No.

In The

Supreme Court of the United States

Alfred DeGennaro,
Petitioner

v.

American Bankers Insurance
Company of Florida;
Government Employees Insurance
Company;
Assurant Specialty Property

Respondents

On Petition for Writ of Certiorari
To The United States Court of Appeals
For the Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the Third Circuit Court of Appeals improperly stated the law when it read the heightened pleading requirements of Fed. R. Civ. P. 9(b) for notification of fraudulent conduct as applying to pleading the actual monetary value of the resulting damages and can that pleading burden be reconciled with: (1) the conflicting ruling of the Fifth Circuit Court of Appeals in *Grubbs v. Kanneganti;* and (2) the United States Supreme Court's decision in *Story v Parchment* keeping the burden of the uncertainty of damages on the Defendant.

2. Whether a regulation focal to Plaintiff's case, plead factually in the complaint and fully briefed before both the District Court and Appellate Court, can be ignored on appeal because there was no citation to that regulation in the complaint, given the recent Supreme Court's pleading standards in *Skinner v. Switzer*,

3. Whether the Court of Appeals improperly stated the law in denying the Plaintiff a private right of action, recognized by the highest courts in New Jersey, because the text of N.J.A.C. 11:1-22.5(b)(2) only denies an insured the right to enforce those penalties "set forth in this subsection"

4. Whether the monetary value attributed to damages for carrying risk, should be extended as a remedy to consumers in insurance contracts when

they are forced to carry risk through a period of time due to fraud or breach of contract by their insurance company(s).

5. Whether the Court of Appeals violated reviewing standards of *Byers v. Intuit, Inc* by not viewing the facts in a light most favorable to the Plaintiff after it ignored the regulation focal to Plaintiff' complaint (Question 1 above) during a motion to dismiss for failure to state a claim.

6. Whether the denial of the measuring Plaintiff's damages by the risk he was forced to carry for a period of time due to the breach and/or fraud of the Defendant insurance companies is a violation of Plaintiff's rights of Substantive Due Process.

7. Whether the Defendant(s) insurance companies schemed to illegally change the Plaintiff's coverage mid-term by using, excessive, ambiguous, and illegal communication rendering them liable for common law torts, breach of contract and under the New Jersey Consumer Fraud Act.

PARTIES TO THE PROCEEDING

The parties to the proceeding in the United States Court of Appeals for the Third Circuit were Petitioner Alfred DeGennaro, and Respondents, American Bankers Insurance Company of Florida (hereinafter "ABIC"); Government Employees Insurance Company (hereinafter "GEICO"); and Assurant Specialty Property (hereinafter "Assurant").

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Alfred DeGennaro petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case

OPINIONS BELOW

The unreported opinion of the Third Circuit Court of Appeals is reproduced at App. 1. The unreported decision of the United States District Court of New Jersey is reproduced at App. 18.

JURISDICTION

The Third Circuit Court of Appeals issued its opinion on June 8, 2018. This Court has jurisdiction under 28 U.S. Code § 1254

STATUTES AND CONSTITUTIONAL PROVISION INVOLVED

The New Jersey Consumer Fraud Act (NJSA 56: 8-1 et. seq.; The Substantive Due Process Clause of the Fifth Amendment of the United States Constitution. Federal Rule of Civil Procedure 9 (b); N.J.A.C. § 11:1-22.2 (a) (1), N.J.A.C.; § 11:1-22.5 (pertinent parts appended)

STATEMENT OF THE CASE

(A) Proceedings Below

1. The Jurisdiction of the District Court of New Jersey was through 28 U.S. Code § 1332 (Diversity of Citizenship). Plaintiff appealed the dismissal under 12 (b) (6)[1]. The Third Circuit placed a heightened burden of pleading the valuation of his damages on all of Plaintiff's claims citing Rule 9(b): A burden which conflicts with the Fifth Circuit case of U.S. ex rel. *Grubbs v. Kanneganti* 565 F.3d 180, 186 (5th. Cir. 2009) which applied a lenient "context specific" standard while reviewing pleading claims under the False Claim Act (31 U.S. Code § 3729). That Court stated the Rule 9(b) supplements but does not supplant Rule 8(a) and did not want to stymie legitimate efforts to expose fraud.

The holding also conflicts with Supreme Court precedent as set forth in *Skinner v. Switzer*, 562 U.S. 521 (2011) holding that the Plaintiff need not present an exposition of their legal argument in their complaint. The Appellate Court refused to consider a regulation on appeal which rendered all of Defendants' relevant communications illegal because the court found it was being raised for the first time on appeal. The regulation was generally referred to without a caption in Plaintiffs complaint at paragraphs 60 and 67 of the Statement of Facts (reproduced below). The applicable regulation was

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1 The dismissal was without prejudice. Plaintiff did not amend his complaint because he had no additional facts.

cited with the caption and was contained and fully argued in Plaintiff's briefs before both the lower courts (see Plaintiff's District Court brief's opposing GEICO Appellate Joint Appendix page 584 hereinafter "APPX--584" and opposing ABIC APPX -436) and see the Plaintiff's Appellate Brief at 2,3,4,7,11,12,14,15,20,21,39,40,46 hereinafter PABp-2 etc.). The Statement of Facts of the Plaintiff's Complaint and references to its paragraphs are hereinafter "PC-60" APPX-49) etc. The regulation in question was N.J.A.C. § 11:1-22.2(a)(1) (Appendix 64,65 - "App. 64" etc.) which prohibits a mid-term decrease in insurance without approval from the Commissioner. After 59 paragraphs of details, Plaintiff's Complaint clearly explained the regulatory violation as follows:

> Paragraph 60 stated "ABIC is in violation of legal requirements regarding the reduction of Plaintiff's personal comprehensive liability coverage from $300,000 to $100,000"; and paragraph (67) (APPX-50) stated: "Defendants Assurant and Geico cooperated with Defendant ABIC in the violation of applicable laws and/or regulations regarding changing the liability coverage of Plaintiff's Renters Insurance Policy"

N.J.A.C. § 11:1-22.2(a)(1) rendered all of the communications about changing Plaintiff's insurance coverage illegal. The complaint itself

detailed a scheme involving all Defendants using excessive, misleading and ambiguous paperwork over a long period of time, in order to conceal a change in coverage.

