Auto Liability/PIP Claims
Under the Pennsylvania Motor Vehicle Responsibility Law and Similar State Statutes

FOR
BROADSPIRE

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PRESENTED BY
WAYMAN, IRVIN & MCAULEY, LLC
WWW.WAYMANLAW.COM
(412) 566-2970

DALE K. FORSYTHE, ESQ.
SCOTT W. STEPHAN, ESQ.
Wayman, Irvin & McAuley, LLC

401 Liberty Avenue
Suite 1700, Three Gateway Center
Pittsburgh, PA 15222
(412) 566-2970

www.waymanlaw.com

- Dale K. Forsythe, Esq.
  dforsythe@waymanlaw.com

- Scott W. Stephan, Esq.
  sstephan@waymanlaw.com
The Pennsylvania Motor Vehicle Responsibility Law (MVFRL) requires all owners of vehicles registered in Pennsylvania to maintain financial responsibility for their vehicles, i.e., maintain insurance on them.

Under the MVFRL first party benefits (PIP) are required in each insurance policy issued in Pennsylvania.
The MVFRL is a means of insurance reform, enacted by the legislature to reduce the escalating costs of purchasing motor vehicle insurance in our Commonwealth.

The underlying objective of the MVFRL is to provide broad coverage to assure the financial integrity of the policyholder.

According to case law, courts should liberally construe the MVFRL to afford the greatest possible coverage to injured claimants.

In close or doubtful insurance cases, a court should resolve the meaning of insurance policy provisions or the legislative intent in favor of coverage for the insured. 720 A.2d 1051, 382 Pa. Super. 29
Personal Injury Protection Benefits, better known as first party benefits, are a type of insurance coverage.

As defined under the MVFRL (75 Pa.C.S.A § 1702), first party benefits include: medical benefits, income loss benefits, accidental death benefits and funeral benefits.

First party benefits provide the first line of coverage in the case of injuries resulting from the use or operation of a motor vehicle.

First party benefits are paid to the insured by his or her own insurance carrier, as opposed to third party benefits, liability benefits, and property damage benefits.
PA: What Benefits Are Required?

- Under PA 75 Pa.C.S.A. § 1711, the minimum coverage necessary is a $5,000 medical benefit.

- Failure to maintain the minimum prohibits an insured from recovering income loss and medical benefits from a third party tortfeasor.
PA: What Benefits Are Available?

An insurance company must make available for purchase:

- Medical benefits, up to at least $100,000
- Extraordinary medical benefits, from $100,000 to $1,100,000, which may be offered in increments of $100,000
- Income loss benefits, up to at least $2,500 per month up to a maximum benefit of at least $50,000
- Accidental death benefits, up to at least $25,000
- Funeral benefits, up to at least $2,500
PA: WHAT QUALIFIES FOR COVERAGE UNDER FIRST PARTY BENEFITS?

Medical Benefits
In *Tagliati v. Nationwide Ins. Co.*, 720 A.2d 1051 (Pa. Super. Ct. 1998), Tagliati, along with other insured persons, sought reimbursement for the cost of thermographic studies for the purpose of diagnosis and treatment, after they were injured in motor vehicle collisions. Each of the insured persons held a policy with Nationwide entitling them to first party medical benefits. Nationwide refused to reimburse the insured persons, arguing that thermography is not a reasonable and necessary medical treatment under the terms of the MVFRL, and therefore is not compensable. The insured persons brought separate suits against Nationwide seeking payment for their thermography expenses and attorney fees. The Court of Common Pleas of Allegheny County denied all of the insured persons claims, stating as a matter of law that thermography is not a reasonable and necessary medical treatment. The insured persons brought a consolidated appeal.

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1 Thermography is “a diagnostic procedure that measures infrared energy emitted by the skin.”
The Superior Court of Pennsylvania reversed the trial court ruling, holding that courts must decide whether something is a reasonable and necessary treatment, under the reasonable person standard on a case-by-case basis. The Court found that thermography was a reasonable and necessary treatment in the cases on appeal, and therefore the insurance company should reimburse the insured persons for their treatment costs. The Court held, however, that Nationwide did not have to reimburse the insured persons for attorney fees. The Court reasoned that because there is conflicting authority on the validity of thermography in the medical community, Nationwide had a reasonable basis for denying the claims. The Court further stated that while courts should not exclude thermography as a reasonable and necessary treatment as a matter of law, it is not compensable in all cases. To claim thermography as reasonable and necessary, the insured must prove that the circumstances warranted it, and the claimant must prove the value of the treatment by credible and reliable evidence.
In *Stiffler v. Ins. Comm'r of Pa.*, 786 A.2d 296 (Pa. Commw. Ct. 2001), Stiffler sought reimbursement for the cost of a special cart that allowed him to travel and hunt in the woods. A motor vehicle collision in 1988 paralyzed Stiffler from the chest down, qualifying him for Catastrophic Loss Trust Fund benefits. Although paralyzed, Stiffler maintained his driver’s license and operated vehicles with hand controls. The Catastrophic Loss Benefits Continuation Fund denied Stiffler’s reimbursement, after a doctor who examined Stiffler found the cart solely aided Stiffler in his hobby, hunting, and had no medical benefit. Therefore, the reviewing board ruled that the cart was not medically necessary, and denied Stiffler’s request for reimbursement. Stiffler filed an appeal with the Insurance Commissioner.

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The Commissioner upheld the review board’s denial. Stiffler then filed an appeal with the Commonwealth Court of Pennsylvania, arguing that the Commissioner erred on ruling as a matter of law that the cart was not a necessary and reasonable medical treatment. On review, the Court found that Stiffler presented no evidence that the cart provided “treatment, accommodations, products or services which are determined to be necessary by a licensed health care provider” as required by the MVFRL, and therefore, upheld the Insurance Commissioner’s ruling.
*Bickerton v. Ins. Comm'r*, 808 A.2d 971 (Pa. Cmwlth. 2002), also involved the denial of catastrophic loss benefits. Mr. Bickerton qualified for benefits from the Catastrophic Loss Benefits Continuation Fund following a motor vehicle collision that left him without a sense of safety and judgment and requiring 24-hour unskilled home health care. He needed supervision for most daily activities, as well as specialized medical care. Mrs. Bickerton claimed to be the primary caretaker for Mr. Bickerton and sought payment for taking care of him, but repeatedly failed to itemize her care-taking activities.

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The review board denied her claim for payment for home health care services. Mrs. Bickerton appealed to the Insurance Commissioner, who affirmed the denial of payment. Mrs. Bickerton then appealed to the Commonwealth Court of Pennsylvania, arguing that she was entitled to receive payment based on forms that stated her health care activity as monitoring. The Court disagreed with Mrs. Bickerton’s reasoning, finding that monitoring was not a treatment or rehabilitative service because it did not assist or increase Mr. Bickerton’s ability to care for his self, and upheld the Commissioner’s ruling.
Recovery of Benefits Not Allowed:

In *Zerr v. Erie Ins. Exch.*, 446 Pa. Super. 451 (Pa. Super. Ct. 1995), Mr. Zerr and his wife sued Erie Insurance Exchange, after Erie denied Mr. Zerr first party medical benefits under his insurance policy. Mr. Zerr suffered from several mental illnesses as a result of a near collision with a tractor-trailer on the turnpike. Erie filed preliminary objections in the nature of a demurrer, arguing that because Mr. Zerr suffered no physical injuries, he had no cause of action. Mr. Zerr then filed a brief in opposition to Erie’s preliminary objections, arguing that because his mental illnesses had physical manifestations, he should receive first party medical benefits. The trial court, after oral arguments, dismissed the complaint.

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The Zerr’s appealed, arguing that the insurance policy should grant first party medical benefits to insured persons suffering from physical manifestations of mental illnesses caused by a motor vehicle incident. The Superior Court of Pennsylvania found that the language of the applicable insurance policy and of the MVFRL stated that first party medical benefits are available to those suffering from illness, disease or death as the result of a bodily injury. The Court found this contrary to Mr. Zerr’s condition, because he suffered from bodily injury as a result of mental illness. The Court held that “the law states with certainty that no recovery is possible, by means of the MVFRL...for mental injury that is not the result of bodily injury.” Therefore, the Court affirmed the trial court’s granting of Erie’s preliminary objections in the nature of a demurrer.
Recovery of Benefits Allowed:

In *Glikman v. Progressive Cas. Ins. Co.*, 2007 PA Super 41 (Pa. Super. Ct. 2007), the Superior Court of Pennsylvania revisited the issue of whether a person may recover first party medical benefits for mental illnesses resulting from a motor vehicle collision. Glikman sued Progressive Casualty Insurance after they failed to pay her first party medical benefits for treatment of post-traumatic stress syndrome she suffered from, after witnessing her husband being struck and killed by a vehicle whose driver Progressive insured. Both Glikman and Progressive moved for summary judgment. The trial court granted Progressive’s motion for summary judgment, denying Glikman’s motion for summary judgment. On appeal, the Superior Court of Pennsylvania found that the language of the applicable insurance policy specifically covered any disease caused by an accident arising out of the use of a motor vehicle as a bodily injury.

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The Court found that because post-traumatic stress syndrome is a disease, Glikman suffered from a bodily injury under the meaning of the policy. The Court found that because the language of the insurance policy at issue in the present case and in the Zerr case differed, the Zerr holding did not apply. The Court held that because the insurance policy entitled Glikman to recover it was unnecessary to determine whether the MVFRL also allowed her to recover. The Court vacated the trial courts order granting Progressive’s motion for summary judgment and remanded the case to the trial court for reconsideration of Glikman’s motion for summary judgment.
PA: WHAT QUALIFIES FOR COVERAGE UNDER FIRST PARTY BENEFITS?

Income Loss Benefits
Insurers are required to offer income loss benefits. 75 Pa.S.C.A. § 1712 defines what benefits must be provided.

