a radiology technician at a hospital. The facts presented to the court revealed that the plaintiff had several incidents where he demonstrated difficulties with attitude and anger, which included outbursts toward his co-workers. In addition to these prior incidents, the plaintiff was also provided with a written warning for abusing sick time during his final year of employment. Also, the plaintiff was disciplined for mistakes with the substance of his job duties during the final months of his employment, including performing an incorrect examination on a patient and another incident where the patient blacked out because the examination should have been conducted with the patient lying down. Finally, the plaintiff also began yelling and cursing at a student working at the hospital in front of a patient, which prompted a complaint from the student. Following these later incidents, an investigation was conducted, and the employer made the decision to terminate the plaintiff's employment. During the litigation, the plaintiff argued that the employer's failure to strictly adhere to its progressive discipline policy was evidence that his termination from employment was a pretext for unlawful gender discrimination. The court, however, rejected this argument, noting that, even if it accepted the plaintiff's contention as true (which it did not), the employer's policy indicates that disciplinary action may be initiated at a higher level based upon the seriousness of an offense. More importantly, however, was the fact that the failure to strictly adhere

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to the progressive discipline policy "[i] s simply not the kind of inconsistency that challenged the credibility of [the employer's] proffered reason, because jumping to a higher level of discipline is perfectly consistent with an employer being concerned about an employee's angry outbursts affecting the safety and peace of mind of other employees."

The court granted employer's motion to dismiss, holding that plaintiff's wrist injury was not a disability under the Americans with Disabilities Act as a matter of law.

Trelenberg v. 21st Century Ins. & Fin. Servs., Inc., 2014 U.S. Dist. LEXIS 57051 (E.D. Pa. 4/24/14)

The plaintiff alleged that she sustained a wrist injury during her employment and that the injury resulted in chronic tendonitis, which required her to wear a wrist splint and restricted her lifting to less than 20 pounds. Following her injury, the plaintiff alleged that her employment was terminated in violation of the Americans with Disabilities Act. Following the receipt of her complaint, the employer filed a motion to dismiss, arguing that the plaintiff could not sustain a claim under the Americans with Disabilities Act because she failed to plead sufficient facts supporting her contention that she was "disabled." The plaintiff opposed the motion, arguing that she was disabled in the "major life activities" of lifting and working. In rejecting the plaintiff's argument, the court determined that the plaintiff was not "disabled" under the Americans with Disabilities Act. In so holding, the court reasoned that plaintiff failed to plead any facts demonstrating that her alleged lifting restriction was "substantial" (as required by the ADA), as she readily admitted that she could perform the essential functions of her job. Similarly, the court noted that the plaintiff merely asserted that she could not perform one facet of her position (lifting boxes of copy paper), as opposed to the requirement that she was precluded from performing a broad class of jobs due to her alleged "disability." This opinion demonstrates the importance of questioning plaintiffs about their potential job limitations in disability discrimination cases, as their deposition testimony will often demonstrate that they can, in fact, perform the essential functions of a variety of positions.

Pennsylvania Workers' Compensation Update

By Francis X. Wickersham, Esquire, Marshall Dennehey Warner Coleman & Goggin, King of Prussia. PA

Pennsylvania Supreme Court Vacates Commonwealth Court Decision Finding Psychic Injury Suffered By Liquor Store Clerk Robbed At Gunpoint Not Compensable.

Kochanowicz v. Workers' Comp. Appeal Bd. (Pa Liquor Control Bd.), 2014 Pa. LEXIS 410

In a *per curiam* order from February 2014, the Supreme Court of Pennsylvania vacated a Commonwealth Court decision that found a post-traumatic stress disorder (PTSD) claim, made by a liquor store clerk robbed at gunpoint, not compensable and remanded it to the Commonwealth Court for reconsideration. The Commonwealth Court had held that the psychic injury claim was not compensable since the injury was the result of normal working conditions, a conclusion the court based on the frequency of such incidents in the area. The Commonwealth Court was also swayed by evidence from the employer that the claimant received considerable training on workplace violence before the robbery occurred.

However, the Pennsylvania Supreme Court felt compelled to have the Commonwealth Court revisit the case in light of the Supreme Court's recent opinion in *Payes v. WCAB (Commonwealth of PA State Police)*; 79 A.3rd 543 (Pa. 2013). In that case, the Supreme Court reversed a Commonwealth Court's decision which held that a psychic injury claim made by a Pennsylvania state trooper after striking a woman in his patrol car to be not compensable.

