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VIOLATIONS OF THE "ANTI-TELEMARKETING" LAW

By Michael R. Kelley

In 1991, Congress passed the Telephone Consumer Protection Act ("TCPA"), better known as the "anti-telemarketing" law. The purpose of the law is to limit the perceived invasion of privacy from telemarketers calling our homes and businesses and sending out "blast faxes" and similar activity. A telemarketer named Paradise Distributing allegedly sent out over a million "blast faxes" to numerous recipients. The recipients, in turn, brought a class action lawsuit against Paradise, asserting that Paradise violated the TCPA and seeking damages for the costs of paper and ink and administrative time in dealing with the faxes. Paradise submitted the complaint to its insurer, Bretheren Mutual. Bretheren denied coverage.

Paradise's commercial liability policy from Bretheren contains a typical clause covering "personal and advertising injury" claims. Specifically, it covers claims arising out of "oral or written publication of material that violates a person's right to privacy." Paradise argued that the class action suit, by asserting that the blast faxes violated of the TCPA, clearly alleged that Paradise published written material that violated the class members' right to privacy. The claim, therefore, should be covered.

The Pennsylvania Superior Court disagreed, and on August 23, 2010, found that Paradise was owed no coverage. The Superior Court noted that the case was one of first impression in Pennsylvania, but that numerous other courts around the country had faced the same issue. Those other courts were split, with several denying coverage and several holding that such claims were covered. In denying coverage, the Superior Court stated that it believed the policy only covered invasion of privacy claims if the content of the publication allegedly invaded one's privacy, not merely the act of bombarding an otherwise harmless publication to recipients in such numbers as to harass or annoy.

The Court acknowledged that the policy did not define the key policy language, and that ambiguous language must be interpreted in favor of the insured, in this case Paradise. A policy's language is

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ambiguous if it is capable of more than one rational interpretation, one favoring coverage and one disfavoring coverage. Nonetheless, the Court found that the policy language was clear and unambiguous, so that the rule regarding such language did not apply. Judge Allen dissented, noting:

> *Although we are aware that an insurance policy is not ambiguous merely because two conflicting interpretations of it are suggested by the litigants, in evaluating the ambiguity of the phrase, we cannot ignore the body of national case law addressing the same or similar policy language and falling on both sides of this interpretive ledger. It is fair to say that even the most sophisticated and informed insurance consumer would be confused as to the boundaries of advertising injury coverage in light of the deep difference of opinion symbolized in these cases.*

Look for this one to be appealed to the Pennsylvania Supreme Court. ■

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VAGUE OR UNCERTAIN RESPONSES FROM YOUR INSURANCE COMPANY – WHAT DO YOU DO?

By Charles T. Young, Jr.

You get sued, or you have a loss. You contact your insurer, and expect a decision. However, in many instances, you may not receive one – at least, not a clear one. The insurer may "continue its investigation." It may agree to provide some payment or defense, but with a disclaimer. It may not respond at all.

Welcome to the "gray area" and the reservation of rights letter ("ROR Letter"). When an insurer issues an ROR Letter, it typically will agree to defend the insured or take some other tentative step. However, the insurer will reserve its rights to deny coverage at a later date. In this instance, a business should carefully consider its options. On occasion, it might be in the company's best interests to simply tell its insurance company, "Thanks, but no thanks."

When an insurer issues an ROR Letter, it's not really accepting responsibility. At that same time, most companies will let the insurer handle the litigation. This combination of control and failure to accept responsibility can create a difficult situation for the business. If the company simply hands over the case to its insurer, it may be shocked by the results. This is particularly true when certain "red flags" exist – multiple policies, multiple cases, problematic issues, and/or insufficient coverage.

Initially, your insurer may have an obligation to defend the case, but it does not necessarily have an obligation to "play nice" with your other insurers. Someone needs to handle this function. Many businesses have a liability policy, an excess policy, as well as other policies that apply. If a claim involves multiple policies, then the insured must notify the other insurance carriers. You may need to coordinate and pass information between them; you should not expect any one insurer to do this for you.