Income loss benefits include eighty percent of actual loss of gross income.

Income loss does not include loss of expected income for any period following a person’s death or expenses incurred for services performed following a person’s death.

If an insured uses sick days, those days can be considered an actual loss of gross income.

- A salaried employee who misses more than five days at work, but whose employer has no sick plan and whose salary is unaffected may not have a claim for income loss benefits.
PA: When are Benefits Available?

- An insured cannot claim income loss under their insurance policy until five working days have been lost after the date of the accident.
The “But For” test:

In *Persik v. Nationwide Mut. Ins. Co.*, 382 Pa. Super. 29 (Pa. Super. Ct. 1989), Persik filed a claim with Nationwide for income loss benefits, after a motor vehicle collision left her incapable of maintaining gainful employment. Persik was unemployed, but seeking employment, at the time of the collision. Nationwide denied the claim. Persik sued Nationwide for the income loss benefits. Nationwide motioned for summary judgment, arguing that because Persik was not working at the time of accident or for 12 months before the accident, she was not entitled to income loss benefits.

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The trial court granted Nationwide’s motion for summary judgment. The Superior Court of Pennsylvania held that the right to recover income loss benefits does not depend on whether the claimant worked on the date of the accident. Rather, to receive income loss benefits the claimant must prove that income would have been earned “but for” the injury caused by the accident. Therefore, the Superior Court held that the trial court erred in summarily dismissing Persik’s claim, reversed the trial court’s holding and remanded for further proceedings.
As defined under 75 Pa.S.C.A. § 1712 an insured person who is self-employed may recover:

- Reasonable expenses actually incurred for hiring a substitute to perform self-employment services thereby mitigating loss of gross income

- Reasonable expenses for hiring special help to enable them to work and mitigate loss of gross income.
If an insured is injured in the course of employment then workmen’s compensation becomes their primary source of medical and income loss benefits, over the first party benefits under their insurance policy.

An insured may combine workmen’s compensation benefits and first party benefits under their insurance policy to obtain the maximum allowable amount recoverable of lost wages and medical expenses. This is also known as a “wrap around” claim.
In *Kilgallen v. Liberty Mut. Ins. Co.*, 1990 Pa. Super. LEXIS 2895 (Pa. Super. Ct. Apr. 11, 1990), Kilgallen made a claim with Liberty for income loss and medical benefits after the workmen’s compensation benefits he received after sustaining injuries in a motor vehicle accident in the course of employment were terminated. Liberty denied benefits, claiming that the workmen’s compensation benefits were Kilgallen’s sole remedy. Kilgallen sued Liberty to obtain the benefits. Liberty filed an answer and new matter, which Kilgallen answered. Liberty then motioned for summary judgment, which the trial court granted, and Kilgallen appealed.

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On appeal, the main issue was whether the Workmen’s Compensation Act takes precedence over the MVFRL so as to preclude the injured employee from recovering first party benefits under the employer’s insurance policy. The Superior Court ruled that although workmen’s compensation is the primary source of benefits, the MVFRL operates to provide first party benefits to those unable to collect workmen’s compensation benefits. The Court held that section 1713 of the MVFRL can operate to require the employer’s insurance carried to provide first party benefits when workmen’s compensation benefits are unavailable. The Court reversed the order of summary judgment and remanded the case back to the trial court for further proceedings.
In *Danko v. Erie Ins. Exch.*, 428 Pa. Super. 223 (Pa. Super. Ct. 1993), Danko filed a claim to recover income loss benefits from her insurer, Erie, after she sustained injuries in a motor vehicle accident while performing her job with a bus company. Erie denied that any benefits were due, because Danko received workmen’s compensation benefits from the bus company. Danko sued Erie on four counts, including breach of contract. The trial court granted summary judgment to Erie on the charge of breach of contract, which Danko appealed. On appeal, the Superior Court looked to the MVFRL, which states that income loss benefits must be provided to the insured in the amount of eighty percent of actual loss of gross income. Because Danko’s workmen’s compensation benefits did not provide her with the entirety of her salary before she was injured, she argued her actual loss of gross income equaled the difference between her previous salary and the amount paid to her under workmen’s compensation.

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Erie argued that because Danko was already receiving over eighty percent of her previous salary through the workmen’s compensation benefits, they were not obligated to pay her anything. The Superior Court agreed with Danko, finding that the MVFRL contains a coordination of benefits provision, which makes workmen’s compensation benefits primary for income loss and other benefits which might be due a claimant who suffers disability in a work-related accident involving a motor vehicle. The Court held that Danko could recover eighty percent of the difference between her previous salary and her workmen’s compensation benefit, thereby reversing the trial court’s summary judgment.
In Panichelli v. Liberty Mut. Ins. Group, 543 Pa. 114 (Pa. 1996), Panichelli filed a claim with Liberty for income loss benefits after injuries sustained in a motor vehicle accident left him unable to work. Liberty began paying Panichelli income loss benefits, but deducted an amount equal to the monthly social security benefit Panichelli received at the time. Panichelli then sued Liberty for the entire amount of his lost income. The trial court entered summary judgment in favor of Panichelli. The Superior Court affirmed the summary judgment. Liberty appealed, arguing that allowing Panichelli to recover income loss benefits while receiving social security benefits resulting in a double recovery.

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Panichelli continued...

The main issue on appeal was whether sick pay and social security benefits received by an insured should be deducted by an insurer in calculating the insured’s actual loss of gross income. The Supreme Court, agreeing with the lower courts, found that based on the language of the MVFRL, sick pay and social security benefits programs must be construed as providing benefits in excess of and not in duplication of the income loss benefits under section 1712(2). The Supreme Court affirmed the lower courts’ rulings in favor of Panichelli.
PA: WHAT QUALIFIES FOR COVERAGE UNDER FIRST PARTY BENEFITS?

Accidental Death Benefits
Death benefits are paid to the representatives of the insured.

To qualify for death benefits, death must occur within 24 months of the date of the motor vehicle accident and must be caused by injuries sustained in the motor accident.

Only those insured as defined in 75 Pa.C.S.A §1702 qualify for death benefits. That is:

- An individual identified by name as an insured in a policy of motor vehicle liability insurance OR
- A spouse or other relative of the named insured or a minor in the custody of either the named insured or relative of the named insured who resides in the same household

Occupants and non-occupants such as pedestrians cannot recover death benefits.
Funeral Benefits
It is mandatory that insurance companies offer funeral benefits, but it is not mandatory for the insured to have funeral benefits.

The funeral benefit is only recoverable if the insured dies within 24 months of the accident.

Funeral benefits are limited to expenses directly related to the funeral, burial, cremation or other form of disposition of the remains of the individual after death.

(A) (1) No person shall operate, or permit the operation of, a motor vehicle in this state, unless proof of financial responsibility is maintained continuously throughout the registration period with respect to that vehicle, or, in the case of a driver who is not the owner, with respect to that driver's operation of that vehicle.
**ORC § 4509.45**

- (A) **Proof of financial responsibility when required may be given by filing any of the following:**

  1. A financial responsibility identification card as provided in section 4509.104 of the Revised Code;

  2. A certificate of insurance as provided in section 4509.46 or 4509.47 of the Revised Code;

  3. A bond as provided in section 4509.59 of the Revised Code;

  4. A certificate of deposit of money or securities as provided in section 4509.62 of the Revised Code;
• (A) **Proof of financial responsibility when required may be given by filing any of the following:**

(5). A certificate of self-insurance, as provided in section 4509.72 of the Revised Code, supplemented by an agreement by the self-insurer that, with respect to accidents occurring while the certificate is in force, the self-insurer will pay the same amounts that an insurer would have been obligated to pay under an owner's motor vehicle liability policy if it had issued such a policy to the self-insurer.
COMPARE WITH PA: Drivers must purchase and maintain car insurance in order to legally drive in Pennsylvania. Under Pennsylvania law, this is called maintaining “financial responsibility” on your vehicles.

75 Pa.C.S. 1786 (a) provides – Every motor vehicle of the type required to be registered under this title which is operated or currently registered shall be covered by financial responsibility.
Optional Coverages in Ohio

Medical Payments (Med Pay) Coverage

Uninsured/Underinsured Motorist Benefits

Collision Coverage v. property liability insurance coverage
Arkansas : No-Fault Law


Essentially, the benefits must extend to the named insured as well as to other enumerated third-parties, irrespective of the insured’s fault. *Ark. Code. Ann.* § 23-89-202 (*Repl. 2008*).

However, the Code also provides that “the named insured shall have the right to reject, in writing, all or any one (1) or more of the coverages enumerated in § 23-89-202.”
However, the General Assembly has expressly provided that the No-Fault Law is not intended in any way to alter or affect the validity of any policy provisions, exclusions, exceptions or limitations contained in a motor vehicle insurance policy required by the Law. § 27-22-101 (a)

- In fact, the Supreme Court of Arkansas has long held that the Legislature’s intent in this provision is clear and has upheld several exclusions
Arkansas: No-Fault Law (Exclusions Upheld)

- See Castandeda v. Progressive Classic Ins. Co, where the Court affirmed a named-driver exclusion that operated to deny benefits to the injured policyholder. 166 S.W.3d 556 (Ark. 2004).
- See Cook v. Wausau Underwriters Ins. Co., where the Court affirmed a provision excluding coverage to the spouse of a policyholder. 772 S.W.2d 614 (Ark. 1989).
- See Smith v. Shelter Mut. Ins. Co., where the court affirmed a named-drive exclusion where the injured party was an innocent third-party pedestrian. 937 S.W.2d 180 (Ark. 1997).
Arkansas : No-Fault Law

• Compare to PA: in 1984, the Pennsylvania Legislature repealed the Pennsylvania No-Fault Act, replacing it with the MVFRL
  ○ The primary concerns in repealing the No-Fault Act were the spiraling costs of automobile insurance and the resultant increase in the number of uninsured motorists. *Windrim v. Nationwide Insurance Company*, 641 A.2d 1154, 1157 (Pa. 1994).
• In 1987, the Arkansas General Assembly passed the Compulsory Insurance Law, which requires all motor vehicles to be covered by a liability insurance policy.

