OFFICE OF THE INSURANCE COMMISSIONER
MARYLAND INSURANCE ADMINISTRATION

K.K.[1],	*	
Plaintiff,	*	
v.	*	**Case No. 27-1001-23-00001**
Progressive Select, Insurance Company,	*	
Defendant.	*	

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DECISION

K.K. ("Plaintiff") alleges that Progressive Select Insurance Company ("Defendant") breached its contractual duties by failing to pay Plaintiff's first-party claim for damages under the terms of the uninsured motorist policy ("Policy") in connection with a traffic accident on December 22, 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 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;
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> 2. The amount the insured was entitled to receive from the insurer;
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> 3. Whether the insurer breached its obligation to cover and pay the claim;
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> 4. Whether an insurer that breached its obligation failed to act in good faith; and
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> 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 3, 2023, the Administration received Complaint No. 27-1001-23-00001 (the "Complaint") stating a cause of action in accordance with Section 27-1001. In the Complaint, Plaintiff alleges Defendant breached its obligations under the Policy by not giving a justification for discounting the amount of monetary losses for Plaintiff's uninsured motorist coverage. Similarly, Plaintiff also contends that Defendant did not provide a justification on the valuation of the non-economic losses. Furthermore, Plaintiff asserts that Defendant tried to extend the

claims process unnecessarily by having Plaintiff undergo unneeded additional evaluations. As required by Section 27-1001(d)(3), the Administration forwarded the Complaint and accompanying documents to Defendant on February 1, 2023. Defendant provided a response to the Complaint and accompanying documents as required by Section 27-1001(d)(4) on March 29, 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 November 27, 2020, Defendant sent Plaintiff the invoice for the coverage period from December 4, 2020 through June 4, 2021. Plaintiff made the payment of $374.46 on December 3, 2020, which was posted on December 7, 2020.

On December 22, 2020, Plaintiff was involved in a collision in Baltimore County, MD. Plaintiff was traveling northbound on Rolling Road when the other driver ("S.D.") struck Plaintiff's vehicle in the rear passenger side. This collision caused Plaintiff's car to continue to move forward across two lanes of traffic and cause a subsequent collision. As a result of this accident, the Police were called to the scene and took a report of Plaintiff's injuries and the damage to the car. Specifically, the police report noted that the damage to the car was superficial and Plaintiff had no apparent injuries.

At the time of the accident, S.D. was insured by Allstate Indemnity Company ("Allstate") and had a policy limit of $30,000 per person/$60,000 per accident. Additionally, Plaintiff was insured by Defendant with UIM limits of $250,000 per person/$500,000 per accident.

On December 23, 2020, Plaintiff went to Multi Specialty Healthcare ("Multi") with complaints of pain in back, neck, and left shoulder that was aggravated with movement. During this visit, an x-ray was performed which showed moderate degenerative changes in his cervical and lumbar spine. Plaintiff was diagnosed with multiple sprains in the spine, a left shoulder sprain, a slipped disc, and degenerative changes in the neck and spine. Plaintiff was referred to one week of physical therapy and told to not return to work for five days.

On January 4, 2021, Plaintiff was still experiencing ongoing tenderness and pain. The doctor ordered an MRI and extended the Plaintiff's work slip through January 18, 2021.

On January 8, 2021, Defendant sent Plaintiff a letter notifying him that his Policy was cancelled on December 4, 2020 for nonpayment and therefore, the claim was denied.

On January 12, 2021, Allstate sent Plaintiff a letter advising him that its insured, S.D., had a coverage limit of $30,000 per person and $60,000 per an accident.

On January 15, 2021, Plaintiff received multiple MRIs on each level of the spine. This imaging revealed that he had two disc protrusions, and a herniated disc. Three days later, on January 18, 2021, Plaintiff was re-evaluated by his doctor for continued pain, tenderness, and limited movement. Plaintiff was advised to continue physical therapy and chiropractic treatment, as well as refrain from working for an additional two weeks.

During a follow-up visit on February 4, 2021, Plaintiff exhibited minimal improvement and was referred to an orthopedic specialist. Plaintiff was also prescribed another MRI.

On February 8, 2021, Plaintiff underwent a MRI of his left shoulder, which revealed bursitis. The next day, February 9, 2021, Plaintiff followed-up with the doctor, who advised Plaintiff to continue therapy for another three weeks and to be kept off work during that time

period. Plaintiff returned on February 25, 2021 with continued shoulder discomfort and no improvements, thus Plaintiff was again referred to an orthopedic evaluation.

