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IN THE COURT OF COMMON PLEAS FOR CENTRE COUNTY PENNSYLVANIA
CIVIL DIVISION

MOUNTAINSIDE HOLDINGS, LLC, DOUGLAS R COLKIT, M.D., JOANNE RUSSELL and JEROME DERDEL, M.D., Plaintiffs, vs. AMERICAN DYNASTY SURPLUS LINES INSURANCE COMPANY and GREAT AMERICAN INSURANCE COMPANY, Defendants.	No. 2003-127

Opinion and Order on Defendants' Motion for Summary Judgment

Presently before the Court is Defendants' Motion for Summary Judgment on Counts I and II of Plaintiffs' Amended Complaint, in which insured Plaintiffs allege Breach of Contract and Bad Faith against insurer Defendants.

Count I of the Plaintiffs' action seeks coverage for certain costs the Plaintiffs incurred defending and settling a *qui tam* complaint. Plaintiffs allege they are entitled to indemnification of those costs under a tertiary Director and Officer liability insurance policy (hereinafter "Policy") issued by Defendants. Count II of Plaintiffs' action is a tort claim in which Plaintiffs allege Bad Faith under 42 Pa.C.S.A. § 8371[1].

Defendants' basis for their summary judgment motion is based on four parts[2]—two for each count: 1) Plaintiffs' Bad Faith allegations are time-barred; 2)

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[1] Actions on insurance policies

[2] The Court will address these issues in the order in which they appear in Defendants' Motion for Summary Judgment.

even if Plaintiffs' Bad Faith allegations were not time-barred, Plaintiffs cannot, as a matter of law, meet their burden of proving Bad Faith; 3) Plaintiffs cannot, as a matter of law, prove that Defendant breached their agreement, as it is undisputable that Plaintiffs had not incurred a Loss covered under Defendants' excess insurance policy, triggering Defendants' layer of coverage; and 4) even if Plaintiffs' did have a covered Loss within the layer of Defendants' excess insurance policy, Defendants were not liable for payment based on the subject insurance policy's "Prior and Pending Litigation" exclusion; therefore, Plaintiffs cannot recover, as a matter of law.

The parties have submitted briefs in support of their positions and presented oral arguments. The Court is now ready to render its decision.

RELEVANT FACTS

1. EquiMed, Inc. was a corporation with a principal place of business in State College, Centre County, Pennsylvania
   a. EquiMed was incorporated on February 2, 1996 as a Delaware Corporation.
   b. EquiMed was a management company which, through its subsidiaries, provided comprehensive services to specialty medical providers, including radiation oncologists.
2. Douglas R Colkitt, M.D. (hereinafter "Colkitt") was an officer and director of EquiMed.
3. Joanne Russell and Jerome Derdel are individuals who were officers and directors of EquiMed, Inc.

4. On May 9, 1996, Steadfast Insurance Company issued a Director and Officers Liability insurance Policy (hereinafter "Steadfast Policy") to EquiMed, Inc.

   a. The Steadfast Policy was a Primary Policy.

   b. The Steadfast Policy limit was $5 million.

   c. An *insured person* is defined as a "duly elected director or duly elected or appointed officer of the Company." Policy § III(F)

   d. A *claim* is "a civil proceeding commenced by the service of a complaint or similar pleading...against any Insured Person for a Wrongful Act, including any appeal therefrom." Policy § III(A)(2)

   e. a *Loss* is "the amount which the Insured Persons become legally obligated to pay on account of each Claim...made against them for Wrongful Acts for which coverage applies, including but not limited to, damages, judgments, settlements, and Defense Costs." Policy § III(H)

   f. The language of the "Pending or Prior Date" clause (hereinafter "PPD clause") states

      > Claim made against any Insured Person...based upon, arising out of, or attributable to any demand, suit or proceeding pending, or order, decree or judgment entered against the Company or any Insured Person on or prior to the Pending or Prior Date set for in Item 8 of the Declarations, or the same or substantially the same fact, circumstance or situation underlying or alleged therein.

      Policy § IV(A)(2)

   g. The PPD clause date is January 24, 1996.

5. Around the time of the issuance of the Steadfast Policy, Reliance National Insurance Company issued an excess Director and Officers Liability insurance Policy (hereinafter "Reliance Policy") to EquiMed, Inc.

a. The Reliance Policy was an excess policy, secondary to the Steadfast Policy.

b. The Reliance Policy limit was $5 million.

6. On or about February 25, 1997, Great American Insurance Company issued a Director and Officers Liability insurance Policy (hereinafter "Policy" or "GAF Policy") to EquiMed, Inc.

a. The GAF Policy was an excess policy, tertiary to the Steadfast Policy and Reliance Policy.

b. The GAF Policy limit was $10 million.

c. The GAF Policy was issued retroactively, so that the initial policy period was January 24, 1997 through January 24, 1999.

d. A pertinent portion of key language of the Policy state

...this Policy shall then apply subject to the following:

A. the terms, conditions, exclusion and endorsements of the Underlying Insurance; and

...

C. the terms, conditions, exclusions and endorsements of this Policy.

e. The Language of the "Prior or Pending Litigation" exclusion of the Policy states,

> The Insurer shall not be liable to make any payment for loss by reason of or in connection with any litigation, proceeding, administrative act or hearing brought prior to or pending as of 1/24/97 as well as any future litigation, proceeding, administrative act or hearing based upon any such pending or prior litigation, proceeding, administrative act or hearing or derived from the essential facts or circumstances underlying or alleged in any such pending or prior litigation, proceeding, administrative act or hearing.