• The Compulsory Insurance Law is supplemental to and cumulative to the Motor Vehicle Safety Responsibility Act, § 27-19-101 et seq.
Pursuant to A.C.A. § 27-22-104, the Policy shall provide as a minimum the following coverage:

1. Not less than $25,000 for bodily injury or death of one person in any one accident
2. Not less than $50,000 for bodily injury or death of two or more persons in any one accident; and
3. If the accident has resulted in injury/destruction to property, not less than $25,000 for the injury to or destruction of property of others
Furthermore, the Arkansas Supreme Court has held that while the Compulsory Insurance Law requires an automobile liability insurance policy to include certain minimum amounts of coverage, it does not require the policy to insure against all kinds of risk.

- Essentially, the Court explained that a policy cannot cover certain types of automobile accidents but provide less coverage than the minimum required by statute. *S. Farm Bureau Cas. Ins. Co. v. Easter*, 287 S.W.3d 537, 542 (Ark. 2008).
- However, the Compulsory Insurance Law does not require that every liability insurance policy cover every type of accident and expressly states that *any* exclusions, exceptions or limitations are permitted. *Id.*
In summary, § 23-89-202, the Arkansas Compulsory Insurance Law is the starting point for its No-Fault law, but an insurer and the insured are permitted by law to change the coverage as long as it does not run afoul of public policy.

- *See S. Farm Bureau Cas. Ins. Co. v. Easter,* where the Court upheld an exclusion preventing innocent third-parties from recovering PIP benefits where their injuries were received while the policyholder was eluding lawful apprehension or arrest.

- The stated purpose of the No-Fault Act is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault, and to require motor vehicle insurance securing such benefits, for motor vehicles required to be registered in this state and, with respect to motor vehicle accidents, a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience. (1999).
The Florida No-Fault Act requires:

- Every insurance policy complying with the security requirements of the No-Fault Act shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle ... to a limit of $10,000 for loss sustained by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:
  - Medical benefits
  - Disability benefits
  - Death benefits
The No-Fault Act requires:

- Every owner or registrant of a motor vehicle required to be registered and licensed in this state shall maintain security in effect continuously throughout the registration or licensing period. *Fla. Stat. § 627.733(1)(a) (2009).*

- Such security shall be provided:
  - By an insurance policy issued in this state by an authorized or eligible motor vehicle liability insurer which provides the benefits and exemptions contained the No-Fault Act; or
  - By any other method authorized by the Florida Motor Vehicle Financial Responsibility Law, *Fla. Stat. § 324.031(2)-(4),* and approved by the Department of Highway Safety and Motor Vehicles as affording security equivalent to that afforded by a policy of insurance or by self-insuring. *Fla. Stat. § 627.733(3)(a)-(b).*
The Supreme Court of Florida has held that the language of the Personal Injury Protection provision of the No-Fault Act should be interpreted liberally to effectuate the legislative purpose of providing broad PIP coverage for Florida motorists. See, Blish v. Atlanta Cas. Co., 736 So. 2d 1151, 1155 (Fla. 1999).

For example: the Court held interpreted the Statute to include reimbursement for travel expenses and transportation costs incurred in connection with medical treatment, as they are considered “reasonably medically necessary” under the Act. Malu v. Sec. Nat’l Ins. Co., 898 So. 2d 69, 76 (Fla. 2005).

The purpose of the Financial Responsibility Law is to recognize the privilege to own or operate a motor vehicles, and to promote safety and provide financial security requirements for such owners or operators whose responsibility it is to recompense others for injury to person or property caused by the operation of a motor vehicle.
Pursuant to the Motor Vehicle Financial Responsibility Law, the operator of a motor vehicle involved in a crash or convicted of certain traffic offenses must respond for such damages and show proof of financial ability to respond for damages in future accidents as a requisite to his or her future exercise of driving privileges in Florida.

The Law also provides that:

- Every owner or operator of a motor vehicle required to be registered in this state shall establish and maintain the ability to respond in damages for liability on account of accidents arising out of the use of the motor vehicle in the amount of $10,000 because of damage to, or destruction of, property of others in any one crash.

- In addition to any other financial responsibility required by law, every owner or operator of a motor vehicle that is required to be registered in this state, or that is located within this state, and who, regardless of adjudication of guilt, has been found guilty of or entered a plea of guilty or nolo contendere to a charge of driving under the influence under ... shall establish and maintain the ability to respond in damages for liability on account of accidents arising out of the use of a motor vehicle in the amount of $100,000 because of bodily injury to, or death of, one person in any one crash and, subject to such limits for one person, in the amount of $300,000 because of bodily injury to, or death of, two or more persons in any one crash and in the amount of $50,000 because of property damage in any one crash.
Motorists can prove compliance with the financial responsibility law by purchasing a commercial insurance policy or by obtaining a certificate of self-insurance issued by the Department of Insurance, as well as through other statutorily approved methods. *Fla. Stat. § 324.031* (1995).

For example: the Supreme Court of Florida has held that a self-insured motorist exclusion in an insurance policy is contrary to the statutory scheme set forth in the uninsured motorist statute, and therefore an exclusion refusing to treat a self-insured motorist as either an underinsured or uninsured is void. *Young v. Progressive Southeastern Ins. Co.*, 753 So. 2d 80, 87 (Fla. 2000).
The Michigan Legislature enacted the No-Fault Automobile Insurance Act, which partially abolished the common law remedy in tort for persons injured by negligent motorists.

The No-Fault Automobile Insurance Act is remedial in nature and is to be liberally construed in favor of the persons who are intended to benefit from it. See Putkamer v. Transamerica Ins. Corp. of Am., 563 N.W.2d 683 (Mich. 1997).

The intended purpose of the Act is to provide a contractual right of action against one’s own insurer for wage loss and medical expenses arising from a motor vehicle accident. See Bradley v. Mid-Century Ins. Co., 294 N.W.2d 141 (Mich. 1980).
Michigan: No-Fault Automobile Insurance Act

- The Act provides:
  - The owner or registrant of a motor vehicle required to be registered in Michigan is required to maintain security for payment of benefits under personal protection insurance, property protection insurance, and residual liability insurance. *MCLS § 500.3101 (2009).*

- Furthermore, the security shall only be required to be in effect during the period the motor vehicle is driven or moved upon a highway.
  - Notwithstanding any other provision in this act, an insurer that has issued an automobile insurance policy on a motor vehicle that is not driven or moved upon a highway may allow the insured owner or registrant of the motor vehicle to delete a portion of the coverages under the policy and maintain the comprehensive coverage portion of the policy in effect. *MCLS § 500.3101 (2009).*
The Act provides for Personal Protection Insurance benefits payable for the following (with certain exclusions):

- Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.
- Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured.
- Expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.
- A person who is 60 years of age or older and in the event of an accidental bodily injury would not be eligible to receive work loss benefits under subsection (1)(b) may waive coverage for work loss benefits by signing a waiver on a form provided by the insurer. An insurer shall offer a reduced premium rate to a person who waives coverage under this subsection for work loss benefits. Waiver of coverage for work loss benefits applies only to work loss benefits payable to the person or persons who have signed the waiver form.
The Michigan Supreme Court has held that non-resident owners or registrants of motor vehicles not registered in the state may not operate or permit such vehicles to be operated within the state for more than thirty (30) days in any calendar year unless security for payment of benefits is continuously maintained. See *Parks v. Detroit Auto Inter-Insurance Exchange*, 393 N.W.2d 833 (Mich. 191)
Furthermore, the court has determined that residual liability coverage for injury or death arising from the use of a vehicle not owned by the insured is not required by the No-Fault Act. Thus, the extent of an insurer’s obligation for injury or death arising from an insured’s use of a non-owned vehicle is governed by the insurer’s policy. See Husted v. Auto-Owners Ins. Co., 540 N.W.2d 743 (Mich. App. 1995).
Michigan has also enacted a Financial Responsibility Act, which serves to secure payments of judgments rendered against owners or operators of motor vehicles.

- The Act also provides that if a person fails to satisfy a judgment within thirty (30) days, the secretary of state shall suspend the license and registration or a non-resident’s operating privilege. *Mich. Comp. Laws §§ 257.511, 257.512*

The purpose of the Financial Responsibility Act is to assure compensation of automobile accident victims

- Consequently, because of their common legislative objective, the two statutes should be read together. *See Crawford County v. Secretary of State*, 408 N.W.2d 112 (Mich. App. 1987).
Maryland law requires that the owners of motor vehicles required to be registered have certain minimum coverage (or comparable security acceptable to the Motor Vehicle Administration).

- The Court has explained that the purpose of requiring personal injury protection is to guarantee some compensation to a motor vehicle accident victim without regard to fault. See Larimore v. American Ins. Co., 552 A.2d 889 (Md. 1989) and to provide the speedy provision of PIP benefits without the lengthy delays entailed by tort litigation. See Ins. Comm’r v. Property & Cas. Ins. Guar. Corp., 546 A.2d 458 (Md. 1988).

- The requirements imposed upon vehicle owners to have mandated security are provided in title 17 of Transportation Article of the Maryland Code.

- The requirements imposed upon insurers to offer the specified coverages are found in title 19 of Insurance Article of the Maryland Code.

