OFFICE OF THE INSURANCE COMMISSIONER
MARYLAND INSURANCE ADMINISTRATION

R.C.D.P.[1],	*	
Plaintiff,	*	
v.	*	**Case No. 27-1001-23-00026**
Penn National Security Insurance Company,	*	
Defendant.	*	

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DECISION

R.C.D.P. ("Plaintiff") has alleged that Penn National Security Insurance Company ("Defendant") breached its contractual duties by failing to pay Plaintiff's first-party claim for damages under the terms of the auto insurance policy ("Policy") in connection with a traffic accident on December 9, 2019 (the "Claim"), which occurred in Montgomery County, MD. Pursuant to Section 27-1001 of the Insurance Article of the Annotated Code of Maryland ("Section 27-1001"), the Maryland Insurance Administration (the "Administration") concludes that Plaintiff has failed to demonstrate that Defendant breached any duties owed to Plaintiff or otherwise failed to act in good faith in connection with Plaintiff's claim.

I. STANDARD OF REVIEW

Section 3-1701 of the Courts and Judicial Proceedings Article of the Annotated Code of Maryland ("Section 3-1701") authorizes the award to an insured of certain statutory remedies if the insured demonstrates that the insurer failed to act in good faith in denying, in whole or in

[1] The Maryland Insurance Administration uses initials to protect the plaintiff's and other individuals' privacy.

part, a first-party property insurance or disability insurance claim. However, before the insured may file an action pursuant to 3-1701, Section 27-1001 requires that the insured first submit a complaint to the Administration.

Section 27-1001 defines "good faith" as "an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insured made the claim." The Administration in rendering a decision on the complaint is required by Section 27-1001(e)(1)(i) to focus on five issues:

1. Whether the insurer is required under the applicable policy to cover the underlying claim;

2. The amount the insured was entitled to receive from the insurer;

3. Whether the insurer breached its obligation to cover and pay the claim;

4. Whether an insurer that breached its obligation failed to act in good faith; and

5. If there was a breach and the insurer did not act in good faith, the amount of damages, expenses, litigation costs and interest.

A plaintiff has the burden of proof and must meet this burden by a preponderance of the evidence. *See* Md. Code Ann., State Gov't, § 10-217 (2020 Repl. Vol.); *Md. Bd. Of Physicians v. Elliott,* 170 Md. App. 369, 435, *cert denied,* 396 Md. 12 (2006).

II. PROCEDURAL BACKGROUND

On April 21, 2023, the Administration received Complaint No. 27-1001-23-00026 (the "Complaint") stating a cause of action in accordance with Section 27-1001. In the Complaint, Plaintiff alleged Defendant breached its obligations under the Policy by failing to provide additional Underinsured Motorist ("UIM") coverage in accordance with Plaintiff's policy. Furthermore, Plaintiff asserts that Defendant failed to make a good faith offer or payment for UIM coverage. As required by Section 27-1001(d)(3), the Administration forwarded the

Complaint and accompanying documents to Defendant on May 1, 2023. Defendant provided a timely response to the Complaint and accompanying documents as required by Section 27-1001(d)(4) on May 30, 2023, and acknowledged the obligation to provide coverage on the claim.

III. FINDINGS

Based on a complete and thorough review of the written materials submitted by the Parties, and by a preponderance of the evidence, the Administration finds that Plaintiff has failed to establish that he is entitled to additional coverage for the Claim under the Policy.

On December 9, 2019, Plaintiff was involved in a collision in Montgomery County, MD. Plaintiff was traveling northbound on I-270, coming home from her cleaning business, when the other driver ("M.S.") struck Plaintiff's vehicle in the rear, causing her to hit the vehicle in front of her. As a result of this accident, Plaintiff went to the hospital where she was assessed for injuries to her right leg, left shoulder, left breast, abdomen, neck, back, and left-hand, as well as headaches and nausea.

At the time of the accident, M.S. was insured by Geico General Insurance Company ("GEICO") and had a policy limit of $250,000 in liability coverage. Additionally, Plaintiff was insured by Defendant with a business auto policy that provide $1,000,000 in UIM coverage.

On December 11, 2019, Plaintiff called Defendant to report the accident and initiate a claim. Plaintiff advised Defendant that M.S. has accepted all liability and that Plaintiff's vehicle is already being repaired. Plaintiff also confirmed that the claim was for medical expenses only. Additionally, Plaintiff submitted a Personal Injury Protection ("PIP") claim application to Defendant.

On December 12, 2019, Defendant called Plaintiff to discuss the details of the accident. Defendant also provided PIP forms and advised Complainant of the PIP claims process.

On January 6, 2020, Defendant received a letter of representation from Plaintiff's attorney at Perez Halpern, LLC. Plaintiff's attorney requested a certified copy of Plaintiff's policy, which Defendant provided.

On February 14, 2020, Plaintiff advised Defendant that she was receiving medical treatment from Family Back & Neck ("Family"), which included physical therapy, electrical stimulation, as well as hot and cold packs. Defendant received the medical bills for treatments from December 16, 2019 through January 27, 2020.

