PATRICIA ACCISANO, Plaintiff-Appellant vs. ALLSTATE INSURANCE CO., Defendant-Respondent	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION DOCKET No.: A-156-06T2 CIVIL ACTION On Appeal from Order of Superior Court, Law Division, Monmouth County SAT BELOW HON. DANIEL M. WALDMAN, JSC (Docket No.: MON-L-5818-03)

ATLA-NJ'S AMICUS CURIAE BRIEF IN SUPPORT OF APPELLANT, PATRICIA ACCISANO'S APPEAL

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PRELIMINARY STATEMENT

This case raises a significant issue for the Court to address. As has been occurring for several years, especially in UM/UIM trials, plaintiffs have been forced to try their cases, even when there is no logical reason for a carrier not to pay the policy, or at least enough to settle the case. Their position has always been as follows: "Why not simply try the case? If we are fortunate and the jury returns a verdict of less than we have offered or less than the policy limits, then we will pay it. If the jury returns a verdict of 10 times the policy, then there is still no problem, as we will simply pay the policy"

In third party cases, carriers cannot take that position as the plaintiffs and more importantly the insureds are protected by the Rova Farms Resort, Inc. v. Investors Insurance Co, 65 N.J. 474 (1974) Decision. However, even though there is a statute dealing with the Insurer's obligation for good faith and fair dealing, N.J.S.A. 17:29B-4(9) and even though there are cases like Pickett v. Lloyds, 131 N.J. 457 (1993). Courts have been reluctant to actually assess bad faith damages in the context of first party claims in the UIM/UM context. If a carrier forces an insured to try a UIM/UM case, spend money for doctors, spend time in Court, only to get something

that should be have been offered previously, then in fact the plaintiff/insured has been harmed. Clearly the Statute and Pickett were intended to protect the insured from said harm. Unfortunately that has never been the case in New Jersey.

When this Court looks at the trend in other jurisdictions, especially, our neighboring State of Pennsylvania and looks at their statute (similar in text to ours), and the case of Bonenberger v. Nationwide Mutual Ins. Co., 791 A.2d. 378 (Pa. 2002) and numerous other cases cited in this brief, it should be easy to analyze what the plaintiff/insured has potentially lost and why a carrier should be held to a standard more closely related to Rova Farms, then to no standard at all.

Merely because a case is a first party case, rather than a third party case should not make a difference where the carrier is clearly using the lack of a "bad faith" law to penalize a plaintiff, his or her attorney, and more importantly clog the Court system with cases that should have been settled long ago.

The Case currently before this Court, is merely one of many, even hundreds that have similar results every year. Until and unless this Court starts to place consequences on carriers for making unreasonable decisions, as in this

case, the carriers will continue to control the courts, control their own money, and unfortunately, penalize both their insureds and the plaintiffs who have brought such cases.

Amicus Curiae, ALTA-NJ, joins in Appellant/Plaintiff, Patricia Accisano (hereinafter "Appellant") appeal for the reversal or modification of the Court's July 25, 2006 Order for Judgment.

PROCEDURAL HISTORY/STATEMENT OF FACTS

Amicus Curiae, ALTA-NJ, relies on the procedural history and statement of facts contained in the appellate brief of Appellant.

LEGAL ARGUMENT

POINT I ALLSTATE HAS ENGAGED IN BAD FAITH BY FAILING TO SETTLE THE CLAIM WITH PLAINTIFF, AND, THEREFORE, IT SHOULD BE LIABLE FOR THE FULL AMOUNT OF THE JURY VERDICT

The common practice among insurance companies in New Jersey regarding non-settlement of first parties claims must now come to an end. New Jersey statutes and case law exists, which seek to protect insureds from the very type of unfair practices that insurance companies in New Jersey engage in with respect to the payout of settlements in first party underinsured or uninsured actions. However, insurance companies in New Jersey have been able to cleverly circumvent New Jersey statutory regulations and the doctrine of implied covenant of good faith and fair dealing in refusing to make a good faith and reasonable effort to settle a case with first party insureds. This uncanny and manipulative scheme of settlement practices of first party claims must now come to an end.

