I. FIRST PARTY BENEFIT ISSUES

A. STATUTE OF LIMITATIONS ON FIRST PARTY BENEFITS CLAIM IS FOUR YEARS.

Glover vs. State Farm, 950 A.2d 335 (Pa.Super. 2008).

In Glover, the plaintiff was a pedestrian injured when struck by State Farm's insured. More than two years after the accident (but less than four) the plaintiff sued State Farm for failure to pay first party benefits.

The trial court found that the statute of limitations had run and dismissed all claims. The trial court also found that State Farm was not the proper party and that plaintiff's claims for first party benefits should have been brought against the policyholder/tortfeasor rather than directly against the insurer.

On appeal, the Superior Court reversed, finding that the statute of limitations for first party benefits is clearly four years. *See*, e.g., 75 Pa.C.S. §1721(a) ("If benefits have not been paid, an action for first party benefits shall be commenced within four years from the date of the accident giving rise to the claim. If first party benefits have been paid, an action for further benefits shall be commenced within four years from the date of the last payment.")

With regard to the proper party defendant, the Court held that State Farm was the proper defendant although it observed that the issue was more complex than it might seem at first blush. Recognizing that the insurance carrier is ordinarily the named defendant in the first party claim, the Court further observed that this is almost certainly due to the fact that the vast majority of claims are brought by insureds who are suing their own insurer. In this case, the claimant was a pedestrian who had no contractual relationship with State Farm and whose claim derived from statute (75 Pa.C.S. §1713(a)(4)).

Nevertheless, the Court observed that the benefit is payable regardless of the negligence of the insured party and further is to be paid by the insurer. Thus, the Court discerned no reason to name the insured party as a defendant to an action seeking first party benefits and held that the carrier was the proper party defendant.

B. SABBATICAL PAY WILL NOT REDUCE PLAINTIFF'S THIRD PARTY RECOVERY.

Verdier vs. Matson, 5 Pa. D&C 5th 560 (Franklin Co. 2008).

Ms. Verdier was injured in an automobile accident and sought compensation for, *inter alia*, lost wages from the negligent tortfeasor.

At the time of her injury, Verdier was a public school teacher who was entitled to sabbatical leave pursuant to the collective bargaining agreement with her school district. The school district sabbatical leave policy, as required by the collective bargaining agreement, allowed Ms. Verdier to take an extended leave from work and receive one-half of her salary during the period of her sabbatical.

Ms. Verdier testified at trial that she was unable to work due to her injury and sought (and was granted) sabbatical leave during the period of her recovery. The jury awarded her lost wages unreduced by the amount of her sabbatical leave pay. On post-trial motion, the defendant sought to mold the verdict so that it was reduced by the sabbatical pay. Defendant claimed that this result was required by 75 Pa.C.S. §1722 which provides that, "in any action for damages against a tortfeasor arising out of the maintenance or use of a motor vehicle, a person who is eligible to receive benefits under any program, group contract or other arrangement for payment of benefits ... shall be precluded from recovering the amount of benefits paid or payable under any program, group contract or other arrangement for payment of benefits as defined in §1719."

The Court held that defendant was not entitled to have the verdict molded for two separate reasons. First, §1722 does not apply to benefit types such as sick pay, social security disability payments and funds received under a self-payed disability insurance policy. *See*, e.g., Panichelli vs. Liberty Mutual Insurance Group, 543 Pa. 114, 669 A.2d 930 (1996); Browne vs. Nationwide, 449 Pa.Super. 661, 674 A.2d 1127 (1996); Carroll vs. Kephart, 717 A.2d 554 (Pa.Super. 1998); Tannenbaum vs. Nationwide, 919 A.2d 267 (Pa.Super. 2007), *appeal granted*, 594 Pa. 4, 934 A.2d 687 (2007). Second, the Court observed that the collateral source rule provides that payments from a third party do not diminish the damages otherwise recoverable from a wrongdoer. *Citing*, Johnson v. Beane, 541 Pa. 449, 664 A.2d 96 (1995). The principle underlying the rule is that it is better for the victim to receive a windfall than for the tortfeasor to be relieved of responsibility for the wrong. The principle applies to many types of benefits, including sick pay, medical expense reimbursements or similar monies paid voluntarily or under contract by the victim's employer, including gratuitously continued salary. Thus here, where the injured party furnished consideration (i.e., her labors) making it an obligation of the employer to pay the benefits, plaintiff's recovery against the tortfeasor would not be diminished by the amount of those benefits.

Further, the Court observed that it is the defendant's burden to come forward with the legal and factual grounds which demand that a jury verdict be disturbed. In Verdier, the defendant failed to produce evidence or authority for their position.

C. UNLICENSED MASSAGE THERAPISTS ARE NOT PERMITTED TO RECOVER FIRST PARTY BENEFIT PAYMENTS UNDER THE MVFRL.

Keiper vs. Progressive Casualty Insurance Company, 2409 EDA 2007 (Pa.Super. January 9, 2009) (memorandum opinion).

Mr. Keiper, an unlicensed massage therapist, treated a patient for injuries sustained in a motor vehicle accident. When he submitted his bills to the patient's first party carrier (Progressive), the carrier denied payment. Mr. Keiper brought an action against the carrier which the trial court dismissed on the carrier's preliminary objections. On appeal, the Superior Court considered the language of 75 Pa.C.S. §1712 which states that the insurer "shall make available for purchase first party benefits ... including ... licensed physical therapy" as well as the Physical Therapy Act, which states that "it is unlawful for any person to practice interior 'physical therapy' and interior '... by the utilization of ... physical measures ... mechanical stimulation, heat, cold, **massage** ... ' ". *See,* 63 P.S. §1302 (*emphasis added*).