- The purpose of the Insurance Article is to put a limited amount of money in the hands of an injured individual under certain circumstances without regard to whether another person is liable for the injuries which the claimant sustained. See Smelser v. Criterion Ins. Co., 444 A.2d 1024 (Md. 1982).
Maryland: Personal Injury Protection Coverage

- The nature and extent of the required security is set forth in § 17-103.
- With a few exceptions, the Transportation Article requires the security to be in the form of an insurance policy providing:
  - liability coverage for bodily injury or death arising from an accident of up to $ 20,000 for one person and up to $ 40,000 for two or more persons;
  - liability coverage for damage to the property of others of up to $ 10,000;
  - unless waived, the benefits described under § 19-505 of the Insurance Article as to PIP coverage; and
  - the benefits required under § 19-509 of the Insurance Article as to required additional coverage.
Maryland: Personal Injury Protection Coverage

- **§ 19-505** of the Insurance Article provides:
  - Unless waived by the insured ... each insurer who sells motor vehicle insurance in Maryland must provide Personal Injury Protection coverage of at least $2,500 for:
    - The first named insured under the policy and any family member of that insured who resides in the insured's household, who is injured in any motor vehicle accident, including an accident that involves an uninsured motor vehicle;
    - Any other individual who is injured in a motor vehicle accident while using the insured vehicle with the permission of the named insured; an individual injured in a motor vehicle accident while occupying the insured vehicle as a guest or passenger; and an individual injured in a motor vehicle accident that involves the insured vehicle, either as a pedestrian or while in, on, or alighting from a vehicle operated by animal or muscular power.
The benefits shall be payable without regard to:

(1) the fault or non-fault of the named insured or the recipient of benefits in causing or contributing to the motor vehicle accident; and

(2) any collateral source of medical, hospital, or wage continuation benefits. *Md. INSURANCE Code Ann. § 19-507 (a) (2009).*
Subject to the following paragraph, if the insured has both coverage for the benefits described in § 19-505 of this subtitle and a collateral source of medical, hospital, or wage continuation benefits, the insurer or insurers may coordinate the policies to provide for non-duplication of benefits, subject to appropriate reductions in premiums for one or both of the policies approved by the Commissioner.

The named insured may:

- Elect to coordinate the policies by indicating in writing which policy is to be the primary policy; or
- Reject the coordination of policies and non-duplication of benefits. 

For example: where the passenger in the covered vehicle was entitled to PIP benefits from the insurer of the vehicle under the priority provision of the coordination of policies contained, the meaning of the priority language in the insurance policy was a non-issue. See Bishop v. State Farm Mut. Auto Ins., 757 A.2d 783 (Md. 2000).
Maryland: Personal Injury Protection Coverage (Surcharge Prohibition)

- An insurer that issues a policy that contains the coverage described in § 19-505 of this subtitle may not impose a surcharge or retire the policy for a claim or payment made under that coverage and, at the time the policy is issued, shall notify the policyholder in writing that a surcharge may not be imposed and the policy may not be retired for a claim or payment made under that coverage. *Md. INSURANCE Code Ann.* § 19-507(c) (2009).
Maryland: Personal Injury Protection Coverage
(Subrogation)

An insurer that provides the benefits described in § 19-505 of this subtitle does not have a right of subrogation and does not have a claim against any other person or insurer to recover any benefits paid because of the alleged fault of the other person in causing or contributing to a motor vehicle accident. *Md. INSURANCE Code Ann. § 19-507(d)* (2009).
The Maryland Code also provides that Personal Injury Protection coverage will **not** extend to the named insured or a family member of the named insured who resides in the named insured's household for an injury that occurs while the named insured or family member is occupying an uninsured motor vehicle owned by the named insured; or an immediate family member of the named insured who resides in the named insured's household. *Md. Code Ann., § 19-505(c)(1)(ii).*

The Pennsylvania statute, 75 Pa. C.S.A. § 1714, provides in pertinent part:

- “An owner of a currently registered motor vehicle who does not have financial responsibility . . . cannot recover first party benefits.” In the cases cited by MAIF, the Pennsylvania court sustained the constitutionality of that statute and enforced it in accordance with the legislative intent behind it.

- As noted by the Pennsylvania Court: the Act has the effect of requiring all owners of registered vehicles to share in the burden of insurance before they can obtain the benefits. By denying benefits to a certain class of people -- those not insuring their registered vehicles -- the Act encourages the purchase of insurance by all owners who register vehicles which can be legally operated on the highways."

The court explained that although it did not intend to quarrel with the Pennsylvania decisions, the similar Maryland provision, § 19-513(c)(2), had a very different purpose and was *not* intended to disqualify a person from recovering PIP benefits to which the person is otherwise entitled, merely because that person owns an uninsured motor vehicle that was not involved in the accident. *Maryland Auto Ins. Fund* at 1118.
New Jersey: Compulsory Automobile Insurance Coverage

New Jersey also requires owners of motor vehicles to maintain motor vehicle liability insurance coverage:

- Every owner or registered owner of a motor vehicle registered or principally garaged in this State shall maintain motor vehicle liability insurance coverage ... insuring against loss resulting from liability imposed by law for bodily injury, death and property damage sustained by any person arising out of the ownership, maintenance, operation or use of a motor vehicle wherein such coverage shall be at least in:
  - an amount or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and
  - an amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to or death of, more than one person, in any one accident; and
  - an amount or limit of $5,000.00, exclusive of interest and costs, for damage to property in any one accident.

- Notwithstanding the provisions of the previous paragraphs, an owner or registered owner of an automobile, registered or primarily garaged in the State may satisfy the requirements of this section by maintaining a basic automobile insurance policy containing coverages.

- Notwithstanding the provisions of the previous paragraphs, an owner or registered owner of an automobile, registered or primarily garaged in the State may satisfy the requirements of this section by maintaining a special automobile insurance policy containing coverages. *N.J. Stat. § 39:6A-3 (2009).*
PA: WHO MAY CLAIM FIRST PARTY BENEFITS?
PA: Eligible Claimants of First Party Benefits

- Named insured on the policy
  - An insured cannot recover first party benefits in an action for damages against a tortfeasor or an uninsured or underinsured motorist. 75 Pa.C.S.A. § 1722

- Not the named insured on the policy but resides in the same house as the named insured
  - Named excluded persons are not eligible for benefits

- Occupant of the insured vehicle

- Non-occupant who is injured in an accident with an insured vehicle
PA: Who Qualifies as an “Occupant?”

- Occupying means performing an act or acts, which is or are normally associated with the immediate use of the vehicle.

- A person qualifies as an occupant of a vehicle, as long as they meet four criteria:
  - There must be a causal relation or connection between the injury and use of the vehicle
  - The person must be reasonably close to the vehicle
  - The person must be vehicle oriented, rather than sidewalk or highway oriented
  - The person must be engaged in a transaction essential to the use of the vehicle at the time

In *Utica Mut. Ins. Co. v. Contrisciane*, 504 Pa. 328 (Pa. 1984), the court set forth the criteria for “occupying” a vehicle. Mr. Contrisciane was involved in a minor motor vehicle collision while he was operating a vehicle owned by his employer. He left his vehicle to give a police officer his driver’s license and owner’s card. While standing outside of the officer’s vehicle an unknown, and therefore presumed uninsured, motorist struck and killed Mr. Contrisciane. Mr. Contrisciane’s estate sued Utica Mutual Insurance for uninsured motorist coverage. The claim proceeded to arbitration, where the arbitrator denied Mr. Contrisciane’s estate benefits under the policy of the vehicle, claiming he was not occupying the vehicle at the time and therefore the policy did not cover him as an insured person. After Utica denied the claim for benefits, the executrix of Mr. Contrisciane’s estate appealed to the Court of Common Pleas of Delaware County.

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The Court of Common pleas found that Mr. Contrisciane was occupying the vehicle, and reversed the arbitrator’s award, holding that Mr. Constriciane’s estate was eligible to receive up to full amount. Utica appealed to the Superior Court who affirmed the trial court’s decision. Utica then appealed to the Supreme Court of Pennsylvania. On the issue of whether Mr. Contrisciane was “occupying” the vehicle, the Supreme Court rejected the view that “occupying” meant being inside or in physical contact with the vehicle. The Court adopted the view that “occupying” meant “performing an act or acts, which is or are normally associated with the immediate use of the auto.” The Court found this definition more consistent with the Uninsured Motorist Act, the purpose of which is to protect people lawfully using roadways who suffer grave injuries through the negligence of others. The Court found that Mr. Contrisciane met the criteria for occupying a vehicle and therefore, as an occupant, was entitled to coverage under the Utica policy.
In *Prop. & Cas. Ins. Co. v. Caperilla*, 2004 U.S. Dist. LEXIS 13032 (E.D. Pa. July 9, 2004), Property and Casualty Insurance Company filed an action seeking declaration that there is no coverage under a commercial automobile insurance policy issued to a borough. Caperilla, a borough police office, filed a claim for benefits under the policy. Both parties motioned for summary judgment. The Court denied Property and Casualty’s motion and granted Caperilla’s motion. The main issue in the case was whether Caperilla was occupying the vehicle at the time of the accident and was therefore insured. Caperilla exited his vehicle to assist another officer with a pedestrian stop. When he realized an approaching vehicle might strike him, he ran back towards his vehicle but the approaching vehicle still struck him.

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The court found that because the nature of the officer’s job required him to exit and reenter his vehicle frequently, the fact that he was temporary out of his vehicle did not render him highway oriented as opposed to vehicle oriented. Additionally, the court found that the officer was engaged in activity essential to the use of his vehicle, as one of the uses of the vehicle was to transport him to pedestrian stops. Therefore, the court held that Caperilla was occupying the vehicle and was insured.
In Petika v. Transcon. Ins. Co., 2004 PA Super 275 (Pa. Super. Ct. 2004), Petika applied to Transcontinental Insurance Company for uninsured motorist benefits when he was struck by a vehicle while directing traffic on a highway, after leaving his work truck to reclaim objects that fell off his coworker’s truck. Transcontinental denied the claim. Petika filed a complaint for declaratory judgment and Transcontinental counterclaimed for declaratory judgment.