In the Supreme Court's view, the Commonwealth Court in *Kochanowicz* overlooked the highly fact-sensitive nature of psychic injury claims and erred by not accepting the well-supported facts found by the judge, which established the existence of an extraordinarily unusual and distressing single work event that resulted in the claimant's disabled mental condition. According to the Supreme Court, such an event constituted abnormal working conditions as a matter of law.

An employer will not be penalized for a utilization review organization's (URO) failure to timely issue a determination in accordance with the Act, as the URO was not a party to the utilization review petition.

Lancess Womack v. WCAB (School District of Philadelphia); 1137 C.D. 2013; filed 1/14/14; by Judge Brobson

Following a decision from a WCJ finding that the claimant sustained work-related injuries, the employer filed a request for utilization review (UR) of the provider's treatment for the period beginning August 19, 2010, and ongoing. A UR determination was issued on November 15, 2010. The reviewer found that the treatment was unreasonable and unnecessary. The provider then filed a utilization review petition. The judge issued a decision dismissing the utilization review petition and finding that the treatment

was not reasonable or necessary. The claimant appealed to the Board, which affirmed.

At the Commonwealth Court level, the claimant argued that the utilization review determination was null and void since it was not issued by the URO in a timely manner. The court noted that a request for utilization review is considered complete upon the URO's receipt of pertinent medical records or 35 days from the assignment of the matter by the Bureau of Workers' Compensation, whichever is earlier. At the latest, a URO has 65 days from the date of assignment to issue a written report. Here, the assignment to the URO was made on September 21, 2010. The URO then received records on October 5, 2010, which meant that the URO had until November 4, 2010, to issue its written determination. It did not do so, however, until November 15, 2010. The court rejected the claimant's argument that the utilization review determination should be null and void. It pointed out that the employer did not fail to follow any prescribed statutory time period in either the Act or the regulations. The court held that the entity that failed to comply with the statutory and regulatory requirement was not a party, nor was it under the control or supervision of a party. They rejected the claimant's request to penalize the employer for a dereliction that was not of their doing.

An insurer is entitled to subrogation under §319 of the Pennsylvania Workers' Compensation Act for injuries sustained by the claimant while driving in Delaware during the course and scope of employment.

Natasha Young v. WCAB (Chubb Corporation and Federal Insurance Company); 1432 C.D. 2013; filed 3/10/14; by Judge Cohn Jubelirer

The claimant sustained injuries in a motor vehicle accident that took place in Delaware, while in the course and scope of her employment, and she received workers' compensation benefits pursuant to the Pennsylvania Workers' Compensation Act. The claimant then reached a settlement of a third party action that had been filed in Delaware. The insurer filed a petition to review to recover their subrogation lien under §319 of the Act.

The claimant took the position that the laws of Delaware, not Pennsylvania, applied with respect to employer's subrogation rights. Delaware law follows a more equitable approach, whereas under §319 of the Pennsylvania Act, an employer's right to subrogation is absolute.

The WCJ granted the employer's review petition, and the Workers' Compensation Appeal Board affirmed. The claimant then appealed to the Commonwealth Court.

On appeal, the claimant argued that Delaware law applied since Delaware had more significant contacts to the matter than Pennsylvania. The court, however, rejected this argument and affirmed the decisions below. The court concluded that Pennsylvania had more significant contacts with the underlying controversy than Delaware. Although the litigation from which the lien arose occurred and was governed by the laws of Delaware, the claimant was a resident of Pennsylvania and the employer did business in Pennsylvania while holding a Pennsylvania workers' compensation insurance policy. More importantly, the claimant availed herself of the Pennsylvania Act, the employer paid benefits under the Act, and all of the litigation concerning the claimant's receipt of workers' compensation benefits had been in Pennsylvania pursuant to the Act. For that matter, the claimant had entered into a C&R agreement under the Act in which she affirmed the employer's subrogation lien.

Employer's modification petition that is based on the results of an IRE was properly dismissed because the IRE physician failed to satisfy §306 (a.2) of the Act by not being active in clinical practice for at least 20 hours per week.

Verizon Pennsylvania, Inc. v. WCAB (Ketterer); 1188 C.D. 2013; filed 3/12/14; by Senior Judge Colins

The claimant began receiving workers' compensation benefits for injuries he sustained in a work-related motor vehicle accident. The employer filed a request to the Bureau to designate a physician to perform an IRE. The physician selected performed the IRE and concluded that the claimant had an impairment rating of 16 percent. The employer then filed a modification petition based on the results of the IRE.