The Superior Court concluded that the Physical Therapy Act precluded Mr. Keiper from lawfully performing therapeutic massage without a license and, without a license, he was not entitled to be compensated by the insurer. Therefore, the Court affirmed the decision of the trial court in finding that Mr. Keiper was not entitled to payment for his services from the first party carrier.

D. GOOD CAUSE SHOWING NOT NECESSARY WHEN POLICY REQUIRES MEDICAL EXAMINATION.

Williams vs. Allstate Insurance, 595 F.Supp.2d. 532 (E.D. Pa. 2009).

Ms. Williams was an Allstate insured injured in a motor vehicle accident. Among her injuries were spinal complaints and gastrointestinal dysfunction, including chronic constipation.

Allstate initially paid plaintiff's claim for first party benefit medical and wage loss benefits. However, after approximately seven months, Allstate requested that the plaintiff attend an orthopaedic medical exam. Allstate's orthopaedic examiner concluded that plaintiff had recovered from her spinal injuries but noted that her main problem was the chronic constipation on which the examiner admitted he was not qualified to opine. Based on this report, Allstate declined to pay for further treatment for the spinal injuries.

Two months later, Allstate requested that plaintiff attend a medical exam by a gastroenterologist of Allstate's selection. Ms. Williams, through her counsel, refused to attend Allstate's medical examination. Ms. Williams' counsel provided Allstate with a report from a well-qualified treating gastroenterologist which

confirmed that the gastrointestinal issues were related to the motor vehicle accident. Ms. Williams' counsel further advised Allstate that Allstate was not entitled to an insurance medical examination without showing "good cause" and filing a motion pursuant to 42 Pa.R.C.P. 4010. Ms. Williams' counsel further suggested that Allstate's motive for requesting the medical examination was motivated by a desire to achieve an improper purpose.

In response, Allstate unilaterally terminated Ms. Williams' remaining first party benefits. Allstate never produced a medical report from a physician which refuted or questioned the reasonableness and necessity of Ms. Williams' gastrointestinal treatment; never filed a petition to compel a medical examination; and never sought additional documentation or explanation regarding Ms. Williams' gastrointestinal treatment.

Ms. Williams sued Allstate, seeking payment of her first party benefits and also seeking compensation for Allstate's purported bad faith conduct. Allstate counterclaimed seeking declaratory judgment. In the counterclaim, Allstate alleged that the policy explicitly provided that, "the [insured] shall submit to mental and physical examinations by physicians selected by [Allstate] when and as often as [Allstate] may reasonably require ... ". The policy further provided that, "no one may bring an action against [Allstate] in any way related to the existence or amount of coverage, or the amount of loss for which coverage is sought ... unless there is full compliance with all policy terms ... ."

The Court began with an examination of 75 Pa.C.S. §1796(a) and 42 Pa.R.C.P. 4010(a)(2), both of which generally allow an insurer to compel its insured to attend a medical examination upon a showing of good cause.

The Court further considered the published trial court opinions in Erie Insurance vs. Dzadony, 39 Pa. .D. & C. 3rd 33 (1986) and Nationwide Insurance Company vs. Hoch, 36 Pa. D. & C. 4th 256 (1997). In both of those cases, the trial court (The Honorable R. Stanton Wettick, Jr.) found language in an insurance policy which required an insured to submit to physical examination without a showing of good cause to be unenforceable. In both of those opinions, the Court found that the MVFRL, and more particularly Section 1796 of the MVFRL, to be a comprehensive regulation of the area of when an insured may be compelled to submit to a physical examination. The Court in both cases held that the insurance language to the contrary was unenforceable and that the insurance carrier's only avenue for relief was to petition the Court to compel a medical examination and to show good cause in connection with same.

The District Court in Williams chose to reject the holdings and reasoning of Dzadony and Hoch and instead predicted that the Pennsylvania Supreme Court would find that policy provisions requiring an insured to submit to a medical examination without a separate petition or a showing of good cause would be

enforceable. *See also*, Fleming vs. CNA Insurance, 409 Pa.Super. 285, 597 A.2d 1206 (1991), in which the Superior Court observed, arguably in dicta, that the language of a policy requiring the insured to submit to physical examination obviated the need of showing good cause as a prerequisite to obtaining the medical examination.

Despite the Court's holding that the insurance language was enforceable and that there was no need for the carrier to petition the Court for relief or show good cause, the Court nevertheless declined to rule that Allstate was entitled, as a matter of law, to stop benefits.

The Court noted that, "the contract language itself required the insured to submit to examination ... when and as often as we may *reasonably* require ... " *(emphasis added).* Because of the procedural posture of the case (i.e., Allstate's motion for judgment on the pleadings) the Court was required to view the allegations in a light most favorable to Williams. At that stage, the Court determined that it was not apparent that Allstate's requested examination was "reasonably required." The Court observed that had Ms. Williams "simply based her refusal to attend the examination on [Allstate's] failure to obtain an order under Section 1796, her non-cooperation could be deemed a contractual violation, which, in turn, would (1) permit Allstate to discontinue benefits and (2) preclude ... plaintiff's lawsuit." In Williams, however, Ms. Williams contested that the requested examination was reasonable because it was denied that Allstate had any legitimate reason to question her gastrointestinal treatment. Given the procedural posture of the case, in which all facts and reasonable inferences are to be viewed in a light most favorable to the non-moving party, the Court found that it could not determine that Allstate's requested exam was "reasonably required" and thus could not determine that Allstate had a contractual right to terminate benefits.