On February 18, 2020, Defendant paid for Plaintiff's treatments at Family under the PIP claim up to the policy limit of $2,500, but after that payment Plaintiff's PIP benefits were exhausted.

On April 29, 2020, Defendant received a letter of representation for Plaintiff's new attorney at ChasenBoscolo law firm. Plaintiff's attorney requested a copy of the PIP log, which Defendant provided.

On July 20, 2020, Plaintiff went to Premier Orthopedics ("Premier") for an orthopedic consultation. Plaintiff was diagnosed with a cervical and left shoulder sprain. Therefore, she was advised to get an MRI scan to determine further treatment.

On August 10, 2020, Plaintiff returned to Premier for a follow-up visit. It was determined that Plaintiff had degenerative disc disease and was prescribed physical therapy as well as cervical epidural steroid injections.

On September 21, 2020, Plaintiff went to Premier for a follow-up visit. Plaintiff was again advised to receive physical therapy and cervical epidural steroid injections.

On October 19, 2020, Plaintiff returned to Premier for a follow-up visit. The doctor determined that the cervical disc disease was improving and advised Plaintiff to continue at home exercises.

On June 21, 2021, Plaintiff sought medical treatment from Baltimore Neurosurgery & Spine Center ("Spine Center"). During this visit, the doctor determined that the accident caused or exacerbated a disc herniation and suggested physical therapy as treatment. The doctor also requested a nerve conduction study to look for evidence of a cervical radiculopathy and for Plaintiff to follow up in 6 to 8 weeks.

On July 27, 2021, Plaintiff returned to Spine Center with neck pain and tingling in her upper extremities. The doctor advised Plaintiff that surgery was not the best course of action at the time and that Plaintiff should continue physical therapy.

On February 8, 2022, Plaintiff again returned to Spine Center with continued neck and shoulder pain. During this visit, Plaintiff was referred to an orthopedic surgeon for evaluation.

On March 15, 2022, Spine Center advised Plaintiff's attorney that Plaintiff continues to have symptoms from her injuries due to the accident. Spine Center further explained that the next course of action for treatment would be surgery that would cost $85,000.

On April 29, 2022, Plaintiff's attorney contacted Defendant inquiring about the status of the UIM claim. That same day, Defendant left a message for GEICO's adjuster requesting information on the UIM claim status.

On May 2, 2022, GEICO contacted Defendant to advise that it had offered Plaintiff the full $250,000 policy limit. GEICO further noted that it evaluated the claim to be valued between $150,000 and $200,000 but offered the full limit because Plaintiff's attorney was unwilling to negotiate. That same day, Defendant told Plaintiff's attorney about GEICO's offer and the

attorney requested that Defendant waive subrogation. In response, Defendant requested proof of offer, proof of limits, and an affidavit of no other insurance.

On May 4, 2022, Defendant received the proof of offer and proof of limits. It also received the affidavit of no other insurance on May 9, 2022.

On May 10, 2022, Plaintiff returned to Spine Center with complaints of still having some pain. Plaintiff noted that she had been receiving injections for pain management that seemed to be working. Plaintiff was advised to continue physical therapy and injections as needed.

On May 17, 2022, Defendant consented to GEICO's settlement and waived subrogation.

On May 20, 2022, Defendant followed up with Plaintiff's attorney to request a status on the UIM claim, as well as any medical records, bills, loss wages, or other special damages.

On May 25, 2022, Plaintiff's attorney responded by indicating that Plaintiff was still in active care for her injuries.

Defendant followed up again on June 30, 2022, August 11, 2022, and September 29, 2022 regarding the status of the UIM claim. Defendant did not receive a response or any requested documents.

On September 30, 2022, Defendant was advised that Plaintiff commenced a lawsuit.

On December 13, 2022, Premier preformed a final medical evaluation of Plaintiff. It determined that Plaintiff was still experiencing persistent pain in her cervical spine that radiates out to her arms. Nonetheless, Premier concluded that Plaintiff had reached maximum recovery from her injuries and that the remaining injuries are likely permanent.

On January 27, 2023, Defendant requested that Plaintiff make a UIM demand. In response, on January 31, 2023, Plaintiff's attorney made a demand for $750,000, which was the remaining amount under the policy.

On February 15, 2023, at the request of Defendant, Dr. Matthew Ammerman submitted an Independent Medical Evaluation ("IME"). In this IME, Dr. Ammerman reviewed Plaintiff's medical history and treatment to determine that Plaintiff has recovered from her injuries due to the accident and any current pain is due to underlying conditions. Dr. Ammerman concluded that the total cost of the medical bills related to the injuries sustained in the accident is $11,163.99.

On February 24, 2023, at the request of Plaintiff's attorney, The Coordinating Center prepared a life care plan for Plaintiff. This report analyzed Plaintiff's medical and social history to determine the cost of future life care expenses. The report concluded that the cost of Plaintiff's future care expenses was $254,790.86.

On March 2, 2023, Dr. Thomas Borzilleri and Mr. Michael Borzilleri submitted their report on Plaintiff's present value of future life care expenses. This report concluded that, based on its on evaluation of Coordinating Center's report, the present value of the future life care expenses was $236,121.