The trial court entered a declaratory judgment for Transcontinental following a bench trial, finding that Petika was not vehicle orientated at the time of the accident and therefore, not insured. Petika appealed. The Superior Court affirmed the trial court ruling, finding that Petika did not meet all four criteria set forth in Utica, namely he was not vehicle oriented and was not engaged in activity essential to the use of the vehicle. He was highway oriented, because he was directing traffic, and his vehicle was extraneous, not essential, to his efforts to control traffic.
In *Bodnik v. Philadelphia*, 135 Pa. Commw. 453 (Pa. Commw. Ct. 1990), Bodnik filed a claim for benefits on behalf of the estate of Anderson, who was struck and killed by a vehicle while he was standing next to an occupied police vehicle and speaking with the officer inside. Travelers Insurance Company and Pennsylvania Financial Responsibility Assigned Claims Plan motioned for summary judgment asserting they were not liable under Section 75 Pa.C.S.A. § 1752(a) since another source of benefits was available from the city, as the patrol vehicle was insured under Philadelphia’s self-insurance plan. Section 75 Pa.C.S.A. § 1752(a) states that the Pennsylvania Financial Responsibility Assigned claims is the source of recovery only if no other sources are available.

The Court of Common Pleas granted summary judgment, and the City of Philadelphia appealed, arguing their vehicle was not involved in the accident, and therefore they were not liable. Under 75 Pa.C.S.A. § 1713(a) a person who is not an occupant of a vehicle, or otherwise insured, may recover from any vehicle involved in an accident. The court rejected the City of Philadelphia’s argument that the vehicle must cause the accident to be involved in the accident, and affirmed the summary judgment.
Nationwide Mutual Insurance Co. v. Yungwirth, 940 A.2d 523 (Pa. Super. 2008). On May 11, 2002, Defendant Yungwirth was a passenger in an all-terrain vehicle (“ATV”), which was owned and operated by Michael Tomasic. At the time of the accident, the ATV was not being operated on a public road, but was operated on a public road both prior to and after the accident. The ATV was not insured. However, Tomasic was insured under two automobile policies issued by plaintiff Nationwide. Both policies contained UM coverage and each had an identical provision that excluded certain vehicles from the definition of “uninsured motor vehicles.” One of the exclusions was for “[a]ny equipment or vehicle designed for use mainly off public roads except while on public roads.” Based on this exclusion, Nationwide denied UM coverage to Yungwirth and filed the instant declaratory judgment action.
The Superior Court found, contrary to the trial court, that these exclusions were permissible under the applicable provisions of the MVFRL. Specifically, the Superior Court held that the definition of “motor vehicle” under the Snowmobile All-Terrain Vehicle Law, 75 Pa.C.S. 7702 and 7721, superseded the more general definition contained in the Vehicle Code at 75 Pa.C.S. 102. Accordingly, the Superior Court held that the exclusion at issue did not impermissibly narrow the MVFRL, and remanded with instructions to enter judgment in favor of Nationwide.
Burdick v. Erie Insurance Group, 946 A.2d 1106 (Pa. Super. 2008). - Appellant insureds filed a complaint for declaratory judgment against appellee insurer. The insureds argued they were entitled to uninsured motorist (UM) benefits. The Court of Common Pleas of Elk County Civil Division (Pennsylvania) granted summary judgment in favor of the insurer concluding that a policy exclusion did not violate the Motor Vehicle Financial Responsibility Law (MVFRL), 75 Pa.C.S. § 1701 et seq. The uninsured motorist was operating an uninsured dirt bike in a private driveway when the dirt bike entered the roadway and collided with the insured's vehicle. Consequently, the insureds filed a claim for UM benefits. The insurer denied the claim on the basis that the dirt bike was specifically excluded because it was designed for use primarily off road.
Burdick, continued...

The appellate court held that the dirt bike fell within the definition of a motor vehicle as defined by 75 Pa.C.S. § 102. 75 Pa.C.S. § 1731 clearly provided that UM coverage was to provide protection for persons who suffered injury arising out of the maintenance or use of a motor vehicle and were legally entitled to recover damages therefore from owners or operators of uninsured motor vehicles. 75 Pa.C.S. § 1731(b). Accordingly, the exclusion which excluded UM coverage for a collision with a motor vehicle intended primarily for off-road use, violated the MVFRL as it was clear that the Legislature considered whether the MVFRL should be applicable to situations involving recreational vehicles not intended for highway use, but specifically chose not to limit UM coverage where the accident involved this type of vehicle. The judgment of the trial court was reversed. The case was remanded for entry of judgment in favor of the insureds.
PA: WHO MAY NOT CLAIM FIRST PARTY BENEFITS?
Under 75 Pa.C.S.A. § 1714 the following persons may not recover first party benefits:

- An owner of a currently registered motor vehicle who does not have financial responsibility
  - This applies regardless of whether the uninsured vehicle was involved in the accident
- An operator or occupant of a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedalcycle or like type vehicle required to be registered
Under 75 Pa.S.C.A 1718 1st party benefits will not be paid to:

- A converter of the vehicle who is using it without permission
  - Converters are prohibited from recovering first party benefits only under policies in which they are not insured. They may still recover under their own policy.

- A person committing a felony that contributes to his injury

- A person eluding lawful apprehension

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- A person intentionally injuring or attempting to injure himself or others

- A person excluded under named driver exclusions
  - The insurer or the first named driver may name a person as an excluded driver.
    - The named driver exclusion only applies if the named driver is actually driving the vehicle. The named driver may still recover first party benefits as an occupant or non-occupant injured by the vehicle.
    - If the named insured, and not the insurer, names a driver to be excluded under their policy, the exclusion may only apply if the named driver excluded is insured on another policy.
In *McClung v. Breneman*, 700 A.2d 495 (Pa. Super. Ct. 1997), McClung filed a complaint against the Brenemans seeking noneconomic damages and reimbursement for medical bills, following a motor vehicle collision with the Brenemans in which she sustained injuries. McClung was driving her uninsured vehicle at the time of the accident. The Brenemans motioned for summary judgment, arguing that since McClung was uninsured at the time of the accident, the MVFRL deemed her to have chosen the limited tort option, and therefore she could not recover noneconomic damages because her injuries were not serious. They also argued that she could not recover medical benefits because she was uninsured.

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McClung continued...

The trial court agreed with the Brenemans and granted summary judgment in their favor. McClung appealed, arguing that the trial court erred in determining as a matter of law that her injuries were not serious. McClung was able to return to work without limitations shortly after the accident, and offered no evidence of serious injury. Therefore, the Court waived this issue on appeal. McClung also argued that the trial court erred in holding that her lack of insurance prevented her from recovering medical benefits. The Court disagreed, finding that even though it is not explicitly stated in the MVFRL, the legislature intended that uninsured motorists are precluded from recovering medical expenses from either insurers or third-party tortfeasors. Based on this reasoning, the Superior Court affirmed the ruling of the trial court.
In Swords v. Harleysville Ins. Cos., 584 Pa. 382 (Pa. 2005), Wayne Swords sought to recover first party benefits after he sustained injuries in an accident in his father Bernell’s vehicle. Bernell’s vehicle was registered and insured in Pennsylvania. Wayne owned a vehicle that was registered in Pennsylvania, but was uninsured. Pennland Insurance, now Harleysville Insurance, denied the claim. The Swords then sued Pennland under eight counts, included a request for declaratory judgment. Pennland filed an answer and new matter, arguing that section 1714 of the MVFRL requires the owner of a registered vehicle to insure the vehicle in order to obtain first party benefits, and therefore, because Wayne owned a registered but uninsured vehicle, he was ineligible for benefits. The Swords answered Pennland’s new matter and filed a motion for partial summary judgment on their declaratory judgment count. The Swords argued that, under earlier decisions, the limits of section 1714 do not apply to a driver who is not operating his vehicle at the time of the accident. Based on this reasoning, the trial court granted the Sword’s motion for partial summary judgment.

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The Superior Court found that the language of section 1714 unambiguously precluded owners of uninsured vehicles from recovering first party benefits and reversed the trial court decision on appeal. In doing so, the Superior Court thereby reversed their own earlier decisions that allowed owners of registered but uninsured vehicles to recover first party benefits when they were injured in accidents involving vehicles other than their own. The Swords appealed the Superior Court decision. The Supreme Court affirmed the Superior Court decision. The Court agreed with Pennland’s argument that regardless of the fact that he was driving his father’s insured vehicle at the time of the accident, Wayne did not have the financial responsibility required to obtain first party benefits on his own vehicle, therefore he could not recover the benefits. The Court stated that section 1714 clearly precludes owners of registered but uninsured vehicles from recovering first party benefits under any situation. The Court also points out that although owners of uninsured registered vehicles may not recover first party benefits, they can recover by other means for injuries sustained in accidents.
In Santorella v. Donegal Mut. Ins. Co., 2006 PA Super 202 (Pa. Super. Ct. 2006), Santorella applied for first party benefits from his parents’ insurer after he sustained injuries in a motor vehicle accident. Santorella owned an uninsured vehicle registered in California. He was not in his own vehicle at the time of the accident, but a third party’s vehicle. Santorella’s parents’ policy provided first party benefits to any member of their household, which included Santorella. Donegal Insurance denied Santorella’s claim because he owned a registered, uninsured vehicle. Santorella then filed a complaint to recover the benefits. Both parties motioned for summary judgment. The trial court granted Santorella’s motion and denied Donegal’s motion. Donegal appealed.

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Santorella continued...

