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SUPERIOR COUR OF NEW JERSEY
LAW DIVISION-CIVIL PART
Docket No. Cam-**L-779-15**

ELIZABETH LOPEZ-NEGRON,
Individually and on behalf of others similarly situated,

Plaintiff,

OPINION

v.

PROGRESSIVE CASUALTY INSURANCE COMPANY, ET AL.,

Defendants

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Decision: November 5, 2015

KASSEL, J.S.C.

Please note that this letter opinion is not intended for publication and supplements the comments the court made during oral argument on October 23, 2015.

In this putative class action lawsuit, individual plaintiff, Elizabeth Lopez-Negron (hereinafter referred to as plaintiff) alleges damages, including an "ascertainable loss" under the New Jersey Consumer

Fraud Act, as a result of receiving the "health first" personal injury protection benefits option in an automobile insurance policy purchased from defendant Progressive Garden State Insurance Company. (Hereinafter referred to as defendant).[1]

The underlying facts that form the basis of plaintiff's claims are not in serious dispute. On July 20, 2010 plaintiff was involved in a motor vehicle accident and incurred medical expenses. Several months before the automobile accident, plaintiff purchased the automobile insurance policy in question from defendant, utilizing defendant's online application process. During the online application process the prospective policyholder is asked for certain information, and relevant to this case, questions are addressed concerning whether or not the applicant and/or members of the applicant's household are covered by "health insurance", and if yes, whether that health insurance covers injuries in the event of an accident. If the prospective policyholder responds by indicating yes to both those questions concerning health insurance coverage, the prospective policyholder is quoted and recommended a policy with the health first option. Plaintiff indicated yes to both questions, and requested and received an automobile policy that contained the health first PIP option. After the above stated automobile accident, defendant determined that the plaintiff was not eligible for the health first option because she was a Medicare recipient with no private health care insurance.

An explanation of the "health first" option in regard to personal injury protection coverage is in order. The New Jersey Fair Automobile Insurance Reform Act, and specifically *N.J.S.A*. 39:6a-4.3(d), requires automobile insurance companies to provide prospective and current policyholders with the option to have their health insurance coverage be primary coverage for medical expenses resulting from automobile accidents. *N.J.S.A.* 39:6a-4.3(d) provides as follows:

> For policies issued or renewed on or after January 1, 1999, the option that other health insurance coverage or benefits of the insured, including health care services provided by a health maintenance organization and any

[1] Plaintiff has named four insurance companies as defendants, and defendants allege that they are all "Progressive entities". For purposes of clarity they will be referred to collectively as "defendant" in this opinion.

> coverage or benefits provided under any federal or State program, are the primary coverage in regard to medical expense benefits pursuant to section 4 of P.L. 1972, c. 70 (C.39:6A-4). If health insurance coverage or benefits are primary, an automobile insurer providing medical expense benefits under personal injury protection coverage shall be liable for reasonable medical expenses not covered by the health insurance coverage or benefits up to the limit of the medical expense benefits coverage. The principles of coordination of benefits shall apply to personal injury protection medical expense benefits coverage pursuant to the subsection;

Pursuant to *N.J.A.C*. 11:3-37.6(a), if a policyholder chooses the health first option, the policyholder's health insurance carrier is primarily responsible for paying the policyholder's first-party medical expenses for injuries incurred in an automobile accident.

Particularly relevant to this case, the health first option does *not* apply to any coverage or benefits provided pursuant to Medicare or Medicaid. *N.J.A.C*. 11:3-14.5(a). Under Federal law, the Medicare Secondary Payer Act makes Medicare the secondary payer rather than the primary payer, when other sources of payment exist to cover the costs of a Medicare beneficiary's injury. Primary payers include automobile insurance and/or no fault policies, and Medicare is precluded from paying for a beneficiary's medical expenses when payment has been made or can reasonably be expected to be made by a primary plan. 42 *U.S.C* 1395y(b)(2)(A)(ii).

It was obviously the intent of the above quoted legislation to encourage automobile policyholders to select their private health care carrier as primary for medical bills resulting from automobile accidents so as to reduce their automobile insurance premiums, except in the case of Medicare or Medicaid recipients, since those funds are provided by taxpayer dollars.

