OFFICE OF THE INSURANCE COMMISSIONER
MARYLAND INSURANCE ADMINISTRATION

Z.J.[1],	*	
Plaintiff,	*	
v.	*	**Case No. 27-1001-23-00013**
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,	*	
Defendant.	*	

* * * * * * * * * * * * * *

DECISION

Z.J. ("Plaintiff") has alleged that State Farm Mutual Automobile Insurance Company ("Defendant") breached its contractual duties by failing to pay Plaintiff's first-party claim for damages under the terms of an automobile insurance policy ("Policy") in connection with a traffic accident on September 1, 2020 (the "Claim"), which occurred in Baltimore 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 not demonstrated 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 January 5, 2023, the Administration received Complaint No. 27-1001-23-00013 (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 not providing any explanation of the valuation of the Claim. Furthermore, Plaintiff asserts that Defendant did not complete a fair and honest evaluation of the Claim. As required by Section 27-1001(d)(3), the Administration forwarded the Complaint and accompanying documents to Defendant on January

17, 2023. Defendant provided a response to the Complaint and accompanying documents as required by Section 27-1001(d)(4) on March 9, 2023, and acknowledged that Plaintiff maintained an automobile insurance policy with Defendant providing UM/UIM coverage with policy limits of $100,000 per person/$300,000 per accident.

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 she is entitled to additional coverage for the Claim under the Policy.

On September 1, 2020, Plaintiff was involved in a motor vehicle accident in Baltimore County, MD. Plaintiff was driving on westbound I-695 when her vehicle was struck by a second driver ("C.D.J.") causing Plaintiff's vehicle to flip and land upside down on the right side of the roadway. Plaintiff was treated by paramedics at the scene and then taken to the hospital to receive emergency treatment for injuries to her neck, left hip, right knee, and right hand.

On the date of the accident, Plaintiff contacted Defendant and reported the accident to initiate a claim, which Defendant acknowledged.

At the time of the accident, Plaintiff was insured under an automobile insurance policy issued by Defendant which provided Underinsured Motorist ("UIM") coverage with a policy limit of $100,000 per person/$300,000 per accident. Additionally, Plaintiff's Policy also included Personal Injury Protection ("PIP") coverage up to $2,500.

With respect to the coverage protection limitations under the Policy:

UNINSURED MOTOR VEHICLE COVERAGE

Insuring Agreement

We will pay compensatory damages for ***bodily injury*** and ***property damage*** an ***insured*** is legally

> entitled to recover from the owner or driver of an ***uninsured motor vehicle***. The ***bodily injury*** must be sustained by an ***insured***. The ***bodily injury*** and ***property damage*** must be caused by an accident arising out of the ownership, maintenance, or use of an ***uninsured motor vehicle*** as a motor vehicle. ***We*** will pay only if the full amount of all available limits of all bodily injury liability bonds, policies, and self-insurance plans that apply to the ***insured's bodily injury*** have been used up by payment of judgments or settlements, or have been offered to the ***insured*** in writing.
>
> ****

On September 2, 2020, Defendant, on behalf of Plaintiff, set up a rental car for Plaintiff's use through September 24, 2020. Also on September 2, 2020, Defendant sent Plaintiff a letter notifying her that she had PIP coverage up to $2,500 that would be paid as documentation is received until the limit is reached.

On September 3, 2020, Defendant notified Plaintiff via letter that her vehicle was a total loss and offered $5,308.56 as settlement for the vehicle loss. Plaintiff accepted and Defendant submitted payment to Plaintiff on September 4, 2020. Also, on September 4, 2020, Plaintiff went to Patient First with complaints of neck, back, and chest pain. During this visit, Plaintiff was given a document excusing Plaintiff from work through September 7, 2020.

On September 9, 2020, without a medical referral, Plaintiff began treatment with ATI Physical Therapy ("ATI"). Treatment included hot/cold packs, electrical muscle stimulation, and manual therapy. Plaintiff went to 14 therapy sessions at ATI through November 6, 2020.