"The duty of good faith and fair dealing pervades insurance contracts." Sears Mortgage Corp. v. Rose, 134 N.J. 326 (1993). In Rova Farms Resort, Inc. v. Investors Insurance Co., the New Jersey Supreme Court held that an insured may recover more than the policy limit for a liability insurer's bad-faith refusal to settle a third-party claim against its insured within that limit, when the refusal results in the third party obtaining a judgment against the insured that exceeds the policy limit. 65 N.J. 474 (1974). Moreover, the Supreme Court reasoned that the relationship of the company to its insured regarding settlement is one of inherent fiduciary obligation. Id. at 492.

Subsequently, in Pickett v. Lloyd's, 131 N.J. 457 (1993), the Supreme Court acknowledged an insurance company's duty of good faith to its insured in processing a first party claim. As part of its reasoning to extend bad faith claims to first party claims, the court noted that "every contract imposes on each party the duty of good faith and fair dealing in its performance and enforcement. In New Jersey, we have stated that obligation to be an implied term of every contract." Id. at 467.

Moreover, the court further recognized a cause of action for bad-faith failure to pay an insured's claim

under New Jersey law. Id. at 470. In making this ruling, the Court reasoned that compensation should not be dependent on what label we place on an action but rather on the nature of the injury inflicted on the plaintiff and the remedies requested. Id.

In addition to case law, there is statutory framework which details an insurance company's obligation to handle its claim in a fair manner. N.J.S.A. 17:29B-4(9), addresses unfair claim settlement practices as to all insurers. Unfair practices include:

> b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
>
> . . .
>
> e. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.
>
> f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
>
> g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;
>
> . . .

> n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

As to unfair claims settlement practice, an insurer includes any legal entity authorized to represent an insurer with respect to a claim. N.J.A.C. 11:2-17.3. An insurer's breach of its fiduciary obligation imposed by virtue of its sound policy, by its wrongful failure to settle, sounds in both tort and contract. Pickett, 131 N.J. at 471.

To prove bad faith, "a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's reasonable basis for denying the claim." Pickett, 131 N.J. at 473; see also N.J.A.C. 11:2-17.8(h) & (i). The knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless indifference to facts or to proofs submitted by the insured. Id.

In addition, Polito v. Continental Casualty, Co., 689 F.2d 457 (3rd Cir. 1982), involved a first party claim filed by the insured against its fire insurer. The Court ruled that there could be a recovery above the policy limits on a

tort theory if the insurance company acted in bad faith. While the Plaintiff in Polito, submitted a proof of loss and demand for appraisal in October 1979, and additional proofs of loss in December 1979, the insurer did not acknowledge the claim until January 17, 1980. As such, the court found that a jury could have found that by delaying the appraisal process and subsequent payment, the insurance company breached the insurance contract. Id. at 461. Consequently, the Court determined that a wrongful failure to settle the claim sound in both tort and contract and it made no difference how the claim of action was labeled. More importantly, the Polito court found that the doctrine of the implied covenant of fair dealing was fully applicable to such insurance contracts, and that an insurance company, as a fiduciary of the party with whom they had a contractual relationship, has a duty, which if breached, could result in a claim for consequential damages.

The relief sought by appellant is consistent with the intent of the statutory framework of N.J.S.A. 17:29B-4(9) and New Jersey law which seeks to protect the insured from unfair insurance practices. Although Picket, supra, is somewhat restrictive as it requires the Plaintiff to demonstrate a financial loss absent egregious

circumstances, there are many jurisdictions which have taken the lead and in fact have extended bad faith litigation to first party claims, without the necessity of proving a financial loss.

In Fletcher v. Western National Life Insurance Co., 10 Cal. App. 3d 376 (1970), the California appeals court allowed recovery above and beyond disability policy where there had been a showing that the carrier's failure to pay on a disability policy was in bad faith. The Fletcher court extended the former recognized duty to settle third party claims to first party claims, holding the carrier to the same implied duty of good faith and fair dealing in resolving cases.

