



**THE 2022 NEW JERSEY INSURANCE FAIR CONDUCT ACT
AND THE INCOMPLETE EVOLUTION OF POLICYHOLDER
PROTECTION**

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ABSTRACT

Passage of New Jersey’s Insurance Fair Conduct Act (“IFCA”) was the culmination of efforts by policyholder advocates to revise unfortunate caselaw and provide increased protection for insurance policyholders presenting uninsured (“UM”) or underinsured (“UIM”) (collectively “UM/UIM”) claims. The IFCA significantly expands policyholder rights beyond those provided in the widely adopted Model Unfair Claims Settlement Practices Act promulgated by the National Association of Insurance Commissioners (“NAIC”)—enough that New Jersey insurers have raised questions about its application and concerns about its reach. In addition to describing the Act, and attempting to answer questions about its likely future application, this Article attempts to site the IFCA in the larger regime of insurer-policyholder relations, a regime that has largely fallen short of consumer expectations. Although the IFCA presents a significant step forward, the legal landscape largely remains one unduly favorable to insurers but can be improved by the concluding suggestions of this Article.

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INTRODUCTION

New Jersey's Insurance Fair Conduct Act ("IFCA") became law in January 2022,¹ and immediately caused a stir in the legal and insurance community.² Policyholder counsel³ and the professoriate⁴ generally

1. N.J. STAT. ANN. § 17:29BB-1 (West 2022); *see also* Gerald H. Baker, *The New Jersey Insurance Fair Conduct Act*, LAW.COM (Feb. 12, 2022, 8:05 AM), <https://www.law.com/njlawjournal/2022/02/12/the-new-jersey-insurance-fair-conduct-act/>. The IFCA went into immediate effect upon its signing by Governor Phil Murphy on January 18, 2022. N.J. STAT. ANN. § 17:29BB (West 2022); *see also* Bryan M. Shay, *New Jersey Governor Signs Bill Creating Civil Action for Insurance Bad Faith*, POST & SCHELL INS. L. POSTS (Jan. 18, 2022), <https://www.postschell.com/insights/new-jersey-governor-signs-bill-creating-civil-action-for-insurance-bad-faith>.

2. *See, e.g.*, Baker, *supra* note 1; *see sources cited infra* notes 3–4.

3. By "policyholder counsel," I mean attorneys who regularly represent those covered or purportedly covered pursuant to an insurance policy. A person or entity may be an "insured" under a policy without being the policyholder—also often referred to as the "named insured"—that purchased the insurance. For clarity, particularly when speaking, because of the aural difficulty of distinguishing between an insurer and an insured, I prefer to use the term policyholder rather than insured unless the latter is required for accuracy or has substantive implications. For example, an exclusion may negate coverage for misconduct by "an insured" or "any insured," a limitation that may be triggered by misconduct by someone other than the named policyholder.

Regarding policyholder counsel praise for the IFCA, *see, for example*, Frederic J. Giordano et al., *The New Jersey Insurance Fair Conduct Act: One Step Closer to Accountability*, K&L GATES HUB (Feb. 14, 2022), <https://www.klgates.com/The-New-Jersey-Insurance-Fair-Conduct-Act-One-Step-Closer-to-Accountability-2-14-2022> ("New Jersey policyholders finally have a statutory cause of action for bad faith for [first party] claims . . ."); George H. Flammer, Jr., *The New Jersey Insurance Fair Conduct Act—Signed Into Law*, FARRELL & THURMAN, P.C. (Feb. 1, 2022), <https://farrellthurman.com/story?id=21> ("Under the prior laws, insurance companies were almost incentivized to delay claims, as doing so would drive up litigation costs. This would then eat away at the injured party's recovery or act to place the injured individual in a situation of desperation, where they would accept a lower payment rather than continue to fight for a reasonable settlement.").

4. By the "professoriate," I refer to full time law faculty. Law faculty familiar with the Act also supported the measure. *See, e.g.*, Jay Feinman, *A Much-Needed Protection for Insurance Consumers*, STAR-LEDGER, Aug. 29, 2018, at A18 (commenting favorably on a predecessor version of IFCA) ("The bill would correct a major gap in the law. Right now, a policyholder has an effective recourse only if his or her insurance company knows that it has no basis at all for denying a claim but denies the claim anyway. That is one of the toughest standards in the country; many other states have consumer protections like those proposed in this legislation. And the current standard is almost impossible to meet. The law is so stacked against insurance consumers that since the Supreme Court established the current rule in 1993, only one case has even made it to a jury trial.").

Professor Feinman and his colleagues, Professors Adam Scales and Rick Swedloff, along with me, expressed similar approval of the IFCA in connection with the Rutgers Center for Risk and Responsibility Continuing Legal Education Program on the IFCA on April 13, 2022. The webinar also included policyholder attorney Gerald Baker and insurer counsel Jessica Wachstein, who unsurprisingly had differing reactions to the Act. *See generally* *New Jersey Insurance Fair Conduct Act*, RUTGERS, <https://events.law.rutgers.edu/#!/view/event/>

praised the new law,⁵ while insurer counsel expressed concern and predicted the law would be a net setback for policyholders and consumers.⁶ After reviewing the larger background of insurance

date/20220413/event_id/1791 (last visited Dec. 30, 2022). In thirty-five years of interacting with insurance law and insurance department—business and economics—faculty, I have yet to find a full-time law professor who opposes a statutory private right of action for policyholders, although insurance scholars may differ regarding the precise content of such acts, available remedies, and the extent to which statutory relief should limit common law relief.

5. See sources cited *supra* notes 3–4.

6. By “insurer counsel” I refer to attorneys whose practice involves the regular representation of insurers in connection with disputes over whether insurance coverage exists and whether an insurer has acted in bad faith. This is in distinction to “panel counsel,” known to laypersons as “insurance defense lawyers,” who are retained by liability insurers to defend potentially covered claims against the policyholder.

Although many lawyers engage in both defense of claims against the policyholder, and direct representation of the insurer, these are considered separate categories by practicing lawyers.

In many states, panel counsel is considered to represent not only the policyholder defendant being sued but also the insurer that selects and pays the attorney. See, e.g., *Nev. Yellow Cab Corp. v. Eighth Jud. Dist. Ct.*, 152 P.3d 737, 740–41 (Nev. 2007) (stating that both policyholder-defendant’s and insurer’s procuring and supervising panel counsel are clients of panel counsel, with policyholder primary client in case of conflict).

For examples of insurer counsel criticism of the IFCA, see Brian E. O’Donnell et al., *The New Jersey Insurance Fair Conduct Act Means Big Changes for NJ Auto Insurers*, RIKER DANZIG LLP, <https://riker.com/publications/the-new-jersey-insurance-fair-conduct-act-means-big-changes-for-nj-auto-insurers/> (last visited Dec. 30, 2022); Dakota Knehans, *New Statute May Spell Trouble for New Jersey Insurers*, COZEN O’CONNOR: AVOIDING INSURANCE BAD FAITH, <https://www.nobadfaith.com/new-statute-may-spell-trouble-for-new-jersey-insurers/> (last visited Dec. 30, 2022) (“Several proponents of the bill believe it allows plaintiffs, and plaintiffs’ attorneys, to bring lawsuits against insurers based on trivial or minor delays and denials without regard for the reasoning behind those same denials or delays. It is likely that the passage of the bill will result in a surge of bad faith and [Unfair Claims Settlement Practices Act] claims based on little or no evidence of delay or unreasonable denial. As the bill contains no definition of ‘unreasonable,’ New Jersey Courts will be responsible for setting the standard.”); Kurt H. Dzugay et al., *The New Jersey Insurance Fair Conduct Act*, LEWIS BRISBOIS BISGAARD & SMITH LLP (Jan. 25, 2022), <https://lewisbrisbois.com/newsroom/legal-alerts/the-new-jersey-insurance-fair-conduct-act>

(describing the Act and raising concerns about its impact and questions about its application, in particular, applicable statute of limitations, retroactivity, right to jury trial, severance of IFCA claims from other policyholder claims, and bifurcation); see also Shay, *supra* note 1 (describing IFCA as “a substantial change in New Jersey’s first-party bad faith law,” and stating that “if suits for statutory bad faith in other jurisdictions are any guide, the IFCA is certain to generate a substantial amount of litigation,” in particular regarding what constitutes “unreasonable” conduct); Flammer, Jr., *supra* note 3 (“Insurance companies hotly contested the new law, arguing that the law could potentially result in a flood of litigation driving up car insurance premiums. Further, many insurance companies sent their New Jersey insureds warnings of potential drastic increases in car insurance premiums. They asked insurers to contact their legislators and demand they vote against the bill.”).

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consumer protection and its shortcomings in Part I, this Article in Part II addresses the IFCA, its key provisions, and its likely impact, concluding that the Act will significantly improve the operation of claims handling. Nonetheless, even with the addition of the IFCA, the metaphorical playing field of insurance claims remains one distinctly slanted in favor of insurers in the majority of states.⁷ As outlined in Part III, the example of New Jersey and other states with policyholder protections above the norm should be duplicated, enhanced, and expanded nationwide.

I. THE EXISTING FRAMEWORK OF LEGAL PROTECTIONS FOR
POLICYHOLDERS

Notwithstanding my view that insurers have the clear upper hand in claims matters, the legal system provides some significant tools for policyholders seeking coverage and claims payment. These include the contract axiom that ambiguities are construed against the drafter of the contract, the use of a policyholder's reasonable expectations in construing disputed language, particular rules favoring broad construction of coverage, concepts of unconscionability and public policy, general regulation to protect consumers, and common law bad faith doctrine as well as statutory protections for policyholders in addition to the IFCA.

A. *Contract Construction Conventions*

1. The Ambiguity Principle (Contra Proferentem)

Insurance policies are, of course, contracts, and their construction is governed by general contract law. Insurers and other observers sometimes complain that courts on occasion twist contract law in favor of

In addition to noting insurer lobbying against the bill, George H. Flammer, of Farrell & Thurman, P.C., provided a pithy view of policyholder counsel perspective: "think about what the insurance companies were asking [policyholders] to do. They asked that [policyholders] help shut down a bill that would hold them responsible if they did not treat [policyholders] fairly. Thus, allowing them to continue to unreasonably delay and deny claims [without significant consequence]." *See id.*

7. *See infra* Section I.D and Part III.

policyholders.⁸ One can make a strong argument to the contrary,⁹ and one can certainly find stacks of judicial opinions affirming fidelity to

8. See, e.g., Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171, 173, 176 (1995); David S. Miller, *Insurance as Contract: The Argument for Abandoning the Ambiguity Doctrine*, 88 COLUM. L. REV. 1849, 1857, 1860–64 (1988); see also Steven S. Skarlat, *A Comment on Readability*, 21 FOR THE DEFENSE 17, 20 (1980), excerpted in KENNETH H. YORK & JOHN W. WHELAN, *INSURANCE LAW* 65 (2d ed. 1988).

9. For example, (too) many courts have taken a broad and hyper-literal approach to the pollution exclusion contained in the standard form commercial general liability (“CGL”) policy and denied coverage to defendants whose defective work or negligence caused injury in what normal English speakers would not regard as a “pollution” claim. See, e.g., *Reliance Ins. Co. v. Moessner*, 121 F.3d 895, 900 (3d Cir. 1997) (applying Pennsylvania law) (holding a claim involving carbon monoxide poisoning from faulty equipment is pollution claim excluded from CGL coverage); *Madison Constr. Co. v. Harleysville Mut. Ins. Co.*, 735 A.2d 100 (Pa. 1999) (finding coverage excluded for claim against construction company because fumes emitted in the course of contractor’s alleged defective work); *Deni Assocs. of Fla. v. State Farm Fire & Cas. Ins. Co.*, 711 So. 2d 1135, 1140–41 (Fla. 1998) (holding an exclusion requires that any claim linked to any of the terms used in definition of pollutant falls outside the scope of CGL coverage, and finding there is no coverage where a blueprint machine negligently tipped, releasing dangerous ammonia, or where a farmer was hit with insecticide); see also Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the “Absolute” Exclusion in Context and in Accord with Its Purpose and Party Expectations*, 34 TORT & INS. L.J. 1, 6–7 (1998) [hereinafter *Reason and Pollution*] (discussing in depth the arguments both for and against broad and constrained application of the absolute pollution exclusion).

Although contrary to prevailing case law, one can make a similar argument about courts taking a strained view of language to avoid the ambiguity principle in the bulk of COVID-19 business interruption claims by retailers forced to restrict patronage or close due to presence of the virus on property and government closure orders. Property insurance policies require physical loss or damage to property and a standard dictionary definition of “damage” or “loss” includes “deprivation.” Nonetheless, most courts have, to date, ruled as a matter of law that the words “loss” or “damage” in a policy require something more than mere deprivation of use of the property. See Erik S. Knutsen & Jeffrey W. Stempel, *Infected Judgment: Problematic Rush to Conventional Wisdom and Insurance Coverage Denial in a Pandemic*, 27 CONN. INS. L.J. 185, 232–39 (2020) (criticizing this approach); accord Richard P. Lewis et al., *Couch’s “Physical Alteration” Fallacy: Its Origins and Consequences*, 56 TORT & INS. L.J. 621, 634–36 (2021). In effect, courts making these rulings are bending the standard definitions of “loss” and “damage” to favor insurers.

And, despite some contract construction rules and regulations favoring policyholders, some courts simply make erroneous decisions inconsistent with the proper operation of insurance. See, e.g., *McCall v. State Farm Mut. Auto. Ins. Co.*, No. 16-cv-01058, 2018 WL 3620486, at *1 (D. Nev. July 30, 2018), *aff’d*, 799 Fed. App’x 513 (9th Cir. 2020). In *McCall*, the court dismissed a bad faith claim because the insurer eventually, in 2017, paid \$25,000 policy limits in connection with a 2013 collision, where, after originally denying coverage based on arguably incorrect refusal to acknowledge that exacerbation of prior injuries is compensable and subsequent suit by the policyholder, the insurer then obtained additional medical analysis and paid limits. *Id.* The court took the view that the insurer “ultimately fully performed its contractual obligation when it paid [the policyholder] her contractually capped amount.” *Id.* at *2. It is hard to imagine a court taking a similarly generous approach to a multi-year delay in consumer payment of mortgages, credit cards, utility bills,

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general contract principles when deciding insurance disputes.¹⁰ That said, there are contract principles that at the margin assist policyholders in coverage disputes.

One is the ambiguity doctrine or *contra proferentem* principle (herein referred to as *contra proferentem sans italics*) holding that ambiguous contract document language is construed against the drafter unless the ambiguity can be resolved by extrinsic or contextual evidence.¹¹ But this rule is not an unwarranted gift to policyholders.¹² It exists because

or car payments. Adding insult to injury, the policyholder who waited four years for her rather modest UM/UIM payment was taxed \$12,333.80 in costs. *See* *McCall v. State Farm Mut. Auto. Ins. Co.*, No. 16-cv-01058, 2019 WL 2476731 at *1 (D. Nev. June 13, 2019).

This sort of if-the-insurer-eventually-pays-what-is-the-big-deal? thinking has been disapproved of for decades, including in one of the opinions in the famous *Campbell v. State Farm* litigation. *See* *Campbell v. State Farm Mut. Auto. Ins. Co.*, 840 P.2d 130, 139 (Utah Ct. App. 1992) (rejecting State Farm’s similar argument when, after a trial that resulted in a judgment of \$200,000, it paid \$50,000 per accident policy limits, despite rejecting multiple settlement offers prior to trial) (“[A]n insurer’s eventual payment of an excess judgment does not necessarily [preclude a bad faith claim.]”); *see also* JEFFREY W. STEMPER, LITIGATION ROAD: THE STORY OF *CAMPBELL V. STATE FARM* 192–97 (2008) [hereinafter STEMPER, LITIGATION ROAD].

Although one might defend decisions like *McCall* because it involved a UM/UIM claim rather than a liability claim resulting in a tangible judgment exceeding policy limits, this is a clichéd distinction without a difference. In both cases, the policyholder had been injured by a carrier’s failure to promptly, fairly, and reasonably perform its duties of investigation, evaluation, and settlement. *See* Jeffrey W. Stempel & Erik S. Knutsen, *Protecting Auto Accident Victims from the UM/UIM Insurer Identity Crisis*, 26 CONN. INS. L.J. 1, 89 (2019) [hereinafter *Protecting Auto Accident Victims*] (concluding that UM/UIM insurers should approach claims as would liability insurers).

10. *See, e.g.*, *Calogero v. Shows, Cali & Walsh, LLP*, No. 18-6709, 2022 WL 2704470, at *23 (E.D. La. July 12, 2022) (holding where contract text is clear, “it is not the duty of the courts to bend the meaning of the words of a contract into harmony with a supposed reasonable intention of the parties” (quoting *Prejean v. Guillory*, 38 So. 3d 274, 279 (La. 2010))); *Rosebud Rest., Inc. v. Regent Ins. Co.*, No. 20 C 5526, 2022 WL 2669522 at *5 (N.D. Ill. July 11, 2022) (“While ‘ambiguities in an insurance policy will be construed against the insurer, courts will not distort the language of a policy to create an ambiguity where none exists.’” (quoting *Mashallah, Inc. v. West Bend Mut. Ins. Co.*, 20 F.4th 311, 322 (7th Cir. 2021) (applying Illinois law))).

11. *See* 1 JEFFREY W. STEMPER & ERIK S. KNUTSEN, STEMPER & KNUTSEN ON INSURANCE COVERAGE § 4.08 (4th ed. 2016) [hereinafter STEMPER & KNUTSEN, VOLUME ONE] (reviewing ambiguity principle for insurance policy construction); Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 531–33 (1996) (regarding the ambiguity rule as key pillar of policyholder protection and effective operation of insurance system).

12. At least not if the rule is properly applied. I agree with insurers that a finding of facial ambiguity in an insurance policy should not be the end of the matter and thereby decree an immediate victory for the policyholder. A court correctly using *contra proferentem* will first assess the context of the policy and consider apt extrinsic evidence proffered by the parties, including drafting history, overall purpose, and materials reflecting a particular understanding of a provision by the disputing parties (e.g., course of

insurers are almost always the authors of the language in dispute because insurance policies are sold on a take-it-or-leave-it basis.¹³ Consequently, when an insurer-drafted document is facially unclear, policyholders should win unless—and it can be a big “unless”—there is extrinsic or contextual evidence resolving the uncertainty.

Despite the generally pro-insurer economic, cognitive, and contracting environment discussed in Part III, this general rule of contract interpretation as applied to insurance provides some significant assistance to policyholders. But there is a fly in the ointment: contrary to the complaint of insurers that insured stretch language to find ambiguity, many judges strain to read policy language as clear, and refuse to admit rather obvious textual ambiguity in policy text.¹⁴

2. The Reasonable Expectations Principle

Also often helpful to policyholders but frequently helpful to insurers as well is the reasonable expectations principle. I prefer describing the concept as a “principle” or “approach” rather than a “doctrine,” by which it is often referred, in part because the “strong” version of the reasonable expectations approach associated with Judge Robert Keeton’s important article¹⁵ is seldom applied.¹⁶

performance, course of dealing, usage in trade, reasonable reliance, admissions). See *Reason and Pollution*, *supra* note 9, at 9–11.

13. But although fixed by the insurer, policy content may differ significantly among insurers, making comparison more difficult for prospective policyholders. See Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263, 1264–66 (2011); Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. 394, 397 (2014).

14. See *supra* note 9 and accompanying text.

15. In Part I, Judge Keeton discussed three broad principles distilled from decisions that tended to show courts deciding insurance coverage disputes by means other than strict focus on text and resort to standard interpretative techniques. In Part II, he reviewed the courts’ steady relaxation in treatment of warranty representations made by applicants and policyholders, another judicial development favorable to policyholders. See Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970) [hereinafter Keeton, *Part One*]; Robert E. Keeton, *Insurance Law Rights and Variance with Policy Provisions: Part Two*, 83 HARV. L. REV. 1281 (1970).

16. See generally STEMPEL & KNUTSEN, VOLUME ONE, *supra* note 11, § 4.09 (reviewing and analyzing reasonable expectations approach and its varieties).

Although Keeton’s article created the reasonable expectations movement, another prominent insurance scholar, Professor Edwin Patterson, hinted at the doctrine several years earlier when he noted courts’ tendency to interpret contracts in a manner that would uphold their validity: “If not, the reasonable expectations of the parties are sacrificed to sheer verbalism.” Edwin W. Patterson, *The Interpretation and Construction of Contracts*, 64 COLUM. L. REV. 833, 852 (1964) (quoting *Zdanok v. Glidden Co.*, 288 F.2d 99, 104 (2d Cir. 1961), *aff’d on other issue*, 370 U.S. 530 (1962) (applying New York law)).

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The strong, or what might be termed “full-bore” Keeton approach, required courts to honor the objectively reasonable expectations of the policyholder regarding coverage (and implicitly this includes claim valuation) even if this was contrary to the policy language itself.¹⁷ While nearly every jurisdiction supports applying reasonable expectations analysis to construing facially ambiguous policy language,¹⁸ there is arguably no jurisdiction that has completely embraced the strong version of the approach in which objectively reasonable policyholder expectations are accorded more weight than clear policy language.¹⁹ To trigger application of a stronger form of reasonable expectations analysis that can overcome facially clear policy language, there must usually be something about the policy form, its placement, the context of the transaction, or the conduct of the insurer or its agents that makes it apt to decline to give the policy language its prevailing linguistic meaning.²⁰ For example, in one leading case, the text of the policy required that there be visible marks of forced entry for burglary coverage, but this language, contained in the definitions section of the policy rather than its exclusions, was deemed to disappoint the objectively reasonable expectations of the policyholder unfairly.²¹

Certainly, no jurisdiction *regularly* employs the strong version of the reasonable expectations concept to override clear policy text without at least something more, such as a context creating strong policyholder

17. Keeton, *Part One*, *supra* note 15, at 967.

18. See *Max True Plastering Co. v. U.S. Fid. & Guar. Co.*, 912 P.2d 861, 866 (Okla. 1996) (collecting cases and finding that thirty-two states have accepted reasonable expectations principles in moderate form as a resolver of ambiguity, while four states have rejected them). The *Max True* assessment is probably an undercount. Although the court found nothing definitive in ten states, this is likely because courts apply a reasonable-understanding-of-ambiguous-language approach without formally labeling it a reasonable expectations analysis.

19. See STEMPPEL & KNUTSEN, VOLUME ONE, *supra* note 11, at § 4.09.

20. See *id.* (noting acceptance of reasonable expectations analysis of unclear policy provisions despite judicial resistance to applying strong form as articulated by Prof. Keeton).

21. *Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 275–79 (Minn. 1985); *accord C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169 (Iowa 1975). In both cases, premises were robbed by thieves that were able to gain entrance without breaking windows or doors. *Atwater*, 366 N.W.2d at 278; *C & J Fertilizer*, 227 N.W.2d at 171. This of course raises the issue of whether the thefts were fraudulent “inside jobs,” a concern the court largely dismissed because the visible marks of forced entry language would not prevent a fraudulent policyholder from merely breaking a window on the way out after initially using a key to gain entry. See *Atwater*, 366 N.W.2d at 276; *C & J Fertilizer*, 227 N.W.2d at 177. In effect, an insurer suspicious of the bona fides of a burglary was required to prove policyholder misconduct and could not deny what appeared to be a genuine burglary merely because the burglars were accomplished at picking locks. See *Atwater*, 366 N.W.2d at 277–78; *C & J Fertilizer*, 227 N.W.2d at 177.

expectations.²² Examples include hidden or misleading policy language (even if key terms are not ambiguous *per se*);²³ reliance-inducing conduct by the insurer (even if falling short of estoppel);²⁴ strong functional or public policy reasons for extending coverage despite policy language to the contrary;²⁵ or an insurer's push for an overly broad and literal meaning of a word that extends too far beyond common use of language.²⁶ The benefit of the reasonable expectations concept to policyholders is further diluted where courts unduly resist conceding textual ambiguity.

Often lost in the debate about reasonable expectations analysis is its role not just regarding insurance disputes, but in all contract dispute decisions. When determining the meaning of contract document text, courts consider the reasonable expectations of the contracting parties, as most famously associated with then-Judge Benjamin Cardozo's statement that contracts are construed with the "reasonable expectation

22. See STEMPEL & KNUTSEN, VOLUME ONE, *supra* note 11, § 4.09.

23. See, e.g., *Atwater*, 366 N.W.2d at 276–78.

24. Cf. *Vos v. Farm Bureau Life Ins. Co.*, 667 N.W.2d 36, 50 (Iowa 2003) (finding individual inquiries regarding each class member's purchase of insurance overshadows any common issues) ("The party asserting the doctrine of reasonable expectations must show not only the expectations, but also that they were *relied upon* by the insurance purchaser in deciding to buy the policy."). Some courts require conduct tantamount to estoppel before invoking the reasonable expectations principle. See, e.g., *Hums. & Res., LLC v. Firstline Nat'l Ins. Co.*, No. 20-2152, 2022 WL 657067, at *4 (E.D. Pa. Mar. 4, 2022) ("The reasonable expectations doctrine applies only where an insurer or its agent has made an 'affirmative misrepresentation . . . about the contents of the policy'—absent deceptive behavior on the part of the insurer, the plain language of the policy 'must be enforced.'" (quoting *West v. Lincoln Ben. Life Co.*, 509 F.3d 160, 169 (3d Cir. 2007) (applying Pennsylvania law))). This approach to reasonable expectations construction errs in that it conflates or even confuses reasonable expectations analysis with equitable estoppel. But it unfortunately reflects a segment of case law limiting application of the reasonable expectations approach.

25. Because automobile insurance is effectively required as a condition of licensing, courts may refuse to enforce literal language limiting coverage where it would operate to violate the state's financial responsibility requirements, or reduce coverage below the state's statutory minimum of required coverage (usually a low limit such as \$25,000 per person and \$50,000 per accident). See *Proformance Ins. Co. v. Jones*, 887 A.2d 146, 155–56 (N.J. 2005).

26. See *Kent Farms, Inc. v. Zurich Ins. Co.*, 998 P.2d 292, 295–96 (Wash. 2000) (rejecting insurer's invoking pollution exclusion to deny claim where victim was injured by gasoline spouting into his face); see also *Keggi v. Northbrook Prop. & Cas. Ins. Co.*, 13 P.3d 785, 792–93 (Ariz. Ct. App. 2000) (rejecting insurer's attempt to deny coverage pursuant to pollution exclusion when professional golfer was injured by tainted drinking water at tournament). Although cases like these can also be described—and often are by rendering courts—as decisions based on the ambiguity of an exclusionary term or the rule of strict construction of exclusions, their analysis and outcome reflects reasonable expectations analysis as well.

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. . . of the ordinary business man” in mind.²⁷ Often this reading of text—for statutory interpretation as well as contract construction—is implicit or not emphasized, in both insurance and other contract disputes.²⁸

Often forgotten is that injecting reasonable expectations into the analysis may redound to the insurer’s benefit. When it is the policyholder that asserts an overly literal or excessively expansive, out-of-context meaning of a word, courts are often unwilling to agree notwithstanding the *contra proferentem* principle.²⁹ Absent other evidence to the contrary, the rule requires that the policyholder win whenever its construction of a disputed term is reasonable, even if the insurer proffers a reasonable alternative meaning.

But, of course, to get the benefit of the *contra proferentem* principle, the policyholder’s asserted interpretation must be reasonable. Consequently, an insurer can use the reasonable expectations principle to its benefit against a strained policyholder interpretation of the term. Decisions favoring insurers in these circumstances are reasonable expectations decisions in favor of insurers but are often unrecognized as such because courts often do not use the term. Instead, a court may deny relief to the policyholder because it is unwilling to “torture” or “twist” or “bend” or “rewrite” policy language.³⁰ What the courts are also deciding in these cases is that the policyholder’s proffered definition of the terms at issue is not objectively reasonable.

27. See, e.g., *Bird v. St. Paul Fire & Marine Ins. Co.*, 120 N.E. 86, 87–88 (N.Y. 1918) (Cardozo, J.) (noting that meaning attributed to words in contract document should generally be that which a reasonable person would attribute to the words).

