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SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1632-15T4

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

Plaintiff-Appellant,

v.

PROGRESSIVE CASUALTY INSURANCE
COMPANY, PROGRESSIVE GARDEN STATE
INSURANCE COMPANY, PROGRESSIVE
FREEDOM INSURANCE COMPANY, and
DRIVE NEW JERSEY INSURANCE COMPANY,

Defendants-Respondents.

Argued February 13, 2017 – Decided March 6, 2017

Before Judges Sabatino, Haas and Currier.

On appeal from Superior Court of New Jersey, Law Division, Camden County, Docket No. L-779-15.

John K. Weston (Sacks Weston Diamond, LLC) of the Pennsylvania bar, admitted pro hac vice, argued the cause for appellant (Sacks Weston Diamond, LLC, Dilworth Paxson, LLP, and Mr. Weston, attorneys; Mr. Weston, Jeremy E. Abay, Thomas S. Biemer, and Jerry R. DeSiderato, on the briefs).

Michael K. Loucks (Skadden, Arps, Slate, Meagher & Flom, LLP) of the Massachusetts bar,

admitted pro hac vice, argued the cause for respondents (Carl D. Poplar, P.A. and Mr. Loucks, attorneys; Mr. Loucks and Kara E. Fay (Skadden, Arps, Slate, Meagher & Flom, LLP) of the Massachusetts bar, admitted pro hac vice, of counsel and on the briefs; Carl D. Poplar, on the briefs).

PER CURIAM

Plaintiff Elizabeth Lopez-Negron appeals the Law Division's November 5, 2015 order dismissing her complaint against defendants Progressive Casualty Insurance Company, Progressive Garden State Insurance Company, Progressive Freedom Insurance Company, and Drive New Jersey Insurance Company (collectively, "Progressive"), pursuant to Rule 4:6-2(e) for failure to state a claim upon which relief may be granted.

The complaint pleads various causes of action. They essentially contend that Progressive acted improperly by causing plaintiff and other customers through its website to purchase online "health-first" automobile insurance policies, even though Medicare and Medicaid recipients such as plaintiff are not eligible to utilize those government programs for their primary medical coverage in the event of a motor vehicle accident. The complaint further alleges that Progressive acted improperly in initially rejecting claims for medical services that plaintiff incurred after being injured in a motor vehicle accident, thereby forcing

her to present those claims in the first instance inappropriately to Medicare.

Applying the well-established principles of Printing Mart-Morristown v. Sharp Electronics Corp., 116 N.J. 739, 746 (1989), we conclude that the trial court dismissed plaintiff's claims prematurely. Among other things, the court decided fact-dependent matters of knowledge, intent, feasibility and reasonableness improvidently before an answer was filed or any discovery was pursued. We therefore vacate the dismissal order and remand the case to the Law Division.

As a threshold procedural matter on remand, the Law Division shall determine in the first instance whether it is appropriate to have this restored state court lawsuit go forward while the identical parties are actively litigating related and substantially overlapping factual and legal contentions in a qui tam action plaintiff has brought against Progressive in the United States District Court. For reasons we explain infra, the simultaneous pendency of the federal and state court cases implicates issues of entire controversy, issue preclusion, claim preclusion, supplemental federal jurisdiction, and the duplicative consumption of judicial resources. Those forum-related issues, which the parties briefed before oral argument on the appeal at

our request, are best addressed promptly on remand before the litigation continues on parallel federal/state tracks.

I.

We describe the following background, mindful that this case is in the pre-answer and pre-discovery phase and that relevant facts have yet to be fully developed or proven. We also note that Progressive's motion to dismiss was not converted by the trial court pursuant to Rule 4:6-2(e) into a motion for summary judgment. Consequently, we refrain from reliance upon matters outside of the complaint and plaintiff's related complaint in federal court. That said, the parties' briefs do suggest that some core facts are undisputed, such as Progressive's issuance of an auto policy to plaintiff and its subsequent handling of her post-accident claims.

A.

Under the Fair Automobile Insurance Reform Act, N.J.S.A. 17:33B-1 to -22, automobile insurers in New Jersey must offer applicants the option to designate their health insurance providers as the primary payer of Personal Injury Protection ("PIP") benefits. See N.J.S.A. 39:6A-4.3(d). This option is commonly referred to as a "health-first" policy.

Under this option, auto insurers only serve as secondary medical payers for injuries sustained by policyholders in motor vehicle accidents. N.J.S.A. 39:6A-4.3(d). As the Law Division

motion judge correctly noted, the overall objective of a "health-first" option is to provide a mechanism for reducing eligible drivers' automobile insurance premiums.

A key facet of a "health-first" option allows insureds to designate other types of health insurance as their primary insurers for PIP benefits, rather than their auto insurers. As an important exception, persons insured through Medicare or Medicaid are ineligible under federal and state law to elect the health-first option. See N.J.A.C. 11:3-14.5(a). Auto insurers must still provide primary coverage for treatment rendered to such policyholders resulting from motor vehicle accidents. This constraint stems from federal law, which requires Medicare to be a secondary payer if a primary payer — such as Progressive here — exists. See 42 U.S.C.A. 1395Y(b)(2)(A)(ii).[1]

Although plaintiff is covered by Medicare, she nonetheless selected, paid for, and received a "health-first" plan from Progressive. Plaintiff obtained that auto coverage by applying for her policy on the insurer's website. The online process she used in applying is a pivotal aspect of her claims.