With regard to the bad faith claim, the Court acknowledged that Ms. Williams could not sustain a bad faith claim merely because Allstate requested an examination as permitted by the terms of the policy. However, the Court recognized that "an unreasonable request for a medical examination" might sustain a bad faith claim. Thus, the Court declined to dismiss the bad faith allegation.

PRACTICE POINTERS:

(1) Does it make sense to unilaterally refuse to allow your client to attend a medical examination when you believe the exam to be unreasonable and motivated by a desire to achieve an improper purpose when the policy includes language requiring your client to submit to such exam?

(2) Are there other methods of accomplishing your goals (protecting your client from unreasonable medical exams) without exposing your client to the risk that the carrier may be entitled to terminate first party benefits?

a. Consider a letter to the carrier which informs the carrier of the inconvenience, embarrassment, etc. posed by the requested exam and asks the carrier to consider whether other less intrusive options (like a record review) might adequately address their needs. Invite the carrier to explain why an exam is necessary but stop short of refusing to comply.

What are the carrier's options? They have really only three:

1. We need an exam but won't tell you why.

2. We need an exam and here's why.

3. OK. We'll try something other than an exam.

Regardless of what the carrier chooses you're almost certainly further ahead than you would have been had you just refused to allow your client to attend the exam. First, you've put the carrier on notice of the harm their proposed course of action will inflict on their insured. Second, you've either had your request granted (no exam) or you get a reason for the exam (which allows you to more meaningfully assess the reasonableness of the request) or you have evidence that the carrier will act the bully in the face of your reasonable request. Third, you have preserved your option to cooperate (and thus avoid any risk that your client will lose his benefits for non-cooperation).

b. If you still think you should resist the exam, consider seeking relief from the Court (perhaps by way of a declaratory judgment action) rather than unilaterally choosing to refuse to allow your client to attend the exam. This method is less likely to imperil your client's contract rights.

II. PEER REVIEW

A. AN INSURER IS PERMITTED TO TERMINATE FIRST PARTY BENEFITS WITHOUT USING PEER REVIEW.

Allied Medical vs. State Farm, 2009 WL 1578603 (E.D. Pa.).

In Allied Medical, State Farm determined that a particular provider had engaged in a pattern of conduct which suggested that it was providing unnecessary or unreasonable treatment to 125 of State Farm's insureds. Without employing the peer review process, State Farm stopped making payments to the provider and the provider sued pursuant to those provisions of the MVFRL that authorize providers to sue first party carriers.

The Court examined the peer review provisions of the MVFRL in some detail, including Section 1716, which requires that payments for reasonable and necessary medical treatment are "overdue if not [made] within 30 days after the insurer receives reasonable proof of the amount of the benefits ... overdue benefits ... bear interest at the rate of 12% per annum from the date the benefits become due" and which further provides that, if the "insurer's found to have acted in an unreasonable manner in refusing to pay the benefits when due, the insurer shall pay, in addition to the benefits owed and the interest thereon, a reasonable attorney fee ... "; Section 1797(b)(1)-(3), (5), (7), which collectively sets forth the peer review process; Section 1797(b)(4), which provides that where an insured does not use the peer review system and instead simply refuses payment, a provider can "challenge before a court an insurer's refusal to pay for past or future medical treatment"; and which authorizes the court to award treble damages if the insurer's conduct is wanton; and Section 1797(b)(6), which provides that if the court finds that the "medical treatment or rehabilitative services or merchandise were medically necessary, the insurer must pay to the provider the outstanding amount plus interest at 12%, as well as the cost of the challenge and all attorney's fees."

The Court observed that the peer review system permits an insurer to choose from one of two options. The insurer can submit the claim to peer review which can limit the insurer's liability (if performed in good faith) or the insurer can simply refuse to pay the provider and in so doing subject itself to a provider's civil action and the risk associated with the enhanced penalties set forth in the MVFRL.

Regardless of which choice the carrier makes, the MVFRL only requires insurance carriers to pay for "reasonable and necessary medical treatment." *See*, 75 Pa.C.S. §1712(1). Without an obligation to pay, the insurer's failure to pay does not subject the insurer to liability under the MVFRL.

B. AS A GENERAL RULE, SECTION 1797 PROVIDES THE EXCLUSIVE REMEDIES FOR AN INSURED WHEN THE CARRIER INVOKES THE PRO PROCESS.

W<u>right vs. Ohio Casualty Group Insurance Company</u>, 2009 WL 1120354 (M.D. Pa. 2009)

Mr. Wright was an Ohio Casualty insured when he was injured in an automobile accident. Ohio Casualty initially paid Mr. Wright's medical expenses and lost wages but, after a year, requested a medical examination and, after the exam, ceased paying first party benefits.

Mr. Wright filed suit and sought to compel Ohio Casualty to pay his outstanding medical expenses plus interest and further sought an order (1) directing the carrier to pay future medical bills as they are submitted subject only to the applicable policy limits or further order of the Court and (2) to appoint an independent medical examiner to review Mr. Wright's need for continued treatment on a periodic basis.

