IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

YVONNE GREEN, WILMINGTON PAIN & REHABILITATION CENTER, and REHABILITATION ASSOCIATES, P.A., on behalf of themselves and all others similarly situated,	)	
Plaintiffs,	)	
v.	)	C.A. No.: N17C-03-242 EMD CCLD
GEICO GENERAL INSURANCE COMPANY,	)	
Defendant.	)	

Submitted: January 8, 2021[1]
Decided: March 24, 2021

Upon Defendant's Motion for Summary Judgment
GRANTED in part and DENIED in part
Upon Plaintiffs' Motion for Summary Judgment
GRANTED in part and DENIED in part

Richard H. Cross, Jr., Esquire, Christopher P. Simon, Esquire, Cross & Simon, LLC, Wilmington, Delaware, *Attorneys for Plaintiffs Yvonne Green, Wilmington Pain & Rehabilitation Center, and Rehabilitation Associates, P.A.*

Paul A. Bradley, Esquire, Stephanie A. Fox, Esquire, Maron Marvel Bradley Anderson & Tardy, LLC, Wilmington, Delaware, George M. Church, Enquire, Joshua Kahn, Esquire, Miles & Stockbridge P.C., Baltimore, Maryland, Meloney Perry, Esquire, Perry Law, P.C., Dallas, Texas, *Attorneys for Defendant GEICO General Insurance Company*

DAVIS, J.

I. INTRODUCTION

This is a class action assigned to the Complex Commercial Litigation Division of the Court. Yvonne Green, Wilmington Pain & Rehabilitation Center ("WPRC"), and Rehabilitation

[1] D.I. No. 242. A hearing was held on the various motions on October 2, 2020.

Associates, P.A. ("RA") sued on behalf of themselves and all others similarly situated (collectively, "Plaintiffs"). Plaintiffs filed suit against Geico General Insurance Company ("GEICO"). Plaintiffs allege that GEICO uses two computerized rules, the Geographic Reduction Rule ("GRR") and the Passive Modality Rule ("PMR") (collectively, the "Rules"), to evaluate insurance claims submitted by insureds or their assignees to GEICO. Plaintiffs argue that the Rules improperly analyze and make determinations for these claims without evaluating the substantive facts underlying the claim.

Before the Court are Plaintiffs' claims for Breach of Contract ("Count I"), Bad Faith Breach of Contract ("Count II"), and Declaratory Judgment ("Count III"). Both parties submitted motions for summary judgment—hereafter referred to as the "Plaintiffs' Motion" and the "GEICO Motion." The main issue in the cross-motions for summary judgment is the method in which GEICO processes PIP claims constitutes a violation of their contract and/or a violation of Delaware law.

For the reasons set forth below, the Court **DENIES** the Plaintiffs' Motion as to Counts I and II. The Court **GRANTS** the Plaintiffs' Motion as to Count III. In addition, the Court **GRANTS** the GEICO Motion as to Counts I and II and **DENIES** the GEICO Motion as to Count III.

II. RELEVANT FACTS

A. POLICY CONCERNS SURROUNDING AUTOMATED SYSTEMS IN THE INSURANCE CONTEXT

Given the issues in this civil action, the Court believes that some background regarding policy issues is appropriate. Automobile insurers typically promise to pay the "reasonable" cost of medically necessary services for injuries their insureds suffer in covered accidents.[2]

For many years, insurers have used automated systems to perform an initial evaluation of the reasonableness of medical bills.[3] The systems typically consult databases with information about millions of bills submitted by healthcare providers.[4] For example, by comparing one provider's prices with those charged in the same geographic area, the Rules—GEICO's system—can determine whether the submitted claim exceeds the prices charged by 80 percent of relevant professionals in that geographic region. This is a simple machine learning function known as classification.[5] If the system determines that a claim is in the 81st percentile or higher, the claim is reduced, and the insurer will only pay the 80th percentile amount.[6]

The Court recognizes that automation has the potential to eliminate persistent errors in human-based systems and to produce consistent decisions.[7] The Court also recognizes that the systems could fail to take advantage of the potential for error correction and could become devices for error propagation themselves.[8] For over a decade, policyholders and health providers have been filing lawsuits, most of them class actions, that challenge the validity of these automated systems. Most have argued that the insurers' approach to paying claims is inherently

---

[2] Robert D. Helfand, *Big Data and Insurance: What Lawyers Need to Know and Understand*, 21 J. Internet L. 1, 23 (2017); s*ee, e.g.*, 21 *Del. C.* § 2118(a)(2).
[3] *Id*.
[4] *Id*.
[5] *Id*.
[6] *Id*.
[7] Danielle Keats Citron, *Technological Due Process*, 85 Wash. U.L. Rev. 1249, 1313 (2008).
[8] *Id*.

unreasonable because, for instance, a charge over the 80th percentile amount might be valid in some circumstance and because the insurers' approach does not allow a human being to exercise judgment in those conditions.[9] Some courts have ruled in favor of plaintiffs where machines acted alone in making decisions.[10]

Other courts report having felt "strong pressures to discourage ... insurers from taking advantage of their superior bargaining position to ... force insureds to accept less than they are entitled to."[11] These courts declare that insurers "may not obtain any advantage over the insured by ... threat or adverse pressure of any kind."[12] The laws of some states specifically prohibit certain tactics, such as: "[m]aking known to insureds ... a practice ... of appealing from arbitration awards ... for the purpose of compelling [claimants] to accept settlements ... less than the amount awarded in arbitration,"[13] and delaying payment or settlement under one form of coverage, "in order to influence settlements under other portions of the insurance policy."[14]

The articulated concern seems to be the importance of the sound exercise of human judgment and of ensuring that technology supports, rather than obscures, that goal. Professor Kenneth A. Bamberger, when discussing the use of analytics in making decisions, recommends:

> But, as the level of judgment required increases--from decisions governing how to sort and characterize data, to rules constraining its use, to analytics deriving

[9] *See e.g., Johnson v. GEICO Cas. Co.*, 673 F.Supp.2d 255, 266 (D. Del. 2009), *aff'd*, 672 Fed.Appx. 150 (2016) ("Plaintiffs allege that Defendants have intentionally set this rule to deny payments without the possibility of human review").

[10] *See Strawn v. Farmers Ins. Co.*, 350 Or. 336 (2011), *cert. den.*, 132 S. Ct. 1142 (2012) (affirming jury award on behalf of plaintiff class) ("the 'recommendation' [of the automated system] was, as a practical matter, the final determination of reasonableness"); *see also In re Farmers Med-Pay Litigation*, 229 P.3d 551 (Okla. Ct. App. 2010) (certifying class on the basis of an allegation that the insurer "had essentially abandoned an individualized approach to assessment of med-pay claims").

[11] *Universe Life Ins. Co. v. Giles*, 950 S.W.2d 48, 61 (Tex. 1997).

[12] *Id.*

[13] *Id.*

[14] *Id.*

> meaning and predictions, to rules automating decisions accordingly--accountability measures must increasingly promote its exercise.[15]

Professor Danielle Citron states that "[p]rogrammers routinely change the substance of rules when translating them from human language into computer code […] The resulting distorted rules effectively constitute new policy that can affect large numbers of people." [16] Professor Citron argues that decisions best addressed by standards should not be automated:

> Policies that explicitly or implicitly require the exercise of human discretion cannot be automated. For instance, agencies *should not automate policies that allow individuals to plead extenuating circumstances that software cannot anticipate*. Legal materials providing that a "decision maker may" take a given action explicitly signal that automation is inappropriate. Others implicitly do so by including indeterminate terms that require decision makers to consider conflicting norms that resist precise weighting.[17]

Robert Helfand, Esquire, notes that a court could decide that the duty of good faith, as a matter of law, prohibits exclusive, or even excessive, reliance on "secret algorithms."[18] Undisclosed algorithms in the operation of insurance company functions seem to raise accountability concerns that run counter to the policy goals of insurance law. Technology can make the claims process more efficient and effective. Similar to issues with closed-source code present in technology-based compliance systems, however, the Rules—undisclosed to insureds—can leave insureds "unable to discern how a system operates and protects itself"[19] and could shield unintended errors that distort even clear legal and managerial goals. "Programming and mathematical idiom can shield layers of embedded assumptions from high-level firm

[15] Kenneth A. Bamberger, Technologies of Compliance: Risk and Regulation in a Digital Age, 88 Texas L. Rev. 669, 727 ((2010).
[16] Danielle Keats Citron, *Technological Due Process*, 85 Wash. U.L. Rev. 1249, 1308 (2008).
[17] *Id*.
[18] Robert D. Helfand, *Big Data and Insurance: What Lawyers Need to Know and Understand*, 21 J. Internet L. 1, 24 (2017).
[19] *Id*.

decisionmakers charged with meaningful oversight and can mask important concerns with a veneer of transparency."[20]

Similar to automated decision systems used in the agency context, these systems also seem to jeopardize the right to be given notice of reasons for denial.[21] Clear notice decreases the likelihood a decision will rest upon "incorrect or misleading factual premises or on the misapplication of rules."[22] As a result, affected individuals could lack the information they would need to effectively respond.[23] Mr. Helfand advises:

> The solution to the problems outlined here cannot be simply to avoid those models. Rather, it lies in how those models should be developed and deployed [...] At the time when it first puts an automated tool to use in claims handling, the insurer also should prepare a way to demonstrate that the tool performs a well-defined task in a reasonable way.[24]

From these sources, the Court takes guidance. The Court realizes that there is no *per se* rule on whether automated rules can be employed in handling insurance claims. Moreover, the Court must examine the particular facts before it without inappropriately shifting the burden of proof.[25] The Court recognizes that these sources are merely persuasive and not controlling here. Delaware law, not law review articles, will govern the resolution of Plaintiffs' claims against GEICO.

B. PIP COVERAGE LAW IN DELAWARE

GEICO sells Delaware automobile insurance policies that provide no-fault personal injury protection ("PIP") coverage.[26] PIP coverage is mandatory in Delaware.[27] The purpose of

---

[20] *Id*.
[21] Danielle Keats Citron, *Technological Due Process*, 85 Wash. U.L. Rev. 1249, 1308 (2008).
[22] Danielle Keats Citron & Frank Pasquale, *The Scored Society: Due Process for Automated Predictions*, 89 Wash. L. Rev. 1, 27 (2014).
[23] Danielle Keats Citron, *Technological Due Process*, 85 Wash. U.L. Rev. 1249, 1308 (2008).
[24] Helfand, *supra* note 18.
[25] *See State Farm Mut. Auto. Ins. Co. v. Spine Care Del., LLC*, 238 A.3d 850, 858-60 (Del. 2020).
[26] 21 *Del. C.* §2118 and App.1.
[27] 21 *Del. C.* §2118B(a).