In between these paragraphs of the complaint were references to N.J.A.C. § 11:1-20.2 (App. 66) which governs Renewal, Cancellation and Nonrenewal of an insurance policy. These regulations regarding Renewal, Cancellation and Nonrenewal were cited with their subsections (see PC-59, PC-61, PC-62, (APPX-49) The aforementioned paragraphs 60 and 67 specifically leave out the subsections and were therefore references to the broader regulatory scheme. Plaintiff explained in his briefs that once the policy issued "if" Defendants were going to change any terms of the coverage they had to cancel the policy within the first 60 days by law, or wait until the end of term, and then abide by the aforesaid regulations (APPX - 436, and APPX-584 and PABp-7) This they did not do.

Both the District Court and Appellate Court found N.J.A.C. § 11:1-20.2 inapplicable because ABIC never canceled nor failed to renew the renter' s policy (App -10) However, this misses the aforesaid fact that once the policy was issued "if" Defendants wanted to change the policy they had to cancel and renew according to N.J.A.C. § 11:1-20.2. As clearly stated in the complaint Defendants were in violation of N.J.A.C. § 11:1-20.2. Therefore, the change they admitted to was in violation of both

N.J.A.C. § 11:1- 22.2(a)(1) and N.J.A.C. § 11:1-20.2. Though strict liability is not relevant at the pleading stage, it was stated in the complaint (PC-63 APPX-49) as to violations of "Title 11" therefore was broadly referring to both N.J.A.C. § 11:1-22.2(a)(1) and N.J.A.C. § 11:1-20.2. Strict liability was argued in Plaintiff's lower court briefs APPX-439, APPX 586, 587 and on appeal PABp-21-22).

Nothing is more fundamental to an insurance contract than the fact that an insurance company cannot unilaterally change any insurance coverage during the term. Therefore, these sophisticated companies knew that these excessive communications were illegal. As will be discussed infra, there is a private right of action under N.J.A.C. §11:1-22.2(a)(1) and it is recognized by the highest courts in New Jersey and federal case law (argued in detail infra).

In addition to conflicting with *Skinner* the Appeals Court's decision also conflicts with Supreme Court precedent as set forth in *Bell Atlantic Corp. v. Twombly* 550 U.S. 544 (2007), and *Ashcroft v. Iqbal,* 556 U.S. 662 (2009), holding that the Plaintiff needs to plead "facts' sufficient to show that their claim has substantive plausibility. In addition, under *Twombly* (Id. at 556), the court must evaluate the pleading in context and draw on its judicial experience. Therefore, when the court analyzed the situation it should have seen that the insurance companies knew they were making illegal "unilateral" communications against this fundamental regulation. Consequently, under

Twombly, the pleading should have been analyzed by the Court in that context, even if Plaintiff had not claimed a violation of regulations (which he did as explained above). There is another United States Supreme Court case which should have been considered under the *Twombly* judicial context and experience standard. In *Story Parchment Co. v. Paterson Parchment Paper Company,* 282 U.S. 555, 563 (1931) the United States Supreme Court held that when damages are difficult to measure, they should be construed against the Defendants. Therefore, that context and experience standard should have analyzed damages against the Defendants when reading the complaint.

The Appellate Court violated Fed. R. Civ. P. 9(b) (App. 64) by applying the heightened pleading requirement for pleading fraud to pleading damages from that fraud (App-10). This severely prejudiced the analysis of Plaintiff's case which proposes an extremely important and unique approach to the evaluation of damages and has far-reaching implications for consumers in the insurance setting. This case, filed by an attorney pro se, argues that the consumer is entitled to damages measured by the value attributed to their having to carry risk through a period of time caused by the fraud or the breach of the insurance company. This carrying of risk is therefore independent of any need to make an actual claim for the underlying funds as in the case of an accident. The Appellate Court cited to no prior case or authority for extending Rule 9 (b) to alleging

damages from a fraud. Assigning a value to carrying risk can be best illustrated to by the fact that attorneys are allowed to charge higher fees for contingency fee cases. *Gisbrecht v. Barnhart,* 535 US 789, 810, (2002). This is true even if the fees are in excess of their hourly fee if the case settles early This value for carrying risk, independent of an accident claim for the underlying funds is particularly true under the highest case law of The New Jersey Consumer Fraud Act (hereinafter the "NJCFA" App. 62) discussed infra. This is not just a question of social policy, this is the actual the correct legal measure of damages in an insurance contract. Plaintiff's argument sets the value at the contractual exchange between the parties during the meeting of the minds of an insurance contract from the following contractual point of view:

> Consumers carry the inherent risks of life throughout the term of their life and they associate a value to those risks. In the insurance setting the consumer is saying: "I am carrying a risk that has a value to me, you have solicited me. I will allow your company to carry that value instead of your competitor in exchange for paying your premium." Once the contract is formed the consumers "risk" has changed to a concern that the company may defraud him or breach, but the underlying

> value being protected is exactly the same.

To nullify the value of the risk the consumer is carrying, nullifies the role that the insurance company is playing. For what value is being shifted over to the insurance company if there was none to begin with in the consumer's life? Why do they assign a premium and not refund it when no accident occurs and no payout is necessary if there is no value to carrying risk? The representation to a consumer from a contractual point of view is: "You have protection" and it is the monetary value underlying that value which is the basis of the contract. The moment the insurance company defrauds or commits a breach, that value constitutes the damage. What will be a matter of first impression for this Court is the extension of these damages to the insurance industry. Plaintiff concedes that such an extension is not a straightforward one given the complexity of the insurance industry and judicial constraints, but the Plaintiff contends that social policies (discussed in detail infra) at this point in history are strong enough to necessitate it. To that extent, Plaintiff argues that not extending the damages violates his rights to Substantive Due Process regarding depriving property under the Fifth Amendment of the United States Constitution (App. 63).

The Appellate Court also violated the Court's standard on reviewing a motion to dismiss a complaint under *Byers v. Intuit, Inc.*, 600 F.3d 286,

291 (3d Cir. 2010) holding that for a dismissal under Fed. R. Civ. P. 12(b)(6) the Court must consider all factual allegations as true, and construe the complaint in the light most favorable to the Plaintiff, and determine whether, under any reasonable reading of the complaint, the Plaintiff may be entitled to relief. The Appellate Court actually construed ambiguities against the Plaintiff (discussed infra).