The IRE physician was Board Certified in occupational medicine and received training on the AMA Guides, 6th Edition. In addition, the physician was approved by the Bureau as a certified IRE physician. At the time of the IRE, however, the physician did not treat or manage the care of any patients. Her practice consisted solely of workers' compensation IMEs, IREs, physical examinations for pilots to determine certification requirements, commercial driver's license examinations, utilization reviews and peer reviews. In fact, at the IRE physician's deposition, she said that her practice at the time the IRE was performed was mostly administrative.

The judge denied the modification petition on the grounds that the IRE physician did not meet the requirement of §306 (a.2) (1) of the Act, which says that physicians performing IMEs must be active in clinical practice at least 20 hours per week. In deciding this issue, the court turned to the Bureau Regulations. In the court's view, the regulations require that a physician's work involve some connection to the care or treatment of patients in order to constitute a "clinical practice." The court rejected employer's argument that the legislative intent of the "clinical practice" requirement was only to ensure that IRE physicians were up-to-date in their qualifications and medical knowledge. The employer further argued that the clinical practice requirement would exclude competent occupational medicine physicians from performing IREs, who generally do not have private patients. The court rejected this position as well. According to the court, the "clinical practice" requirement was broad and may be satisfied by treatment or

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management of injuries as a panel physician hired by the employer or workers' compensation insurer.

The Workers' Compensation Judge properly granted a claim petition even though the claimant's medical expert testified that he thought the claimant's condition would continue to improve and projected the claimant's ability to return to work.

Pennsylvania Uninsured Employer's Guaranty Fund v. WCAB (Bonner & Fitzgerald); 300 C.D. 2013; filed 2/12/14; by Judge McCullough

The claimant, who worked as a laborer, fell from a roof and landed on a cement slab. He suffered a seizure and was placed in a drug induced coma for one week. The claimant was diagnosed with a skull fracture, seizures and left eye injury. The claimant filed a claim petition against the employer, and then a claim petition against the Fund, since the employer was uninsured.

In testifying in connection with the claim petition, the claimant said he did not think he could go back to work since he continued to experience headaches, difficulty with balance and pain in his left eye. He also presented testimony from a medical expert, who said that the claimant sustained a moderate traumatic brain injury and that he was unable to work as a laborer as of the last time he saw the claimant. On cross examination, the expert said that he thought the claimant's condition would continue to improve and that, when he last saw the claimant, he thought he would be able to return to work in six weeks, pending test results.

The WCJ granted the claim petition, and the Fund appealed. The Board affirmed the judge's decision, concluding that the claimant's medical expert's testimony provided substantial evidence to support the judge's finding that the claimant's disability extended beyond November 25, 2009 (the last time the expert saw the claimant).

The Commonwealth Court agreed and affirmed the decision of the Board. The court pointed out that a claimant's medical expert is not required to be an eyewitness to the claimant's disability throughout the pendency of a claim petition. They further found the claimant's expert's testimony to be "speculation," as the expert anticipated the claimant would be able to go back to work. The court held that in light of this speculative testimony and the claimant's testimony that total disability from his work injuries continued, the judge properly denied the employer's request for a suspension of benefits as of the last date the claimant's expert saw him.

Defendant's joinder petitions, which were filed more than 20 days after evidence was presented that provided the basis for the joinders, were properly dismissed as untimely.

Pennsylvania Uninsured Employers Guaranty Fund v. WCAB (Dudkiewicz, Deceased, Builders Prime Window and T.H. Properties); 1540 C.D. 2013; filed 4/7/14; by Judge McCullough

The claimant filed a claim petition against Employer A and the Uninsured Employers Guaranty Fund (UEGF), alleging that, while employed as a laborer for Employer A, he sustained multiple injuries after falling from a second story roof. The UEGF filed an answer denying the allegations and the existence of an employment relationship. At the first hearing, the parties requested bifurcation of the employment issue, and the claimant testified as to the entire case. The WCJ stated that he did not want the case to drag out, given that the claimant was homeless, and imposed a litigation deadline on the parties. The proceedings, however, were delayed, and the judge extended the deadline with the proviso that the case be concluded expeditiously.