Ohio Casualty filed a motion to dismiss. The carrier did not contest plaintiff's right to seek payment of outstanding medical expenses or interest associated with same. However, the carrier alleged that the relief sought as to future medical expenses and appointment of an independent medical examiner was barred by the MVFRL.

The Court agreed with Ohio Casualty Group. While recognizing that Section 1797 does not provide the exclusive source of remedy where a plaintiff's claim falls outside the scope of the PRO process, the Court nevertheless observed that Section 1797 preempts other remedies when the plaintiff's claim falls within the scope of the PRO process. In <u>Wright</u>, plaintiff merely raised a claim for payment of first party benefits, past and future, and sought to impose a judicially created "independent medical examiner" to adjudicate future disputes. Because none of these latter remedies were authorized by Section 1797 and because Mr. Wright was limited to the remedial scheme outlined therein, the Court dismissed that portion of Mr. Wright's claims which sought relief other than payment of prior medical expenses and the interest associated with same.

C. PREEMPTION OF BAD FAITH CLAIMS BY THE MVFRL.

1. <u>Perkins vs. State Farm</u>, 589 F.Supp. 2d 559 (M.D. Pa. 2008).

Ms. Perkins was a State Farm insured with $50,000.00 in first party medical coverage when she was struck by a motor vehicle while walking in a grocery store parking lot. Initially, State Farm paid for Ms. Perkins' medical treatment but

ultimately State Farm obtained a peer review which found that her treatment was not reasonable or necessary and State Farm refused further payment.

Ms. Perkins brought suit against State Farm and included a count for violation of the bad faith statute. 42 Pa.C.S. §8371. State Farm challenged the complaint via Rule 12(b)(6) motion alleging that the MVFRL preempted Ms. Perkins' right to assert a bad faith cause of action.

The Court considered the relevant case law and the particular allegations of plaintiff's complaint and determined that plaintiff's bad faith claim was not preempted by the MVFRL.

In brief, here is a summary of the unsettled state of the law in this regard:

(1) In Okkerse by Okkerse vs. Prudential, 425 Pa.Super. 396, 625 A.2d 663 (1993), the plaintiff sought relief pursuant to the provisions of Pennsylvania's former No-Fault Act which was the predecessor to Sections 1716 and 1797(b). The plaintiff also sought relief for alleged bad faith conduct pursuant to Section 8371. The trial court found Section 8371 and the No-Fault Act to be irreconcilably inconsistent and dismissed the plaintiff's Section 8371 claim. The Superior Court reversed and found that the two statutes simply did not conflict.

(2) Less than eight months later, a different panel of the Superior Court came to a different conclusion regarding the interplay between Section 8371 and the MVFRL. In Barnum vs. State Farm, 430 Pa.Super. 488, 635 A.2d 155 (1993), the Superior Court dismissed the insured's bad faith claim which arose from the carrier's refusal to pay medical bills after a PRO determination which found that the treatment was not necessary. Significantly, for reasons that will be apparent shortly, the Court in Barnum also held that the insured had failed to exhaust his statutory remedies because he had failed to seek reconsideration of the PRO prior to bringing suit. Thus, the Court held that the insured could not proceed to seek a remedy in court until he had first exhausted his right to seek reconsideration of the PRO determination.

(3) Less than eight months after Barnum (and while an appeal of Barnum was pending before the Supreme Court), the Supreme Court held in Terminato vs. Pennsylvania National Insurance Company, 538 Pa. 60, 645 A.2d 1287 (1984) that an insured is not required to seek reconsideration of an adverse PRO decision before initiating a court action to recover medical benefits under an auto policy. The Supreme Court in Terminato did not address the question of whether Section 8371 bad faith claims were preempted by or

inconsistent with MVFRL.

(4) Less than four months later, the Third Circuit in Gemini Physical Therapy vs. State Farm, 40 F.3d 63 (3d Cir. 1994) predicted that the Pennsylvania Supreme Court would follow the ruling in Barnum, i.e., that Section 8371 bad faith claims relating to failure to pay first party benefits are preempted by the PRO provisions of the MVFRL.

(5) Two weeks later, the Pennsylvania Supreme Court reversed the Barnum decision and remanded the case for further proceedings consistent with its decision in Terminato (i.e., because of the incorrect ruling that an insured was required to seek reconsideration of an adverse PRO determination prior to seeking judicial review). Barnum vs. State Farm, 539 Pa. 673, 652 A.2d 1319 (1994). The Court did not address the question of whether the PRO provisions of the MVFRL preempted Section 8371 claims.

(6) Since that time, there have been many courts that have held that the MVFRL (more particularly the provisions at Section 1797) is the exclusive remedy for insurers alleging bad faith in the PRO process. Many other courts have held that Section 8371 is preempted by the MVFRL only when the insured's claim falls within the parameters of the peer review process and that when the insured's allegations are based on conduct which goes beyond the scope of Section 1797(b), such as claims involving contract interpretation or claims that the insurers did not properly invoke or follow the PRO process, Section 8371 bad faith claims may be pursued in tandem with or independent of MVFRL claims. (For a detailed listing of the opinions preceding Perkins, *see,* 589 F.Supp. at 564-565 (fn.2 and fn.3)). None of the opinions following Barnum are opinions of controlling precedential value in Pennsylvania courts.

