**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

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| **JAMES COLLINS** | : | **CIVIL ACTION** |
| **v.** | : | |
| **ALLSTATE INSURANCE COMPANY** | : | **NO. 95-592** |

**M E M O R A N D U M**

**WALDMAN, J.** **October 31, 1997**

**Background**

Plaintiff alleges that defendant acted in bad faith in its handling of his underinsured motorist claim and specifically in refusing his request for full benefits. Plaintiff asserts a claim pursuant to 42 Pa. C.S.A. § 8371. Jurisdiction is predicated on diversity of citizenship.

The court has reviewed the testimony and documentary evidence offered at trial, as well as various depositions and materials submitted for posttrial review. As is frequently the case, a determination of the facts necessitates an assessment of the credibility of witnesses on certain points. As is infrequently the case, in making such a determination in this action the court faces the unpalatable task of formally deciding which of two attorneys who gave diametrically opposed and irreconcilable testimony should be credited.

This matter was vigorously and ably presented on behalf of both parties. The court now makes the following findings of fact and conclusions of law.

## Findings of Fact

Plaintiff is a Philadelphia police officer. While on patrol duty on June 24, 1992 near the Philadelphia Airport, plaintiff was in an automobile accident. An automobile driven by B. Christopher DiSantis and traveling at approximately 50 mph collided with the driver's door of the vehicle operated by plaintiff. Plaintiff's vehicle spun around and was hit again on a rear panel.

An investigating officer prepared a contemporaneous police accident report. That report records that Mr. DiSantis lost control of his vehicle, crossed into plaintiff's lane and collided with his official vehicle. The report notes that the left front fender on the DeSantis vehicle was "crushed" and the headlight assembly was "smashed and broken." The report notes that plaintiff's left front door was "crushed and dented" with damage which "continues to the corner panel." The investigating officer variously recorded "no injuries reported" and under the heading "INJURY" that "There were injuries reported to the assigned as a result of this accident."

The day following the accident, plaintiff reported to his supervisor that he had sustained injuries. He experienced headaches and discomfort in his shoulders, neck, lower back and right leg. He was referred to a workers compensation clinic and from there to Jeans Hospital. He was later referred for medical attention to Northeastern Hospital. Following examination and an MRI in July 1992, plaintiff was found to have two herniated discs

in his lumbar spine with radiculopathy, that is radiating pain from his lower back into his right leg. From July 1992 through early September 1994 plaintiff underwent substantial physical therapy.

Plaintiff was out of work for four months following the accident on "IOD" or injury on duty status. He never returned to his moonlighting job with Best corporation where he did stock work for 12 to 14 hours per week.

Plaintiff's medical expenses and lost wages totaled approximately $25,000. Because plaintiff was injured while on duty, these losses were covered by the City and workers compensation.

Prior to this accident, plaintiff was in good physical condition. He was 47 years old at the time and had no prior problems with his lower back or right leg.

Plaintiff submitted a claim to Nationwide Insurance Company which had issued a policy covering Mr. DeSantis. After reviewing the claim and supporting documentation, Nationwide agreed to tender the policy limit of $50,000 to plaintiff in April 1994. It did so without requiring a further medical examination or deposition of plaintiff and with the approval of defendant Allstate which was formally given on May 16, 1994.

On April 25, 1994 Bernard Gross, Esq. on behalf of plaintiff presented to his insurer, defendant Allstate, an underinsured motorist ("UIM") benefits claim.

On May 5, 1994 Mr. Gross also provided defendant with the

same documentation on which Nationwide had relied. This included the MRI study of July 1992 showing lateral disc herniations at L3-4 and L4-5; reports of Dr. Dan Jacobs reflecting treatment from the summer of 1992 to the summer of 1993 and noting cervical strain and sprain, disc herniation with right lumbar radiculopathy and a limited range of motion in the neck and lower back; and, reports of an orthopaedic surgeon, Dr. Corey Ruth, reflecting examinations and evaluations from December 24, 1992 to April 5, 1994 which essentially parallel the findings of Dr. Jacobs and also note mild weakness in plaintiff's right leg. The documentation also included a verification of the time lost by plaintiff from work.

Mr. Gross is an experienced plaintiffs' personal injury lawyer who has negotiated thousands of claims with insurers on behalf of clients. Mr. Gross valued plaintiff's claim for pain and suffering at $250,000 and so advised defendant by letter of May 5, 1994.

Plaintiff's UIM claim was referred to Allstate adjuster William A. Schmidt III who prepared a written evaluation of the claim on May 31, 1994. The evaluation included a description of the "strengths" of the case from defendant's point of view.