Likewise, the Supreme Court of Rhode Island addressed the same bad faith issue in the context of uninsured motorist insurance in an advisory opinion. See Bibeault v. Hanover, Ins., Co., 417 A.2d 313 (R.I. 1980). In Bibeault, the Supreme Court held that the state law permitted compensatory and punitive damages in bad faith claims involving uninsured motorist claims. The Court noted that any restrictions on an insured's recovery of bad faith claims to contract damages did not provide any incentive to insurance carriers to treat their insureds fairly. As such, the worst outcome for the carrier would be an award of the

contract amount, plus interest. Id. at 318. The Court further reasoned that contract theory alone in effect guards an insurer's pocketbook against any threat of punitive damages. Id. The Court proceeded to explain its rationale for bad faith claims as follows:

> In this atmosphere, insurers, backed by sufficient financial resources are encouraged to delay payment of claims to their insureds with an eye toward settling for a lesser amount than that due under the policy. The potential loss could never exceed the contract amount plus interest. Thus, when the legal rate of interest is lower than the commercial rate, an unscrupulous insurer would be wise to delay payment for the maximum period of time. The inequity of this situation becomes particularly apparent in the areas of disability insurance [where the] insured, often pursed by creditors and devoid of bargaining power, may easily be persuaded to settle for an amount substantially lower than that provided for in the insurance contract. Id.

Similarly, Pennsylvania has established bad faith claims against insureds by both Statute and Case law. The case of Bonenberger v. Nationwide Mutual Ins. Co., 791 A.2d. 378 (Pa. 2002) contains language that goes to the heart of the issue of policy considerations:

> Individuals expect that their insurers will treat them fairly and properly evaluate any claim they may make. A claim must be evaluated on its

> merits alone, by examining the particular situation and the injury for which recovery is sought. An insurance company may not look to its own economic considerations, seek to limit its potential liability and operate in a fashion designed to "send a message." Rather, it has a duty to compensate its insureds for the fair value of their injuries. Individuals make payments to insurance carriers to be insured in the event coverage is needed. It is the responsibility of insurers to treat their insureds fairly and provide just compensation for covered claims based on the actual damages suffered. Insurers do a terrible disservice to their insureds when they fail to evaluate each individual case in terms of the situation presented and the individual affected. Id. at 382.

Likewise, other jurisdictions have reported decisions in which the Courts have found that the insurer acted in bad faith by failing to settle underinsured motorist case within the policy limits. In Harter v. Plains Insurance Company, 579 N.W. 2d 625 (S.D. 1998), an insured sued her underinsured motorist insurer, claiming that it acted in bad faith by failing to tender the policy limits of her UIM policy. At trial, the court entered judgment on a jury verdict awarding the insured $25,000.00 in compensatory damages and $75,000.00 in punitive damages. As evidence of the insurance company's bad faith, the trial judge allowed the insured to introduce evidence that an underinsured

motorist insurer acted in bad faith by asserting its subrogation right and intervening in the insured's trial against a motorist, where the UIM insurer acknowledged the motorist's liability prior to the trial against the motorist, yet disputed liability during the trial. On appeal, the South Dakota Supreme Court found that allowing the insured to introduce evidence that the insurer acted in bad faith by asserting its subrogation right and intervening in the insured's trial against the motorist was not an abuse of discretion. Id. at 630-31. In addition, the Court found that there was sufficient evidence of malice to support submission of the issue of punitive damages to the jury, where there was evidence that when the insurer did offer its policy limits, the offer was conditioned on the insured's release of the bad faith action. Id. at 634.

Another example where the Court upheld a bad faith claim against the insurer in an underinsured motorist is Geraci v. Byrne, 934 So.2d 263 (La. 2006). In this case, the insured brought an action against an automobile insurer for bad faith failure to make an offer to settle the claim for underinsured motorist benefits. The lower court awarded the insured damages for arbitrary and capricious failure to pay a claim and attorneys fees. On appeal,

Allstate contended that the court erred in finding it arbitrary and capricious in ruling that the insured was entitled to attorneys' fees and in the alternative that the fees were excessive. In assessing whether Allstate had in fact breached the state statute in which an insurer has a good faith duty to adjust claims fairly and promptly and make a reasonable effort to settle claims with the insured and pay out claims within a specified period of time, the Court focused on the overwhelming evidence and documentation that was presented to Allstate in support of the insured's entitlement to her underinsured benefits. The Court found that Allstate was arbitrary and capricious in refusing to make any offer in settlement of the claim, although the insured requested settlement, and where all the medical releases and authorizations, medical bills, medical reports, and correspondence of summary of injuries, relating to the loss were provided to Allstate. Although Allstate had this pertinent information for close to one year, it made no offer of settlement other than the cost of defense. Id. at 268.