The Court in Perkins determined that the "pivotal question becomes whether Ms. Perkins' allegations fall within the pervue of Section 1797, thus invoking the remedies established therein and precluding resort to Section 8371." The Court held that some of Ms. Perkins' allegations fell within the pervue of Section 1797 and did not therefore give rise to a separate claim under Section 8371. For example, the allegation that State Farm failed to conduct a reasonable investigation, fairly evaluate coverage or timely notify her of a denial of benefits "are nothing more than a challenge to the denial of first party benefits and would fall under Section 1797." However, the allegations "that State Farm engaged a PRO that does substantial work for State Farm and thus has a financial interest in providing a biased determination, and that the PRO has continuously provided negative peer review reports to State Farm ... to maintain their business ... [are] allegations of abuse of the PRO process [that] are not within the scope of Section 1797 ..." and therefore state a claim under Section 8371.

2. Miller vs. Allstate, 2009 WL 577964 (W.D. Pa. 2009).

In Miller, the District Court recognized the general proposition that the MVFRL provides the exclusive remedy for claims of first party medical benefits and thus preempts the bad faith statute. However, the Court further recognized that where there is both a denial of first party medical benefits and mishandling and/or abuse of the peer review process, a bad faith claim can be maintained.

In Miller, plaintiff was insured with Allstate when injured in an automobile accident. Allstate initially paid Mr. Miller's medical expenses but ultimately submitted the matter to a PRO and thereafter terminated payment of first party medical expenses. Mr. Miller sought judicial review and asserted therein a claim for bad faith. Allstate filed a 12(b)(6) motion claiming that as a matter of law Mr. Miller's bad faith claims were preempted by the MVFRL.

In denying the insurer's motion to dismiss, the Court recognized the general rule and exception thereto set forth above and set forth, without much discussion, the allegations of plaintiff's complaint, which included allegations that Allstate "misused the peer review process as a method to minimize its financial exposure under the subject insurance policy and misused the peer review process as a method to minimize its exposure to plaintiff's potential underinsured motorist claim and filed a peer review report that is defective on its face."

The Court held that Miller's claims were premised on alleged abuse of the peer review process which are separate and distinct from his claims that he was entitled to payment of his bills and as such the Court determined that Miller was entitled to bring separate claims under both the MVFRL and Section 8371.

3. Veltri vs. Traveler's, PICS Case No. 09-1653 (C.P. Lackawanna, September 20, 2009) (*note*, opinion not available at time of publication, summary based on report of Pennsylvania Law Weekly).

In Veltri, plaintiff was injured in an automobile accident and initially received first party benefits from his carrier. The carrier ordered an IME which supported the insured's position. The insurer then demanded another IME where the second examiner questioned whether the injuries were still related to the automobile accident. Based on the second IME, the carrier denied benefits, disregarding the first IME and Mr. Veltri's treating physician.
Mr. Veltri brought an action which included a claim for bad faith. The carrier filed preliminary objections arguing that bad faith claims are preempted by the MVFRL as a matter of law.

The Court reportedly held that the general rule that the MVFRL preempts general bad faith statutory remedies does not apply where there are separate and distinct claims relating to improper behavior under the MVFRL in bad faith handling of the claim. The Court overruled the carrier's preliminary objections.

III. THIRD PARTY LIABILITY COVERAGE

A. PERMISSIVE USE - GARAGE POLICY LIMITED COVERAGE TO CIRCUMSTANCES THAT WERE NECESSARY OR INCIDENTAL TO THE GARAGE BUSINESS.

State Auto Mutual Insurance Company vs. McCutcheon, 2009 WL 36446 (W.D. Pa. 2009).

Mr. McCutcheon was the owner of a towing service. He employed a gentleman who he knew did not possess a valid driver's license. Mr. McCutcheon nevertheless permitted the unlicensed driver/employee to operate a certain vehicle that had been abandoned by its owner and was in Mr. McCutcheon's possession. The scope of the explicit permission provided by Mr. McCutcheon to his employee was limited to those circumstances necessary for the employee to repair the vehicle and test the repairs.

One evening, the unlicenced employee took Mr. McCutcheon's vehicle for ostensibly a "test drive." The test drive turned into an evening of drinking and socializing with his friends. After several hours of drinking (and approximately five hours after having clocked out of work) the unlicensed employee went to fetch more beer and was involved in an accident for which he was responsible.

Mr. McCutcheon's liability carrier filed a declaratory judgment action and, on the carrier's summary judgment motion, the Court granted the carrier the relief requested. The Court addressed two separate but related issues.

First, the Court addressed the question of implied permission. In this regard, the Court noted that Mr. McCutcheon had notice that his unlicensed employee was operating the vehicle and did not object to such use. Given the procedural posture of the case (in which the Court was required to judge the facts in the light most favorable to the non-moving party), the Court found sufficient facts from which a jury could determine that the unlicensed employee had implied permission to drive the van.

The second issue addressed by the Court was the question of whether, even if implied permission was provided, the carrier was required to provide coverage. The Court noted that the policy provided that coverage for "non-owned auto used in your garage business" applied only to "operations necessary or incidental to a garage business."

In light of the facts that the unlicensed employee was operating the vehicle more than five hours after the end of his shift and was driving to an ATM to get cash to purchase beer after an evening of socializing and drinking, the Court found that there was no way to conclude that the vehicle was being used in a way that was

"incidental" or even casually related to the garage business.