PIP coverage is "to ensure reasonably prompt processing and payment of sums owed by insurers . . . and to prevent the financial hardship and damage to personal credit ratings that can result from the unjustifiable delays of such payments."[28] Delaware regulations mandate that PIP claims "shall be payable within 30 days of the demand thereof by the claimants provided that reasonable proof of loss for which the benefits as demanded has been submitted to the PIP carrier."[29]

Specifically, 21 *Del. C.* § 2118(a)[30] provides:

> The purpose of this section is to ensure reasonably prompt processing and payment of sums owed by insurers to their policyholders and other persons covered by their policies pursuant to § 2118 of this title, and to prevent the financial hardship and damage to personal credit ratings that can result from the unjustifiable delays of such payments.[31]

Further, Section 2118B(c) mandates that insurers respond to claims within thirty days:

> When an insurer receives a written request for payment of a claim for benefits pursuant to § 2118(a)(2) of this title, the insurer shall promptly process the claim and shall, no later than 30 days following the insurer's receipt of said written request for first-party insurance benefits and documentation that the treatment or expense is compensable pursuant to § 2118(a) of this title, make payment of the amount of claimed benefits that are due to the claimant or, if said claim is wholly or partly denied, provide the claimant with a written explanation of the reasons for such denial. If an insurer fails to comply with the provisions of this subsection, then the amount of unpaid benefits due from the insurer to the claimant shall be increased at the monthly rate of:
>
> (1) One and one-half percent from the thirty-first day through the sixtieth day; and
> (2) Two percent from the sixty-first day through the one hundred and twentieth day; and
> (3) Two and one-half percent after the one hundred and twenty-first day.[32]

[28] 21 *Del. C.* §2118B(a).
[29] Dept. of Ins. Reg. 603 at § 6.2.
[30] The Court will be citing to Title 21 regularly. For simplicity, the Court will hereafter use "Section 2118__."
[31] 21 *Del. C.* § 2118B(a).
[32] 21 *Del. C.* § 2118B(c).

If the insurer fails to comply with Sections 2118B(b) or (c), the claimant (insured or assignee) may file suit under Section 2118B(d).[33] Section 2118B(d), in part, provides:

> If an insurer fails to comply with subsection (b) or (c) of this section, the claimant may recover the amount due through a civil action in any court of competent jurisdiction….Any judgment entered for a claimant in a civil action or arbitration proceeding brought under this section shall include, in addition to the amount due and any additional amount provided for by subsections (b) and (c) of this section, an award for the costs of the action and the prosecution of the action, including reasonable attorney's fees; provided, however, that the costs of the action and the prosecution of the action, including reasonable attorney's fees shall only be awarded if it is found that the insurer acted in bad faith. The burden of proving that the insurer acted in bad faith shall be on the claimant. Any sums other than the original claim paid under this subsection shall not reduce the amount of coverage available under the insurance policy that is the basis for the claim.[34]

The remedies provided in Section 2118B are not a claimant's exclusive remedies. Section 2118B(f) states that the remedies available in Section 2118B are in addition to all other remedies available to a claimant under statute or common law.[35]

C. GEICO'S INSURANCE POLICY

Under the terms of GEICO's policies (the "GEICO Policies"), when a claimant is injured and incurs a potentially reimbursable PIP claim (*i.e.*, obtains medical treatment for an injury), the claimant submits a "written proof of claim" to GEICO.[36] The insured further agrees to provide any information requested by GEICO and submit to a medical examination if requested by GEICO.[37]

GEICO is obligated to pay, among other benefits, "medical expenses." The GEICO Policies define medical expenses as:

---

[33] 21 *Del. C.* § 2118B(d).
[34] *Id.*
[35] 21 *Del. C.* §2118B(f).
[36] Def. Op. Br., Ex. B (Aff. of Jacqueline Todd) at Ex. 1 at p. 9 of 22.
[37] *Id.* at p. 9 of 22, 21 of 22.

> 5. ***Medical expenses*** means reasonable expenses for necessary medical, hospital, dental, surgical, x-ray, ambulance and professional nursing services, prosthetic devices, and treatment from recognized religious healers. (emphasis in original).[38]

The GEICO Policies are governed by Delaware law and state that—

> [a]ny terms of this policy in conflict with the statutes of Delaware are amended to conform to those statutes.[39]

The GEICO Policies state that, if there is an exclusion in the policy that is deemed invalid, GEICO will provide at least the minimum coverage required by law.[40]

D. GEICO'S CLAIMS HANDLING

GEICO's PIP claims-processing system is entirely automated, systematized, and rule-based, notwithstanding any contractual, regulatory, and statutory obligations to investigate and accurately process claims. In lieu of any factual investigation of claims, GEICO deploys the Rules as the sole determinant of whether a claim is denied or allowed.[41] As a GEICO witness testified: "Q: So it gets done without a person looking at it? A: Exactly."[42]

As stated above, the Rules are the Geographic Reduction Rule and the Passive Modality Rule. When a claim is submitted to GEICO, GEICO first ensures that it has all the information it needs from the claimant before submitting the claim to its computers for processing.[43] At that point, whether to pay and how much to pay an otherwise valid claim is determined solely by the Rules.

GEICO does not disclose the use of the Rules in the GEICO Policies.

---

[38] *Id*. at p. 7 of 22.
[39] *Id*. at p. 22 of 22.
[40] *Id*. at p. 21 of 22.
[41] *See, e.g.*, Pl. App. Exs. 3 through 8 (discussion of use of Fair Isaac and Medata databases).
[42] Pl. App. Ex. 9 at 42:6-8.
[43] *See, e.g.*, Pl. App. Ex. 16 at 31:8-32:7; Pl. App. Ex. 17 at 65:12-66:3.

i. Geographic Reduction Rule

The GRR is a computer rule that reduces full payment of claims based on an "80th percentile" cap.[44] This cap is a percentage reduction that acts as a sublimit. The GRR caps payment at the 80th percentile of other bills in GEICO's database.[45] The GRR is not disclosed anywhere the GEICO Policies. GEICO reportedly informs its insureds/assignees of the GRR in "Message Modifier" code 765.[46] This code states:

> Submit medical records so that we may determine if the appropriate CPT code was used to describe the services provided. If the appropriate CPT code was used, we will compare the payment made to you with amounts charged by providers of the same type in the surrounding geographic area to determine if an adjustment is appropriate.[47]

Each procedure performed by a medical provider is billed using a Current Procedural Terminology code ("CPT Code") identifier—a universal code assigned to each treatment procedure. GEICO has a database that contains all bills submitted by all claimants and is updated every six months.[48] The database stores: (i) information on the date of the procedure; (ii) CPT code; (iii) the amount charged by the medical provider; (iv) the geographic location of the provider (using the first three digits of the zip code ("GeoZIP")); and, (v) the type of provider (which is only broken down in three broad categories – doctors, chiropractors and physical therapists).[49] GEICO sorts the claims from lowest amount to highest amount and amount that is at the 80th percentile in the linear stack is the maximum amount that GEICO will pay for a given CPT code.[50]

---

[44] *See, e.g.*, Pl. App. Ex. 19 at 54:1-55:6.
[45] *Id.*; see also Pl. App. Ex. 20.
[46] Def. Op. Br., Ex. B at Ex. 3 (GEICO 000043).
[47] *Id.*
[48] Pl. App. Ex. 21 at 25:17-24.
[49] Pl. App. Ex. 22 at 133:11-22 and 134:9-18; Pl. App. Ex. 23 at 130:10-131:8.
[50] Pl. App. Ex. 19 at 54:10-55:6.

GEICO apparently implemented the GRR in the 1990s. GEICO representatives state that the GRR's implementation was based on a recommendation from a software vendor.[51] During the time that GEICO has used the 80th percentile, GEICO has not conducted any study or analysis to determine whether it is a fair or accurate measure of reasonableness.[52]

ii. Passive Modality Rule

The parties have generally described "Passive Modalities" as "'treatment/care modalities' by the care-giver to a patient who 'passively' receives the care" (*e.g.*, hot/cold pack, electrical stimulation, massage).[53] GEICO utilizes the PMR to review PIP claims submitted for passive treatment that occur more than eight weeks after an accident.[54] The PMR identifies the following data before denying a claim: (i) the date of loss; (ii) the date of treatment; and (iii) the CPT code designated on the claim form.[55] If the treatment is for a passive modality performed more than eight weeks following the accident, the software provides the adjuster with a recommendation which has the seeming effect of denying payment in full without human review of the patient or medical treatment notes whatsoever.[56]

The PMR is not in the GEICO Policies. GEICO reportedly informs its insureds/assignees of the PMR in "Message Modifier" code 767.[57] Message Modifier code 767 provides:

> Submit medical records so that we may determine the length of acute care based on the patient's age, diagnosis and medical intervention. The medical records must include positive, specific, objective findings to indicate the appropriate use of the physical modality as well as a progression to an active therapeutic exercise program with a decrease in passive modalities. If we are unable to validate ongoing acute care, we may seek independent medical review.[58]

---

[51] Pl. App. Ex. 26 at 16:6-17:9; Pl. App. Ex. 27 at 53:2-17.
[52] Pl. App. Ex. 26 at 17:10-18:8; Pl. App. Ex. 27 at 18-24
[53] *See, e.g.*, Pl. App. Ex. 59:57:14-22 (general description of passive modalities by Rhea Cohn, PT, DPT); Pl. Mot. for Summ. J. at 12.
[54] Pl. App. Ex. 42; Pl. App. Ex. 43 at 153:21-155:4.
[55] *Id*.
[56] Pl. App. Ex. 44 at 78:20-81:18.
[57] Def. Op. Br., Ex. B at Ex. 3 (GEICO 000043).
[58] *Id*.

E. PROCEDURAL BACKGROUND

On March 10, 2014, Ms. Green filed the initial class action complaint (the "Initial Chancery Complaint") against GEICO in the Delaware Court of Chancery. The Initial Chancery Complaint alleged causes of action for Injunctive Relief, Bad Faith Breach of Contract, Breach of Duty of Fair Dealing, Consumer Fraud, and Tortious Interference with Contract. The Initial Chancery Complaint also sought class action status pursuant to Court of Chancery Rule 23. GEICO filed its initial responsive pleading on April 14, 2014.

The case was dormant until February 2015 when the Chancery Court requested a status report from the parties. Ms. Green's counsel requested a stay pending the outcome of a motion to decertify classes filed in a similar case in the United States District Court for the District of Delaware (the "Delaware District Court") titled *Johnson v. GEICO Casualty Co.*[59] In September 2015, the Delaware District Court decertified two classes previously certified. Upon being advised of this outcome, the Chancery Court conducted a status conference on November 3, 2015.

On December 11, 2015, Ms. Green filed an amended class action complaint (the "Amended Chancery Complaint") in the Chancery Court. The Amended Chancery Complaint added two additional plaintiffs, WPRC and RA, and replaced four of the five original counts. The Amended Chancery Complaint asserted claims for Breach of Contract, Bad Faith Breach of Contract, Declaratory Relief, and Deceptive Trade Practices Act violations.

GEICO then moved to dismiss the Amended Chancery Complaint. Following a hearing and additional briefing, the Chancery Court dismissed the Amended Chancery Complaint for

[59] 310 F.R.D. 246 (D. Del. 2015).

lack of subject matter jurisdiction on February 1, 2017. The Plaintiffs then elected a timely transfer to this Court on February 24, 2017.