In this appeal, the pivotal consideration is whether Defendant/Respondent, Allstate Insurance Co., (hereinafter "Allstate") engaged in bad faith litigation, by failing to settle the case within the policy limits of the Appellant's

UIM coverage. A review of the record in this case clearly illustrates yet another example of the insurance companies testing the system to the detriment of the insured. This simply cannot go on New Jersey, which has implemented barriers to ensure the successful and reasonable negotiation of settlements with insurance claims. As previously discussed, supra, this Court has in fact provided an apparatus for an insured to recover against insurance companies when they do in fact engage in bad faith litigation. This case warrants the application of the awarding of damages for Allstate's bad faith practices.

In September of 2001, Appellant was carefully and lawfully operating her motor vehicle when another driver ran a stop sign, striking Appellant. Liability of this accident was clear from the onset of the litigation and the wrongful driver settled the case for $14,750.00, which was the full policy limit of the wrongful driver.[1] On both December 30, 2002 and May 9, 2003, Allstate was put on notice of a potential Underinsured Motorist claim. Moreover, Allstate was provided with medical records, bills, a copy of the release from the tortfeasor and medical authorizations. On November 7, 2003, Appellant

[1] The policy limits were $15,000.00, but often times, Plaintiffs give the carrier a small discount to settle the case sooner.

resorted to filing an Order to Show Cause to compel Allstate to name an arbitrator and compel them to submit to arbitration. The Order to Show Cause was withdrawn when Allstate elected to proceed to trial rather than through arbitration, as was their option under the policy. Although Appellant suffered permanent injuries, including a herniated disc, which compressed the spinal cord on the left, Allstate rejected Appellant's settlement offer of $50,000.00 and failed to make a counteroffer in April 2004. Moreover, Allstate also rejected Plaintiff's Offer of Judgment for $50,000.00.

Even though Appellant had presented Allstate with evidence of the permanent injuries, Allstate arbitrarily and capriciously failed to settle the matter for $50,000.00, which is $35,000.00 lower than the policy limits remaining on Appellant's underinsured motorist policy. Allstate usurped Appellant's opportunity to settle the case in a fair and reasonable manner.

However, the case was tried and the jury rendered a verdict in favor of Plaintiff in the amount of $250,000.00, which is in excess of the policy limits. This $250,000.00 verdict is clear evidence that Allstate acted in bad faith by failing to settle the case for $50,000.00, when this offer was made by Appellant. As such, this jury verdict

should be upheld and Allstate should in fact be responsible for damages resulting from its bad faith litigation. As such, the Appellate Division should reverse the Law Division's Order, which reduced the judgment to the policy limits of the underinsured coverage limits.

Without the threat of the actual application of bad faith damages or awards in excess of the policy limits, Allstate and other insurance companies will continue to refuse payment or delay settlement of legitimate claims with the expectation of circumventing payment completely or reaching a settlement for an amount substantially lower than the claim's true worth.

Moreover, even if Allstate contends that Plaintiff's claim was fairly debatable, such subjective standard cannot continue to be used as a tool for refusal to deal with an insured in a good faith manner. Insurance companies have utilized this standard to its benefit and to the detriment of all first party claims. However, this fairly debatable standard should not alleviate an insurance company's duty to negotiate in good faith with the insured. Although cases in other jurisdictions are not controlling, some courts have addressed the complex analysis of bad faith litigation in the context of a "fairly debatable claim." For instance, in Skaling v. Aetna Insurance Company, 799 A.2d

997 (R.I. 2002), the court held that insurance companies can be liable for bad faith action, even if the claim is fairly debatable. In Skaling, the plaintiff filed a complaint against Aetna alleging breach of contract by Aetna for its refusal to pay underinsured motorist insurance benefits and insurer bad faith in the investigation and handling of Plaintiff's claim. Plaintiff was permanently injured when he fell from a railroad trestle while attempting to rescue a passenger from a jeep, which was operated by an underinsured tortfeasor. The underinsured automobile liability insurer subsequently settled Plaintiff's claim and paid him $25,000, which was the limit of the policy. Plaintiff's claim seeking underinsured insurance benefits from Aetna, was denied based on Aetna's determination that Plaintiff's injuries did not arise from the ownership, maintenance or use of the underinsured's vehicle.