The defendant's online application process provides a "link" to the New Jersey Buyer's Guide and Auto Insurance Consumer Bill of Rights. The Buyer's Guide is prepared by the New Jersey Department of Banking and Insurance and contains a brief description of all available policy coverages and benefits limits, and also identifies which coverages are mandatory and which are optional, as well as all options offered

by the insurer. *N.J.S.A*. 39:6A-23. The Buyer's Guide explicitly informs prospective policyholders of the following:

> **HEALTH CARE PRIMARY-** Cost savings can also be achieved by using your own health insurance as a primary source of coverage in the case of injury related to and/or to an accident. Before selecting this option, you should find out if your health insurance will cover auto accident injuries and how much coverage is provided. *MEDICARE* and *MEDICAID* ***cannot be used*** *for the Health Care Primary option*.
> (Emphasis in original at Buyer's Guide page 7).

Additionally, the defendant's online application process provides an explanation for each option, and the explanation for "PIP Primary Insurer" provides in relevant part the following:

> What does this cover?
>
> This option determines whether Progressive Direct will be your **primary** or **secondary** insurer for PIP Medical Coverage.
>
> What does it pay?
>
> If you select "**Yes**" to the PIP Primary Insurer question, Progressive Direct will be the Primary insurer for your PIP Medical Coverage. In the event you are injured in an automobile accident, Progressive Direct, not your health insurer, will be primarily responsible for your medical bills. You should select "**Yes**" if:
>
> - one or more drivers listed on the policy are on MEDICARE or MEDICAID.
> - one or more drivers listed on the policy are on active military duty.
> - one or more drivers listed on the policy have no health insurance coverage.
>
> If you select "**No**" to the PIP Primary Insurer question, your health insurer will be the primary insurer for your PIP Medical coverage, and Progressive Direct will be secondary. In the event you are injured in an automobile accident, your health insurer will be primarily responsible for your medical bills. **Please note that many health insurers will NOT pay medical expenses associated with injuries sustained in an automobile accident.** If you are uncertain about the scope of your health insurance coverage, please check with your health insurer.

Subsequent to the accident, plaintiff incurred several medical bills at issue in this case. A bill from Diagnostic Imaging, Inc. for x-rays was denied by defendant because the plaintiff's policy was a health first policy. Plaintiff then sent the Diagnostic bill to Medicare, and Medicare paid the bill. Plaintiff received

medical bills from the City of Philadelphia for ambulance services, and from Oxford Health Care and from Aria Health Systems. Defendant transmitted the same denial letter to those medical providers as it did to Diagnostic Imaging. Medicare denied the City of Philadelphia ambulance bill because it was untimely; denied the Oxford Health Care bill because Oxford was not an approved Medicare provider; and denied the Aria Health System bill because it was also submitted on an untimely basis. Subsequently, defendant paid the Oxford Health Care bill after defendant was advised Oxford Health Care was not an approved Medicare provider, and Aria Health System subsequently wrote off its' bills as a loss. It is unknown what happened to the City of Philadelphia ambulance bill. Plaintiff pursued a third party bodily injury claim against the tortfeasor who allegedly caused the automobile accident, said tortfeasor being insured by GEICO. GIECO ultimately settled the plaintiff's personal injury claim, and Medicare then asserted a subrogation lien on the settlement proceeds, seeking reimbursement for Medicare's payments to Diagnostic Imaging. There is no indication that any of the settlement proceeds have actually been used to satisfy the Medicare subrogation lien.

Importantly, New Jersey's statutory and regulatory scheme concerning the health first PIP option recognizes that there will be policyholders who have selected and/or obtained the health first policy even though they were ineligible to do so due to their status as Medicare recipients who lack private health insurance coverage. *N.J.S.A*. 39:6A-4.3(f) provides, in relevant part as follows:

> If it is determined that an insured whose selected or is otherwise covered by the option provided in subsection d. of this section did not have such health coverage in effect at the time of the accident, medical expense benefits shall be payable by the person's automobile insurer and shall be subject to any deductible required by law or otherwise selected as an option pursuant to subsection a. of this section, any copayment required by law and additional deductible in the amount of $750.

N.J.A.C. 11:3-37.5(a) provides that the automobile insurer may eliminate the premium deduction that the policyholder received by selecting the health first option if it is verified by the insurer that the policy's PIP primary payer in fact "provides that it is always secondary, or otherwise will not be a primary

provider of benefits". Such is the case here, with the plaintiff being a Medicare recipient with no private health care insurance.

The gist of plaintiff's argument against defendant is that she was wrongfully either recommended or permitted a health first policy when indisputably she was ineligible for same due to her status as a Medicare recipient without any primary health insurance coverage, and that defendant failed to verify her Medicare status.