7. On February 3, 1995, Sayed Rahman, M.D. filed suit against Oncology Associates, P.C., Oncology Services Corporation, and Douglas Colkitt, M.D., alleging breach of contract, fraud, and tortious interference with contract in connection with Dr. Rahman's termination from employment at the Union Memorial Cancer Center in Baltimore, MD (hereinafter "Rahman Action").
    a. EquiMed, Inc. was not named in this action, nor could it be, as EquiMed, Inc. did not exist until February 2, 1996.
    b. In his Complaint, Dr. Rahman alleged he was terminated from his position as a radiation oncologist, in part, because he questioned the billing practices of Oncology Services Corporation and Oncology Associates, P.C.
    c. As part of that litigation, Plaintiffs (defendants in the Rahman action) filed a Motion In Limine To Exclude Evidence Of Alleged Overbilling. Def Ex. 4.
    d. Colkitt was dismissed from the action prior to judgment being rendered.
8. On August 2, 1995, a *qui tam* complaint, brought pursuant to the False Claims Act, 31 U.S.C. §§3729-33, was filed against Oncology Associates, P.C., Oncology Services, Douglas Colkitt, M.D., and Jerome Derdel, M.D.
    a. EquiMed, Inc. was not named in this action, nor could it be, as EquiMed, Inc. did not exist until February 2, 1996.
    b. The *qui tam* complaint was filed under seal *in camera* and was not served on any of the defendants.
9. On August 12, 1996, an amended *qui tam* complaint was filed.
    a. The amended complaint was filed under seal *in camera.*
    b. The amended complaint added EquiMed, Inc. and others to the action.

10. Oncology Associates, P.C. and Oncology Services were not at any time subsidiaries or associates of EquiMed, Inc.

11. In December 1997, EquiMed, Inc. learned of the *qui tam* action.

12. In a letter dated February 20, 1998, Marcy L. Colkitt informed Defendants, Steadfast, and Reliance that the Plaintiffs had learned in December of 1997 of the *qui tam* action, and that they had retained the law firm of Freishtat & Sandler to represent them.

13. On August 24, 1998, the United Stated intervened in the *qui tam* action and filed a Complaint.

    a. At the same time, the seal on the action was lifted.

    b. The Complaint was served on the defendants.

14. On August 25, 1998, Marcy Colkitt notified Defendants and the other carriers that the seal had been lifted and subsequently provided a copy of the Government *qui tam* Complaint, and requested defense and indemnification.

15. On October 29, 1998 and November 10, 1998, the Plaintiffs notified Defendants of two new claims (*Neheme v. EquiMed,* et al, and *Skarinsky v. EquiMed*)[3], requesting the retention of Wolf-Block, Schorr and Solis-Cohen as lead counsel and Marcy L. Colkitt & Associates, P.C. as defense counsel.

16. In a letter dated May 17, 1999, Defendants sent a letter to Plaintiffs denying coverage on the basis of that coverage was barred by the Policy's Prior and Pending Litigation Exclusion.

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[3] Securities Class Action suits

a. Defendants' letter went on to state that there may be as many as eight other reasons as to why coverage would be denied; however, given the conclusive bar of the Prior and Pending Litigation Exclusion on which Defendants' denial of coverage was premised, there was no need for Defendants to discuss them in detail.

b. Defendants' letter also stated "If you have any additional information or materials that you would like [Defendants] to consider in connection with this matter, please contact me."

17. On May 6, 1999 EquiMed, Inc. and the three plaintiffs[4] filed a case against the primary insurer, Steadfast, in the Court of Common Pleas of Centre County, Pennsylvania—EquiMed, Inc., *et al* v. Steadfast Insurance Company, No 1999-0585 (hereinafter "EquiMed I")—seeking an injunction to force Steadfast to cover plaintiffs' defense costs in the *qui tam* action.

a. On March 24, 2000, Reliance was brought into the action.

b. Defendants in the instant action were never brought into EquiMed I action.

c. Steadfast claimed that their PPD clause barred plaintiffs from coverage based on the Rahman action.

d. This Court held that the Steadfast Policy's PPD clause did not exclude Plaintiffs from defense coverage from Steadfast in the *qui tam* action.

18. In December 1999 — January 2000, Plaintiffs and the U.S. government agreed to settle the *qui tam* action for $10 million.

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[4] who are the same Douglas Colkitt, Joanne Russell, and Jerome Derdel in the case *sub judice*.

19. In February 2000, an involuntary chapter 7 bankruptcy petition was filed against EquiMed, Inc. before the settlement could be memorialized and funded.

20. A multitude of subsequent litigation ensued, and a final settlement for the *qui tam* action was renegotiated and approved.

21. The funding for the final *qui tam* settlement was as follows:

Personal Payment	
Douglas Colkitt	$ 122,000
Publically traded company, never a subsidiary of EquiMed, not insured	
National Mediacl Financial Services	$ 1,200,000
Entities not owned by EquiMed or Colkitt at time of payments	
Keystone Oncology, LLC	$ 400,000
Oaktree Cancer Care, Inc	$ 400,000
Rosewood Cancer Care, Inc	$ 400,000
Subtotal	$ 1,200,000
Defendant in Raham Action and entity never a Subsidiary of EquiMed	
Onco. Services	$ 1,364,000
Professional Corporations 100% owned by Colkitt that were never subsidiaries of Equimed and never insured	
Albemarle Onco. Associates, P.C.	$ 331,000
Oaklance Cancer and Hematology Clinic, P.C.	$ 512,000
Derdel Riverside Onco. Associates, P.C.	$ 764,000
Holyoke Onco. Associates, P.C.	$ 445,000
Tampa Onco. Associates, P.C.	$ 391,000
Salsubry Onco. Associates, P.C.	$ 192,000
Derdel Chesapeake Onco Associates, P.C.	$ 233,000
Community Radiology Associates, P.C.	$ 408,000
Key West Onco, Associates, P.A.	$ 84,000
Subtotal	$ 3,360,000
Setoff Funds withheld by U.S. Government for overrbilling	
Suspense fund, monies owed to professional medical corporations	$ 2,961,000

22. The *qui tam* settlement has been paid in full.

23. On October 3, 2001, Reliance was declared insolvent and placed into liquidation.

24. On January 14, 2003, Plaintiffs filed a Writ of Summons in this Court, giving rise to the case, at bar.

25. In early 2004, Plaintiffs settled with Reliance for $376,703.76.

26. On November 9, 2010, Plaintiffs filed their Complaint.

27. On October 11, 2011, after Preliminary Objections were sustained in part, Plaintiffs filed an Amended Complaint, adding a third count—Intentional Interference With Contractual Relations.