On appeal, the Supreme Court posited:

> In recognition of the imbalance in the bargaining positions of the parties to an insurance contract, we concluded that limiting an insured to recovery of the policy limits for a breach of the insurance contract, without the threat of punitive damages or awards in excess of the policy limits would do little to promote the prompt payment of refusing payment or delaying settlement of legitimate claims in hopes of either

> avoiding payment completely or reaching a settlement for an amount substantially lower than the claim's true worth. Id. at 1003-04 (citation omitted)

With respect to an insurance company's duty to engage in settlement discussions in an effort to relieve the insurer from the burden and expense of litigation, the Court reasoned as follows:

> Although we decline to abandon the fairly debtable standard and recognize that an insurer is entitled to debate a claim that is fairly debatable, **we are not persuaded that an insurer is relieved of its obligations to deal with its insured consistent with its implied in law obligations of good faith and fair dealing simply because the claim is fairly debatable.**
>
> * * *
>
> **Moreover, although a claim may be fairly debatable and the insurer may elect to engage in a debate, consistent with its obligations of good faith and fair dealing, an insurer is nonetheless obliged to engage in settlement discussions in an effort to relieve the insurer from the burden and expense of litigation.** When, as here, the damages were substantial and the claimant was permanently injured, **we are satisfied that, in light of the amount of the policy limits at issue, and the strength of the claim, the insurer was not relieved of its obligation to make any settlement offers, even if the claim was fairly debatable.** One of the tests of insurer good faith is whether the insurer was reasonable in both its investigation of the claim and in its settlement behavior. It is the policy

> of this state to encourage settlement of controversies in lieu of litigation. Id. at 1011-12.

There is nothing in this present case to indicate that Allstate should not have made a good faith effort to settle the case. The fact that Allstate outright rejected Appellant's settlement offer of $50,000.00 without any counteroffer is disingenuous in this case as the medical records reflect the permanency of the injuries suffered by Plaintiff. Allstate simply failed to make a reasonable effort to settle this first party benefits claim, in the hopes that any need for a pay-out would dissipate. They did so, knowing that under the law as it exists in New Jersey, there would be no consequences, even if the verdict was well in excess of their policy limits. The continuation of Allstate and other insurance companies not being held accountable for their bad faith actions in failing to make an effort to settle first party claims has and will continue to frustrate the statutory intent of N.J.S.A. 17:29B-4(9) and case law, which seeks to protect the right of first party claimants. Insurance companies should not be allowed to have public policy considerations aggravate the reasonableness of settling claims. The Court in Rova Farms acknowledged that when the carrier retains

control over litigation and opts not to settle the case, even when presented with the opportunity to do so within the policy limits, the insurance company in essence compromises the interest of its insured in order to promote its own interests. Id. at 508. The Court further took note of the likely business politics that are associated with settling insurance claims. Although carriers are obligated to consider each case on its own merits, they are likely to be:

> Polluted by institutional considerations which ignore the interests of the specific insured involved . . . .These considerations may extend to a purpose to keep future settlement costs down, to numb the public's claim-consciousness, to create a conservative image for the discouragement of future claimants or to establish a favorable precedents, none of which purposes has anything to do with the protection of the particular insured at hand. Such efforts, it might be hoped, would result in overall savings to the company by discouraging the pressing of marginal claims or by creating a body of low-verdict cases which could be used as a bargaining tool in settling subsequent claims. Id. at 508-09.

