COMMONWEALTH OF MASSACHUSETTS
APPEALS COURT

SJC-10911

~~NO. 2009-P-0619~~

MARCIA RHODES, HAROLD RHODES, AND REBECCA RHODES

Plaintiffs/Appellants

v.

AIG DOMESTIC CLAIMS, INC. f/k/a AIG TECHNICAL SERVICES, INC., NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA, and ZURICH AMERICAN INSURANCE COMPANY

Defendants/Appellees

ON APPEAL FROM A JUDGMENT OF THE
SUFFOLK COUNTY SUPERIOR COURT

BRIEF FOR THE DEFENDANT-APPELLEE ZURICH AMERICAN INSURANCE COMPANY

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COUNTER-STATEMENT OF THE ISSUES

I. If The Court Affirms The Trial Court's Decision That Plaintiffs Did Not Suffer Any Actual Damages As A Result Of AIGDC's Violation Of G.L. ch. 176D § 3(9)(f), Then The Judgment In Zurich's Favor Must Also Be Affirmed

II. The Trial Court Did Not Err In Concluding That Zurich Tendered Its Policy Limits Promptly Once Its Liability Under The Policy Became Reasonably Clear

A. The Trial Court Properly Concluded That Zurich's Duty To Effectuate Settlement Did Not Attach Until Late November 2003

1. The Evidence At Trial Amply Supports The Trial Court's Factual Finding That Damages In Excess Of $2 Million (Zurich's Policy Limits) Did Not Become Reasonably Clear Until October 2003

2. The Evidence At Trial Amply Supports The Trial Court's Factual Finding That The Existence Or Non-Existence Of Other Applicable Primary Insurance Did Not Become Reasonably Clear Until mid-November 2003

B. The Trial Court Properly Concluded That Zurich Acted Promptly In Effectively Tendering Its Policy Limits To AIGDC In November 2003 And Formally Tendering in January 2004

III. The Trial Court Did Not Err In Concluding That, Even If Zurich's Tender of Its Policy Limits to the Excess Insurer Was Not Prompt, Any Delay Did Not Harm Plaintiffs Because It Altered Neither The Amount Nor The Timing Of AIGDC's Settlement Offer to Plaintiffs and, Therefore, Caused Plaintiffs No Injury

COUNTER-STATEMENT OF FACTS

The facts relevant to Plaintiffs' appeal of the judgment in favor of Zurich are as follows:

On January 9, 2002, Plaintiff Marcia Rhodes was injured when the passenger vehicle she was driving was struck from behind by a trailer truck on Route 109 in Medway, Massachusetts. As a result of this accident, Ms. Rhodes sustained serious injuries and lost the use of her legs. The truck was owned by Penske Truck Leasing, Inc., was carrying materials owned by Building Materials Corporation of America d/b/a GAF Building Materials ("GAF"), and was being operated by Carlo Zalewski, an employee of Driver Logistics Service, Inc. ("DLS"). Findings of Fact, Conclusions of Law, and Order, June 3, 2008 (Gants, J.) (hereafter "*Decision*"); Appendix Vol. I ("App. I"), at 17-81.

At the time of the Accident, Zurich American Insurance Co. insured GAF under a primary policy of automobile liability insurance with a bodily injury limit of $2 million, while National Union Fire Insurance Co. provided excess liability coverage to GAF in limits of $50 million. Id. at 2; App. I at 18. GAF had earlier retained Crawford & Company as a third-party administrator to investigate and adjust

all potential claims against it; Zurich had also entered into a contract with Crawford to adjust GAF's losses. In that role, Crawford provided all necessary adjustment services, including investigating the loss and evaluating its merits, and proposing a reserve amount. Id.; App. I at 18. Crawford received notice of the Rhodes accident on the day it occurred. Senior Adjuster John Chaney issued his first report on the Rhodes claim on January 30, 2002, detailing the loss, noting that Ms. Rhodes had already retained counsel, and advising that the case would likely "carry a high value" due to the injuries Ms. Rhodes suffered. Id. at 2-3; App. I at 18-19. Chaney retained defense counsel on behalf of GAF and advised GAF that it should put its excess carrier, National Union, on notice of the loss. Id. at 3-4; App. I. at 19-20.

Chaney's report was sent to both Zurich and AIG Domestic Claims, Inc. ("AIGDC") which served as the claims administrator for National Union. For reasons that remain unclear, this report did not find its way to any of Zurich's claim representatives, Id. at 4; App. I at 20, nor did Chaney's next report dated April 8, 2002. In this correspondence, Chaney reported that Zalewski was clearly liable for the accident and there

was a chance that his misconduct might be imputed to GAF. Id. Chaney also reported that there might be financial contribution from Penske, as well as from Professional Tree Service whose work was the cause for the partial blockage of Route 109 when the accident occurred. Id. at 5; App. I at 21.

In July 2002, six months after the accident, Ms. Rhodes, Mr. Rhodes, and their minor daughter filed a complaint seeking compensatory damages and consortium damages. Id. at 6; App. I at 22. The defendants named were Zalewski, DLS, Penske, and GAF. Id. Chaney's notes indicate that he forwarded a copy of the complaint to Zurich on August 1, 2002, but it was not until Chaney telephoned Zurich soon thereafter, speaking to David McIntosh, a claims director there, that Zurich first received notice of this loss. Id. at 7; App. I at 23. Chaney sent McIntosh various papers from his claim file, but omitted copies of the first and second reports from January and April 2002. Id.

Because Crawford was responsible for the investigation of the accident and the administration of the Rhodes family's claims, all Zurich needed to do initially was resolve the open questions concerning who was covered under its policy, and it retained

coverage counsel (Taylor Duane Barton & Gilman LLP) to perform this task. Id. Between August and December 2002, coverage counsel worked to gather necessary documentation from Penske, DLS, and Zalewski, and analyzed Zurich's coverage obligations.[1] Chaney sent another report to Zurich and GAF in September 2002 which estimated that the potential case value was between $5 and $10 million. Id. at 8; App. I at 24.

A new adjuster, Jody Mills, took over the file at Crawford and she next sent a report dated May 6, 2003 which noted that no demand had yet been made. Id. McIntosh thereafter asked Mills for a full formal report. This report, delivered in early June 2003, noted that Plaintiffs' counsel had not yet submitted a demand or provided a copy of medical records. Id. As of this date, Zurich had yet to receive any documentation concerning the claimed damages.

In July 2003, Mills reported that GAF's defense counsel had received an oral settlement demand of $18.5 million, with incurred medical expenses at $1.3

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[1] Even without all the necessary documents, coverage counsel delivered its analysis to Zurich in mid-December 2002, only four months after Zurich received notice of the action. App. VIII at 3738 (Exh. 67, Bates ZA0583, 1/16/03 entry).

million and future medical expenses at $2 million. Id. at 8-9; App. I at 24-25. Plaintiffs counsel had promised a more detailed demand package to follow, including a "day in the life" video presentation. Id. at 9; App. I at 25. Still, Ms. Rhodes's medical records still had not been provided to Zurich. Id.

Plaintiffs' counsel sent a written demand package to GAF's defense counsel on August 13, 2003. Notably, the amount of incurred medical expenses ($413,977) was significantly less than the $1.3 million previously represented by the Rhodes' attorneys. Id. The overall settlement demand was now $16.5 million. Id. The sought-after medical records were included in the settlement package, Id. at 10; App. I at 26, along with a life care plan for Ms. Rhodes, and an expert economist's valuation. Id.; App. I at 26.

Meanwhile, in August 2003, Kathleen Fuell of Zurich took over responsibility for the Rhodes' claim from David McIntosh. Id. Fuell received the Plaintiffs' settlement package from Crawford in early September 2003. Id. at 11; App. I at 27. In response to the information contained therein, Fuell authorized the retention of a life care expert and received that expert's preliminary report on October 2, 2003. Id. at

30; App. I at 46. Fuell also asked Crawford to obtain a case evaluation from GAF's defense counsel regarding the strength of the Rhodes's claims and any possible defenses. Id. at 12; App. I at 28. Fuell received this evaluation (the "Deschenes" evaluation) the same week in November that she received another report from Mills, this one reporting for the first time that DLS (the truck driver's employer) had no primary insurance of its own due to an error by its insurance agent, and "strongly" suggesting that Zurich surrender its $2 million policy limits as a good faith showing before mediation. Id. at 13; App. I at 29. On the basis of these two reports, Fuell scheduled a conference call for November 19, 2003. Id.