28. On November 4, 2011, Defendants filed Preliminary Objections, seeking dismissal on the grounds that Plaintiffs did not seek leave to amend the Complaint beyond the limited resubmission authorized by the Court.

29. On December 12, 2012, the Court sustained in part Defendants' Preliminary Objections precluding Plaintiffs from proceeding with Count III—Intentional Interference With Contractual Relations—of their claim, but allowing Plaintiffs to proceed with the rest of the action.

30. On January 27, 2014, Defendants' filed the instant Motion for Summary Judgment.

    a. Both parties have submitted their briefs.

    b. On April 21, 2014, the Court held Oral Arguments.

CONCLUSIONS OF LAW

1. After the relevant pleadings are closed, but within such time as not to unreasonably delay trial, any party may move for summary judgment in whole or in part as a matter of law
   (1) whenever there is no genuine issue of any material fact as to a necessary element of the cause of action or defense which could be established by additional discovery or expert report, or
   (2) if, after the completion of discovery relevant to the motion, including the production of expert reports, an adverse party who will bear the burden of proof at trial has failed to produce evidence of facts essential to the cause of action or defense which in a jury trial would require the issues to be submitted to a jury.

   Pa.R.C.P. 1035.2.

2. "All doubts as to the existence of a genuine issue of a material fact are to be resolved against the granting of summary judgment." *Stimmler v. Chestnut Hill Hosp.*, 981 A.2d 145, 154 (citing *Thompson Coal Co. v. Pike Coal Co.*, 412 A.2d 466 (Pa. 1979)).

3. The Court may grant summary judgment where, examining the record in the light most favorable to the non-moving party, the moving party's right to summary judgment is clear and free from doubt. *See Blackman v. Federal Realty Inv. Trust*, 664 A.2d 139, 141 (Pa. Super. 1995).

4. The issue of Statute of Limitations is an affirmative defense. *See* Pa.R.C.P. 1030.

5. The general rule with an affirmative defense is a defendant bears the burden of proof, *see Beato v. DiPilato*, 106 A.2d 641, 643 (Pa. Super. 1954).

6. However, the Superior Court has carved out an exception in cases where denial of coverage is at issue:

   > Where the statute of limitations is at issue, the burden of proof falls on the plaintiff to demonstrate that the cause

> of action is not barred by the passage of time and that his or her failure to file the action in timely fashion is excusable.

Corbett v. Weisband, 551 A.2d 1059, 1067 (Pa. Super. 1988).

7. The statute of limitations for a Bad Faith action is limited to two years. *See Ash v. Cont'l Ins. Co.*, 932 A.2d 877, 885 (Pa. 2007).

8. The statute of limitations for a Bad Faith claim based on denial of coverage begins to toll when insurer's position is made clear *e.g.* a denial of coverage letter. *See Adamski v. Allstate Ins. Co.*, 738 A.2d 1033, 1042 (Pa. Super. 1999).

9. To establish bad faith under section 8371, our Court has utilized a two-part test, both elements of which must be established by clear and convincing evidence: (1) the insurer lacked a reasonable basis for denying coverage; and (2) the insurer knew or recklessly disregarded its lack of a reasonable basis.

Adamski v. Allstate Ins. Co., 738 A.2d 1033, 1036 (Pa. Super. 1994) citing *Terletsky v. Prudential Property & Casualty Ins. Co.*, 649 A.2d 680 (Pa. Super. 1994).

10. A plaintiff seeking damages for an insurer's bad faith conduct under section 8371 may, in addition to other available methods, attempt to prove bad faith by demonstrating that the insurer has violated one or more provisions of related Pennsylvania insurance statutes or regulations, even if those provisions do not provide for private rights of action.

Berg v. Nationwide Mut. Ins. Co., Inc., 44 A.3d 1164, 1174 (Pa. Super. 2012), reargument denied (June 29, 2012), appeal denied, 65 A.3d 412 (Pa. 2013).

11. Section 8371 is not restricted to an insurer's bad faith in denying a claim. An action for bad faith may extend to the insurer's investigative practices. Bad faith conduct also includes lack of good faith investigation into facts, and failure to communicate with the claimant.

Grossi v. Travelers Personal Ins. Co., 79 A.3d 1141, at 1149 (Pa. Super. 2013).

12. To *investigate* is "to observe or study by close examination and systematic inquiry." Merriam-Webster online dictionary, http://www.merriam-webster.com/dictionary/investigate (May 23, 2014).

13. A breach of contract claim under Pennsylvania law requires proof of the contract's existence, breach of a duty imposed by the contract, and damages resulting therefrom. *See Williams v. Nationwide Mut. Ins. Co.*, 750 A.2d 881, 884 (Pa. Super. 2000).

14. *[Excess insurance companies]* have a clear, bargained-for interest in ensuring that the underlying policies are exhausted by actual payment. If [the Directors] were able to trigger the Excess Policies simply by virtue of their aggregated [but unpaid] losses, they might be tempted to structure inflated settlements...that would have the same effect as requiring the Excess Insurers to drop down and assume coverage in place of the insolvent carriers.