28. See YONG Q. HAN, *POLICYHOLDER’S REASONABLE EXPECTATIONS* 105–06 (2016) (noting that consideration of parties’ reasonable expectations is used regularly to decide cases but reasonable expectations may not be expressly discussed in judicial opinions); ANTONIN SCALIA & BRYAN A. GARNER, *READING LAW: THE INTERPRETATION OF LEGAL TEXTS* 33–34 (2012) (noting that courts inherently consider the purpose of a document and general context of the matter even when focusing on text, and resisting receipt of extrinsic evidence *per se*).

29. See discussion *supra* Section I.A (discussing the *contra proferentem* principle of construing ambiguous terms against the drafter); see also STEMPEL & KNUTSEN, *VOLUME ONE*, *supra* note 11, § 4.14[J][1] (noting judicial rejection of policyholder attempts to obtain coverage pursuant to Part B of general liability for “trespass” when claim was that policyholder’s pollution discharge injured third party claimant); *S. Md. Agric. Ass’n v. Bituminous Cas. Co.*, 539 F. Supp. 1295, 1305–06 (D. Md. 1982); *County of Columbia v. Continental Ins. Co.*, 634 N.E.2d 946, 950–51 (N.Y. 1994). *But see* *Kitsap County v. Allstate Ins. Co.*, 964 P.2d 1173, 1184–87 (Wash. 1998) (en banc) (finding the term “trespass” sufficiently ambiguously broad to permit pollution coverage under Part B of CGL policy).

30. See cases cited *supra* note 9.

3. Canons of Construction Based on Insurance Structure and Operation

As noted above, the ambiguity and reasonable expectations principles are broadly applicable to all contract disputes. So, too, are contract construction conventions based on the structure of the contract. But three have particular application to insurance.

One is the ground rule that policy provisions providing coverage (e.g., the main insuring agreement of the policy) are construed broadly and in favor of coverage.³¹ The idea is that an insurer's promise should not be curtailed through crabbed construction of the insuring agreement lest the policyholder be misled into thinking it had purchased more coverage than it would actually receive from a court according narrow construction to the insuring agreement.³²

Another is that exclusions are narrowly and strictly construed against the insurer³³ because by their very nature exclusions seek (often through the proverbial fine print) to cut back on the coverage promised by the policy's insuring agreement that is often broad and is the part of the policy most important for marketing and sales. Because the exclusion seeks to take away previously promised coverage, the insurer bears the burden of persuasion regarding imposition of the exclusion.³⁴

Exclusions may contain exceptions that limit their applicability. Although it is the insurer's burden to demonstrate the applicability of an exclusion, it is the policyholder's burden to establish that an exception to the exclusion applies to restore coverage.³⁵ Perhaps the most famous

31. See STEMPER & KNUTSEN, VOLUME ONE, *supra* note 11, § 4.04 (arguing that insuring agreements should be broadly construed).

32. Admittedly, this rationale also contains elements of the reasonable expectations principle in that it seeks not to disappoint policyholders by providing less coverage than seemingly promised in the insuring agreement in particular and the policy as a whole. See discussion *supra* Section I.A. Where the insuring agreement is particularly broad, as in an all-risk policy promising to provide coverage against all risks of property damage, insurers and policyholders deploy the above-discussed interpretation principles in competition. See Knutsen & Stempel, *supra* note 9, at 232–39. Policyholders, of course, argue that “all risks” means anything not expressly excluded. *Id.* at 198. Insurers, particularly those without strong exclusions, attempt to place a reasonable expectations limit on the term when they argue, for example, that risks like pandemics, government, seizure of property, or war are not covered. *Cf. id.* But they may do this through different verbiage, as insurers have done in the COVID-19 business interruption cases by arguing that an all-risk policy is not triggered by deprivation of property unless the property has been structurally altered and physically damaged in the traditional sense such as being broken. See *id.* at 232–39.

33. STEMPER & KNUTSEN, VOLUME ONE, *supra* note 11, § 4.04.

34. *Id.* § 2.06[C].

35. *Id.*; see, e.g., *Zurich Am. Ins. Co. v. Ironshore Specialty Ins. Co.*, 497 P.3d 625, 626–30 (Nev. 2021) (answering certified question from U.S. Court of Appeals for the Ninth Circuit).

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example is the “qualified” pollution exclusion that dominated commercial general liability (“CGL”) policies during the 1973–1986 time period.³⁶ The exclusion barred coverage for claims arising out of the “discharge” or “release” of a “pollutant” (broadly defined) unless the discharge or release was “sudden and accidental.”³⁷ A policyholder that wished to obtain coverage for pollution liability by asserting that the discharge was sudden and accidental bore the burden of persuasion.³⁸ Although there was much debate over the meaning of the term “sudden”—essentially a clash between “unexpected” versus “abrupt”³⁹—there was no

36. See 2 JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL & KNUTSEN ON INSURANCE COVERAGE § 14.11[B] (4th ed. 2016) [hereinafter STEMPEL & KNUTSEN, VOLUME TWO] (describing background history and judicial interpretation of qualified exclusion). Because judicial construction of the qualified exclusion frequently found it insufficient to bar coverage for risks insurers wished to avoid, the industry moved to an “absolute” or “total” pollution exclusion in the mid-1980s. See *id.* § 14.11[C] (showing the absolute pollution exclusion adopted in 1986 revision to standard commercial general liability form contains no exception for abrupt or unintentional discharge of “pollutants” with term broadly defined to include substances such as dust and smoke).

37. See *id.* §14.11[B]. “Pollutant” is commonly defined as “any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.” See, e.g., ISO PROPS., INC., COMMERCIAL GENERAL LIABILITY COVERAGE 14 (2003), <https://eperils.com/wp-content/uploads/2016/09/cg-01-1204.pdf>.

38. See STEMPEL & KNUTSEN, VOLUME TWO, *supra* note 36, §14.11[B].

39. See generally *id.* § 14.11. Compare *ACL Techs., Inc. v. Northbrook Prop. & Cas. Ins. Co.*, 22 Cal. Rptr. 2d 206, 216 n.42 (Ct. App. 1993) (explaining that although “sudden” can mean “unexpected” or “abrupt,” it is unreasonable to think of sudden as meaning “gradual”), with *Claussen v. Aetna Cas. & Sur. Co.*, 380 S.E.2d 686, 689 (Ga. 1989) (“[O]n reflection one realizes that, even in its popular usage, ‘sudden’ does not usually describe the duration of an event, but rather its unexpectedness: a sudden storm, a sudden turn in the road, sudden death. . . . Thus, it appears that ‘sudden’ has more than one reasonable meaning.”).

Beyond competing textual approaches, it also appears that qualified pollution exclusion cases reflect distinctions of judicial approach. If the facts of the case showed a policyholder that as a regular business practice dumped pollutants knowing of the damage caused, there was of course no coverage. But the record in many cases reflected a policyholder that did not expect injury from disposal—older readers might remember the hegemony of “sanitary landfills”—or purported not to know of gradual seepage. See, e.g., *Claussen*, 380 S.E.2d at 689 (finding qualified exclusion inapplicable to landfill operator who claimed no knowledge of hazardous wastes being deposited on site by customers); *Upjohn Co. v. N.H. Ins. Co.*, 444 N.W.2d 813, 817–18 (Mich. Ct. App. 1989) (stating leak from corroded underground storage tank at pharmaceutical manufacturer was unexpected discharge making qualified exclusion inapplicable). Decisions favoring policyholders took a charitable view of what was “accidental” and noted that a major dictionary definition of “sudden” was “unexpected,” thus finding the requisite ambiguity for coverage. But see *Upjohn Co. v. N.H. Ins. Co.*, 476 N.W.2d 392, 410 (Mich. 1991) (reversing court of appeals and finding “sudden” to mean abrupt in divided opinion), perhaps demonstrating that different perspectives of judges matter more than the context of policyholder activity.

disagreement of the shifting burdens of proof regarding exclusions and exceptions.⁴⁰

B. Regulation and Public Policy

Although all contract disputes are adjudicated against the backdrop of a broad legal regime of statutes, agency regulations, opinion letters and less codified understandings of public policy, these factors matter more in insurance disputes. Insurance is more heavily regulated than most businesses,⁴¹ and is considered more affected by public interest than most economic activities.⁴²

To illustrate: if one's Amazon order does not arrive on time (or at all), the consequences are typically not severe and are relatively easily remedied through re-order, a purchase credit, a trip to a conventional store, or some combination of these responses. But, if after the policyholder suffers a home fire and then finds the home insurer defunct or refusing a valid payment request, the consequences are considerably more severe and less amenable to remedy.

The nature of insurance that, as discussed below, creates vulnerability for policyholders and gives insurers advantages not enjoyed by ordinary vendors,⁴³ has prompted not only solvency regulation,⁴⁴ but

Decisions favoring insurers noted another, arguably dominant dictionary definition of "sudden" as "abrupt." The nearly 50-50 split in the cases spurred insurer development of the stronger pollution exclusion in use today.

40. For a good recent analysis of the issue, see *Zurich Am. Ins. Co. v. Ironshore Specialty Ins. Co.*, 497 P.3d 625, 629–33 (Nev. 2021) (embracing the traditional burden-shifting approach outlined in text in response to a certified question from the Ninth Circuit). The holding in the case was not surprising as well as the federal court's perceived need for clarification by the state's highest court. The rule was rather well-established nationally, but a split between two District of Nevada trial judges prompted the appeals court's request for clarification. *Id.* at 626.

41. See generally JEFFREY W. STEMPER ET AL., *PRINCIPLES OF INSURANCE LAW* § 3 (5th ed. 2020) [hereinafter *PRINCIPLES OF INSURANCE LAW*] (regarding the prevalence of insurance regulation).

42. See *id.* (showing how insurance is affected by public interest).

43. See *infra* Section I.F (discussing the nature of insurance and the power imbalance between insurers and policyholders).

44. See generally *PRINCIPLES OF INSURANCE LAW*, *supra* note 41, §§ 3.01–.02. Solvency regulation forms the main objective of insurance regulators. *Id.* As a result, there is considerable regulation of insurer solvency, including required reserves and requirements or limitations on the manner in which premium dollars can be invested. *Id.* States vary in the degree to which they regulate the rates charged by the insurer and particular policy language, although most all states require approval of basic policy forms and all states require licensing, at least for insurers selling directly to individual consumers. *Id.*

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conduct regulation,⁴⁵ such as the claims handling statutes and administrative provisions discussed below.⁴⁶

In addition, notions of good public policy such as a preference for spreading losses and compensating accident victims may influence coverage decisions, primarily aiding policyholder-victims suing insured defendants.⁴⁷ Application of the unconscionability doctrine in favor of policyholders seeking to avoid oppressive insurance policy terms can also be viewed as a public policy driven canon of construction favoring policyholders.⁴⁸

Regarding auto insurance, courts and legislatures are disinclined to permit insurance policy provisions that could result in coverage for an amount less than the statutory minimum required for licensed drivers. The “financial responsibility laws” that essentially require insurance as a condition of driving are themselves a reflection of the public interests and regulatory reach affecting insurance.⁴⁹ But cynics might note that the very low minimum policy limits (e.g., \$25,000 per person/\$50,000 per accident) required to enable driving suggest insufficient concern for auto-inflicted injuries.⁵⁰

45. State regulation requiring approval of policy language is not conduct per se but influences the behavior of insurers. An insurer is, for example, discouraged from self-dealing if it cannot gain approval of a policy form with text unfair to the policyholder. See PRINCIPLES OF INSURANCE LAW, *supra* note 41, § 3.02.

46. See discussion *infra* Sections I.D, I.E.

47. PRINCIPLES OF INSURANCE LAW, *supra* note 41, § 2.

48. A court may refuse to enforce a contract term that is sufficiently unfair or oppressive to be considered “unconscionable.” JOSEPH M. PERILLO, CONTRACTS § 9.39 (7th ed. 2014). Commentators generally distinguish between “procedural” unconscionability such as when a contract provision is part of deceptive contracting or sales practice and “substantive” unconscionability, meaning that the term is unduly oppressive even if not the product of deceptive dealing. See *id.* §§ 9.39–.40; E. ALLAN FARNSWORTH, CONTRACTS § 4.28 (4th ed. 2004); see also Arthur Allen Leff, *Unconscionability and the Code—The Emperor’s New Clause*, 115 U. PA. L. REV. 485, 487 (1967) (characterizing procedural unconscionability as “bargaining naughtiness”). Most courts require some combination of both forms of unconscionability as a prerequisite for refusing to enforce an otherwise clear contract term. See, e.g., *Burch v. Second Jud. Dist. Ct.*, 49 P.3d 647, 650 (Nev. 2002) (“Generally, both procedural and substantive unconscionability must be present in order for a court to exercise its discretion to refuse to enforce a contract or clause as unconscionable.”).

49. *Protecting Auto Accident Victims*, *supra* note 9, at 5–6.

50. New Jersey is in this regard even “worse” than most states in terms of having low minimum policy limits of \$15,000 per person/\$30,000 per accident. See N.J. STAT. ANN. § 17:28-1.1(a); *id.* § 39-6B-1(a); see also *id.* § 17:28-1.1(b) (requiring that policyholders be offered a chance to purchase UM/UIM coverage “up to at least” limits of \$250,000 per person and \$500,000 per accident but not mandating such purchase or requiring that UM/UIM coverage be part of policy). See generally *Consumer Automobile Insurance Coverage State Law Survey*, LEXISNEXIS (Mar. 21, 2022), <https://plus.lexis.com/api/permalink/284aad8d-7c4e-45c7-85c6-c40bc64cdac3/?context=1530671> (collecting fifty-state information

C. Common Law Bad Faith and Its Limitations

All contracts contain an obligation of good faith and fair dealing,⁵¹ which is defined by the Uniform Commercial Code as “honesty in fact and the observance of reasonable commercial standards of fair dealing.”⁵² Although a potentially important factor in determining the relative rights and responsibilities of contracting parties, breach of the covenant in a typical contract dispute does not give rise to a claim for relief unless “accompanied by an independent tort” such as fraud or conversion.⁵³ By contrast, nearly all states treat bad faith performance by an insurer as an independent tort giving rise to tort remedies,⁵⁴ including possible

regarding minimum limits and showing that most states require higher minimums than New Jersey, but not much higher, with \$25,000 per person/\$50,000 per accident as the most common amount).

These amounts will often be inadequate to compensate collision victims. A ride in an ambulance coupled with diagnostic tests, such as an MRI or a CT scan, can easily total more than \$15,000 or \$25,000 in medical bills alone, even without hospitalization, surgery, continued care, laboratory work, prescription drugs, physical therapy, or prosthetic devices. *See, e.g., Protection from High Medical Costs*, HEALTHCARE.GOV, <https://www.healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/> (last visited Dec. 30, 2022) (stating that “[f]ixing a broken leg can cost up to \$7,500” and “[t]he average cost of a 3-day hospital stay is around \$30,000”); CONGRESSIONAL BUDGET OFFICE, *THE PRICES THAT COMMERCIAL HEALTH INSURERS AND MEDICARE PAY FOR HOSPITALS’ AND PHYSICIANS’ SERVICES 4–7* (2020), <https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf>.

51. *See* PERILLO, *supra* note 48, § 11.38; FARNSWORTH, *supra* note 48 § 7.17; *see also* RESTATEMENT (SECOND) OF CONTRACTS § 205 (AM. L. INST. 1981) (“Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.”).

52. U.C.C. § 1-201(b)(20) (AM. L. INST. & UNIF. L. COMM’N 2021).

53. *See, e.g.,* Haagenon v. Nat’l Farmers Union Prop. & Cas. Co., 277 N.W.2d 648, 652 (Minn. 1979) (adopting general rule); Wild v. Rarig, 234 N.W.2d 775, 790 (Minn. 1975) (refusing to permit claim for punitive damages in contract action alleging bad faith breach absent allegations of independent tort such as fraud or conversion); *see also* Mesaba Holdings, Inc. v. Fed. Ins. Co., No. CIV. 02-660, 2002 WL 1378221, at *4 (D. Minn. June 25, 2002) (dismissing policyholder’s claim *against its own insurer* because it was pled as bad faith breach of contract rather than as an independent tort for breach of duty owed because of contractual covenant of good faith and fair dealing).

54. *See* STEMPER & KNUTSEN, VOLUME ONE, *supra* note 11, § 10.03. A slight qualifier might be in order. Although it appears that all states treat bad faith performance by a third-party insurer as a tort, some states treat first-party bad faith as a matter of contract and preclude tort remedies such as punitive damages. *See, e.g.,* Beck v. Farmers Ins. Exch., 701 P.2d 795, 798–99 (Utah 1985). Other states refuse to recognize a common law bad faith action, but appear to have created a bad faith right of action by statute. *See, e.g.,* 42 PA. CONS. STAT. § 8371 (2022) (stating that if court finds insurer bad faith, court “may” impose prejudgment interest, cost, counsel fees, and punitive damages upon insurer).

In New Jersey, as discussed below in Section II.A, the *Pickett v. Lloyd*’s case and its progeny did not bar a first-party bad faith claim per se, but made it so difficult that attorneys commonly thought of New Jersey as a state that did not recognize first-party bad

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punitive damages if the breach reflects conscious disregard for the rights of the policyholder.⁵⁵

For insurance, good faith is often defined as the absence of bad faith with varying definitions of bad faith. In a largely dominant definition, the American Law Institute (“ALI”) Liability Insurance Restatement posits that:

An insurer is subject to liability to the insured for insurance bad faith when it fails to perform under a liability insurance policy:

- (a) Without a reasonable basis for its conduct; and
- (b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.⁵⁶

But, “[g]eneralizations about the state of the law are questionable; one of the striking features of bad-faith law is the frequency of generalization about the law and the inaccuracy of those generalizations when tested against the details of the law in particular jurisdictions.”⁵⁷

Although there is division among jurisdictions, it appears that the majority of cases addressing the issue do not require a finding of coverage for imposition of bad faith liability, however some states have a bright line rule against recovery of bad faith/unfair claims handling damages in the absence of coverage.⁵⁸ In such bad-faith-without-coverage cases, the

faith. Even with enactment of the IFCA, which applies only to UM/UIM claims, New Jersey remains a state with relatively anemic bad faith remedies for other first-party insureds. *Pickett v. Lloyd’s*, 621 A.2d 445, 454 (N.J. 1993); *see also* discussion *infra* Section II.A.

55. The precise verbal test for finding conduct sufficiently egregious to warrant punitive damages varies between statements. Common formulations are “conscious disregard” or “reckless disregard” for policyholder rights. Some states appear to permit punitive awards for gross negligence, while some states require misconduct tantamount to intent to injure. No state permits recovery of punitive damages for mere negligence, and nearly all states require a heightened standard of proof—a showing of misconduct by “clear and convincing” evidence rather than a mere preponderance of evidence. 1 JOHN J. KIRCHER & CHRISTINE M. WISEMAN, *PUNITIVE DAMAGES: LAW AND PRACTICE* § 5:3 (2d ed. 2022); 2 LINDA L. SCHLUETER, *PUNITIVE DAMAGES* § 20.1 (8th ed. 2021).

56. *RESTATEMENT OF LIAB. INS.* § 49 (AM. L. INST. 2019).

57. Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 *TORT & INS. L.J.* 693, 701 (2012) [hereinafter Feinman, *Beyond Bad Faith*].

58. *See, e.g., Liberty Ins. Underwriters v. Cocrystal Pharma, Inc.*, No. 19-cv-02281, 2022 WL 1624363, at *4 (D. Del. May 23, 2022) (stating that “[u]nder Washington law, an insured may pursue a bad faith claim even in the absence of coverage” while “[u]nder Delaware law,” insurers are subject to bad faith liability only if they have breached the contract and refused to pay for matters covered under policy); *Westminster Am. Ins. Co. v. Sec. Nat’l Ins. Co.* 555 F. Supp. 3d 75, 88 (E.D. Pa. 2021) (finding no bad faith liability absent coverage); *Country Club of Fairfield, Inc. v. N.H. Ins. Co.*, No. 13-CV-00509, 2014

policyholder's damages may be slight, negating the deterrent impact of this approach.⁵⁹

The bad faith tort was slow in coming. Until the twentieth century, the law of insurer-policyholder relations and insurer conduct could be described as caveat policyholder. No matter how bad the insurer's conduct or how unreasonably extreme its coverage positions, the insurer was unlikely to be responsible for paying more than the applicable policy limits.⁶⁰ Under this regime, insurers had strong incentive to take

WL 3895923, at *6–7 (D. Conn. Aug. 8, 2014) (stating “Connecticut courts have not negated the existence of an independent tort for procedural bad faith in the absence of coverage,” and that New Hampshire appears to expressly permit such claims (quoting *Tucker v. Am. Int'l Grp., Inc.*, No. 09-CV-1499, 2011 WL 6020851 (D. Conn. Dec. 2, 2011))).

Compare Feinman, *Beyond Bad Faith*, *supra* note 57, at 729–30 (arguing that a finding of coverage should not be a prerequisite to bad faith liability where the insurer misconduct violates the covenant of good faith) with Douglas R. Richmond, *Bad Insurance Bad Faith Law*, 39 TORT TRIAL & INS. PRAC. L.J. 1, 7–8 (2003) (arguing that without coverage, insurer has not breached contract and that without breach policyholder has not been denied benefit of the bargain and hence has not suffered bad faith contract performance at hands of insurer). The Feinman position is considerably more persuasive:

The focus on the contractual duty to indemnify is too narrow in light of the true nature of the insurance relation. That relation is one in which the company makes not merely a promise to pay in the event of loss but also to promptly, fairly, and objectively process, investigate, evaluate, and resolve the claim. Violation of that obligation may impose harm on the insured, and that harm ought to be compensable.

Feinman, *Beyond Bad Faith*, *supra* note 57, at 729–30.

59. See *Mathias v. Accor Econ. Lodging, Inc.*, 347 F.3d 672, 676 (7th Cir. 2003). For example, an insurer may repeatedly fail to communicate with an insured for a year in a clear case of non-coverage. The compensatory damages for the lack of communication would likely be small based on only the policyholder's inconvenience—but conversely could be large if the communication failure prevented the policyholder from engaging in prudent business conduct while being forced to wait to hear from its insurer.

Punitive damages are a possible remedy for reprehensibly unreasonable, substandard insurer behavior but are reduced in deterrent value where compensatory losses are small. *State Farm Mutual Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003), requires that a punitive award bear a reasonable relation to the injury imposed and compensatory damages award, suggesting a maximum ratio of 9:1 where compensatory damages are as significant as they were in *Campbell* (more than \$1 million) and there are no other factors permitting a larger award. See *id.* at 425–26. Post-*Campbell*, courts have permitted multiples of as high as 35:1 or 40:1 where compensatory damages are small. See *Mathias*, 347 F.3d at 676–77 (permitting punitive damages award of \$186,000 to each of two plaintiffs where compensatory award was \$5,000 and explaining why *Campbell*'s 9:1 presumptive maximum ratio should not apply) (applying Illinois law); *Kemp v. AT&T*, 393 F.3d 1354, 1364–65 (11th Cir. 2004) (permitting punitive damages of \$250,000 in case with compensatory damages of \$115.05) (applying Georgia law).

60. See, e.g., *New Orleans Ins. Co. v. Piaggio*, 83 U.S. 378, 380 (1872); *Mannheimer Bros. v. Kan. Cas. & Sur. Co.*, 184 N.W. 189, 191 (Minn. 1921); *C. Schmidt & Sons Brewing v. Travelers Ins. Co.*, 90 A. 653, 654 (Pa. 1914). See generally Feinman, *Beyond Bad Faith*, *supra* note 57, at 695–701 (reviewing history and development of bad faith claims).

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extreme, even frivolous, positions that would produce economic gain if successful. If unsuccessful, the consequences for the insurer would be no more severe than merely paying policy limits.

But as the twentieth century progressed, courts became more receptive to the concept of insurer liability exceeding policy limits as a consequence of unreasonable positions, decisions, or conduct by the insurer, even if the regime was not expressly labeled one of “bad faith.”⁶¹ Regarding third-party tort claims subject to insurance, courts began to require insurers to pay the full consequences of breach of the covenant even if that meant imposing damages in excess of policy limits or for injury beyond breach of contract.⁶²

Development of bad faith liability proceeded at a slow pace until mid-century but ramped up considerably through a series of important decisions by the California Supreme Court.⁶³ Other jurisdictions, in particular Arizona, embraced and perhaps even expanded the stronger

Professor Feinman attributes a significant amount of judicial opposition to bad faith actions to the influence of *Hadley v. Baxendale*, 156 Eng. Rep. 145 (1854), famous for its “rule” that a party in breach is not liable for consequential damages unless it has reason to know that its breach would cause such damages and that they were within the contemplation of the parties at the time of contracting. Feinman, *Beyond Bad Faith*, *supra* note 57, at 695–96 (noting that this was a “narrow interpretation” of the case). This judicial error of thought should be emphasized and remembered during modern debates about recovery for insurer misconduct.

Insurers as experienced contracting parties selling products promising home repair, defense against lawsuits (auto-based and other), disability benefits, life insurance proceeds to survivors, and other forms of protection should hardly be surprised that a homeowner burned out from fire is displaced and emotionally distraught if benefits are not paid, or that a policyholder defendant denied a defense or a reasonable settlement becomes subject a judgment exceeding policy limits, or that a disabled policyholder wrongfully denied coverage is both distraught and often unable to make ends meet, as are widows and orphans denied timely payment of life insurance benefits. The “*Hadley* rule” on reasonable foreseeability should never have been seen as a valid basis for limiting extra-contractual liability for the tortious consequences of an unreasonable contract breach that deprives the victimized party of the benefit of the bargain.

61. See, e.g., *G.A. Stowers Furniture v. Am. Indem. Co.*, 15 S.W.2d 544, 547 (Tex. Comm’n App. 1929) (holding that failure to pay policy limits in response to reasonable demand negates protection of the limits and requires the insurer to pay the entire amount of a judgment against the liability insurance policyholder but not using the term bad faith). The duty of an insurer controlling defense of a liability claim regarding settlement continues to be called the “*Stowers* Duty” rather than bad faith.

62. See, e.g., *Hilker v. W. Auto Ins. Co.*, 231 N.W. 257, 258 (Wis. 1930); *Douglas v. U.S. Fid. & Guar.*, 127 A. 708, 711 (N.H. 1924); see also *Brassil v. Md. Cas. Co.*, 104 N.E. 622, 624 (N.Y. 1914).

63. See *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200 (Cal. 1958); *Gray v. Zurich Ins. Co.*, 419 P.2d 168, 173 (Cal. 1966); *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 178 (Cal. 1967).

version of insurer duty reflected in California cases.⁶⁴ By the end of the century, a bad faith regime was established that applied to first-party claims in most states.⁶⁵

But there are differences in the formulation and application of the bad faith concept that can limit its utility. There is, for example, a rough divide between what might be termed a Wisconsin approach and a California approach. In *Gruenberg v. Aetna Ins. Co.*,⁶⁶ the California Supreme Court noted an insurer's obligation of good faith and fair dealing and found it violated if the insurer "unreasonably and in bad faith withholds payment of the claim of its insured."⁶⁷ The court deemed breach of the duty a tort, entitling a successful claimant to compensation for the tortious conduct, including lost earnings from the policyholder business hindered by loss of prompt insurance payments, the cost of defending claims by creditors, and other economic loss sustained as a cause of the insurer's misconduct.⁶⁸ Although not a large part of *Gruenberg*, this tort-based approach permitted recovery of emotional distress damages⁶⁹ and punitive damages,⁷⁰ something ordinarily barred in contract litigation.

64. See, e.g., *Dodge v. Fid. & Deposit Co.*, 778 P.2d 1240, 1244 (Ariz. 1989); *Rawlings v. Apodaca*, 726 P.2d 565, 566 (Ariz. 1986); *Linthicum v. Nationwide Life Ins. Co.*, 723 P.2d 675, 679 (Ariz. 1986); *Sparks v. Republic Nat'l Life Ins. Co.*, 647 P.2d 1127, 1130 (Ariz. 1982); *Noble v. Nat'l Am. Life Ins. Co.*, 624 P.2d 866, 872 (Ariz. 1981); *Farr v. Transamerica Occidental Life Ins. Co.*, 699 P.2d 376, 377 (Ariz. Ct. App. 1984). All of these decisions ruled in favor of policyholders bringing bad faith claims and contained strong language supporting such claims as a means of repairing and discouraging insurer failure to honor policy obligations.