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Multiple pieces of litigation also create issues and potential problems. Your workers' compensation insurer will not defend you in a civil action. Your liability insurer is not going to be involved in a workers' compensation claim. They may take contradictory or otherwise conflicting positions. Similarly, if you switched insurers, the later carrier will not necessarily be monitoring an earlier piece of litigation. Here again, a business should not expect that the insurance companies will work together in a manner that necessarily benefits it.

When dealing with multiple insurers or lawsuits, a business should think about being more actively involved. It should monitor the progress of different cases and keep open the flow of information. Insurer #1 should not be defending lawsuit "A" in a manner that conflicts with the strategy of Insurer #2 in defending lawsuit "B." If this happens, the conflict could torpedo the company's defense in both cases.

Litigation and the way it's handled can also affect whether the insurer will protect the company in the end. In issuing the ROR Letter, the insurer is refusing to accept responsibility. At the same time, the insurer's control over the litigation may influence whether the policy will provide coverage. You don't want the insurer's influence over the case to hurt your coverage. At the end of the day, you may need the insurer to pay the judgment entered against you.

There are common "triggers" that affect coverage. The difference between findings of intentional or negligent conduct is significant. The distinction between an individual acting within the scope of his employment or outside his job responsibilities can also be important. Finally, the determination of whether the activity in question falls within or outside of the company's business field is often significant.

When these or other triggers form the basis of the ROR Letter, and the insurer is handling the lawsuit, it is important to realize that the insurer's interests and the company's interests may not be the same. To you, a finding of intentional or reckless conduct may mean that you have no coverage. In contrast, a finding of intentional or reckless conduct means that the insurer benefits – it pays nothing.

Another conflict of interest may arise if you do not have enough coverage to pay the potential judgment. The insurer may be looking to save some money by playing hardball in settlement. You, however, are facing the possibility of an excess verdict. The insurer is only on the hook for the policy amount. You may be responsible for much more. The insurer's attitude towards settlement and your attitude may be significantly different.

When facing an ROR Letter, you have options. You can accept the insurer's offer and let the insurer handle the case. This may be appropriate in many cases. Another option may involve tasking someone at the company to oversee the litigation or retaining counsel to do it. A third option may actually be suing the insurer to ensure coverage. Finally, because the complaint's allegations typically determine coverage, you might even work with plaintiff's counsel in some circumstances.

When deciding what option is best for the company, there are many questions to answer. Could the case result in a judgment that exceeds the policy amount? What is the trigger or issue creating the uncertainty as to coverage? How does the policy treat attorneys' fees? Is there a significant self-insured retention? What are the potential advantages of controlling the litigation? Will control over the litigation increase the potential for a timely settlement? Is coordination between insurers or cases an issue? What is the relationship with the plaintiff? Is this truly a business dispute or something more?

Regardless of what option a business chooses, it is important to ask questions and consider the options available. When confronted with a reservation of rights letter, you should realize that the insurer is not accepting responsibility, and it is dangerous to assume that the insurance company will handle the lawsuit or loss in the manner that most benefits you. ■

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PERSONAL GUARANTEE INSURANCE

By Michael R. Kelley

As the owners of many small and medium-sized businesses can attest, obtaining a business loan in the current economic climate often requires that the business owner provide a personal guarantee for the business loan. This means that the owner places his or her home and other personal assets at risk in the event that the business cannot repay the loan. Can a personal guarantee be covered by insurance?

The answer is YES! Personal guarantee insurance essentially covers up to 50% of the loan obligation in the event that the liquidated assets of the company are insufficient to pay the remainder of the loan. Coverage is not offered for more than 50% of the obligation so as not to unduly encourage dissolution of a company. Personal guarantee insurance has not been approved in every state, so clients will need to check with their counsel or broker to determine availability. ■

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