On March 20, 2017, Plaintiffs filed the Class Action Complaint in this Court. The Class Action Complaint is essentially identical to the Amended Chancery Complaint, asserting the same claims for Breach of Contract, Bad Faith Breach of Contract, Declaratory Relief, and Deceptive Trade Practices Act violations. The Class Action Complaint alleged class certification on behalf of all persons, including insureds and medical providers, whose claims for PIP benefits were denied or reduced as a result of the Rules. The members of this class are referred to as "The Claimant Class" and the "The Insured Class."

On April 4, 2017, GEICO moved to dismiss the Class Action Complaint through Defendant GEICO General Insurance Company's Motion to Dismiss Plaintiffs' Class Action Complaint. On July 12, 2017, the Court granted a stipulation to allow Plaintiffs to file the Amended Complaint thereby rendering the pending motion moot.[60]

The Amended Complaint had four counts.[61] In Count I, the Plaintiffs allege that GEICO breached the GEICO Policies. In Count II, the Plaintiffs' assert that GEICO committed a bad faith breach of contract under Section 2118B(d) and are liable for attorneys' fees and costs associated with the action. In Count III, the Plaintiffs seek a declaratory judgment that GEICO's continued use of the Rules is unlawful and violates Section 2118. Finally, in Count IV, the Plaintiffs contended that GEICO engaged in unfair and deceptive practices in violation of 6 *Del. C.* §2532(a)(5) and (12). Specifically, the Plaintiffs claimed that GEICO violated 6 *Del.* C.

[60] The Amended Complaint is titled "First Amended Class Action Complaint." D.I. 31.
[61] The only differences between the Amended Class Action Complaint and the Class Action Complaint are: (i) the Amended Class Action Complaint requested an injunction requiring GEICO to recalculate all claims without using the Rules, which Plaintiffs have replaced with a request for damages resulting from GEICO's use of the Rules, and (ii) unlike the Amended Class Action Complaint, the present Class Action Complaint includes a request for punitive damages.

§2532(a)(5) and (12) by failing to disclose its use of the Rules to insureds and failing to perform an investigation before reducing or denying its insureds' claims.

On August 1, 2017, GEICO filed a Motion to Dismiss the Amended Complaint (the "MTD"). The Court issued an opinion granting in part and denying in part the MTD on April 24, 2018. The Court dismissed Count IV but allowed the rest of the claims to proceed.

On January 3, 2019 GEICO filed the GEICO Motion. The Court stayed action on the GEICO Motion until after the hearing and decision on class certification.

On August 17, 2018, Plaintiffs filed their motion for class certification. Following additional discovery taken by GEICO and a hearing, the Court granted Plaintiffs' motion for class certification on August 27, 2019. On October 8, 2019, the Delaware Supreme Court refused GEICO's interlocutory appeal.

After the decision on class certification, the Court lifted the stay with respect to the GEICO Motion. On December 5, 2019, Plaintiffs filed the Plaintiffs' Motion.

F. THE AMENDED COMPLAINT

As discussed above, the Amended Complaint contains three claims—Breach of Contract (Count I); Bad Faith Breach of Contract (Count II); and Declaratory Judgment (Count III). The factual basis of each of Plaintiffs' claims is straightforward. Each insured or assignee files a PIP claim for benefits in accordance with the terms of the GEICO Policies. GEICO then processes the PIP claim using on the Rules. After using the Rules, GEICO pays, reduces or denies the PIP claim without the exercise of any human discretion or review. If the claim is denied or reduced, GEICO generates an explanation of benefits that is transmitted to the insured or his/her assignees. GEICO only uses the Rules to determine whether a PIP claim is reasonable or not. GEICO, however, does not disclose the use of the Rules to its insureds or their assigns. The

Amended Complaint assumes that all of this is done within the deadlines set out in Section 2118B(c).

Plaintiffs allege in Count I that GEICO had a contractual duty to its insureds and their assignees under the GEICO Policies to provide PIP benefits. Plaintiffs state that they paid premiums for coverage under the GEICO Policies. Plaintiffs argue GEICO breached the terms of the GEICO Policies by using the Rules to reduce or deny payment of covered PIP benefit claims. Plaintiffs contend that, due to GEICO's breach, they have been deprived of the benefit of the insurance coverage.

Count II is styled as "Bad Faith Breach of Contract." Plaintiffs rely on Section 2118B(d) as the basis for their relief. Plaintiffs contend that GEICO did not pay covered PIP benefits within thirty days. Because GEICO used the Rules, GEICO allegedly failed to process the claims for PIP benefits and triggered Section 2118B(d). Therefore, under Section 2118B(d), Plaintiffs argue that they are entitled to statutory interest and "an award for the costs of the action and the prosecution of the action, including reasonable attorney's fees…." GEICO's purported bad faith is GEICO's use of the Rules resulting in allegedly arbitrary and improper bill reductions and denials.

Count III seeks a declaratory judgment. Here, Plaintiffs claim that GEICO was required to pay covered claims for PIP benefits under Delaware law. Plaintiffs contend that GEICO violated Delaware law—i.e., Section 2118—by using the Rules when determining the amount of the Plaintiffs' claims for PIP benefits. Plaintiffs want the Court to declare that GEICO violated Section 2118 and that GEICO cannot lawfully use the Rules.

Plaintiffs' case is very straightforward. Plaintiffs' case does not seek to shift any burdens of proof on the reasonableness of the claims for PIP benefits. Instead, Plaintiffs seek a judicial

determination that the Rules deny claims for PIP benefits in a way that breaches the GEICO Policies and/or violates applicable Delaware law. Plaintiffs contend that the use of the Rules violates GEICO's obligation to conduct a proper, good-faith investigation of a claim before denying the claim in part or in whole.

III. PARTIES' CONTENTIONS

A. PLAINTIFFS

In the Amended Complaint, Plaintiffs allege that GEICO's use of the Rules amounts to a (i) breach of contract, (ii) bad faith breach of contract, and (iii) entitles them to a declaration that GEICO's use of the Rules violates Section 2118 and that GEICO should be precluded from further use of the Rules. In the Plaintiffs' Motion, Plaintiffs argue they are entitled to this relief because: (i) GEICO's use of the Rules violates their contracts and Section 2118; (ii) GEICO is precluded from asserting defenses as to Plaintiffs' PIP claims that were based on the Rules; and (iii) GEICO is precluded from asserting any defense not asserted within the first 30 days when claims were first submitted.

B. GEICO

GEICO argues that the GEICO Policies do not prohibit GEICO from using the Rules, nor do they require GEICO to consider—or prohibit GEICO from considering—any particular methodology in determining payment of no-fault benefits, other than the requirement that GEICO pay reasonable expenses for necessary treatment.

Likewise, GEICO argues that Section 2118(a)(2)a does not prohibit GEICO from using the Rules to evaluate payment of no-fault benefits. Section 2118B(d) only applies "if an insurer fails to comply with subsection [§ 2118B] (b) or (c) […]." GEICO contends that there is no allegation nor is there any evidence that GEICO has violated either of those subsections.

GEICO disputes factual inferences raised by Plaintiffs in the Plaintiffs' Motion. Although GEICO disputes the facts, GEICO contends that none of these disputed facts prevent the Court from granting the relief sought in the GEICO Motion, which presents purely legal issues requiring no consideration of the facts.

IV. STANDARD OF REVIEW

The standard of review on a motion for summary judgment is well-settled. The Court's principal function when considering a motion for summary judgment is to examine the record to determine whether genuine issues of material fact exist, "but not to decide such issues."[62] Summary judgment will be granted if, after viewing the record in a light most favorable to a nonmoving party, no genuine issues of material fact exist and the moving party is entitled to judgment as a matter of law.[63] If, however, the record reveals that material facts are in dispute, or if the factual record has not been developed thoroughly enough to allow the Court to apply the law to the factual record, then summary judgment will not be granted.[64]

The moving party bears the initial burden of demonstrating that the undisputed facts support his claims or defenses.[65] If the motion is properly supported, then the burden shifts to the non-moving party to demonstrate that there are material issues of fact for the resolution by the ultimate fact-finder.[66] The non-moving party must do "more than simply show that there is some metaphysical doubt as to material facts."[67]

---

[62] *Merrill v. Crothall-American Inc.*, 606 A.2d 96, 99-100 (Del. 1992) (internal citations omitted); *Oliver B. Cannon & Sons, Inc. v. Dorr-Oliver, Inc.*, 312 A.2d 322, 325 (Del. Super. 1973).
[63] *Id.*
[64] *See Ebersole v. Lowengrub*, 180 A.2d 467, 470 (Del. 1962); *see also Cook v. City of Harrington*, 1990 WL 35244 at *3 (Del. Super. Feb. 22, 1990) (citing *Ebersole*, 180 A.2d at 467) ("Summary judgment will not be granted under any circumstances when the record indicates . . . that it is desirable to inquire more thoroughly into the facts in order to clarify the application of law to the circumstances.").
[65] *See Moore v. Sizemore*, 405 A.2d 679, 680 (Del. 1970) (citing *Ebersole*, 180 A.2d at 470).
[66] *See Brzoska v. Olsen*, 668 A.2d 1355, 1364 (Del. 1995).
[67] *Id.* at 1364 (citing *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586, 106 S .Ct. 1348, 89 L.Ed.2d 538 (1986)).

V. DISCUSSION

A. COUNT I – BREACH OF CONTRACT CLAIM

To properly plead or prove a claim for breach of contract in Delaware, a plaintiff must prove (i) the existence of a contract, (ii) the breach of an obligation imposed by the contract, and (iii) damages that the plaintiff suffered as a result of the breach."[68] In addition, the plaintiff must identify an express contract provision breached by the defendant.[69]

The eligibility to receive PIP benefits in an automobile accident is "entirely statutory in origin and operation."[70] This is because the eligibility to receive PIP benefits derives from the Delaware No–Fault Insurance Statute rather than common law.[71] The Supreme Court has found that the statute only creates a cause of action if there is a breach of the PIP contract.[72] Under Section 2118 and Section 2118B, the insurer is obligated to pay PIP claims "so long as they are reasonable."[73] Under Section 2118B, the insurer waives defenses to a written PIP claim if the insurer does not respond to the PIP claim within thirty (30) days.[74]

Plaintiffs contend in Count I that GEICO had a contractual duty to fully investigate any PIP claim made under the GEICO Policies and not just rely on the Rules. Therefore, the first issue before the Court is whether GEICO owed Plaintiffs a duty to investigate in a certain manner under the contract, common law, statutory law, and Delaware regulations. The second issue is whether this duty was breached by GEICO.