On the November 19th conference call with Fuell were GAF's insurance broker, GAF's in-house counsel, Deschenes (GAF's defense counsel), and Nick Satriano, AIGDC's Complex Director. Id. at 14; App. I at 30. The purpose of the call was to discuss the merits of the claims and defenses of the case, and to plan a strategy for moving it into a settlement posture, including mediation. During that teleconference, there was a consensus that it would take more than $2 million to settle the Rhodes family's tort claims.

Based on statements Deschenes made, Fuell understood that Plaintiffs' counsel had indicated that Plaintiffs would not participate in mediation unless an offer of at least $5 million was extended. In light of that information, and based on her evaluation and independent verification of the records contained in the demand package, Fuell committed to seek authority from her superiors to tender Zurich's $2 million policy limits to AIGDC for its use in settlement discussions with the Plaintiffs. Id.

By announcing that she intended to tender Zurich's policy limits, Fuell put AIGDC on notice that any settlement of the Rhodes family's claims would require a contribution from National Union. Id. at 14-15; App. I at 30-31. And, in fact, although unhappy about being pressured to put money on the table, Satriano understood that the ball was now in his court. Id. at 14, 38; App. I at 30, 54.

Following this call, Fuell prepared a "Bodily Injury Claim Report," which was a prerequisite to her obtaining authority from her superiors to tender the policy limits to AIGDC. Id. at 16; App. I at 32. In early December, she received the final version of the defense life care plan which determined that Ms.

Rhodes's life care costs would be roughly $1.2 million. Id. Fuell submitted the Bodily Injury Claim Report in mid-December, asking for approval to tender Zurich's $2 million policy limits. Id. at 17; App. I at 33. The next day, Fuell telephoned Satriano and verbally tendered Zurich's policy limits. Id.[2] The $2 million was offered to Plaintiffs' counsel in late March, but he rejected the offer out of hand. Id. at 22; App. I at 38.

Following Zurich's tender, resolution of the action rested with AIGDC. Plaintiffs' counsel had indicated a willingness to mediate the claim, but AIGDC wanted additional information before committing itself to a dollar value. Id. at 22-23; App. I at 38-39. Legal jousting ensued from January until August 2004 when the mediation finally took place. Going into the mediation, GAF's defense counsel was given $4.75

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[2] Satriano rejected the verbal tender and insisted on clarification whether Zurich would continue to fund the defense. *Decision*, at 17; App. I at 33. Fuell responded with a formal letter dated March 29, 2004 stating that Zurich (1) was tendering its $2 million policy limits, and (2) its obligation to pay for the defense of GAF, DLS and Zalewski terminated with the tender. Id. at 20-21; App. I at 36-37. AIGDC disagreed with Zurich's position and insisted that it had no duty to fund the defense after Zurich's tender. Zurich ultimately agreed to continue to pay all defense costs, reserving its right to later recover those amounts from AIGDC. Id. at 21-22; App. I at 37-38.

million in authority to settle, which represented Zurich's $2 million, $1 million from Professional Tree Service, and the remaining $1.75 million coming from AIGDC. However, facing demands from Plaintiffs of $15.5 and $15 million, AIGDC never offered more than $3.5 million. Id. at 24; App. I at 40. (Professional Tree Service, however, independently settled with Plaintiffs for $550,000. Id.)

No further negotiations took place between the mediation and the commencement of trial on September 7, 2004. Just prior to closing arguments, AIGDC's claim representative (having seen that the evidence went in well for Plaintiffs) increased National Union's offer to $6 million, but Plaintiffs rejected it, opting instead to send the case to the jury. Id. at 25; App. I at 41. The jury returned a verdict of $9.412 million on all of the claims. Id.

Although AIGDC initially appealed the judgment, it ultimately resolved the litigation with Plaintiffs for the amount of $8.965 million. Id. at 26; App. I at 42. All in all, Plaintiffs received roughly $11.835 million in their tort action, including the settlement with Professional Tree Service, and the $2 million (plus interest) paid by Zurich in December 2004. Id.

About two months before the conclusion of the tort action, Plaintiffs commenced this action against Zurich and AIGDC claiming that both insurers violated G.L. ch. 176D § 3(9)(f) (and, in turn, G.L. ch. 93A) by failing to effectuate a prompt, fair, and equitable settlement of a tort claim in which liability was reasonably clear. Id. at 1; App. I at 17. The trial court conducted a 16-day bench trial, and issued a thorough 65-page written exposition of his findings of fact and conclusions of law.

As set forth in more detail infra as appropriate, the Trial Court concluded that the evidence at trial established that, (1) Zurich acted reasonably in handling Plaintiffs' claim and tendered its $2 million policy limits to the excess insurer promptly; Id. at 34-35, App. I at 50-51; and (2) even if Zurich had violated its duty to provide a prompt tender, an earlier tender "would not in any way have affected either the timing or the amount of AIGDC's subsequent settlement offer," therefore, Plaintiffs had suffered no injury. Id. at 35-36; App. I at 51-52.

With respect to AIGDC, the Trial Court first held that AIGDC had violated ch. 176D § 3 by not making a prompt settlement offer once liability was reasonably

clear; i.e., by May 1, 2004. Id. at 44; App. I at 60. However, because the evidence established that Plaintiffs would not have accepted a prompt settlement offer made by AIGDC at that time, "the delay did not cause the plaintiffs any actual compensable damages." Id. at 48; App. I at 64.

Finally, the Trial Court concluded that AIGDC breached its obligation to provide a reasonable post-trial settlement offer, id. at 57-59; App. I at 73-75, which Plaintiffs would have accepted, therefore, AIGDC was liable under ch. 176D, and the Court assessed Plaintiffs' damages at $448,250. Id. at 61; App. I at 77. That amount was then doubled as a punitive award for AIGDC's willful and knowing violation. Id. at 63; App. I at 79. This appeal by Plaintiffs followed. National Union and AIGDC have filed a cross-appeal.

STANDARD OF REVIEW

Plaintiffs repeatedly state in their brief that they are challenging the Trial Court's entry of judgment in Zurich's favor not on the basis of the court's factual findings, but as a matter of law. See e.g., Appellant's Brf. at 16, 36. Yet, in the very first heading of the argument directed at Zurich, Plaintiffs argue that: "The Facts Demonstrate Zurich

Violated its Statutory Obligation as Early as 2002." Id. at 37 (emphasis added); see also Id. at 40 (complaining that "[t]he Trial Court, however, did not address these facts."). And the ensuing discussion bears out the contention that, while purporting to attack the judgment solely on legal grounds, in actuality, Plaintiffs disagree with the Trial Court's resolution of this case on its facts, but endeavor to avoid having to establish clear error by claiming otherwise.

> "In applying the clearly erroneous standard to the findings of a [judge] sitting without a jury, appellate courts must constantly have in mind that their function is not to decide factual issues *de novo*. The authority of an appellate court, when reviewing the findings of a judge as well as those of a jury, is circumscribed by the deference it must give to decisions of the trier of the fact, who is usually in a superior position to appraise and weigh the evidence.

First Pa. Mge. Trust v. Dorchester Sav. Bank, 395 Mass. 614, 621 (1985); see also Demoulas v. Demoulas Super Mkts., Inc., 424 Mass. 501, 509-510 (1997).

Moreover, to the extent that Plaintiffs challenge the Trial Court's ultimate holding that Zurich acted reasonably by effectively tendering its policy limits to AIGDC in November 2003, such a holding is also a question of fact, not law. Clegg v. Butler, 424 Mass.

413, 421 (1997) (citing Kohl v. Silver Lake Motors Inc., 369 Mass. 795, 799 (1976) (determination of reasonableness is a question of fact)). Thus, Plaintiffs cannot urge this Court to view the evidence in a way more favorable to them or urge this Court to substitute its opinion of the evidence for that already reached; the judgment in Zurich's favor should be affirmed because the court's findings are not clearly erroneous.

SUMMARY OF THE ARGUMENT

In the underlying action, Plaintiffs recovered more than $11.8 million dollars in compensation for the injuries they sustained as a consequence of Marcia Rhodes's tragic accident. *Decision*, at 7; App. I at 23. In addition, through this action, Plaintiffs claim entitlement to an additional $22.7 million dollars under G.L. ch. 93A against Zurich as the primary insurer, based on the claim that the two-month delay between the date on which it became reasonably clear that Zurich's policy limits were exposed and the date of Zurich's actual tender of the full policy limits was a violation of the insurer's duties under G.L. ch. 176D §3(9)(f). Appellant's Brf. at 47.