(B). Factual Background

1. The Plaintiff was the victim of an illegal scheme by the cooperating Defendants to deceptively change his insurance coverage after it had been sold, by using excessive, misleading and ambiguous paperwork over a long period of time. This created a $200,000 gap between the renter's liability and umbrella coverage. Given the fact that nothing is more fundamental to an insurance contract than the fact that an insurance company cannot unilaterally change an insured's coverage during the term, any communications about changing coverage were done with the Defendants' knowledge of their illegality both under N.J.A.C. § 11:1-22.2(a)(1) and N.J.A.C. § 11:1-20.2. Also, ABIC violated its own policy regarding notifications which were similar to N.J.A.C. § 11:1-20.2 (see Policy Sections I and II CONDITIONS - Subsection 5 Cancellation – subsection b ("APPX – 168" etc., and PC- 64 APPX 49). Therefore, there is no

question that Defendants knew the communications were illegal.

The facts of the scheme were plead as follows: The Plaintiff was insured by GEICO auto insurance and entered into negotiations by phone with GEICO at the end of the year 2013 for a comprehensive personal liability policy and a $1 million umbrella policy (APPX-39-41). Plaintiff was told that in order to acquire that coverage he would have to acquire a renter's policy with a minimum of $300,000 liability and was referred to Assurant. (APPX-516). The policies were purchased (APPX-39). On January 21, 2014, Defendant GEICO sent a letter stating "After careful review" Plaintiff "may not meet the required underlying liability limit of $300,000" (APPX-512). "Careful review": how could they not know what it was?

Ten (10) days later on January 31, 2014, Defendant Assurant sent an email (APPX-514-515) forwarding the issued policy. That email also contained 2 letters (APPX-516-517) dated January 30, 2014 about the renter's coverage and also contained the Declaration Page (APPX - 518). The Declaration Page listed the personal liability as the full $300,000 which Plaintiff had ordered, thereby representing there were no problems as suggested in the letter ten (10) days earlier. The second letter thanked Plaintiff for choosing GEICO to protect him and if he had a GEICO auto policy he would "automatically" get multi-policy discounts (APPX-517). On February 3, 2014, GEICO sent an umbrella declaration page structured to convey

that the requisite $300,000 limit was satisfied (APPX-519-520) with no mention of any possible problem or gap. As an extra precaution, on February 3, 2014, Plaintiff sent GEICO a FAX (APPX-521-522) explaining the policy had issued, the attached declaration page would not print legibly, and asked GEICO to notify of any problems.

Instead of notifying the Plaintiff of any belief of a problem, the Defendants waited over three (3) weeks and then sent him an email on February 27, 2014 thanking him, supposedly transmitting the policy (there was none) and attaching a Declaration Page with a very ambiguous "$100,000 per occurrence" language (APPX-523). The ambiguous language (which can mean $300,00 aggregate) capitalizes on the fact that Plaintiff was remembering for almost a month, that he needed $300,000 coverage (which he already received) to support the umbrella. Using language such as "$100,000 per occurrence" doesn't trigger a realization that the form of expressing the same coverage had changed giving the Defendants a "paper trail" from which to argue. The Declaration Page also had a $16.00 premium reduction easily confused with the multi-policy discount mentioned in the letter of January 31, 2014 (APPX-517). Such a $16 change would be an approx. 1% saving in premium (APPX-52) in exchange for a $200,000 reduction in coverage which is also in a critical position causing a $200,000 gap preventing access to the $1 million umbrella. Also, no aggregate

coverage sums were ever used on declarations pages: An anomaly in insurance.

When Plaintiff realized the gap in coverage and complained (APPX-45-46), Assurant claimed he did not qualify for the coverage because there was a business on the premises, (APPX-45-46) however, any business activities would be an exclusion to the policy (APPX-513- Policy Sect. II page 10). Also, Plaintiff's certified complaint (PC-38 APPX-46) clearly stated that there was no business visitation to the premises. All requisite states of mind e.g. intent, knowledge, cooperation reliance, malice, misrepresentation, of the scheme were plead (APPX 50-51) ABIC then offered to provide him with coverage back to the inception of the policy (i.e. the "occurrence based" coverage). Plaintiff rejected the settlement because his damages should be measured by the exposure to risk he carried for the 2 years. Proximate Cause was plead (APPX-81).

After complaining to the DOBI, Assurant and ABIC allege it sent Plaintiff a letter, by email, explaining that his coverage was reduced because he did not qualify. A "sample" of this letter was sent to the DOBI and was a "generic letter" which contained no information about the Plaintiff or reasons (APPX-51). Why would they not have a copy of the actual letter to Plaintiff and not a sample? Plaintiff, in his certified complaint, disputes having ever received such a letter and the District Court accepted that it was not received (APPX-16). However, the Appellate Court held this disputed letter, against the Plaintiff despite the

standard of review in *Byers* (see App-7 Footnote 14). Again, it is an illegal document under N.J.A.C. 11:1-22.2 (a) (1) even if it was credible evidence.

REASONS FOR GRANTING THE WRIT

Pleading standards can be defined under this case. Rule 9(b) was applied in a conflicting manner in this case and in other circuits (as to the theory of "loss causation") [2]. Also, Plaintiff's valuation of damages will have profound impact in fighting fraud and assuring competence in the insurance industry in support of consumer rights.

I. The Court Should Grant This Petition to Assure Adherence to Supreme Court Precedents Regarding Pleading Standards and Adherence to the Federal Rules of Civil Procedure.

While evaluating the factual evidence of the Defendants' guilt, the Appellate Court refused to consider the illegality as well as the Defendants' knowledge of that illegality of all their communications after the policy had issued. This violated of the Supreme Court precedents of *Skinner, Twombly,* and *Ashcroft.* The Appellate

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[2] *See Oregon Public Employees Retirement Fund v. Apollo Group, Inc.*, No. 12-16624, 2014 WL 7139634 (9th Cir. Dec. 16,) which conflicts with the traditional approach of Lormand v. U.S. Unwired, Inc., 565 F.3d 228, 258 (5th Cir. 2009).