Plaintiff has alleged violations under the New Jersey Consumer Fraud Act and the New Jersey Truth- in- Consumer Contract, Warranty and Notice Act, and has also plead causes of action for common law fraud, unjust enrichment, breach of contract, and bad faith. Plaintiff seeks monetary damages and equitable relief. Suffice it to say that all of plaintiff's allegations involve the central allegation that the defendant *wrongfully* issued the plaintiff a health first policy when the plaintiff was an ineligible Medicare recipient without any private health insurance coverage.

Defendant has filed for dismissal of plaintiff's complaint pursuant to *Rule* 4:6-2(e), for failure to state a claim for which relief can be granted. The well-known case of *Printing Mart v. Sharp Electronics.*, 116 *N.J*. 739 (1989) sets forth the standard concerning these types of motions to dismiss:

> The importance of today's decision…as in its signal to trial courts to approach with great caution applications for dismissal under *Rule* 4:6-2(e) for failure of a complaint to state a claim on which relief may granted. We have sought to make clear that such motions, almost always brought at the very earliest stage of the litigation, should be granted in only the rarest of instances. If a complaint must be dismissed after it has been accorded the kind of meticulous and indulgent examination counseled in this opinion, then, barring any other impediment such as a statute of limitations, the dismissal should be without prejudice to a plaintiff's filing of an amended complaint. *Id*. at 771-72.

Inasmuch as plaintiff's claims involve causes of action that require fraud or other wrongful type conduct, this court determines, for the reasons set forth in this opinion, which supplements this court's oral opinion of October 23, 2015, that there is nothing alleged in plaintiff's complaint, as a matter of law, that can be found to be wrongful or fraudulent.

Plaintiff argues that defendant fraudulently and/or wrongfully permitted plaintiff to purchase the health first policy in question, arguing that since plaintiff was ineligible for same, the defendant unlawfully issued the policy in question. This court notes that there are several statues and administrative regulations that are relevant to the issue concerning responsibility for appropriate selection of PIP option coverage. *N.J.S.A*. 39:6A-4.3(f) places the burden of providing proof that the named insured and members of his family residing in his household are indeed covered by health insurance on the "named insured", and *N.J.A.C*. 11:3-14.5(b) provides that policyholders can fulfill their obligation to provide proof by identifying the health care insurer providing PIP medical expense benefits on a Coverage Selection Form submitted to the insurer.

The court notes the case of *Phillips v. MetLife Auto & Home*, 378 *NJ Super* 101(App. Div. 2005). In *Phillips*, plaintiff instituted suit against his automobile insurance carrier alleging his auto carrier failed to properly advise him concerning the lawsuit (verbal) threshold, resulting in plaintiff selecting the lawsuit threshold. The Appellate Division held that because New Jersey statutes expressly define the information that must be included in the Buyers Guide and because those statutes did not require inclusion of the information that the plaintiff argued was necessary, plaintiff's claim was without merit. In this case, there is no dispute that the online application process that plaintiff utilized to procure her insurance contained a link to the Buyers Guide, which unambiguously advises that "Medicare and Medicaid cannot be used for the health care primary option.", and, in addition, the defendant's online application itself unambiguously explained that the customer should select PIP primary for PIP medical coverage if "one or more drivers listed on the policy are on Medicare…".

Most importantly, this court notes that the regulatory scheme set forth as a result of the New Jersey Fair Automobile Insurance Reform Act clearly anticipates and provides for appropriate procedures when the policyholder obtains a health first policy even though they were ineligible to do so because, for example, they were a Medicare beneficiary without any private health insurance coverage. *N.J.S.A.* 39:6A-

4.3(f) requires that the automobile insurance carrier "shall" pay the medical expense benefits, subject to any deductible required by law or otherwise selected as an option, any copayment required by law, and an additional deductible in the amount of $750. *N.J.A.C*. 11:3-37.5(a) permits the automobile insurer to eliminate the premium reduction that the policyholder obtained by virtue of the policyholder selecting the health first option, provided the insurer complied with certain notice requirements to the policyholder. *N.J.A.C*. 11:3-37.5(b)(2) permits the automobile insurer to include in the above stated notice a demand for payment of the premium reduction difference with an explanation that failure to pay may result in early cancellation of the policy. The insurer is entitled to recover, for the contract period, the difference between the reduced premiums paid on the policy and the amount of the premium which would of been due on the policy had the named insured not selected the health first option. *N.J.A.C*. 11:3-37.8(c). As a bottom line, even when an automobile insurer does not take advantage of any of the above stated options, upon determining that the policyholder is ineligible for the health first option, the automobile insurer must still pay PIP medical expense benefits, subject to a per accident deductible equaling the total of $750.00 plus the PIP deductible selected by the named insured. *N.J.A.C*. 11:3-37.8(a)(1).

