PENNSYLVANIA SUPREME COURT RULES IN FAVOR OF POLICYHOLDERS ON BAD FAITH STANDARD

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Insurance Coverage Alert

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The Pennsylvania Supreme Court just made it easier for policyholders to hold their insurers accountable for bad faith conduct. In *Rancosky v. Washington National Insurance Company* (No. 28 WAP 2016), the Supreme Court held that, to prevail on a bad faith action, a policyholder must present clear and convincing evidence: (1) that the insurer did not have a reasonable basis for denying benefits under the policy; and (2) that the insurer knew of or recklessly disregarded its lack of a reasonable basis. In reaching this decision, the Court rejected insurance industry arguments that policyholders must prove subjective ill will or malice to prevail on a bad faith claim. As the Court noted, a malice standard would have made it much more difficult for policyholders to prove bad faith in Pennsylvania.

BACKGROUND

The *Rancosky* case reads like a case study in insurer bad behavior. In March of 1992, LeAnn Rancosky purchased a cancer insurance policy from Conseco Health Insurance Company. To pay for the policy, Ms. Rancosky's employer deducted bi-weekly premium payments from her paycheck. The policy provided, among other things, that the policyholder was excused from making premium payments if she was diagnosed with cancer and unable to work for more than 90 consecutive days.

On February 4, 2003, Ms. Rancosky was admitted to the hospital with intense abdominal pain. She was later diagnosed with ovarian cancer and underwent surgery and chemotherapy treatment. Though she never returned to work, she remained on her employer's payroll for several months and continued to make premium payments via payroll deduction until June 24, 2003. Because premium payments were made in arrears, the June 24, 2003 premium payment extended coverage through May 24, 2003 (more than enough time to qualify for waiver-of-premium status). Beginning in April 2003, Ms. Rancosky made several attempts to obtain waiver-of-premium status, stating she was unable to work due to cancer beginning on February 4, 2003.

In May 2004, Ms. Rancosky's cancer returned, and she began another course of chemotherapy. In early 2005, Conseco discovered, apparently for the first time, that Ms. Rancosky had discontinued making premium payments in June 2003. Conseco subsequently informed Ms. Rancosky that her policy had lapsed as of May 24, 2003. At Conseco's request, Ms. Rancosky submitted a waiver-of-premium claim form that included a statement from her physician. Unbeknownst to Ms. Rancosky, her physician's statement incorrectly listed her date of disability as beginning on April 21, 2003, rather than February 4, 2003. Conseco, however, did not advise Ms. Rancosky that

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there was any problem with her renewed request for waiver-of-premium status. On July 18, 2005, Conseco paid Ms. Rancosky's claim for medical services received in 2004 and 2005.

In 2006, however, following another recurrence of her cancer, Conseco denied Ms. Rancosky's claim for further benefits based on her alleged failure to pay premiums. In response, Ms. Rancosky asked Conseco to reconsider its decision, again reiterating her oft-stated assertion that she was excused from making additional premium payments because she was disabled within the meaning of the policy beginning on February 4, 2003. Ms. Rancosky also expressed her growing frustration with Conseco:

> I am battling cancer. I shouldn't have to battle an insurance company who doesn't honor their contracts. I signed your contract in 1992 and had premiums paid through payroll deduction until June 14, 2003, at which time I went on disability retirement. I have filled out every form you send me, some twice. I feel my cancer insurance coverage has been cancelled in error and believe my policy should be reinstated and reimbursed for the claims I submitted in March 2006.

In evaluating Ms. Rancosky's request for reconsideration, Conseco reviewed its in-house documentation, which included contradictory information regarding the start date of her disability. Notwithstanding numerous authorizations by Ms. Rancosky permitting Conseco to contact her employer, physician, or anyone else with information regarding the actual start date of her disability, and a variety of information that supported Ms. Rancosky's waiver-of-premium status, including hospital records from February 2003, Conseco simply "*accepted*" the April 21, 2003 start date listed on one of the physician statements she submitted (other physician statements she submitted over the years listed different start dates) and took the position that her policy lapsed due to nonpayment of premiums. As a result, Conseco denied her request for reconsideration.

LAWSUIT AND LOWER COURT DECISIONS

Ms. Rancosky subsequently filed a lawsuit against Conseco, alleging breach of contract and bad faith pursuant to 42 Pa.C.S.A. § 8371. Section 8371 provides as follows:

> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions: 1. Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%. 2. Award punitive damages against the insurer. 3. Assess court costs and attorney fees against the insurer.

Ms. Rancosky's bad faith claim eventually proceeded to a nonjury trial. Though the trial court found that Conseco was "*sloppy and even negligent*" in its handling of Ms. Rancosky's claim, it ultimately found in favor of Conseco because it held that she did not prove that the insurer acted out of some motive of self-interest or "*ill will*." On

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appeal, however, the Pennsylvania Superior Court vacated the trial court's judgement and held that Ms. Rancosky was not required to prove self-interest or ill will to prevail on her bad faith claim.

PENNSYLVANIA SUPREME COURT DECISION

The Pennsylvania Supreme Court affirmed the judgment of the Superior Court and held that, to prevail on a bad faith action, a policyholder must present clear and convincing evidence: (1) that the insurer did not have a reasonable basis for denying benefits under the policy; and (2) that the insurer knew of or recklessly disregarded its lack of a reasonable basis.

In reaching this decision, the Supreme Court rejected Conseco's argument that policyholders must prove subjective ill will or malice to prevail on a bad faith claim. The Court also rejected Conseco's argument that a higher standard of proof is necessary when a policyholder seeks punitive damages. As the Court noted, a malice standard would have made it much more difficult for policyholders to prove bad faith in Pennsylvania:

> Given our conclusion that there is no basis to distinguish between punitive damages and other categories of damages under Section 8371, an ill-will level of culpability would limit recovery in any bad faith claim to the most egregious instances only where the plaintiff uncovers some sort of “smoking gun” evidence indicating personal animus towards the insured. We do not believe the General Assembly intended to create a standard so stringent that it would be highly unlikely that any plaintiff could prevail thereunder when it created a remedy for bad faith. Such a construction could functionally write bad faith under Section 8371 out of the law altogether.

The *Rancosky* case is a perfect example of why malice is too high a standard for insurer bad faith. Reading the facts of the case (particularly as set forth in the Superior Court opinion), you get the strong impression that Conseco was looking for reasons to deny Ms. Rancosky's claim rather than conducting a good faith investigation into whether she qualified for waiver-of-premium status. At the same time, there was no "smoking gun" document and Conseco had plausible deniability in the form of the physician's statement that incorrectly listed April 21, 2003 as the start date for Ms. Rancosky's disability. But we should expect more from our insurers than plausible deniability that they are acting in bad faith. We should expect our insurers to conduct a good faith investigation of every claim presented to them. And we should expect our insurers to bear the consequences if they fail to do so.

To that end, it is significant that the Pennsylvania Supreme Court did not try to "split the baby" and impose a higher standard for proving bad faith on policyholders seeking punitive damages. The realistic threat of punitive damages is what will hold insurers accountable for their actions. If the Supreme Court had decided to impose a higher standard of bad faith on policyholders seeking punitive damages, it would still have been a good decision for policyholders, but it would not have had as much teeth. As it stands now, insurers will take notice of this decision and policyholders will be the beneficiaries.

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