The main issue on appeal was whether Santorella’s vehicle, which was registered in California, qualified as a registered uninsured vehicle under the MVFRL. Santorella argued that because he did not intend to drive the vehicle for several months, it did not need to be registered. The Court stated that, as pointed out in previous rulings, the terms of the MVFRL are clear, and that owners of registered but uninsured vehicles cannot recover first party benefits, regardless of what state the vehicle is registered in. The Court granted summary judgment to Donegal, and reversed the summary judgment in favor of Wayne.
Exclusion Applies Regardless of Whether the Vehicle is Operable:

In *Allen v. Erie Ins. Co.*, 369 Pa. Super. 6 (Pa. Super. Ct. 1987), Allen filed a claim with Erie after he sustained injuries while driving a vehicle owned by a friend that Erie insured. Erie denied the claim because Allen owned a registered but uninsured vehicle that was inoperable at the time of the accident. Allen sued to recover the benefits. On appeal, one of Allen’s arguments was that because his vehicle was not maintained or used, he did not need to insure it.

The trial court found, and the Superior Court agreed, that there is no language in the MVFRL that states the registered vehicle must be operable to require insurance. The Superior Court declined to create an exception to the rule that all registered vehicles must have insurance for their owners to recover first party benefits, and affirmed the trial court ruling.
Ownership Carries Over from Spouse:

In *Allen v. Merriweather*, 22 Phila. 304 (Pa. C.P. 1991), Allen filed a complaint with Travelers insurance, as assignees of the Pennsylvania Assigned Claim’s plan, for benefits after he sustained injuries in an accident while driving a vehicle registered to his wife. The PACP filed an answer and new matter arguing that because Allen failed to comply with the requirements of the MVFRL he was ineligible to recover benefits. Allen’s wife owned an uninsured vehicle at the time of the accident.

The court concluded that as her husband, Allen had an ownership interest in the uninsured vehicle. Therefore, the court found that he did not comply with the requirements of the MVFRL and denied him first party benefits. The court dismissed Allen’s complaint with prejudice and granted the PACP motion for summary judgment.
Out of state motor vehicles are required to be registered in PA even if they are registered in another state.
In *Pugh v. Government Employees Ins. Co.*, 380 Pa. Super. 606 (Pa. Super. Ct. 1989), Pugh, a Maryland resident, initiated action to recover medical and income loss benefits under the Pennsylvania MVFRL after he was involved in a motor vehicle accident in Pennsylvania. The issue in this case was whether MVFRL section 1711 requires a claimant’s vehicle to be both registered and operated in Pennsylvania for the claimant to recover medical and income loss benefits. The trial court found that section 1711 applied to vehicles that are operated but not registered in Pennsylvania, and found for Pugh. Government Employees Insurance motioned for a judgment on the pleadings, which was denied. Government Employees then appealed to the Superior Court of Pennsylvania.

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The Superior Court reversed the order of the trial court and granted Government Employees’ motion for judgment on the pleadings. The Superior Court stated two requirements for determining whether a claimant is eligible to recover benefits under the MVFRL: the insured vehicle must be a vehicle of the type required to be registered in the Commonwealth, and the insured vehicle must actually be registered in the Commonwealth. The Court stated that to find otherwise would negate the purpose of the statute.

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Bridges continued...

The Court analyzed MVFRL section 1752, which allows eligible claimants who cannot recover from other sources to recover benefits under the Assigned Claims Plan, to determine that Bridges was not eligible for the benefits. The Court found that because section 1752(a)(5) states that a claimant is not entitled to recover benefits if he is an occupant of a vehicle not required to provide coverage under the MVFRL. Because the vehicle involved in the accident that Bridges occupied was registered in Florida, it was not required to provide coverage under the MVFRL. Therefore, the Court found Bridges ineligible for benefits under the Assigned Claims Plan.
In *Gallo v. Nationwide Ins. Co.*, 2002 PA Super 25 (Pa. Super. Ct. 2002), the Gallos filed for first party benefits on behalf of their minor son after he sustained injuries when a vehicle struck him while he was crossing the highway on a snowmobile. Nationwide filed preliminary objections in the form of demurrer that the trial court sustained. The Gallos appealed. The Superior Court affirmed the trial court ruling, holding that because snowmobiles are recreational vehicles not intended for highway use, under both the policy in question and the MVFRL, injuries obtained on a snowmobile are not covered.
- First party benefits are paid by the insured’s own carrier regardless of who was at fault for the accident.

- Is there a limit on claims?
  - First party benefits are recoverable on a per person, per accident basis.
  - Each insured person injured in an accident may recover up to the full benefit amount for each injurious accident.
As established by 75 Pa.C.S.A. § 1713(a), except as pertains to ineligible claimants, a person who suffers injury arising out of the maintenance or use of a motor vehicle shall recover first party benefits against applicable insurance coverage in the following order of priority:

1. For a named insured, the policy on which he is the named insured.

2. For an insured, the policy covering the insured.
   - This is a person who is not the named insured but still qualifies under the policy, such as a spouse, relative or minor in the custody of the named insured or a relative of the named insured who resides in the same household as the named insured.
   - This may be defined more broadly in the policy than it is under the MVFRL

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3. For the occupants of an insured motor vehicle, the policy on that motor vehicle.
   - “Occupant” may be defined more broadly under the policy than in the MVFRL

4. For a person who is not the occupant of a motor vehicle, the policy on any motor vehicle involved in the accident. A parked and unoccupied motor vehicle is not a motor vehicle involved in an accident unless it was parked so as to cause unreasonable risk of injury.
Under 75 Pa.C.S.A. § 1713(b), when there are two or more policies of equal priority, the insurer against whom a claim is asserted first under the priorities set forth above shall process and pay the claim as if wholly responsible.

The insurer is thereafter entitled to recover contribution pro rata from any other insurer for the benefits paid and the costs of processing the claim.

If contribution is sought among insurers responsible under subsection (a)(4), proration shall be based on the number of involved motor vehicles.
Stacking (adding together the limits per vehicle of multiple vehicles under one policy or multiple policies) is not permitted for 1st party benefits.

If there are multiple sources of equal priority of first party benefits stacking is still not permitted. The claimant may seek the full amount of first party benefits allowable under the policy with the higher limit.

If the insured makes a claim against the policy with the lower limit, and exhausts his benefits under that policy, he may still recover up to the full amount of first party benefits allowable under the policy with the higher limit, but no more.

- E.g. Policy A has a limit of $100,000 and Policy B has a limit of $200,000. If insured makes a claim against Policy A and recovers $100,000, he is entitled to make a subsequent claim against Policy B for an additional $100,000, bringing his total recovery to $200,000, the limit under Policy B.
In *Neilson v. Nationwide Ins. Co.*, 1999 PA Super 229 (Pa. Super. Ct. 1999) Neilson, who was injured in a motor vehicle accident was a named insured on two insurance policies, one issued by Nationwide and the other issued by Allstate. Neilson exhausted the income loss benefits under the Allstate policy and filed a claim with Nationwide. Nationwide initially paid him a portion of the benefits under its policy. Nationwide then refused to pay benefits, arguing that under the MVFRL they could not pay him benefits because he had exhausted benefits for the same loss under the Allstate policy. The trial court ordered Nationwide to pay the remainder of the limits of their policy, deducting the amount Neilson received under the Allstate policy. Nationwide appealed the order.

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Neilson continued...

The Superior Court affirmed the trial court’s order, finding that the MVFRL prohibition against stacking coverage limits did not apply where a claimant only sought to recover first party benefits in an amount equal to the highest applicable policy limit. The Court held that where a claimant exhausts the first party benefit limits of its policy with one carrier, the claimant may bring a claim against another carrier of equal priority where the policy issued by that second carrier provides for a higher limit of benefits. In doing so the claimant may only recover the for the difference between the amount paid by the first carrier and the limits of the coverage provided by the second carrier.
In *Wheeler v. Nationwide Mut. Fire Ins. Co.*, 2006 PA Super 197 (Pa. Super. Ct. 2006), Wheeler filed a claim under his mother’s policy with Nationwide for income loss benefits after he sustained injuries in a motor vehicle collision. Wheeler was the named insured on his own policy, which did not provide income loss benefits. He was not a named insured on the Nationwide policy, which covered the vehicle he was driving at the time of the accident. Nationwide filed preliminary objections in the form of demurrer, arguing that the MVFRL anti-stacking provisions precluded Wheeler from collecting income loss benefits.

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Wheeler continued...

The trial court sustained Nationwide’s demurrer. On appeal, the Superior Court of Pennsylvania affirmed the demurrer. In their analysis, the Superior Court differentiated the instant case from Neilson, in that the two policies in this cases were of different priority, whereas in Neilson they were of the same priority. The court stated that claimants may only recover from the policy of the highest priority, and may not recover benefits from multiple sources at different priority levels. Because Neilson’s insurance policy was of higher priority than his mother’s Nationwide policy, he was precluded from recovering benefits under the Nationwide policy.
PA: Choice of Law When Multiple States Are Involved
In *Jarrett v. Pa. Nat'l Mut. Ins. Co.*, 400 Pa. Super. 565 (Pa. Super. Ct. 1990), Jarrett, along with two other persons sustained injuries in a motor vehicle collision. Jarrett and the other plaintiffs were Pennsylvania residents, and the accident took place in Pennsylvania; however, the vehicle the accident occurred in was registered and insured in North Carolina. Jarrett et al sued Pennsylvania National Insurance Company (PNI) to recover for their injuries. PNI settled the third party claims for bodily injury with the plaintiffs individually, but denied all claims for medical expenses and wage loss, arguing that neither the policy nor North Carolina law required payment of such benefits.

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Jarrett continued...