Court consequently found that the foregoing set of facts of the scheme "clearly" put the Plaintiff on notice that his coverage had changed. This was in violation of the *Breyer* standard including the facts that: (a) Plaintiff denied receiving the email letter supposedly notifying of the change in his certified complaint, (b) the "$100,000 per occurrence" language is ambiguous as an insurance term as it can mean $300,000 aggregate, (c) the ambiguity of the $16 credit which is confused with multi-discount was construed against the Plaintiff, (d) all communications violated the policy's own notification requirements (APPX– 68,), (e) the court also held against the Plaintiff the subsequent declaration pages for the following years with the same ambiguous per occurrence language and multi-policy discount ambiguity even though under the New Jersey Supreme Court Case *Bauman v. Royal Indemnity Co.,* 36 N.J. 12, 25 (1961) absent notification that there have been changes in the restrictions, conditions or limitations of the policy, the insured is justly entitled to assume that they remain the same and that his coverage has not in any way been lessened, and (f) in addition to the *Breyer* standard regarding all the above ambiguities, the New Jersey Supreme Court has ruled that insurance contracts are considered contracts of adhesion and strictly construed against the insurance companies *Zacarias v. Allstate Ins. Co.*, 168 N.J. 590, 595 (2001),

Plaintiff contends the facts plead alone are suspicious enough to support the plausible claim of

breach and fraud even without the evaluation in his favor which was his entitled right under *Byers* and *Zacarias*. Defendants theory of the case is far-fetched; it assumes that to save merely $16, representing an approximately 1% savings in premiums, the Plaintiff' wanted to put a $200,000 gap in a critical place cutting himself off from the $1 million umbrella coverage. Most importantly, none of these communications are part of a negotiation on the part of the Plaintiff. These unilateral communications, all of which are patently illegal under the most fundamental laws and it is implausible that sophisticated insurance companies were unaware of their illegality.

It should also be pointed out that Assurant incorrectly stated to the DOBI that Geico's underwriting guidelines were on file with the State of New Jersey (APPX-374,375). These underwriting guidelines supposedly were the basis of the "systemic" mistake giving Plaintiff his coverage. The truth is, under the regulation N.J.A.C. 11:1-20.4 (f) underwriting guidelines are not filed with the State but maintained by the insurance company for requests by the DOBI. This is enormously suspicious because having a business on the premises was an exclusion to the policy anyway (APPX-513-). In addition, it is doubtful such guidelines would even apply to the Plaintiff at all since there was no business visitation to the premises (PC- 38 APPX-36). In this age, people work on home computers (selling on Amazon, etc.). Plaintiff pointed out this misstatement in his

appeal brief (PABp-11,12) but Defendants never commented on it. Misstating the law not only enabled the Defendants to hide the underwriting guidelines which were supposedly the basis of their defense, but thereby could have lulled the DOBI representative into a false sense of security and not requesting them from Defendants' to check. To this day Plaintiff believes that the "business on the premises" excuse was made up after-the-fact. Why wouldn't a defendant want to include the excerpt from the actual guidelines to the DOBI to establish they were applicable to the Plaintiff since they were an exception to the policy anyway and there was no business visitation to the premises.

The Appellate Courts decision is also based on a faulty evaluation of the evidence in which the court attributed to a second notice that the Plaintiff "might" have insufficient coverage. The court was not clear which document they were referring to (App-7 n.14). Another document stating it had "no legal effect" and citing coverage as "100,000" was sent but the Court did not seem refer to it.

II. All Defendants Are Liable for Breach of Contract and Common Law Torts.

The NJCFA will be discussed in detail infra and it is the strongest application of the law to find liability as well as damages in the form of exposure to risk. At the time being it will suffice to point out that the NJCFA is one of the strongest laws of the nation for protecting the public welfare, see

Governor's Press Release for Assembly Bill No. 2402, at 1 (Apr. 19, 1971). Often common law discussions consider minority or majority rules in other state jurisdictions. Plaintiff contends that the NJCFA is part of the will of the people in New Jersey that the jurisprudence under the common law in New Jersey should reflect that will and should be consider for claims outside the NJCFA. It should also be noted that at the present time, the New Jersey Supreme Court held that an insured may recover "more" than the policy limit for a liability insurer's bad-faith, *Rova Farms Resort, Inc. v. Investors Insurance Co.*, 65 N.J. 474, 323 A.2d 495 (1974),

The Plaintiff's pleading, as outlined above, establishes a very plausible case of fraud and breach of contract. The Defendants attempt to hide their actions behind the fact that it was ABIC that had the direct contract with the Plaintiff. However, though ABIC underwrote the policy with the $200,000 reduction, the other Defendants cooperated in the scheme (supra). Though the automobile policy side of the umbrella coverage had no gap they were deficient because of the unknown gap on the renter's side (PC -79 APPX 52). If Plaintiff knew of the gap he could have acquired three new policies, he would not want to carry a gap in the package. He carried all three polices and Defendants collected all three premiums. GEICO does not insure through other insurance companies offering renter's and general liability. If it is also established that they cooperated in the scheme

they not only helped ABIC breach its contract but they breached their own contracts through this scheme. The policies were essentially presented as a package deal. This is evidenced by (1) the referral by Geico to Assurant (PABp-8 and APPX-516), (2) the letter of January 30, 2014 (APPX-516) referring to the renter's policy was on a letterhead of GEICO* Portfolio (the word portfolio implies they are a group) and (4) explaining in the footnote* that GEICO is the Registered Trademark of Government Employees Insurance Company. Under that letterhead are two headings: (5) one from Assurant Specialty Property (the trade name for Assurant Inc.) and (6) the other as "secured through" GEICO Insurance Agency, Inc (hereinafter GIA). This gets confusing because GIA uses the GEICO Trade Mark as part of the name of GIA. This is why GIA was mistakenly not named as a defendant in the original Complaint and represents an advertising violation trademark under 15 U.S.C. § 1125 Section 43 of the Lanham Act. (7) The January 30, 2014 letter (APPX-516) stated in part that Assurant Specialty Property, a "strategic partner" with GEICO, would provide the valuable protection underwritten by ABIC. (8) When GEICO sent the "may have a problem" letter (APPX-512), it was performing a function of the provider of insurance and that function was notification of ABIC's coverage.