Under these circumstances, the Court ruled in favor of the carrier and granted the declaratory judgment action which sought to declare that there was no coverage owed under the circumstances.

B. NO COVERAGE FOR CRIMINAL RESTITUTION.

Brethren Mutual Insurance vs. McKernan, 961 A.2d 205 (Pa.Super. 2008).

Ms. McKernan was an insured under a Brethren Mutual policy when she got involved in a heated argument with her boyfriend. In an effort to scare him away from her, she grabbed a knife, swung it and struck the boyfriend, causing his death.

Ms. McKernan was convicted of reckless endangerment and simple assault and sentenced to pay restitution of her boyfriend's funeral expenses in the amount of $5,190.00. Ms. McKernan paid the restitution amount herself.

The boyfriend's estate commenced a wrongful death and survival action and Brethren Mutual provided a defense and ultimately settled the claim without exhausting the policy limits. Ms. McKernan sought to compel her insurance company to cover the costs of the funeral (which she had paid pursuant to a criminal restitution order) because the damages for which she paid were caused by her negligence, an occurrence and damages covered under the insurance contract.

The Superior Court held that Ms. McKernan was not entitled to indemnity for expenses incurred in satisfaction of a criminal restitution order, even when a criminal conviction is based upon the negligence of the insured. The Court observeded that, "while the [restitution] order aids the victim, its true purpose, and the reason for its imposition, is the rehabilitative goal it serves by impressing upon the offender the loss he has caused and his responsibility to repair that loss as far as it is possible to do so."

The Court noted that if an insurer were permitted to insure against ordered criminal restitution, such insurance would defeat the purpose of a restitution order entirely.

The Court held that "a convict, in the context of the criminal litigation, cannot utilize a policy of insurance to cover a restitution order ... this decision should not in any way be interpreted as affecting the law regarding insurance coverage available in civil actions based upon conduct which creates civil as well as criminal responsibility."

IV. POST-KOKEN

As a consequence of **Koken v. Insurance Federation of Pennsylvania, 889 A.2d 550 (Pa. 2005),** insurers are no longer required to include arbitration clauses in their policies for the resolution of UM/UIM claims. Many carriers have totally eliminated the arbitration clauses from their policies and thus UIM claims are, more and more often, going to be resolved in the Court of Common Pleas.

As a consequence, case law is developing on whether UIM claims and the underlying tort claim can be tried together and, if so, whether evidence of insurance is thereby admissible in the case. Also developing is case law on whether UIM claims and related bad faith claims can be tried together. What follows is a summary of the most recent cases on these points:

A. **Six vs. Phillips, 2009 WL 2418861 (Beaver County 2009)**. In Six, the Court of Common Pleas addressed the joinder of an injured party's claims against the tortfeasor and his own underinsured motorist carrier. The Court considered 42 Pa.R.C.P. 2229(b)(addressing permissive joinder) which allows that a plaintiff may join as defendants persons against whom the plaintiff asserts any right to relief jointly, severally, separately or in the alternative in respect of or arising out of the same transaction, occurrence, or series of transactions or occurrences if any common question of law or fact affecting the liabilities of all such persons will arise in the action.

The Court further observed that both the third party claim and the UIM claim arose out of the same occurrence, i.e., the pertinent automobile accident that involved the same factual questions of liability and damages. Thus, the Court determined that both defendants and both claims could be tried together.

The Court also addressed Rule 411 of the Pennsylvania Rules of Evidence, which provides that, "evidence that a person was or was not insured...is not admissible upon the issue whether the person acted negligently or otherwise wrongfully. This Rule does not require the exclusion of evidence of insurance...when offered for another purpose ... ."

The tortfeasor complained that evidence of his liability limits would necessarily be admissible in the context of the UIM claim and that this evidence would be unduly prejudicial because it might influence the jury's assessment of liability and/or damages in the third party case where ordinarily such evidence would be inadmissible.

The trial court agreed that evidence of the insurance limits would necessarily be required in the case but determined that such evidence was not precluded by Rule 411 nor was it unduly prejudicial. With regard to Rule 411, the Court noted that Rule 411 excludes insurance evidence only when the purpose of admission was to influence findings about liability or damages. When evidence of insurance is

relevant as to other issues in the case, it is not barred merely because it might be prejudicial. Thus, Rule 411 does not preclude the admission of insurance evidence in the context of an underinsured motorist claim because it is not offered for the purpose of proving liability or damages.

As for prejudice, the Court observed that insurance carriers should have known and anticipated that insurance policy information would be relevant and admissible in UIM claims. Because they chose to remove the arbitration clauses from their policies, they would not now be heard to complain about the prejudice associated with their decision.

See also, **Jannone vs. McCooey, 2009 WL 2418862 (Pike County 2009)**.

B. **Gunn vs. The Automobile Insurance Company of Hartford, 2008 WL 6653070 (Allegheny County 2008)**. In Gunn, the Court addressed a situation in which an insured brought a UIM claim against his insurer together with a claim for bad faith. Both the plaintiff and the insurer agreed that the bad faith claim could not be tried until after trial of the UIM claim. However, plaintiff sought to consolidate the two claims for all other purposes, including discovery and to schedule trial of the bad faith claim immediately following trial of the underinsured motorist claim. The carrier, by contrast, sought to bifurcate the two for purposes of discovery and trial.