One such "strength" was said to be that plaintiff had not visited an emergency room for treatment until July 16, 1992, three and one half weeks after the accident. Mr. Schmidt had available at the time records documenting that in fact plaintiff sought medical treatment the day following this accident and

before July 16, 1992 had diagnostic tests, had at least half a dozen visits to physicians and was found unable to work. Plaintiff in fact never sought or received treatment in an emergency room.

Another "strength" noted by Mr. Schmidt was that plaintiff was involved in two subsequent vehicular accidents on July 15, 1992 and October 9, 1992 respectively. Mr. Schmidt reported that Allstate would "strongly argue" plaintiff's injuries in the covered accident were exacerbated by the subsequent accidents. Mr. Schmidt knew at the time that plaintiff had not claimed any injury as a result of these two accidents and had available plaintiff's medical records none of which suggested the later accidents caused or aggravated any injuries. Mr. Schmidt never sought to obtain pertinent insurance records regarding the subsequent accidents.

One of these accidents occurred when a vehicle operated by plaintiff tapped the bumper of the vehicle in front of his at a shopping mall. There was no property damage or physical injury as a result. The other accident occurred when a driver lost control of his vehicle on Bustleton Avenue and collided with plaintiff's vehicle. This collision resulted in moderate property damage but no physical injury to plaintiff.

Mr. Schmidt recognized that there was no question of liability. In his evaluation of May 31st, he placed a value on plaintiff's claim of $65,000 and accordingly valued the UIM claim at $15,000. This was the only evaluation undertaken by Mr.

Schmidt or anyone else at Allstate. Mr. Schmidt was empowered to settle claims on his own authority for up to $25,000.

By letter of June 10, 1994 to Mr. Schmidt, Mr. Gross made a formal demand for arbitration of plaintiff's UIM claim. Alfred Dragon, Esq. was selected as plaintiff's arbitrator on June 10, 1994. Josh Greenbaum, Esq. was selected as defendant's arbitrator on July 5, 1994. Leon Mankowski, Esq. was selected as the neutral arbitrator on July 15, 1994. Arbitration proceedings were then scheduled for November 14, 1994 and later continued to November 18, 1994.

By letter of June 14, 1994 to Mr. Gross, Mr. Schmidt offered $10,000 to satisfy plaintiff's UIM claim. By letter of June 21, 1994, Mr. Gross rejected this amount and demanded the policy limit of $25,000.

Allstate set a reserve on plaintiff's claim of $24,999.

Defendant requested that plaintiff submit to a medical examination by Dr. Robert Glazer, an orthopaedic surgeon. Plaintiff did so on August 23, 1994. Dr. Glazer issued a written report on August 25, 1994.

Dr. Glazer found limited motion in the cervical and lumbar spine and tenderness in the lumbar spine area. He reported complaints of pain with straight leg raising to 60 degrees and with hip rotation, but said he "felt that [plaintiff] was hyper reacting." Dr. Glazer diagnosed plaintiff with chronic muscle strain, chronic low back pain and possible disc injury and stated these "diagnoses are related to the incident of 6/24/92." Dr.

Glazer opined that plaintiff had reached "maximum medical benefit" from treatment and therapy, while also noting that some ongoing treatment "may occasionally be necessary" because of "residual" discomfort.

By letter of September 16, 1994, Mr. Schmidt again offered $10,000 to satisfy plaintiff's claim. By letter of September 21, 1994, Mr. Gross again rejected this offer, again demanded the policy limit of $25,000 and advised Mr. Schmidt that he believed defendant was acting in bad faith in refusing to meet that demand.

Agnes McKenna was Mr. Schmidt's supervisor at Allstate. She played no role in evaluating plaintiff's claim. She did, however, look at the claim file after Mr. Gross indicated his intention to pursue a bad faith claim. She did not pick up Mr. Schmidt's errors regarding a delay in seeking treatment and the effects of the two later accidents.

In October 1994, Mr. Gross assigned to John Coste, Esq. of his office responsibility for presenting plaintiff's claim to the arbitrators. On October 14, 1994, defendant engaged Kevin McNulty, Esq. to represent it at the arbitration.

Mr. Coste reviewed the case file and concluded that plaintiff's damages were "far in excess of $75,000," the combined policy limits. Mr. McNulty testified that after reviewing defendant's case file, he concluded that the value of plaintiff's claim was less than $50,000, that Nationwide had thus overpaid and that the value of the UIM claim was thus zero. Mr. McNulty

said he shared that assessment with Mr. Schmidt. Mr. McNulty never contacted the Nationwide adjustor to ascertain how and why that insurer evaluated plaintiff's claim as it did.