---

[68] *Johnson v. GEICO Cas. Co.*, 672 Fed. Appx. 150, 155 (3d Cir. 2016).
[69] *Anderson v. Wachovia Mortg. Corp*., 497 F. Supp. 2d 572, 581 (D. Del. 2007) (citing *Wal-Mart Stores, Inc. v. AIG Life Ins. Co*., 901 A.2d 106, 116 (Del. 2006)).
[70] *Harper v. State Farm Mut. Auto. Ins. Co*., 703 A.2d 136, 140 (Del. 1997).
[71] *Id.*
[72] *Id.*; *see also State Farm Mut. Auto. Ins. Co.*, 238 A.3d at 860.
[73] *State Farm Mut. Auto Ins. Co.*, 238 A.3d at 862.
[74] *Spine Care Del. LLC v. State Farm Mut. Auto. Ins. Co.*, 2007 WL 495899, at *2-3 (Del. Super. Aug. 3, 2007) (holding that insurer is precluded from asserting a defense to a PIP claim if not made during the 30-day period).

i. The Contract Does Not Incorporate 18 Del. C. § 2304.

"The Delaware Unfair Trade Practices Act ('UTPA'), 18 *Del. C.* § 2301, *et seq*. (1975), empowers the Delaware Commissioner of Insurance ... to deal with unfair trade practices within the insurance industry."[75] The UTPA does not create a private right of action.[76]

Plaintiffs argue that 18 *Del. C.* § 2304 is incorporated by the conflict clause stating that "[a]ny terms of this policy in conflict with the statutes of Delaware are amended to conform to those statutes."[77] Plaintiffs explain that the United States District Court for the District of Delaware reviewed the same provision of GEICO's form contract and found "the only possible interpretation of the cited language is that the contract is to be interpreted consistent with Delaware law. The clause is meant to avoid conflicts between the contract and Delaware law."[78] Plaintiffs contend that "[p]arties to a contract are also generally presumed to take all existing laws into account when entering into a contract."[79] The Court in *Sammons v. Hartford Underwriters Insurance Company* stated:

> Moreover, the incorporation of applicable, existing law into a contract does not require a deliberate expression by the parties. The laws in force at the time and place of making the contract enter into, and form a part of it as if they had been expressly referred to, or incorporated in, its terms.[80]

GEICO contends that the breach of contract action fails because 18 *Del. C.* § 2304(16) does not create a private right of action and Plaintiffs fail to point to any provision in the policy that conflicts with Delaware law. GEICO claims that Plaintiffs have failed to show that 18 *Del.*

---

[75] *Correa v. Pennsylvania Mfrs. Ass'n Ins. Co*., 618 F. Supp. 915, 925 (D. Del. 1985).
[76] *Davidson v. Travelers Home & Marine Ins. Co.*, 2011 WL 7063521 (Del. Super. Dec. 30, 2011).
[77] Pl. App.1 at 22.
[78] *Johnson v. Gov't Employees Ins. Co.*, 2014 WL 1266832, at *3 (D. Del. 2014), *aff'd sub nom., Johnson v. GEICO* Cas. Co., 672 Fed. Appx. 150 (3d Cir. 2016).
[79] *High Voltage Beverages, LLC v. Hartford Cas. Ins. Co*., 2011 WL 7063295 at *2 (Del. Super.2011)
[80] *Sammons v. Hartford Underwriters Ins. Co*., 2010 WL 1267222, at *3 at n.15 (Del. Super. 2010)

C. § 2304(16) should be incorporated under the policy because Plaintiffs have not stated an explicit provision in the policy that should conform to 18 *Del. C.* § 2304(16).

Plaintiffs try to argue 18 *Del. C.* § 2718(b) operates to include the requirements of 18 *Del. C.* § 2304(16) within the policy. 18 *Del. C.* § 2718(b) states:

> Any condition, omission or provision not in compliance with the requirements of this title [Title 18] and contained in any policy, rider or endorsement hereafter issued and otherwise valid shall not thereby be rendered invalid but shall be construed and applied in accordance with such condition, omission or provision as would have applied had the same been in full compliance with this title.[81]

Still, Plaintiffs have not argued that any particular provision in the policy will be "invalid" if not construed in a certain way. The only duty in the policy cited by Plaintiffs is the duty to pay reasonable medical expenses. There is no express duty under the GEICO Policies on how to review those medical expenses. Thus, it seems that the only theory Plaintiffs could prevail under is an implied duty of good faith and fair dealing. GEICO's theory for why Plaintiffs have not asserted this claim has some merit:

> The original verified class action complaint filed in Chancery Court included a separate cause of action for "Count III - Breach of the Duty of Fair Dealing." In December 2015, Plaintiffs' counsel filed an amended complaint in which they abandoned the fair dealing claim, likely realizing the futility of such claim given the entry of summary judgment a few months earlier on an identical claim in *Johnson*. Likewise, Plaintiffs did not reassert that claim either in the original or the FAC filed in this Court after the case was transferred.

Plaintiffs attempt to bring a successful breach of contract claim seems similarly futile under the District Court of Delaware's reasoning of *Johnson*. In *Johnson*, the District Court of Delaware set out why summary judgment should be granted in favor of the defendant:

> The Plaintiff argues that, "GEICO has frustrated the overarching purpose of the insurance contacts—and PIP law—and has taken advantage of its position to control processing of claims, to its benefit, to the detriment of policyholders, and with fraud, deceit, misrepresentation, or furtive design, in violation of the

[81] 18 *Del. C.* § 2718(b).

> covenant." (D.I. 599 at 43). However, except for the aforementioned generic statement, the Plaintiff does not cite to a single location in the record that would demonstrate any such violation.
>
> […]
>
> Here the Plaintiff is not using the § 2304 to satisfy an element of a claim, but is instead arguing that the statutory requirements should be read into the contract that the insured and the insurer agreed to. In other words, the Plaintiff is attempting to reform the contract via the implied covenant of good faith and fair dealing, to include the requirements of 18 Del. C. § 2304. For the Court to read into the insurance contract the requirements of § 2304 would require the Court to find that the parties would have agreed to such a term had the parties thought to have negotiated with respect to the matter. *See Dunlap*, 878 A.2d at 442. Here, as § 2304 contains no private right of action, the Court will not read the requirements into the contract without compelling evidence that the parties would have agreed to include the clause if they had negotiated the issue. The Plaintiff has provided no such evidence.[82]

The Third Circuit affirmed and specifically refused to rewrite the policy as Plaintiffs are again requesting here:

> [W]e cannot reform [the plaintiff's] contract to prohibit the use of GEICO's claims processing rules because [the plaintiff] has not offered any evidence of the parties' intent at the time of contracting for us to conclude that one of the fruits of the contract was review of her claim without those rules.[83]

By not specifying a particular provision that conflicts with Delaware law, Plaintiffs essentially argue that all Delaware law should be incorporated into the contract. The absence of a provision does not mean that there is a conflict warranting reformation. The Court cannot reform the GEICO Policies to prohibit GEICO's claims processing rules where there was no evidence of parties' intent to have a contractual duty to review claims based on all available information.

[82] *Johnson v. Gov't Employees Ins. Co*., 2014 WL 2708300, at *4 (D. Del. June 16, 2014), *aff'd sub nom*. *Johnson v. GEICO Cas. Co*., 672 F. App'x 150 (3d Cir. 2016).
[83] *Johnson v. GEICO Cas. Co.*, 672 F. App'x. 150, 156 n.20 (3d Cir. 2016) (emphasis added).

ii. There is No Common Law Duty to Investigate in a Certain Manner

GEICO disputes that there is a common law duty to investigate. All the cases cited by Plaintiffs notably involve situations of bad faith breach of contract. This is because the failure to investigate can show bad faith but is not sufficient in itself to show a breach of contract.

In *Ponzo v. Nationwide Mut. Ins. Co.*, the insured was successful in a bad faith claim against the insurer seeking payment for personal injury protection benefits.[84] In *Tackett v. State Farm Fire and Cas. Ins. Co.*, the Supreme Court held "[w]here an insurer fails to investigate or process a claim or delays payment in bad faith, it is in breach of the implied obligations of good faith and fair dealing underlying all contractual obligations."[85]

The *Ponzo* and *Tackett* cases cited by Plaintiffs both provide that a lack of good faith, or the presence of bad faith, is actionable where the insured can show that the insurer's denial of benefits was clearly without any reasonable justification. In both cases, it was the breach of contract by the denial of benefits without any reasonable justification that made the bad faith actionable. The cases do not stand for the proposition that GEICO had a common law duty to investigate—only that the denial of benefits must be made with a reasonable justification.

Plaintiffs contend a duty to investigate is also supported by the decision in *Spine Care Delaware, LLC v. State Farm Mut. Auto. Ins. Co.*[86] The Court summarized the PIP claims process as follows:

> Delaware provides a system in which the medical provider renders the initial bill for services provided, and the insurer then has the right to investigate the reasonableness of the charges. However, any adjustment to the bill by the insurer must have a basis in fact that conforms to the *Anticaglia* and *Watson* factors.[87]

---

[84] 2013 WL 3965396 (Del. Com. Pl. 2013).
[85] 653 A.2d 254 (Del. 1995).
[86] 2019 WL 5581441 (Del. Super. 2019), *rev'd. State Farm Mut. Auto. Ins. Co. v. Spine Care Del., LLC,* 238 A.3d 850, 858-60 (Del. 2020).
[87] *Id*.

Plaintiffs contend that *Spine Care* stands for the proposition that GEICO has the initial burden to investigate and pay or deny the claim in good faith with an explanation. The Supreme Court, however, reversed *Spine Care* in *State Farm Mut. Auto. Ins. Co. v. Spine Care Delaware, LLC*.[88] The Supreme Court held that the plaintiff in an action carries the initial burden to prove his/her position.[89] Moreover, the Supreme Court stated that burden does not change in the "PIP context."[90] The Supreme Court also provided that, if the Court finds that the insured's claim was reasonable and necessary, then the PIP insurer is obligated to pay the claim.[91]

In *Mt. Hawley Ins. Co. v. Jenny Craig, Inc.*,[92] defendant brought an action for declaratory judgment to pay the balance of the settlement out of the excess policy defendant had with Mt. Hawley. Mt. Hawley declined to pay the balance. The Court in *Mt. Hawley* makes the statement that there is "a duty on insurers to fully and/or properly investigate claims made to them" and that this is the law in Delaware.[93] Plaintiff contends:

> GEICO asks this Court to ignore the precedent because of an errant cite to *E.I. duPont deNemours & Co. v. Admiral Ins. Co.* – cited in *Mt. Hawley* as "Del.Super., C.A. No. 89C-AU-99, Steele, V.C. (February 15, 1994)." It appears clear that the Court intended to cite to *E.I. duPont deNemours & Co. v. Admiral Ins. Co.*, 1994 WL 465547 (Del. Super. 1994) (another decision from the same lawsuit that discussed the duty to investigate).

However, the case that Plaintiffs cite fails to support their argument and ignores the ruling in *Jenny Craig*. For instance, it states:

> While the *Casson* case does not stand for the proposition Delaware law has recognized a claim for breach of the insurer's duty to deal or to investigate in good faith, the court in *Casson* assumed Delaware law would one day permit an action for "wilful or malicious breach of contract" where a plaintiff could also show the insurer's denial of benefits was "clearly without any reasonable justification."