The Trial Court correctly found that Plaintiffs did not prove that Zurich violated ch. 176D § 3(9)(f) by "failing to effectuate a prompt settlement" because there is no evidence that either liability or damages in excess of Zurich's $2 million policy limits became "reasonably clear" at any time before November 2003 – the point at which Zurich first informed AIGDC that Zurich's primary policy limits would be exhausted. Plaintiffs do not take issue with the Trial Court's factual findings regarding the critical timeline of Zurich's handling of the claim, thus there is no ground for this Court to reverse the Trial Court's careful analysis. See infra at 17-39.

Moreover, even if Plaintiffs could prove a violation of § 3(9)(f), they cannot recover under Chapter 93A as there was no proof offered at trial that Plaintiffs suffered any injury due to the timing of Zurich's tender to AIGDC. To the contrary, Plaintiffs could not have suffered any harm because the action could not settle without the participation of AIGDC. Even Plaintiffs acknowledge that "[s]ettlement negotiations require the participation of two parties." Appellant's Brf. at 30. Here, AIGDC (1) had no intent to settle with Plaintiffs before

August 2004, and (2) did not ever present Plaintiffs with a high enough offer to settle. See infra at 39-50. Thus a pre-trial compromise was impossible.

The Trial Court, then-Superior Court Judge Ralph D. Gants, issued a thorough and thoughtful 65-page written opinion, outlining its factual findings and legal conclusions. Plaintiffs cannot show that the findings are not supported by evidence in the record, nor have Plaintiffs established that the legal conclusions are illogical or incorrect. The judgment should be affirmed.

ARGUMENT

I. If The Court Affirms The Trial Court's Decision That Plaintiffs Did Not Suffer Any Actual Damages As A Result Of AIGDC's Violation Of G.L. ch. 176D § 3(9)(f) Before the Entry of Judgment In the Underlying Action, Then The Judgment In Zurich's Favor Must Be Affirmed As Well

The Trial Court held that, although AIGDC had violated Chapter 176D by "mak[ing] no reasonable effort to resolve promptly the outstanding coverage issues," *Decision*, at 43; App. I at 59, that failure did not cause Plaintiffs to suffer any damages because Plaintiffs conceded that they would not have accepted the offer AIGDC was prepared to make. Id. at 48, 53; App. I at 64, 69.

> Since there is a "required causal connection between the deceptive act and an adverse consequence or loss," [Hershenow v. Enterprise Rent-A-Car, 445 Mass. 790, 800 (2006)], and since there can be no adverse consequence or loss from the failure of an insurer to make a prompt and reasonable settlement offer if the plaintiff would have rejected that offer, Hershenow, although not an insurance case, must stand for the proposition that a plaintiff, to prevail on a Chapter 93A/Chapter 176D claim, must prove not only that the insurer failed to make a prompt or reasonable settlement offer but also that, if it had, the plaintiff would have accepted that offer and settled the actual or threatened litigation.

Id. at 53; App. I at 69.

Plaintiffs have challenged this ruling on appeal, claiming that the Trial Court erred in concluding that they must establish that they would have accepted AIGDC's offer. If this Court (as it should) affirms Judge Gants's ruling on this issue, however, then the judgment in favor of Zurich must also be affirmed. This is so because if Plaintiffs must establish that they would have accepted AIGDC's pre-trial offer (which offer included Zurich's $2 million policy limits as well) and they cannot make that showing, then there can be no recovery against either AIGDC or Zurich. To wit, it would have

made no difference whether Zurich had made a prompt offer of its policy limits to Plaintiffs if Plaintiffs never would have accepted that offer. As Judge Gants held, it takes "two to tango." *Decision*, at 56; App. I at 72.

II. The Trial Court Did Not Err In Concluding That Zurich Tendered Its Policy Limits Promptly Once Its Liability Under The Policy Became Reasonably Clear

Plaintiffs urge this Court to reverse the judgment in Zurich's favor because the trial court "misapplied the law" in holding that Zurich's claim practices in this case complied with G.L. ch. 176D §3(9)(f). See Appellant's Brf. at 37. Plaintiffs claim that the Trial Court should not have found that the operative "trigger date" (at which Zurich's obligation to effectuate a settlement attached) was November 19, 2003, but, rather should have found that Zurich's obligation attached much earlier, in 2002, the year of the accident. Appellant's Brf. at 38-40.[3] The Plaintiffs are wrong; the Trial Court acted fully within its discretion to conclude that liability and

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[3] Plaintiffs do not suggest a specific date in 2002 to be the trigger date; they just generally allege that Zurich should have settled in 2002.

damages were not reasonably clear until mid-November 2003. Clegg, 424 Mass. at 422.

The determination of when the necessary information became "reasonably clear" is a question of fact, not law. See Clegg, 424 Mass. at 422. As such, the Trial Court's findings in this regard can only be overturned if they are clearly erroneous. Clegg, 424 Mass. at 420 ("We will not disturb a judge's findings of fact in a c. 93A claim unless those findings are clearly erroneous, Bressel v. Jolicoeur, 34 Mass. App. Ct. 205, 211 (1993)"). Here, Plaintiffs do not claim that that the Trial Court committed clear error in reaching any of the findings it did, and there is ample evidence in the record to support the Trial Court's findings, as set forth below.

A. The Trial Court Properly Concluded That Zurich's Duty To Effectuate Settlement By Tendering Its Policy Limits to The Excess Insurer Did Not Attach Until Late November 2003

1. The Evidence At Trial Amply Supports The Trial Court's Factual Finding That Damages In Excess Of $2 Million (Zurich's Policy Limits) Did Not Become Reasonably Clear Until October 2003

The credible evidence at trial fully supports the Trial Court's finding that the existence of damages exceeding Zurich's $2 million policy limits did not

become "reasonably clear" until early October 2003. *Decision*, at 32, App. I at 48; see also App. VI at 2489-92 (Tr. Day 15 pp. 129-132 (Karl Maser)); App. V at 2124-25 (Tr. Day 13 pp. 50-51 (William Cormack)). The evidence at trial plainly showed that Zurich received no documentation of Ms. Rhodes's injuries, past medical treatment or prognosis until mid-September 2003, when a copy of the Plaintiffs' August 13, 2003 demand package arrived. App. II at 375-78 (Tr. Day 2 pp. 107-110 (Johanna Mills)); App. VII at 2900-3408 (Exh. 10). The demand package contained medical bills, medical records, doctors' and nurses' reports, bills from rehabilitation facilities and the other types of documentation Zurich needed to begin evaluating Plaintiffs' claimed damages. *Decision*, at 10; App. I at 26.

Plaintiffs argue that Zurich could have ascertained the extent and full value of Ms. Rhodes's injuries in 2002. Appellant's Brf. at 42-43. This argument overlooks two salient points. First, there was undisputed evidence that John Chaney of Crawford requested medical bills and other information concerning Ms. Rhodes's injuries from Plaintiffs' counsel in January 2002, just weeks after the

accident. Plaintiffs' counsel chose not to comply with that request and instead opted to file suit and build his case. App. VII at 5217, 5229, 5236 (Exh. 73, Chaney Depo. pp 61, 130-31, 166).

Second, as the Trial Court correctly pointed out, the extent of Mrs. Rhodes's medical bills - the "starting point of any calculation of total damages," *Decision*, at 30, App. I at 46 - was not reasonably clear to Plaintiffs' counsel until the summer of 2003 due to the confusion over the calculation of incurred medical expenses. See supra at 5.

Also, in light of Ms. Rhodes's permanent paralysis and her apparent need for future care and treatment, the life care plan and other expert reports and medical summaries contained in the Plaintiffs' demand package, see App. VII at 2900-3408 (Exh. 10), were equally critical to any evaluation of damages. App. III at 631-34 (Tr. Day 4 pp. 27-30 (Kathleen Fuell)). That information had not been furnished to Crawford or Zurich before the demand package arrived in September 2003. App. III at 635-44 (Fuell pp. 31-40).

Although Fuell reviewed Plaintiffs' demand package in mid-September 2003, it was necessary and consistent with accepted claim handling practices to verify the

damages being claimed so that she could secure appropriate settlement authority from her superiors. App. VI at 2489-91 (Maser, pp. 129-131). To verify the damages, Fuell: (i) obtained the opinions of the life care planner whom GAF's defense counsel had retained in September 2003; (ii) in early October 2003, requested detailed reporting from GAF's defense counsel concerning the merits of the parties' claims and defenses and the potential value of the Plaintiffs' damages (defense counsel's reports were received in early November 2003); and (iii) conducted independent jury verdict research to get a sense for Plaintiffs' verdicts in similar cases in Massachusetts. App. III at 680-85 (Fuell, pp. 76-81); App. XI at 6732 (Exh. 115); App. VI at 2489-92 (Maser, pp. 129-132). As the Trial Court observed, it was reasonable and consistent with good claim handling practice for Zurich to obtain its own life care plan and Zurich did so promptly. *Decision*, at 30; App. I at 46. In sum, the evidence plainly showed that Fuell's efforts to verify the damages were reasonable, timely, and consistent with industry standards. App. VI at 2490-92 (Maser, p. 130-132).