At a hearing of May 20, 2010, Employer A testified that he was a sub-contractor for Defendant B and that Defendant C was the owner of the construction site. Counsel for UEGF informed the judge that the UEGF planned to file a joinder petition. Seven days after the hearing, UEGF filed a joinder petition against Defendant B. On September 3, 2010, UEGF filed a second joinder petition against Defendant C. The judge then issued an interlocutory order dismissing both joinder petitions as untimely and finding, alternatively, that the petitions did not comply with the applicable regulations.

Ultimately, the judge granted the claim petition and found that the claimant was an employee of Employer A. The UEGF appealed to the Appeal Board, which affirmed the judge's decision and his dismissal of the joinder petitions.

On appeal to the Commonwealth Court, the UEGF argued that the joinder petition filed against Defendant B was in compliance with the regulations in that the 20-day deadline for filing a joinder petition did not begin to run until the hearing on May 20, 2010, at which time, Employer A testified that he was a sub-contractor for Defendant B. But, the court pointed out that the claimant testified at the first hearing on February 9, 2010, that it was his understanding that Employer A was installing windows for Defendant B. According to the court, the 20-day time period for filing a joinder petition began at that hearing. The court held, therefore, that the judge properly dismissed the joinder petition and did not abuse his discretion in doing so.

In a claim petition where there is both a documented work injury—either by adjudication or acceptance—and that injury gives rise to disability, the proper burden of proof is that of a reinstatement petition.

Philip Furnari v. WCAB (Temple Inland, et al.); 1171 C.D. 2013; filed 4/10/14; by Judge Covey

The claimant sustained a work-related injury to his right knee. Thereafter, the employer issued a medical only NCP. The employer also agreed to continue paying the claimant's salary. The claimant returned to work on modified duty, and the employer continued paying full salary. The claimant then resigned, at which time the employer stopped paying his salary. The claimant filed a reinstatement petition,

alleging his injury had worsened and that his earning power was affected.

The WCJ denied the reinstatement petition on the basis that the employer's issuance of the medical only NCP and its payment of the claimant's salary was a *de facto* NCP and that the claimant failed to meet his burden of proving his condition had worsened such that he could not perform a modified-duty job. The Appeal Board affirmed the judge's decision on appeal. However, the Board disagreed with the finding that the medical only NCP was a *de facto* NCP. The claimant appealed to the Commonwealth Court.

The claimant first argued that the Judge improperly used the burden of proof for a claim petition rather than a reinstatement petition (in the underlying case, the claimant amended his reinstatement petition to a claim petition). The court held, however, that the judge did use the burden of proof for a reinstatement petition. According to the court, the employer's issuance of a medical only NCP, along with salary continuation to the claimant and evidence from the employer that the claimant was a valued employee whom they intended to transition back to work, established a *de facto* NCP. Therefore, the court concluded that the judge properly found that the claimant failed to meet his burden of proof on a reinstatement petition. The court also rejected the claimant's argument that the *de facto* NCP obligated the employer to pay him workers' compensation benefits since the employer did not file a suspension petition after the claimant resigned from the employer. The court found that the judge properly suspended the claimant's benefits without a formal petition since strictness of pleadings is not required in workers' compensation cases and because the judge is empowered to take appropriate action based on the evidence presented.

A presumption of prejudice does not exist in every case where an employer seeks to recover an overpayment of compensation made to a claimant also receiving pension.

City of Pittsburgh & UPMC Benefit Management Services, Inc. v. WCAB (Wright); 329 C.D. 2013; filed 5/1/14; Judge Leavitt

The claimant, a firefighter, sustained a work injury. The employer accepted liability and paid the claimant Heart and Lung benefits equal to his full salary for over a year after the injury. The claimant then elected to take a disability pension, and the Heart and Lung benefits were replaced with workers' compensation benefits. For a period of approximately two months, the employer paid the claimant total disability workers' compensation without an offset for the disability pension the employer was also paying. The employer later issued a Notice of Workers' Compensation Benefit Offset form (LIBC-761), which indicated that benefits were being reduced for an offset the employer was taking for the disability pension. The form also stated that the employer was further reducing the claimant's weekly wage loss benefit by $100 a week for an overpayment of compensation made during the period of time the claimant received both temporary total disability benefits and pension benefits.