65. See, e.g., *Zilisch v. State Farm Mut. Auto. Ins. Co.*, 995 P.2d 276, 280 (Ariz. 2000) (en banc); *Deese v. State Farm Mut. Auto. Ins. Co.*, 838 P.2d 1265, 1267 (Ariz. 1992); Feinman, *Beyond Bad Faith*, *supra* note 57, at 701–05. See generally 2 RANDY MANILOFF ET AL., GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE 409–513 (5th ed. 2020) [hereinafter MANILOFF ET AL., KEY ISSUES VOLUME TWO] (providing state-by-state description of bad faith doctrine).

66. 510 P.2d 1032 (Cal. 1973).

67. *Id.* at 1038; Feinman, *Beyond Bad Faith*, *supra* note 57, at 700 ("Although there were predecessors, *Gruenberg v. Aetna Insurance Co.* was the landmark case for extending the good-faith duty from third-party to first-party insurance.").

68. See *Gruenberg*, 510 P.2d at 1037–42.

69. See *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 178–79 (Cal. 1967) (allowing recovery of emotional distress damages for insurer bad faith in response to a third-party claim, which is logically available for insurer misconduct in first-party matters as well); see also *id.* at 176–79 (making the insurer responsible for the full amount of judgment against the policyholder, regardless of policy limits, where the insurer's bad faith was a failure to make a reasonable settlement decision).

70. Feinman, *Beyond Bad Faith*, *supra* note 57, at 739 (noting that recovery of punitive damages requires proof of greater misconduct such as fraud, oppression, or malicious behavior).

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Taking a slightly different tack, the Wisconsin Supreme Court in *Anderson v. Continental Insurance Co.*⁷¹ held that to prevail in a bad faith claim, the policyholder must demonstrate “the absence of a reasonable basis for denying the claim,”⁷² a formulation that has come to be known as the “fairly debatable” test in which the insurer may avoid bad faith liability so long as its coverage or valuation position was fairly debatable, which implies at least some reasonable argument for the position.⁷³ The Wisconsin *Anderson* line of cases—which represents the majority approach⁷⁴—reflect judicial hesitancy to find a breach of covenant of statute merely because the insurer’s coverage or valuation position does not prevail.

Insurers argue that under the approach taken in *Anderson* and similar opinions, an insurer cannot have acted in bad faith or engaged in unfair claims handling if its position in a dispute is “fairly debatable.” That view is oversimplified and outright wrong unless one recognizes that not every articulated rationale for denying or diminishing coverage is reasonable simply because it can be enunciated. The insurer position must at least satisfy Rule 11 of the Federal Rules of Civil Procedure⁷⁵ and Rule 3.1 of the ABA Model Rules of Professional Conduct⁷⁶ as a non-frivolous position.⁷⁷

In addition, a focus solely on whether an insurer’s coverage position is colorable overlooks a wide range of insurer obligations regarding adequate communication, investigation, evaluation, and even-handed claims processing. Insurers’ failure to adequately fulfill these duties breaches the covenant even if the carrier’s ultimate coverage or payment position is arguable. As Professor Feinman notes:

The fundamental error is to view the standard for judging claim practices as stating only a requirement that, evaluated after the fact, there is an objectively reasonable basis for the denial of the

71. 271 N.W.2d 368 (Wis. 1978).

72. *Id.* at 377.

73. See Feinman, *Beyond Bad Faith*, *supra* note 57, at 702–05 (analyzing the Wisconsin and California approaches and their followings in the states).

74. See *id.* at 702.

75. FED. R. CIV. P. 11.

76. MODEL RULES OF PRO. CONDUCT r. 3.1 (AM. BAR ASS’N 1983).

77. For example, if an insurer refuses to cover a frozen pipes claim because the policyholder’s decision to turn off the heat to save money in Minnesota in March in response to a favorable weather forecast was foolish, the position is so demonstrably incorrect that it cannot qualify as a fairly debatable matter. Unless specifically excluded, mere negligence by the policyholder does not prevent coverage. The very purpose of property insurance is to protect against unlucky breaks. So long as there was not specific intent to inflict damage, a policyholder’s poor decision-making does not defeat coverage.

claim; the correct view focuses on whether the company *acted reasonably* in denying the claim. Acting reasonably first requires that the company fully and fairly investigate the claim and use that investigation as the basis for a reasonable evaluation of the claim. Acting reasonably requires that the company fully and objectively evaluate the factual information relevant to the claim, interpret the relevant policy language, and apply the controlling law.

Therefore, when a company claims that it acted reasonably in denying a claim, it really must have done so. . . . [I]f those reasons [given by the insurer] are asserted as mere subterfuges for opportunistic behavior, they should be ignored and the company found to have acted unreasonably, but opportunism is not required; unreasonable conduct—the failure to give an “honest and informed judgment”—is itself a violation.

* * *

The genuine dispute rule is subject to misinterpretation, has been misapplied in a number of settings, and needs to be properly understood. Of course, the insurer has not acted unreasonably where it fails to pay a claim because it genuinely and reasonably disputes the claim. However, the inquiry into whether a dispute is genuine is not purely a mechanical determination whether there is an objectively reasonable basis for denying a claim; if an insurer has acted unreasonably in making that determination, it has violated the standard of good faith, even though such reasons might exist. And, as above, a genuine dispute can arise only after a reasonable investigation.

* * *

. . . The general rule in the interpretation of insurance policy terms is that in cases of ambiguity, the insured’s interpretation is to be preferred. Subsidiary rules support this position, such as the rule that language of exclusion is to be interpreted narrowly. These rules are based on the principle of *contra proferentem* and, with respect to the claim process, are also supported by a more general understanding of the insurance relation. In evaluating a claim, the company must give the insured’s interests at least as

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much weight as it gives its own, so that in cases of reasonable dispute, it cannot prefer its own interpretation.⁷⁸

Although less favorable to policyholders than the California approach, the Wisconsin/genuine dispute approach, if properly understood in this manner, should not mean that any proffered reason for claim denial will suffice. And the California/*Gruenberg* approach, despite being more favorable to policyholders, reflects similar reluctance to inflict extra-contractual liability upon insurers merely for being wrong.⁷⁹ But compared to the Wisconsin approach, California law is more

78. Feinman, *Beyond Bad Faith*, *supra* note 57, at 730–33 (footnotes omitted). I quote Feinman at length because I find it a particularly good and succinct criticism of the *Anderson* articulation of the genuine dispute approach. Accord Marc S. Mayerson, “First Party” Insurance Bad Faith Claims: Mooring Procedure to Substance, 38 TORT TRIAL & INS. PRAC. L.J. 861, 874 (2003) (making similar criticisms of fairly debatable standard and arguing for stronger standard that focuses more on insurer conduct and less on whether it can produce an ostensibly reasonable argument in favor of its coverage or payment position same); see also Jay M. Feinman, *The Regulation of Insurance Claim Practices*, 5 U.C. IRVINE L. REV. 1319, 1347–48 (2015) [hereinafter Feinman, *Regulation*] (restating criticisms of fairly debatable test in shorter form, stating that “the fairly debatable rule fails to provide adequate incentives to enforce standards,” noting that under the pre-IFCA New Jersey regime of *Pickett v. Lloyd’s*, only five cases of first-party bad faith survived summary judgment and “only *Pickett* itself involved a claim that was successful before a jury” and concluding that “the appropriate liability rule is that an insurer must promptly, fairly, and objectively process, investigate, evaluate, and resolve the claim” which “includes the responsibility to use the insurer’s own resources to investigate rather than simply relying on its insured or others”); Jay M. Feinman, *The Insurance Relationship as Relational Contract and the “Fairly Debatable” Rule for First-Party Bad Faith*, 46 SAN DIEGO L. REV. 553, 562–71 (2009) (finding that the fairly debatable test fails to appreciate relational nature of insurance policies and policyholder vulnerability to opportunistic behavior by insurers).

79. See, e.g., *Pinto v. Farmers Ins. Exch.*, 276 Cal. Rptr. 3d 13, 21 (Ct. App. 2021) (holding insurer’s failure to accept a reasonable settlement offer by claimant is not per se unreasonable behavior or bad faith by insurer; insurer’s “duty to accept a reasonable settlement offer is not absolute”); *Graciano v. Mercury Gen. Corp.*, 179 Cal. Rptr. 3d 717, 725 (Ct. App. 2014) (finding “mere” errors by insurer in discharging obligations do not necessarily constitute bad faith or subject insurer to liability); *Walbrook Ins. Co. v. Liberty Mut. Ins. Co.*, 7 Cal. Rptr. 2d 513, 521–22 (Ct. App. 1992) (determining insurers are not subject to strict liability for declining settlement offer within policy limits when later trial results in judgment exceeding policy limits; policyholder must prove not merely mistake but unreasonable conduct or decision-making).

Wisconsin has been more openly skittish about imposing extra-contractual liability upon insurers. See *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 377 (Wis. 1978) (voicing fear that bad faith liability for erroneous claims decisions could “result in extortionate lawsuits”). *Anderson* read *Hilker v. Western Auto Ins.*—a key early bad faith decision involving claims handling by a liability insurer—as requiring intentional misconduct by the insurer and reasoned that there could not be an intentional breach of the covenant of good faith if the insurer could proffer a reasonable argument for its position. See *Anderson*, 271

explicit in establishing that an insurer's claim position must be the result of a timely, fair, adequate investigation and that an arguable disputing position alone does not immunize the insurer from bad faith or unfair claims handling liability.⁸⁰

Distilled, it appears the national common ground regarding bad faith is that the insurer must not deprive the policyholder of the benefit of the bargain and must do a minimally adequate job of timely claim response, effective communication, sufficient investigation, and reasonable assessment of a claim (as to both coverage and valuation). Where the insurer fails to do this with actual or constructive knowledge of its failings or in reckless disregard of its obligations, bad faith liability is apt.

Reading cases at large, differences in application emerge. The courts most favorable to insurers require something akin to subjectively intended failure to meet the minimum standard of care. Courts more favorable to policyholders find it sufficient if the insurer's conduct has been reckless or perhaps even grossly negligent in disregarding its duty to the policyholder, including the requirement that the insurer give equal consideration to the interests of the policyholder. Some courts may even find a strict liability approach: either the insurer satisfied the minimum standard of claims handling care, or it did not; state of mind matters little if at all. Policyholder protection for insurer actions can vary substantially based on which of these approaches is used.

D. *Unfair Claims Settlement Practices Acts*

Even before the modern expansion of the bad faith tort remedy, states often enacted some form of fair claims handling statutes. New Jersey's

N.W.2d at 375 (citing *Hilker v. W. Auto Ins. Co.*, 231 N.W. 257 (Wis. 1930), *aff'd on reh'g*, 235 N.W. 413 (Wis. 1931)).

But this *Anderson* reading of *Hilker*, although now likely too established to be reconsidered, is arguably a misreading, or at least a pro-insurer strained reading. *Hilker* stated that the claims process required reasonableness and honesty by the insurer, which presumably means reasonable claims handling as well as a coverage or valuation position sufficiently reasonable to qualify as fairly debatable. See *Hilker*, 235 N.W. at 415 (stating that the insurer's decision "should be the result of the weighing of probabilities in a fair and honest way" and "it must be based upon a knowledge of the facts and circumstances upon which liability is predicated, and upon a knowledge of the nature and extent of the injuries so far as they reasonably can be ascertained").

80. See, e.g., *Zilisch v. State Farm Mut. Auto. Ins. Co.*, 995 P.2d 276, 280 (Ariz. 2000) (finding that fair debatability is a necessary but not sufficient condition for satisfying covenant; adequate investigation, evaluation, and process of claim are relevant to the bad faith inquiry); *Sanderson v. Am. Fam. Mut. Ins. Co.*, 251 P.3d 1213, 1217-18 (Colo. App. 2010) (stating that fair debatability is not threshold inquiry whose outcome is determinative as a matter of law).

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first emerged in 1947 but was largely symbolic, in that it not only lacked a private right of action but appears not to have been vigorously enforced by state insurance regulators.⁸¹ Policyholder protection statutes began to move closer to center stage with the Model Unfair Claims Settlement Practices Act promulgated by the National Association of Insurance Commissioners (“NAIC”) in 1971.⁸² It was revised in 1990, and again into its current form in 1997.⁸³ The Model Act, adopted in some form in nearly all states, and in its New Jersey format, provides that specifically enumerated misconduct will be considered an “[u]nfair claim settlement practice[]” if it is done “with such frequency as to indicate a general business practice.”⁸⁴ These include:

- (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- (b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

81. A rather broad LEXIS search (“court (new jersey) and name (insur! or assur! or Lloyd! or fidelity or surety or casualty and unfair claims settlement or unfair claims practices”) (conducted Aug. 24, 2022) reveals not a single case involving the 1947 version of the Act. It is of course possible that state insurance regulators were enforcing the law informally or in less digitized administrative proceedings that did not result in litigation, but I am skeptical. The same LEXIS search examining cases after 1971 produces sixty-three cases involving an allegation of violation of the modern New Jersey UCSPA, beginning in 1979. *See, e.g., In re Midland Ins. Co.*, 400 A.2d 813, 819 (N.J. Super. Ct. App. Div. 1979) (upholding \$79,000 penalty imposed by Commissioner of Insurance for bail bond insurer’s failure to make prompt payments). *Midland’s* application of the law to sureties was subsequently overruled by regulation. *See U.S. Sewer & Drain, Inc. v. Earle Asphalt Co.*, No. 15-1461, 2015 U.S. Dist. LEXIS 70178, at *5–6 (D.N.J. June 1, 2015) (stating that “the holding in *In re Midland* with regards to the applicability of the UCSPA to sureties was overruled by N.J.A.C. 11:2–17.2, a regulation promulgated in 1982,” which stated that the law does not apply to policies of “ocean marine, fidelity and surety, boiler and machinery and workers’ compensation insurance”).

82. Julia Kagan, *Unfair Claims Practice*, INVESTOPEDIA (Oct. 20, 2021), <https://www.investopedia.com/terms/u/unfair-claims-practice.asp>.

83. UNFAIR CLAIMS SETTLEMENT PRACTICES ACT (NAIC 1997).

84. N.J. STAT. ANN. § 17:29B-4 (West 2022). Although stronger than its predecessor, the New Jersey UCSPA has had limited utility. As discussed above, *see supra* note 81, sixty-three cases in more than forty years does not reflect particularly vigorous use of the UCSPA for disciplining insurers—not only because of its lack of a private right of action, but also because it suggests no need for additional remedies for policyholders. *See, e.g., Milcarek v. Nationwide Ins. Co.*, 463 A.2d 950, 954–55 (N.J. Super. Ct. App. Div. 1983) (refusing to permit policyholders to recover punitive damages against insurer for breach of insurance policy because UCSPA already provides sufficient deterrence).

- (c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- (d) Refusing to pay claims without conducting a reasonable investigation based upon all available information;
- (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;
- (h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;
- (i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;
- (j) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;
- (k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- (l) Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

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(m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(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;

(o) Requiring insureds or claimants to institute or prosecute complaints regarding motor vehicle violations in the municipal court as a condition of paying private passenger automobile insurance claims.⁸⁵

The New Jersey adaptation of the claims conduct law also defines the following as unfair and deceptive practices: (1) misrepresentations and false advertising of policy contracts; (2) false information and advertising generally; (3) defamation; (4) boycott, coercion and intimidation; (5) false financial statements such as false accounting entries; (6) over-promising of investment returns; (7) unfair discrimination; as well as (8) regulating rebates between insurers and agents.⁸⁶

In addition to the language of the Model Act, approximately thirty enacting jurisdictions added a provision establishing a violation of the Act when the insurer delays payment “where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.”⁸⁷ Also, commonly added is a prohibition on the insurer “[m]aking known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.”⁸⁸

Like its predecessors, the current Act is often largely precatory unless actively enforced by state insurance regulators, because

85. N.J. STAT. ANN. §§ 17:29B-4(9)(a)–(o). The “regular business practice” provision of the New Jersey version of the Act provides insurers with another avenue of defense in that the insurer may argue that the poor treatment received by a policyholder was an isolated event not in keeping with company norms. This limitation on applicability of the Act is eliminated in some state versions of the Act. *See, e.g.*, NEV. REV. STAT. § 686A.310 (2022).

86. *See* N.J. STAT. ANN. §§ 17:29B-4(1)–(8).

87. *See, e.g.*, NEV. REV. STAT. § 686A.310(1)(l); *see also* WILLIAM T. BARKER & RONALD D. KENT, *NEW APPLEMAN INSURANCE BAD FAITH LITIGATION* § 10.04 (2d ed. 2022).

88. *See, e.g.*, NEV. REV. STAT. § 686A.310(1)(j); *see also* BARKER & KENT, *supra* note 87, § 10.03.

approximately half the states do not provide for a private right of action by the policyholder or its assignee. To be fair, the mere existence of the Act still aids policyholders in that it logically deters insurers from misconduct for fear of attracting regulator interest. But given the limited resources of regulators, the Act's deterrence is inevitably weakened by the absence of a private right of action.

In the states (the exact count requires some interpretation)⁸⁹ permitting a private right of action, which now includes New Jersey in part, the Act has some actual clout. The statutory duties and language spell out insurer conduct requirements in a manner that may not be reached by the bad faith doctrine in all states and provide another avenue of damages.

Within the realms of both regulatory and private enforcement, states also divide as to the number, amount, and instances of misconduct necessary to trigger application of the statute. Many states require something akin to a pattern or practice of insurer misconduct while others treat a single violation as actionable by either regulators or aggrieved policyholders.⁹⁰

As with the common law bad faith tort, there is also inter-state division over whether there can be a statutory violation if the

89. By my count, it appears that nearly half the states (twenty-four) permit some sort of private right of action for violation of statutory fair claims handling duties. *See, e.g.*, FLA. STAT. § 624.155 (West 2022); *see also* UNITED POLICYHOLDERS, 50 STATE SURVEY OF BAD FAITH LAWS AND REMEDIES 9–97 (2014), <https://uphelp.org/wp-content/uploads/2020/09/Final-Bad-Faith-Survey-1.pdf>. The contour of the statutes regarding liability and remedies varies. For example, in Hawai'i, it applies only to automobile claims, while in Maryland, there is a cap on counsel fees at one-third of actual damages. UNITED POLICYHOLDERS, *supra*, at 29, 44. Minnesota limits any recovery beyond policy limits to one-half damages in excess of limits up to a maximum of \$250,000. *Id.* at 50. Missouri limits are based on the percentage of contract damages but are not particularly draconian, with a maximum of ten percent of such damages exceeding \$1,500. *See* INT'L ASS'N OF DEF. COUNS., 50 STATE INSURANCE AND BAD FAITH QUICK REFERENCE GUIDE 1 (2014) [hereinafter BAD FAITH QUICK REFERENCE GUIDE], https://www.iadclaw.org/assets/1/7/50_State_Insurance_Bad_Faith_Reference_Guide.pdf.

90. *See generally* Victor Schwartz & Christopher E. Appel, *Common-Sense Construction of Unfair Claims Settlement Statutes: Restoring the Good Faith in Bad Faith*, 58 AM. U. L. REV. 1477 (2009) (reviewing differing applications of UCSPA; arguing against finding of violation for isolated failure or mistake by insurer); Gerald M. Sherman & Richard R. Crowl, *The Judicial Response to Unfair Claims Practices Laws: Applying the National Experience to the Minnesota Act*, 12 WM. MITCHELL L. REV. 45 (1986) (reviewing approaches of different states and courts); Thomas C. Cady et al., *The Law of Insurance Company Claim Misconduct in West Virginia*, 101 W. VA. L. REV. 1 (1998) (stating that an insurer is not liable under the Act unless it committed violations with such frequency as to indicate a general business practice).

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policyholder is unable to establish coverage.⁹¹ And as with the bad faith tort, the correct position is that coverage is not necessary, although the absence of coverage (as well as items such as policyholder emotional distress, lost work, etc.) obviously can impact the size of any damage award for insurer mistreatment.

Further refinement and differentiation of state versions of the NAIC Model Act can come from state administrative regulations. In every state, the insurance statutes are supplemented by state administrative code provisions,⁹² but these of course vary regarding their application of statutory regulation.

E. General Consumer Protection and Procedural Statutes

Unfair claims practices acts are by definition aimed at insurers alone or (sometimes) their agents or intermediaries as well. But many states have general consumer protection of ethical business conduct statutes, typically labeled Unfair and Deceptive Practices (“UDAP”) statutes that courts sometimes find applicable to insurance claims.⁹³

In addition, certain facially neutral procedural statutes or rules tend to benefit policyholders more than insurers. For example, a claimant is typically able to recover prejudgment interest on an award, frequently at

91. See TODD S. SCHENK, TRESSLER LLP, STATE-BY-STATE ANALYSIS: BAD FAITH IN THE ABSENCE OF COVERAGE (2016), https://www.tresslerllp.com/docs/default-source/Publication-Documents/50_state_bad_faith_in_the_absence_of_coverage.pdf?sfvrsn=0 (providing a fifty-State survey by national law firm reflecting division over the issue). Compare *LeRette v. Am. Med. Sec., Inc.*, 705 N.W.2d 41, 48–49 (Neb. 2005) (stating that where facts of a bad faith claim differ sufficiently from facts of a breach of contract/coverage claim, coverage is not required for pursuit of a bad faith claim), and *Klepper v. ACE Am. Ins. Co.*, 999 N.E.2d 86, 98–99 (Ind. Ct. App. 2013) (permitting bad faith claim to proceed where court had ruled that an insurer was not required to provide coverage), with *Zarrella v. Minn. Mut. Life Ins. Co.*, 824 A.2d 1249, 1261 (R.I. 2003) (stating that a policyholder must first establish coverage before “he or she can prove that the insurer dealt with him or her in bad faith”), and *Davis v. GHS Health Maint. Org.*, 22 P.3d 1204, 1210 (Okla. 2001) (deciding that coverage is a prerequisite to bad faith recovery).

92. See, e.g., NEV. ADMIN. CODE § 686A.660 (2022) (barring misrepresentation of policy provisions); *id.* § 686.665 (requiring prompt insurer acknowledgment of claim); *id.* § 686A.670 (setting standards for investigation of claims); *id.* § 686A.675 (imposing additional requirements upon insurers and payment of undisputed amount where claim is that the insurer and policyholder differ as to value of loss or amount of damages “except for a claim involving health insurance”); *id.* § 686A.680 (setting additional standard for automobile insurance claims).

93. See generally CAROLYN L. CARTER, NAT’L CONSUMER L. CTR., CONSUMER PROTECTION IN THE UNITED STATES: A 50-STATE REPORT ON UNFAIR AND DECEPTIVE ACTS AND PRACTICES STATUTES 5, 13 (2009), https://www.nclc.org/wp-content/uploads/2022/08/report_50_states.pdf.

a rate of interest higher than that prevailing in the marketplace.⁹⁴ Ordinarily, policyholders are the ones pursuing a monetary award and thus eventually will obtain prejudgment interest if successful.⁹⁵ The same holds true for post-judgment interest,⁹⁶ should the party responsible for paying a judgment (usually the insurer rather than the policyholder) be slow in paying.

States may also provide for shifting of counsel fees to prevailing parties.⁹⁷ This is typically by rule or statute but occasionally takes place via common law and may be generally applicable or particular to insurance disputes.⁹⁸ To prevail under most fee shifting schemes, a policyholder must of course prevail, at least in substantial part, submit sufficiently detailed records, and obtain court approval, which can include reduction of the fees claimed. But as discussed below, counsel fee shifting awards are often bilateral and may entitle a prevailing insurer to counsel fees.⁹⁹

94. See, e.g., N.J. CT. R. 6:6-3(a) (setting post-judgment interest at “the average rate of return to the nearest whole or one-half percent,” of the State Cash Management Fund, which was 1.5 percent in 2021, an amount that could easily undercompensate policyholders waiting for payment by an insurer); N.J. CT. R. 4:42-11; NEV. REV. STAT. § 17.130 (2022) (setting pre-judgment interest rate of “the prime rate at the largest bank” in the state as determined by the Commissioner of Financial Institutions plus 2 percent, which was 5.25 percent in 2021).

These rules and statutes are generally considered substantive law under the Rules of Decision Act, 28 U.S.C. § 1652, and the *Erie* Doctrine, see *Erie R.R. v. Tompkins*, 304 U.S. 64, 78 (1938), and thus apply in both federal and state court. This is helpful for policyholders in that insurance disputes are generally governed by state law, but insurer-policyholder disputes often satisfy diversity of citizenship jurisdiction and thus can be removed to federal court even if originally commenced in state court. See 28 U.S.C. §§ 1441–47.

95. At the risk of pointing out the obvious, the typical insurer objective in claims/coverage litigation is to avoid or reduce payment, while the typical policyholder objective is payment for injuries and perhaps bad faith or statutory damages. Rarely will an insurer plead and prove tortious injury by a policyholder. See N.J. STAT. ANN. § 6:6-3 (West 2022).

96. Prevailing parties are uniformly entitled to post-judgment interest on the award unless the judgment is paid within a prescribed period. See, e.g., 28 U.S.C. § 1961 (determining the rate to be “equal to the weekly average [one]-year constant maturity Treasury yield . . . for the calendar week preceding. [sic] the date of judgment” (footnote omitted)); N.J. STAT. ANN. § 4:42-11(a) (West 2022) (using the same formula used for pre-judgment interest); NEV. REV. STAT. § 17.130 (2022) (using the same formula used for pre-judgment interest).

97. See, e.g., NEV. REV. STAT. § 18.010(2) (2022) (providing that a court “may” award counsel fees to a prevailing party that recovers \$20,000 or less as well as in cases where claims are brought “without reasonable ground”).

98. *Id.*

99. *Christiansburg Garment Co. v. EEOC*, 434 U.S. 412, 422 (1978).

2022] *NEW JERSEY INSURANCE FAIR CONDUCT ACT* 215*F. Shortcomings of the Current Regime*

Although the array of substantive and procedural weapons available to policyholder claimants are significant, at times even substantial, they are nonetheless limited. Some of the factors favoring policyholders most of the time/much of the time/at times may depend upon the particular dispute. The attorney fee shifting regime discussed above is one example. Contract construction canons may work the same way where disputed unclear language was drafted by a policyholder or its broker rather than the insurer. Similarly, extrinsic evidence or objectively reasonable expectations may support the insurer rather than the policyholder.

Unfair claims practices and consumer protection statutes by contrast are largely “one-way” in that they provide benefit to policyholders and impose burden on insurers.¹⁰⁰ But these benefits and burdens, largely in place for the past fifty years, have not been sufficiently weighty to neutralize the heavy advantages possessed by insurers in their dealings with policyholders.¹⁰¹

To a certain degree, insurance is “just like” any other business that creates a product, advertises it, sells it, and services it. But even as compared to mainstream, image-fomenting, feel good, contentless advertising in general, insurer advertising is particularly uninformative. Insurance advertising and marketing is long on image and assurance (selling “peace of mind” if you will) but short on specifics. The viewer is assured that he or she will be protected by the insurer but is told nothing about what constitutes basic coverage, what options might be available, and certainly is not informed about price, insurer ability to cancel or deny renewal, the prospect of claim denial, and the insurer’s control of any claims against the policyholder.¹⁰²

100. Brian E. O'Donnell, et al., *The New Jersey Insurance Fair Conduct Act Means Big Changes for NJ Auto Insurers*, RIKER DANZIG SCHERER HYLAND PERRETTI, LLP (Jan. 21, 2022), <https://riker.com/publications/the-new-jersey-insurance-fair-conduct-act-means-big-changes-for-nj-auto-insurers/>.

101. *Id.*

102. Some insurer advertising can be affirmatively detrimental to policyholders. For example, for the past several years, Liberty Mutual has been using its “LIMU Emu” to encourage policyholders to “only pay for what you need” when purchasing insurance. See generally Liberty Mutual, *Wedding LiMu Emu & Doug Liberty Mutual Insurance Commercial*, YOUTUBE (Apr. 21, 2022), https://www.youtube.com/watch?v=R_t9mqUJpAc. Animal mascot kitsch aside, the problem with this approach is that the average consumer has no idea what scope of insurance coverage is required for adequate protection. Insurers are the experts in this regard and should at least be providing policyholders with a presumptive amount of what the insurer deems adequate coverage. Fortunately, basic form insurance policies, including automobile policies, tend to do this by including things the typical consumer would not, such as debris removal and loss of use coverage if a building is not touched but damaged elsewhere or if a government order prevents use of the building.