Given the above eight (8) levels of cooperation in presenting the various insurance policies which benefited each other, and allowed Defendants to

collect premiums, the Plaintiff argued third-party beneficiary status between them. The Appellate Court found this largely irrelevant. (App.-16 n. 36). The relevance lies not only in the contractual liability for damages, (strict liability under the NJCFA - discussed infra). Those damages are also "in addition to" the treble damages awarded under the NJCFA (N.J.S.A. 56:8-2, N.J.S.A. 56:8-19). Plaintiff's third-party beneficiary argument explained that cooperation, reliance and overall performance has created such a status. *Thomas G. Snavely Co. v. Brown Construction Co.*, 239 N.E.2d 759 (C.P. 1968). Note, when GEICO sent the "might have a problem letter" it was preforming a primary function of an insurer notifying of the ABIC coverage. When an implied party to an agreement accepts the benefits of the contract (premiums from the package deal, he must accept all of its implied as well as express, obligations *Austin v. United States*, 125 F. 2d 816 (7th Cir.1942). See also, Corbin 1951 Chapter 41 Preliminary Analysis §777: The existence of legal relations is not dependent upon an intent to create them..... facts will create a right and a duty even though the parties are quite unaware of the law or of what a "consideration" is.

The Appellate Court's finding denying damages under NJCFA (infra) was applied throughout its analysis to the common law torts and breach of contract claims. The Plaintiff also takes issue with the other aspects of the Appellate Court's findings as to common law torts and contract claims:

Tortuous Interference with Prospective Advantage (Count 8). The Appellate Court ruled that Plaintiff did not allege the required economic benefit that he lost from Defendants actions nor that they were done intentionally or with malice. (App - p12 -13). As to damages, they were explained and are again infra: They represent the carrying of risk. Plaintiff certified and pled (APPX-53) he wanted and did later obtain replacement insurance (the name of the company is irrelevant). The complaint and briefs establish intent. Denying insurance is malicious. Insurance is important.

Common Law Fraud (Count 9). The court again finds that Plaintiff was clearly on notice and plead no facts suggesting that Defendants knew any of the statements were false and suffered no damage (App-13-14). Plaintiff's complaint outlined in great detail such facts and knowledge even without his right to have everything construed in his favor under *Byers* and *Zacarias*.

Intentional Breach of Contract (Count 10). Plaintiff concedes there is no cause of action with this title. The title should be Breach of Good Faith in Contract but all the factual allegations and legal elements for the pleading requirements are there and incorporated. Therefore, since it satisfied all pleading requirements the count should not have been dismissed Also, Plaintiff would have made a clerical correction on the amended pleading he explained he was planning in order to add GIA as a

defendant. (App-14). Dismissal due to a clerical error was also a violation under *Skinner, Twombly*, and *Ashcroft*.

Breach of Contract (Count 12) (App-15,16) The court ruled that the typical remedy is placing the innocent party to the position they would or should be in, referring to ABIC offer to increase the coverage limit retroactively to the inception of the contract As explained supra, increasing coverage retroactively does nothing about the exposure to risk, the payment of a full premium for a minimal risk adjustment and also third-party beneficiary aspects (App-16 footnote 36).

Breach of Fiduciary Duty (Count 11). The Appellate Court relied on existing law explaining that the fiduciary duty is owed under "certain circumstances" such as when it is settling claims on behalf of the insured (App-16). But if a plaintiff has a right to representation while settling claims, doesn't the fraudulent extinguishment of their coverage deny that same right? Wouldn't the reasonable consumer prefer to be violated during the settlement of the claim then to have no coverage at all? Which is more nefarious?

III. The Measure of Damages for Illegally Changing an Insured's Coverage is Equivalent to The Exposure to Risk They Were Forced to Carry.

The lower courts have continually viewed damages as though it were a negligence action and

were looking for some type of tangible manifestation in order to find damages (pain, broken leg, nervous condition, monetary loss, etc.) This isn't negligence, this is a contractual solicitation in which an insurance company voluntarily assumes an obligation for profit. In addition, the distinction between risk and physical pain is an elusive one. Protection is often more valuable. A soldier may climb through barbed wire and choose physical pain in order to relocate to an area of decreased risk. A parent may choose physical pain in order to protect their children from the exposure to risk.

There are two United States Supreme Court cases which serve as the building blocks for applying carrying risk as a measure of damage. The first is *Gisbrecht,* which allowed attorneys to charge higher fees in a contingent-fee agreement because they are carrying risk. Note, that attorneys are not required to refund the excess collected if the case settles for an amount more than their hourly fee. The second is the United States Supreme Court case *Story Parchment Co.* which held that when applying the rule of the extent of uncertain damages "the risk of uncertainty should be thrown upon the wrongdoer instead of upon the injured party."

Intangible damages in the form of risk are replete throughout our legal system, for example:

(1) The Tort of Interference of Prospective

Economic Advantage in New Jersey is itself a recognition of monetary compensation for loss of a Possibility, i.e. the "reasonable probability" of receiving the anticipated economic benefit: *Lighting Lube, Inc. v. Witco Corp.*, 4 F.3d 1153, 1167 (App. Div. 1993); (2) The calculation of damages for the loss of chance (or loss of a chance) can be found at *Melvin Aron Eisenberg, Probability and Chance in Contract Law*, 45 UCLA L. Rev. 1005 (1998), under its rubric of "lost chances", (3) An example of attributing a value to risk after contract formation is illustrated by the concept of an efficient breach: Suppose a company providing a distinguished bodyguard wanted to use that particular bodyguard for a newly arrived dignitary. It might have to pay additional values in order to maintain the same level of protection to the original party. These additional values represent values assigned to carrying risk; (4) Consider the case of *A & M Produce Co. V. Fmc Corp.*, 135 Cal.App.3d 473, 487, 4th Appellate (1982) which cited:

> The most detailed and specific commentaries observe that a contract is largely an allocation of risks between the parties, and therefore that a contractual term is substantively suspect if it reallocates the risks of the bargain in an objectively unreasonable or unexpected manner. Murray,

Unconscionability: Unconscionability (1969) 31 U.Pitt.L.Rev. 1, 12-23);

Therefore, during the normal contractual process parties will often allocate a value to risk by adjusting the contract price, and (5) After contract formation, the courts will impute a value to risk in a contract when dealing with an analysis of unconscionability, (or when analyzing custom and usage when needed to construct contract terms). The extent to which courts impute this value is found through a Westlaw search of all state and federal cases with the terms "risk", and "unconscionable", but without the word "insurance". Said search produces 10,000 cases. These cases include a New Jersey Supreme Court case which found that an agreement as written, but as yet uninterpreted [emphasis added] was too great of a risk for the plaintiff to carry. *Delta Funding Corporation v. Harris*, 189 N.J. 28, 2006);