The claimant then filed a petition to review the offset, alleging that the calculation was wrong. Additionally, the claimant challenged the employer's attempt to recoup the overpayment on the basis of financial hardship and argued that the employer was not entitled to any offset since he was never provided with an LIBC-756 form (employee's report of benefits for offsets) before notifying him of its intention to take an offset. However, this argument was made after the record was closed, and the WCJ found that the claimant waived it. Nevertheless, the judge determined that the employer was not required to issue form LIBC-756 before taking the offset since they were already aware of the pension. The judge agreed, however, that the employer was barred from recouping the overpayment due to the financial hardship it would cause. The judge allowed the employer an ongoing pension offset, but disallowed the recovery of the overpayment. The judge also ordered the employer to reimburse the claimant the full amount recouped. Both the claimant and the employer appealed to the Workers' Compensation Appeal Board.

The Board affirmed the judge. Although they agreed that the claimant had waived the issue of the LIBC-756 form being sent before taking an offset, they nevertheless held that tender of the form was a condition precedent to recovering an overpayment of benefits in every case. The Board also concluded that the employer was not entitled to a recoupment of the overpayment. The employer appealed.

The Commonwealth Court held that the issue of the employer's failure to provide the claimant with LIBC-756 form before recouping its overpayment was waived by the claimant and, therefore, did not address the judge's holding that the employer did not have to issue the form before taking its offset. The court then addressed whether the employer's recovery of the amount it overpaid to the claimant was barred by equitable principles and whether there was a "presumption of prejudice" whenever an employer seeks to recoup an overpayment of offset benefits. The court held there was no such presumption in every case. The court noted that the overpayment in question covered a period of weeks and not a period in excess of six months, and it found that the employer's recoupment of the $100 per week from the claimant was permissible.

Dismissal of claim petition was proper where the claimant failed to prove extraterritorial jurisdiction for a work injury that occurred in New York State while the claimant was working at a New York job site.

Charles Greenwalt v. WCAB (Bristol Environmental, Inc.); 1894 C.D. 2013; filed 5/12/14; Judge Simpson

The claimant filed a claim petition alleging that he sustained a work-related low back injury while working for the employer. The employer took the position that Pennsylvania lacked

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jurisdiction since the claimant's injury occurred in New York and because the claimant's injury did not occur in the course and scope of employment. The WCJ dismissed the claim petition, determining that the claimant did not prove that jurisdiction in Pennsylvania was proper under §305.2 of the Act. Specifically, the judge found that at the time of injury, the claimant worked under a contract of hire made in Pennsylvania for employment that was principally localized in New York. The claimant, a union laborer, accepted a job with the employer at a job site in New York State that was located by a business agent. While in New York, the employer obtained lodging for the claimant. The claimant would work throughout the week and return home to Pennsylvania on weekends. The claimant alleged that he hurt his back from a slip and fall on ice as he was walking to his car to warm it up before leaving for the job site.

The claimant appealed, and the Appeal Board affirmed. The claimant then appealed to the Commonwealth Court. It was the claimant's contention that his employment was principally localized in Pennsylvania and argued that he was hired in Pennsylvania, trained in Pennsylvania and completed over 30 jobs in the past for the employer in Pennsylvania. Further, the claimant maintained that the job in New York was expected to last only three months for the claimant. Alternatively, the claimant argued that, if it was found that employment was not localized in Pennsylvania, it must be found that employment was not localized in any state, thereby making jurisdiction proper under §305.2 (a) (2) of the Act.

The Commonwealth Court, however, rejected the claimant's arguments and affirmed the judge's decision. According to the court, the judge's findings revealed that the claimant's employment was principally localized in New York and not in Pennsylvania. It pointed out that in finding whether employment is principally localized in a given state under the Act, one must consider whether a claimant worked at the location as a rule and not as an exception. The court concluded that the judge's findings showed that the claimant worked exclusively at a New York job site after undergoing a week of training in Pennsylvania needed to start that work. Further, the court held that the judge correctly determined that various jobs the claimant performed previously for the employer did not establish a continuous employment relationship for the purposes of determining where employment was principally localized.

An order from the Judge denying a claim made against the Uninsured Employers Guaranty Fund on the basis of untimely notice was properly reversed where evidence showed that the claimant did not know of the employer's uninsured status until being notified of that possibility by the Bureau.