Plaintiff is highly critical of the defendant's online application questionnaire because at no point in the application process is the prospective policyholder specifically asked whether or not they are a Medicare recipient. The online application process includes 42 questions, one of which specifically asks whether or not the prospective policyholder or members of his household are covered by "health insurance" and a follow-up question as to whether said health insurance covers injuries in the event of an accident. Although this court was initially concerned that an unsophisticated consumer might interpret "health insurance" to include Medicare, both the online application process and the Buyers Guide (which is "linked" to the online application) explicitly point out that Medicare recipients are not eligible for the health first policy. Moreover, all the relevant statutes and administrative regulations subsumed within

the New Jersey Fair Insurance Reform Act repeatedly make reference to "health benefit plans", "health plan coverage", "health benefits contract ", "health benefits provider" and so forth. In all these occasions, Medicare is never meant to be included in those benefit plans or coverage. All the defendant did in this case was use the same terminology contained in the statutes and administrative regulations that govern the health first option. The online application process already has 42 questions; making the process longer or more complicated was not required as a matter of law.

Plaintiff also argues that defendant had an obligation to verify to make sure that the plaintiff was eligible for a health first policy before issuing the same. This court disagrees. A review of the relevant statutes and administrative regulations resulting from the New Jersey Fair Insurance Reform Act certainly does not reveal any explicit requirement on the insurer to verify or check that the prospective policyholder has valid health insurance in order to be eligible for the health first option. Indeed, it appears that the onus is on the prospective policyholder himself/herself. For example, the burden on providing the appropriate "proof" is on the policyholder, *N.J.S.A.* 39:6A-4.3(f), and that statute does not add any verification requirement to the insurer. The New Jersey Department of Insurance, in its August 20, 1990 bulletin concerning the Fair Automobile Insurance Reform Act, stated that "Note, however, that verification of the validity of the alternative coverage option is voluntary at this time". *Id*. at page 6. Perhaps more importantly, in the rather common situation where a policyholder's private health insurance has terminated during the automobile policy period (which can happen any time a policyholder loses his/her job), or when a policyholder turns 65 and obtains Medicare benefits, there is no practical way the insurer could repeatedly check or verify that their insured has still maintained appropriate private health insurance coverage. Before a court places such an extraordinary obligation on automobile insurers to verify and/or continually monitor their insureds' private health coverage status there would have to be a far more clear indication that the New Jersey Legislature wished to impose the same. As of

now, no such indication exists, particularly when it is the prospective policyholder who is in a far better situation to determine their own eligibility for the health first option.

Rather than requiring automobile insurance carriers to either initially verify and/or continue to monitor the eligibility of it's insured to remain in the health first option, this court determines that the Legislature instead intended that in the event that the policyholder was initially ineligible for the health first option, or subsequently became ineligible, the automobile insurance carrier would have to pay the PIP medical expenses, and the insurer's remedy would be as outlined above, and most particularly as set forth in *N.J.A.C*. 11:3-37.8. Indeed, even an individual who appropriately selected the health first option, thereby receiving the premium discount, will be liable for the additional deductible and premium under *N.J.A.C*. 11:3-37.8(a)1 if that insured seeks medical treatment from a provider outside of his health care network and as a result the PIP carrier pays those medical bills. *N.J. Mfrs. Ins. Co. v. Longo*, 303 *N.J. Super* 286 (App. Div. 1997).

Plaintiff also argues that defendant's failure to obtain a completed Coverage Selection Form (CSF) from the plaintiff provides a basis for defendant's liability. However, this court finds insufficient statutory or case law support in New Jersey for extending liability to an automobile insurer for failure to obtain a completed CSF in the context where the policyholder selected the health first option when in fact were ineligible to do so. The case cited by plaintiff, Oravsky *v. Encompass Ins. Co.,* 804F.Supp.2d 228 (D.N.J. 2011) is not on point. In *Oravsky*, the plaintiff purchased an insurance policy with minimum PIP coverage of $15,000, without the insurer first obtaining a CSF with the plaintiff's written waiver of the higher $250,000 PIP coverage. *N.J.S.A*. 39:6a-4.3(e) explicitly provides that if any insured does not affirmatively choose the lower PIP coverage in writing, the policy then has to provide the maximum $250,000 PIP coverage. In this case plaintiff does not challenge his monetary PIP coverage, but only the selection of the health first option. (Plaintiff could not have been damaged by the monetary limit in any event, since there is no claim that her bills from the accident came close to exceeding $15,000). This court concludes

that The New Jersey Fair Insurance Reform Act does not impose a similar consequence if the insured fails to disclose his/her Medicare status in writing. If an ineligible Medicare recipient is issued the health first option, upon verification of that, as indicated above, the auto insurer becomes primary, subject to the additional deductible.[2]