2. The Evidence At Trial Amply Supports The Trial Court's Factual Finding That The Questions Concerning Who Was Covered By Zurich And The Existence Or Non-Existence Of Other Applicable Primary Insurance Became Reasonably Clear In November 2003

General Laws Chapter 176D, Section 3(9)(f) requires an insurer to effectuate the prompt settlement of claims "in which liability has become reasonably clear." In this case, a number of factors needed to be considered before Zurich could conclude that its liability for the actions of various defendants was reasonably clear. First, there had to be proof that a Zurich insured was legally responsible for the accident, which consideration involved identifying all entities that were possibly entitled to coverage under the policy issued to GAF. Second, Zurich had to determine whether any of the covered entities under the policy had other, independent liability insurance which could either make Zurich's policy an excess policy or could share with it on a pro rata basis. Third and finally, there was an open question about the amount of liability insurance available to Professional Tree Service, a third-party defendant. The Trial Court properly held that Zurich needed to address each of these questions and that

they were not all resolved until mid-November 2003. *Decision*, at 31; App. I at 47. The Trial Court's finding in this regard was amply supported by the evidence in the record.

Contrary to the implications made in Plaintiffs' brief, Zurich did not sit idly from the date of the accident in January 2002 until it effectively tendered its limits to AIGDC in November 2003. Indeed, it was actively attempting to resolve issues of coverage under the policy. The evidence at trial revealed that Zurich did not receive notice of the accident until August 7, 2002 when John Chaney of Crawford telephoned David McIntosh of Zurich. App. VIII at 3774 (Exh. 68, Bates No. ZA1164 (8/7/2 entry)); App. VIII at 3733-34 (Exh. 67, Bates Nos. ZA587-588 (8/12/02 entry)); App. IX at 5387 (Exh. 74, McIntosh Depo. p. 62); App. II at 573-74 (Fuell, pp. 137-38). It was at that time, less than one month after Plaintiffs had filed the underlying action, that Penske requested a defense under the Zurich policy. App. VIII at 3774 (Exh. 68, Bates No. ZA1164 (8/7/2 entry)); *Decision*, at 7; App. at 23. After discussing the matter with Chaney, McIntosh determined that it was prudent to provide a defense to Penske under a reservation of rights, and

to refer the coverage question to a qualified Massachusetts coverage attorney. App. VIII at 3773 (Exh. 68, Bates No. ZA1163 (8/21/02 entry)).

In September 2002, DLS and Zalewski likewise sought coverage under the Zurich policy. App. VIII at 3683 (Exh. 66D, p. 2 ("Current Status")). Their request was also referred to Zurich's coverage counsel (Taylor Duane Barton & Gilman LLP) for review and analysis. Id. Between August and December 2002, coverage counsel worked to gather necessary documentation from Penske, DLS, and Zalewski, and analyzed Zurich's coverage obligations. Although it did not obtain all the necessary documents, counsel's analysis of Zurich's defense obligations to these entities was completed and furnished to Zurich in mid-December 2002, only four months after Zurich received notice of the Rhodes family's claims. App. VIII at 3738 (Exh. 67, Bates ZA0583, 1/16/03 entry)).

Zurich, through its coverage counsel, subsequently sent letters to Penske, DLS, and Zalewski explaining that it would defend them subject to a reservation of rights to disclaim indemnity coverage. The reservations of rights were predicated on the potential availability of other primary insurance for

DLS, Zalewski, and Penske, the potential impact of those policies on Zurich's indemnity obligation, and the need to gather such policies. App. XI at 6712, 6719 (Exhs. 105 & 106).

Plaintiffs suggest that Zurich should have resolved any coverage issues relating to DLS, Zalewski, and Penske in 2002, through a simple review of the Zurich policy. Appellant's Brf. at 38. As insurance expert Karl Maser explained, however, this was not a simple, run-of-the-mill coverage analysis; there were several factors that necessitated review by qualified Massachusetts coverage counsel. App VI at 2457-59 (Maser, pp. 97-99). For instance, to determine whether Penske, DLS, and Zalewski were covered under the Zurich policy, it was necessary to carefully examine the business contracts between those parties and GAF to determine the extent to which those contracts might impact the respective insurance obligations. App. VI at 2458 (Maser, pp. 98).

In addition, the policy form - a Massachusetts-specific, statutorily-mandated Business Auto form - contained non-standard coverages, terms and conditions. Id. It was prudent and consistent with good claim handling practices for McIntosh (a Florida-

based employee responsible for oversight of TPA-handled claims in numerous states) to obtain the assistance of a coverage lawyer familiar with Massachusetts law and the unique coverage form in question. App. VI at 2458 (Maser, pp. 98); App. V at 1951 (Cormack, p. 41).

The trial court's conclusion that it was "certainly reasonable for Zurich to seek to determine whether Zalewski and DLS had their own primary coverage" is unassailable. It is axiomatic that Zurich owed a duty to its policyholder, GAF, to ascertain whether Penske, DLS, and Zalewski had their own policies of automobile liability insurance and, if so, what the limits of such insurance were. App. VI at 2462-63 (Maser, p. 102-03); *Decision* at 31; App. I at 47. This inquiry was critical for two reasons. First, it was quite possible that a policy maintained by Penske or DLS would provide *primary* coverage for GAF (as an additional insured), thereby rendering GAF's insurance policy with Zurich excess. App. VI at 2464-65 (Maser, pp. 104-05); App. V at 1901 (Tr. Day 11, p. 141 (Arthur Kiriakos)). Second, even if the analysis revealed that GAF's policy provided primary coverage for GAF, Penske, DLS, and Zalewski, it was

possible that any primary coverage that DLS or Penske had would be shared on a *pro rata* basis with the Zurich policy. App. VI at 2464-65 (Maser, pp. 104-05); App. V at 1916-22 (Kiriakos, pp. 6-12).

In either scenario, the availability of other insurance had the potential to substantially affect whether and the extent to which the $2 million Zurich policy was exposed. App. VI at 2463 (Maser, p. 103); App. V at 1892-93 (Kiriakos, p. 132-33).[4] The uncertainty regarding the existence and impact of other insurance was the basis for Zurich's decision to fund the defense of Penske, DLS, and Zalewski subject to a reservation of rights. App. XI at 6717-18 (Exh. 105, pp. 6-7); App. XI at 6725 (Exh. 106, p. 7); App. II at 181 (Fuell, p. 71). Zurich did not withdraw its reservation of rights as to that issue before tendering its policy limits to AIGDC. App. II at 231-32 (Fuell, pp. 121-22).

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[4] It was reasonable for Zurich to expect that Penske would have its own coverage given Penske's size and the general rule that "the coverage follows the vehicle." App. VI at 2463-65 (Maser, p. 103-05). Similarly, it was reasonable to anticipate that DLS would have insurance to protect it and its drivers against liability given the nature of its business. App. VI at 2463-64 (Maser, pp 103-04).

Consistent with industry custom and practice, Zurich delegated to its coverage counsel the tasks of identifying other sources of primary coverage and, if such coverage was found, analyzing the so-called "other insurance" clauses of those policies and the Zurich policy under Massachusetts law to determine their impact on Zurich's obligations. App. VI at 2456-64 (Maser); App. V at 2114-15 (Cormack). On a number of occasions between September 2002 and August 2003, Zurich's coverage counsel wrote to DLS's private counsel, DLS's assigned defense counsel, Penske, and other parties seeking documentation of any primary insurance maintained by Penske, DLS, and Zalewski. App. VI at 2465-66 (Maser, p. 105-06); App. V at 1923-30 (Kiriakos, pp. 13-20); App. XI at 6712, 6719 (Exhs. 105 & 106). Coverage counsel received little cooperation, however. Indeed, DLS's private counsel, Steven Leary, actually *refused* to share information concerning DLS's insurance program. App. VIII at 3738 (Exh. 67, Bates No. ZA0583); App. V 1926-28 (Kiriakos, pp. 16-18).[5] Consequently, the extent to which

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[5] Even Plaintiffs' expert witness opined that, based on DLS's refusal to provide this critical information, Zurich had every right to disclaim coverage to DLS. App. V at 1929 (Kiriakos, p. 19). In

Zurich's policy would contribute as primary insurance remained unclear until November 2003, at which time Fuell received Crawford's letter dated November 13, 2003. App. II at 257 (Fuell, p. 147); App. II at 405, 418 (Mills, pp. 137, 150); App. VIII at 3710 (Exh. 66L). In that letter, Crawford noted that, due to an apparent error by DLS's insurance agent, DLS did not maintain a policy of primary auto liability insurance. App. VIII at 3711 (Exh. 66L, p. 2 ("Remarks" section)); *Decision* at 12-13; App. I at 28-29.