On September 11, 2020, Plaintiff and Defendant terminated the rental car use. Also on September 11, 2020, Plaintiff contacted Defendant for an update on the Claim. Defendant explained that it was still awaiting a police report with C.D.J.'s information before it could

proceed with evaluating the Claim. In response, Plaintiff offered Defendant information pertaining to C.D.J.'s actions during the accident.

On September 25, 2020, Plaintiff contacted Defendant for an update on the Claim. Defendant explained what to expect from the settlement process. Plaintiff remarked that she was not willing to settle the claim yet because she was still in pain and receiving treatment. Also during this conversation, Defendant noted that C.D.J. was not insured and explained how the subrogation process would work going forward.

With respect to the PIP coverage under the Plaintiff's Policy, on September 28, 2020, Defendant issued two payments of $461.48 to ATI for Plaintiff's physical therapy. On October 6, 2020, Defendant issued two payments of $461.48 to ATI for Plaintiff's physical therapy. On October 9, 2020, Defendant issued a payment of $461.48 to ATI for Plaintiff's physical therapy. On October 13, 2020, Defendant issued a payment of $192.60 to ATI for Plaintiff's physical therapy. Also on October 13, 2020, Plaintiff submitted additional medical documents for PIP coverage, but was denied because the $2,500 limit had been reached.

On October 15, 2020, Defendant issued a payment of $544 to Enterprise Rent-a-Car for rental car costs.

On November 6, 2020, Plaintiff had her final visit to ATI. At the end of this visit, it was determined that Plaintiff had full function, like she had before the accident, and she was therefore discharged from physical therapy.

On November 20, 2020, Defendant finished its evaluation of the Claim based on documents Plaintiff provided. Defendant offered Plaintiff $10,428.53 as a settlement of the Claim. Plaintiff advised Defendant of her dissatisfaction with the offer and specifically noted that all of the time she took off from work was not included. Defendant told Plaintiff that it could

increase the offer to $10,668.53 if she could provide documentation of the lost wages. Thus, Defendant sent Plaintiff a letter requesting documentation for lost wages.

On December 24, 2020, Defendant contacted Plaintiff with a status update on the Claim. Plaintiff stated that she was still gathering the lost wage documentation and additional medical documents.

On January 5, 2021, Plaintiff submitted documentation of additional lost wages to Defendant. Defendant acknowledged receipt of the lost wage documents on January 15, 2021.

Also on January 15, 2021, Defendant requested Plaintiff submit all medical documentation, including EMS and hospital treatments.

On January 29, 2021, Plaintiff contacted Defendant with dissatisfaction of the last settlement offer from Defendant. Defendant explained that the offer was calculated using estimates since Plaintiff had not submitted all the needed documentation. Defendant further advised Plaintiff that the offer could change once she submits the rest of the medical documents and lost wage documentation.

On February 4, 2021, Plaintiff went to Premier Orthopedics, P.A. ("Premier") with complaints of continued lower back pain. Plaintiff was referred for an MRI and continued treatment at Premier through November 30, 2021.

On February 24, 2021, Defendant emailed Plaintiff's counsel a copy of its payment log. To this date, Defendant had made payments on this claim totaling $9,437.56.

On April 27, 2021, Plaintiff was treated at Advanced Radiology and received an MRI of her spine.

On July 6, 2021, Plaintiff visited Premier for follow-up treatment. At that time, her treating physician noted that Plaintiff had a persistent lumbar strain, but that she had reached maximum recovery for her injuries from the accident.

On October 10, 2021, Defendant sent Plaintiff notice that it was unable to subrogate C.D.J. because he did not have insurance. Therefore, Defendant explained that it was closing the subrogation claim but would reopen if C.D.J. can pay in the future and the statute of limitations has not expired.

On November 30, 2021, Plaintiff returned to Premier for additional treatment. The doctor again determined that Plaintiff had a persistent lumbar strain and that she had reached maximum recovery. The doctor told Plaintiff that further treatment was not necessary and to return only if needed.