Plaintiff argues that defendant violated *N.J.A.C.* 11:3-15.7(a), which provides as follows:

> For all new policies, an insurer or an insurance producer *shall receive* a Coverage Selection Form signed by the named insured and indicating the prospective insured's coverage choices. Coverage shall not become effective until the signed Coverage Selection Form is received from the named insured, unless otherwise authorized by Law. (emphasis added)

Defendant concedes that it did not receive a completed Coverage Selection Form signed by the plaintiff prior to or contemporaneous with issuing the policy in question. This court, for the purposes of this motion, therefore assumes that defendant violated the above quoted regulation. Defendant also concedes that the Coverage Selection Form requests the name of the policyholder's health insurer when the policyholder has selected the health first option. This court therefore agrees with the plaintiff that had defendant received a completed Coverage Selection Form before issuing the policy, and had plaintiff correctly indicated in the Coverage Selection Form that she was insured by Medicare, defendant would not have issued the health first policy in question. However, this court concludes that the defendant's violation of *N.J.A.C* 11:3-15.7(a) does not constitute a *per se* violation of the Consumer Fraud Act, or amount to fraud, bad faith, or an unreasonable or unconscionable commercial practice. While violations of specific regulations may constitute an "unlawful act" under the Consumer Fraud Act, and of which strict liability is imposed, they must be regulations promulgated under the Act. *Cox v. Sears Roebuck & Co.,* 138 *N.J.* 2, 18(1994). This court concludes that *N.J.A.C.* 11:3-15.7(a) is not a specific regulation promulgated under the Consumer Fraud Act, nor is it an administrative regulation a violation of which

[2] The additional deductible is not a penalty. See NJ Department of Ins. Bulletin 90-06, page 7.

constitutes a fraudulent or wrongful act. In the context of this case, the only "harm" to a prospective policyholder resulting from the insurer incorrectly issuing the health first option to an applicant not otherwise eligible for same is for the remedies outlined in *N.J.A.C.* 11:3-37.8 to kick in, and as previously indicated, the additional $750 deductible is not a penalty, but rather a cost containment measure for the insurer which had not factored in the cost of providing PIP benefits as the primary provider for the insured. See Bulletin 90-06 of the New Jersey Department of Insurance, at page 7.

In order to prevail on the Consumer Fraud Act claim, a private plaintiff must prove the following:

1. Unlawful conduct by the defendant.
2. An ascertainable loss on the part of the plaintiff.
3. A cause or relationship between the defendant's unlawful conduct and the plaintiff's ascertainable loss.

See *Dabush v. Mercedes-Benz USA, LLC.* 378 *N.J.Super*. 105, 114(App. Div. 2005) *certif.denied*, 185 *N.J.* 265(2005). "To constitute consumer fraud…the business practice in question must be 'misleading' and stand outside the norm of reasonable business practice in that it will victimize the average consumer…" *New Jersey Citizen Action v. Schering.* , 367 *N.J. Super* 8,13 (App. Div. 2003)(citation omitted).

N.J.S.A. 56:8-2 defines, in relevant part, "unlawful" conduct as follows:

> The act, use or employment by any person of any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing, concealment, suppression, or omission of any material fact with intent that others rely upon such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise…whether or not any person has in fact been misled, deceived or damaged thereby. . .

While the Consumer Fraud Act has been held applicable to insurance sales practices, *Lemelledo v. Beneficial Mgmt. Corp*., 150 *N.J.* 255 (1997), it has also been held that the "Consumer Fraud Act is not appropriate where a regulatory scheme deals specifically, concretely , and pervasively with a particular activity, implying a legislative intent not to subject parties to multiple regulations that, as applied, will

work at cross-purposes". *Myska v. New Jersey Mfrs. Ins*., 440 *N.J. Super* 458, 485 (App. Div. 2015) (citation and sub quotes omitted). Furthermore, while the Consumer Fraud Act does cover the sale of insurance policies as goods and services marketed to consumers, it was not intended as a vehicle to recover damages for an insurance company's refusal to pay benefits. *Id*.