At trial, Plaintiffs presented no evidence suggesting that Zurich waited for the results of its coverage counsel's investigation before attempting to evaluate damages. Indeed, the evidence showed that that investigation proceeded independently from Zurich's repeated efforts to gather documentation of the Plaintiffs' damages. App. VI at 2466-67 (Maser, pp. 106-07). Thus, Plaintiffs' contention that Zurich's attempts to identify sources of other insurance distracted the company from its efforts to determine damages is baseless.

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good faith, however, Zurich "stepped up" and defended DLS and Mr. Zalewski, subject to a reservation of rights on the issue of other insurance. App. V at 1929 (Kiriakos, p.19); App. XI at 6712 (Exh. 105).

B. The Trial Court Properly Concluded That Zurich Acted "Promptly" In Effectively Tendering Its Policy Limits to AIGDC in November 2003 And Formally Tendering In January 2004

The Trial Court held that liability and damages did not become reasonably clear until November 19, 2003 (when Zurich informed AIGDC that it intended to tender its full policy), and that Zurich actually tendered on January 23, 2004. *Decision*, at 32-33; App. I at 48-49. Thus, in the Trial Court's eye, the question before it was whether the tender was "prompt" within the meaning of ch. 176D § 3(9)(f), coming as it did roughly two months after the trigger date. The Trial Court ultimately found that, yes, it was prompt:

> [T[his Court does not find that Zurich's delay from November 19, 2003 to January 23, 2004 violated its obligation to make a "prompt" tender. It is reasonable for an insurance company to require a tender as large as $2 million to be authorized at a high level in the company and it is equally reasonable to require that such a request be accompanied by a detailed written justification such as the BI Claim Report. It is reasonable to expect that such a written justification will require a significant amount of time to prepare and for the authorizing officer to consider, and it is reasonable to expect that the time needed will be greater when this work is being performed during the busy holiday season between Thanksgiving and New Year's Day.

Decision, at 35; App. I at 51 (emphasis added). These findings are not clearly erroneous.

In determining when liability, coverage, and damages became "reasonably clear," a court must bear in mind that an insurer "must be given the time to investigate claims thoroughly to determine their liability." Clegg, 424 Mass. 413, 422 (1997). The Supreme Judicial Court's decisions interpreting the obligations of an insurer under ch. 176D, § 3(9) "in no way penalize insurers who delay in good faith when liability is not clear and requires further investigation." Id. The standard requires that the circumstances of each situation be examined and the court determine "not whether a reasonable insurer might have settled the case within the policy limits, but whether no reasonable insurer would have failed to settle the case within the policy limits." Hartford Cas. Ins. Co. v. New Hampshire Ins. Co., 417 Mass. 115, 121 (1994) (emphasis added).

Plaintiffs seem to suggest that when Zurich first determined that it should tender its policy limits in November 2003, it was legally obligated to do so instantaneously. Appellant's Brf. at 43. This argument, however, ignores the practical realities of

the situation. The Trial Court engaged in a painstaking review of the facts and ultimately determined that the process by which Kathleen Fuell of Zurich had to obtain approval for the tender of the $2 million dollars was reasonable. See supra.

The Trial Court properly determined that the "promptness" of Zurich's tender of its policy limits to National Union and AIGDC must be considered in context. The evidence, including expert testimony, supported each of the Trial Court's findings that, (1) it was reasonable to require that a tender of $2 million be authorized at a high level within Zurich; (2) it was reasonable for Zurich to require a detailed report like the Bodily Injury Claim Report as part of that authorization process; (3) it was reasonable to expect that such a report would take a substantial amount of time to prepare; and (4) it was reasonable that the holiday season between November and January interfered with the approval process. *Decision*, at 33-35; App. I at 49-51.

Plaintiffs boldly dismiss Judge Gants's reasoning as a series of "feeble excuses, which are trivial and insulting." Appellant's Brf. at 45. But Plaintiffs offered no countervailing evidence at trial to support

their contention that a tender of policy limits to AIGDC should have been made instantaneously once Fuell learned that there was no other primary insurance available to DLS or Zalewski.[6]

Thus, in sum, there is more than ample evidence in this record to support the Trial Court's factual findings that Zurich's liability for the actions of GAF, DLS, Zalewski and Penske and damages in excess of Zurich's primary policy limit did not become reasonably clear until November 19, 2003. These findings should not be disturbed.

C. This Case Has Little In Common With Mongeon, The Only Case Relied On By Plaintiffs To Establish A Lack Of Prompt Settlement

In their argument outlining what they consider to be Zurich's "reckless indifference" toward their claim, Plaintiffs assert that this case is "strikingly similar" to the insurer's conduct in Mongeon v. Arbella, 17 Mass. L. Rep. 631, 636-38 (Mass. Super.

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[6] To the extent that Plaintiffs contend that Zurich did not adequately investigate Plaintiffs' claims or took too long, see Appellant's Brf. at 38, that claim is not before this Court. In March 2007, Plaintiffs filed a post-trial motion seeking to amend their complaint to add a claim that Zurich had failed to conduct a proper investigation of the claim. See Plaintiffs' Motion to Amend Complaint to Conform to the Evidence, 3/28/07. The Trial Court denied that motion.

Ct. April 23, 2004). Appellant's Brf. at 41. This case and Mongeon are about as similar as apples and oranges; all they have in common is that both concerned claims made pursuant to ch. 176D § 3(9)(f), while their dissimilarities abound.

The plaintiff in Mongeon was rammed at an intersection by an uninsured driver in October 2000. Although not severely injured, Mongeon sought medical treatment within an hour of the accident for chest pain. He was hospitalized and a cardiac catheterization procedure was performed that, unfortunately, later resulted in a serious post-operative infection, requiring a lengthy stay at a residential rehabilitative treatment center and ultimately prevented Mongeon from returning to his previous level of activity, including his employment. Id. at *3-5.

Mongeon's insurer, the defendant Arbella, was notified of the accident the day that it happened. The policy Arbella issued to Mongeon had policy limits of $100,000; at the time he left the rehabilitation center, his medical expenses were in excess of $60,000. Id. at 5.

Four days after Arbella received notice of the accident, an Arbella claims adjuster noted that it was important to determine the insurance status of the tortfeasor because there was possible uninsured motorist exposure for Arbella. Id. at *6. Within a month, Arbella had a copy of the police report indicating that the driver who struck Mongeon did not have his own liability insurance. Id. at *8, 10. Mongeon's counsel stayed in regular contact with the Arbella claim representative, updating him frequently on Mongeon's medical status. Id. at *9.

Arbella first resisted payment of Mongeon's claim on the ground that it was unclear whether the tortfeasor was truly uninsured; Arbella did not undertake any investigation of its own, instead positing that it was the insured's obligation to establish lack of insurance in order to make an uninsured motorist claim. Id. at *10-11. Mongeon's counsel soon thereafter submitted proof that the tortfeasor's insurance had been canceled four months before the accident. Id. at *12.

Arbella then contested the significance of Mongeon's injuries, whether they were causally related to the accident or pre-existing and, indeed, whether

the catheterization was merely an elective procedure. Arbella maintained its position that coverage was not clear for more than a year and a half, despite receiving medical records and expert opinions (including a report from its own expert) that supported Mongeon's claim. It was not until after Mongeon commenced suit that Arbella tendered the $100,000 policy limits to him, more than two years after the accident and twenty-three months after Mongeon made a 93A demand. Id. at *11, 26.

Based on this evidence, the trial court in Mongeon held that Arbella had violated ch. 176D § 3(9)(f) by failing to effectuate a prompt settlement. Id. at *33. The court held that the evidence revealed that Arbella was told right away that the tortfeasor was not insured and that Arbella (not the insured) had the duty to investigate to verify or disprove that assertion; any delay stemming from Arbella's failure to confirm or deny coverage was its fault, not the insured's. Id. at *36.