    ...the plain meaning of the phrase "payment of losses" refers to the actual payment of losses suffered by the Directors—not the mere accrual of losses in the form of liability.

Ali v. Fed. Ins. Co., 719 F.3d 83, 94 (2d Cir. 2013).

15. A *qui tam* action is "an action brought under a statute that allows a private person to sue for a penalty, part of which the government or some specified public institution will receive." *Black's Law Dictionary* 1262 (7th Ed. 1999).

16. Insurance cannot, as a matter of law, cover disgorgement of ill-gotten gain. *See Central Dauphin School Dist. v. American Casualty Co.*, 426 A.2d 94, 97 (Pa. 1981).

17. Settlement of an action is the equivalent to a determination, reached through agreement of the parties, that a party had been unjustly enriched. *See Reliance Grp. Holdings, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 188 A.D.2d 47, 55, 594 N.Y.S.2d 20 (1993).

18. "The interpretation of an insurance contract regarding the existence or non-existence of coverage is 'generally performed by the court.'" *Prudential Prop. & Cas. Ins. Co. v. Sartno*, 903 A.2d 1170, 1175 (Pa. 2006) citing *Minnesota Fire & Cas. Co. v. Greenfield,* 855 A.2d 854, 861 (Pa. 2004).

19. "Whether a claim is within a policy's coverage or barred by an exclusion is a question of law that may be decided by a motion for summary judgment." *Butterfield v. Giuntoli*, 670 A.2d 646, 651 (Pa. Super. 1995).

20. In close or doubtful insurance cases, policy construction should be determined in favor for the insured. *See Motley v. State Farm Mut. Auto Ins. Co.*, 466 A.2d 609 (Pa. 1983).

21. "Where the language of the contract is clear and unambiguous, a court is required to give effect to that language." *Koenig v. Progressive Ins. Co.*, 599 A.2d 690, 692 (Pa. Super. 1991).

OPINION

Time-barred allegations (Count II - Bad Faith)

In determining the time limitation to bring an action in bad faith under an insurance policy, the Supreme Court has held, "an action under [42 Pa.C.S.A.] § 8371 is ... subject to the two-year statute of limitations under 42 Pa.C.S. § 5524." *Ash*, 932 A.2d at 885.

For this issue, neither party disputes the aforementioned two-year rule; rather, the Court is called upon to determine at what point in time Plaintiffs' claim for Bad Faith began to toll. Defendants assert, under the holding of *Adamski, supra*, Bad Faith actions brought under § 8371 begin to toll when Defendants first

made their position clear with their May 17, 1999, denial of coverage letter. Plaintiffs dispute the May 17, 1999, date by distinguishing the *Adamski* holding, noting that in that case, the insurer was a primary insurer; whereas, in the instant case, Defendants were a tertiary insurer, and as such, Plaintiffs argue, a Bad Faith claim was not ripe for litigation at the time of the denial of coverage letter, as the primary and secondary insurance policies had not yet been paid out, thus Defendants' duty to pay on the claim had not yet been triggered.

As a tertiary insurer, under the terms of the policy at issue, Defendants were not liable for indemnification until after Plaintiffs suffered a $10 million Loss. As such, Plaintiffs argue, the Bad Faith statute of limitations tolling period should not begin when the denial of coverage letter was sent, since Plaintiffs had not incurred a $10 million loss at that point.[5] According to Plaintiffs, in order for the Court to grant summary judgment on the Bad Faith claim, based on a statute of limitations defense,

> [Defendants] must show that the full $10 million was paid more than two years before Plaintiffs file[d] the instant lawsuit. Plaintiffs filed suit on January 14, 2003. So [Defendants] must show that payment of the $10 million was made **before January 14, 2001**.

Pls.' Br. Opposing Defs.' Mot. For Summ. J. p. 34 (**emphasis in original**). Unfortunately for Plaintiffs, this argument is flawed for two reasons.

The first flaw in Plaintiffs' argument is the incorrect assignment of the burden of proof. To claim that Defendant must show that payment of the $10 million was

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[5]The Court notes that although Plaintiffs argue against May 17, 1999, as a starting date for tolling the statute of limitations, they proffer no alternative.

made before January 14, 2001—or that Defendants must show *anything*—is inconsistent with the holding in *Corbett, supra*. It is the Plaintiffs who bear the burden to show that the alleged action, actions, lack of action, or lack of actions, which gave rise to the Bad Faith claim fall within the statute of limitations.

Plaintiffs' second flaw is attributed to a false assumption. Plaintiffs' argument assumes that Defendants' sole act of alleged bad faith is the denial of payment on the Plaintiffs' claim on the insurance policy, as was in the case in *Adamski*; however, this is not the situation with the case at bar. In their Amended Complaint, Plaintiffs allege,

> [Defendants] acted in bad faith by inter alia, interfering with Plaintiffs' defense, failing to investigate the claim for coverage of the Government Qui Tam Complaint promptly, by failing to investigate the claim in the time period proscribed by the Unfair Claim Settlement Act 31 P.S. Sec. 146.1 et seq., by violating the Unfair Insurance Practice Act, 40 P.S. Sec. 1171.5 for, inter alia, not promptly acknowledging and acting upon communications with the insured, for denying the claim and others based upon the actual knowledge and/or the knowingly reckless disregard for the truth, that the basis for the denial was in fact false and without merit, by investigating the claims with the intent to deny them regardless of their actual merit and by investigating the claims with animus towards its Insureds.

Pls.' Am. Compl. ¶ 145.