On March 2, 2021, Plaintiff went to an orthopedic specialist with continued severe pain in the left shoulder, back, and neck despite continuing his physical therapy. The doctor advised Plaintiff to receive cervical and lumbar epidural injections for pain management as well as to refrain from working for another four weeks. Plaintiff followed up on March 30, 2021 with continued pain but was not interested in having steroid injections. Instead, Plaintiff was prescribed Medrol Dosepak, advised to continue physical and chiropractic therapy and kept off work for two to three weeks until he was reevaluated.

On April 7, 2021, Plaintiff returned to his doctor with little improvement in his pain level. Under the advice of the doctor, Plaintiff received multiple steroid injections and continued therapy over the following four months.

On July 9 2021, Plaintiff had a follow up visit with Multi. During this visit, Plaintiff told his doctor that his pain level was improved and that he was ready to return to work, though he never did. Also after this visit, Plaintiff officially withdrew from medical treatment.

On August 3, 2021, Allstate sent Plaintiff a settlement offer of $30,000 that aligned with their client's policy coverage limit of $30,000 per person and $60,000 per an accident.

Several months later, on March 29, 2022, Plaintiff was evaluated by an orthopedic surgeon to determine if surgery was an option for Plaintiff's injuries. The doctor noted that though there was some pain in Plaintiff's back, there were no deformities and minimal restriction in movement. The doctor advised Plaintiff that he already reached maximum improvement and future treatment is not needed.

On April 21, 2022, Defendant sent Plaintiff a letter stating that Plaintiff did not have coverage on the date of loss. Additionally, Defendant requested that Plaintiff submit any supporting documentation of his coverage during the period of the accident. That same day, Plaintiff, through counsel, emailed Defendant supporting coverage documents, including the renewal letter from December 4, 2020 through June 4, 2021.

A month later, on May 16, 2022, having received a voicemail from Defendant stating that Plaintiff's Policy was reinstated during the time of the accident, Plaintiff's counsel emailed Defendant requesting a subrogation update. That same day, Defendant notified Plaintiff that it was waiving its right to subrogation against S.D. and that Plaintiff could accept Allstate's settlement offer.

On May 22, 2022, Plaintiff, being referred by his counsel, underwent a vocational assessment. During this assessment, Plaintiff expressed concerns about difficulties performing activities including walking, standing, lifting, and carrying because of the residual pain in his back. The assessment concluded that Plaintiff's post-accident condition could hinder his ability to work as a rideshare driver and the potential loss of earning from the date of the accident could be $52,078 per year.

On June 1, 2022, Plaintiff also participated in a lost earnings report that was prepared by an economic consultant. This report calculated Plaintiff's total economic loss from the time of the accident until a retirement age ranging from age 66 to age 70. Specifically, the report calculated that total lost earnings range from $445,294 at the retirement age of 66 to $607,886 at retirement age of 70. These calculations were determined by taking Plaintiff's current gross income and determining the expected income if Plaintiff were uninjured until the average age of retirement.

On June 27, 2022, Plaintiff's counsel issued a demand letter to Defendant. In this letter, Plaintiff's counsel discussed Plaintiff's injuries, economic damages, and the impact on his life. The demand letter included the vocational report, medical bills totaling $53,628 and the police report. However, Defendant did not receive any pay subs, W2's or any tax documentation. In the end, Plaintiff demanded $220,000 in exchange for a full release of his individual claims for injuries sustained in the December 22, 2020, collision.

In response, on August 25, 2022, during a phone call with Plaintiff's counsel, Defendant counteroffered with $99,667 to resolve the claim. Defendant further explained that the offer was based on medical expenses and lost wages that were supported by doctors' notes from Plaintiff's treating physicians who issued Work Disability Forms keeping him out of work essentially from the date of the accident until June 29, 2021. During the same phone call, Plaintiff's attorney reduced the demand to $210,000 and Defendant responded with $110,000. Defendant also specified that in order to consider future lost earnings, it would need documentation from the doctors that provided treatment for injuries from the accident corroborating Plaintiff's inability to work.

On October 4, 2022, Plaintiff returned to Multi for an evaluation regarding his ongoing disability and his inability to work. The doctor noted that Plaintiff's pain issues, and reduced physical capacity, stemmed from the December 22, 2020 collisions and precluded him from to returning to employment as an Uber/Lyft driver. Plaintiff emailed this evaluation to Defendant for review on October 24, 2022, and again asked for $210,000 to resolve the claim.

In response, on November 6, 2022, Defendant extended its settlement offer to include high/low arbitration with a high of $200,000 and a low of $120,000. Plaintiff rejected this offer.