Compared to the average vendor, insurers have strong transactional advantages relative to their customers. Typical consumer transactions allow the buyer to assess the product or service at close range, make a preliminary assessment, and often pay only after receiving the product or service and being satisfied.¹⁰³ Consider purchases of food, clothing, and even shelter.

A shopper at the grocery store can, for example, look at baked goods, meats, produce, and dairy products and make at least some evaluation of their wholesomeness. After purchase, if the milk is spoiled or an apple rotted underneath the skin, the shopper can demand a refund or take business to a nearby competing grocer. Even in an era of online shopping that requires prepayment, the buyer, aided by the market and the vendor's interest in maintaining customers and a good reputation, a shopper has significant leverage regarding many purchases (food, entertainment, clothing, education). Where buyers have immediate experience with the quality of goods (e.g., clothing) or services (e.g., newspaper delivery) and repeated patronage is essential to vendor success, consumers can informally police vendor negligence or misconduct.

By contrast, insurance is sold as a promise based on contingencies to consumers who usually understand the insurance arrangement and policy provisions considerably less well than they do consumer staples. Even a rather dull consumer can see if bananas are bruised, bread or cheese has mold, etc. And this same dull consumer can also quickly evaluate goods used at home in the wake of purchase and then exert consumer leverage for frequently used products, leverage that becomes significant if a sufficient number of consumers make frequent use of such products and have had similar experiences with the vendor.¹⁰⁴

However, there remain aspects of risk and insurance where the customer retains some choice and where following the implicitly minimalist approach of the LIMU Emu can easily lead to adverse outcomes for the policyholder. In purchasing auto insurance, for example, the policyholder may unwisely opt for low policy limits, decline UM/UIM coverage, and reject comprehensive coverage. Although there can be situations in which the policyholder is better off buying disability insurance rather than spending the money on UM/UIM coverage and self-insuring for glass broken by vandals or a rock thrown loose by a passing truck, these are in my view comparatively rare. And low policy limits almost never make sense unless the policyholder is planning to be in a collision and "set up" the insurer for a bad faith/unfair claims handling lawsuit.

103. See Feinman, *Regulation*, *supra* note 78, at 1321–23 (labeling this aspect of the relationship "Information Problems").

104. Even housing purchases are more consumer-friendly than insurance. Although there may be hidden problems with a home or apartment, visual inspection provides a wealth of information easily understood by the average buyer. In addition, the home must be inspected by an expert evaluator as a condition of sale. Even if the realtor is retaining a friendly inspector disinclined to impede sales, minimum professional standards and a need

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When the consumer/applicant/policyholder buys insurance, she has relatively little notion of the contingent risks for which she seeks protection. Although purported information asymmetry can lead to adverse selection, this concern is probably overstated unless the prospective policyholder is verging on scamming the insurer by, e.g., seeking to purchase insurance on a planned risk of known magnitude (e.g., planning a marijuana growing facility in the basement of an insured home, in which case the policy's crime (in most states), business pursuits, or vandalism exclusion may prevent coverage).¹⁰⁵ Most purchasing policyholders are not engaged in insurance fraud and do not know more about the risk facing property than their insurers. The average driver purchasing automobile insurance is unlikely to know even the most basic statistics regarding driving risk and the costs of collisions. The average insurer will have extensive loss data from which it can gauge future risks.¹⁰⁶

For example, a policyholder in rural Northern California may realize that there is risk of loss due to wildfire. The insurer has precise historical loss data and other information with which it can calculate the risk.¹⁰⁷ In this "gamble" about risk of loss, the insurer is akin to the casino and the policyholder the recreational player. To be sure, there can be specific instances where the policyholder knows something specific that affects risk (e.g., the cracking noise from a key support beam in the house), but

for both to retain a good reputation, usually ensures that the buyer is not acquiring a "money pit" home on the verge of collapse or requiring immediate extensive work (unless the home is specifically marketed as a tear-down or fix-up project).

105. See generally Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004); Tom Baker & Peter Siegelman, *Behavior Economics and Insurance Law: The Importance of Equilibrium Analysis*, in THE OXFORD HANDBOOK OF BEHAVIORAL ECONOMICS AND THE LAW 491 (Eyal Zamir & Doran Teichman eds., 2014); Liran Einav & Amy Finkelstein, *Selection in Insurance Markets: Theory and Empirics in Pictures*, 25 J. ECON. PERSPS. 115, 124 (2011).

106. See *Big Data*, NAT'L ASS'N OF INS. COMM'RS, <https://content.naic.org/cipr-topics/big-data> (Nov. 10, 2022) ("As insurers collect more granular data about insurance consumers, state insurance regulators need greater insight into what data is available to the industry, how it is being used, and whether it should be used by insurers. . . . While the use of big data can aid insurers' underwriting, rating, marketing, and claim settlement practices, the challenge for insurance regulators is to examine whether it is beneficial or harmful to consumers.") (raising privacy concerns); Peter Siegelman, *Information and Equilibrium in Insurance Markets with Big Data*, 21 CONN. INS. L.J. 317, 317 (2014) [hereinafter Siegelman, *Information and Equilibrium*] ("Big Data techniques might lead to a 'flip' in informational asymmetry, resulting in a situation in which insurers know more about their customers than the latter know about themselves."); LOSS DATA ANALYTICS: AN OPEN TEXT AUTHORED BY THE ACTUARIAL COMMUNITY 9 (2018), <https://instruction.bus.wisc.edu/jfrees/UWCAELearn/LossDataAnalytics/LossDataAnalytics.pdf> ("Insurance is a data-driven industry.").

107. Siegelman, *Information and Equilibrium*, *supra* note 106, at 317.

that is the exception. Contrary to the conventional wisdom of insurer risk due to adverse selection, insurers ordinarily have an informational advantage about risk in general and can use it to charge premiums based on overwrought customer fears while also charging adequately protective premiums for risks undervalued by consumers.¹⁰⁸

Unlike most vendors, the insurer typically is able to sell its wares without even providing a sample of the wares. For most insurance purchases, the written policy is not provided to the policyholder until after purchase, sometimes weeks or months after purchase.¹⁰⁹ Many states require insurers to post exemplar policies online, but this imposes another layer of search and evaluation costs on the policyholder.¹¹⁰

Even a motivated policyholder obtaining and reading a policy will probably not fully understand many of the provisions of the policy. Agents may be helpful as interpreters, but they have a sales incentive to soft-pedal limitations on coverage and are not infallible in their assessments, even if surmounting self-interest. Further, there is no guarantee that their assurances will be seen by courts as binding the company. Even if encouraged to be helpful to the prospective policyholder by the desire to make a sale, insurance agents are afflicted with divided loyalties and will more likely resolve disclosure conflicts in favor of their employers rather than an isolated customer.¹¹¹ When purchasing typical

108. *See id.*

109. For example, in the insurance coverage dispute surrounding the terrorist attack on the World Trade Towers in 2001, the property insurance at issue had been purchased in July 2001, but the policy had not been issued as of the time of the attacks. Consequently, a key portion of the case was decided based on the language of the “binder,” or receipt of purchase, issued by the insurance broker. *See* Jeffrey W. Stempel, *The Insurance Aftermath of September 11: Myriad Claims, Multiple Lines, Arguments over Occurrence Counting, War Risk Exclusions, the Future of Terrorism Coverage, and New Issues of Government Role*, 37 TORT & INS. L.J. 817, 823 n.19, 832–34 (2002) (describing the controversy). This two-month delay is a more extreme version of normal policy placement resulting in part from the need to memorialize a complex policy involving multiple insurers and lawyers of coverage. But even for simple insurance transactions, policyholders tend to purchase based on a summary of benefits or an oral discussion with an agent, with the actual policy arriving a significant time later. This has been the case for every automobile or homeowner’s policy I have ever purchased.

110. *See* Daniel Schwarcz, *Re-Evaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263, 1267–68, 1329–32 (2011) (explaining that a search of homeowner’s policies posted online reveals substantial differences in policy language in coverage). Professor Schwarcz’s research received justifiable attention and praise (it was covered by the *New York Times*, *Wall Street Journal*, and cited in legal scholarly literature sixty-two times—a large amount of attention for one article in a specialized field—as of October 8, 2022 via LexisNexis search). But I am not confident that the average consumer, or even a very inquisitive consumer, would replicate Professor Schwarcz’s energy for comparing policies.

111. Professor Feinman notes this as one of a number of “Agency Problems.” *See* Feinman, *Regulation*, *supra* note 78, 1323–25.

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insurance policies, the average consumer is unlikely to retain counsel and pay for legal analysis of policy meaning that many counter-balance agency or information asymmetry issues.

Even commercial policyholders seldom retain legal counsel to assess policy provisions at time of purchase and instead limit their evaluation of policy coverage to what they are told by the insurance broker.¹¹² The broker is technically an agent of the applicant/policyholder but is often paid commission by the insurer as well as having certain agency responsibilities (e.g., premium collection; policy transmittal) to the insurer, a situation that makes the broker something less than an unconflicted champion for the policyholder.

Even if insurance consumers could regularly invest the resources required for policy and coverage evaluation, they would remain at a disadvantage relative to insurers because the average policyholder has relatively few instances where it must “use” the insurance product by requesting defense of a lawsuit or making a claim for property damage, disability benefits, or death benefits. Except for commercial policyholders that generate a large number of liability claims (e.g., trucking companies, manufacturers, livery companies (Uber and Lyft as well as taxis)), even commercial policyholders have little claims experience by which they can judge the performance of the insurer. Individual consumers have practically none. A home fire or a lawsuit is a rare event in the populace and an individual policyholder is unlikely to have more than one such matter during an adult life.

Under these circumstances, it is difficult for the individual policyholder to determine the precise contours of coverage or the quality of insurer conduct. To be sure, the objectively reasonable policyholder has an understanding of what has been purchased and there exists some reputational information about most large insurers. But the policy is unlikely to be read, and if read its meaning at the margins may be uncertain. One need only look at the different interpretations courts give to the very same policy language to realize that even the “painstaking”

112. In twenty-five years of expert witness and consulting work, I have reviewed scores of insurance placement materials, and in all but a few cases, the policyholders—even large, purportedly sophisticated commercial policyholders—have not retained coverage counsel to aid in analyzing coverage or policy forms. The norm is reliance on the broker, who in turn may often rely on insurer representations without close reading of policy language. For consumers, the norm is reliance on a retail agent’s statements and short summaries or brochures regarding the policy. This does not necessarily mean that there has been no legal analysis. Some broker, insurer, or policyholder (e.g., in-house counsel) employees may be involved and have examined the contours of coverage. But, at the purchasing stage, formal retention of outside counsel specializing in insurance coverage is rare.

study of policy text, discussed by Professor Keeton, does not provide certainty for the policyholder.¹¹³

More important is that, at the time of policy purchase, the policyholder has no idea how her insurer will respond to a claim. A very ambitious policyholder could scour insurance regulatory files to the extent they are open to the public. For example, regulators do conduct market conduct examinations of insurers, but these are relatively infrequent and not widely known to consumers. A prospective policyholder could, of course, research customer commentary (à la checking the Yelp reviews for a restaurant), which may be facilitated in part by an online insurance realtor.

The prospective policyholder could also look at court records or court decisions to see if specific insurers seem more or less willing to pay claims. But this would entail paying the costs of PACER or equivalent services, or having access to Westlaw, LexisNexis, or LexMachina as well as the human search costs involved. Unsurprisingly, individual policyholders—and most commercial policyholders—seldom engage in this sort of exploration of insurer treatment of claims.

Absent a most unusual individual policyholder, this depth of research will not occur. And even if it did, it would be no guarantee that the policyholder's insurer would respond to a future claim in the predicted manner.¹¹⁴ Although insurers over time may acquire a general reputation for claims fairness (or its absence) with brokers, risk managers, and policyholders, these may be misleading or outdated. Equally important: even small insurers are fairly large operations, at least at the consumer retailing level. Insurer response to a claim may depend more on the individual adjuster assigned to the file than on any company-wide culture. And company culture can change depending on the identity of corporate counsel, other executives, or the most recent consultant recommendations. Consequently, a policyholder is to some extent flying blind in attempting to purchase insurance with an eye toward obtaining claim fairness in the future.

These advantages are institutionalized by insurers through policy format and language, which in addition to being written by the insurer is extensively standardized as to company products and not subject to negotiation, at least for individual policyholders. Although commercial

113. See PRINCIPLES OF INSURANCE LAW, *supra* note 41, §§ 9.03–12, 11.04 (juxtaposing opinions that give different construction to the very same policy language, reflecting judicial division over word meaning in general liability and automobile liability policies).

114. Professor Feinman sees this disadvantage as part of the “Opportunism” problem that, along with information and agency problems, is part of the overall market failure of insurance claims practices. See Feinman, *Regulation*, *supra* note 78, at 1325–26.

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policyholders may obtain concessions regarding coverage and shape the policy through requested endorsements and eliminating certain coverage reductions through negotiation, the actual language used in the policy will be that provided by the insurer. And in the event of customer resistance, the insurer's insistence upon particular policy language almost always prevails. Although contract doctrines like *contra proferentem* and reasonable expectations analysis soften this blow, policyholders remain subject to the insurance policy language desired by the insurer.

In addition, the very nature of insurance provides structural advantage to the insurer. Insurance is usually defined as a transaction in which one party (the policyholder) incurs a relatively small but certain loss (premium payment) in return for the promise of another (the insurer) to provide compensation in the event a larger but contingent loss (e.g., fire liability) takes place.¹¹⁵ The insurance contract thus shifts risk from policyholder to insurer in return for a premium payment.

The shifted risk is then distributed by the insurer among a large pool of uncorrelated risk. Through the use of sound underwriting, the law of large numbers, and investment income derived from premium dollars, the insurer obtains sufficient funds to pay claims and still profit.¹¹⁶

115. See PRINCIPLES OF INSURANCE LAW, *supra* note 41, § 1.03 (providing a definition of insurance and illustrative—but divergent—cases).

116. See, e.g., Letter from Warren E. Buffett, Chairman of the Board of Directors, Berkshire Hathaway Inc., to Shareholders of Berkshire Hathaway Inc. (Feb. 26, 2022), <https://www.berkshirehathaway.com/letters/2021ltr.pdf> (“Berkshire has become the world leader in insurance ‘float’—money we hold and can invest but that does *not* belong to us. . . . Berkshire’s total float has grown from \$19 million when we entered the insurance business to \$147 billion. . . . [Although] we have experienced a number of years when insurance losses combined with operating expenses exceeded premiums, *overall* we have earned a modest 55-year profit from the underwriting activities that generated our float. . . . [In addition], float is very sticky. Funds attributable to our insurance operations come and go daily, but their aggregate total is immune from precipitous decline. When it comes to investing float, we can therefore think long-term.”).

Consequently, receipt of premium payments, prior to insurer need to pay claims, permits an insurer to earn substantial sums through investing premiums, even if underwriting profit lags. An insurer’s “loss ratio” is the proportion of its claims payments in relation to premiums received. If the loss ratio is less than one (which is the case for many insurers much of the time), the insurer is profitable even without investment income. An insurer’s “combined ratio” is the relation of its claim payments and administrative expenses (e.g., salaries, office overhead, etc.) in relation to claims payments. As with loss ratio, a proportion less than one is good, and greater than one means losses that must be, and for most insurers generally are, compensated by investment income. Because it costs money to run the insurance company operation, a favorable combined ratio is harder to achieve. See *generally* KNUTSEN & STEMPEL, VOLUME ONE, *supra* note 11, §§ 1.01–.03; PRINCIPLES OF INSURANCE LAW, *supra* note 41, §§ 1.01–.03, 1.06.

The Buffett view, that invested premiums are not owned by the insurer, assumes that eventually all premium dollars will be paid in claims, an assumption that makes insurers

Insurers thus spread losses across time and geography.¹¹⁷ If well managed, the insurer can survive even a major catastrophe (e.g., hurricane in Florida, freeze in Minnesota) because only a relatively modest amount of its risks are located in a particular zone of the catastrophe. Unless business is unduly concentrated in the vicinity of the catastrophe, the insurer can literally and metaphorically weather the storm.¹¹⁸

Because insurers operate over an extended time horizon, risk is spread in this regard as well. For example, a particular region (e.g., the Lake Tahoe area) may suffer significant wildfire losses in a given year. But despite the increased risk provided by climate patterns and climate change due to greenhouse gases, the area is unlikely to suffer out-of-the ordinary fire losses year after year, at least until the law of large numbers is repealed or climatic conditions permanently alter the risk.¹¹⁹ To the extent this takes place, insurers can react and recover by raising premiums upon renewal or refusing to accept risks in the adversely affected region.

Insurers further spread their losses through purchasing reinsurance—insurance for insurers. In a typical transaction, the insurer provides or “cede[s]” some of its premium income to the reinsurer in

look less profitable than they really are, as reflected in the experience of Berkshire itself. If an insurer (or combination of insurers such as the Berkshire holdings) has an underwriting profit over more than fifty years, it is axiomatic that at least some premium dollars remain in the coffers of the company.

117. It is important that insured risks not be unduly correlated. For example, a property insurer with all of its customers in Miami’s Dade County, Florida would have suffered severe losses when Hurricane Andrew hit in August 1992. But if that same insurer had a manageable percentage of its risks in South Florida combined with a risk pool of property throughout the nation, it could withstand the losses from even a catastrophic storm. See PRINCIPLES OF INSURANCE LAW, *supra* note 41, § 1.03 (regarding risk shifting, risk pooling, and risk correlation).

118. *See id.*

119. The law of large numbers, often referred to by laypersons as the law of averages, provides that, over time, loss experiences tend to revert to the mean, and “normal” relatively predictable probabilities can be estimated. See EMMETT J. VAUGHAN & THERESE M. VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 36–40 (11th ed. 2014). This is, for example, why we have “average” rainfall and temperatures. There are of course times of unusually rainy, dry, hot, or cold weather. But the weather experiences of a given locale will be consistent over time. Minneapolis will be colder in January than Miami.

The same principle applies to automobile accidents and their consequences. Although there may be a particularly bad month for collisions and fatalities in, for example, metropolitan Newark, the rate of collisions per capita and per mile driven, as well as the medical and economic consequences, will reflect a general norm.

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return for the reinsurer's promise to share losses on a proportional basis or cover losses in excess of a certain amount.¹²⁰

Notwithstanding that, insurance as a concept involves risk shifting from policyholder to insurer; insurers further protect themselves by requiring that policyholders share in the risk through self-insured retentions, deductibles, and co-pays.¹²¹ Risk is thus not completely offloaded from policyholder to insurer. Insurers can impose this risk-sharing relatively late in their relationships with the policyholder through retroactive premium calculation¹²² and, in the case of liability insurance, seeking reimbursement of some or all defense costs.¹²³

In addition, if the loss paid by a first-party insurer stems from the negligence of a third party, the insurer can pursue a subrogation action against the tortfeasor/third party (that presumably is solvent or has liability insurance) and obtain some reduction in its net costs related to a given loss.¹²⁴ Risk then in part is absorbed by a third party responsible for the damage.

As noted above, insurers seek to profit not only through effective underwriting but also, sometimes even primarily, through investment income. The prepayment of premiums combined with investment income

120. For a general description and explanation of reinsurance, see STEMPEL & KNUTSEN, VOLUME TWO, *supra* note 36, §§ 17.01–.07; GRAYDON S. STARING & DEAN HANSELL, LAW OF REINSURANCE § 1:1 (2022 ed.).

121. See GEORGE E. REJDA & MICHAEL J. MCNAMARA, PRINCIPLES OF RISK MANAGEMENT AND INSURANCE 189 (12th ed. 2014); MARK S. DORFMAN & DAVID A. CATHER, INTRODUCTION TO RISK MANAGEMENT INSURANCE 172–73 (10th ed. 2012); see also *Crown Energy Servs. v. Zurich Am. Ins. Co.*, 512 F. Supp. 3d 997, 1003 (N.D. Cal. 2021) (stating that the purpose of deductibles and retentions is to allow the policyholder to contain costs by managing claims within deductible or retention, as well as to contain insurance premium costs and share risk among the insurer and policyholder).

122. See VAUGHAN & VAUGHAN, *supra* note 119, at 131–36; REJDA & MCNAMARA, *supra* note 121, at 140 (describing the use of retroactive premium adjustments and increases in situations where the loss experience is greater than anticipated).

123. See 1 RANDY MANILOFF ET AL., GENERAL LIABILITY INSURANCE COVERAGE: KEY ISSUES IN EVERY STATE 305–39 (5th ed. 2020) [hereinafter MANILOFF ET AL., KEY ISSUES VOLUME ONE] (discussing status of “recoupment” efforts by insurers to recover defense costs expended on claims deemed outside potential coverage). Courts are divided on the issue with a slight majority permitting such actions, but the ALI has opposed such efforts. See RESTATEMENT OF LIAB. INS. § 19 (AM. L. INST. 2019). See generally Jeffrey W. Stempel, *A Deeper Dive into Nautilus: Differentiating Insurer Efforts to Recover Defense Costs and Assessing Recoupment in the Wake of the ALI Restatement*, 57 TORT, TRIAL & INS. PRAC. L.J. 57 (2022) (reviewing arguments for and against recoupment, the division of courts, and a recent decision rejecting the ALI approach by a closely divided Nevada Supreme Court).

124. Subrogation is the process in which an insurer, having paid a policyholder for loss that was caused by a third-party, seeks to recover by bringing an action against the third-party. See STEMPEL & KNUTSEN, VOLUME ONE, *supra* note 11, § 11.01 (describing subrogation); VAUGHAN & VAUGHAN, *supra* note 119, at 171–72; REJDA & MCNAMARA, *supra* note 121, at 170–71.

provides insurers with substantial capital well ahead of their expenditures on claims.¹²⁵ Even if the premium dollars originally paid are eventually consumed (and then some) in claims payment, a competent insurer will survive and even thrive due to the time lag between premium payment and claims payment.

In addition to whatever revenue is earned from investments, insurers will pay claims in currency that has lost some value due to inflation. For liability insurers, this can be a pronounced benefit because of the longer gestation and resolution times required for liability claims as compared to property, life, health, and disability first-party claims.¹²⁶

When coverage battles ensue, insurers are in effect holding the majority of the cards if not almost the entire deck in that they have the money sought by third-party claimants or policyholders. Simply by saying “no” to claims and settlement demands, the insurer continues to earn investment income and place pressure to abandon claims or settle more cheaply than desired. Unless the insurer’s conduct or coverage/valuation position is sufficiently unreasonable to produce bad faith or statutory liability, it can play metaphorical hardball with policyholders relatively free of punishment. As the adage provides, possession is nine-tenths of the law. And insurers have a clear possessory advantage.

The practical advantage of insurer leverage is enhanced by the dispute resolution system. At a minimum, a dissatisfied policyholder must sue, an action that requires both a leap of activation energy and an expenditure of both cash and in-kind resources. Insurers are frequent litigants spreading losses across a volume of business and are well-equipped to win a war of attrition against all but the most well-heeled commercial policyholders.¹²⁷

125. See *supra* note 116 (discussing the economics of insurance and the importance to insurers of income from investment of premiums prior to the payment of claims).

126. Most first-party claims have the advantage of having a certain predictability and lower administrative costs because they do not involve counsel fees and other defense costs that are often beyond the control of the insurer due to opposing party actions and judicial decisions. See STEMPER & KNUTSEN, VOLUME ONE, *supra* note 11, § 9.02 (discussing how liability insurance typically obligates the insurer to defend claims against the policyholder).

UM/UIM coverage is different in that it is a hybrid blending ordinary first-party insurance with the insurer assuming the role of an inadequately insured tortfeasor’s insurer, which makes defense expenditures a relevant consideration in valuing claims and an actual expenditure for both parties when UM/UIM claims are sufficiently disputed. See *Protecting Auto Accident Victims*, *supra* note 9, at 23–50 (describing the nature of UM/UIM coverage and the fusion of first-party and third-party characteristics).

127. See RICHARD ERICSON ET AL., INSURANCE AS GOVERNANCE 4 (2003). General liability insurance and automobile liability insurers are to a large extent in the business of managing litigation. See *id.* As such, they develop expertise and economies of scale as well as substantial resources. See *id.* If the insurance industry were a sovereign nation, it would

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Equally important is that insurers are, to use the vernacular popularized by Professor Marc Galanter, classic “repeat players” who have substantial litigation experience and expertise as well as a large portfolio of cases throughout which different approaches can be explored, losses spread, and learning applied from prior cases.¹²⁸ Insurers, particularly liability insurers, are to a large degree in the business of claims management and litigation. Like artificial intelligence software, they can learn from their mistakes and make corrections not only to their disputing strategy and technique but also by rewriting policy provisions as necessary, exiting markets deemed unfavorable, limiting coverage through not only policy limits and sub-limits but also through exclusions, and perhaps even lobbying for changes in the law.¹²⁹

rank among the largest economies in the world. *See A Firm Foundation: How Insurance Supports the Economy*, INS. INFO. INST., <https://www.iii.org/publications/a-firm-foundation-how-insurance-supports-the-economy/introduction/insurance-industry-at-a-glance> (last visited Dec. 30, 2022) (stating property and liability insurers collected more than \$700 billion in premiums in 2021); *see Biggest Economies in 2021 by Gross Domestic Product*, WORLDDATA.INFO, <https://www.worlddata.info/largest-economies.php> (last visited Dec. 30, 2022) (listing the largest economies in the world ranked by GDP).

128. Marc Galanter, *Why the “Haves” Come Out Ahead: Speculations on the Limits of Legal Change*, 9 LAW & SOC’Y REV. 94, 97 (1974) (describing the classic explanation of the situation). Regarding insurance and the comparative advantages of insurers relative to policyholders, see JAY FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON’T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT 4–9 (2010) [hereinafter DELAY, DENY, DEFEND]; Feinman, *Beyond Bad Faith*, *supra* note 57, at 714.

129. For example, when insurers found themselves being unable to avoid coverage for what they regarded as pollution pursuant to policies with a “qualified” pollution exclusion (permitting an exception to the exclusion where the discharge in question was “sudden and accidental”), the industry revised the standard commercial general liability insurance policy to contain an “absolute” pollution exclusion without the sudden-and-accidental exception language. *See* STEMPER & KNUTSEN, VOLUME TWO, *supra* note 36, §14.11; *see also* MANILOFF ET AL., KEY ISSUES VOLUME TWO, *supra* note 65, at 143–81 (surveying case law that reflects insurers frequently unsuccessful attempts in arguing that a “sudden” discharge must be abrupt as well as unexpected); *id.* at 182–242 (surveying case law that reflects increased insurer success defeating coverage claims in policies containing the absolute pollution exclusion).