The Court in Gunn recognized that it is conceivable that material discoverable in a bad faith case might not be discoverable in a UIM case. For example, if the insurer had a statement in its file to the effect that, "plaintiff's lawyer does not like to try cases so you have only $30,000.00 to settle prior to trial, but at the call of the list you may go to $40,000.00, but only if the plaintiff first offers to settle for that amount - do not ever ask me for more than $40,000.00." The Court acknowledged that this information might well not be discoverable in the underinsured motorist claim. However, it would certainly be discoverable in the later bad faith claim.

In Gunn, however, the carrier did not allege that it had such information. The Court held that a party seeking to bifurcate and stay discovery involving a bad faith claim until resolution of the UIM claim has the burden of showing actual prejudice that outweighs the benefits that ordinarily flow from having the judge who presided over the UIM claim trial try the bad faith claim immediately after the trial of the UIM claim. Once a party has shown actual prejudice, the Court must balance the relevant factors in determining how the case should proceed.

In Gunn, the Court ordered that the carriers' efforts to bifurcate the bad faith and UIM claims and to stay proceedings as to the bad faith claim would be denied. The Superior Court recently quashed an effort by the carrier to appeal the trial court decision in Gunn. *See*, Gunn vs. Automobile Insurance Company of Hartford, 2009 WL 1001029 (Pa.Super. 2009).

C. Other cases in which trial courts have declined to sever claims against tortfeasors from the claims against the UM/UIM carrier include: Hess vs. Cosgrove, Philadelphia, July Term, 2008, No. 3708; Hess vs. Dickel, Philadelphia, October Term, 2008, No. 3220; Fuhrman vs. Frye and State Farm, 2008 CV 17687 (Dauphin County); Sellers vs. Hindes and State Farm, 2009 CV 1989 (Dauphin County 2009); Collins vs. Zeiler and State Farm, GD 2008-Civil-014817 (Allegheny County, October 22, 2008); Moyer vs. Harrigan and Erie Insurance, 2008-Civil-1684 (Lackawanna County, October 24, 2008); Serulneck vs. Kilian and Allstate, 2008-Civil-2859 (Lehigh County, April 7, 2009); and Glushefski vs. Sadowski and Erie Insurance, 1189-Civil-2009 (Luzerne County, July 24, 2009).

V. TRIAL PREPARATION AND PRACTICE

A. INJURED PARTY'S BIOMECHANIC EXPERT WITNESS PERMITTED TO TESTIFY THAT THE FORCE SUSTAINED BY PLAINTIFF IN THE SUBJECT ACCIDENT COULD POTENTIALLY CAUSE CERTAIN INJURIES.

Burke vs. TransAm Trucking, Inc., 617 F.Supp.2d 327 (M.D. Pa. 2009).

In this case, the Court addressed the admissibility of expert testimony pursuant to Federal Rule 702 as interpreted by Daubert vs. Merrell Dow Pharm., Inc., 509 U.S. 579 (1993) and its progeny. The Court found that a biomechanical expert, who was a professor of mechanical engineering at North Dakota State University, an adjunct professor of neuroscience of the University of North Dakota School of Medicine and director of the Impact Biomechanical Laboratory and Automotive Systems Laboratory at North Dakota State University's College of Engineering, had sufficient specialized knowledge, skill and training to qualify as an expert in the field of biomechanics.

The Court also found that Dr. Ziejewski's proffered testimony (i.e., quantification of the forces involved in the accident and their potential impact on the plaintiff's person) were well within his realm of expertise and were based upon "methods and procedures" (i.e., testable hypothesis, subjected to peer review, with a known potential rate of error and generally accepted) were such that it was sufficiently reliable to be admitted.

Finally, the Court determined that the expert's testimony "fits" the case because it is "relevant for the purposes of the case" and will "assist the trier of fact."

The Court noted that the expert was not a medical physician and thus would not be permitted to testify as to the identification and diagnosis of plaintiff's medical condition.

B. EVIDENCE CONCERNING SEATBELT USAGE IS PROHIBITED IN A CASE CONCERNING AN AUTOMOBILE'S CRASH WORTHINESS.

Gaudio vs. Ford Motor Company, 976 A.2d 524 (Pa.Super. 2009).

Plaintiff's decedent was driving a 1996 Ford F-150 pickup. He was not wearing a seatbelt. He was killed as a consequence of a low speed collision and suit was brought against the manufacturer alleging that a product defect caused his death.

The jury found for the manufacturer at trial. On appeal, plaintiff complained that the manufacturer had been permitted to introduce evidence concerning decedent's failure to use a seatbelt.

The trial court had permitted the evidence despite 75 Pa.C.S.A. § 4581(e) which provides that "...failure to use...a safety seatbelt system [shall not] be considered as contributory negligence nor shall failure to use such a system be admissible as evidence in the trial of any civil action." Despite this provision, the trial court found that § 4581(e) "does not mandate an absolute bar." Instead, the trial court found that the section prohibited the use of seatbelt evidence as a means of proving contributory negligence. Where the reason for introducing seatbelt evidence is "for the purpose of proving causation in a product's liability claim" the Court found that the disallowance of "such evidence where it is necessary to disprove a product's liability claim would be unjust."