On November 18, 2022, Plaintiff's counsel sent Defendant a final demand letter for $195,000. Defendant responded on December 2, 2022, with a final offer of $134,000 and again offered to resolve the claim with arbitration. Plaintiff did not accept this settlement offer.

Lastly, on January 3, 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 have any justification for discounting the amount of Plaintiff's losses. Additionally, Plaintiff contends that Defendant had no justification in under valuing Plaintiff's non-economic losses. Lastly, Plaintiff argues that Defendant unreasonably required Plaintiff to undergo additional evaluation in order to lengthen the claims process. 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 $195,000 under the Policy.

First, I find that Defendant did not breach its obligations under the Policy in calculating the amount of the loss. Here, Plaintiff argues that Defendant incorrectly calculated Plaintiff's losses from the accident. Specifically, Plaintiff contends that Defendant erroneously did not give enough weight to loss of future earnings when calculating the Plaintiff's loss. In this case, the record shows that Defendant evaluated Plaintiff's economic losses based on the documentation provided by Plaintiff. Specifically, Defendant used documents from Plaintiff's June 27, 2022 demand packet, which included: an independent medical evaluation dated March 29, 2022; a Vocational Assessment dated May 25, 2022; a Loss of Earning Capacity report dated June 1, 2022; the police report; and medical records and medical bills totaling $53,628. Another

document of note of the Defendant was the medical record of Plaintiff's final visit to Multi on July 9, 2021 because the doctor notes indicated that Plaintiff had ended medical treatment for his injuries. However, the documentation did not include any pay stubs, W2's or tax documentation for Defendant's review. Based on this provided information, Defendant gave Plaintiff an initial offer of $99,667 on August 25, 2022. Defendant explained that it considered the $53,628 in medical costs, as well as general damages, and six months of past lost wages, based on the medical disability notes from December 23, 2020 through June 29, 2021. Therefore, Plaintiff has not demonstrated that Defendant failed to act in good faith during its calculation of Plaintiff's economic losses.

Also, I find Plaintiff was offered a

Second, I find that Defendant did not breach its obligations under the Policy in its valuation of non-economic damages in the claim. Here, Plaintiff asserts that Defendant had no justification for not fully including non-economic damages in its valuation of the claim. However, in this case, the record shows that Defendant concluded its valuation of the claim based on the documents sent with Plaintiff's June 27, 2022 demand letter. Again, this documentation included medical records, a police report, an independent medical evaluation, a vocational report, and a lost earning capacity report. Specifically, Defendant noted that during Plaintiff's last medical visit with Multi on July 9, 2021, Plaintiff stated that his pain had improved and that he was ready to return to work. Furthermore, during its valuation of the claim for its initial offer, Defendant did evaluate and include general damages and loss of past wages despite there being a lack of wage documentation. Additionally, Plaintiff contends that the vocational report and lost earning capacity reports shows that Plaintiff is unable to work; and thus, will lose future earnings. However, the reports concluded that there was only a potential for

loss of earnings that could be $52,078 per year. Based on these provided reports, Defendant may not have been able to calculate the non-economic damages, like loss of capacity, especially since Plaintiff did not provide any tax documentation to aid Defendant in its valuation of the claim. Given the record, Plaintiff has not shown that Defendant acted in bad faith in its valuation of non-economic damages in the claim.

Also, I find Defendant continued to act fully participate in negotiations with Plaintiff. On November 6, 2022, Defendant extended its settlement offer to include high/low arbitration with a high of $200,000 and a low of $120,000. Plaintiff rejected this offer. It is striking Plaintiff chose not to participate in the high/low arbitration when, at worst, Plaintiff would have received $10,000 more than Defendant's highest offer, or, at best, Plaintiff would have received $10,000 less than Plaintiff's lowest demand.

Finally, I find that the record does not show that Defendant failed to act in bad faith in requesting Plaintiff undergo additional evaluation. Here, Plaintiff contends Defendant required Plaintiff to undergo additional evaluations in order to delay the claims process. However, the evidence in this case does not support this accusation. In this case, Defendant requested an additional medical evaluation to further investigate Plaintiff's claim that he would have a diminished capacity to work in the future. Specifically, on August 25, 2022, Defendant explained to Plaintiff that in order to consider future lost earnings, it would need documentation from the doctors that provided treatment for injuries from the accident corroborating Plaintiff's inability to work. Thus, the Defendant's request was part of the investigation and was not a tactic to unreasonably extend the claims process. Therefore, Plaintiff has not demonstrated that Defendant failed to act in good faith by requesting Plaintiff undergo additional evaluations.

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 22, 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 he 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 18th 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/ *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).