[88] 238 A.3d 850 (Del. 2020).
[89] *Id*. at 858-59.
[90] *Id*. at 859.
[91] *Id*. at 861-62.
[92] 1995 WL 716929, at *1 (Del. Super. 1995).
[93] *Id*. at *1.

> […]
>
> DuPont cites *Playtex, Inc. v. Columbia Casualty Co.*, (March 10, 1993) *supra*, and *Hickman v. Hartford Ins. Group*, Del.Super., C.A. No. 85C-DE-15, Ridgely, J. (Aug. 31, 1988) as well as cases from other jurisdictions for the proposition the Court should recognize a separate action for a bad faith failure to investigate and distinct damages arising from that action. However, after an examination of *Playtex* and *Hickman* it appears the parties and the court in these cases *assumed the benefit denied to be the ultimate payment of the claims asserted under the insurance contract.* The denial of payment, though theoretically generated by a flawed investigation, constituted the harm proximately caused by the carrier's breach.
>
> [..]
>
> This Court will not exert its powers in unexplored social and economic territory better left to the Delaware General Assembly. In the absence of a quantified harm, this Court is not in a position to recognize the mere possibility of payment as a legally cognizable injury. Because this mere possibility of payment does not constitute actual damages, DuPont has failed to set forth all the elements necessary to proceed with its cause of action for the tort of malicious wilful, and intentional breach of contract. Therefore, the Court finds DuPont cannot maintain its bad faith claim on this ground.[94]

Delaware law seems straightforward that GEICO did not have a common law duty to investigate. The duty to investigate must come from Section 2118 or Section 2118B.

iii. The Rules arguably fall within the scope of Delaware Insurance Regulation 603

Delaware Insurance Regulation 603 at 6.3 – which specifically and exclusively concerns PIP insurance – states that "[a]ny insurer, in accordance with filings made with the Insurance Department, may provide for certain deductibles, waiting periods, sublimits, percentage reductions, excess provisions or similar reductions . . . . *The owner's election of any reduced benefits described in this section must be made in writing and signed by that owner*."[95]

[94] *E. I. Du Pont De Nemours & Co. v. Admiral Ins. Co*., No. 89C-AU-99, 1994 WL 465547, at *6 (Del. Super. Ct. Aug. 3, 1994).
[95] Del. Ins. Reg. 603, n. 3 (emphasis added).

Plaintiffs argue that the Rules fall within the definition of a percentage reduction or sublimit. The Court stated "[a] sublimit is part of, rather than in addition to, the limit that would otherwise apply to the loss. In other words, it places a maximum on the amount available to pay that type of loss, rather than providing additional coverage for that type of loss."[96] If not a sublimit, Plaintiffs argue that the GRR also appears to fall within the concept of a "percentage reduction" and both the GRR and PMR fall within the "similar reductions" cited in the regulation.

GEICO never discloses the Rules, and insureds are not aware of the Rules when purchasing a policy or obtaining required treatment. GEICO argues that these "Rules are claims processing tools to assist in the evaluation and payment of reasonable expenses for necessary treatment."[97] Although not an explicit sublimit, the Rules are basically incorporated into the GEICO Policies under GEICO's interpretation of reasonableness and very much operate like sublimits or similar reductions. Consistent with the policy goals to protect insureds, the coding of the program in effect has established a new rule with important implications that should be disclosed. However, the Rules are not applied in the same way to each of the GEICO Policies. For example, the GRR is a rule that reduces payment by geographic location of the provider, the type of provider and other variables. So, for example, an insured may not have a claim paid in full or in part based on whether the treatment is in one county or another even if the doctor is of the same quality in each county.

---

[96] *Starstone Nat'l Ins. Co. v. Polynesian Inn, LLC*, 2019 WL 4016151, at *4 (M.D. Fla. 2019); s*ee also Doctors Hosp. 1997 LP v. Beazley Ins*., 2009 WL 3719482, at fn. 6 (S.D. Tex. 2009) (discussing generally accepted definitions and applications of sublimits as "limit[ing] the coverage for certain types of loss to amounts less than the limits of liability" and "smaller internal limits").

[97] Def. Reply at p. 30.

The Court finds fault with Plaintiffs' breach of contract theory under Delaware Insurance Regulation 603. Moreover, Plaintiffs have failed to show a breach of contract claim due to non-disclosure rather than application. The Court finds Plaintiffs' claims are better addressed as straight breach of contract or as declaratory relief.

iv. The Court would grant summary judgment in favor of Plaintiffs on Count II but must abide by the recent Supreme Court ruling in State Farm Mutual Automobile Insurance Company v. Spine Care Delaware, LLC decision.

Plaintiffs theory of breach of contract can be simplified. Under Section 2118B(c), GEICO has thirty (30) days to process the claim and either (i) make payment on the claims or (ii) "…provide [Plaintiffs] with a written explanation of the reasons for such denial" if the claim is denied in whole or in part.[98] Plaintiffs claim that the Rules do not constitute a valid processing and response within the applicable time period. As such, Plaintiffs contend that GEICO has breached the GEICO Policies and/or Section 2118 and Section 2118B if Plaintiffs' PIP claims were not paid in full.

The Court, on Count III *infra*, enters a declaration that GEICO's use of the Rules violated Section 2118, and that GEICO cannot lawfully use the Rules exclusively in processing PIP claims. It would seem, therefore, that the Court would find that Plaintiffs are entitled to judgment on Count I. Moreover, the Court could do so and not by incorporating 18 *Del. C.* § 2304(16), finding a common law duty to investigate, or utilizing insurance regulations. Plaintiffs have submitted PIP claims to GEICO under the GEICO Policies The reasoning is straightforward. Under the GEICO Policies and Section 2118 and Section 2118B, GEICO must appropriately process PIP Claims and pay all reasonable and necessary claims.[99] GEICO use of

[98] 21 *Del. C.* § 2118B(c).
[99] *See, e.g., State Farm Mut. Auto. Ins. Co.,* 238 A.3d at 861-62l; App.1 at p.21.

the Rules fails to determine the reasonableness of claims in accordance with applicable law. GEICO uses no other process in the first thirty days. Accordingly, Plaintiffs' PIP Claims would be deemed unobjected to under Section 2118(c) and *per se* reasonable. Thus, GEICO's failure to pay the PIP claims in full would be a breach of the GEICO Policies and applicable Delaware PIP statutes.

The Court, however, feels restrained from doing so under the reasoning articulated by the Supreme Court in *State Farm Mutual Automobile Insurance Company v. Spine Care Delaware, LLC*. There, the Supreme Court held that, in a suit under Section 2118B(d), the PIP claimant bears the initial burden of demonstrating the reasonable and necessary nature of the PIP claim. If the claimant carries that burden, then the insurer must show that denial of the PIP claim, in whole or in part, was factually supportable. Factually, State Farm unilaterally used a multiple payment reduction rule ("MPR") to all PIP claims. While not identical to the Rules, State Farm's use of the MPR is substantially like how GEICO utilizes the Rules. This Court found that the insurers payment practices contravened Section 2118(a)(2). The Supreme Court reversed, holding that the lower court had improperly shifted the burden of proof in a Section 2118(d) action from the insured to the insurer. While the use of computerized rules in assessing claims was not addressed by the Supreme Court, the Supreme Court could have easily upheld this Court's ruling on the theory pursued by Plaintiffs here.[100] The Supreme Court did not make an alternative ruling. As such, the Court feels it cannot engage in a breach of contract claim under Section 2118B(d) without first having a factual presentation that Plaintiffs' PIP claims

[100] *State Farm Mut. Auto. Ins. Co.*, 238 A.3d at 858 ("Because [the claimant]'s evidence goes far in establishing the reasonableness of its fees, and because the court expressly found that [the insurer]'s MPRs bore no correlation to the fees, we could be tempted to affirm based upon the record before us. However, we remand because [the claimant] should have had the burden of proof as to the reasonableness of its fees, and because, as explained below, we think the unique circumstances of this declaratory judgment action call for a more flexible approach to the reasonableness determination, as opposed to a rigid application of all factors set forth in *Anticaglia* and *Watson*.").

were reasonable and necessary. Plaintiffs chose not to take that individualized claim approach in this case. Instead, Plaintiffs ask the Court to find all the PIP claims to be reasonable and necessary because GEICO use of the Rules means GEICO has no valid objection to the PIP claims.

For all these reasons, the Court enters summary judgment on Count I in favor of GEICO.

B. COUNT II – BAD FAITH BREACH OF CONTRACT

As discussed above, the eligibility to receive PIP benefits in an automobile accident is statutory in origin and operation.[101] This is because the eligibility to receive PIP benefits derives from the Delaware No–Fault Insurance Statute rather than common law.[102] The Supreme Court has found that the statute only creates a cause of action if there is a breach of the PIP contract.[103] Furthermore, under Delaware law, a "cause of action for bad faith delay, or nonpayment, of an insured's claim in a first-party insured-insurer relationship is ... a breach of contractual obligations."[104]

In Delaware, when an insurer denies reimbursement and payment of claims and breaches duties under its contract with insureds, that breach may trigger bad faith claims.[105] "Under Delaware law, a bad faith insurance claim 'sounds in contract and arises from the implied covenant of good faith and fair dealing.'"[106] The claimant bears the burden of proof for a bad faith claim.[107] The claimant must show that the insurer lacked "reasonable justification" to deny the coverage to the insured.[108] The relevant question is "whether at the time the insurer denied

---

[101] *Harper,* 703 A.2d at 140.
[102] *Id*.
[103] *Id*.; *see also State Farm Mut. Auto. Ins. Co.*, 239 A.3d at 860.
[104] *D'Orazio v. Hartford Ins. Co*., 2011 WL 1756004 (E.D.Pa. May 6, 2011), *aff'd*, 459 Fed.Appx. 203 (3d Cir. 2012) (citing *Tackett v. State Farm Fire and Cas. Ins. Co.*, 653 A.2d 254, 264 (Del. 1995)).
[105] *Tackett v. State Farm Fire & Casualty Ins. Co*., 653 A.2d 254, 264 (Del. 1995).
[106] *Coleman Dupont Homsey v. Vigilant Ins. Co*., 496 F.Supp.2d 433, 437 (D. Del. 2007).
[107] *Bennett v. USAA Cas. Ins. Co.*, 158 A.3d 877, ¶ 13 (Del. 2017).
[108] *Enrique v. State Farm Mut. Auto. Ins. Co.*, 142 A.3d 506, 511 (Del. 2016).

liability, there existed a set of facts or circumstances known to the insurer which created a bona fide dispute and therefore a meritorious defense to the insurer's liability."[109] "Where the issue to be tried is one of disputed fact, the question of bad faith refusal to pay should not be submitted to the jury unless it appears that the insurer did not have reasonable grounds for relying upon its defense to liability."[110]

Section 2118(B)(d) provides that if the insurer is found to have acted in bad faith, the Court can award the costs of the action and the prosecution of the action, including reasonable attorney's fees.[111] A claimant carries the burden of proving that the insurer acted in bad faith.[112]

An insurer engages in bad faith denial of claimed PIP benefits when an insured plaintiff can prove "that the insurer's refusal to honor [the claim] was clearly without any reasonable justification."[113] In other words, the issue is "whether at the time the insurer denied liability, there existed a set of facts or circumstances known to the insurer which created a bona fide dispute and therefore a meritorious defense to the insurer's liability."[114] If there is a "general business practice of claims denial without a reasonable basis, [such conduct] may subject the insurer to a bad faith claim."[115] Further, the defendant may, in addition, be held liable for punitive damages if the conduct is willful or malicious, with malice being demonstrated through "a reckless indifference to the plight of the insured."[116]

If GEICO is liable for paying bills previously denied through the Rules—even if the Court finds it was not bad faith—GEICO must pay the statutory interest penalty set forth in

---

[109] *Casson v. Nationwide Ins. Co.,* 455 A.2d 361, 369 (Del. Super. Ct. 1982).
[110] *Id.*
[111] 21 *Del. C.* § 2118B(d).
[112] *Id*.
[113] *Albanese v. Allstate Ins. Co.*, 1998 WL 437370, at *2 (Del. Super. 1998) (citing *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 369 (Del. Super. 1982)).
[114] *Id*. (citing *Casson*, 455 A.2d at 369).
[115] *Fay v. Unum Life Ins. Co*., 1999 WL 1611318, at *2 (Del. Super. 1999).
[116] *Id*. (emphasis added).