On appeal, the Superior Court held that the language of § 4581(e) was clear and not ambiguous. Because the language of the statute provides for no exceptions or references, the Court enforced it as written, i.e., the Court concluded it was error to allow the manufacturer to introduce evidence of the decedent's failure to use the seatbelt system.

The Court further held that evidence that the vehicle had a seatbelt system and/or that the purpose of the seatbelt system was to serve as the primary restraint system, was similarly inadmissible. "Allowing defendant to introduce evidence of the existence of the seatbelt systems falls but a half step short of allowing defendant to introduce evidence of the decedent's failure to use a seatbelt system." Introduction of such evidence allows the jury to infer that the decedent was not wearing a seatbelt at the time of the accident and thus such evidence is prohibited by § 4581(e).

C. TRIAL COURT HAS DISCRETION TO PERMIT PLAINTIFF TO WITHDRAW PA.R.C.P. 1311.1 STIPULATION.

DME PHYSICIAN MAY TESTIFY FOR PLAINTIFF OVER DEFENDANT'S OBJECTION.

Dolan vs. Fissell, 973 A.2d 1009 (Pa.Super. 2009).

In Dolan, defendant appealed an arbitration award against him and plaintiff filed a stipulation under 42 Pa.R.C.P. 1311.1 indicating plaintiff's consent to limit damages to $25,000.00 and thus proceed on medical records as set forth at 42 Pa.R.C.P. 1305(b).

At the settlement conference, plaintiff moved for permission to withdraw the Rule 1311.1 stipulation and the Court granted plaintiff's request, continuing the case to February 28, 2007.

Following a verdict in favor of the plaintiff in the amount of $410,000.00, the defendant filed an appeal and complained, *inter alia*, that it was error to allow plaintiff to withdraw the Rule 1311.1 stipulation.

The Rule itself does not address whether or when a plaintiff's counsel is permitted to withdraw the stipulation. The Court therefore held that it is a matter of discretion for the trial court to decide whether to permit the withdrawal of a Rule 1311.1 stipulation. The Court directed that the trial judge should consider the reason for the withdrawal and whether there would be any substantial prejudice to the other parties. The Superior Court noted that they did not believe withdrawal should be allowed where the trial court believes that the plaintiff is simply "sandbagging" the defendant.

Another issue of interest in the Dolan case was the Superior Court's affirmation that the plaintiff was permitted to call the defense medical exam expert to testify for plaintiff at trial. Defense counsel had retained a chiropractic expert to perform a defense medical exam. The DME report corroborated plaintiff's position that plaintiff had a permanent back injury. Plaintiff's counsel contacted the DME physician and asked him if he would testify to his findings. Plaintiff's counsel and the doctor had no conversations other than those necessary to make arrangements for the court appearance. Therefore, there was no discussion of any possible expert-client communication about the case.

Nevertheless, defense counsel claimed that it was error to permit the DME physician to testify for plaintiff. The Court recognized that no one can compel an expert to give his opinion testimony. However, if the expert is willing to testify, he is free to do so. The Court noted that defense counsel did not include a contractual provision which would have precluded the expert from testifying for the opposing side. Therefore, the Court noted that the defense counsel took the chance that the report would be unfavorable and the other side might use it.

D. EVIDENCE OF DRIVER'S MARIJUANA USE EXCLUDED AT TRIAL WHERE THERE WAS INSUFFICIENT 'SUPPLEMENTAL' EVIDENCE OF IMPAIRMENT.

Pennington v. King, 2009 WL 415718 (E.D. Pa. 2009).

A tractor trailer operator allegedly caused an accident which resulted in a death and serious injuries to other motorists. A toxicology screening performed on the driver revealed the presence of marijuana in his blood and the driver admitted to having smoked marijuana approximately 36 hours prior to the accident.

Plaintiffs attempted to admit the toxicology screen results together with testimony from their toxicology expert to the effect that marijuana levels of the sort found in the driver's tox screen can cause impairment.

The Court observed that evidence of use of intoxicants is admissible only when there is additional evidence that the driver's consumption was sufficient to demonstrate impairment. For example, evidence of "staggering, slurred speech, bloodshot eyes, strong odor of alcohol, unusual behavior" and the like may be sufficient, when coupled with toxicology results, to admit the evidence of intoxicant use.

In Pennington, however, all of the eyewitnesses testified that the driver did not appear to be impaired. While there was some evidence of mildly "erratic driving" which preceded the accident, the Court observed that such behavior is as consistent with non-impairment as it is with impairment. Thus, the Court excluded the evidence of marijuana use.

E. HIGH/LOW AGREEMENT BARRED RECOVERY OF RULE 238 DAMAGES IN EXCESS OF CAP IMPOSED BY AGREEMENT.

Thompson v. T.J. Whipple Co., 2009 WL 807467 (Pa. Super. 2009).

In Thompson, the parties entered into a high/low agreement prior to trial in which it was agreed that, "(T)he high will be $1,000,000 and the low will be $250,000. If the jury should award more than $1,000,000 then Mr. Thompson would receive $1,000,000. And if the jury should award less than $250,000, or it should be a defense verdict, Mr. Thompson would receive $250,000."

The jury awarded plaintiff $1,071,041.67 which was reduced to $1,000,000 pursuant to the high/low agreement. Thereafter, the plaintiff filed a petition for Rule 238 delay damages to be added to the molded agreement. The trial court found, and the Superior Court affirmed, that the high/low agreement precluded plaintiff from recovering Rule 238 damages.