The large disparity between the dollar amount assigned to carry that risk by an insurance company in the form of a premium and the exposure to a consumer when denied his coverage, is only because insurance companies are billion-dollar companies highly regulated by the government. The polio vaccine was highly regulated by the government and was free: But its value was not zero. The reason no claim for the underlying funds is necessary (i.e. no accident occurs) is because the value of carrying risk does

not expire. If you hire a bodyguard you can't refuse to pay them at the end of the term simply because they did not experience an injury while protecting you. Expiration of the risk is irrelevant. Also, the value of risk is not discounted by the probability that an insured will encounter an accident. This is because purchasing the policy by the consumer is a statement that the consumer wants to foreclose "any" risk of such a loss. The representation to a consumer from a fraudulent or a contractual point of view is: "You have protection". To that extent, the government requires insurance companies to keep reserves to make sure that the consumer will be "paid in full". It should also be remembered that an insurance company is allowed to deny full coverage if the insured doesn't notify them in a timely fashion: Why shouldn't an insurance company be penalized similarly if they defraud or breach coverage.

In cases of fraud there are two basic theories (1)"out-of-pocket" principle, and (2) the "benefit-of the-bargain" rule, *Correa v. Maggiore*, 196 N.J. Super. 273, 284 (App. Div.1984). Using the benefit-of-the-bargain for the measurement of damages the beginning point is at the premiums paid and moves to the value of the property had the representations been true i.e. a suitable and complete policy. As to the "out-of-pocket theory", the recovery is permitted for the difference between the price paid and the actual value of the property acquired. Actually, both the benefit-of-the-bargain and out-

of-pocket theory produce essentially the same result if an imaginary line is not drawn at zero and one considers the negative value of the perilous purchase (carrying risk). This is because under the "out-of-pocket" principle, the actual value of the property acquired actually has a negative value. i.e., a value less than zero. Negative valuation of assets is nothing new in accounting or in law and certainly anyone who purchases real estate and inherits environmental cleanup problems could easily find themselves with a "negative value" (less than worthless). Another negative value is a purchase of a business with undisclosed legal claims. Here, the Plaintiff unknowingly purchased a $200,000 nightmare with ramifications well beyond the $200,000. In *Furst v. Einstein Moomjy,* 182 NJ 2 (2004) the New Jersey Supreme Court held that the innocent party has a right to damages "based on his expectation as measured by ..... The loss of value to him" (note that the standard of damages is "to him" (and see *Rova Farms*).

IV. The Defendants Are Liable Under the NJCFA For Illegally Changing the Terms of Consumer's Insurance Policy

As explained the NJCFA is one of the strongest laws of the nation for protecting the public welfare. The New Jersey Supreme Court has held that interpreting the act is one of constant expansion of consumer protection." *Gennari v. Weichert Co. Realtors,* 148 N.J. 582, 604 (1997) and is "remedial

legislation that we construe liberally to accomplish its broad purpose of safeguarding the public." *Furst v. Einstein Moomjy*, 860 A. 2d 435, 441, (2004). The NJCFA is an action by the Attorney General's Office which, through the 1971 Amendment [L. 1971 c. 247 § 7, codified at N.J.S.A. 56:8-19] can be enforced by a private attorney. Therefore, NJCFA is prosecutorial in nature. When, the NJCFA is enforced by a private attorney there is a requirement of an "ascertainable loss" *D'Agostino v. Maldonado,* 216 N.J. 168, 184 (2013). The NJCFA imposes liability on any person who uses any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing, concealment, suppression, or omission of any material fact with the intent that others rely upon such concealment, suppression or omission or with the subsequent performance of such person as aforesaid. (N.J.S.A. § 56:8-2, App. 62). The standard of conduct that the term "unconscionable" implies is lack of "good faith, honesty in fact, and observance of fair dealing." *Cox v. Sears Roebuck & Co* 138 N.J. 2, 18 (1994). The word unconscionable must be interpreted liberally so as to effectuate the public purpose of the NJCFA. *Kugler v. Romain*, 58 N.J. 522, 543 (1971). Under NJCFA affirmative acts establish intent (see *Cox* 138 N.J. 17,19). Since N.J.A.C.-11:1-22.2(a)(1) is a Prohibition, any acts in violation of the prohibition are affirmative acts and therefore establish intent. Violation of the regulation also establishes a causal connection to Plaintiff being deceived.

Also, under *Cox* (138 N.J. at 18-19) violation of the regulations of the Attorney General create strict liability [emphasis added]. Consumer concedes that N.J.A.C. 11:1-22.2(a) (1) was not a regulation passed directly by the Attorney General, but in *Boc Group v. Lummus Crest*, 51 N.J. Super. 271 at 280 (1990) the court explained as to the Attorney General rules and regulations N.J.S.A. 56:8-4 that the "general [definition] can be construed under the doctrine of ejusdem generis as a comprehensive definition intended to incorporate other products or services [emphasis added] similar in nature to those enumerated."

Insurance was incorporated into the NJCFA by case law, see *Lemelledo v. Beneficial Mgt. Corp. of Am.* 150 N.J. 255 (1997) and *Weiss v. First Unum Life Ins. Co.* 482 F.3d 254, 266 (3d Cir. 2007) Therefore, the Attorney General would have had to review every single insurance regulation which would have been totally impractical. What could be more important to an insurance company's business and a consumer's life than a regulation forbidding unilaterally changing a coverage limit. This critical protection is or should be incorporated as an Attorney General regulation by the doctrine ejusdem generis. (*Boc* N.J. Super 51 at 280) Otherwise, a literal restricted reading of the original 21 types of transactions creates strict liability for wrongful delivering furniture (N.J.A.C. 13:45A-5.1 -see *State v. Hudson Furniture Co.,* 165 N.J. Super. 516 App. Div. 1979) but not for a unilateral changing a consumer's insurance

policy after it issued causing them a financial catastrophe. Third party contractual liability renders all the Defendants strictly liable under *Boc.*

The NJCFA is a powerful vehicle for the enforcement of the intangible damage of carrying risk. This is illustrated by three cases from the highest courts in New Jersey. In *Bosland v. Warnock Dodge Inc.* 197 N.J. 543, 964 A.2d. 741 at 750 (2009), the New Jersey Supreme Court stated: "The NJCFA does not demand that a Plaintiff necessarily point to an actually suffered loss or to an incurred loss, but only to one that is ascertainable". The *Bosland* Court ruled a demand for a refund of the overcharge did not matter because: "the fact that the Plaintiff could have secured complete relief in no way diminishes the fact that she sustained an immediate quantifiable loss when she paid the fee representing the over-charge".