Section 2118B(c).[117] This is true whether or not GEICO acted in bad faith or not. If, by use of the Rules, GEICO failed to properly process the claims, and since GEICO is liable for the statutory interest, it would trigger an analysis under Section 2118B(d). This type of award would be a measure of damages in Count I.

Count II seeks relief solely under Section 2118B(d). If successful on Count II, therefore, Plaintiffs would be entitled to only an award for costs of the action and the prosecution of the action, including reasonable attorneys' fees. Plaintiffs carry the burden on demonstrating that GEICO acted in bad faith—*i.e.*, GEICO's refusal to the PIP Claim in part or in whole using the Rules was clearly without any reasonable justification.

The Court finds that Plaintiffs have not carried their burden on bad faith. Given the state of the law on the use of computerized rules in assessing PIP-type claims, the Court cannot find that GEICO's use of the Rules was without any reasonable justification. Now that the Court is providing a decision on the use of the Rules, GEICO's continued use of the Rules (as presently formulated) could conceivably constitute bad faith. However, the Court does not presently see this as a situation where GEICO was refusing PIP claims, in whole or in part, with reckless indifference to the plight of Plaintiffs.

C. COUNT III – DECLARATORY JUDGMENT

The Amended Complaint seeks a declaration that "GEICO may not use the Geographic Reduction Rule and Passive Modality Rule and that such rules violate 21 *Del. C.* § 2118." In the Plaintiffs' Motion, Plaintiffs request:

i. GEICO's use of the GRR and PMR violates their contracts and Section 2118;

[117] *Cf. First State Orthopaedics, P.A. v. Liberty Mut. Ins. Co*., 2019 WL 3797376 at *3-4 (Del. Super. 2019) (finding that statutory interest in analogous statute must be paid if claim was denied, even if denied in "good faith." "If the statutes were not interpreted in this fashion, it would give the insurers a limitless ability to deny payments and experience no penalty if their denial was later found to be invalid.").

ii. GEICO is precluded from asserting defenses that were based on the Rules; and

iii. GEICO is precluded from asserting any defense not asserted within the first 30 days when claims were first submitted.

Unlike the Plaintiffs' Motion, Plaintiffs' application in Count III only seeks a declaration that GEICO's use of the Rules violated Section 2118 and that GEICO cannot lawfully use the Rules. For the reasons set out below, the Court will grant summary judgment in favor of Plaintiffs on Count III.

In order for a controversy to merit declaratory relief, it must satisfy four requirements: (i) it must be a controversy involving the rights or other legal relations of the party seeking declaratory relief; (ii) it must be a controversy in which the claim of right or other legal interest is asserted against one who has an interest in contesting the claim; (iii) the controversy must be between parties whose interests are real and adverse; and (iv) the issue involved in the controversy must be ripe for judicial declaration.[118] The purpose of a declaratory judgment is "to settle and to afford relief from uncertainty and insecurity with respect to rights, status and other legal relations[.]"[119] In other words, the objective of such an action is to advance the stage of litigation between the parties in order to address the practical effects of present acts of the parties on their future relations. In this way, the declaratory judgment serves to "promote preventive justice."[120] Action in declaratory judgment is available only where no other remedy is available under circumstances where impending injury has not yet occurred.[121]

[118] *Hoechst Celanese Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 623 A.2d 1133, 1136–37 (Del.Super. 1992) (citing *Marshall v. Hill*, 93 A.2d 524 (Del. Super. 1952); *Playtex Family Products, Inc. v. St. Paul Surplus Lines Ins. Co.*, 564 A.2d 681, 687 (Del. Super. 1989)).
[119] 10 *Del. C.* § 6512 (1981) (Declaratory Judgment Act, "Purpose and construction of chapter").
[120] *Stabler v. Ramsay*, 88 A.2d 546, 551 (Del. Super. 1952).
[121] *Hampson v. State ex rel. Buckson*, 233 A.2d 155 (Del. 1967).

The only declaration the Court may make is the original request in the Amended Complaint that GEICO's use of the Rules violates Section 2118. Plaintiffs do not assert any case law supporting otherwise. The only case that is cited is irrelevant in that it discusses a situation in which declaratory and coercive relief may be properly joined in the same action.[122] The *Spine Care* case reaffirms that Plaintiffs are "entitled to summary judgment *on the relief sought in its complaint.*"[123]

Plaintiffs appear to contend that GEICO violated Section 2118(a)(2) and/or Section 2118B(c). Pursuant to Section 2118(a), every motor vehicle owner, other than a self-insurer pursuant to Section 2904, must obtain insurance providing "[c]ompensation to injured persons for reasonable and necessary expenses incurred within 2 years from the date of the accident."

The Supreme Court has held that Section 2118(a)(2) requires a PIP insurer to pay "reasonable and necessary expenses."[124] In other words, GEICO is obligated to pay Plaintiffs claims so long as they are reasonable. In *State Farm*, the Supreme Court noted that an insurer could not use a unilaterally applied payment reduction if the claimant possesses reasonable and necessary PIP claims.[125]

Declaratory relief on Count III is appropriate. Unlike what GEICO contends, a determination of whether the claimants' particular expenses are reasonable is not necessary for declaratory judgment. In fact, the Court, in *Spine Care,* court issued a declaration that "State Farm's practice of applying Medicare-prescribed MPRs to reduce Spine Care's bills for bilateral and multilevel procedures violates 21 *Del. C.* § 2118(a)(2)."[126] The Supreme Court also

---

[122] *See Clemente v. Greyhound Corp*., 52 Del. 223, 236, 155 A.2d 316, 323 (Del. Super. 1959)
[123] *Spine Care Delaware, LLC*, 2019 WL 5581441, at *2, *rev'd on other grounds by State Farm Auto. Ins. Co. v. Spine Care Delaware, LLC*, 238 A.3d 850 (Del. 2020) (emphasis added).
[124] *State Farm Mut. Auto. Ins. Co.*, 238 A.3d at 861-62.
[125] *Id*. at 862.
[126] *Spine Care Delaware, LLC*, 2019 WL 5581441, at *5, *rev'd on other grounds by State Farm Auto. Ins. Co. v. Spine Care Delaware, LLC*, 238 A.3d 850 (Del. 2020).

indicated that relief could be available when addressing the use of computerized rules.[127] In this instance, Plaintiffs are challenging in the class context the application of the Rules to any PIP claim made under the GEICO Policies.

Plaintiffs also make a compelling case for why Section 2118B(c) has been violated. First, Section 2118B(c) is applicable because requires GEICO to process claims, and the word "process" must have meaning invoked by the statute. In this case, GEICO failed to "process" the claims and investigate all available information when GEICO failed to appropriately investigate the reasonableness of claims and instead applied the inflexible and flawed Rules. GEICO therefore violated Section 2118B(c).

GEICO's system arbitrarily caps reimbursements without any investigation of elements that affect bill pricing or necessity of treatment. GEICO implemented cost containment rules that were simply recommendations by software vendors. Regarding the GRR, GEICO concluded that 80th percentile was the industry standard, but it does not give evidence supporting why the 80th percentile was an industry standard. Just because Medata stated that it could defend anything above the 50th percentile does not make the 80th percentile reasonable. Even if this was an industry standard, the fact remains that the GRR was not disclosed to insureds in the GEICO Policies and left them with no way to determine what reasonable really means. GEICO has also cited "peer reviewed medical literature" for support, although this was not a factor that was considered in imposing the Rules in the first place.

In *Lundberg v. State Farm Mut. Ins. Co.*,[128] the Court of Common Pleas considered whether an insurance company could deny a claim as unnecessary merely by relying on the use

[127] *State Farm Mut. Auto. Ins. Co.*, 238 A.3d at 861-62 (noting that the parties were not contesting the matter in the abstract but whether State Farm could apply its MPRs to plaintiff's' fees)
[128] 1994 WL 1547774 (Del. Com. Pl. 1994).

of medical journal articles, software vendors and alike. The *Lundberg* Court concluded it could not:

> [S]urely, the legislature did not envision nor intend[] to create a statutory scheme where a trained medical doctor would prescribe a medical procedure and the insurer through its adjuster, with no medical training or background would be able to deny coverage payment merely by reading a series of articles in medical publications and reviewing the file. If such a procedure was envisioned or created, it would subject the medical decision of a physician to open questions without a reasonable standard.[129]

There does not appear to be any reasonable justification for how these rules correlate sufficiently with reasonableness of specific medical expenses. In other words, GEICO's system arbitrarily caps reimbursements without any investigation of elements that affect bill pricing or necessity of treatment. The Supreme Court recently reaffirmed the application of the *Anticaglia* and *Watson* when determining the reasonableness of medical expenses.[130] Although not to be applied rigidly, the factors are:

- ordinary and reasonable charges usually made by members of the same profession of similar standing;
- nature and difficulty of the case;
- time devoted to it;
- amount of services rendered;
- number of visits;
- inconvenience and expense to which the physician was subjected;
- size of the city or town where the services were rendered;
- physician's education and training;
- physician's experience, skill or capacity;
- physician's professional standing or reputation;
- extent of the physician's business or practice; and
- ability of the defendant to pay.[131]

[129] *Id*. at *2.
[130] *State Farm Mut. Auto. Ins. Co.*, 238 A.3d at 862.
[131] *Id*.

These factors are relevant not because of an inherent duty to investigate but because the factors are to be used to determine if the methods being utilized were consistently related to what reasonable fees should be.