More importantly, the court held that when Mongeon's Chapter 93A demand letter was received, there was no basis on which Arbella could deny payment. Even by that early date, liability was clear,

the medical records revealed the connection between Mongeon's treatment and the accident and also detailed the course of Mongeon's recovery, and, finally, the medical bills ($60,000) and evidence of lost wages were such that the demand for the policy limits ($100,000) was reasonable and clearly not excessive. Id. at * 38-39. Not only that, the court concluded that Arbella had acted in bad faith. Id., at * 41-42.

Of course, with the facts of Mongeon laid out so plainly, this Court can quickly appreciate the factual differences between it and this case. Here, Zurich did not learn of Ms. Rhodes's January accident until late August of 2002, about a month and a half after the Rhodes' attorneys filed suit in the underlying action. *Decision*, at 6-7; App. I at 22-23. The Trial Court held that while it was reasonably clear in January 2002 that the truck driver was negligent in causing the accident, the scope of Ms. Rhodes's damages "could not have been reasonably clear at least until August 13, 2003, when the Rhodes[es] made their written settlement demand, which set forth the amount of medical expenses she had incurred. *Decision*, at 29; App. I at 45. Even then, as noted by the Trial Court, Zurich had the obligation to investigate the damages

claim submitted by Plaintiffs, especially the "life care plan" for Mrs. Rhodes' future medical needs (in that these needs comprised almost all of the $2,8 million in special damages sought). Zurich promptly obtained an independent assessment which it received in early October 2003.

Even then, though, the Trial Court held that it was not "reasonably clear" that Zurich should tender its policy limits, because the question of the availability of other primary coverage had not yet been resolved. *Decision*, at 30-31; App. I at 46-47. Finally, about six weeks after receiving the independent life care plan, in November 2003, all of the information necessary to determine both liability and damages was in Zurich's hands. *Decision*, at 31; App. I at 47. It was then, on November 19, 2003, that Zurich informed AIGDC that it intended to tender its policy limits. *Decision*, at 32; App. I at 48 (terming it an "effective tender"). The actual tender was made roughly two months later, on January 23, 2004. *Decision*, at 33; App. I at 49.

Thus, unlike Mongeon where there was a gap of almost two years between the date when Arbella's liability and damages in excess of its policy limit

became "reasonably clear" and the date when it offered those policy limits to the plaintiff, here, it was a question of two months. Also, unlike Mongeon, here there was no bad faith on Zurich's part in investigating the claims made by Plaintiffs, especially considering the significance of the damages at issue. For Plaintiffs to compare this case with Mongeon merely shows that, rather than accept the factual findings of the Trial Court as they purport to do, Plaintiffs are actually trying to get this Court to re-try the facts on appeal. This is not permissible. First Pa. Mge. Trust v. Dorchester Sav. Bank, 395 Mass. at 621.

III. The Trial Court Did Not Err In Concluding That, Even If Zurich's Tender Was Not Prompt, Any Delay Did Not Harm Plaintiffs Because It Altered Neither The Amount Nor The Timing Of AIGDC's Settlement Offer to Plaintiffs

The Trial Court was "certain" that AIGDC would not have made a settlement offer prior to the August 2004 mediation, regardless of whether Zurich had tendered its full policy limits at some date earlier than January 23, 2004. *Decision*, at 36; App. I at 52. Without proof that AIGDC was poised to settle the action with Plaintiffs, then a trial was in

Plaintiffs' future whether Zurich made a "prompt" offer or not. Thus, Plaintiffs could not prove that they had suffered any injury on account of what they claimed was Zurich's violation of ch. 176D, § 3(9)(f). Id.

In their brief, Plaintiffs give short shrift to the Trial Court's finding on the element of causation; certainly, they do not argue that it is clearly erroneous. Appellant's Brf. at 46-47.[7]

The Trial Court's finding that AIGDC would not have acted any sooner in making a settlement offer to Plaintiffs distinguishes this case from *Clegg v. Butler*, 424 Mass. 413 (1997) (relied on by Plaintiffs), and establishes - conclusively - that the Plaintiffs could not have been harmed by Zurich's conduct. *Decision*, at 35; App. I at 51 ("There is literally nothing that AIGDC would have done differently. . . ."); *see also* Id. at 35-37; App. I at 51-53 (discussing lack of any harm to Plaintiffs). Without proof of such harm, the Plaintiffs cannot

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[7] The Plaintiffs dedicate less than two pages of their brief to discussion of this issue. In those two pages, Plaintiffs make no mention of the Trial Court's analysis of Clegg and Hershenow. Instead, they cite to a bevy of cases that have no relevance to this issue. Appellant's Brf. at 47 n.25.

recover. *Decision*, at 36-37 n.11; App. I at 52-53; see also Hershenow v. Enterprise Rent-A-Car Co. of Boston, Inc., 445 Mass. 790, 800, 802 (2006); see also Wallace v. American Mfrs. Mut. Ins. Co., 22 Mass. App. Ct. 938, 940 (1986) (a plaintiff must prove "a *causal connection* between the insurer's *failure to settle* (amounting to an unfair act by [the insurer] under relevant provisions of G. L. c. 93A and c. 176D) and the *injury* and loss for which recovery is sought").

In 2006's Hershenow, the Supreme Judicial Court reaffirmed that to be entitled to relief under Chapter 93A, § 9, a plaintiff must demonstrate that the defendant's unfair or deceptive conduct caused the plaintiff an actual loss. The Court held that: "A consumer is not ... entitled to redress under G.L. c. 93A, where no loss has occurred. To permit otherwise is irreconcilable with the express language of G.L. c. 93A, § 9, and our earlier case law." 445 Mass. at 802.

Absent proof that the defendant's conduct caused a cognizable loss, not even statutory damages of $25.00 are available under Chapter 93A, § 9. Id. at 799, n. 18 ("The statutory damage provision [of Section 9] does not supplant the requirement to prove causation under § 9. It merely eliminates the need to

quantify an amount of actual damages if the plaintiff can establish a cognizable loss caused by a deceptive act."). There is no logical reason that this analysis would not apply in cases arising under ch. 176D § 3(9)(f), just as it does in other 93A cases.

To establish the element of causation, Plaintiffs were required to prove that if Zurich had taken earlier steps to effectuate settlement, it is more likely than not that Plaintiffs would have reached a compromise with AIGDC and received the insurance proceeds without the need for a trial. Here, as the primary carrier, Zurich never actually had the ability to effectuate a full settlement of the Plaintiffs' claims in the underlying tort action because Plaintiffs would not have been willing to release all of their claims for the (meager, in this case) amount of $2 million, which was the extent of Zurich's primary policy. As used in G.L. 176D, § 3(9)(f), the phrase "effectuate . . . settlement" connotes the making of a payment in exchange for a full release of all claims against the insured. Lazaris v. Metropolitan Prop. & Cas. Ins. Co., 428 Mass. 502, 505 (1998). The Supreme Judicial Court has recognized that there are circumstances in which a liability

insurer cannot "effectuate settlement" because the damages far exceed coverage. Then, "the best that the insurance company can do in effectuating settlement is to offer the policy limit in exchange for a release. As we have said, to pay without a release is not a settlement. The claimant can either accept the offer or proceed to trial." Id. at 505-06.

In this case, the Plaintiffs were never willing to release their claims for a payment of $2 million or less. *Decision*, at 22; App. I at 38. This was borne out by Plaintiffs' counsel's immediate rejection of Zurich's $2 million settlement offer on the day it was made. Id. In fact, from the date of the accident through trial, the Plaintiffs were unwilling to settle for less than $8 million. See infra. Thus, Zurich never had the ability to truly "effectuate settlement" within its policy limit. Nor could Zurich pay the proceeds of its policy to the Plaintiffs without obtaining a release. See Lazaris, 428 Mass. at 505.[8]

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[8] The Lazaris Court held that,

> The insurer has a duty to its insured. If it does not fulfill that duty, it may violate G.L. c. 176D, § 3(9) and be liable to its insured. If we read § 3(9)(f) as requiring payment of the policy limit without a settlement of claims against the insured, then an insurance company

Under Massachusetts law, the best Zurich could do was offer its policy limits to Plaintiffs in exchange for a release and make its policy proceeds available to the excess insurer for use in further settlement negotiations with Plaintiffs. That is precisely what Zurich did. Id. *Decision*, at 21-22; App. I at 37-38.