According to Plaintiffs' Amended Complaint, Defendants' alleged acts, or failures to act, which gave rise to the instant Bad Faith claim, along with the dates in which they occurred, are as follows:

- Interfering with Plaintiffs' defense: May 17, 1999 (¶ 52); June 22, 1999 (¶ 104)
- Failing to investigate the claim for coverage of the Government *qui tam* Complaint promptly: February 20, 1998 through May 17, 1999 (¶ 51)

- Failing to investigate the claim: September 18, 1998 (¶ 35)
- Not promptly acknowledging and acting upon communications with the insured: February 20, 1998 (¶ 28); August 25, 1998 (¶¶ 29, 30, 98); October 29, 1998 (¶¶ 32, 33); December 2, 1998 (¶¶ 37, 38); December 8, 1998 (¶¶ 39, 40); March 24, 1999 (¶¶ 43, 44)
- Denying the claim: May 17, 1999 (¶ 48)
- Investigating the claims with the intent to deny: February 22, 1999 and February 23, 1999 (¶¶ 101)

Plaintiffs began this action on January 14, 2003. As such, under *Ash*, *supra*, all alleged Bad Faith allegations occurring prior to January 14, 2001, fall outside the statute of limitations. Referring to Plaintiffs' own Complaint, all of Defendants' alleged Bad Faith conduct occurred prior to the January 14, 2001 cut-off date; therefore, Plaintiffs' Bad Faith claim is time-barred.

Inability to Prove Bad Faith (Count II - Bad Faith)

Defendants proffer four reasons why they believe summary judgment is appropriate for the Bad Faith claim:

1) Plaintiffs' claim of *alleged interference with litigation defense* is not actionable under a § 8371 Bad Faith claim;
2) Plaintiffs' claim of *alleged failure to promptly acknowledge and investigate* is not actionable under a § 8371 Bad Faith claim, and even if it was, there is no genuine issue of material fact that [Defendants] promptly acknowledged Plaintiffs' letter;

3) Plaintiffs' claim of *alleged wrongful denial of coverage* cannot succeed as a matter of law, as Plaintiffs failed to cooperate as required by providing requested information; and

4) Plaintiffs' claim of *alleged interference with Steadfast and Reliance* is not actionable under a § 8371 Bad Faith claim.

The bases for the Bad Faith Claim of Defendants' *alleged interference with litigation defense* and *alleged interference with Steadfast and Reliance* can be easily be disposed of, as they are an overt attempt by Plaintiffs to shoehorn the previously dismissed Intentional Interference With Contractual Relations claim.[6]

As for the remaining bases on which Plaintiffs allege their Bad Faith claim, Defendants begin their argument by stating, what they believe to be, the required elements for a claim:

> To establish bad faith under section 8371, our Court has utilized a two-part test, both elements of which must be established by clear and convincing evidence: (1) the insurer lacked a reasonable basis for denying coverage; and (2) the insurer knew or recklessly disregarded its lack of a reasonable basis.

Adamski, 738 A.2d at 1036. However, since *Adamski*, the Superior Court has expanded upon what constitutes Bad Faith under § 8371.

> [A] plaintiff seeking damages for an insurer's bad faith conduct under section 8371 may, in addition to other available methods, attempt to prove bad faith by demonstrating that the insurer has violated one or more provisions of related Pennsylvania insurance statutes or regulations, even if those provisions do not provide for private rights of action.

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[6] See Relevant Facts ¶¶ 27-29

Berg, 44 A.3d at 1174. As *Berg*, clearly states, a Bad Faith claim is not limited to denial of coverage. Further, the Superior Court has also held,

> ...section 8371 is not restricted to an insurer's bad faith in denying a claim. An action for bad faith may extend to the insurer's investigative practices. **Bad faith conduct also includes lack of good faith investigation into facts, and failure to communicate with the claimant.**

Grossi, 79 A.3d at 1149 (**emphasis added**). In light of the holdings in *Berg* and *Grossi*, Plaintiffs' Bad Faith claim based on an *alleged failure to promptly acknowledge and investigate* is clearly actionable.

Whether or not Defendants did fail to promptly acknowledge and investigate, and whether or not Defendants did wrongfully deny Plaintiffs coverage are not questions this Opinion answers. Despite Defendant's protestations to the contrary, the Court finds that these allegations are not wholly belied by the undisputed evidence; these are disputed material facts.

It is true that Defendants proffered evidence indicating that they responded to Plaintiffs' initial claim and Defendants' request for further information went unanswered. This does not, however, address the ultimate question of denial of coverage; it could conceivably be found that Defendants wrongfully denied coverage, and did so knowingly with the limited information they had.

Defendants' proffered evidence also does not address the question of whether or not Defendants failed to investigate the claim. The definition of the term *investigate* is "to observe or study by close examination and systematic inquiry." Merriam-Webster online dictionary, http://www.merriam-webster.com/dictionary/investigate (May 23, 2014). It remains unanswered

whether Defendants' request for more information was a systematic inquiry, or if more was required.

The responsibility of answering these questions would lie with a trier of fact, and not with this Court within the instant motion; therefore, the Court, under *Stimmler, supra*, cannot grant summary judgment based on an *alleged failure to promptly acknowledge and investigate a claim* and/or an *alleged wrongful denial of coverage*.

Inability to Prove Breach (Count I – Breach of Contract)

Defendants argue that summary judgment should be granted on Count I of Plaintiffs' Amended Complaint on the grounds that Plaintiffs, by their own admissions, have no covered Loss within the layer of Defendants' excess insurance policy, and as such, a duty was never imposed on Defendants, rendering a breach of duty an impossibility.

Plaintiffs have previously conceded that Defendants are not required to "drop down" their coverage to the $5 million dollar level to assume the gap created by the Reliance insolvency. In an earlier brief, Plaintiffs stated, "Plaintiffs are simply seeking to have the instant Insurance Companies pay at the level of coverage they agreed to in the first place, plus any damages that are ordinarily recoverable for breach of contract." Pls.' Br. Opposing Defs.' Prelim. Objections, 3/17/11 at 1-2.