Plaintiffs argue that GEICO does not consider any of these factors in denying claims with costs above the 80th percentile and passive modalities after 8 weeks.[132] For example, the Plaintiffs provide:

> Even the first of the *Anticaglia* and *Watson* factors (*i.e.*, Ordinary and reasonable charges usually made by members of the same profession of similar standing) is not captured by capping payments at the 80th percentile as it doesn't look at medical providers of "similar standing." This was something that District Court Judge Farnan raised with GEICO when he compared GEICO capping payments to a well-known, highly-respected surgeon at the same level as a less respected surgeon who might not be able to accomplish the same level of care and GEICO admitted that specialty was not a factor GEICO considered.[133]

The Court has not seen on this factual record that GEICO implements any type of analysis that tracks the factors to be used to determine whether a claim is reasonable and necessary beyond the automated application of the Rules to each PIP claim.

GEICO has relied on *St. Louis Park Chiropractic, P.A. v. Federal Ins. Co.*,[134] to support the contention that the use of a computerized auditing system does not violate underlying insurance policies. However, the analysis there actually supports Plaintiffs' argument. In *St. Louis Park Chiropractic*, a consolidated appeal of six similar PIP class actions, class plaintiffs alleged that defendant insurers breached the underlying insurance contracts by using a "'computerized auditing system[s]' to determine the amount to be paid for each PIP reimbursement."[135] Similar to this civil action, the computerized auditing systems included

[132] Pl. Mot. for Summ. J. at 24.
[133] *Id*. at p. 24, n. 9.
[134] 342 Fed. Appx. 809 (3d Cir. 2009).
[135] *Id*. at 812.

databases compiled by third parties used to calculate the prevailing billing rates for covered medical services within a given geographic area.[136] On appeal, plaintiffs argued that the district court, in refusing to certify the class action, misconstrued their breach of contract claim. Specifically, plaintiffs explained that they were "not challenging individual determinations of reasonableness for the claims of individual class members because the insurer never made any. Rather, plaintiffs are challenging the uniform process that the insurers apply to all claims."[137]

The Third Circuit, accepting that the gravamen of plaintiffs' claim was that the "use of computerized auditing itself violated the insurance contracts," held as a matter of law that the insurers' "use of a computerized auditing system – whether taken by itself or as a means to reduce some reimbursements – does not violate any provision of the underlying insurance policies" and therefore concluded that plaintiffs had "failed to state a legally cognizable breach of contract claim."[138] The Court explained:

> Appellants are unable to identify any contractual provision that: (1) prohibits Appellees from using a computerized auditing system; or (2) requires Appellees to consider-or prohibits them from considering-any particular criterion in determining whether an expense is "reasonable."[139] Rather, the authority offered by appellants was inapposite because the cases involved "(1) policies that required insurance companies to consider specific criteria when determining 'reasonableness"; or (2) state law that required insurers to evaluate claims in a particular manner. . . . *Strawn v. Farmers Ins. Co. of Or.*, 228 Or.App. 454, 209 P.3d 357, 365–66 (2009) (computerized auditing might contravene the Oregon statute that prohibits insurers from "[r]efusing to pay claims without conducting a reasonable investigation based on all available information" (quoting *Or.Rev.Stat.* § 746.230(1)(d))).[140]

The case before the Court differs in that this is a situation where Delaware requires insurers to evaluate claims in a particular manner—Section 2118(a) and Section 2118B. In

[136] *Id.*
[137] *Id.* at 814.
[138] *Id.* at 813, 815.
[139] *Id.* at 813 (emphasis added).
[140] *Id.* at 814.

Oregon, there is a statutory right to recover for individuals if claims are not evaluated in a particular manner.[141] Delaware requires all available information to be considered before denying a claim.[142] The operation of the Rules clearly has prevented the consideration of all information. GEICO argues that Delaware's PIP statute is similar to Massachusetts in that both provide that an insurer must provide PIP coverage to its insureds for all reasonable expenses incurred within two years from the date of the accident for necessary medical, surgical, x-ray and dental services. GEICO further contends that, because Oregon's statute is distinguishable from Massachusetts, Delaware is also distinguishable from Oregon where conducting a reasonable investigation on all available information has been construed as imposing a duty to evaluate claims in a particular manner.

GEICO's logic is simply flawed. The Massachusetts PIP statute is like the Delaware PIP statute in that it contains a reasonable expense provision. However, the Delaware PIP statute contains a process very similar to the Oregon PIP statute.[143] The Oregon PIP statute has an "express presumption of reasonableness unless the insurer denies the claim within 60 days of receipt."[144] The Delaware PIP statute provides that the PIP claim "shall be payable within 30 days of the demand thereof by the claimants provided that reasonable proof of loss for which the benefits as demanded has been submitted to the PIP carrier."[145] Moreover, the Court has held that an insurer's defenses to a PIP claim are waived if not asserted within the statutory framework.[146]

---

[141] Or. Rev. Stat. § 746.230(1)(d).
[142] *State Farm Mut. Auto. Ins. Co.*, 238 A.3d at 861-62 (stating that an insurer must pay reasonable and necessary expenses incurred and cannot just multiple payment reduction without undertaking a factual analysis as to the claim).
[143] *Compare Or. Rev. Stat.* § 742.528 *with* 21 *Del. C.* § 2118(c).
[144] *See Or. Rev. Stat.* § 742.520(a); *McBride v. State Farm Mut. Ins. Co.*, 386 P.3d 679, 684-86 (Or. App. 2016).
[145] See 21 *Del. C.* § 2118B(c).
[146] *Spine Care Del. LLC*, 2007 WL 495899, at *2-3 (holding that insurer is precluded from asserting a defense to a PIP claim if not made during the 30-day period).

Here, the dispute concerns a situation where an insured has already submitted sufficient information rather than a situation where there is not enough information submitted. The Rules constitute, in essence and in application, a "limitation to coverage" in the GEICO Policies – the Rules basically make determinations before a claim is even submitted – known only to GEICO. The Rules exclude benefits without any investigation of the actual claim and ignore relevant factors of a valid claim. Well-settled law in Delaware places the burden on an insurer who asserts an exclusion to coverage and exclusions are interpreted narrowly.[147]

Like Oregon law, the "reasonable investigation based on all available information" requirement in Delaware law dictates a requirement to evaluate claims in a particular manner. Although the use of automated systems is not a direct violation of Delaware law, the fact that these systems did not process all available information and actually made investigations less likely to include all available information—by creating these Rules that recommend a denial or reduction in what may otherwise be a valid PIP claim—make the process and investigation unreasonable. "For public policy reasons, the insurer should not be relieved of their burden of proof as to an exclusion simply because they have the tactical advantage of being able to place the exclusion within a coverage provision."[148]

The operation of the Rules does not precisely correlate with what is considered to be reasonable. For example, GEICO has admitted that passive modalities performed in conjunction with active modalities (*e.g.*, therapeutic exercises (active) together with massage and heat pack (both passive)) after 8 weeks are appropriate.[149] GEICO's expert has admitted that (1) passive

[147] *See, e.g. Scottsdale Ins. Co. v. Lankford*, 2007 WL 4150212 at *4 (Del. Super. 2007).
[148] *See Hoechst Celanese Corp. v. Nat'l Fire Union Ins. Co.*, 1994 WL 721786 (Del. Super. 1994); *see also Dairyland Ins. Co. v. Ward*, 517 P.2d 966, 969 (Wash. Supr. 1974) (analyzing language as an exclusion even though "the subject clause is sandwiched into the general coverage provisions of the respondent's insurance contract").
[149] Pl. App. Ex. 51 ("Passive therapy after the acute phase of the injury should only continue in conjunction with an active modality").

modalities may be appropriate beyond eight weeks, (2) she would need to investigate all of the circumstances of a case, including the diagnosis and whether it was being performed in conjunction with other treatment, and, (3) most importantly she would want to perform a clinical examination before making a decision.[150]

The Court will grant declaratory relief on Count III in that GEICO's practice (*i.e.*, the use of the Rules) violates Section 2118B(c) and 2118(a)(2). The Court is not, in effect, eliminating the ability for insurers to use automated systems to make the claims process more efficient. Under the circumstances of this case, the Rules are antiquated and need updating to be able to apply the Rules in a manner that accounts for all the relevant *Anticaglia* and *Watson* factors. Until such a system is in place, human judgment should not be eliminated from the process.

D. THERE IS NO GENUINE DISPUTE OF FACT THAT PREVENTS SUMMARY JUDGMENT ON COUNT III IN FAVOR OF PLAINTIFFS.

GEICO raises twelve issues of disputed facts. These issues are either immaterial or flawed. There is no reasonable factual dispute that GEICO employs the Rules and conducts no additional investigation of claims. Regardless of material, individualized facts underlying a claim, and without any investigation whatsoever, GEICO denies bills as "unreasonable" simply on the basis that they exceed the 80th percentile of other claims submitted to GEICO (the GRR), and GEICO denies treatment as "unnecessary" simply if passive modalities are performed more than eight weeks after the accident (the PMR). Through the Rules, GEICO imposes uncommon meanings to the terms "reasonable" and "necessary." GEICO does not disclose these uncommon meanings in its policies.

[150] Pl. App. Ex. 59 at 68:7-70:4.

i. "Automated/No Human Review"

Plaintiffs state "GEICO's PIP claims-processing system is entirely automated, systematized, and rule-based," "GEICO deploys computer rules as the sole determinant of whether a claim is denied or allowed," and "whether to pay and how much to pay an otherwise valid claim is determined solely by GEICO's rules."

GEICO tries to raise a dispute of fact by discussing how adjusters are involved in the PIP claims process. However, there is no genuine dispute that there is some human involvement in GEICO's PIP claims processing. Plaintiffs' argument does not discuss how adjusters are involved in the PIP claims process because it is irrelevant to the problem at hand. The actual problem raised by Plaintiffs is that there is not enough human oversight over claims that are in effect capped by the Rules. Even though GEICO argues that the Rules generates a "recommended amount," the evidence shows no instance in which a GEICO employee did not follow the generated recommendation.

Although adjusters were ultimately given discretion, there were no other procedures set forth to make sure that adjusters did not simply follow the automated recommendations and outright deny reasonable claims. Plaintiffs state:

> it is clear from her complete testimony that adjusters have no training of what constitutes reasonable pricing, they rely on the software to deny passive modalities and follow those decisions, the only 'adjustment' is when the CPT code is keyed in incorrectly (in which case she testifies they key in the right CPT code and submit the bill to the rules for processing) or where the bill is for an emergency room visit within 72 hours of the accident. The testimony does not support any suggestion that adjusters apply any discretion to override the GRR and PMR decisions.

This evidence is especially concerning because there are many inherent biases that automated systems produce accurate results.

To place the problem on individuals seeking coverage for their medical care to try to piece together why their coverage should not have been denied after sufficient information has already been submitted would be counter to the goals underlying Delaware law, that is to say avoiding individuals from getting balanced billed. There is no problem with using automated systems to make the process more efficient, but the logic of the system is clearly flawed and does not align with what is a reasonable claim. Under the circumstances of this case, the goal of efficiently processing claims should not outweigh the goal of protecting all individuals' right to reasonable medical coverage under the policy. Moreover, the system is not disclosed to the insured.