Since Zurich could not "effectuate settlement" within its $2 million policy limits, and because Zurich had no duty under Massachusetts law to pay Plaintiffs any portion of its policy proceeds without obtaining a release, Plaintiffs never would have received the proceeds of Zurich's Policy before the entry of judgment in the underlying action. Thus, Plaintiffs could not have avoided the alleged injuries

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> would be forced to watch both flanks. On one side, the company may be sued for unfair settlement practices by a claimant disgruntled by the company's failure to pay, and, on the other side, the company may be sued by an insured disgruntled by the company's payment of the policy limits without obtaining a release. We do not construe G.L. c. 176D, § 3(9)(f) to place insurers in such a position."

Id. at 506; see also Clegg, 424 Mass. at 423, n. 8 (acknowledging that primary liability insurer could not make payment to insured until excess carrier settled plaintiff's claims, as its duties to insured "would not have terminated until complete settlement was concluded.")

they now claim unless they settled their tort claims with AIGDC before trial.

Yet, the Trial Court found that settlement with AIGDC was impossible, finding that it was "certain" that AIGDC would not have made an offer to Plaintiffs any earlier than the August 2004 mediation, *Decision*, at 36; App. I at 52, and that AIGDC's decision to wait until the mediation was intentional. Id. at 42; App. I at 58 ("The fact of the matter is that AIGDC . . . delayed its settlement offer because it did not want to make any offer until mediation and it wanted, for strategic purposes, to wait until nearly the eve of trial to mediate the case."). See also Id. at 54 n.15; App. I at 70. Thus, the Trial Court held that Zurich's tender of policy proceeds even earlier than November 2003 would have made no difference to AIGDC's strategic plan for handling this claim.

Moreover, as duly noted by the Trial Court, the evidence at trial revealed that the Plaintiffs' demand exceeded by $2 million the highest amount AIGDC was willing to pay (which was roughly $6 million). *Decision*, at 48 n.13; App. I at 64; see also Id. at 24; App. at 40 (citing Harold Rhodes's testimony that

the family "would not have accepted any settlement offer at mediation less than $8 million").[9]

While Plaintiffs were unwilling to accept less than $8 million to settle their claims, AIGDC never valued Plaintiffs' damages at more than $6 million. At the mediation, AIGDC first offered Plaintiffs $2.75 million which was later increased to $3.5 million. Plaintiffs' demand was $15 million. *Decision*, at 24; App. I at 40. After the close of evidence but before closing arguments, AIGDC increased its offer to $6 million, a sum that included Zurich's $2 million primary policy limits and a $4 million contribution from AIGDC. Id. at 25; App. I at 41. Plaintiffs rejected it out of hand and did not counter.

Plaintiffs put forth no evidence at trial from which the Court could reasonably infer that AIGDC would have valued Plaintiffs' claimed damages higher

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[9] This finding was buttressed by interrogatory responses wherein Plaintiffs stated that "the family was willing to accept $8 million to resolve the underlying matter up through the [August 2004] mediation." App. XI at 6780-81 (Exh. 122, pp. 8-9); App. XI at 6797 (Exh. 123, p. 8); App. XI at 6814 (Exh. 124, p. 8); App. XI at 6832-33 (Exh. 125, pp. 8-9). Mr. and Mrs. Rhodes testified to this, as well. App. III at 112-30 (Tr. Day 6, p. 173-74 (Marcia Rhodes)); App. IV at 1567-68 (Tr. Day 9, pp. 131-32 (Harold Rhodes)).

than $6 million at an earlier point if Zurich had notified AIGDC earlier of its intent to tender its policy limits. AIGDC arrived at its initial valuation after it had undertaken the additional discovery it felt was essential to a proper valuation of damages, including the deposition and an independent medical examination of Marcia Rhodes. Even after completing the deposition of Rebecca Rhodes between the mediation and the trial, AIGDC's valuation did not change.

It is noteworthy that AIGDC's offer of $6 million - the highest and best offer National Union authorized - was not authorized or communicated to Plaintiffs before the trial began, or even during the course of the trial as the evidence was coming in. Rather, AIGDC authorized and extended the $6 million offer on the last day of trial, after the close of the evidence, and after its representative had observed the jury's reaction to the Plaintiffs' testimony and reported to his superiors that the evidence had gone in much more favorably for the Plaintiffs than AIGDC had anticipated. *Decision*, at 25; App. I at 41.

That was, without question, the point in time of greatest litigation risk and uncertainty for AIGDC. By no process of logic could one conclude that AIGDC

and National Union would have valued the case or authorized a settlement for more than $6 million at some earlier point when a jury verdict was not imminent and when AIGDC had no idea how the evidence would present. The evidence very clearly supports the conclusion that, if Zurich had tendered its policy limits earlier, AIGDC would not have conducted itself any differently and the case would not have settled before trial. This finding was not clearly erroneous.

Finally, Plaintiffs make passing reference to the Supreme Judicial Court's decision in Clegg v. Butler, quoting from the decision but studiously avoiding any real analysis of it. Nothing in Clegg suggests an outcome different than that reached here by the Trial Court.[10] Moreover, although citing Clegg, Plaintiffs fail to cite to the Supreme Judicial Court's decision in Hershenow, which, as noted by the Trial Court,

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[10] The facts of Clegg are fundamentally different from this case. There, the primary carrier's offer of its policy limit was immediately followed by an offer from the excess insurer which the plaintiff then accepted. Id. at 416. The Court concluded that the promptness with which the case was settled supported an inference that "had [the primary] offered its policy limits earlier, [the excess] would have settled earlier too." Id. at 423, n.8. Here, unlike *Clegg*, AIGDC did not offer enough additional monies to be able to settle Plaintiffs' claims. *Decision*, at 36 n.11; App. I at 52.

repudiated any construction of Clegg that 93A claimants need not prove that an unfair practice caused a consumer loss. *Decision*, at 37; App. I at 53. Plaintiffs cannot rely on Clegg to save their claim against Zurich.

In conclusion, Plaintiffs failed to prove that if Zurich had taken steps to tender its policy limits earlier than November 2003, it is more likely than not that Plaintiffs would have settled their tort claims with AIGDC/National Union, avoided a trial, and thereby avoided the injuries they now claim. In fact, the evidence supports the Trial Court's conclusion that the Plaintiffs and AIGDC always had substantially different views as to the value of Plaintiffs' damages and were not going to bridge the multi-million dollar gap that divided them. Absent proof of a causal link between Zurich's alleged violation of Chapter 93A and the damages Plaintiffs seek in this action, the Trial Court properly entered judgment in Zurich's favor.

CONCLUSION AND STATEMENT OF RELIEF REQUESTED

For all of the foregoing reasons, the judgment of the Trial Court should be affirmed.

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CERTIFICATE OF COMPLIANCE PURSUANT TO R.A.P. 16(k)

I, Danielle Andrews Long, counsel for Defendant-Appellee Zurich American Insurance Company, hereby certify that the ***Brief for the Defendant-Appellee Zurich American Insurance Company*** complies with the Rules of Court that pertain to the filing of briefs, including, but not limited to, the Rules noted in R.A.P. 16(k).

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ADDENDUM

Mass. Gen. Laws ch. 93A, § 9

Mass. Gen. Laws ch. 176D, § 3

ALM GL ch. 93A, § 9

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XV REGULATION OF TRADE
Chapter 93A Regulation of Business Practices for Consumers Protection

GO TO MASSACHUSETTS CODE ARCHIVE DIRECTORY

ALM GL ch. 93A, § 9 (2009)

§ 9. Civil Remedies of Consumers; Class Actions; Demand for Relief; Award of Costs and Attorney's Fees; Suspension of Proceedings Pending Administrative Action.

(1) Any person, other than a person entitled to bring action under section eleven of this chapter, who has been injured by another person's use or employment of any method, act or practice declared to be unlawful by section two or any rule or regulation issued thereunder or any person whose rights are affected by another person violating the provisions of clause (9) of section three of chapter one hundred and seventy-six D may bring an action in the superior court, or in the housing court as provided in section three of chapter one hundred and eighty-five C whether by way of original complaint, counterclaim, cross-claim or third party action, for damages and such equitable relief, including an injunction, as the court deems to be necessary and proper.

(2) Any persons entitled to bring such action may, if the use or employment of the unfair or deceptive act or practice has caused similar injury to numerous other persons similarly situated and if the court finds in a preliminary hearing that he adequately and fairly represents such other persons, bring the action on behalf of himself and such other similarly injured and situated persons; the court shall require that notice of such action be given to unnamed petitioners in the most effective practicable manner. Such action shall not be dismissed, settled or compromised without the approval of the court, and notice of any proposed dismissal, settlement or compromise shall be given to all members of the class of petitioners in such manner as the court directs.