The language of the Policy states, in relevant part,

> Coverage shall attach only after all such Underlying insurance has been exhausted solely as a result of actual payment or payment in fact of losses of all applicable Underlying Insurance limits...

Def. Ex 2. p.1 ¶ I. Further, as Defendants correctly point out, the United States Court of Appeals in the Secord Circuit has stated,

> *[Excess insurance companies]* have a clear, bargained-for interest in ensuring that the underlying policies are exhausted by actual payment. If [the Directors] were able to trigger the Excess Policies simply by virtue of their aggregated [but unpaid] losses, they might be tempted to structure inflated settlements...that would have the same effect as requiring the Excess Insurers to drop down and assume coverage in place of the insolvent carriers.
>
> ...the plain meaning of the phrase "payment of losses" refers to the actual payment of losses suffered by the Directors—not the mere accrual of losses in the form of liability.

Ali, 719 F.3d at 94. This Court recognizes that the Second Circuit expressly applied both New York and Pennsylvania Law when analyzing *Ali*; further, the facts in *Ali* were almost identical to the case at bar.[7] For these reasons, this Court is persuaded that the holding in *Ali* should apply to the case at bar.

The plain language of the Policy, bolstered with the holding in *Ali*, establish that Plaintiffs must have actual payment totaling the required $10 million before Defendants would have a duty to any indemnification under the Policy.

Defendants claim that Plaintiffs' own documents production and Colkitt's deposition testimony establish that Plaintiffs are unable to show the required $10 million actual loss, and as a result, Defendants' duty to indemnify on the claim was never triggered. Plaintiffs disagree with Defendants' assertion and argue that

[7] Specifically, in *Ali*, the directors and officers of a failed Pennsylvania-based international computer company were defendants in a multitude of law suits. As with the case at bar, the directors and officers purchased a primary insurance policy and subsequent excess policies creating a "tower" of coverage. Two of the underlying insurance policies (Reliance Insurance Company being one of the two) became insolvent and liquidated their assets, resulting in non-payment of claims to the insured directors and officers, thus creating a gap in coverage before a final level of insurance attached.

Plaintiffs actually paid over $10 million in losses. The Court rejects Plaintiffs' argument and agrees with Defendants.

Defendants concede that Plaintiffs' primary insurance carrier, Steadfast, paid $2,185,905.46 for Defense fees in the *qui tam* action, $219,300.58 for Defense expenses in the *qui tam* action, and $2,030,000.00 for the Securities Class Action settlement, for a total of $4,435,206.04. Defendants claim this is the extent of Plaintiffs' actual loss; whereas Plaintiffs claim the actual loss is significantly higher.

Qui Tam

Plaintiffs first argue that monies paid to cover the *qui tam* settlement are actual covered losses that should be attributed to Plaintiffs. The Court disagrees for two reasons.

First, the definition of Loss, outlined in the underlying Steadfast Policy, on which the instant Policy incorporates by reference, specifically states "Loss does not include...matters uninsurable under the law pursuant to which this policy is constructed." Defs. Ex. 2 at III.H.(5). Further, as Defendants correctly point out

> ...it is well settled that as a matter of public policy insurance cannot, as a matter of law, cover disgorgement of ill-gotten gain, e.g., wrongfully received overpayments from the government. *See Level 3 Comm 'ens Inc. v. Fed. Ins. Co.*, 272 F.3d 908 (7th Cir. 2001). *See also, e.g.. Bank of the West v. Superior Court*, 2 Cal. 4th 1254, 1268 (Cal. 1992) ("insurable damages do not include costs incurred in disgorging money that has been wrongfully acquired"); *Central Dauphin School Dist. v. American Casualty Co.*, 426 A.2d 94, 97 (Pa. 1981) (holding that improperly collected tax money school district was ordered to disgorge to its taxpayers was uninsurable under Pennsylvania law and therefore outside policy's definition of loss); *Reliance Group Holdings v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 188 A.D.2d 47,55 (N.Y. App. Div. ist Dep't 1993) ("one may not insure

> against the risk of being ordered to return money or property that has been wrongfully acquired").

Defs.' Mem. Of Law in Supp. of Defs.' Mot. for Sum. J. p. 44-45.

The *qui tam* Complaint establishes that the money paid by Plaintiffs was due to Plaintiffs fraudulently billing, and subsequently collecting fees to which they were not entitled in violation of the False Claims Act. *See* Def. Ex. 10 ¶¶ 77-79, 82-84. The *qui tam* settlement agreement defines the covered conduct as,

> ...submitting claims...for radiation oncology services that were not provided or ordered by a physician, were not medically necessary, or for which defendants misrepresented the medical services rendered to obtain improperly higher reimbursement.

Def. Ex 9 p. 6.

Plaintiffs counter-argue stating that "it was not established 'in fact' that any of the defendants received any illegal personal profit." Pls.' Br. Opposing Defs.' Prelim. Objections, 3/21/14 at p 19. The Court rejects this argument, using Defendants' cited case of *Reliance Group, supra*, as guidance. As with the case *sub judice*, in that case, the court was asked to determine whether payment of a settlement agreement established unjust enrichment for the purposes of the public policy against insuring against the risk of being ordered to return money or property that has been wrongfully acquired. In that case, the court stated,

> [t]he settlement of that action...was essentially equivalent to a determination, reached through agreement of the parties, that [plaintiffs] had been unjustly enriched...through its actions..... In other words, determination of this appeal should not hinge on the circumstance that [plaintiffs] made restitution by way of settlement instead of in satisfaction of a judgment after trial.