Therefore, even securing complete relief (obtaining a refund) is not a bar to a NJCFA action. In the second case, *D'Agostino v. Maldonado* 78 A. 3d 527, 545 (2013). The New Jersey Supreme Court granted the Plaintiff access to all forms of NJCFA relief even though the Plaintiff had already achieved satisfaction through the lower court's equitable powers and held: "the existence of an ascertainable loss should be determined on the basis of a Plaintiff's position following the defendant's unlawful commercial practice". Also, and most importantly because it regards damages

from insurance coverage, in *Abbas v. Pennymac Corp.* (Docket No. A-3466-13T2 – Decided July 2015 WL 4275962) (APPX- 537-542) the New Jersey Appellate Division found that the defendant failed to forward the insurance proceeds to Plaintiff in a timely fashion and therefore the funds became the ascertainable loss "the moment" the funds were wrongly withheld. The *Abbas* Court went on to say that the defendant's arguments of later payment would leave the door ajar for unconscionable commercial practices as long as the merchant could close the door before the consumer initiated legal action (like the offer ABIC made in this case). *Abbas* prevents insurance defendants from correcting wrongdoing and returning a value to escape prosecution. In addition to these New Jersey state court cases, the Third Circuit Court of Appeals articulated the ascertainable loss concept in *Marcus v. BMW of N. Am.*, LLC, 687 F.3d 583, 606 (3d Cir. 2012) held that a Plaintiff is not required to show monetary loss, but only that he purchased something and received `less than what was promised.'"

Consider this hypothetical noting that the NJCFA applies to acts subsequent to sale:

> A consumer hires a tour guide who runs a business touring the desert and providing all supplies including water. The tour guide gets lost but is able to put in a call to rescuers. The tour guide, steals all the water and secludes

> himself. The rescuers eventually arrive in time and both survive. Hiding the water is an unconscionable practice.

The wrongdoer is unable to utilize a defense based upon the fact that resolution of the wrongdoing had been corrected (*Bosland, D'Agostino, and Abbas*). Note also the value of the water is not the value of tap water before or afterwards but instead during the violation and is astronomical (i.e. the value under *Furst* "to him").

The leading case on denying an ascertainable loss and which the Appellate Court accepted Defendants argument was *Thiedemann v. Mercedes-Benz USA* 183 NJ 234, 872 A. 2d 783, 795 (2005). However, *Thiedemann* is not only distinguishable but is fundamentally different case. *Thiedemann* specifically stated that there was a warranty and the warranty was part of the meeting of the minds and benefit of the bargain between the parties (Id. at 789, 794) . Therefore, the parties had already agreed on a method of solving any problems and the Plaintiffs sued despite this. Also, the court did not want to discourage self-improvement in the consumer industry after so much work had been done between consumers and the industry to accomplish these warranties. Therefore, a defect addressed by warranty, at no cost to the consumer is not an ascertainable loss (Id. at 789). The *Thiedemann* Court also pointed out: (1) the Plaintiffs expected a perfect car, unaffected by the laws of physics and common sense and

sought legal remedy because of an unrealistic disappointment (Id. at 789); (2) A mere defect in a complex instrumentality will not suffice (Id. at 794).

In the present case, (1) this $200,000 insurance gap was not an insignificant defect and unrealistic disappointment per the meeting of the minds, and (2) coverage limits are not complex, and (3) there had been no prior agreed upon method to resolve problems between the parties. In the instant matter, the Appellate Court stated that "Courts adjudicating CFA claims have dismissed complaints for lack of ascertainable loss where a defendant takes action to ensure that the plaintiff sustains no out-of-pocket loss or loss of value prior to litigation." citing *D'Agostino,* (App-10). This was a reference to the Defendants' offer to increase the coverage limit to $300,000 retroactively to the inception (occurrence-based). The actual quotation in *D'Agostino* (78 A. 3rd at 543) is "in some circumstances" courts have dismissed complaints and they cite to *Thiedemann*. This is not one of those type of cases. The entire argument of damages is centering around the fact that the damages are actually the exposure to risk and not the $16 premium differential (confused with the multi-policy discount). Also, the Defendants knew that there was virtually no risk to them since that period of time had gone by without a claim (a claim that Plaintiff had to report immediately or be denied coverage). Also, it should be noted that the Defendants never offered a solution until after the

DOBI complaint. Also, another argument in support of intangible damages and finding reasonable certainty under the NJCFA is *Ferguson v. Jonah* 445 NJ Super 129 (Docket L-5473-12) (2014) allowing emotional damages (PABp-42).

The Appellate Court held that the Plaintiff did not quantify the difference in carrying the additional risk (App-9). However, both the pleadings (PC-17-43 APPX 41-47) and his brief (PABp-41 to 44) explained the $200,000 gap in coverage for both years and this manner of valuing it i.e. financial ramifications of at least $400,000 for such a gap for the average consumer. The Plaintiff included a 26-page explanation in the Amount in Controversy section of his complaint due to the uniqueness of this case. Plaintiff extensively explained how to determine the value of damages even though no claim was made for the underlying funds (APPX-17-43); As to quantification of the risk for a "person with unknown gap" APPX-17-28; Applying it to the NJCFA (APPX-25 to 28); applying it to the common law APPX-37, 38. Note, Plaintiff did not place all of his personal financial information into the complaint and will seek a protective order protecting his privacy for the individual analysis to estimate the ramifications of a $200,000 gap "to him" under *Furst.*

V. There Is A Private Right of Action Under N.J.A.C. 11:1-22.2(a)(1)

The Appellate Court severely prejudiced its analysis by misreading the text of N.J.A.C. 11:1-22.5(b)(2) (App. 65) as precluding a private right of action. Said text specifically does not preclude the private right and case law on both the federal and highest state level support such a private right of action. Referring to the regulation as a statue, (App-11 footnote 25)" the court misread the text of N.J.A.C. 11:1-22.5(b)(2) quoting "Nothing herein shall be deemed to create any right or cause of action on behalf of any insured". Actually, the full text prevents an insured from having a private right of action to enforce "penalties set forth in this subsection" referring only to the penalties set forth in that subsection. Plaintiff pointed this out in his reply brief at page 1 (Plaintiff's Appellate Reply Brief page 1 hereinafter "PARB- p 1" etc.). The limitation applies only to the subsection not to any of the other causes of action that a consumer would have. These causes of action are recognized by the highest courts in New Jersey.