Arbitrators in the Court of Common Pleas found that PNI owed Jarrett et al the full amount they requested. PNI appealed, then all parties motioned for summary judgment, which was granted in favor of Jarrett et al. PNI filed a post trial motion seeking judgment notwithstanding the verdict which was denied, and PNI subsequently appealed. PNI argued that the MVFRL does not require vehicles not registered in Pennsylvania to conform to its scheme regarding first party benefits. The Superior Court agreed with PNI and held that PNI was not required to provide medical and wage loss benefits to Jarrett and the other plaintiffs under the express terms of the MVFRL because the coverage minimums did not apply to vehicles registered in other states.
In *Smith v. Firemen’s Ins. Co.*, 404 Pa. Super. 93 (Pa. Super. Ct. 1991), Smith, a Pennsylvania resident sued Firemen's, a New Jersey insurance company, to recover first party medical expense benefits after she sustained injuries that rendered her a quadriplegic in a motor vehicle accident in New Jersey. Firemen's paid Smith an initial $10,000 but refused to pay for any additional medical expenses. The trial court held that under the MVFRL Firemen's did not owe Smith any additional benefits and granted summary judgment in favor of Firemen's. Smith appealed.

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Smith continued...

The main issue on appeal was whether New Jersey’s Compulsory Insurance Law provisions requiring New Jersey Insurance companies to pay unlimited first party benefits to an out-of-state insured that operates her vehicle in New Jersey were applicable to the case. The Superior Court held that Firemen's could not avoid application of its own state's compulsory insurance laws and applied the comity principle because the application of the New Jersey statute furthered Pennsylvania's interest in insurance coverage. The Superior Court reversed the summary judgment in favor of Firemen's and remanded the case for further proceedings.
In *Bennison v. Nationwide Mut. Ins. Co.*, 1999 Pa. Dist. & Cnty. Dec. LEXIS 162 (Pa. C.P. 1999), Bennison, a resident of New York, sustained injuries in a motor vehicle collision in Pennsylvania while riding in a vehicle registered and insured in New York. Under the terms of the applicable insurance policy, Bennison was not entitled to recover benefits. Bennison argued, however, that Pennsylvania law, which would invalidate certain provisions of the contract, should apply, because Pennsylvania had more significant contacts with the parties and a greater interest in the proceedings, and that choice of law principles require that Pennsylvania law apply. Bennison sued to recover and Nationwide motioned for a judgment on the pleadings.

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The court granted Nationwide’s motion for a judgment on the pleadings. The court found that the terms of the contract were valid and enforceable under the law applicable to it, which was New York law and that the contract should be interpreted according to the law of the state of its formation. The court found that although Bennison’s accident took place in Pennsylvania and Bennison later moved to Pennsylvania, that alone was not enough to render Pennsylvania’s laws applicable in determining issues of contract validity and enforceability. Because the contract was validly written the court found that all of the applicable provisions should apply.
In *Racicot v. Erie Ins. Exch.*, 2005 PA Super 286 (Pa. Super. Ct. 2005), Racicot, a Pennsylvania resident sustained injuries in a motor vehicle accident in Ohio, with Miranda, an Ohio resident. Racicot received some benefits from his Miranda’s policies, then applied for underinsured motorist benefits under his policy with Erie. During the underinsured motorist arbitration to determine what benefits Racicot was owed, the arbitrators applied Ohio law. Erie filed a petition to vacate the award. The award was vacated, and the court of common pleas determined that Pennsylvania law should apply.

A new, lesser award was determined and Racicot appealed, arguing that Ohio law should apply. The Superior Court stated that the policies and interests underlying the case and not the location of the injury should determine which states law should apply. The Superior Court affirmed the award under Pennsylvania law, finding that because the policies and interests underlying the case concern the application of Pennsylvania statutes, the only reasonable choice of law is Pennsylvania.
Under the terms of Pa.C.S.A. § 1797(a), medical providers cannot bill the insured client directly, but must bill the insurance company directly. The insurance company then calculates the correct amount to pay the medical providers, subject to the following limits:

- A medical provider shall not require, request or accept payment for treatment or services in excess of 110% of the prevailing charge at the 75th percentile; 110% of the applicable fee schedule, the recommended fee or the inflation index charge; or 110% of the diagnostic-related groups (DRG) payment; whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services at the time the services were rendered, or the provider's usual and customary charge, whichever is less.

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- If a prevailing charge, fee schedule, recommended fee, inflation index charge or DRG payment has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed 80% of the provider's usual and customary charge.

- If acute care is provided in an acute care facility to a patient with an immediately life-threatening or urgent injury by a Level I or Level II trauma center or to a major burn injury patient by a burn facility which meets all the service standards of the American Burn Association, the amount of payment may not exceed the usual and customary charge.
The time period within which an insured person may file for first party benefits is defined by 75 Pa.C.S.A. § 1721

- **Adults**
  - The statute of limitations to bring first party benefit claims is four years from the date of the accident.
  - If benefits are paid the statute of limitations runs from the date of the last payment.
  - The claim may be brought by the individual or the medical care provider.

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- **Minors**
  - The four year statute of limitations does not begin until the minor reaches the age of 18

- **Death**
  - If the insured dies within 24 months of the accident and death and funeral benefits become available, this alone does not toll the statute of limitations.

- **Out of state accidents may have shorter statute of limitations periods.**
Ohio: First Party Benefits / Claims Handling

A. Unfair Property And Casualty Claims Settlement Practices

B. Unfair Trade Practices Act

C. Bad Faith
Ohio: First Party Benefits / Claims Handling

Unfair Property And Casualty Claims Settlement Practices

The Ohio Department of Insurance has created the “Unfair Property/Casualty Claims Settlement Practices” (“UCSP”). OAC Ann. 3901-1-54 (2008). This code is to provide uniform minimum standards for the investigation and disposition of property and casualty claims arising under insurance contracts or certificates issued to residents of Ohio. It does not create or imply a private cause of action for violation of this rule; however, violations thereof can be considered in adjudicating whether an insurer acted in bad faith. *Furr v. State Farm Mut. Auto. Ins. Co.*, 128 Ohio App. 3d 607 (1998).
Unfair Property And Casualty Claims Settlement Practices

When A Claim is Received:

Per OAC Ann. 3901-1-54 (F)(2), an insurer has **15 days** to acknowledge receipt of a claim. This can be satisfied by making payment within 10 days (see OAC Ann. 3901-1-54 (G)(6)), or by providing necessary claim forms and instructions to claimant.
Unfair Property And Casualty Claims Settlement Practices

When A Claim is Received:

It is incumbent on the insurer to provide any specific claims forms for completion with specific instructions. But, an insurer cannot deny a claim solely on the basis that the proof of loss produced by claimant was not on insurer’s usual form.
Unfair Property And Casualty Claims Settlement Practices
When A Claim is Received:

Per OAC Ann. 3901-1-54 (F)(3), an insurer has 15 days to respond to any communication from a claimant, when that communication suggests a response is appropriate.
When Proof of Loss is Received:

Per OAC Ann. 3901-1-54 (G)(1), an insurer has **21 days** of the receipt of properly executed proof(s) of loss to decide whether to accept or deny such claim(s). If more time is needed to investigate, the insurer must provide an explanation of the need for more time within the 21 days. There is a continuing obligation to notify the claimant in writing, at least every **45 days** of the status of the investigation and the continued time for the investigation.
Unfair Property And Casualty Claims Settlement Practices
When Claim is Accepted and Amount Undisputed:

Per OAC Ann. 3901-1-54 (G)(6), an insurer shall tender payment to a first party claimant no later than 10 days after acceptance of a claim if the amount of the claim is determined and is not in dispute, unless the settlement involves a structured settlement, action by a probate court, or other extraordinary circumstances as documented in the claim file.
Unfair Property And Casualty Claims Settlement Practices

When Claim is Accepted and Amount Undisputed:

Per OAC Ann. 3901-1-54 (G)(8), if a claim involves multiple coverages under any policy, no insurer shall withhold payment under any such coverage when the payment is known, the payment is not in dispute, and the payment would extinguish the insurer's liability under that coverage. No insurer shall withhold such payment for the purpose of forcing settlement on all other coverage to effect a single payment.
Unfair Property And Casualty Claims Settlement Practices

When Claim is Accepted and Amount Undisputed:

Per OAC Ann. 3901-1-54 (E)(5), no insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that the payment is final or a release of any claim unless the policy limit has been paid or the first party claimant and the insurer have agreed to a compromise settlement regarding coverage and the amount payable under the insurance contract.
Unfair Property And Casualty Claims Settlement Practices
When Claim is Accepted and Amount Undisputed:

Per OAC Ann. 3901-1-54 (E)(6), no insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.
Unfair Property And Casualty Claims Settlement Practices

When Coverage is Being Denied:

Per OAC Ann. 3901-1-54 (G)(2), no insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The claim file of the insurer shall contain documentation of the denial in accordance with section (D) of this rule.
Unfair Property And Casualty Claims Settlement Practices

Duty to Disclose Policy Information or Suit Limitations to Claimant:

Per OAC Ann. 3901-1-54 (E)(1), an insurer shall fully disclose to first party claimants all pertinent benefits, coverage or other provisions of an insurance contract under which a claim is presented.
Unfair Property And Casualty Claims Settlement Practices

Fraud by Claimant:

If an insurer reasonably believes, based upon information obtained and documented within the claim file that a claimant has fraudulently caused or contributed to the loss as represented by a properly executed and documented proof of loss, such information shall be presented to the fraud division of the department within 60 days of receipt of the proof of loss. Immunity is afforded for the reporting and the information submitted will be confidential as provided by sections 3901.44 and 3999.31 of the Revised Code. OAC Ann. 3901-1-54 (G)(1)
Unfair Trade Practices Act

SECTION 3901-1-07(C) OF THE OHIO ADMINISTRATIVE CODE enumerates sixteen unfair practices which "[i]t shall be deemed an unfair or deceptive practice to commit or perform with such frequency as to indicate a general business practice.