On August 24, 2022, Plaintiff, through counsel, sent Defendant a demand letter that included medical reports, medical expenses, and lost wage information. This demand letter determined that the special damages alone for the claim was $22,387.09, which included all medical expenses and lost wages.

On September 2, 2022, Defendant acknowledged receipt of Plaintiff's demand.

On September 30, 2022, in response to Plaintiff's demand letter, Defendant offered $20,182.61 for settlement of the claim.

On October 3, 2022, Plaintiff's counsel called Defendant to discuss its counteroffer. Plaintiff's counsel requested the policy limit of $100,000 and claimed that Plaintiff's lost wages were undervalued. Defendant explained that its offer was based on the documents Plaintiff provided and if Plaintiff had documentation of additional lost wages, she would need to provide

the documents for further evaluation. Defendant then offered $22,000 to settle the claim and noted that its maximum authority was $24,582.61.

On January 5, 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 that Defendant did not properly provide an explanation of its valuation of the Claim. Additionally, Plaintiff contends that Defendant did not complete a fair and honest evaluation of the Claim. 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 her claim that she is entitled to $100,000 under the Policy.

First, I find Defendant made appropriate efforts to notify Plaintiff as to how it valued the Claim. While Plaintiff asserts that Defendant failed to provide an explanation of its valuation of the Claim, the evidence demonstrates that Defendant did provide an explanation as to how it valued the Claim on at least three occasions. Specifically, Defendant first explained its valuation of the Claim on November 20, 2020 when, in response to Plaintiff's dissatisfaction of the valuation of the Claim, Defendant told Plaintiff that its valuation was based on the documents she had provided and that for the valuation to change, she would need to provide additional documentation of medical records and lost wages. Similarly, on January 29, 2021, Plaintiff contacted Defendant with dissatisfaction of the last settlement offer and Defendant explained again that the offer was calculated using estimates since Plaintiff had not submitted all the needed documentation. Lastly, on October 3, 2022, while discussing Plaintiff's demand and Defendant's counteroffer, Defendant explained that its offer was based on the documents

Plaintiff provided and if Plaintiff had documentation of additional lost wages, she needed to provide the documents. Given the record, Plaintiff has not shown that Defendant acted in bad faith in its explanation of the Claim valuation.

Second, I find that Defendant did not breach its obligations under the Policy in evaluating Plaintiff's Claim. On this point, Plaintiff argues that Defendant did not complete a fair and honest evaluation of the Claim. However, the record demonstrates that Defendant properly evaluated Plaintiff's claim based on the limited documentation that she provided. First, Defendant began its evaluation of the Claim on September 3, 2020 when it determined that Plaintiff's vehicle was a total loss and was worth $5,308.56, which was explained to Plaintiff and eventually paid by Defendant. Next, on November 20, 2020, Defendant finished its evaluation of the Claim based on documents Plaintiff provided and offered $10,428.53 as a settlement of the UIM portion of the claim. After Plaintiff noted her dissatisfaction based on lack of lost wages coverage, Defendant advised her that the offer could change but Plaintiff would need to provide additional documentation for review. Similarly, on January 29, 2021, Plaintiff again notified Defendant of her dissatisfaction with the Defendant's offer to settle the Claim due to its valuation of Plaintiff's lost wages. In response, Defendant advised her that it would continue its evaluation of the Claim if she provided additional documentation of the lost wages. Lastly, on October 3, 2022, when Plaintiff's counsel averred that Defendant erroneously undervalued the lost wages in the Claim, Defendant again noted that it used the documentation Plaintiff had provided to evaluate the Claim and to formulate its offer. However, as no additional documents were provided to Defendant, it could not further evaluate Plaintiff's Claim. Therefore, Plaintiff has not demonstrated that Defendant acted in bad faith by failing to perform a fair and honest evaluation of the Claim.

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 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 automobile insurance policy obligating Defendant to pay a claim for injuries caused by a traffic accident on September 1, 2020.

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 24th day of April 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/ Erica J. Bailey
Erica J. Bailey
Associate Commissioner for Hearings

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).