This court determines that this case is, at its core, a dispute concerning PIP payment of medical expense benefits pursuant to an automobile insurance policy. However argued, and no matter how strenuously plaintiff asserts that defendant's conduct was fraudulent, this case is ultimately a dispute resulting from an ineligible Medicare recipient selecting and receiving the health first option rather than her automobile PIP as her primary payer of medical expense benefits. As previously set forth, there are ample and comprehensive statutory and regulatory remedies when an ineligible Medicare recipient selects or receives the health first option. The Legislature never intended that mistakes in the selection of the health first option, whether it be by the policyholder or by the insurer, be the subject of tort or breach of contract lawsuits, either by individuals or in class-actions.

Plaintiff argues that defendant "fraudulently steered" her into the health first option. However, a review of plaintiff's complaint does not reveal any specifics to support a claim of fraud, and at oral argument plaintiff's counsel could offer nothing more than the fact that the defendant recommended that the plaintiff choose the health first option after plaintiff indicated during the online application process that she had health insurance to cover medical bills for automobile accidents. *Rule* 4:5-8 requires that all allegations of fraud be plead with particularity. A conclusionary statement, without the particulars in as great detail as practicable, is insufficient. *Rego Industries, Inc. v. American Mod. Metals Corp.,* 91 *N.J. Super* 447, 456 (App. Div. 1966). This court re-reviewed plaintiff's complaint subsequent to oral argument and determines that insufficient particulars of fraud are set forth to comply with *Rule* 4:5-8.

All of the plaintiff's claims, including the contract and quasi-contract claims,[3] require some kind of "*wrongful*" conduct on the part of the defendant. As to the breach of contract claim and other contract type claims, this court determines that the defendant did not "wrongfully" issue the health first policy in question. Plaintiff got what she bargained for: an automobile insurance policy that contained the health first option. There was no "bad faith" or "unjust enrichment". As a Medicare recipient, after the defendant verified her ineligibility, the relevant regulatory provisions kicked in, and defendant became primary payor.

Although defendant's motion to dismiss included arguments that the plaintiff suffered no cognizable damages or losses, in light of the court's ruling in favor of the defendant on the basis that there was no fraudulent or wrongful conduct on the part of the defendant, the court will not reach that issue, except to note that defendant's arguments on damages are generally not susceptible to resolution on motions to dismiss pursuant to *Rule* 4:6-2(e), and this court would permit the plaintiff an opportunity to take discovery to determine, for example, as to whether or not the Medicare lien has affected the plaintiff's credit or is in any other way the basis of a cognizable damages claim. Although this court concludes that the issue of damages is not susceptible to disposition by way of a *Rule* 4:6-2(e) motion, a considerable amount of time was spent during oral argument discussing exactly how this plaintiff was damaged. She did not pay any of the bills, the Medicare lien was not satisfied from her personal injury settlement, and as far as could be determined there has been no economic loss. It was unknown whether or not the Medicare lien has effected the plaintiff's credit. In any event, this court focused on damages to determine whether a policyholder, who had incorrectly selected or received the health first option and then had the policy converted to PIP primary, would suffer any harm other than trivial or speculative

[3] Even as to the quasi-contract claim, "The unjust enrichment doctrine requires that plaintiff show that it expected remuneration from the defendant at the time it performed or conferred a benefit on defendant and that the failure of remuneration enriched defendant beyond its contractual rights*." VRG Corp. v. GKN Realty Corp*., 135 *N.J*. 539, 554 (1994).

economic losses. Based upon this court's reading of the briefs and oral argument, the answer appears to be "no". Nothing remotely significant enough to justify the types of damages available under causes of action such as the Consumer Fraud Act, common law fraud, etc. This is particularly true in the context of automobile insurance, a heavily regulated industry. The New Jersey Legislature and the New Jersey Department of Insurance have codified statutes and administrative regulations that provide specific remedies if and when an ineligible person either selects the health first policy or becomes ineligible during the policy period. This court concludes that the Legislature did not intend that there be private causes of action under either tort law or contract law based upon allegations of consumers incorrectly being issued the health first option in their automobile insurance policy.

Defendant's Motion to Dismiss the Complaint for Failure to State a Claim for Which Relief can be Granted, under *Rule* 4:6-2(e), is Granted. The dismissal shall be without prejudice. *Printing Mart v. Sharp Electronics*., 116 *N.J*. 739, 772(1989). An executed Order is included with this opinion.