Reliance Grp. Holdings, Inc, 188 A.D.2d at 55. The Court recognizes that it is not bound by the holding of the Appellate Division of the Supreme Court of New York; however, as there is no controlling law on this issue in Pennsylvania, and as the facts pertaining to the issue are identical, it is persuaded by that court's determination.

The second reason the Court holds that the *qui tam* settlement payments are not covered losses rests with the source of their funding. Plaintiffs argue that the one source of funding for the *qui tam* settlement was the sale of Colkitt's Medical Practices. Although not expressly stated in their brief, the Court assumes Plaintiffs are proffering the argument that since these medical practices were assets owned by Colkitt, his sale of these assets to pay the *qui tam* settlement would be analogous to liquidating any other asset, such as real estate or a stock portfolio, to settle a debt. Unfortunately for Plaintiffs, these assets are critically distinguishable from other assets, defeating the analogy.

All the medical practices were professional corporations 100% owned by Colkitt; they were never subsidiaries of EquiMed, Inc. and were never insured by Defendants. Most importantly, and what proves fatal to Plaintiffs' argument, is the fact that all the practices, save one[8], were also named defendants in the *qui tam* action. The total amount that these liquidated medical practices paid to the *qui tam* settlement was $3.36 million. That these payments were made is an undisputed material fact. However, the Court is called upon to answer the question of law of

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[8] Oaklane Cancer and Hematology Clinic, P.C.

whether these payments are to be attributed to the Plaintiffs for purposes of computing actual losses under the Policy. The Court holds they are not.

As these medical practices were named defendants in the *qui tam* action, the Court holds the payment of funds resulting from their liquidation to the *qui tam* settlement should be attributed to themselves as defendants, not to the Plaintiffs of the instant motion. To do otherwise is nothing more than an irrational shell game, designed to unjustly force Defendants to cover entities for which they did not bargain to cover, and for which they have received no consideration in the form of premiums.

Plaintiffs also cite $2.96 million, owed to Colkitt's medical practices, which the U.S. Government held in a suspense fund, which were subsequently credited to the *qui tam* settlement. Plaintiffs argue, "as the 100% owner of these medical practices, but for the Qui Tam Settlement, Dr. Colkitt would have been entitled to the Suspense Funds." Pls.' Br. Opposing Defs.' Prelim. Objections, 3/21/14 at p 18. The Court rejects Plaintiffs' argument using the same principle as before. As Plaintiffs' state in their own brief, the money held in the suspense fund was owed to the medical practices; the money was not owed to Colkitt personally. Since the money held in the suspense fund was owed to the medical practices, which were themselves defendants in the *qui tam* action and subsequent settlement, those funds are rightly attributed to the entities themselves, and as a result cannot be attributed as actual losses incurred by Colkitt, nor any other Plaintiff.

The Court does note, however, that Colkitt personally paid $122,000 towards the *qui tam* settlement. If no such public policy against insuring against the risk of

being ordered to return money or property that has been wrongfully acquired existed, this amount would be considered an actual loss.

Other Defense Fees

Plaintiffs allege that there were substantial sums paid for defense fees that were not paid by Steadfast. Specifically, Plaintiffs claim the following:

> • Frieshtat(sic) & Sandler billed [and] was paid $650,000 in defense fees and costs by Dr. Colkitt's medical practices. Sandler then billed another $358,000 which was not paid. Instead Sandler's firm sued Steadfast and Steadfast settled that claim for $150,000.
>
> • Wolf Block's statements show that it billed $658,766 in fees and expenses, that it was paid a total of $556,804 in fees and expenses. Steadfast only paid WolfBlock(sic) a total of $314,957.
>
> • Pepper Hamilton's records show payments made of about $1.2 million. Steadfast's records show payments to Pepper Hamilton of $350,252. When payments by other insurance carriers are accounted for, $300,000 in defense fees were left unreimbursed.

Pls.' Br. Opposing Defs.' Prelim. Objections, 3/21/14 at p 20-21.

The amounts of $150,000, $314,957, and $350,252 that Steadfast paid Freishtat & Sandler, Wolf Block, and Pepper Hamilton, respectively, are already accounted for in Defendants' stipulated $2,185,905.46 amount. *See* Def. Ex. 27.

The $650,000 paid to Freishtat & Sandler from the medical practices are not covered losses. As previous stated, the medical practices were named defendants in the *qui tam* action and they were not entities insured by Defendants. Therefore, this amount is attributed to the medical practices themselves and not Plaintiffs, individually or collectively.

Although Wolf Block billed $658,766 in fees and expenses, this figure is irrelevant, as a billed amount is not an actual loss required by the Policy and *Ali*, *supra;* however, there is $241,847 created by the gap between the $556,804 Wolf Block actually received and the $314,957 Steadfast paid that has the potential to be considered an actual loss. This potential exists due to the fact that it is undisputed that the amount has been paid; however, despite Defendants' argument to the contrary, *infra*, it remains unclear as to whether this amount was paid by the medical practices or by Colkitt himself.

Lastly, Plaintiffs allege there are $300,000 in unreimbursed defense fees paid to Pepper Hamilton. This amount along with the $241,847 paid to Wolf Block totals $541,847 of potential actual loss. Defendants argue, "Colkitt admitted that he personally never paid any fees," Defs.' Mem. Of Law in Supp. of Defs.' Mot. for Sum. J. p. 38, citing deposition testimony from October, 2013. The Court does not accept Defendants' interpretation of Colkitt's testimony, the relevant portion being:

> Q: Do you recall writing checks out of your own personal account as opposed to corporate accounts to any of the lawyers?
>
> A: I don't recall writing checks. I don't normally write the checks in my household anyways.
>
> Q: Okay.
>
> A: My Wife Does it.
>
> Q: Well, besides the physical act of writing them, do you recall checks being issued from your personal accounts as opposed to corporate accounts to pay any attorneys?
>
> A: I don't recall specifically doing that.