The current state of litigation of UM/UIM cases as utilized by Allstate and other insurance company, foster the very type of bad faith conduct that was discussed in Rova Farms as detailed above. Unless the Appellate

Division clarifies and/or reinforces that bad faith claims will actually be upheld in first party UIM cases when the carrier fails to act in good faith in settlement negotiations with insured, insurance companies will continue to usurp the system and try UIM claims which warrant resolution by way of settlement. While third party personal injury cases contain a different vantage point as Plaintiff is conscious that it may lose the litigation and recover nothing in litigation or under the circumstances of clear liability, Plaintiffs in first party cases are conscious that trial expenses may be significant in comparison to the award. While on the other hand, defendants are aware that its evaluation of the merits of the injury and/or liability may not be accepted by the jury and that there is always a risk of a verdict in excess of its expectations. This balance is removed from first party claims and you have the insurance companies who are motivated to continue litigation and let the chips fall where they may. Unless bad faith damages are actually assessed against insurance companies who fail to properly attempt to settle a case or pay an outstanding claim, first party insureds will continue to be prejudiced and disadvantaged. The insurance companies can in fact afford to handle a large amount of cases at relatively low costs,

and even risk the sporadic large verdict since they are shielded and comforted in knowing that they will never have to pay more than the policy limit, irrespective of the actual value of the case.

Therefore, this court should reinstate the original jury verdict of $250,000.00 and reverse the lower court's reduced judgment of $85,000.00

POINT II THE LOWER COURT ERRED IN UNILATERALLY REDUCING THE JUDGMENT TO THE POLICY LIMITS OF THE UNDERINSURED/UNINSURED COVERAGE

The lower court matter was tried to a jury verdict in favor of Plaintiff in the amount of $250,000.00. On June 30, 2006, Plaintiff's attorney submitted a proposed Form of Order for Judgment in the amount of $269,734.00 ($250,000.00 verdict and interest of $18,734.00). A copy of the Judgment was served upon the Defendant under the 5 day rule. No objection was ever filed by defense counsel. However, on July 25, 2006, the Honorable Daniel M. Waldman, J.S.C., prepared and signed an Order and *sua sponte*, reformed the judgment to the policy limits of $85,000.00, without interest. This amount was the remaining policy proceeds of the $100,000.00 UM/UIM endorsement. The lower court did not have authority to reform the judgment and erred in reducing the judgment to $85,000.00.

Moreover, there was no objection to the proposed judgment of the full amount of the jury verdict of $250,000.00. The trial court incorrectly presumed that Allstate is only liable for the $85,000.00 remaining on the UM/UIM policy at the time of trial. However, as discussed in Point I, supra, bad faith damages can be assessed

against insurers and insurance companies have a good faith duty to attempt to settle cases with its insureds. The facts of this case unequivocally illustrate that Allstate breached its duty of good faith and fair dealing, which resulted in unnecessary protracted litigation. Not only did Appellant have to wait an ordinate amount of time to receive what she was entitled to under her UIM policy, but she also has now incurred unnecessary litigation costs. Allstate arbitrarily and capriciously rejected the $50,000.00 settlement without any regard to the appropriateness and viability of settling the claim within the policy limits. Now the jury has in fact confirmed that Appellant's injuries are worth $250,000.00, which evidences Allstate's conscious disregard of Appellant's attempts of settlement negotiations. In this context of bad faith settlement practices of Allstate, the lower court erred in reforming the judgment, especially considering that Allstate did not make any objection to the proposed judgment, which reflected the jury verdict.

Further, in third party cases, courts do not *sua sponte* reform the judgment to the policy limits. For instance, in a third party case, such as Rova Farms, where the verdict was well in excess of the defendant's policy, the judgment was entered for the full amount, even if the

policy precluded collecting anything more than that amount. The trial judge in Rova Farms, as here, had no legal authority to unilaterally conform the verdict to the policy limits.

The same standard that is applied to third party insurance claims should equally be applied to first party insurance claims. There is no basis and/or justification to apply a different standard, especially in the context of bad faith litigation, which is abundantly present in this case. Therefore, the lower court erred in reforming the judgment to the remaining policy limits.

CONCLUSION

For the reasons discussed above, the Appellate Division should reverse the trial court's reformed judgment and affirm the jury verdict.

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