(3) At least thirty days prior to the filing of any such action, a written demand for relief, identifying the claimant and reasonably describing the unfair or deceptive act or practice relied upon and the injury suffered, shall be mailed or delivered to any prospective respondent. Any person receiving such a demand for relief who, within thirty days of the mailing or delivery of the demand for relief, makes a written tender of settlement which is rejected by the claimant may, in any subsequent action, file the written tender and an affidavit concerning its rejection and thereby limit any recovery to the relief tendered if the court finds that the relief tendered was reasonable in relation to the injury actually suffered by the petitioner. In all other cases, if the court finds for the petitioner, recovery shall be in the amount of actual damages or twenty-five dollars, whichever is greater; or up to three but not less than two times such amount if the court finds that the use or employment of the act or practice was a willful or knowing violation of said section two or that the refusal to grant relief upon demand was made in bad faith with knowledge or reason to know that the act or practice complained of violated said section two. For the purposes of this chapter, the amount of actual damages to be multiplied by the court shall be the amount of the judgment

on all claims arising out of the same and underlying transaction or occurrence, regardless of the existence or nonexistence of insurance coverage available in payment of the claim. In addition, the court shall award such other equitable relief, including an injunction, as it deems to be necessary and proper. The demand requirements of this paragraph shall not apply if the claim is asserted by way of counterclaim or cross-claim, or if the prospective respondent does not maintain a place of business or does not keep assets within the commonwealth, but such respondent may otherwise employ the provisions of this section by making a written offer of relief and paying the rejected tender into court as soon as practicable after receiving notice of an action commenced under this section. Notwithstanding any other provision to the contrary, if the court finds any method, act or practice unlawful with regard to any security or any contract of sale of a commodity for future delivery as defined in section two, and if the court finds for the petitioner, recovery shall be in the amount of actual damages.

(3A) A person may assert a claim under this section in a district court, whether by way of original complaint, counterclaim, cross-claim or third-party action, for money damages only. Said damages may include double or treble damages, attorneys' fees and costs, as herein provided. The demand requirements and provision for tender of offer of settlement provided in paragraph (3) shall also be applicable under this paragraph, except that no rights to equitable relief shall be created under this paragraph, nor shall a person asserting a claim hereunder be able to assert any claim on behalf of other similarly injured and situated persons as provided in paragraph (2).

(4) If the court finds in any action commenced hereunder that there has been a violation of section two, the petitioner shall, in addition to other relief provided for by this section and irrespective of the amount in controversy, be awarded reasonable attorney's fees and costs incurred in connection with said action; provided, however, the court shall deny recovery of attorney's fees and costs which are incurred after the rejection of a reasonable written offer of settlement made within thirty days of the mailing or delivery of the written demand for relief required by this section.

(5) [Stricken.]

(6) Any person entitled to bring an action under this section shall not be required to initiate, pursue or exhaust any remedy established by any regulation, administrative procedure, local, state or federal law or statute or the common law in order to bring an action under this section or to obtain injunctive relief or recover damages or attorney's fees or costs or other relief as provided in this section. Failure to exhaust administrative remedies shall not be a defense to any proceeding under this section, except as provided in paragraph seven.

(7) The court may upon motion by the respondent before the time for answering and after a hearing suspend proceedings brought under this section to permit the respondent to initiate action in which the petitioner shall be named a party before any appropriate regulatory board or officer providing adjudicatory hearings to complainants if the respondent's evidence indicates that:

(a) there is a substantial likelihood that final action by the court favorable to the petitioner would require of the respondent conduct or practices that would disrupt or be inconsistent with a regulatory scheme that regulates or covers the actions or transactions complained of by the petitioner established and administered under law by any state or federal regulatory board or officer acting under statutory authority of the commonwealth or of the United States; or

(b) that said regulatory board or officer has a substantial interest in reviewing said transactions or actions prior to judicial action under this chapter and that the said regulatory board or officer has the power to provide substantially the relief sought by the petitioner and

the class, if any, which the petitioner represents, under this section.

Upon suspending proceedings under this section the court may enter any interlocutory or temporary orders it deems necessary and proper pending final action by the regulatory board or officer and trial, if any, in the court, including issuance of injunctions, certification of a class, and orders concerning the presentation of the matter to the regulatory board or officer. The court shall issue appropriate interlocutory orders, decrees and injunctions to preserve the status quo between the parties pending final action by the regulatory board or officer and trial and shall stay all proceedings in any court or before any regulatory board or officer in which petitioner and respondent are necessarily involved. The court may issue further orders, injunctions or other relief while the matter is before the regulatory board or officer and shall terminate the suspension and bring the matter forward for trial if it finds (a) that proceedings before the regulatory board or officer are unreasonably delayed or otherwise unreasonably prejudicial to the interests of a party before the court, or (b) that the regulatory board or officer has not taken final action within six months of the beginning of the order suspending proceedings under this chapter.

(8) Except as provided in section ten, recovering or failing to recover an award of damages or other relief in any administrative or judicial proceeding, except proceedings authorized by this section, by any person entitled to bring an action under this section, shall not constitute a bar to, or limitation upon relief authorized by this section.

HISTORY: 1969, 690; 1970, 736, §§ 1, 2; 1971, 241; 1973, 939; 1978, 478, §§ 45, 46; 1979, 72, § 1; 1979, 406, §§ 1, 2; 1986, 557, § 90; 1987, 664 § 3; 1989, 580, § 1; 2004, 252, § 1.

ALM GL ch. 176D, § 3

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE XXII CORPORATIONS
Chapter 176D Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance

GO TO MASSACHUSETTS CODE ARCHIVE DIRECTORY

ALM GL ch. 176D, § 3 (2009)

§ 3. Unfair Methods of Competition and Unfair or Deceptive Acts and Practices Defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:--

(1) Misrepresentations and false advertising of insurance policies: making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement which:--

(a) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(b) Misrepresents the dividends or shares of the surplus to be received on any insurance policy;

(c) Makes any false or misleading statements as to the dividends or share or surplus previously paid on any insurance policy;

(d) Misleads or misrepresents the financial condition of any person or the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) Misrepresents for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(g) Misrepresents for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) Misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally: making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement or

statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation: making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(4) Boycott, coercion and intimidation: entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; any refusal by a nonprofit hospital service corporation, medical service corporation, insurance or health maintenance organization to negotiate, contract or affiliate with a health care facility or provider because of such facility's or provider's contracts or affiliations with any other nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization; or any nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization establishing the price to be paid to any health care facility or provider at a level equal to the lowest price paid to such facility or provider under a contract with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or government payor.

(5) False statements and entries: (a) knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person; or (b) knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) Stock operations and advisory board contracts: issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Unfair discrimination: (a) making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; or (b) making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(8) Rebates: except as otherwise expressly provided by law, knowingly permitting or offering to make or making any insurance contract, including but not limited to a contract for life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or

offering to give, sell, or purchase as inducement to such insurance contract, or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

Nothing in clauses (7) or (8) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:-- (i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payment directly to an office of the insurer in the amount which fairly represents the saving in collection expenses; (iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Unfair claim settlement practices: an unfair claim settlement practice shall consist of any of the following acts or omissions:

(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;

(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) Failing 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 insured or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) Making known to insured or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements of compromises less than the amount awarded in arbitration;

(l) Delaying the investigation or payment of claims by requiring that an insured or claimant, or the physician of either, 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;

(m) Failing to settle claims promptly, 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; or

(n) Failing to provide promptly 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.

(10) Failure to maintain complaint handling procedures; failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination, which record shall indicate in such form and detail as the commissioner may from time to time prescribe, the total number of complaints, their classification by line of insurance, and the nature, disposition, and time of processing of each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance. Agents, brokers and adjusters shall maintain any written communications received by them which express a grievance for a period of two years from receipt, with a record of their disposition, which shall be available for examination by the commissioner at any time.

(11) Misrepresentation in insurance applications: making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurers, agent, broker, or individual.

(12) Any violation of sections two B, ninety-five, one hundred eighty-one, one hundred eighty-two, one hundred eighty-three, one hundred eighty-seven B, one hundred eighty-seven C, one hundred eighty-seven D, one hundred eighty-nine, one hundred ninety-three E, or one hundred ninety-three K of chapter one hundred seventy-five.

HISTORY: 1972, 543, § 1; 1977, 801, § 8; 1978, 446, § 6; 1986, 618, § 3.