Plaintiff gave a prearbitration statement under oath on November 14, 1994. He testified that he continued to experience pain in his shoulders, lower back and right leg for which he was still receiving treatment. From the day of his accident through the time of his deposition, plaintiff had over 100 visits to Dr. Jacobs.

A videotape deposition of Dr. Glazer for use at the arbitration was also taken on November 14, 1994. Consistent with his "supplemental" report of November 11, 1994, Dr. Glazer now opined that plaintiff's symptoms were unrelated to the disc herniations which were merely "coincidental."

Mr. Coste and Mr. McNulty walked together back to their respective offices following the depositions on November 14, 1994. At that time Mr. Coste told Mr. McNulty that the UIM claim could be resolved for $22,500 and possibly $20,000. Mr. Coste was not lowering the valuation of the case. His statement reflected the practical reality that plaintiff would incur approximately $2,500 in expert and arbitral fees if the matter proceeded to arbitration.

Mr. McNulty testified that he spoke with Mr. Schmidt following the depositions on November 14, 1994 and reiterated his view that the UIM claim was worth nothing. Mr. McNulty and Mr. Schmidt testified that the offer to resolve the claim was

nevertheless increased by Mr. Schmidt at that time to $15,000. Mr. Schmidt testified that counsel never gave him a "specific value" of plaintiff's claim and agreed with Mr. Schmidt's valuation of $15,000. Mr. Schmidt did not rely on advice of counsel in his valuation of plaintiff's claim.

Mr. McNulty testified that he presented a $15,000 offer to Mr. Coste by telephone on November 15, 1994 or November 17, 1994 or possibly the morning of November 18, 1994. Mr. McNulty testified that his normal practice is to convey settlement offers verbally and not in writing. Mr. McNulty testified that although 98% of his practice is personal injury defense work for insurers and he handles numerous cases, he does not ordinarily document settlement offers. He has no written evidence of a $15,000 offer. He testified that he could not recall what Mr. Coste said in response to the $15,000 offer but it was not accepted.

Mr. Coste and Mr. Gross testified that no offer above $10,000 was ever conveyed. Mr. Coste categorically denied Mr. McNulty's account to the contrary. An entry of November 15, 1994 in the Allstate claims diary states that "our offer of $10,000 has been rejected."

Ms. McKenna testified that it is defendant's "policy and procedure" to document settlement offers. She acknowledged that she could find no documentation in defendant's records of a $15,000 offer to resolve plaintiff's UIM claim.

The court finds that Mr. McNulty did not convey an independent valuation of plaintiff's claim to Mr. Schmidt.

The court finds that Mr. Schmidt did not authorize a payment of $15,000 to resolve plaintiff's claim.

The court finds that Mr. McNulty did not offer $15,000 to Mr. Coste.

The matter proceeded to arbitration on November 18, 1994. Mr. McNulty asked that the respective policy limits not be disclosed to the arbitrators and that they be asked to assess plaintiff's damage claim without knowledge of what had been paid or was available from insurance coverage. The dispute was arbitrated on this basis.

Mr. McNulty presented no evidence or argument at the arbitration regarding plaintiff's two later accidents. Mr. McNulty made no argument regarding any delay by plaintiff in seeking treatment.

The three arbitrators unanimously awarded plaintiff $165,000. Upon then being advised of the tender by Nationwide and of the Allstate policy limits, the panel molded the award to $25,000.

On November 30, 1994, defendant tendered a check to plaintiff for $25,000. At the prevailing prime rate plus three percent, plaintiff lost $1,395 in interest from the delay in the satisfaction of his claim.

Calculated on a lodestar basis at a normal hourly rate, attorney fees of $38,603.75 as well as costs of $4,316.10 were incurred in the prosecution of plaintiff's UIM and bad faith claims.

Defendant's net worth is $9,409,365,000.

**Conclusions of Law**

An insurer who acts in bad faith toward an insured in a matter arising under an insurance policy may be liable to the insured for interest on his claim at the prime rate plus three percent, punitive damages, court costs and attorney fees. See 42 Pa. C.S.A. § 8371.