- no private cause of action created by Act, but evidence of violation may be offered as evidence of insurer acting in bad faith
Ohio: First Party Benefits / Claims Handling

- Unfair Trade Practices Act

  - **Prohibited Actions:**
    1) Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverage at issue;

      (a) Misrepresenting a pertinent policy provision by making any payment, settlement, or offer of first party benefits, which, without explanation, does not include all amounts which should be included according to the claim filed by the first party claimant and investigated by the insurer;

      (b) Denying a claim on the grounds of a specific policy provision, condition, or exclusion without reference to such provision, condition, or exclusion;
Ohio: First Party Benefits / Claims Handling

- **Unfair Trade Practices Act**

  (2) Failing to acknowledge pertinent communications with respect to claims arising under insurance policies in writing, or by other means so long as an appropriate notation is made in the claim file of the insurer, within fifteen (15) days of receiving notice of a claim in writing or otherwise;

  (3) Failing to make an appropriate reply within twenty-one days of all other pertinent communications and/or any inquiries of the department of insurance respecting a claim;
• **Unfair Trade Practices Act**

(4) Failing to adopt and implement reasonable procedures to commence an investigation of any claim filed by either a first party or third party claimant, or by such claimant's authorized representative, within twenty-one days of receipt of notice of claim;

(5) Failing to mail or furnish claimant or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant, within fifteen days of receiving notice of claim, unless the insurer, based on the information then in its possession does not yet know all such requirements, then such notification shall be sent, within a reasonable time;
Ohio: First Party Benefits / Claims Handling

- **Unfair Trade Practices Act**
  
  (6) Not offering first party or third party claimants, or their authorized representatives who have made claims which are fair and reasonable and in which liability has become reasonably clear, amounts which are fair and reasonable as shown by the insurer's investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions;

  (7) Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less then the amounts ultimately recovered in suits brought by them when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;
Ohio: First Party Benefits / Claims Handling

**Unfair Trade Practices Act**

(8) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(9) Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge, or consent of insureds;

(10) Attempting to settle or compromise claims for less than the amount which the insureds had been led reasonably to believe they were entitled to, by written or printed advertising material accompanying or made part of an application;
• Unfair Trade Practices Act

(11) Attempting to delay the investigation or payment of claims by requiring an insured and his physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(12) Failing to advise the first party claimant or the claimant's authorized representative, in writing or by other means so long as an appropriate notation is made in the claim file of the insurer, of the acceptance or rejection of the claim, within twenty-one days after receipt by the insurer of a properly executed proof of loss;
Unfair Trade Practices Act

(12)(a) Failing to notify such claimant or the claimant's authorized representative, within twenty-one days after receipt of such proof of loss, that the insurer needs more time to determine whether the claim should be accepted or rejected;

(b) Failing to send a letter to such claimant or the claimant's authorized representative, stating the need for further time to investigate the claim, if such claim remains unsettled ninety days from the date of the initial letter setting forth the need for further time to investigate;

(c) Failing to send to such claimant or authorized representative every ninety days after the first ninety-day claim investigation period, a letter setting forth the reasons additional time is needed for investigation, unless the delay is caused by factors beyond the insurer's control;
Unfair Trade Practices Act

(13) Failing to advise such claimant or claimant's authorized representative, of the amount offered, if such claim is accepted in whole or in part;

(14) Refusing payments of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information;

(15) Failing to adopt and implement reasonable standards for the proper handling of written communications, primarily expressing grievances, received by the insurer from insureds or claimants;
(16) Failing to pay any amount finally agreed upon in settlement of all or part of any claim or authorized repairs to be made upon final agreement not later than five days from the receipt of such agreement by the insurer at the place from which the payment or authorization is to be made or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.
Ohio: First Party Benefits / Claims Handling

Insurance Bad Faith

- Ohio does not have a bad faith statute and the cause of action is grounded in common law, and is considered a tort action.
- An insurer's lack of good faith in the processing of a claim is frequently referred to as "bad faith." Such conduct gives rise to a cause of action in tort against the insurer. *Hoskins v. Aetna Life Ins. Co. (1983), 6 Ohio St. 3d 272, 6 Ohio B. Rep. 337, 452 N.E.2d 1315.*
• Compare/Contrast Pa. Statutes and Regulations controlling insurance claims adjustment:
  
  ▫ 40 P.S. §1171.7 - PA. Unfair Insurance Practices Act (UIPA)
  
  
  ▫ 73 P.S. §201-1 - PA Unfair Trade Practices and Consumer Protection Law
Bad Faith Statute

42 Pa. C.S. Section 8371 provides as follows:

Section 8371. Actions on insurance policies.

In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:

1. award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%;
2. award punitive damages against the insurer;
3. assess court costs and attorney fees against the insurer.
"Bad faith" is not defined in the statute but has been identified by the courts of Pennsylvania as a "frivolous or unfounded refusal to pay proceeds of a policy." Terletsky v. Prudential Prop. and Cas. Ins. Co., 437 Pa. Super. 108, 649 A.2d 680 (1994). To state a statutory "bad faith" claim, a plaintiff must present clear and convincing evidence that (1) an insurer denied benefits under a policy without any reasonable basis to do so and (2) the insurer knowingly or recklessly disregarded its lack of reasonable basis for denying the claim.
Subsequent to *Terletsky*, the Pennsylvania Superior Court adopted the definition of “bad faith” from Black’s Law Dictionary as applicable to “bad faith” in the context of 42 Pa.C.S. 8371. Said definition reads:

“Bad Faith” on the part of an insurer is any frivolous or unfounded refusal to pay proceeds of a policy; it is not necessary that such refusal be fraudulent. For purposes of an action against an insurer for failure to pay a claim, such conduct imports a dishonest purpose and means a breach of a known duty (i.e. good faith and fair dealing), through some motive of self-interest or ill will; mere negligence or bad judgment is not bad faith.

Since *O’Donnell*, there has been a challenge by insured as to whether “motive of self-interest or ill will” is a third element required for a bad faith claim. The Western District Court of Pennsylvania predicted that the Supreme Court of Pennsylvania will rule consistently with the Superior Court concerning the level of culpability that needs to be associated with a finding of bad faith which is that the “motive of self interest or ill will” is *not* a third element required to establish bad faith, but it is probative of the second element identified in *Terletsky*, i.e. that the insurer knew or recklessly disregarded its lack of reasonable basis in denying the claim.” *Employers Mutual Casualty Company v. James Loos et al.*, 476 F.Supp. 2d 478 (W.D. Pa. 2007); *See also Barry v. Ohio Casualty Group*, 2007 U.S. Dist. LEXIS 2684 *23-24* (W.D. Pa. 2007).
As to the level of culpability necessary, mere negligent conduct, however harmful to the interests of the insured, is not sufficient for a finding of bad faith. Also, allegations of negligence in the performance of obligations under an insurance policy is subject to dismissal, based on the gist of the action doctrine. If the requisite wrongful state of mind, i.e., that the insurer knew or recklessly disregarded the lack of reasonable basis to deny coverage, is not alleged, the claim is subject to dismissal. *Kojeszewski v. Infinity Insurance Co.*, 2006 U.S. Dist. LEXIS 79306 (Mem. Op. M>D. Pa. Oct. 2006).
Generally, New York has no bad faith remedy for property insurance claims, except amount due under policy.

To go beyond, at a minimum, needed to prove:
- Insurer has engaged in both egregious tortuous conduct directed at the insured, and
- a pattern of similar conduct directed at the public generally*

Recent decision moves away from this:

Bi-Economy, continued

- Insured owned wholesale and retail meat market

- Insured had 1 year of business interruption insurance

- Destroyed in fire – only 7 months of coverage offered

- Bi-Economy never resumed business

- Bi-Economy sued for breach of contract and for consequential damages of business going under
NY: First Party Benefits / Claims Handling

Bi-Economy, continued

- Court looked at purpose of business interruption policy – financial support to sustain business in the event of disaster
- Part of bargain was to receive funds promptly, so insured could avoid collapse and get back on its feet
- Insurer had agreed to evaluate a claim honestly, adequately, and – most importantly – promptly

Held – where insured suffers additional damages as a result of excessive delay or improper denial, insurer is liable, not to punish insurer, but to give insured his bargained-for benefit.
Alaska has also enacted an Unfair Trade Practices and Consumer Protection law. *Alaska Stat.* § 45.50.471 (2009). The Law states that “unfair methods of competition and unfair or deceptive acts or practices in the conduct of trade or commerce are declared to be unlawful.”

The Law further provides a lengthy list of recognized acts or practices (including: fraudulently conveying or transferring goods or services by representing them to be those of another; selling, falsely representing, or advertising meat, fish, or poultry which has been frozen as fresh food; disconnecting, turning back, or resetting the odometer of a vehicle to reduce the number of miles indicated, etc.).
The California Consumers Legal Remedies Act ("CLRA"), prohibits specified unfair and deceptive acts and practices in a transaction intended to result or which results in the sale or lease of goods or services to any consumer. Cal. Civ. Code, § 1770(a) (2009).

However, life insurance is not a service subject to the Act's remedial provisions.

§ 1760 states that the provisions of the CLRA shall be liberally construed and applied to promote its underlying purposes, which are to protect consumers against unfair and deceptive business practices and to provide efficient and economical procedures to secure such protection.
Louisiana: Bad Faith Statute

- Thus, the insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both.
- Furthermore, a claimant may recover *penalties* under this bad faith insurance statutes.
The Statute provides that any insurer who breaches the duties of good faith and fair dealing "shall be liable for any damages sustained as a result of the breach."

Additionally, the statute provides a list of acts that if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties (including: Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue; Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause etc.). La. R.S. § 22:1973.
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For a more thorough examination of the above opinions, as well as a summary of additional liability and workers compensation decisions, please click on Legal Highlights at www.waymanlaw.com.