As an example of insurer political clout, consider *Dadeland Depot, Inc. v. St. Paul Fire & Marine Ins. Co.*, 945 So. 2d 1216, 1224–27, 1230 (Fla. 2006). In that case, the court held that sureties are insurers for purposes of being subject to a suit for bad faith conduct. *Id.* Unsurprisingly, sureties preferred not to face potential bad faith liability and sought a legislative overruling of the decision, which they obtained from the Florida legislature during the pendency of the *Dadeland Depot* decision, restricting its impact to only cases brought before a 2005 amendment to the statute providing that a “surety issuing a payment or performance bond on the construction or maintenance of a building or roadway project is not an insurer for purposes of [FLA. STAT. ANN. § 624.155 (2020)] subsection (1)” permitting bad faith claims. SUTHERLAND ASBILL & BRENNAN LLP, LEGAL ALERT: FLORIDA SUPREME COURT HOLDS PRE-2005 INSURANCE STATUTE ALLOWS BAD FAITH CLAIMS BY OBLIGEES AGAINST PERFORMANCE BOND SURETIES (2007), <https://s3.amazonaws.com/documents.lexology.com/cbe4e955-7d3b-446d-bbd0->

By contrast, individual policyholders are often “one-shot players” who seldom litigate and lack the expertise and economy of scale enjoyed by insurers. The repeat player effect produces considerable litigation savvy among insurers and their stable of “panel counsel” attorneys who, in part because of their volume of insurer-provided business, become highly competent litigators.¹³⁰

Another byproduct of the repeat player effect is considerable institutional knowledge of insurers and counsel.¹³¹ More than the average policyholder attorney, they are likely to know the optimal jurisdictions and venues for maximizing their chances of victory, including jury selection and the characteristics of particular judges, knowledge that can give them an advantage in using preemptory challenges and motion practice. As well-funded institutional litigants, insurers may also exert substantial influence in judicial elections.¹³² Individual consumer policyholders and small businesses simply lack this type of savvy or clout.¹³³

In theory, these advantages of insurers vis-à-vis their policyholders could be eliminated or at least dramatically reduced by an effective regulatory regime. But insurance regulation for purposes of consumer protection is fragmented and state-centered, a legacy of the McCarran-Ferguson Act (which itself reflects insurer political clout).¹³⁴ Insurance regulatory agencies tend to be understaffed and lack resources for

833afad98eaa.pdf?AWSAccessKeyId=AKIAVYILUYJ754JTDY6T&Expires=1672533369&Signature=O3CKsyH6Xm8iJL7wrWIADfZFKh0%3D; see also ANDREW TOBIAS, THE INVISIBLE BANKERS 16–17 (1982) (stating that President Jimmy Carter invited leading insurer executives to the White House but many responded that they were too busy to attend, a reaction Tobias interprets as reflecting their importance in feeling secure enough to decline a presidential invitation and uses as an illustration of insurer economic power).

130. See Galanter, *supra* note 128, at 114.

131. *Id.* at 98.

132. Insurers have frequently been major contributors to judicial elections. See DOUGLAS KEITH ET AL., BRENNAN CTR. FOR JUST., THE POLITICS OF JUDICIAL ELECTIONS, 2017–2018, at 6, 11 (2019), <https://www.brennancenter.org/our-work/research-reports/politics-judicial-elections-2017-18>; see also Jeffrey W. Stempel, *Impeach Brent Benjamin Now!? Giving Adequate Attention to Failings of Judicial Impartiality*, 47 SAN DIEGO L. REV. 1, 12–13 (2010) (describing insurer support for former workers’ compensation attorney and eventual West Virginia Supreme Court justice because of his perceived resistance to plaintiff claims). Justice Benjamin became notorious for refusing to disqualify himself from a case involving an even larger financial supporter, coal company executive Don Blankenship. See *Caperton v. Massey*, 556 U.S. 868, 872–75, 885–86 (2009).

133. Large commercial policyholders or substantial plaintiffs’ law firms rebalance the situation somewhat with their economic and political clout.

134. The McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1115, was passed in 1945 in swift (by congressional standards) response to *United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533, 552 (1944), which held that insurers were sufficiently engaged in interstate commerce to be subject to federal antitrust laws.

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regular market conduct examinations of insurers and enforcement actions against insurers that are in violation of state law or regulation.¹³⁵ They may also be unenthusiastic or even unwilling to engage in aggressive policyholder protection regulation because of ties to the industry.¹³⁶

This confluence of factors provides insurers with substantial commercial, economic, and legal advantage—a playing field slanted in favor of insurers. Leveling the playing field, or even reducing its imbalance, likely requires significantly stronger statutory protections for insurers than exist today. Currently, too few states permit private causes of action under their unfair claims statutes, which are often limited in remedy and provide inordinate technical defenses to insurers.¹³⁷

135. See Feinman, *Regulation*, *supra* note 78, at 1326–41.

136. See Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 639 (1999) (“[T]he problem of capture as it exists in other regulatory contexts is minimal when compared to the problem in the insurance industry.”); Feinman, *Regulation*, *supra* note 78, at 1340 (“The revolving door between regulators and industry swings frequently. The industry is a major campaign donor at the state and federal level. Influence also comes from organizations, and the insurance industry teems with organizations that generate research and public-relations materials that shape the thinking of regulators . . .” (footnotes omitted)).

137. For example, to vindicate the objectively reasonable expectations of insurers in a statutory unfair claims situation, the policyholder will in many states need to point to specific advertisements of the insurer to prevail. An additional potential defense to unfair claims actions is the requirement in many state versions of the Model Unfair Claims Settlement Practices Act that the misconduct of the insurer must have been known to be permitted by sufficiently high managerial authority. See, e.g., NEV. REV. STAT. § 686A.270 (2022) (“No insurer shall be held guilty of having committed any of the acts prohibited by NRS 686A.010 to 686A.310 [listing unfair practices], inclusive, by reason of the act of any agent, solicitor or employee not an officer, director or department head thereof, unless an officer, director or department head of the insurer has knowingly permitted such act or has had prior knowledge thereof.”).

Insurers have taken to arguing that this language requires something akin to actual knowledge by higher management at the company, taking a narrow view of who is a “department head,” and that constructive knowledge of statutory violations or ratification of misconduct is not sufficient. Policyholders argue correctly, in my view, that an adjuster’s supervisor should be considered a department head for purposes of this provision, and that constructive knowledge or ratification should suffice. For example, an adjuster that violates the fair claims handling statute by following company protocols has either express or implied actual approval from a supervisor, or has continued to be retained, rewarded, or promoted by the insurer despite company knowledge of alleged claims handling violations. This should satisfy what might be termed the “management knowledge” requirement.

Insurers disagree and have found some judicial support. See, e.g., *McCall v. State Farm Mut. Auto. Ins. Co.*, No. 16-cv-01058, 2018 WL 3620486, at *4–5 (D. Nev. July 30, 2018) (rejecting policyholder argument that “because the claims adjusters were following procedures developed by State Farm’s officers and department heads, management was effectively approving claims mishandling” and that “[w]ithout evidence that State Farm’s

This is not, however, to assert that bad faith doctrine and fair claims handling statutes are toothless. For example, one well-known study found that states permitting bad faith claims against first-party insurers resulted in roughly a \$5,000 per claim increased average claims payment as contrasted with states that did not permit bad faith claims outside the third-party context.¹³⁸ The potential for expanding remedies even in the relatively stronger states remains significant. Of the nearly twenty-five states permitting bad faith actions regarding first-party claims, fourteen did not permit the policyholder to pursue compensation for emotional distress or punitive damages for first-party bad faith.¹³⁹

It thus appears that in spite of the substantial disputing advantages enjoyed by insurers, common law bad faith, consumer protection statutes, and fair claims action laws reduce the advantage significantly, without imposing undue costs on insurers or the insurance purchasing public in general.¹⁴⁰ This suggests that additional reforms would further level the playing field.

Against this backdrop, the New Jersey Act takes on significance beyond state borders. It provides a significant increase in policyholder rights in a large, commercially important state and may spur momentum for reform.

II. THE NEW JERSEY INSURANCE FAIR CONDUCT ACT

A. Background

Prior to 2022, policyholders and insurers both could view New Jersey as a state with both good and bad law for their situations. The state imposed common but stringent obligations and remedies on liability insurers defending third-party claims in *Rova Farms Resort, Inc. v.*

upper management knew of and permitted allegedly unfair practices, McCall cannot prove her claim”).

138. See Mark Brown et al., *The Effect of Bad-Faith Laws on First-Party Insurance Claims Decisions*, 33 J. LEGAL STUD. 355, 379–84 (2004).

139. See *id.* at 362. See generally CARTER, *supra* note 93, at 21–23; BAD FAITH QUICK REFERENCE GUIDE, *supra* note 89.

140. See DANIAL ASMAT & SHARON TENNYSON, ECON. ANALYSIS GRP., U.S. DEPT OF JUST., TORT LIABILITY AND SETTLEMENT FAILURE: EVIDENCE ON LITIGATED AUTO INSURANCE CLAIMS 25–26 (2016), <https://www.justice.gov/atr/file/826431/download> (exploring through data analysis how bad faith laws have changed the incidence of settlement failure in automobile insurance cases); Danial Asmat & Sharon Tennyson, *Does the Threat of Insurer Liability for “Bad Faith” Affect Insurance Settlements?*, 81 J. RISK & INS. 1, 22 (2014); INS. RSCH. COUNCIL, THE IMPACT OF FIRST-PARTY BAD-FAITH LEGISLATION ON KEY INSURANCE CLAIM TRENDS IN WASHINGTON STATE 9 (2011).

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*Investors Insurance Co. of America*¹⁴¹ and its progeny. The New Jersey Supreme Court held that a liability insurer defending a claim against the policyholder was required to exercise good faith in seeking to settle the claim within policy limits.¹⁴² Failure to do so made the insurer responsible for the entire amount of a judgment against the policyholder—without regard to policy limits if the insurer had rejected a reasonable opportunity to settle (which does not require a specific settlement demand by the policyholder) the claim within policy limits.¹⁴³ *Rova Farms* placed New Jersey squarely with the majority of states that impose this “duty to settle” (restated by the ALI as a “duty to make reasonable settlement decisions”)¹⁴⁴ with breach removing the policy limits as a cap on the insurer’s liability.¹⁴⁵

But conversely, the state’s common law of first-party bad faith strongly favored insurers. In *Pickett v. Lloyd’s*,¹⁴⁶ the state’s common law of first-party bad faith not only adopted “fairly debatable” rhetoric¹⁴⁷ but also required that to establish bad faith, the policyholder must show that the claim was sufficiently strong to prevail on summary judgment,¹⁴⁸ effectively requiring a finding that the insurer committed bad faith as a matter of law and there were no disputed facts that might excuse the insurer’s actions. Notwithstanding *Pickett’s* extreme advantage for insurers, the supreme court never retreated from the decision,¹⁴⁹ which continued to be cited and followed despite serving as a near-ban on first-party insurer bad faith liability.¹⁵⁰

141. 323 A.2d 495, 510 (N.J. 1974).

142. *Id.* at 500–01.

143. *See id.* at 509–10.

144. *See* RESTATEMENT OF LIAB. INS. § 24 (AM. L. INST. 2002).

145. *See* STEMPEL & KNUITSEN, VOLUME ONE, *supra* note 11, §§ 9.05[D], 10.01[B], 10.06[A]–[B] (stating that the clear majority rule is insurer responsibility for the entire amount of judgment where the insurer fails to fulfill the duty to make reasonable settlement decisions).

146. 621 A.2d 445 (N.J. 1993).

147. *Id.* at 453–54, 457 (stating bad faith “is not to be equated with simple negligence,” and that “[i]f a claim is ‘fairly debatable,’ no liability in tort will arise”); *see also* William T. Barker & Paul E.B. Glad, *Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance*, 30 TORT & INS. L.J. 49, 49 (1994); Mayerson, *supra* note 78, at 874, 884.

148. *Pickett*, 621 A.2d at 454 (stating that a policyholder may not prevail in a bad faith/unfair claims handling action unless she can establish “as a matter of law a right to summary judgment on the substantive claim” regarding coverage or claim handling).

149. *See, e.g.*, *Wadeer v. N.J. Mfrs. Ins. Grp.*, 110 A.3d 19, 26 (N.J. 2015); *Badiali v. N.J. Mfrs. Ins. Grp.*, 107 A.3d 1281, 1290–91 (N.J. 2015).

150. *See* Feinman, *supra* note 4, at A18 (noting lack of success of such actions under the *Pickett v. Lloyd’s* standard).

Unsurprisingly, policyholder advocates were not thrilled with the *Pickett* regime that made it extremely hard for a policyholder to sufficiently demonstrate bad faith by its own first-party insurer¹⁵¹ and sought change that culminated in passage of the IFCA, signed into law and becoming effective immediately on January 18, 2022.¹⁵² The prelude to the Act involved considerable argument and lobbying as insurers claimed strengthening of policyholder rights was unnecessary and would impose undue burdens and increased costs upon insurers who in turn

151. In general, a first-party claim is one in which the policyholder seeks benefits for loss from its own insurer (e.g., a home repair claim after a fire; a claim for replacement of a stolen car; payment for medical care) while a third-party claim is one involving a claim against the policyholder that the insurer is called upon to defend. The divergence between imposing significant duties on the insurer in defending a third-party claim, such as in *Rova Farms*, and granting insurers significant doctrinal protection concerning claims by their own policyholders, such as in *Pickett v. Lloyd's*, is an unfortunate wrong turn in the law. Many states have third-party bad faith law stronger than first-party bad faith law. See MANILOFF ET AL., KEY ISSUES VOLUME TWO, *supra* note 65, at 409–513; STEMPER & KNUTSEN, VOLUME ONE, *supra* note 11, §§ 10.03–.06. This tends, paradoxically and regrettably, to make for better insurer treatment of third-parties suing policyholders than of the policyholders themselves.

In a typical tort action, where the insurer breaches its duty to make reasonable settlement decisions and an excess judgment results, the policyholder avoids actual financial responsibility for the insurer's misconduct by assigning the claim to the plaintiff in return for a covenant not to execute on the judgment. By contrast, a first-party policyholder mistreated by its insurer but lacking a case strong enough to surmount *Pickett's* fence must internalize the damages inflicted by the insurer by spending its own funds for home repair or forgoing health or disability insurance benefits. There is no realistic market value for these claims even if they involved insurer misconduct and injury.

Application of *Pickett v. Lloyd's*-style reasoning to UM/UIM claims is particularly problematic because UM/UIM insurance, although technically first-party in that it is purchased by the policyholder, operates like third-party liability insurance in that it operates as additional liability insurance for the insufficiently insured tortfeasor that injured the policyholder. And the policyholder may obtain UM/UIM benefits only if “legally entitled to recover” and not at greater fault than the uninsured tortfeasor driver.

152. *Pickett v. Lloyd's* represents what Professor Feinman has characterized as the “summary judgment or directed verdict rule” version of the “fairly debatable” standard for assessing insurer bad faith—and effectively demolishes its rationale. See Feinman, *Beyond Bad Faith*, *supra* note 57, at 732–34. Feinman explains that the *Pickett* approach:

is backwards. It states the company is conclusively presumed to have acted reasonably unless its obligation to pay the claim is unquestionable as a matter of law and fact. All facts that suggest the insured had a valid claim are to be construed against the insured. Any legal positions that suggest the claim may have been covered under the policy also are to be construed against the insured. If these steps were taken by an insurer, they would be paradigmatic examples of unreasonableness, and embodying them in a legal standard is even worse. The application of this approach ignores the nature of the insurance relation and the core concept of reasonableness that should govern claim practices.

Id. at 734 (footnotes omitted).

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would be forced to pass price increases on to consumers.¹⁵³ Policyholders argued that the Act was necessary to correct imbalance of power and that the negative collateral consequences predicted by insurers were simply scare tactics by a self-interested industry.¹⁵⁴

B. Key Provisions

The IFCA provides a private right of action for policyholders seeking coverage for injuries inflicted by uninsured or underinsured tortfeasors (“UM/UIIM” coverage) who are injured by an insurer’s unreasonable delay of a claim for payment of insurance policy benefits; unreasonable denial of a claim for payment of insurance policy benefits; or a violation of the NJ Unfair Claims Settlement Practices Act,¹⁵⁵ in effect creating two new private rights of action for UM/UIIM policyholders (but not for insureds with homeowners, medical, disability, life, or commercial property claims). The Act provides that:

- a. . . . [A] claimant who is unreasonably denied a claim for coverage or payment of benefits, or who experiences an unreasonable delay for coverage or payment of benefits, under an uninsured or underinsured motorist policy by an insurer may, regardless of any action by the [state insurance]

153. See *supra* note 6 and accompanying text (describing examples of insurer opposition to IFCA).

154. See *supra* note 3 (describing examples of policyholder support for IFCA); Feinman, *supra* note 4, at A18 (praising state senate passage of precursor to IFCA that was eventually enacted in 2022, dismissing as misplaced and unrealistic insurance industry predictions of increased costs, and justifying IFCA as correction of problematic common law). Feinman wrote:

Policyholders who sue to recover the benefits they are entitled to under their insurance policies are never made whole, because they have to pay attorney fees and court costs to get what was promised. Policyholders with a small or medium-sized claims are even worse off, because the size of the claim doesn’t justify the expense and aggravation of litigation.

The proposed [IFCA] . . . would change that. . . . [I]f an insurance company unreasonably delays or denies payment or violates the law, a policyholder can sue to receive what it is entitled to under the policy along with attorney fees and treble damages. The attorney fees ensure that the policyholder is made whole. The treble damages deter insurers from acting unreasonably in the first place.

The bill would correct a major gap in the law. . . . The law [following *Pickett*] is so stacked against insurance consumers that since the Supreme Court established the current rule in 1993, only one case has even made it to a jury trial. Feinman, *supra* note 4, at A18.

155. N.J. STAT. ANN. § 17:29B-4 (West 2022).

commissioner, file a civil action in a court of competent jurisdiction against its automobile insurer for:

- (1) an unreasonable delay or unreasonable denial of a claim for payment of benefits under an insurance policy; or
 - (2) any violation of the provisions of section 4 of [the New Jersey Unfair Claims Practices Act].
- b. In any action filed pursuant to this act, the claimant shall not be required to prove that the insurer's actions were of such a frequency as to indicate a general business practice.
- c. No rate increase shall be passed on to the consumer or policyholder of a result of compliance with [the New Jersey IFCA] and dissemination of inaccurate or misleading information to policyholder or consumer concerning [the IFCA] shall be strictly prohibited.
- * * *
- d. Upon establishing that a violation of the provisions of this act has occurred, the plaintiff shall be entitled to:
- (1) actual damages caused by the violation of this act which shall include, but need not be limited to, actual trial verdicts that shall not exceed three times the applicable coverage amount; and
 - (2) pre- and post-judgment interest, reasonable attorney's fees, and reasonable litigation expenses.¹⁵⁶

The IFCA also defines the terms "first-party claimant," "claimant," and "insurer."¹⁵⁷

156. *Id.* § 17:29BB-3.

157. *See id.* § 17:29BB-2. The Act states:

"First-party claimant" or "claimant" means an individual injured in a motor vehicle accident and entitled to the uninsured or underinsured motorist coverage of an insurance policy asserting an entitlement to benefits owed directly to or on behalf of an insured under that insurance policy.

"Insurer" means any individual, corporation, association, partnership or other legal entity which issues, executes, renews or delivers an insurance policy in this State, or which is responsible for determining claims made under the policy. "Insurer

2022] *NEW JERSEY INSURANCE FAIR CONDUCT ACT* 233*C. Open Questions Provisionally Answered*

As with any new law, questions may arise as to the exact meaning of the statute and its scope, remedies, and impact. The IFCA was no exception and appears to have generated more than the usual concern, uncertainty, and debate. A brief review of recurring questions¹⁵⁸ and suggestion of some tentative answers follows.

1. Other than the named insured under a UM/UIM policy, who is a “claimant”?

This concern is given a straight-forward answer in the statute itself, which defines both a “claimant” and a “first-party claimant” as “an individual injured in a motor vehicle accident and entitled to the uninsured or underinsured motorist coverage of an insurance policy asserting an entitlement to benefits owed directly to or on behalf of an insured under that insurance policy.”¹⁵⁹ In other words, a policyholder with UM/UIM insurance who has been injured in a motor vehicle accident is entitled to seek UM/UIM benefits subject to the IFCA. As has historically been the case, a policyholder claiming such coverage must establish that he or she is legally entitled to recover for injuries inflicted by an at-fault driver without sufficient auto insurance to adequately compensate the policyholder/victim.

2. Other than the insurance company that issued the UM/UIM policy, who, if anyone, is potentially subject to an action—for example, a third-party adjuster, claims adjuster, or supervisor who “is responsible for determining claims”?

The IFCA defines an “insurer” against whom an action may be brought as “any individual, corporation, association, partnership or other legal entity which issues, executes, renews or delivers an insurance

shall not include an insurance producer as defined in section 3 [of the IFCA] or a public entity.

Id.

158. The questions are drawn from those submitted by panelists and attendees at a webinar on the IFCA held (virtually) at Rutgers Law School on April 13, 2022, and sponsored by the Rutgers Center for Risk and Responsibility and the Rutgers Institute for Professional Education. Participants included Rutgers Law Professor Adam Scales, colleagues Jay Feinman and Rick Swedloff, plaintiff and policyholder counsel Gerald H. Baker, Esq. (Javerbaum, Wurgaft, Hicks Kahn Wikstrom & Sinins, P.C.), insurer counsel Jessica D. Wachstein, Esq. (Marshall Dennehey), and the author.

159. *Id.* § 17:29BB-2.

policy in this State, or which is responsible for determining claims made under the policy.”¹⁶⁰

The Act further provides that an insurer “shall not include an insurance producer as defined in [the state insurance producer statute] or a public entity” as defined in the IFCA.¹⁶¹ In other words, producers are not potential IFCA defendants. In the common vernacular of insurance jargon, the term “producer” is used to denote someone who arranges the sale or placement of insurance, with insurance company sales agents or brokers retained by prospective policyholders as the primary examples of a producer.

Both statutory law and administrative regulation define an insurance “producer” as “a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance.”¹⁶² This clearly includes agents or brokers selling or placing policies and probably managing general agents (“MGAs”) as well to the extent their activity includes placement of policies rather than merely internal administration

The IFCA’s text regarding producers is consistent with the general understanding of the term but leaves unresolved the question of whether MGAs¹⁶³ and third-party administrators (“TPAs”)¹⁶⁴ fall within the statute. One might also ask if attorneys who become sufficiently embroiled in the adjustment process are subject to the IFCA.¹⁶⁵ Because

160. *See id.*

161. *Id.* The IFCA defines “[p]ublic entity” as “the State, any county, municipality, district, public authority, public agency and any other political subdivision or public body in the State, including a joint insurance fund of a public entity.” *See id.*

162. *See id.* § 17:22A-28; N.J. ADMIN. CODE § 11:17B-1.3 (2022).

163. A Managing General Agent, or MGA, is an entity hired by the insurer to, as the name implies, manage the insurer’s business, which can include sales, underwriting, setting and collecting premiums then remitted to the insurer, and regular administration of the business. The MGA may be compensated through a revenue sharing system, a commission, a flat fee, or a fee for services. *See generally* Lorraine Roberte, *What Does an MGA in Insurance Do?*, HOURLY (June 2, 2022), <https://www.hourly.io/post/what-is-an-mga-in-insurance>.

164. A Third-Party Administrator, or TPA, is an entity hired by the insurer to, again consistent with the title, administer the claims made to the insurer. The TPA is essentially a claims adjuster that works as an independent contractor rather than as an employee of the insurer. Like MGAs, TPAs can be compensated in a variety of ways. *See generally* Kev Coleman, *What is a Third-Party Administrator (TPA)?*, ASS’N HEALTH PLANS, INC. (Nov. 18, 2020), <https://www.associationhealthplans.com/group-health/what-is-tpa/> (focusing on TPA use by health insurers).

165. Insurers typically make claims coverage and settlement decisions through non-lawyer adjusters and supervisors. Although it may be geographically isolated, plaintiff/policyholder attorneys in Nevada report increased incidence of seeing insurers retain and deploy outside counsel early in the process of adjusting a claim rather than after litigation has begun.

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the primary role of a TPA is to conduct claims handling, these insurance intermediaries are clearly within the scope of the IFCA. MGAs—and lawyers—would fall within the reach of the IFCA as well to the extent their duties include claims handling.

Claims administrators fit this definition to the extent they negotiate over coverage and payment even though they are not normally viewed as “producers” in the jargon of the trade. But for policyholder counsel, there is little incentive to seek to characterize TPAs or lawyers conducting claims handling as “producers” when they already so clearly fall within the definition of “insurers” to which the IFCA applies.

The IFCA’s jurisdiction over claims professionals who are not employees of the insurer represents a significant expansion of policyholder prerogatives for seeking compensation for claim denial. Under the prevailing law in most states, insurer intermediaries have avoided direct liability to policyholders.¹⁶⁶ The traditional approach reasons that they are agents for a disclosed principal (the insurer) and therefore not independently liable for insurer misconduct.¹⁶⁷ An action against the typically fiscally sound insurer is considered sufficient remedy for the aggrieved policyholder.¹⁶⁸

Some jurisdictions have migrated away from this traditional rule, particularly in cases where the intermediary (usually a TPA handling claims rather than an agent involved in consulting, actuarial analysis, marketing, underwriting, or general management) has played a

This early involvement of counsel can be a good thing for insurers if it induces improved claims handling, but it poses the serious risk that the attorney will be viewed as an adjuster and not as only counsel. In such cases, attorney-client privilege would presumably not apply to insurer-adjuster/counsel communications even if the insurer is not asserting an “advice of counsel” defense to support adverse action on the claim. Where an advice of counsel defense is expressly or constructively asserted, most courts find privilege inapplicable. *See, e.g.,* *Vicinanzo v. Brunswick Fils, Inc.*, 739 F. Supp. 891, 891 (S.D.N.Y. 1990); Brian J. Talcott & Michael J. Weber, *Recent Attorney-Client Privilege Cases Show the Risks of Insurance Counsel Authoring Denial Letters*, DINSMORE (Feb. 25, 2021), <https://www.dinsmore.com/publications/recent-attorney-client-privilege-cases-show-the-risks-of-insurance-counsel-authoring-denial-letters/>; Lee Craig, *Advice of Counsel: Insurance Companies’ First and Last Line of Defense*, MEALEY’S LITIG. REPS.: BAD FAITH (July 20, 1999), <https://www.butler.legal/advice-of-counsel-insurance-companies-first-and-last-line-of-defense-mealeys-litigation-reports-bad-faith/> (“Once the advice of counsel defense is asserted, all communications between the insurer and the attorney will be discoverable.”).

166. *See* Jeffrey W. Stempel, *The “Other” Intermediaries: The Increasingly Anachronistic Immunity of Managing General Agents and Independent Claims Adjusters*, 15 CONN. INS. L.J. 600, 604–11 (2009) (stating the majority rule is that MGAs and TPAs as agents for a disclosed principal are not personally liable for misconduct, but that misconduct and liability is attributed to the insurer that retained them).

167. *See id.* at 608–09.

168. *Id.*

substantial role in claims investigation and decision.¹⁶⁹ Recent case law has tended to follow the traditional majority rule and limited policyholder remedy for defective claims handling to suit against the insurer with no direct action against independent contractor adjusters or adjuster employees.¹⁷⁰ If the IFCA's definition of "insurer" is read reasonably, New Jersey joins the list of states willing to hold TPAs accountable for their misconduct regarding at least UM/UIM claims.

3. How should courts distinguish reasonable and unreasonable insurer conduct?

The IFCA states that liability attaches for "an unreasonable delay or unreasonable denial" of a UM/UIM claim, which raises a cluster of questions as to what constitutes an unreasonable delay or denial and what is meant by "reasonable" conduct generally. Must a denial be total? Or is a small offer or counter-offer tantamount to denial?

Although these questions are valid, one must be a little restrained before criticizing the IFCA for failing to define "reasonable" conduct in its text. Courts—and juries—have been adjudicating reasonableness for centuries and doing it (dare I say it) reasonably well. There is no basis to think that they will do worse applying the concept—i.e., the range of behavior and decision-making of an objectively reasonable person in the circumstances at issue—in IFCA matters. With this in mind, I again suggest some tentative answers to reasonableness-related IFCA questions.

Presumably, New Jersey courts will reject any requirement of total denial to trigger IFCA liability. An unreasonably small offer (e.g., \$1,000 on a \$100,000 policy) or one with improper pre-requisites (e.g., a lawyer's promise not to bring similar claims in the future) is the functional equivalent of total denial in that it is a *de facto* rejection of the policyholder's claim.

To illustrate, consider a policyholder with auto liability limits of \$250,000 per person, \$500,000 per accident, and matching UM/UIM

169. *See id.* at 630–48; *see, e.g.*, *Peterson v. Meritain Health, Inc.*, 508 P.3d 696, 718–19 (Wyo. 2022).