Pennsylvania Uninsured Employers Guaranty Fund v. WCAB (Lyle and Walt and Al's Auto and Towing Service); 1421 C.D. 2013; filed 5/12/14; Judge Covey

The claimant worked for the employer as a mechanic and sustained a compression fracture injury in the course and scope of his employment. The claimant filed a claim petition, and the employer did not respond. The claimant attempted to have medical bills paid through the employer's automobile liability insurance provider and then through the claimant's first party benefits automobile liability insurer, but both companies denied his claims. Thereafter, the Bureau informed the claimant by letter that the employer may not have had workers' compensation insurance. Four days after receiving this letter, the claimant mailed a Notice of Claim Against Uninsured Employer (notice) to the Bureau. Twenty-five days after the letter, the claimant filed a claim petition with the Bureau, seeking benefits from the employer and the Uninsured Employers Guaranty Fund (Fund). The Fund challenged the petition and took the position that the claim was barred due to the claimant's failure to comply with the notice requirements for making a claim against the Fund.

The WCJ granted the claim petition filed against the employer, but denied the claim petition filed against the Fund on the basis that the claimant did not give timely notice to the Fund. On appeal, the Appeal Board reversed the dismissal of the claim against the Fund, holding that notice was timely. The Fund appealed to the Commonwealth Court.

The court noted that the claimant filed his notice with the Fund within 45 days of receiving the Bureau's letter stating that the employer may not be insured. The court found that this was compliant with §1603 (b) of the Act, which provides that an injured worker shall notify the Fund within 45 days after the worker knew that the employer was uninsured. The question for the court was whether the letter was the first point at which the claimant knew the employer was uninsured. The judge found that the claimant knew of the employer's uninsured status before receiving the letter from the Bureau. The Commonwealth Court held otherwise. In the Commonwealth Court's view, the Board properly reasoned that §1603 (b) of the Act is triggered when a claimant "knew" rather than "should have known." The court pointed out that when the claimant learned medical bills were not being paid, he notified the employer, who repeatedly assured him that the problem was being investigated. In addition, when the payment of the claimant's medical bills was denied by the employer's automobile liability insurance carrier, there was no indication in the letter denying the claim that the medical bills would be covered under the employer's workers compensation insurance, nor did it state that the workers' compensation coverage had lapsed. The court, thus, held that the judge's finding that the claimant had knowledge of the employer's uninsured status months before receiving the letter from the Bureau was not supported by the evidentiary record and, therefore, concluded that the claimant gave timely notification to the Fund.

The court vacates Judge's decision dismissing employer's modification petition on the basis that the claimant was not at maximum medical improvement at the time of an IRE where the only evidence of record on the issue of MMI was the opinion of the IRE physician.

Arvilla Oil Field Services, Inc. and State Workers Insurance Fund v. WCAB (Carlson); 1578 C.D. 2013; filed 5/20/14; Judge Leavitt

The claimant sustained a work-related injury to his right hip, low back and right shoulder, which was accepted by the employer by way of notice of compensation payable (NCP). Later, the claimant underwent arthroscopic surgery on the right hip, followed by a total hip replacement. The employer then filed a modification petition, alleging that the claimant had fully recovered from his low back and right shoulder injuries, but stipulated that the claimant had not fully recovered from the hip injury. In connection with that petition, the claimant's medical expert testified and said that the claimant was making progress with treatment, but experienced periodic setbacks. The claimant then filed a petition to review to add lumbar radiculopathy and lumbar spondylosis to the NCP.

Before the pending petitions were decided, the claimant was seen for an IRE. The IRE physician concluded that the claimant had a 10% impairment rating. The employer filed another modification petition based on the IRE results. In support of that petition, the employer relied on the deposition of the IRE physician, who said that, at the time of the exam, the claimant had reached maximum medical improvement (MMI). The claimant presented no evidence in opposition to the opinion given by the IRE physician.

The WCJ granted the employer's modification petition in part, concluding that the claimant had fully recovered from his right shoulder injury. However, the judge also concluded that the claimant had not fully recovered from his low back injury. The judge also dismissed the employer's modification petition based on the results of the IRE, rejecting the opinion of the IRE physician that the claimant had reached MMI. In doing so, the judge relied on the testimony given by the claimant's expert that he was continuing to make progress but continued to experience setbacks. The employer appealed, and the Appeal Board affirmed.

The Commonwealth Court vacated the decisions below, concluding that the judge capriciously disregarded the only competent medical evidence of record on whether the claimant reached MMI for purposes of an IRE. The court pointed out that the claimant's medical expert did not testify on the issue of MMI. The court also concluded that it could not be inferred from the deposition of the claimant's expert whether the claimant had not reached MMI at the time of the IRE. The court remanded the case to the judge and held if the judge chooses to reject what is uncontroverted evidence, the judge must adequately explain the reasons for his or her rejection and could not reject it for no reason or an irrational reason.

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