For example, in the New Jersey Supreme Court in *Pickett v. Lloyd's*, 131 N.J. 457, 467, (1993) though the regulation did not provide for a private cause of action the Court nonetheless allowed an action for the breach of the duty of good faith and fair dealing due to overall policy considerations. And the New Jersey Appellate court upheld a civil remedy when one was in furtherance of the purpose of the legislation and needed to assure the effectiveness of the provision even though there

was no civil remedy for the violation, *Bortz v. Rammel*, 151 N.J. Super. 312, 321, (App. Div. 1977). As to the NJCFA, the New Jersey Supreme Court held where the applicable acts did not provide for a private right of action the court would be "loathe to undermine the CFA's enforcement structure." (*Lemelledo* 150 N.J. at 270*)*.

The Appellate Court then went on to rule that even if the statute allowed a private right of action, the Plaintiff had assented to the change (App-11 footnote 25). This assent was based on the facts presented above and in violation of *Byers* and *Zacarais,* including the generic letter which was never received, construing both the ambiguous "per occurrence" and the confusing $16 multi-discount refund against the Plaintiff. The Appellate Court was relying on the District Court of New Jersey case of *NN&R, Inc. v. One Beacon Ins. Group* 2006 WL 1765077 (Dist. Ct. N.J.). (APPX -741). In that case the consumer lost because he had accepted the changes to coinsurance by faxing a writing by stating: "OK, 80% coinsurance" just prior to the reissue date. That is the opposite of this case in which the consumer sent a fax (confirmed received) explaining the policy had issued and that the insurance company should notify him if there were any problems which they did <u>not</u> do. Most importantly the *NN&R* case was pursuant to negotiations between the parties for a change in coverage and not based on <u>unilateral</u> communications (clearly illegal) by the insurance company.

VI. Policy Considerations Favor Extending the Value of Carrying Risk to Consumer's in Insurance Contracts.

Actually, it is the extent of the damage award against the Defendants which is the main advantage from a social policy point of view. The extent of the damages will make it impractical for insurance companies to perpetrate fraud against the public and will increase their competence. For example, in the case of fraud in the instant matter: There were eight (8) contracts of insurance carrying treble damages under the NJCFA (N.J.S.A. 56:8-19). NJCFA damages are "in addition" to the all other remedies of the torts and breach. (NJSA 56:8-2, N.J.S.A. 56:8-19). The five separate common law torts each carry punitive damages of $300,000 or 5 times actual damages whichever is greater (N.J.S.A. 2A:15-5.9 et seq.). Under *Blazovic v. Andrich* 124 NJ 90 (1991) the Defendants may only apportion the compensatory aspect of damages. There are also breach of contract damages. The rule against double recovery is inapplicable when the damages awarded are punitive *Medina v. District of Columbia* 643 F.3d 323 (D.C. Cir. 2011). Also, compensatory damages can be recovered if they are different in kind." citing *Wirig v. Kinney Shoe Corp.*, 461 N.W.2d 374 (Minn.1990), *Mason v. Okla. Turnpike Auth.*, 115 F.3d 1442 (10th Cir.1997). Since the Plaintiff's exposure to risk is being valued at $400,000 (estimated) and multiplied out by allowances for recovery by law

the Plaintiff has sued for $172,800,000. Because of the arguments regarding the social policies favoring the extension of damages measured by the exposure to risk to the insurance industry, Plaintiff's is asserting his rights for these damages under the Substantive Due Process Clause of the Fifth Amendment of the United States Constitution (App. 63)

Laws evolve with historical circumstances. The industrial revolution being an excellent example. This is the age of the computer and the intellectually elite have been given an unimaginable tool. Insurance companies control the forms and communications. They are risk allocation experts and can profile millions of their consumers in order to determine where to place gaps and non-coverages in order to take advantage of the fact that certain types of people will be less likely to fight or continue to fight thereby skewing the regulatory framework of risk from which they are supposed to abide. They can also hire consultants in the forms of psychiatrists and sociologists to determine which consumers are the most vulnerable. All this with keeping a 97% satisfaction rating because, for example only 5 cases like this one can save a million dollars in coverage (i.e. a skimming scheme).

If there is no fraud involved, applying these actual damages of carrying risk to the insurance industry should merely be a cost of doing business since the same intellectual elites with the help of their computers can utilize systems of rechecking

to make sure that everyone is covered. The entire scholastic aptitude testing system of the United States is run flawlessly by computers. Contrast that cost of doing business to consumers who must argue from a financially devastated position and must also carry the risks, expense and time of litigation even though they are innocent of any wrongdoing or mistake. There is a social policy in making sure insurance companies are competently run. If fraud is involved then the insurance companies have no argument in the application of actual damages to the consumer. Measuring damages from the point of view of carrying the risk by the consumer will make it financially impractical for insurance companies to pursue fraudulent schemes, especially since the executives themselves become personally liable and will be willing to testify as to all they know in order to gain a release.

The distinction between physical pain and risk is elusive, as protection is often the more desirable value. The age of terrorism is going to be met by first responders, bomb squads and security guards. The contracts made for that heroic sacrifice cannot have their values diminished by an after-the-fact argument that somehow the exposure has now expired when the actor is no longer at risk. One might argue that such an approach to carrying risk applies only to heroic undertakings, but any attempt to limit such a value to the undertakings of the heroic creates one of the greatest historical paradoxes:

The heroic would rather the protection go to the citizens.

Conclusion:

For the foregoing reasons the Petition for a Writ of Certiorari should be granted to Alfred DeGennaro.

Respectfully Submitted,

8/20/18 s/Alfred DeGennaro

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