170. *See, e.g.*, *Skillett v. Allstate Fire & Cas. Ins. Co.*, 505 P.3d 664 (Colo. 2022); *De Dios v. Indem. Ins. Co. of N. Am.*, 927 N.W.2d 611, 623–24 (Iowa 2019). *Skillett v. Allstate* involved an in-house adjuster that was an employee of the insurer, which leaves ajar the possibility that an independent contractor adjuster might be held liable for its role in defective claims handling. 505 P.3d at 665. However, the tone and thrust of the opinion suggest Colorado will not support separate liability for TPAs or other agents of an insurer outside the carrier's employee workforce. *See id.* at 667 (basing its decision in part on statutory language referring to the obligation to "pay benefits" as an obligation of the insurer rather than an employee or agent of the insurer).

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coverage. The policyholder is rear-ended by a driver with New Jersey's statutory minimum policy limits of \$25,000 per person, \$50,000 per accident, incurring severe back pain that required months of physical therapy, chiropractic care, pain medication, and has prompted a treating orthopedic physician's recommendation of surgery estimated to cost \$80,000.

The tortfeasor's insurer pays its \$25,000 limit within five weeks of the collision. Policyholder counsel makes a policy limits settlement demand of the UM/UIM carrier, enclosing medical records reflecting \$125,000 in post-collision medical expenses, the future surgery recommendation of \$80,000, proof of three months of lost wages as a high school teacher (\$15,000–\$20,000 at prevailing New Jersey salaries),¹⁷¹ and describes the policyholder's post-collision pain and suffering and the likelihood of future pain and suffering and restricted activity. Medical records for the five years prior to the collision, which indicate no significant prior treatment of the areas currently receiving medical attention, and broad medical release are also submitted to the insurer.

Even if one is a bit skeptical about physician billing when treating an accident victim on a lien basis (i.e., providing services in return for a right to recover from a successful claim rather than receiving payment from a medical insurer that might seek billing reductions) or fear of overpriced medical services generally, this sure looks like a policy limits case. If the future surgery recommendation is credible, special damages alone nearly consume policy limits even without consideration of pain and suffering.

Even if the insurer genuinely thinks medical billings are excessive/overpriced and the victim is exaggerating pain, these concerns do not support rejection of a policy limits settlement offer unless the insurer develops some significant evidence validating these concerns or suggesting outright fraud. There may be some, even considerable, room for debate about the exact amount necessary to fairly compensate the collision victim but where the lower range of that amount exceeds policy limits, a reasonable insurer should accept the policy limits offer.

In this hypothetical, unless there is more to undermine the claim, there is not much ground for debating that the claim is worth more than \$275,000 (the tortfeasor's \$25,000 policy limit and the policyholder's \$250,000 UM/UIM limit) and no reasonable (that word again) ground for

171. See *Public School Teacher Salary in New Jersey*, SALARY.COM, <https://www.salary.com/research/salary/benchmark/public-school-teacher-salary/nj> (last visited Dec. 30, 2022) ("The average Public School Teacher salary in New Jersey is \$60,967 as of September 26, 2022, but the range falls between \$50,919 and \$74,333. Salary ranges can vary widely depending on the city and may other important factors, including education, certifications, additional skills, the number of years you have spent in your profession.").

debating whether the claim value exceeds \$25,000. The UM/UIIM insurer, if it is to act consistent with its good faith duties and standard of care, must at least be offering serious money in timely fashion even if it is balking at paying full UM/UIIM policy limits.

Regarding what is meant by “unreasonable” conduct, insurers have noted that a prior version of the bill used a *Pickett v. Lloyd’s*-like standard requiring conduct so clearly unreasonable based on undisputed facts that the policyholder is entitled to summary judgment.¹⁷² This history can be used to argue that *Pickett’s* pre-requisite of bad faith as a matter of law is implicitly incorporated into the IFCA. More persuasive, however, is the argument that the absence of the former language reflects rejection of *Pickett’s* insurer-favorable standard.

In addition to the reasonable inference that removal of the prior language indicates legislative rejection of the former language, the very thrust and objective of the IFCA is inconsistent with *Pickett v. Lloyd’s* and reflects an implicit legislative overruling of *Pickett v. Lloyd’s* and rejection of its approach. The purpose of the IFCA was to level the metaphorical playing field, which under *Pickett* clearly advantaged insurers¹⁷³ in first-party claims (including, according to conventional wisdom, hybrid coverages such as UM/UIIM), by giving policyholders a private right of action for unreasonable nonpayment or delayed payment of UM/UIIM claims.

It would seriously undermine that legislative objective if the new law designed to help policyholders was read to apply only when the policyholder claim was a proverbial slam dunk resolvable by motion. This sort of restrictive construction of a remedial statute such as the IFCA should logically require express language to that effect in the final version of the law as passed (which is absent in the IFCA) or extremely probative legislative history (also lacking for insurers regarding the IFCA). Basing an interpretation of the statute that undermines its objectives upon unclear legislative history violates basic norms of statutory construction.¹⁷⁴ Further, the common sense of the IFCA was

172. Dzugay et al., *supra* note 6.

173. *See id.* (discussing holding of *Pickett v. Lloyd’s*).

174. An important canon of statutory construction supporting policyholders on this point posits that remedial statutes should be liberally construed to accomplish their purpose. *See* WILLIAM N. ESKRIDGE, JR. ET AL., CASES AND MATERIALS ON LEGISLATION AND REGULATION: STATUTES AND THE CREATION OF PUBLIC POLICY 700–09 (6th ed. 2020) (excerpting Karl Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes Are to Be Construed*, 3 VAND. L. REV. 395 (1950)); LARRY M. EIG, CONG. RSCH. SERV., 97-589, STATUTORY INTERPRETATION: GENERAL PRINCIPLES AND RECENT TRENDS 34–35 (2014) [hereinafter STATUTORY INTERPRETATION: GENERAL PRINCIPLES]; Blake A. Watson, *Liberal Construction of CERCLA Under the Remedial Purpose Canon: Have the Lower Courts Taken a Good Thing Too Far?*, 20 HARV. ENV. L. REV. 199, 229–33 (1996).

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that it was enacted, like most legislation, to change rather than codify the law. Otherwise, there would be little or no reason for legislators to spend scarce policymaking resources on the endeavor. Read properly, the IFCA replaces *Pickett v. Lloyd's* (at least for UM/UIM cases) and does not affirm it.

4. Does the IFCA supplant or supplement common law bad faith?

Although one can argue that the IFCA displaces common law bad faith, it is a weak argument. First, nothing in the language of the IFCA suggests that it was intended to abrogate common law bad faith actions. Second, nothing in the legislative history or informal discussion of the IFCA suggests this result. Third, other states have not regarded the presence of their versions of the NAIC Unfair Claims Settlement Practices Act as eliminating common law bad faith actions.¹⁷⁵ Although the IFCA gives policyholders more rights as a first-party claimant, it is not so different a statute as to alter this longstanding co-existence of common law and statutory protections for policyholders.

The remedies provided by the IFCA are sufficiently broad (actual damages, possible trebling, pre- and post-judgment interest, counsel fees, litigation expenses) that they will undoubtedly overlap or duplicate

Although this liberal construction canon is contradicted more than a little by the canon that statutes in derogation of the common law should be strictly construed in that all remedial statutes “derogate” common law to some extent, the liberal construction canon logically takes precedence over the derogation canon. ESKRIDGE, JR. ET AL, *supra*, at 701; SCALIA & GARNER, *supra* note 28, at 318 (restating the canon as one providing that “[a] statute will be construed to alter the common law only when that disposition is clear”). Otherwise, we would have judicial lawmaking supremacy rather than legislative lawmaking supremacy (subject to constitutional constraints). Consistent with Justice Scalia’s conservative bent, Scalia and Garner do not even present the “remedial statutes should be liberally construed” canon as such but rather attack it, presenting something of a counter-canon. *See id.* at 364 (“The false notion that remedial statutes should be liberally construed.”). False or not, this “notion” is set forth in a sufficient number of judicial opinions over decades, so most lawyers accept it as a fully established canon of construction. *See also* Watson, *supra*, at 230–32 (arguing that remedial-broad construction canon has largely vanquished the derogation-of-the-common-law canon). *But see* STATUTORY INTERPRETATION: GENERAL PRINCIPLES, *supra*, at 34 (“One can search in vain for recent Supreme Court reliance on the [remedial-broad construction] canon.”).

175. For example, Nevada’s version of the NAIC Unfair Claims Settlement Practices Act contains a private right of action, and this has not been viewed as eliminating or preempting the state’s common law cause of action for bad faith. Both are regularly alleged together by policyholders. *See, e.g., Powell v. Liberty Mut. Fire Ins. Co.*, 252 P.3d 668, 671 (Nev. 2011) (describing plaintiff’s claims of both common law bad faith and violation of Nevada’s claims practices statute); *Nalder v. United Auto. Ins. Co.*, No. 70504, 2019 WL 5260073, at *2 (Nev. Sept. 20, 2019) (answering questions about common law bad faith and Nevada’s claims practices statute).

damages available at common law.¹⁷⁶ Double recovery is not permitted but can be easily avoided by shaping the relief awarded rather than precluding common law actions against the insurer. Further, if punitive damages are ruled unavailable under the IFCA, it would unfairly strip policyholders of an existing potential remedy to bar them from making common law bad faith claims due to passage of the IFCA.

5. What sources beyond statutory text are relevant to the determination of unreasonableness?

Unreasonableness is the absence of reasonable behavior. Reasonable behavior is normally determined by the factfinder asked to assume the objective standard of the mythical reasonable person. Use of the concept has long been part of tort law and it logically will continue in the same vein for IFCA claims.

Regarding reasonableness, observers have wondered whether expert testimony is required and the extent to which it is permitted and under what conditions. The answer to that question hinges on the nature of the claim and proffered expert testimony. As a general rule, expert testimony is not required in insurance bad faith or claims handling actions.¹⁷⁷ It is, however, offered with some frequency by policyholders and insurers who wish to present the court and jury with information beyond ordinary lay knowledge.¹⁷⁸

Because the business of insurance and insurance claims processing is a sufficiently specialized matter apart from the experiences of most lay jurors, courts should not be faulted for being receptive to expert testimony. Although reasonable people can debate the knowledge, authority, persuasiveness, and efficacy of different types of insurance experts—e.g., business professor, law professor, actuary, economist,

176. N.J. STAT. ANN. 17:29BB-3 (West 2022).

177. See *City of Hobbs v. Hartford Fire Ins. Co.*, 162 F.3d 576, 586–87 (10th Cir. 1998) (applying New Mexico law and holding that a jury can determine bad faith issues without expert testimony), *aff'd in part, rev'd in part sub nom.* *City of Hobbs v. Nutmeg Ins. Co.*, 242 F.3d 388 (10th Cir. 2000); *Bright v. Ohio Nat'l Life Assur. Corp.*, No. 11-CV-475, 2013 WL 121479, at *2 (N.D. Okla. Jan. 9, 2013) (“While expert testimony may be helpful in bad faith cases, it is not necessary.”). Expert testimony is, however, not uncommon in such actions. See, e.g., *City of Hobbs*, 162 F.3d at 586–87; *Bright*, 2013 WL 121479, at *2.

178. See, e.g., *Raygarr LLC v. Emps. Mut. Cas. Co.*, No. 18-CV-00246, 2020 WL 919443, at *6 (D. Ariz. Feb. 25, 2020); *Williams v. Am. Fam. Mut. Ins. Co.*, No. 09-CV-00675, 2012 WL 1574825, at *4 (D. Nev. May 2, 2012); *Wood v. Provident Life & Accident Ins. Co.*, No. 17-CV-02330, 2021 WL 567902, at *4 (D. Ariz. Feb. 16, 2021); *MI Window & Doors, LLC v. Liberty Mut. Fire Ins. Co.*, No. 14-CV-3139, 2019 WL 1430115, at *1 (M.D. Fla. Mar. 29, 2019); *Charles Miller*, PLAINTIFF MAG., <https://www.plaintiffmagazine.com/authors/item/charles-miller> (last visited Dec. 30, 2022) (proffering former adjuster Charles Miller as expert on insurer conduct and reasonable claims handling).

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underwriter, claims adjuster, manager, agent, broker—as well as individual experts, these are matters usually going to the weight to be accorded to their views, and hence, are apt for consideration by the factfinder, rather than matters of admissibility. In almost all cases, a person with any of these backgrounds has expertise that may be helpful to the factfinder in understanding insurance claims and assessing the conduct of insurer and policyholder.

6. How does the UM/UIM context, which is different than other types of first-party claims, affect the determination of unreasonableness?

UM/UIM insurance is something of a hybrid; it is first-party insurance in that it is purchased by the policyholder, the first party, from the insurer, the second party, and provides compensation to the policyholder for injuries.¹⁷⁹ But like third-party insurance, UM/UIM coverage is applicable only where the first-party policyholder has been injured by a third-party and the policyholder is legally entitled to recover because the third-party is at greater fault and the policyholder's claim is not barred by a defense available to the third-party, such as immunity or damage caps.¹⁸⁰

The UM/UIM insurer stands in the shoes of the tortfeasor's insurer and supplements the tortfeasor's missing or inadequate insurance.¹⁸¹ The UM/UIM insurer logically should model the behavior of a reasonable auto liability insurer and make reasonable settlement decisions that protect the tortfeasor from a judgment in excess of policy limits—in this case, the combined tortfeasor and UM/UIM limits. This has the consequence of requiring the UM/UIM insurer to determine the range of reasonable probable outcomes at the hypothetical trial of Policyholder v. Tortfeasor and to accept reasonable settlement proposals and engage in reasonably pro-active settlement efforts.¹⁸²

As insurers invoking the “fairly debatable” test note, the insurer is not required to accept a policyholder's proffered damages assessment at face value and may investigate accordingly.¹⁸³ Recall that pursuant to this approach, the policyholder must demonstrate that the insurer's conduct was unreasonable, unfair, or substandard.¹⁸⁴ But this does not give the insurer unfettered discretion to refuse payment. Where there is

179. *See supra* Section II.B.

180. *See supra* note 151 and accompanying text.

181. *See supra* note 151 and accompanying text.

182. *See supra* Section II.C.3.

183. *See supra* Section I.C.

184. *See supra* Section I.C.

a conflict of medical testimony regarding severity of injury and amount of damage, the UM/UIM insurer fulfilling this role may not embrace a preferred diagnosis—such as that of its chosen physician—but must balance competing medical evidence and determine the damage exposure to the tortfeasor, as would a liability insurer evaluating the range of trial outcomes and calculating a reasonable settlement offer.¹⁸⁵ This is what a reasonable liability insurer would do if it faced a third-party's claim against the policyholder as tortfeasor.

Insurers may dispute this analysis both because the policyholder claimant, unlike a policyholder tortfeasor, will not actually be subjected to an excess judgment if the insurer errs regarding settlement.¹⁸⁶ Insurers also prefer to see UM/UIM claims as pure first-party claims in the manner of a house fire or medical expense so that the insurer may bargain more aggressively about the amount of damage in a manner that a liability insurer would not if facing significant risk of an excess judgment.¹⁸⁷

If the court adopts the insurer view, this likely has a dampening effect on insurer duties and the value of the policyholder's claim. But it does not give the insurer carte blanche to offer unreasonably low UM/UIM payments. Absent evidence to the contrary, the insurer must accept probative evidence of injury and medical billings consistent with those prevailing in the locale in question.¹⁸⁸ Where it has such evidence, this justifies the insurer's balancing the information as would a liability insurer calculating an insured tortfeasor's exposure. Only if the UM/UIM insurer obtains incontestable evidence refuting the policyholder's claimed damages—e.g., film footage of working on a day when lost wages were claimed or a pay stub that contradicts a claim of inability to work at the time in question—is complete rejection warranted.

Even if the UM/UIM insurer is considered to be free of the liability insurer's duty to make reasonable settlement decisions and has “only” the fair claims handling duties of a first-party insurer with no obligation to protect the policyholder from liability exceeding policy limits, the insurer's duties of communication, investigation, fairness, and resolving close disputes in favor of the policyholder are substantial.¹⁸⁹ Although a

185. *See supra* Section II.C.3.

186. *See supra* note 151 and accompanying text.

187. *See supra* note 151 and accompanying text.

188. *See supra* discussion in Section II.C.3.

189. *See, e.g., Zilisch v. State Farm Mut. Auto. Ins. Co.*, 995 P.2d 276, 279–80 (Ariz. 2000). Summarizing “the basic rules” regarding insurer claim handling duties, the court stated:

The tort of bad faith arises when the “insurer intentionally denies, fails to process or pay a claim without a reasonable basis.” While an insurer may challenge claims

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true first-party insurer such as a property insurer may bargain with its policyholder regarding the cost of a repair and medical insurer may bargain with a hospital over billings, their bargaining and payment cannot be unreasonable or take unfair advantage of the policyholder.¹⁹⁰

7. Is there a right to jury trial? And does the answer differ depending on whether the matter is in state or federal court?

Because IFCA actions seek to obtain damages, a classic legal remedy, they logically will be deemed actions at law subject to the jury trial right pursuant to the Seventh Amendment of the U.S. Constitution, requiring that the right to jury trial be “preserved” in actions at law,¹⁹¹ and the New Jersey Constitution, which states that the “right of trial by jury shall remain inviolate.”¹⁹² The more extensive case law of the Seventh Amendment points rather clearly to a jury trial right.¹⁹³ That same federal line of cases makes it clear that the Amendment controls in federal courts even if the case is one involving substantive state law.¹⁹⁴ Even if the New Jersey Constitution did not support a jury trial right for IFCA damages actions, *Erie Railroad Co. v. Tompkins* would require this result in federal court.¹⁹⁵

But there is likely to be no federal-state split on this issue. In addition to the strong language of the New Jersey Constitution itself, the New Jersey Supreme Court, like the federal courts, has found the jury trial

which are fairly debatable, its belief in fair debatability “is a question of fact to be determined by the jury.” An insurance contract is not an ordinary commercial bargain; “implicit in the contract and the relationship is the insurer’s obligation to play fairly with its insured.” The insurer has “some duties of a fiduciary nature,” including “[e]qual consideration, fairness and honesty.” Thus, “an insurer may be held liable in a first-party case when it seeks to gain unfair financial advantage of its insured through conduct that invades the insured’s right to honest and fair treatment,” and because of that, “the insurer’s eventual performance of the express covenant—by paying the claim—does not release it from liability for ‘bad faith.’” [This Court has] noted that an insurance contract provides more than just security from financial loss to the insured. We said, “the insured also is entitled to receive the additional security of knowing that she will be dealt with fairly and in good faith.” Thus, if an insurer acts unreasonably in the manner in which it processes a claim, it will be held liable for bad faith “without regard to its ultimate merits.”

Id. (first alteration in original) (citations omitted).

190. *Id.*

191. *See* U.S. CONST. amend. VII.

192. N.J. CONST. art. I, para. 9.

193. *See* *Chauffeurs, Teamsters & Helpers, Loc. No. 391 v. Terry*, 494 U.S. 558, 564–65 (1990).

194. *See* BROOKE D. COLEMAN ET AL., *LEARNING CIVIL PROCEDURE* 664–82 (4th ed. 2022).

195. *See* *Byrd v. Blue Ridge Rural Elec. Coop., Inc.*, 356 U.S. 525, 535–38 (1958).

right in state court applicable to “legal” claims seeking (as opposed to claims sounding in equity), including granting a jury trial right to an insurer pursuing a fraud claim against a policyholder pursuant to the Insurance Fraud Prevention Act.¹⁹⁶ Sauce-for-the-goose-is-sauce-for-the-gander is perhaps not refined legal doctrine, but the symmetry it describes would almost certainly apply to IFCA claimants bringing actions against UM/UIM insurers for damages, which are classic legal remedy subject to the jury trial right.

But although a UM/UIM policyholder’s compensatory damages subject to trebling and any punitive damages constitute legal relief, the application of interest, costs, and counsel fees to an award, like the cost awards and fee-shifting generally, remain within the scope of judicial authority.

8. Is severance of claims possible? Likely? How does the general law of bifurcation and judicial discretion control over such matters?

Severance and bifurcation are two procedural devices that may be used, respectively, to separate claims or issues of liability and damages. The rationale for these devices is avoidance of juror confusion or prejudice. Although both fall within the scope of Federal Rule of Civil Procedure 42(b)¹⁹⁷ and its state analogs because they involve separation of matters in a dispute, the devices are distinct. The primary concern of severance is to minimize potential juror confusion and to avoid prejudice by association, while the focus of bifurcation is minimizing juror sympathy that may override reasoned judgment about relative fault.

196. See *Allstate N.J. Ins. Co. v. Lajara*, 117 A.3d 1221, 1223 (N.J. 2015) (praising jury tradition in state and nation, and noting that in assessing jury trial right, the court assesses “whether the grant of a jury trial is consistent without our common-law tradition,” noting that claims for damages “are legal—not equitable—in nature and because the elements necessary to prove an IFPA claim are similar to common-law fraud,” making jury trial required if properly demanded); see also *Jersey Cent. Power & Light Co. v. Melcar Util. Co.*, 59 A.3d 561, 563–65 (N.J. 2013) (per curiam) (striking down provision in Underground Facility Protection Act providing for mandatory binding arbitration for claims of less than \$25,000); *Oriente v. Jennings*, 218 A.3d 806, 809, 818–19 (N.J. 2019) (reiterating the court’s support for the jury trial right in revising rules regarding additur and remittitur); Robert F. Williams, *State Constitutional Protection of Civil Litigation*, 70 RUTGERS U. L. REV. 906, 922 (2018) (noting general state constitutional and court support for jury trial right).

197. See FED. R. CIV. P. 42(b) (providing that “[f]or convenience, to avoid prejudice, or to expedite and economize, the court may order a separate trial of one or more separate issues, claims, crossclaims, counterclaims, or third-party claims” so long as care is taken to preserve the right to jury trial); see also JAMES W. MOORE ET AL., *MOORE’S FEDERAL PRACTICE* §§ 42.20–.24 (3d ed. 2022).

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Advocates of each device also argue that they support efficient use of judicial resources by streamlining and simplifying trials or reducing need for judicial resources (e.g., a finding of no liability obviates the need for trial on damages).¹⁹⁸

Severance of IFCA claims from other claims in a policyholder-insurer dispute will be subject to general law and judicial discretion regarding severance.¹⁹⁹ The statute established no special rules and nothing about the cause of action suggests an approach different than that prevailing in other types of litigation.²⁰⁰

Because the conduct at issue in an IFCA claim (e.g., insurer actions and decisions) will also be at issue in claims for breach of contract or common law, bad faith will also likely be part of the claim, and the commonality of facts ordinarily will counsel strongly against severance.

The case for bifurcation may be stronger but likely will generally be unconvincing. Bifurcation of liability and damages claims, for example, has not become common in tort litigation—even in cases where there may be gruesome, sympathy-inducing plaintiff injuries but serious, close questions of defendant liability for those injuries.²⁰¹ If bifurcation has not become the norm in these situations, it is unlikely to become popular in the insurance claims context.

9. Does the statutory bad-faith claim need to be severed from the underlying tort claim and stayed pending the tort claim's resolution?

The short answer here is generally no. However, as with any civil litigation, the trial court has discretion to sever claims pursuant to Federal Rule 42 and N.J. Court Rule 4:38-2.²⁰² Severance primarily occurs in cases where combination of the claims may lead to juror confusion or prejudice to the defendant (the same holds true for multiple counterclaims or cross-claims).²⁰³

198. See generally Warren F. Schwartz, *Severance—A Means of Minimizing the Role of Burden and Expense in Determining the Outcome of Litigation*, 20 VAND. L. REV. 1197 (1967) (regarding severance); Steven S. Gensler, *Bifurcation Unbound*, 75 WASH. L. REV. 705 (2000) (regarding bifurcation).

199. FED. R. CIV. P. 42(b).

200. N.J. STAT. ANN. § 17:29BB-3 (West 2022).

201. See Gensler, *supra* note 198, at 707–08, 729 n.146 (noting that “bifurcation is not common in the federal courts, nor has it ever been,” and characterizing judicial attitude toward bifurcation as “a cautious, almost grudging approach,” particularly in the first years after enactment of Rule 42).

202. FED. R. CIV. P. 42; N.J. CT. R. 4:38-2.

203. See *Drew v. United States*, 331 F.2d 85, 92–94 (D.C. Cir. 1964).

For example, a fifty-year old Black woman employee with impaired hearing might sue an employer and be making claims breach of contract, common law wrongful discharge on grounds of race and gender discrimination in violation of Title VII, age discrimination in violation of the Age Discrimination Act, and disability discrimination in violation of the Americans with Disabilities Act.

In such a matter involving different law with different evidentiary and liability standards, severance may be regarded as a means of simplifying the case. But disaggregating the claims fragments the employee plaintiff's presentation and may make it unfairly difficult for jurors to appreciate the big picture of an employer who was averse to workers different from the majority of its workforce. In a case of this type, the case for severance is not persuasive despite the differing issues.²⁰⁴

Because a policyholder's common law bad faith claim against its insurer and an IFCA statutory claim will almost always arise out of the same facts and insurer conduct, severance is highly unlikely on grounds of confusion or convenience. An attempted prejudice justification is more logical in that an insurer facing an IFCA claim is logically tarred a bit when simultaneously being accused of common law bad faith. But this amount of optic injury is ordinarily not a compelling reason for severance or stay.

Facing any claim, even a baseless one, imposes some inconvenience-cost-prejudice to a defendant. But to obtain severance, the movant must show not mere inconvenience or tactical injury but must demonstrate undue or severe prejudice that does not exist merely because an insurer is sued on multiple grounds.²⁰⁵ If this alone constituted sufficient prejudice to justify severance, almost all cases with multiple claims for relief would be subject to severance—an absurd result in a civil litigation world in which pleading in the alternative is commonplace.

204. See, e.g., *Mosley v. Gen. Motors Corp.*, 497 F.2d 1330 (8th Cir. 1974). Severance would also run contrary to the now widespread acceptance of the view that claims involving the “intersectionality” of traits (e.g., race, gender, age, ethnicity, religion) may play a role in perceptions about the individual. See generally Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139 (1989).

205. See FED. R. CIV. P. 21 (“On motion or on its own, the court may at any time, on just terms, add or drop a party. The court may also sever any claim against a party.”); MOORE ET AL., *supra* note 197, §§21.01–.02 (describing severance rationale and standards for applying Rule 21 and severance of claims in an action).

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10. How does an insurer reasonably balance its obligation to a claimant and its need to assess the merits of the underlying tort claim?

As discussed above, an acceptable approach for the UM/UIM insurer is that of a liability insurer facing the policyholder's claim against the inadequately insured tortfeasor as if it were a tort claim being defended by the insurer charged with making reasonable settlement decisions.

Because the UM/UIM policyholder must be legally entitled to recover, the UM/UIM insurer must assess liability and may permissibly deny a claim where a collision is clearly the fault of the policyholder (just as it should not contest coverage where the policyholder is clearly not at fault).

Where the evidence of liability is mixed, the UM/UIM insurer, like an auto liability insurer, may factor this into its settlement decisions but must continue to attempt to settle the claim at or below policy limits as if it were defending the claim and seeking to protect the insufficiently insured tortfeasor. This can place UM/UIM insurers in a difficult position where liability is seriously in question. But their position is no worse than that of ordinary liability insurers that must make this calculation every day in attempting to resolve ordinary automobile collision claims.

Where the ordinary auto liability insurer wishes to risk an excess judgment by refusing to settle a seriously injured plaintiff's claim on liability grounds, the prudent liability insurer seeking to protect itself from bad faith liability will inform its policyholder that the insurer will pay the entire amount of any resulting judgment so that the tortfeasor policyholder need not worry about becoming personally liable to the plaintiff because the insurer has miscalculated regarding settlement. Insurers in this position regularly send "peace of mind" or "comfort" letters to defendant policyholders.²⁰⁶

UM/UIM insurers do not have this exact device as readily available but could attempt to obtain its substantial equivalent by agreeing at the outset of a claim to abide by an adjudication (or arbitration if required by law or agreed to by the policyholder) of the collision-related injury to the policyholder without regard to policy limits and to pay the policyholder's litigation expenses and counsel fees if the policyholder obtains more than the insurer's *initial* offer of compensation.

206. James A. Dodrill et al., *Bad Faith Set-Ups of Insurance Companies*, FDCC INSIGHTS June 2016, at 5–6, https://wtotrial.com/files/29651_bad_faith_set-ups_of_insurance_companies.pdf (describing use of such "comfort letters" that assure "the insured that, in the event of an excess verdict, the insurer will indemnify the insured for the excess").