The burden is a shifting one under statute. The insured submits a bill and the insurer is to respond within the statutory time. Once submitted, the statute imposes an investigation of all materials before denying coverage for unreasonable claims. If the insurer fails to respond, the claim is deemed reasonable. Inserting an undisclosed computer system, like the Rules, that responds without explanation seems to improperly shift the burden back in almost every instance to the insured. The Rules currently operate to prevent any such meaningful investigation.

ii. "GEICO's Limited Data Points"

Plaintiffs state "GEICO's computers read and process claims, based on limited points of data submitted with the claim." GEICO claims that Plaintiffs misrepresent the testimony of GEICO employee Troy Arthur.

Although Mr. Arthur does not directly discuss "limited points of data" in his testimony, this potential misstatement is not material to the court's analysis.

iii. "No Rationale for the Rules."

Plaintiffs state GEICO's PIP processing system is "designed by GEICO not to investigate the factual basis for claims, but rather solely to (i) remove human involvement from the claims process and (ii) reduce the dollars GEICO pays in claims."

GEICO argues that the evidence supporting the claims is misleading in that the documents are from a previous vendor, Fair Isaac, and that the evidence shows reduction of GEICO's claim-processing costs rather than reducing the amounts GEICO pays in claims.

Regardless, the reasoning behind why the systems were put in place and that GEICO understood the system to be a valid way to process claims in the industry should not be relevant.

iv. "80th Percentile Cap."

Plaintiffs state the GRR is an 80th percentile cap which is a percentage reduction or sublimit contained nowhere in the GEICO Policies, and that by using the 80th percentile "twenty percent of all bills GEICO receives are always denied as unreasonable."

Although Plaintiffs get the math wrong in saying 20% of claims are denied under this system, the Court does not find this to be a material dispute**.**

v. "Plaintiffs' GRR Chart"

Plaintiffs state that because "the amount GEICO will pay depends on the bills submitted in the preceding period, the GRR results in wild and arbitrary fluctuations of the amount GEICO will pay."

GEICO counters that the chart is too small of a sample of the submitted bills and only uses aberrant billings.

The Court did not base its decisions on the data submitted being inherently flawed, which it could very well be, but rather on GEICO not considering other information submitted. Thus, the fact that this chart might defy basic statistics, is not a material dispute.

vi. "Applicability of Regulation 603"

Plaintiffs state that Regulation 603 requires GEICO to "disclose any cap or sublimit to the insurance commissioner and to obtain written consent from the insured."

GEICO claims that it meets this obligation in disclosing its obligations to pay only reasonable and necessary charges.

This disclosure does not make apparent the reality of the Rules. This is more of a legal dispute than a factual dispute. Moreover, it is irrelevant to the declaratory relief.

vii. "Payment Disparities"

Plaintiffs state: "In addition, the system will often recommend that a physical therapist is paid more than a doctor for the same procedure, a result that even GEICO can't reconcile."

GEICO counters that the provider derives his own individual charges for a procedure based upon the time, skill level, expertise, and cost of operating the practice as major factors.

However, this fact does not resolve the problem, which is that the Rules are not able to accurately sort out the skill of the doctor. There is no evidence that the CPT code can differentiate the skill of the doctor. GEICO previously recognized that there is no analysis for skill: "The way that is handled is that all of the various skill levels for M.D.s versus chiropractors versus physical therapists, all of the various skill levels are contained in the same…"[151] There is no dispute that prices take into account skill, which is why computerized rules that automatically

[151] *See, e.g.,* Pl. App. Ex. 36 at 72:17-73:3.

deny a claim with charges based on higher skill levels and correspondingly higher priced doctors is troubling.

viii. "80th Percentile Unjustified"

Plaintiffs state that GEICO's implementation of the GRR was unsupported and undocumented, and that GEICO never conducted any study or analysis to determine whether the Rules fairly and accurately determines reasonableness.

GEICO appears to raise a legal dispute of how reasonableness should be determined rather than a factual dispute. Regarding the 80th percentile, GEICO concluded that 80th percentile was the industry standard, but it does not give evidence supporting why the 80th percentile was an industry standard. Just because Medata stated that it could defend anything above the 50th percentile does not make the 80th percentile reasonable. Even if it was an industry standard, the fact remains that the Rule was undisclosed to those covered by the GEICO Policies and no way to determine what reasonable really means.

In *Spine Care Delaware, LLC v. State Farm Mutual Automobile Insurance Company,* State Farm also justified its application of the MPRs by arguing that MPRs are commonly used in the insurance industry and also that these reductions are applied according to well-established Medicare Claim Processing Guidelines. The Court rejected both arguments, stating that "State Farm's argument is unpersuasive because there is no demonstrated correlation between the Medicare Guidelines and the reasonableness of medical fees under Delaware law."[152] Thus, GEICO has not demonstrated that the systems are able to accurately determine the reasonableness of medical fees. As such, the Court does not find that this issue creates a genuine issue as to a material fact.

[152] *Spine Care Delaware, LLC*, 2019 WL 5581441, at *2, *rev'd on other grounds by State Farm Auto. Ins. Co. v. Spine Care Delaware, LLC*, 238 A.3d 850 (Del. 2020).

ix. "GEICO Ignores Factors"

Plaintiffs state "GEICO knows that a provider charge can vary based on numerous relevant factors, but the GRR never looks at any of these relevant facts" and "Internal training manuals further confirm that 'experience and specialty' are important factors in determining reasonableness, but GEICO admits that it doesn't take those facts into account[.]"

GEICO raises the same disputes in the argument about payment disputes. GEICO states that all factors are basically accounted for within actual charges, CPT codes, and geographic location.

Problematically, this does not address the fact that the systems cannot differentiate a highly experienced doctor from a less experienced doctor. In any event, the Court finds the issue irrelevant to the declaratory relief sought.

x. "Arbitrary Use of GRR"

Plaintiffs state the "original software vendor for the GRR cautioned GEICO that the GRR 'should not be used arbitrarily.'"

GEICO counters that this conversation was concerning down-coding.

The software vendor's opinion is not material to the Court's analysis in finding that the Rules, which include the GRR, are arbitrary.

xi. "No PMR Justification"

Plaintiffs state "[GEICO] provided no justification for implementing [the PMR]." Plaintiffs also provide that the Rule was not supported by any data – scientific, medical or otherwise" and the PMR denies payment with no investigation." Plaintiffs further state that GEICO attempts to justify denials under the PMR by citing only two articles.[153]

[153] *Id*. at 14 (citing Pl. App. 47-48).

Like the Court's finding is *Spine Care***,** the argument is unpersuasive because there is no demonstrated correlation between the medical literature and the reasonableness of medical fees under Delaware Law.

In *Lundberg v. State Farm Mut. Ins. Co.*,[154] the Court considered whether an insurance company could deny a claim as unnecessary merely by relying on medical journal articles. The Court concluded it could not:

> [S]urely, the legislature did not envision nor intend[] to create a statutory scheme where a trained medical doctor would prescribe a medical procedure and the insurer through its adjuster, with no medical training or background would be able to deny coverage payment merely by reading a series of articles in medical publications and reviewing the file. If such a procedure was envisioned or created, it would subject the medical decision of a physician to open questions without a reasonable standard.[155]

GEICO does not make a case for why the circumstances of this case warrant a different conclusion.

xii. "Insureds Balance Billed"

Plaintiffs state "[t]here are dozens of examples where GEICO is made aware that insureds are balance-billed by Providers and sent to collection agencies" and GEICO has "no system in place to protect its insureds when balance billed."

GEICO argues that the training documents that states "an attorney or policyholder cannot dispute reductions" is contrary to the other exhibits.

The fact that there are letters written to GEICO by attorneys on behalf of claimants challenging a GEICO payment is not contrary to the fact that adjusters received these instructions.

---

[154] 1994 WL 1547774 (Del. Com. Pl. 1994).
[155] *Id*.

Further, it does not matter whether an attorney could request a re-evaluation. There is harm in the initial denial.

Next, GEICO argues there is no evidence that a provider is balanced billed. This assertion deserves no merit. Plaintiffs have supplied evidence of sufficient evidence of balance billing.[156] In case after case, medical providers advised GEICO they were balance billing clients, and insureds advised GEICO that they were being balance billed.

In one example, GEICO is provided with a balance bill letter from a provider (Nanticoke Hospital).[157] GEICO denied payment based on geographic reasons.[158] Later—with respect to the same claim and as part of the same exhibit – GEICO is provided with a letter from a bill collection agency putting GEICO on notice that the insured has gone from being balance billed to being sent to a collection agency.[159] GEICO simply denied the claim again.

In another example, GEICO received notice of an outstanding balance.[160] GEICO, in an internal "written dispute response request," acknowledged that the provider does not negotiate and will balance bill the client.[161] GEICO again responded by denying the claim. GEICO knows that Ms. Green was balance billed by Christiana Care and continues to receive calls from them.[162]

In addition, GEICO has internally acknowledged that the Rules may be causing insureds to be balance billed, stating:

> David, there have been two re-evaluations this week where the [policy holder] is sending in disputes, stating that the provider is balance billing them the unpaid balance of their bill. These [policy holders] are not yet out of pocket. (We discussed one of these)

[156] Pl. App. Exs. 69-90.
[157] Pl. App. Ex. 66 (GEICO025389).
[158] *Id*.
[159] Id. (GEICO025382-83).
[160] Pl. App. Ex. 83.
[161] Id. ("this prov.will not neg-pt responsible for balance)(GEICO014504).
[162] Pl. App. Exs. 97-98, Reply in Support of Class Cert. Exh. K, and Ex. C.

> My feeling is that these [policy holders] need to be directed by the [adjuster] not to pay the balance. That Geico will handle. Obviously my concern is that should we just pay, we would be paying geographic reductions that we never waiver on, and other region 1 cost containment rules. Again obviously concerned with what ugly doors this could potentially open.
>
> However, Grace's concern (valid concern) is that then these [policy holders] are turned over to collection agency, and are concerned about their credit being ruined. And in the past we have ended up paying.
>
> I am thinking we might need to revisit this with Jesse/Joe and Bob for best way to consistently handle.[163]

As such, GEICO recognizes that balance billing is a valid concern.

Even if there is no evidence presented by Plaintiffs that insureds are balance-billed, which there is, there are still concerns that adequate measure are no in place to prevent this from occurring.

VI. CONCLUSION

For all the foregoing reasons, the Court **DENIES** Plaintiffs' Motion as to Counts I and II and **GRANTS** as to Count III. The Court **GRANTS** GEICO's Motion as to Count I and II and **DENIES** as to Count III.

IT IS SO ORDERED.

Dated: March 24, 2021
Wilmington, Delaware

/s/ Eric M. Davis
Eric M. Davis, Judge

cc: File&ServeXpress

[163] Pl. App. Ex. 91 (GEICO089180).