Lastly, on April 21, 2023, Plaintiff filed the subject Section 27-1001 Complaint with the MIA.

IV. DISCUSSION

Plaintiff asserts that Defendant breached its duty under the Policy by failing to act in good faith while handling the Claim. Specifically, Plaintiff asserts she is entitled to additional payment under the UIM coverage in the policy. Lastly, Plaintiff avers that Defendant failed to make a good faith offer or payment under the UIM coverage in the policy. I find, however, that Plaintiff did not prove that Plaintiff is entitled to additional damages under the Policy, as Plaintiff has produced insufficient evidence in support of his claim that he is entitled to at least $750,000 under the Policy.

First, I find that Defendant did not breach its obligations under the Policy in denying additional UIM coverage. Here, Plaintiff argues that Defendant erred in not providing additional UIM coverage. Specifically, Plaintiff contends that Defendant failed to provide appropriate UIM coverage since she accrued more medical bills and might require future medical treatment. In this case, the record shows that Defendant evaluated Plaintiff's claim based on the documentation provided by Plaintiff. Specifically, the only documentation that Defendant received, on February 14, 2020, included treatments from Family for December 16, 2019 through January 27, 2020. As a result of receiving these documents, on February 18, 2020, Defendant paid for Plaintiff's treatments at Family under the PIP claim up to the policy limit of $2,500. Following Defendant's subrogation, on May 20, 2022, Defendant requested that Plaintiff submit any medical records, bills, loss wages, or other special damages. Defendant followed up again on June 30, 2022, August 11, 2022, and September 29, 2022, but never received the requested documents. Therefore, Plaintiff has not demonstrated that Defendant acted in bad faith by failing to provide additional UIM coverage since it never received necessary documentation.

Lastly, I find that the record does not show that Defendant failed to act in good faith by not presenting an offer or additional payment under the UIM coverage in the Policy. Here, Plaintiff contends Defendant should have made a good faith offer or provided additional payment in accordance with Plaintiff's UIM coverage in the Policy. However, in this case, Defendant did attempt to negotiate a settlement offer. On January 27, 2023, Defendant requested that Plaintiff make a UIM demand, and in response, on January 31, 2023, Plaintiff's attorney made a demand for $750,000. Defendant responded by requesting that the demand be more reasonable but Plaintiff never made a different demand. Furthermore, through Defendant's investigation of the claim, it relied on Dr. Ammerman's IME, which concluded that the total cost

of the medical bills related to the injuries sustained in the accident is $11,163.99. Additionally, Dr. Ammerman concluded that any lingering medical issues were due to underlying conditions and not because of the accident. Thus, Plaintiff had been fully paid for the accident when she accepted the $250,000 offer from M.S.'s insurer, GEICO, on or about May 17, 2022. Therefore, Plaintiff has not demonstrated that Defendant failed to act in good faith by failing to provide an offer or additional payment under the UIM coverage.

Plaintiff has not demonstrated that Defendant breached its obligations under the Policy or failed to act in good faith. Instead, based on the evidence in this case, the dispute between the Parties is based solely on a disagreement as to the Parties' valuation of the Claim. Accordingly, I find that Plaintiff has not demonstrated that Defendant breached its obligations under the Policy or failed to act in good faith in connection with the Claim.

V. CONCLUSIONS OF LAW

In accordance with Section 27-1001, the Administration concludes:

1. Plaintiff established by a preponderance of the evidence that Defendant issued to Plaintiff an auto coverage policy obligating Defendant to pay a claim for injuries caused by a traffic accident on December 9, 2019.

2. Plaintiff did not establish by a preponderance of the evidence that Defendant failed to provide the coverage required under the policy.

3. Plaintiff did not establish by a preponderance of the evidence that she is entitled to additional damages as a result of the claim.

4. Plaintiff did not establish by a preponderance of the evidence that Defendant breached its obligation under the policy to cover and pay the claim.

5. Since a breach is a necessary element of a failure to act in good faith, Plaintiff did not establish a failure by Defendant to act in good faith.

6. Plaintiff is not entitled to expenses and litigation costs.

ORDER

Based on the foregoing findings of fact and conclusions of law, it is

ORDERED on this 21st day of July 2023, that Defendant did not violate Section 27-1001 of the Insurance Article of the Maryland Annotated Code; and it is further

ORDERED that pursuant to Section 27-1001(f)(3), this Final Order shall take effect if no administrative hearing is requested in accordance with Section 27-1001(f)(1).

KATHLEEN A. BIRRANE
Insurance Commissioner

/S/ Tammy R.J. Longan
Tammy R.J. Longan
Acting Deputy Commissioner

APPEAL RIGHTS

If a party receives an adverse decision, the party shall have thirty (30) days after the date of service (the date the decision is mailed) of the Administration's decision to request a hearing, which will be referred to the Office of Administrative Hearings for a final decision under Title 10, Subtitle 2 of the State Government Article of the Annotated Code of Maryland. MD. CODE ANN., INS. ART., §27-1001(f).