11. What, if anything, is the necessary relationship between the type of violation and the unreasonableness of the claim denial or delay?

Liability attaches for “any violation” of section 17:29B-4, the state’s Unfair Claims Settlement Practices Act (“UCSPA”).²⁰⁷ Recall that the Model UCSPA, promulgated as a model act by the National Association of Insurance Commissioners, sets forth a list of insurer duties but does not provide an express right of action or set forth a damages regime.²⁰⁸ But the IFCA does and by its terms makes a violation of the New Jersey UCSPA actionable and subject to the IFCA’s damages regime.²⁰⁹

The New Jersey UCSPA defines practices as unfair when they are “committ[ed] or perform[ed] with such frequency as to indicate a general business practice,”²¹⁰ but the IFCA specifically excludes the general business practice requirement.²¹¹ Subsection (9) of the UCSPA defines types of unfair claim settlement practices, including many with vague terms such as “reasonable”²¹²—that are now effectively part of a private right of action for violations of the state UCSPA.²¹³ The state insurance commissioner adopted regulations “defining certain minimum standards for the settlement of claims which, if violated with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices in the business of insurance.”²¹⁴

207. See N.J. STAT. ANN. § 17:29BB-3 (West 2022); *id.* § 17:29B-4.

208. See BARKER & KENT, *supra* note 87, §10.04 (citing cases for the proposition that “[i]n jurisdictions recognizing a common law cause of action, an implied statutory cause of action adds little to the right of an insured” but also noting that the UCSPA could provide additional rights to third-party claimants suing policyholders if the insurer does not attempt to effect reasonable settlement of claims).

209. See N.J. STAT. ANN. § 17:29BB-3(a)(2).

210. *Id.* § 17:29B-4(9). In this sense, the New Jersey version of the UCSPA is more restrictive than the NAIC Model Act, which also considers it an “improper claims practice” if the insurer’s action is “committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder.” MODEL UNFAIR CLAIMS SETTLEMENT PRACS. ACT § 3 (NAT’L ASS’N OF INS. COMM’RS 2016).

211. See N.J. STAT. ANN. § 17:29BB-3(b) (“In any action filed pursuant to [the state UCSPA], the claimant shall not be required to prove that the insurer’s actions were of such a frequency as to indicate a general business practice.”).

212. *Id.* § 17:29B-4(9) (establishing liability for “refusing to pay claims without conducting a reasonable investigation.” (emphasis added)).

213. *Id.*

214. N.J. ADMIN. CODE § 11:2-17.1 (2022).

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12. What, then, is the relevance of insurance commissioner regulations to a potential IFCA violation? Will it be akin to statutory violations in an ordinary tort action: evidentiary but not conclusive?

Logically, insurance department regulations constitute a standard of care. Breach of those standards could be characterized as unreasonableness per se by the insurer. Or, less drastically, a regulatory violation by the insurer facing an IFCA claim could be treated in the manner of a statutory or rule violation in tort claims: highly probative but not conclusive evidence of unreasonable conduct in violation of state regulations.²¹⁵

215. See DAN B. DOBBS, *THE LAW OF TORTS* 315 (2000). The applicable law on this question varies significantly according to the facts of the dispute and the statute in question:

When courts apply the standard or rule of conduct from a nonprescriptive statute, the majority do so under the rule of negligence per se. That rule holds that an adult's violation of statute is negligence in itself if it causes harm of the kind the statute was intended to avoid and to a person within the class of persons the statute was intended to protect. In the absence of a valid excuse, violation conclusively shows negligence.

...

... A few courts reject the per se rule and treat violation as merely some evidence of negligence or as "guidelines for civil liability." This rule permits the jury to conclude that a statute violator behaved in a reasonable way even if he presents no particular excuse.

A number of courts that normally use the negligence per se rule nevertheless apply the evidence of negligence rule selectively [based on the perceived equities of imposing a rule of per se negligence in a given case].

Id. at 315–17 (footnotes omitted).

It should be appreciated that the risk of being held negligent per se for a statutory violation is less than it may first seem in that, as Professor Dobbs notes, the court must first find that the litigant alleging injury from the statutory violation must be within the class of persons intended by the legislature for protection under the statute and the harm of which the litigant complains must be the type of harm that statute was intended to prevent or deter. See *id.* at 317. For example, if a plaintiff is injured by another driver traveling seventy miles per hour in a fifty-five miles per hour zone, most courts would find these conditions satisfied and impose negligence per se. But if the plaintiff is suing the defendant for securities fraud, the defendant's violation of environmental regulations or antitrust laws will not result in a per se finding of fraud and would be unlikely to be considered relevant evidence of such.

In New Jersey, violation of a statute or rule could impose per se liability if the statute or rule was sufficiently specifically designed to attack the behavior at issue or is sufficiently clear that violation is intended to impose per se liability. See *Eaton v. Eaton*, 575 A.2d 858, 862–66 (N.J. 1990) (holding that a guilty plea for violation of careless driving statute is conclusive evidence of tortfeasor fault, reversing trial court due to confusing jury instructions that "charged the jury that a violation [of the careless driving law] was both negligence by itself and negligence."). Summarizing the law, the *Eaton* court stated:

13. What damages are recoverable pursuant to the statute?
And how are they to be determined?

Pursuant to section 3(d)(1) of the IFCA, a successful plaintiff is entitled to “actual damages caused by the violation of this act which shall include, but need not be limited to, actual trial verdicts that shall not exceed three times the applicable coverage amount.”²¹⁶

The statutory language is quite clear and straightforward. Determining “actual” damages may be difficult in operation but the concept is clear. A policyholder injured by a negligent, inadequately insured driver can ordinarily expect to recover the cost of reasonable past medical bills, reasonably anticipated future medical expenses, lost income, an amount for pain, suffering, and loss of enjoyment of life along with a spouse’s claim for loss of consortium damages.²¹⁷

14. Does the “three times the applicable coverage amount”
limitation apply to trial verdicts or all damages?

The language of the IFCA strongly suggests that all damages (as opposed to damage enhancers such as interest, costs, and counsel fees), owed to the policyholder claimant are subject to trebling. Thus, trebling would apply to damages incurred, including amounts in excess of the policy limits but not apply to prejudgment interest, post-judgment interest, costs, and counsel fees. After actual damages are calculated and trebled, the Act states that a successful plaintiff is entitled to “pre- and post-judgment interest, reasonable attorney’s fees, and reasonable litigation expenses.”²¹⁸

Ordinarily, the determination that a party has violated “a statutory duty of care is not conclusive on the issue of negligence, it is a circumstance which the jury should consider in assessing liability.” The reason is that statutes rarely define a standard of conduct in the language of common-law negligence. Hence, proof of a bare violation of a statutory duty ordinarily is not the same as proof of negligence. When, however, a statute specifically incorporates a common-law standard of care, a jury finding of a statutory violation constitutes a finding of negligence.

Id. at 866 (citations omitted).

Insurers might respond that proof of a violation of an insurance commissioner’s rule should not carry as much weight as proof of a statutory violation (admission in the *Eaton* case). Where the rule or regulation does not itself provide that a violation constitutes conclusive of wrongdoing, this argument may succeed. But it is hard to imagine that jurors in IFCA claims will not be allowed to be informed of regulatory violations and at least consider them as at least some evidence of unreasonable conduct toward the policyholder.

216. See N.J. STAT. ANN. § 17:29BB-3(d)(1) (West 2022).

217. *Id.*

218. *Id.* § 17:29BB-3(d)(2).

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This rather straight-forward statutory construction reveals the public policy limitations of the IFCA. In low policy limits cases, the trebling provision will have only modest deterrent impact upon insurers. Although \$75,000 (the minimum \$25,000 policy limit trebled) is hardly a trivial amount, neither is it likely to change the practices of an insurer or merit much attention by well-capitalized insurers.

Revising the statute to require trebling of all damages including interest, fees, and costs would improve the situation. Alternatively, a differential approach to the policy limits trebling ceiling would incentivize better insurer behavior. For example, a statutory multiplier of ten for policies with limits of less than \$100,000, five for policies with limits between \$100,000 and \$250,000, and trebling for policies above \$250,000 would strengthen the provision without having the IFCA mirror the common law regime of punitive damages recovery.

15. Are punitive damages precluded? Limited?

Nothing in the text of the IFCA precludes or limits punitive damages. Existing state punitive damages law has not been explicitly displaced. Insurers may argue that the trebling provisions of the Act are sufficiently punitive to suggest that further exemplary damages are not warranted. Although this may be a good argument for seeking to minimize an award, it is not a persuasive argument for entirely precluding punitive damages. This will depend on the damages award for particular conduct. The IFCA and New Jersey law of punitive damages are not mutually exclusive, but double recovery is not permitted.²¹⁹

A finding of any of the common verbal tests for punitive damages such as conscious disregard, malice, fraud, oppression, or even reckless disregard is not required for IFCA liability (including trebling of damages) upon the insurer.²²⁰ All the Act requires is *unreasonable* denial

219. It appears that plaintiffs frequently seek both statutory damages and common law punitive damages in the same action and that the New Jersey Supreme Court has forbidden this. *See, e.g., Weinberg v. Sprint Corp.*, 801 A.2d 281, 285 (N.J. 2002) (seeking damages pursuant to the state Consumer Fraud Act as well as common law punitive damages). However, punitive damages cannot be imposed in addition to statutory penalties where this produced doubled recovery. *See Jarwick Devs., Inc. v. Wilf*, No. A-2053-13T3, 2018 WL 2449133, at *21–22 (N.J. Super. Ct. App. Div. June 1, 2018); *see also Paletz v. Adaya*, No. B247184, 2014 WL 7402324, at *9–11 (Cal. Ct. App. Dec. 29, 2014) (holding that both statutory penalties and punitive damages may not be imposed for the same conduct if statutory penalties are punitive in nature but can be recovered for separate injurious acts by defendant); *Fassberg Const. Co. v. Hous. Auth. of L.A.*, 60 Cal. Rptr. 3d 375, 409–10 (Cal. Ct. App. 2007).

220. *See* N.J. STAT. ANN. § 17:29BB-3(d) (“Upon establishing that a violation . . . has occurred, the plaintiff shall be entitled to: (1) actual damages caused by the violation of this act which shall include, but need not be limited to, actual trial verdicts that shall not exceed

of a claim by the insurer.²²¹ In order to obtain punitive damages, the policyholder must prove some measure of conduct by the insurer more reprehensible than mere unreasonable behavior. This logically suggests that the IFCA does not eject punitive damages law from applicable claims involving sufficiently reprehensible insurer conduct.

16. What is the statute of limitations for an IFCA claim and how should it be applied?

Because the IFCA is aimed at unreasonable behavior by the insurer in connection with a contract (the insurance policy), the limitations period for IFCA claims should be the limitations period for contract claims: six years in New Jersey.²²² Running begins on the date of accrual, the exact moment of which can sometimes be murky but is generally apparent at the time when it becomes clear that the insurer is refusing to provide the UM/UIM benefits sought by the policyholder. The state's limitations period applies in federal court as well.²²³ Like other limitations periods, that of the IFCA is subject to tolling under apt fact scenarios (e.g., representations or other estoppel conduct by the insurer; incapacity of the claimant for some period of time).²²⁴

17. How does the resolution of the underlying tort claim (settlement, judgment, or otherwise) affect the determination of unreasonableness?

In a UM claim there is almost by definition no recovery by the policyholder from the tortfeasor (uninsured but wealthy tortfeasors may present an occasional exception). In a UIM claim, the insurer for the underinsured tortfeasor typically pays policy limits in relatively short order unless there are serious liability issues, doubt about damages, or the tortfeasor policy limits are quite large.²²⁵

three times the applicable coverage amount; and (2) pre- and post-judgment interest, reasonable attorney's fees, and reasonable litigation expenses.").

221. *Id.* § 17:29BB-3(a)(1).

222. *Id.* § 2A:14-1 (establishing six-year statute of limitations period for breach of contract claims in New Jersey).

223. *Guaranty Trust Co. of N.Y. v. York*, 326 U.S. 99, 110 (1945) (holding that the statute of limitations applicable in state court to state substantive legal claim applies in federal court actions premised on diversity jurisdiction).

224. N.J. STAT. ANN. § 17:29BB-3.

225. See *Protecting Auto Accident Victims*, *supra* note 9, at 4–12, 21. In cases involving low tortfeasor limits, an automobile liability insurer's refusal to pay limits is a rarity. But where tortfeasor limits are large, they are typically large enough to provide full compensation to the policyholder victim and thus eliminate the need for a UM/UIM claim by the injured policyholder. *Id.*

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Although relatively rapid settlement by the tortfeasor's insurer prior to the policyholder's prosecution of a UM/UIM claim against its own insurer is the norm, there is no requirement that the claim against the tortfeasor must be resolved in order to make or even conclude the UM/UIM claim.²²⁶ The UM/UIM insurer may agree that the value of the policyholder's claim exceeds the tortfeasor's policy limits and attempt to resolve the UM/UIM claim under that assumption.

Policyholders as a practical matter will have trouble obtaining an attorney willing to bring their UM/UIM claim on a contingency fee basis where the fault of the tortfeasor and the inadequacy of its insurance is not fairly obvious. But if the tortfeasor's insurer should defend the claim through trial and prevail on liability or obtain an award below policy limits, this would of course preclude a successful UM/UIM claim by the policyholder.

18. Does the New Jersey IFCA apply retroactively?

The general rule is that statutes are applied prospectively and apply only to claims that were unresolved as of the effective date.²²⁷ UM/UIM policyholders with claims pending as of late January 2022 should be subject to the IFCA and, if in litigation, should be able to amend their

226. This flows from the structure of UM/UIM insurance. For example, if a policyholder incurs \$100,000 in medical bills, misses four months of work, and suffers substantial pain after being hit by an at-fault tortfeasor with \$25,000 policy limits, there is no logical reason to require the policyholder victim to wait until the completion of her claim against the tortfeasor before pursuing UM/UIM compensation from her own auto insurer.

In situations like these, the tortfeasor insurer usually pays its limits sufficiently quickly that a suit against both tortfeasor insurer and UM/UIM insurer in the same action does not emerge. But if the tortfeasor insurer unreasonably assesses the claim or has a policy of delaying payment (which can result in the policyholder plaintiff's rejection of a late policy limits offer and an excess judgment against the tortfeasor, who may assign his bad faith or unfair claims handling action to the victim), a policyholder suit against both the tortfeasor insurer and her own UM/UIM insurer may result. *But see What You Should Know About . . . Filing an Uninsured/Underinsured Motorist Property Damage Claim*, N.J. DEP'T OF BANKING & INS., https://www.state.nj.us/dobi/ins_ombudsman/wysk3.htm (last visited Dec. 30, 2022) ("You must . . . submit the claim to the other driver's insurance company, who will pay . . . the liability limit . . . once they have determined that their insured is at fault. If there are [unpaid damages] . . . submit these to your company . . . under Underinsured Motorist Coverage."). The Department explanation is potentially misleading to the extent it suggests that the policyholder cannot take action if the tortfeasor's insurer refuses to concede liability.

227. *See State v. Lane*, 276 A.3d 114, 120–21 (N.J. 2022) (holding that the general rule is that newly enacted statutes have prospective application but are not applied retroactively unless it is clear the legislature intended retroactive application).

pleadings accordingly. However, UM/UIM plaintiffs will not be entitled to reopen decided claims to assert IFCA rights.²²⁸

19. What is the extent of regulatory enforcement authority regarding the new statute?

The IFCA, like any other insurance statute, falls within the regulatory and enforcement authority of the state insurance commissioner.²²⁹ Accordingly, the commissioner has regulatory authority regarding the IFCA commensurate with the commissioner's overall authority.²³⁰

20. What is the current significance of an insurer's "general business practice" as contrasted to an isolated instance of mistake or mistreatment?

In order to prevail in a typical UCSPA statutory claim, even in a state authorizing private rights of action for such claims, the policyholder must often establish that the type of misconduct at issue takes place with sufficient frequency as to reflect a general business practice of the insurer.²³¹ The UCSPA claimant in New Jersey must show that insurer misconduct is part of the insurer's general business practice and not merely an isolated event.²³² This raises questions as to the amount of repetition required and the degree of direction or ratification by upper management that may be required to sustain a claim.

But in New Jersey, such debates are now essentially moot in UM/UIM disputes. The IFCA explicitly states that "[i]n any action filed pursuant to this act, the claimant shall not be required to prove that the insurer's actions were of such a frequency as to indicate a general business practice."²³³

Because the IFCA permits a private right of action (something unavailable under the New Jersey UCSPA) and provides significant remedies, it likely will become the statute of choice for policyholders

228. *See id.*

229. *See* N.J. STAT. ANN. § 17:29BB-3; *see also In re Comm'r of Ins.'s Issuance of Ords.* A-92-189 & A-92-212, 644 A.2d 616, 623–25 (N.J. Super. Ct. App. Div. 1993) (upholding the Commissioner's authority to promulgate rules to achieve the legislative objectives of the Fair Automobile Insurance Reform Act ("FAIR")), *aff'd per curiam*, 644 A.2d 576 (N.J. 1994).

230. *See* § 17:29BB-3.

231. Rita M. Theisen, *Recent Developments in Private Rights of Action Under the Unfair Claims Settlement Practices Act*, 23 TORT & INS. L.J. 19, 32 (1987).

232. *See* § 17B:30-13.1.

233. *Id.* § 17:29BB-3(b).

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seeking relief and recompense from their insurers.²³⁴ Questions as to what constitutes a general business practice may continue to require serious attention from regulators and insurer counsel resisting regulatory discipline but they are likely not to impact individual policyholder actions against their insurers, at least in UM/UIM disputes.

21. Does the “entire controversy doctrine” apply?

New Jersey’s entire controversy doctrine (“ECD”) looks largely like a broad, perhaps overbroad, version of the universal rule that a plaintiff may not split the cause of action against a defendant and widely accepted notions of claim preclusion and issue preclusion.²³⁵ Because state preclusion law, of which the ECD is a part, applies to diversity jurisdiction cases in federal court, the ECD’s applicability or lack thereof should be the same in either state or federal court.²³⁶

To be sure, the ECD is somewhat broader than traditional preclusion doctrine and the no-splitting rule in that it requires joinder of all claims against a defendant and at one time required joinder of all known adverse parties involved in a particular dispute, a requirement later relaxed by an amendment to court rules.²³⁷ But after its zenith in the mid-1990s,²³⁸

234. Compare *id.* §§ 17:29BB-3(a)–(d) (providing a private right of action, potential treble damages, and recovery counsel fees), with N.J. ADMIN. CODE § 11:2-17.1 (2022) (stating the purpose of the unfair claims settlement process is to “promote fair and equitable treatment”), and N.J. ADMIN. CODE § 11:2-17.15 (describing the penalties the Commissioner may impose against persons found in violation of the statute after a hearing); see also *ProCentury Ins. Co. v. Harbor House Club Condo.*, 652 F. Supp. 2d 552, 563 (D.N.J. 2009) (“[T]here is no private cause of action under the Unfair Claims Settlement Practices Act.”). Equally important, the IFCA acts to provide a de facto private right of action under the New Jersey UCSPA by making UCSPA violations actionable in an IFCA action. See N.J. STAT. ANN. § 17:29BB-3(a).

235. See *Bank Leumi USA v. Kloss*, 233 A.3d 536, 540–41 (N.J. 2020) (discussing the entire controversy doctrine, its origin in *res judicata* and claim preclusion, the doctrine’s equitable purpose, and the need for judicial discretion in its application). Regarding the elements and application of claim and issue preclusion, see generally COLEMAN ET AL., *supra* note 194, at 793–811.

236. See *Taylor v. Sturgell*, 553 U.S. 880, 891 n.4 (2008) (“For judgments in diversity cases, federal law incorporates the rules of preclusion applied by the State in which the rendering court sits.” (citing *Semtek Int’l, Inc. v. Lockheed Martin Corp.*, 531 U.S. 497, 508 (2001))).

237. *Cogdell v. Hosp. Ctr. at Orange*, 560 A.2d 1169, 1178 (N.J. 1989); see also N.J. CT. R. 4:30A; Allan R. Stein, *Forward*, 28 RUTGERS L.J. 1, 1 (1996).

238. See *Mortgagelinq Corp. v. Commonwealth Land Title Ins. Co.*, 662 A.2d 536, 537 (N.J. 1995) (holding that “when a party deliberately chooses to fragment litigation by suing certain parties in another jurisdiction and withholds claims against other parties, a New Jersey court need not later entertain the claims against the omitted parties if jurisdiction was available in the first forum”); *Ditrollo v. Antiles*, 662 A.2d 494, 497, 508 (N.J. 1995) (holding that a cause of action against a doctor, after previous litigation against the

the doctrine's reach has been relaxed and leavened by greater appreciation and application of equitable considerations.²³⁹ Most important, it has not generally required that insurers or reinsurers be brought into litigation involving a policyholder.²⁴⁰

Properly applied, the doctrine is unlikely to require that IFCA claims regarding UM/UIM benefits be combined with the underlying vehicular collision that results in an IFCA claim. The ECD, now memorialized in New Jersey Court Rule 4:30A, states that:

hospital, was barred by the entire controversy doctrine because the similarity of the facts "constitute[d] essentially a single controversy that should be the subject of only one litigation"); *Mystic Isle Dev. Corp. v. Perskie & Nehmad*, 662 A.2d 523, 526, 535 (N.J. 1995) (holding that the entire controversy doctrine barred malpractice litigation against attorneys after plaintiff's first action was dismissed without prejudice as to one defendant); *Circle Chevrolet Co. v. Giordano, Halleran & Ciesla*, 662 A.2d 509, 511, 520 (N.J. 1995) (holding that a plaintiff was barred by the entire controversy doctrine from bringing a malpractice claim against an attorney representing the client in the underlying litigation). These four 1995 decisions in particular stirred controversy and criticisms that the doctrine had been taken too far by the supreme court. See Symposium, *Entire Controversy Doctrine*, 28 RUTGERS L.J. 1 (1996). The Symposium featured articles by prominent civil procedure experts Professors Geoffrey C. Hazard, Jr., Allan R. Stein, Stephen Burbank, Rochelle Cooper Dreyfus, Linda J. Silberman, and Perry Dane, as well as noted professional responsibility expert Professor Nancy J. Moore, all largely critical of broad use of the doctrine. *Id.*

239. See, e.g., *Bank Leumi USA*, 233 A.3d at 540–41.

240. See, e.g., *Hobart Bros. v. Nat'l Union Fire Ins. Co.*, 806 A.2d 810, 817–18 (N.J. Super. Ct. App. Div. 2002); *McNally v. Providence Wash. Ins. Co.*, 698 A.2d 543, 549 (N.J. Super. Ct. App. Div. 1997); see also *Allstate N.J. Ins. Co. v. Cherry Hill Pain & Rehab. Inst.*, 811 A.2d 493, 500 (N.J. Super. Ct. App. Div. 2006) (finding where medical provider's suit against insurer lacked standing, later action alleging violation of New Jersey Insurance Fraud Prevention Act not precluded by ECD because first action made no decision on the merits); Andrew T. Berry, *Application of the Entire Controversy Doctrine to Insurance Coverage Litigation: A Bridge Too Far*, 28 RUTGERS L.J. 41, 41 (1996) ("[T]he ECD has never been applied to preclude an insurance coverage claim brought after a related tort case."). But see *Wadeer v. N.J. Mfrs. Ins. Co.*, 110 A.3d 19, 30 (N.J. 2015) (finding ECD bar to bad faith claim where facts surrounding the claim were raised, actually litigated, and necessarily decided in prior action); *Reid v. Transp. Ins. Co.*, 502 F. App'x 157, 160–61 (3d Cir. 2012) (applying New Jersey law) (holding policyholder's failure to raise bad faith claim during seven-year litigation over entitlement to UIM coverage made ECD applicable to bar later bad faith suit after conclusion of UIM litigation). The 2016 Amendment to New Jersey Court Rule 4:30 effectively overruled *Wadeer* and cases taking this approach. See N.J. CT. R. 4:30A. Andrew T. Berry presents persuasive arguments for declining to apply the ECD in the context of insurance coverage or bad faith actions. See Berry, *supra*, at 41, 53. Although these share factual commonality with the auto collision matters that spawned the insurance dispute, there are prudential reasons for generally allowing resolution of collision claims (and permitting counsel leeway on the matter) before addressing alleged insurer misconduct. In addition, of course, a controversy between policyholder and insurer is distinct from a controversy between policyholder and tortfeasor.

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Non-joinder of claims required to be joined by the entire controversy doctrine shall result in the preclusion of the omitted claims to the extent required by the entire controversy doctrine, except as otherwise provided by other [rules governing foreclosure actions, counterclaims, and cross-claims in summary actions]. *Claims of bad faith, which are asserted against an insurer after an underlying uninsured motorist/underinsured motorist claim is resolved in a Superior Court action, are not precluded by the entire controversy doctrine.*²⁴¹

22. Should discovery on IFCA claims be stayed pending discovery/resolution of an underlying UM/UIM action?

Judges have broad discretion regarding the scope and timing of discovery.²⁴² But staying discovery as a matter of course in disputes involving IFCA claims is unwise to the point of at least bordering on abuse of discretion—and perhaps crossing the border.

State law on this point is not clearly established, but the majority position appears to be that a policyholder need not prevail on its coverage claim in order to succeed on a claim for bad faith or unfair claims handling.²⁴³ However, the view that a policyholder need not prevail on its coverage claim in order to succeed on a claim for bad faith or unfair claims handling is correct. Coverage relates to the application of the insurance policy/contract.²⁴⁴ Good faith and compliance with a fair claims handling statutes involve the conduct of the insurer.²⁴⁵ Consequently, sound reasoning supports the proposition that a policyholder need not establish coverage to establish either common law bad faith or a statutory claims handling violation.

241. N.J. CT. R. 4:30A (emphasis added).

242. See, e.g., FED. R. CIV. P. 16 (providing broad case management power to judges); FED. R. CIV. P. 30 (providing judicial authority to regulate deposition practice and alter presumptive time limits); FED. R. CIV. P. 33 (providing judicial authority to grant additional interrogatories); FED. R. CIV. P. 37 (providing judicial authority to compel discovery); FED. R. CIV. P. 26 (providing extensive judicial power to management discovery, including Rule 26(b)(1) giving court power to restrict otherwise relevant discovery based on whether it is “proportional to the needs of the case” and Rule 26(c)(1) power to issue protective orders).

243. Karin S. Aldama et al., *Procedural Bad Faith—Recent Trends and Development*, AM. BAR ASS’N (Mar. 4, 2021), <https://www.americanbar.org/groups/litigation/committees/insurance-coverage/articles/2021/procedural-bad-faith-trends/> (describing the various positions of states, including a minority that allow procedural bad faith claims “even where coverage was properly denied” and noting that “[a] few states have . . . explicitly rejected such claims” and that “[m]ost states are somewhere in the middle [in that] they recognize procedural bad-faith claims but are still developing those claims’ contours and limitations”).

244. See DELAY, DENY, DEFEND, *supra* note 128, at 3–4.

245. RESTATEMENT OF LIAB. INS. § 49 (AM. L. INST. 2019).

Put another way, an insurer may ultimately be found correct about a coverage denial or the valuation of a claim but nonetheless have treated the policyholder in a manner that violates statutory duties or the common law covenant of good faith and fair dealing inherent in any contract.

III. THE UNFINISHED BUSINESS OF POLICYHOLDER PROTECTION

Notwithstanding the IFCA, insurers continue to retain substantial leverage over policyholders. Even under the IFCA regime, insurers retain substantial ability to stave off policyholders with insufficient responses and questionable denials while “running down the clock” with delay favoring them in a war of resources and attrition with policyholders or assignees.²⁴⁶ The problem is particularly pronounced for individual policyholders—e.g., auto policyholders, a group comprising most of the adult population—who are less heavily armed for a “war of attrition” than their commercial counterparts.²⁴⁷ Admittedly, the IFCA aids them, at least if they had the presence of mind to purchase UM/UIM coverage, but that is rather cold comfort to homeowners, life, health, and disability policyholders.²⁴⁸

Because of the factors addressed in Section I.E above, the presence of a private right of action pursuant to the IFCA does not sufficiently correct the power imbalance of insurance. Policyholders, even commercial policyholders, are a long way from being on equal footing with insurers. Seemingly strong remedies like the bad faith cause of action can often be minimized by insurers advancing seemingly plausible—even if actually pretextual—reasons for their conduct that may be deemed sufficient by a court, resulting in pre-trial dismissal of claims.²⁴⁹ Lack of understanding of the nature and operation of insurance and the attendant duties of insurers (and their agents) compounds the problem.²⁵⁰

246. See Letter from Warren E. Buffett to Shareholders of Berkshire Hathaway Inc., *supra* note 116 (describing operation of Berkshire Hathaway insurance companies).