An insurer engages in bad faith when it denies benefits under a policy without a reasonable basis for doing so and knows or recklessly disregards its lack of such reasonable basis. See Klinger v. State Farm Mut. Auto Ins. Co., 115 F.3d 230, 233 (3d Cir. 1997); Terletsky v. Prudential Property & Casualty Ins. Co., 649 A.2d 680, 688 (Pa. Super. 1994), app. denied, 659 A.2d 560 (Pa. 1995).

A determination of bad faith does not require a finding that the insurer was motivated by a dishonest or improper purpose. See Klinger, 115 F.3d at 233-34. Recklessness or acts undertaken by the insurer with a reckless indifference to the interests of the insured can support a finding of bad faith and an award of punitive damages under § 8371. Id. at 235; Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747, 751 (3d Cir. 1994).

A claimant must prove bad faith by clear and convincing evidence. Id. at 750. Evidence is clear and convincing when it is so "clear, direct, weighty and convincing" that a finding of bad faith can be made with "a clear conviction." Id. at 752.

It is now clear that a prevailing § 8371 claimant may

recover attorney fees for time expended in prosecuting the bad faith claim, as well as fees attributable to the prosecution of the underlying benefit claim. See Polselli v. Nationwide Mut. Fire Ins. Co., 1997 WL 598388, *4 (3d Cir. Sept. 30, 1997).

The purposes for which punitive damages are awarded are to punish a party for egregious conduct, which may include reckless indifference to the interests of others, and to deter that party and others similarly situated from engaging in like conduct in the future. See Kirkbride v. Lisbon Contractors, Inc., 555 A.2d 800, 803 (Pa. 1989). Factors to be considered in awarding punitive damages include the character of a defendant's conduct, the nature and extent of the harm intended or caused to the plaintiff; and, the wealth of the defendant. Id.

**Verdict and Judgment**

The clear and convincing standard is a stringent one, surpassed in the law only by proof beyond a reasonable doubt. The court has carefully reviewed and revisited the record in this case. The court concludes that a determination of bad faith is compelled and inescapable.

The court is left with a clear conviction that in persisting in an offer one-third less than its own valuation, defendant evinced bad faith. The court is left with a clear conviction that insofar as defendant refused plaintiff's claim for $25,000 on the basis of purported "strengths" in its position which its adjustor knew or upon reading readily available material would know were untrue, defendant evinced bad faith. The court is left

with a clear conviction that any valuation of plaintiff's UIM claim for less than the policy limit was manifestly unreasonable.

The court finds by clear and convincing evidence that with the information known and readily available to defendant, it lacked a reasonable basis for refusing plaintiff's claim for full benefits and acted in knowing or reckless disregard of the lack of such basis in denying those benefits. Plaintiff is thus entitled to interest of $1,395.72, costs of $4,316.10 and attorney fees of $38,603.75.

Plaintiff argued that only a substantial punitive damage award would fairly punish and seriously deter bad faith conduct by a multi-billion dollar corporation. As an abstract generality this argument has some force. It does not necessarily follow, however, that a substantial corporation can be deterred from wrongfully denying routine claims comparable to plaintiff's only by depriving it of some significant portion of its wealth. As to punishment, there is no requirement of proportionality between actual and exemplary damages. Neither, however, is there a prohibition of some measure of proportionality.

The character of defendant's conduct is apparent. It acted in bad faith to attempt to deprive plaintiff of $15,000 to which he was entitled. The resulting and intended harm to plaintiff was not severe or extensive. It was solely pecuniary. It involved the withholding of a meaningful but not substantial sum of money. There is no evidence or suggestion that the delay in plaintiff's receipt of the $25,000 forced him to forego any

needed treatment or interfered with his ability to sustain himself. Defendant indisputably has substantial wealth.

The court is aware of six figure punitive damage verdicts returned by juries in § 8371 cases where the size of the underlying claim and the amount of compensatory damages approximated those in the instant case. Based on the evidence and the pertinent factors to be considered the court concludes that while an award of punitive damages is highly appropriate in this case, $35,000 is an adequate and reasonable amount to achieve the purposes for which awards of such damages are authorized.

Accordingly, judgment will be entered in this case for plaintiff in the amount of $79,315.57. An appropriate order will be filed.

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**ORDER and JUDGMENT**

**AND NOW**, this day of October, 1997, consistent with the court's findings of fact, conclusions of law and verdict in this case as set forth in the accompanying memorandum, **IT IS HEREBY ORDERED** that **JUDGMENT is ENTERED** in the above action for the plaintiff and against the defendant in the amount of $79,315.57, inclusive of attorney fees and costs of $42,919.85.

**BY THE COURT:**

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**JAY C. WALDMAN, J.**