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Colkitt's answer falls short of admitting he never paid any fees. An inability to recall an event does not mean it didn't happen, and the Court, must resolve this question in favor of Plaintiffs for summary judgment purposes. As a result, the Court must consider that the $541,847 could be actual loss paid by Colkitt, himself. Unfortunately for Plaintiffs, even if proven true, at a subsequent trial, this fact is moot.

To resolve both of the two questionable material facts against the granting of summary judgment, as required by *Blackman*, *supra* and *Stimmler*, *supra*, the Court will assume, *arguendo*, that Colkitt paid the $541,847 in unreimbursed legal fees, and further assume that the $122,000 that Colkitt personally paid in the *qui tam* settlement to be actual losses. Combining these amounts with the $4,435,206.04 in defense costs and settlements already paid by Steadfast, previously stipulated by Defendants, totals $5,099,053.04. This amount falls short, by almost half, of the amount required to trigger a duty for Defendants to indemnify Plaintiffs under the Policy.

Since the duty for Defendants to indemnify Plaintiffs was never triggered, Plaintiffs' Breach of Contract claim must fail under *Williams*, *supra*. As there are no material facts in dispute, and Plaintiffs cannot succeed with their Breach of Contract Claim, as a matter of law, granting summary judgment is appropriate.

Prior and Pending Litigation (Count I – Breach of Contract)

Lastly, Defendants claim that Plaintiffs Breach of Contract claim fails as the Plaintiffs' claim on the Policy is barred by the *Prior and Pending Litigation* ("PPL") Exclusion. Plaintiffs disagree stating that the underlying Steadfast Policy's *Pending*

or Prior Date ("PPD") clause is incorporated in the GAF Policy. Further, this Court, in EquiMed I, issued an injunction directing Steadfast to assume Plaintiffs' defense, overruling their objection based on the Steadfast Policy's PPD clause. Defendants' counter-argue claiming that the GAF PPL Exclusion is critically different from the underlying Steadfast Policy's PPD clause, as it has different language and different effective dates.

In EquiMed I, this Court held:

> The Rahman Employment Dispute did not constitute a Claim pending against any of the insured persons as of January 24, 1996. Also, the Court determined that since the original *qui tam* complaint was not served on any insured persons under the policy prior to January 24, 1996, the *qui tam* complaint does not exclude coverage. This Court reached this decision due to the language of the Policy, which provided that "Claim", as used in the Policy, was defined as "1. a written demand for money damages, 2. a civil proceeding commenced by the service of a complaint or similar pleading, or 3. a criminal proceeding commenced by a return of an indictment." The *qui tam* complaint does not fit any of the definitions of "Claim" as set forth by the policy and therefore the *qui tam* action can obviously not be considered a claim which is "based upon, arising out of, or attributable to any demand, suit or proceeding pending, or order, decree or judgment entered against the Company or any Insured Person on or prior to the Pending Date set forth in Item 8 of the Declarations, or the same or substantially the same fact, circumstance or situation underlying or alleged therein."

EquiMed, Inc. v *Steadfast*, Opinion and Order, June 18, 2008 at 5. (Centre County Court of Common Pleas).

Defendants argue the PPL Exclusion in the GAF Policy is broader than the underlying Steadfast Policy on which the previous Court's opinions was based, stating,

> ...the two policies are materially different in this regard. The [Pending or Prior Date clause] of the Steadfast Policy excludes suits "pending" as of January 24, 1996 against an "Insured Person" or the Company. By contrast, the GAF Policy does not require that the prior action be "pending" or that it be "against an Insured Person," only that it be "*brought prior to* or pending as of 01/24/97." (*emphasis added*)

Defs.' Mem. Of Law in Supp. of Defs.' Mot. for Sum. J. p. 49 (internal citations omitted).

The Court recognizes that the language of the GAF Policy's PPL exclusion materially differs from the underlying Steadfast Policy's PPD clause, and it may in fact be broader. Unfortunately, for Defendants the term "brought prior to" is not defined with enough specificity—or any specificity—to make that determination. The Court cannot determine from the language, either in the clause itself or through reference, whether the phrase "brought prior to" is meant to include actions filed under seal, or whether a party must be served before the exclusion is to take effect. Therefore, under *Motley*, *supra*, the Court is bound to hold that Plaintiffs' are not barred from coverage, and as a result, granting summary judgment would be inappropriate, based on the GAF Policy's PPL exclusion.

Conclusion

The Court holds that Plaintiffs Bad Faith claim cannot proceed based on Defendants' *alleged interference with litigation defense* and *alleged interference with Steadfast and Reliance*. The Court rejects Defendants' argument that Plaintiffs' Bad Faith claim based on Defendants' *alleged failure to promptly acknowledge and investigate a claim* and/or Defendants' *alleged wrongful denial of*

coverage cannot succeed as a matter of law; however, this finding is moot as all Bad Faith claims are time-barred. As such, summary judgment on Count II of Plaintiffs' Amended Complaint is granted.

The Court rejects Defendants' argument that the Prior and Pending Litigation Exemption bars recovery as a matter of law; however, this finding is moot, since Plaintiffs' Breach of Contract claim cannot succeed as a matter of law, as Defendants never owed a duty indemnify Plaintiffs. Therefore, summary judgment on Count I of Plaintiffs' Amended Complaint is granted.

ORDER

AND NOW, this 30 day of June, 2014, the Order of this Court is as follows:

Defendants' Motion for Summary Judgment on Count I, Breach of Contract, of Plaintiffs' Amended Complaint is GRANTED.

Defendants' Motion for Summary Judgment on Count II, Bad Faith, of Plaintiffs' Amended Complaint is also GRANTED.

BY THE COURT

David E. Grine, Judge