247. EUGENE R. ANDERSON ET AL., *INSURANCE COVERAGE LITIGATION* §1.01[b] (2d ed. 2000).

248. Baker, *supra* note 1.

249. See *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (holding judge may dismiss claims found in the eyes of the judge not to be sufficiently “plausible”); *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 557 (2007).

250. A favorite example of simply failing to understand insurer obligations and their violations: after I gave a lengthy presentation on *State Farm Mutual Automobile Ins. Co. v. Campbell*, 538 U.S. 408 (2003), which in spite of the Supreme Court’s vacation-cum-reduction of a \$145 million punitive damages award, involved conduct found reprehensible by a Salt Lake City jury, a trial judge, and twice by the Utah Supreme Court, during the

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Where insurers are unable to avoid liability beyond policy limits by motion, they retain substantial weaponry via appeal. In addition to the risk of complete reversal, even the prospect of remand imposes a chill on a policyholder wins at trial because of the costs and uncertainty of retrial for cash-strapped policyholders and counsel working on contingent fees and advancing costs.²⁵¹ The mere act of filing an appeal will often prompt negotiated reduction of the judgment by policyholders and counsel unwilling to risk the prospect of defeat on appeal.²⁵² And despite prejudgment interest, the appellant insurer may continue to benefit from investments if its portfolio is doing sufficiently better than the prejudgment interest rate.²⁵³

A variety of factors permit insurers to play the proverbial “long game”: the time value of money; even modest attainment of pretrial victory by motion, which prevents jury consideration of insurer conduct; and favorable settlement with fatigued policyholders, some of whom tire sufficiently quickly that they never press claims to the point of litigation.²⁵⁴ These factors all allow insurers to take a comparatively hard-line approach to claims. In addition, as previously noted, UM/UIM insurers—and all liability insurers—are the ultimate “repeat players.”²⁵⁵ They have an extensive portfolio of cases for absorbing and spreading losses as well as banking wins. They are quite literally in the full-time

post-presentation questions session, an audience member asked “What did State Farm do wrong?” *Id.* at 419–20, 429. Not everyone understands insurance. For a longer discussion/criticism of State Farm’s conduct in the matter, see generally STEMPPEL, *LITIGATION ROAD*, *supra* note 9. And the lack of understanding is not confined to the laity or generalist lawyers. Counsel (mostly those representing claimants) frequently relay with astonishment, stories in which a judge at a pretrial conference wonders aloud whether there can be bad faith if the insurer eventually paid policy limits, albeit years after demand, and without a timely investigation and evaluation at the time of the demand. This sort of reaction is concerning in that the law for some time has pretty clearly found such eventual payment not to be a defense to bad faith and unfair claims handling actions. See *Campbell v. State Farm Mut. Auto. Ins. Co.*, 840 P.2d 130, 139 (Utah Ct. App. 1992).

251. See Galanter, *supra* note 128, at 98–114.

252. Jay M. Feinman, *Incentives for Litigation or Settlement in Large Tort Cases: Responding to Insurance Company Intransigence*, 189 *ROGER WILLIAMS U. L. REV.* 211–13 (2008).

253. *Id.* For example, an insurer’s investment returns from securities, real estate, high-yield bonds may be higher than the prevailing rates of pre- and post-judgment interest. During times of low interest rates, perhaps even commercial paper and corporate or government bonds will exceed the litigation interest rates. Further, unless an insurer has very bad judgment, it will not lose every case involving its policyholder and hence will avoid pre- and post-judgment interest in a significant number of lawsuits. But its investment income applies to its use of all premiums collected.

254. See Galanter, *supra* note 128, at 98–114.

255. See *id.* at 97.

business of litigation while “one-shot” policyholders may face legal disputes only once in a lifetime.²⁵⁶

Further, insurers can select which cases in their portfolio will be settled or hotly contested.²⁵⁷ Where faced with a less favorable judge, jurisdiction, venue, jury venire, or scenario, the insurer can settle the case to avoid an unfavorable and potentially precedential outcome.²⁵⁸ A more generous settlement offer may be made in order to obtain a confidentiality agreement.²⁵⁹ Or the insurer may answer a complaint, engage in protracted discovery, and then settle or try the case rather than making dismissal or summary judgment motions that if denied would produce unfavorable precedent.²⁶⁰

Even if policyholders achieve some significant victories, a strategy of consistent-cum-massive resistance can be a winning one financially for insurers. For every policyholder judgment obtaining damages exceeding policy limits—the bare minimum a meritorious policyholder claimant should receive pursuant to basic contract law—or obtaining punitive damages, insurers shaving costs on a book of claims appear to collect more than enough additional income through reduced claim payments and prolonged investment to net out ahead.²⁶¹ At the time of the now-famous *Campbell v. State Farm* bad faith trial, State Farm, one of the world’s largest insurers, apparently did not even keep track of punitive damages awards.²⁶² Although this was disputed by one of the Campbell expert witnesses,²⁶³ the episode suggests that the insurer was not particularly worried about punitive damages.

The New Jersey IFCA will reduce but hardly eliminate the power disparity between insurers and policyholders. Notwithstanding the

256. *See id.*

257. *See id.* at 101–02.

258. *See id.*

259. DELAY, DENY, DEFEND, *supra* note 128, at 9–10.

260. *See id.*

261. A modest thought experiment illustrates the advantage insurers enjoy in this regard. If Insurer A faces 1,000 new claims in a year, it could decide to deny every one of them, even without legitimate basis. Many claimants would simply give up rather than retain counsel or file suit. In the litigated case, the insurer could be found ultimately liable for policy limits on everyone but would prior to forced payment of policy limits have earned substantial investment income during the pendency of the claim prior to judgment. This judicially unsuccessful hardball strategy will lose money only if the amount owed on counsel fees and prejudgment/post-judgment interest exceeds that investment income or policyholder frequently obtain punitive damages. But this is unlikely. Even where bad faith is found, there is no guaranty of punitive damages. Unless the insurer is frequently subject to very large compensatory damages or punitive damages, a denial strategy is likely to be fiscally profitable for insurers.

262. See STEMPER, LITIGATION ROAD, *supra* note 9, at 311, 325.

263. *See id.*

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IFCA, insurers will continue to frequently get away with improper claims denials, underpayment, and delayed payment. Beyond the IFCA, what should be done? More practically, what can be done?

The answer to the second question is perhaps easier if more dismal. Insurance law reform favoring policyholders (commercial as well as individual) is difficult to attain. Insurers have immense political clout and lobbying power.²⁶⁴ In states with strong and organized plaintiffs' bars, that power is reduced but hardly eliminated. Insurers have frequently succeeded in supporting candidates for the bench—both via election and appointment—favoring their interests, and sometimes show sufficient strength to legislatively overrule judicial decisions disliked by insurers or to seek to curtail or ban practices disliked by insurers.²⁶⁵

Even if the bench is not particularly receptive to policyholder claims, judges do follow the law, making statutory reforms such as the IFCA effective if incomplete remedies. As reflected by the IFCA, which became law despite insurer opposition because of years of tenacious work by consumer and policyholder advocates, insurers do not always prevail in the legislative arena.²⁶⁶ But the success of the IFCA, although encouraging, remains a relative rarity in a nation where many states do not even accord aggrieved policyholders a private right of action.

In addition, the IFCA is directed toward curtailing insurer misconduct in UM/UIM claims.²⁶⁷ Where insurer misconduct takes place regarding other coverages or lines of insurance, the aggrieved policyholder cannot take advantage of the Act's private right of action, liability standard, treble damages, or fee shifting.²⁶⁸ The IFCA was enacted in response to concern that insurers were too often rejecting meritorious claims or slow walking them.²⁶⁹ There is little reason to think that these problems are confined to UM/UIM coverage. Policyholders with medical needs, property damage, inability to work, family deaths,

264. See also *supra* note 129 (discussing examples of insurer social, political, and economic capital).

265. See William Rabb, *Fla. Contractors File Suit Challenging Assignment of Benefits Law*, CLAIMS J. (June 1, 2022), <https://www.claimsjournal.com/news/southeast/2022/06/01/310750.htm>. For example, Florida recently enacted limitations on contractors soliciting customers for roof repair or new installation using assignment of homeowners insurance benefits as payment. See *id.*

266. Frederic Giordano et al., *New 'Bad Faith' Claim Law Holds NJ Insurers Accountable*, LAW360 (Mar. 1, 2022, 10:27 AM), <https://www.law360.com/insurance-authority/articles/1467880/new-bad-faith-claim-law-holds-nj-insurers-accountable>.

267. *Id.*

268. *Id.*

269. Eli Flesch, *NJ Gov. Signs Bill to Allow 'Bad Faith' Insurance Suits*, LAW360 (Jan. 19, 2022, 4:45 PM), <https://www.law360.com/insurance-authority/articles/1456179/nj-gov-signs-bill-to-allow-bad-faith-insurance-suits>.

or facing non-automobile litigation deserve just as much legislative concern.

A presumptive wish list (if not a punch list because of the odds against attainment) however, is fairly easy to articulate. Reforms—some legislative, some judicial—that would improve the situation facing policyholders with minimal loss for insurers, at least reputable insurers, include the following.

A. *Broadly Applicable Fair Conduct Statutes Not Limited to UM/UIM Matters or Any Single Type of Insurance*

First and perhaps obviously, the IFCA should be expanded to include all insurance claims, not merely UM/UIM claims. Even restricting statutory coverage to “first-party” claims is probably a mistake. Although the risk of a judgment in excess of policy limits and *Rova Farms* liability exerts substantial (but necessary) pressure on liability insurers, limiting policyholder recovery beyond policy limits to only the excess judgment (not required by *Rova Farms* but often assumed to be the limit of the decision)²⁷⁰ still risks substantial under-compensation of a policyholder who incurs emotional distress, lost work, or other damages from insurer delay or misconduct in addition to judgments exceeding policy limits.

B. *Universal Private Rights of Action for Fair Claims and Consumer Protection Statutes*

Second and more broadly, all states should provide a private right of action for violations of their unfair claims settlement practices acts and provide IFCA-type remedies to the extent these are not in the states’ current versions of the UCSPA. The experience of states where policyholders have this right and need not depend on state officials to achieve the public policy goals of the Act strongly suggests that making policyholders a type of private attorney general and allowing them recompense beyond common law results in better compensation to

270. See *Rova Farms Resort, Inc. v. Inv. Ins. Co. of Am.*, 323 A.2d 495 (N.J. 1974); see also discussion *supra* Section II.A (discussing *Rova Farms* and pre-IFCA New Jersey bad faith law). Although *Rova Farms* concentrates on the amount of a judgment exceeding policy limits as a liability for the insurer failing to make a reasonable settlement decision, it does not preclude other forms of compensation for proven damages such as emotional distress. See discussion *supra* Section II.A; see also STEMPER, LITIGATION ROAD, *supra* note 9, at 133 (discussing how in now-famous *Campbell v. State Farm* case against insurer for failing to accept reasonable offers to settle for \$50,000 policy limits and trial result of more than \$200,000 liability, policyholders not limited to amount of excess judgment but awarded more than \$1 million in emotional distress damages).

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policyholders and better behavior by insurers with little decrease of insurer wealth.²⁷¹

C. Improving and Clarifying the Bad Faith Concept

Third, insurance law would benefit in many states, including New Jersey, from a retooling of the standard for assessing the state of mind required for bad faith. The prevailing definition is one requiring that the insurer act unreasonably with knowledge or reckless disregard as to its conduct.²⁷² Although adequate, this standard makes it too easy for judges and jurors to incorrectly require a showing of something approaching specific intent to injure before finding bad faith.²⁷³

A better standard less likely to unfairly raise barriers to recovery would be defining bad faith as depriving the policyholder of the benefit of the bargain. This standard, which has support in contract law,²⁷⁴ is less subject to misunderstanding. Factfinders need not determine the state of mind of insurers and their representative or whether troublesome conduct rises to the level of reckless disregard. Rather, they can focus on whether the insurer's conduct negated the insurance protection and service the policyholder had a right to expect.²⁷⁵

D. Requiring Insurers to Be Responsible for All Claims Decisions

Fourth, any "institutional" prerequisite for recovery from claims handling statutes should be removed. The typical state UCSPA, like the NAIC Model Act, requires that the insurer misconduct at issue be authorized by management.²⁷⁶ Recently, insurers have attempted to avoid liability by arguing that the misdeeds of individual line adjusters are unknown to upper management and that the UCSPA therefore does not apply.²⁷⁷

271. See Brown et al., *supra* note 138, at 386.

272. See RESTATEMENT OF LIAB. INS. § 49 (AM. L. INST. 2019).

273. See *id.*

274. See *Mkt. St. Assocs. Ltd. P'ship v. Frey*, 21 F.3d 782, 786 (7th Cir. 1994) (applying Wisconsin law) (holding that the duty of good faith prohibits one contracting party from taking deliberate advantage of another or engaging in opportunistic behavior). In an earlier opinion in the dispute, Judge Richard Posner outlined the concept more extensively. See *Mkt. St. Assocs. Ltd. P'ship v. Frey*, 941 F.2d 588, 594–97 (7th Cir. 1991); see also *Apollo Educ. Grp., Inc. v. Nat'l Union Fire Ins. Co.*, 480 P.3d 1225, 1231 (Ariz. 2021) (holding "[i]nsured must receive the bargained-for benefit of its policy").

275. *Apollo Educ. Grp.*, 480 P.3d at 1231.

276. NEV. REV. STAT. ANN. § 686A.270 (2022).

277. See *McCall v. State Farm Mut. Auto. Ins. Co.*, No. 16-CV-01058J, 2018 WL 3620486 (D. Nev. July 30, 2018), *aff'd*, 799 F. App'x 513 (9th Cir. 2020).

Absent truly rogue adjusting in violation of company policy and defiance of managerial directives, this defense is incorrect and unpersuasive. For nearly all claims, adjusters are doing what they do because it is expected of them in light of their training, orientation, and supervision. In addition, insurers seldom reverse a claims decision or discipline an adjuster in response to litigation. More often, the primary adjuster on a disputed claim has been promoted, paid bonuses, or left the company for a better position, something that implies no negative commentary on the adjuster's work.²⁷⁸

But rather than expend disputing resources arguing about the precise managerial knowledge of a particular claim, "management authorization" requirements should be culled from fair claims statutes. Alternatively, courts could interpret the statute to simply impose a strong presumption of strict liability of the insurer for the conduct of insurer employees (and agents) operating within the scope of their authority.

E. Expanded Remedies for Policyholders

Fifth, the available damages against an insurer mistreating a policyholder should be expanded. In addition to treble damages, courts should be permitted to use a higher multiple where the court finds insurer conduct sufficiently egregious. Alternatively, the size of the multiplier could be tied to the policy limits involved. Legislators should consider something like: for limits of \$50,000 or less, a twentyfold multiplier; for limits between \$50,000 and \$100,000, a tenfold multiplier; for limits in the \$100,00 to \$300,000 range, a five-fold multiplier; for policy limits above \$300,000, trebling of the damages. Tiering of this type would provide the necessary deterrence that the IFCA trebling provision fails to fully achieve in cases involving low policy limits.

278. Precise data is of course difficult to obtain because of the confidentiality typically accorded to personnel files, effectively precluding comprehensive empirical study. But in the more than 200 insurance bad faith matters in which I have been involved as a consulting or testifying expert, I have yet to see an instance where an adjuster alleged to have engaged in bad faith unfair claims handling was fired, disciplined, or received a reduction in compensation. In the majority of these cases, the accused adjuster has received favorable job performance reviews from the insurer along with an increase in compensation and often promotion. Or the adjuster has taken a perceived better job with another insurer. Unless the policyholders complaining about the adjuster are 100 percent wrong in all of these cases (and in some of these cases that did not settle, there were subsequent adjudications of bad faith by the adjuster and insurer), this strongly suggests either outright approval of questionable adjuster conduct or the view that some bad faith claims because of the adjuster's conduct are acceptable because of the adjuster's overall track record in suppressing claims payments.

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The treble damages provision of the IFCA is of course a positive development and a good model for other states. But one can legitimately wonder whether something more than trebling is required, at least in some cases. For example, a policyholder may be horribly treated by the insurer but suffer only small actual damages. Increasing this amount by a factor of three does not provide either much reward to the policyholder or much deterrence of bad behavior.

The same problem presents in cases involving modest compensatory damages but egregious defendant conduct.²⁷⁹ There, courts have responded by permitting punitive awards with a much higher multiple than the presumptive 9:1 constitutional ceiling set forth in *State Farm Mutual Auto. Ins. v. Campbell*.²⁸⁰ But many states impose limiting ratios on punitive damages lower than a 9:1 ratio,²⁸¹ although some insurance matters may be excepted from the statute.²⁸² Going further, states should eliminate any stated limit on punitive damages for insurers and rely on the rather stringent *State Farm v. Campbell* criteria²⁸³ alone as a gauge of whether a punitive damages award is too high.

279. See generally *Saunders v. Branch Banking & Tr. Co.*, 526 F.3d 142 (4th Cir. 2008).

280. *State Farm Mut. Auto. Ins. v. Campbell*, 538 U.S. 408, 410 (2003); *Saunders*, 526 F.3d at 153–54 (affirming \$80,000 punitive award in case of \$1,000 damages set by statute); *Abner v. Kan. City So. R.R.*, 513 F.3d 154, 165 (5th Cir. 2008) (affirming punitive damages of \$125,000 in case of \$1 nominal damages); *Mathias v. Accord Econ. Lodging, Inc.*, 347 F.3d 672, 674–78 (7th Cir. 2003) (permitting award of \$186,000 in punitive damages in case of \$5,000 compensatory damages due to presence of bedbugs in hotel; defendant aware of problem, concealed it from customers, and failed to remedy it).

281. See Tara Blake, *50-State Survey of Statutory Caps on Damages and the Applicability of the Collateral Source Rule*, JDSUPRA (Nov. 13, 2020), <https://www.jdsupra.com/legalnews/50-state-survey-of-statutory-caps-on-39804/>; ALA. CODE § 6-11-21(d) (2022) (setting cap of three times compensatory damages or \$1.5 million, whichever is greater, a cap that in many insurance claims will be more plaintiff-friendly than the U.S. Supreme Court's presumptive ratio of 9:1); ALA. CODE §§ 6-11-21(b)–(c) (setting cap of \$50,000 for business with net worth of \$2 million or less at time of infraction or ten times ten percent of net worth, whichever is greater).

282. See, e.g., NEV. REV. STAT. § 42.005 (2022) (setting cap of \$300,000 if compensatory damages less than \$100,000; cap of three times compensatory damages of \$100,000 or more; no cap for product liability, insurance bad faith, housing discrimination, toxic torts, or defamation, or auto accident claims involving alcohol or drugs).

283. See *Campbell*, 538 U.S. at 418–28 (finding that the U.S. Constitution requires judicial review of punitive damages awards to ensure compliance with due process according to factors of (1) reprehensibility of conduct at issue; (2) the ratio of compensatory damages to punitive damages, with a presumption that punitive damages will not be greater than nine times compensatory damages in cases where compensatory award is substantial; and (3) punitive damages award is reasonable in light of regulatory regime and penalties for misconduct).

F. Direct Actions Against Insurers

Sixth, legislation should provide for direct actions against insurers by those injured by policyholders. Although this is not an impediment to UM/UIM claims which by definition are claims between an injured policyholder and its insurer, the current legal regime constrains victim options and misses an opportunity for greater efficiency.

Direct actions have not been permitted by common law. Connecticut, Georgia, Guam, Iowa, Kansas, Louisiana, Nebraska, Puerto Rico, Rhode Island, Wisconsin, and New Jersey have such statutes²⁸⁴ but they have not appeared to significantly improve policyholder fortunes—nor caused detriment to insurers. In the other forty states, the strong general rule is that an accident victim seeking compensation can sue only the tortfeasor/policyholder even where it is quite clear that the tortfeasor has no real assets other than policy limits.²⁸⁵

As a result, the victim's lawyer may need to pursue insurance indirectly by building a sufficiently strong case that the lawyer for the policyholder/defendant recommends payment. Where this does not occur, victim counsel is often willing to settle the claim with a covenant not to execute on a judgment higher than policy limits in return for an assignment of the policyholders' bad faith and statutory claims.²⁸⁶

Although one can characterize this situation as a relatively harmless procedural hoop through which the victim must jump, it creates a needless layer of procedure and expense as well as reduces the insurer's knowledge of and focus upon the merits of the case counseling settlement. Permitting direct actions may not be a great boon to collision victims but would at the margin provide additional incentives for fair claims handling with little detriment to insurers.

284. See generally Mark Mese, *Direct Action Statutes*, 15 CGL REPORTER 1 (2003), https://www.keanmiller.com/files/direct_action_statutes.pdf.

285. See *id.*

286. This form of assignment of the policyholder's bad faith claim against its insurer to the plaintiff who obtained a judgment against the defendant policyholder is common. See, e.g., *Nunn v. Mid-Century Ins. Co.*, 244 P.3d 116, 119–20, 124 (Colo. 2010). Some states may restrict such assignments, however. See, e.g., *Maldonado v. First Liberty Ins. Corp.*, 342 Fed. App'x 485, 487 (11th Cir. 2009) (interpreting Florida law to permit partial but not total assignment of policyholder rights). But there are other means of pursuing bad faith claims. For example, after the judgment against Curtis Campbell, he and his wife agreed to pursue a bad faith claim against State Farm and to share any recovery with the other parties to the underlying lawsuit in which he was found to be the at fault driver. See STEMPEL, LITIGATION ROAD, *supra* note 9, at 152–53.

2022] *NEW JERSEY INSURANCE FAIR CONDUCT ACT* 267*G. Asymmetric Fee Shifting*

Seventh, fee shifting in favor of prevailing policyholders should be mandatory, but fee shifting in favor of prevailing insurers should be available only where the policyholder's position was sufficiently weak to violate Fed. R. Civ. P. 11 or its state equivalents.²⁸⁷ Although this may be the practical status quo in many states, a prevailing de jure norm where policyholders need not fear counsel fee liability for losses would likely permit more policyholder claims that today are not brought due to policyholder fear of losing. Insurers as risk bearers and distributors are in a less vulnerable position. They also deduct litigation expenses from their taxes as an ordinary business expense.²⁸⁸ Forcing insurers to pay plaintiff counsel fees whenever they lose and not only in cases of pronounced misconduct, would provide additional useful incentive for insurers to engage in reasonable conduct from the outset.

H. Providing More Detail About Insurer Duties

Eighth, the duties of insurers could be made more specific. Valuable suggestions are that insurers should be required to "provide policyholders with information about the claim process and policyholder rights" as well as a copy of the claim file on request.²⁸⁹ In addition, "[p]olicyholders should have reasonable time limits for filing claims and,

287. This is the law of fee shifting in Title VII cases. See *Christiansburg Garment Co. v. EEOC*, 434 U.S. 412, 416–18, 422 (1978). Individual and small business policyholders and employment discrimination plaintiffs are in a similar position. Both may typically have modest means and their motivation to seek legal redress will be significantly chilled if they risk paying defendant legal fees if the claim fails. For commercial policyholders, the case for one-way fee shifting (subject to the frivolous claim exception) is less compelling. But insurer advantage in this arena remains strong. For example, the asbestos mass tort was of course a significant economic burden on insurers who sold policies to businesses that became asbestos defendants. But many more of these asbestos defendants went bankrupt than did their insurers. See Jeffrey W. Stempel, *Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute*, 12 CONN. INS. L.J. 349, 353–54, 416–21 (2006) ("While there are a handful of insurer insolvencies linked to asbestos coverage, there are more than seventy bankruptcies of asbestos defendant policyholders.").

288. See Sachin S. Pandya & Stephen Utz, *Designing the Tax Treatment of Litigation-Related Costs*, 21 FLA. TAX REV. 533, 534 (2018) ("Defendants can often deduct from income from their litigation-related costs, such as attorney fees and payments to settle claims or satisfy judgments.").

289. See UNITED POLICYHOLDERS & RUTGERS CTR. FOR RISK & RESPONSIBILITY, ESSENTIAL PROTECTIONS FOR POLICYHOLDERS 8 (2016) [hereinafter ESSENTIAL PROTECTIONS FOR POLICYHOLDERS], https://epp.law.rutgers.edu/epp/wp-content/uploads/sites/16/2016/10/EPP-full-2019_0.pdf.

in case of a dispute, for filing litigation against the insurance company.”²⁹⁰

I. Further Considerations

Beyond improving the claims process, valuable recommendations from policyholder advocacy groups and think tanks include regulator posting online of policy forms and insurer track records regarding claims dispositions and payment, clear policy language requirements, and greater disclosure of information, particularly admonitions to be adequately insured.²⁹¹ Regarding policy content, essential terms and options for additional or expanded coverage should be available for review before purchase.²⁹² In addition, insurers should be prohibited from “cancellation, nonrenewal, or premium increase” based on policyholder inquiry about a single loss or claim.²⁹³

CONCLUSION

Should these suggestions be adopted in some changed world of reduced insurer ability to thwart reform, insurers would likely complain that the effort to level the playing field has resulted in over-correction. Insurers correctly note that duties pursuant to an insurance policy are reciprocal, although they over-simplify. To be sure, policyholders owe insurers a duty of good faith and fair dealing but to a large degree those duties have been codified in the form of policy requirements of prompt notice, adequate cooperation, submission of proof of loss, to an examination under oath, or the like.

By contrast, the duties of the insurer are not as extensively set forth on the face of the policy. This is not particularly surprising because insurers write the policy.²⁹⁴ With the exception of the duty to defend, which is to the insurer’s benefit by permitting it to better control costs and case outcomes), insurers typically have not codified their obligations on the face of the contract.²⁹⁵ And the insurer pipe dream of holding policyholders liable for “reverse bad faith” has achieved little traction, although policyholder misconduct or even neglect is often a powerful

290. *Id.* (recommending reasonableness requirements such as those in the IFCA and remedies of counsel fee awards to prevailing policyholders).

291. *Id.* at 6.

292. *Id.* at 7.

293. *Id.*

294. *See supra* note 13 and accompanying text.

295. For more on insurance duties that should be encoded in policyholders’ contracts, see ESSENTIAL PROTECTIONS FOR POLICYHOLDERS, *supra* note 289.

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source of defense for insurers and is litigated under the nomenclature of failed cooperation, late notice, inadequate documentation, malingering, excessive medical treatment, and other defenses such as fraud.

When the totality of circumstances is considered, even with adoption of the above wish list of imposition and expansion of reforms, insurers would continue to have more than sufficient economic and legal leverage to deploy against opportunistic behavior by policyholders. We live not in a dreamworld of fairness and equality but in one where market forces, wealth, organization, experience, and capital forces continue to strongly favor insurers.

Notwithstanding the potentially perpetually unfinished agenda of reform, the New Jersey IFCA strikes a strong pro-consumer, pro-policyholder blow in the nation's eleventh-largest state with a population of more than nine million.²⁹⁶ It is an achievement not to be taken lightly but at the same time is a manageable increase in policyholder rights that properly deployed will not adversely affect insurers. It should, however, nudge them closer to the better claims handling that should always be the goal.

296. See *QuickFacts: New Jersey*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/NJ> (last visited Dec. 30, 2022); *Annual and Cumulative Estimates of Resident Population Change for the United States, Regions, State District of Columbia, and Puerto Rico and Region and State Rankings: April 1, 2020 to July 1, 2021*, U.S. CENSUS BUREAU, <https://www2.census.gov/programs-surveys/popest/tables/2020-2021/state/totals/NST-EST2021-POP.xlsx> (last visited Dec. 30, 2022).