[1] The same would be true if an auto policyholder were covered by a private health policy and Medicare or Medicaid, in which case the private health coverage would be deemed primary, the auto insurer would be secondary, and Medicare or Medicaid would be the payer of last resort.

The Online Application for "Health-First" Coverage

Plaintiff used Progressive's online application process, which appears on its website at www.progressive.com.[2] The process involved potential customers typing in answers to various coverage-related questions. The insurer's online program then "recommended" a policy, and quoted the applicant a corresponding premium, based on the applicant's responses.

In particular, Progressive's online form posed forty-two questions to applicants. Those questions ranged in scope from the applicant's name, address, and date of birth, to disclosures about his or her employment, driving history, and health insurance coverage.

Pertinent here are two key questions within the online application used to determine when Progressive's automated program would recommend to a customer a health-first policy. Those questions were:

> Are all members of your household covered by health insurance?
>
> Would that health insurance cover injuries in the event of an accident?

[2] Screenshots of the website displays of certain steps within Progressive's online application process were provided to us in plaintiff's appendix.

If an applicant answered "yes" to both of these questions, Progressive's automated response would recommend to the applicant that he or she select a health-first plan.

If an applicant was interested in a "personalized coverage package," Progressive's online process would identify a plan and coverage limits, based on the applicant's answers. Applicants could then raise or lower the calculated premium for the recommended plan by hitting an "Edit" button on the web page, and then adjusting the default range.[3]

Progressive's online application also included a segment on PIP coverage within the personalized section. An applicant could — but is not instructed or required to — click a link on the right side of the computer screen labeled "What is PIP[?]". If he or she chose to activate that link, a "pop-up" would appear on the screen and would provide more information. The pop-up message, if activated, describes PIP coverage as follows:

> 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

[3] Following an example provided in plaintiff's submissions, if, say, Progressive offered a plan that provided for $100,000 per-person and $300,000 per-accident limitations for bodily injury liability, the annual premium for that coverage for the hypothetical vehicle used in the example would be $148.

> 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

This language within the optional pop-up was followed by the following caution:

> 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. Please notify Progressive if your health insurance status changes in the future.
>
> If you select "No" but do not have other medical coverage for injuries sustained in an automobile accident, a penalty deductible of $750 in addition to your elected deductible will apply to your claim. Progressive Direct will also be entitled to recover any premium reduction granted due to your previous

> selection of Progressive Direct as a secondary insurer for PIP Medical coverage.
>
> [(Emphasis partly in original)].

Aside from this, Progressive offered applicants other information about the health-first plan on its website. However, an applicant would have to choose to explore the web site in more depth in order to locate and read it.

Notably, the portion of the online program associated with the "personalized coverage package" provided optional links to the New Jersey Buyer's Guide and the Auto Insurance Consumer Bill of Rights. The web page screen did not contain any message calling the applicant's attention to those links, or explaining why an applicant might want to read the linked materials.

The Buyer's Guide is created by the New Jersey Commissioner of Banking and Insurance. It details insurance plans available in this state. See N.J.S.A. 39:6A-23; N.J.A.C. 11:3-15.5. With respect to the health-first plan, the Buyer's Guide provides the following words of caution for persons who are covered by Medicare or Medicaid:

> 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 an auto accident. Before selecting this option, you should find out if

> your health insurance[4] will cover auto accident injuries and how much coverage is provided. MEDICARE and MEDICAID cannot be used for the Health Care Primary option.
>
> [Buyer's Guide at 7 (emphasis in original)].

Although plaintiff was enrolled in Medicare at the time she purchased her auto policy from Progressive, she nevertheless chose the "health-first" plan. She answered "yes" to both questions concerning other health coverage, despite her being a Medicare recipient.[5] Progressive consequently issued her a health-first policy, apparently unaware at the time that plaintiff was on Medicare.

Progressive, ultimately, did not obtain information about plaintiff's actual health insurance coverage and her Medicare status until after her auto accident and the present controversy arose. Further, Progressive never received a paper copy of plaintiff's Coverage Selection Form ("CSF"), a form required by

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[4] Progressive represents that if an applicant clicked a hyperlink on the screen under the words "health insurance," a different pop-up would launch, explaining the definition of health insurance. However, the record does not provide the language used in this particular pop-up. Hence, it is unclear whether that pop-up explains in an adequate manner the Medicare/Medicaid exception.

[5] In her related federal complaint, which was included in the motion papers submitted to the Law Division judge, plaintiff stated that during the application process she did not click on links on the website that would have explained to her that she was not eligible to enroll in a health-first plan while she was on Medicare.

N.J.S.A. 39:6A-4.3(f) and N.J.A.C. 11:3-15.7, which would have disclosed her Medicaid coverage.[6]

Plaintiff's Auto Accident, Her Medical Bills, and Her Personal Injury Settlement

Plaintiff, a New Jersey resident, had a motor vehicle accident while driving her 1994 Chevrolet G20 van in Philadelphia during the spring of 2010.[7] Plaintiff registered the Chevrolet in New Jersey. The vehicle was insured by Progressive through plaintiff's New Jersey health-first PIP policy.

Plaintiff was transported by a City of Philadelphia ambulance and was briefly hospitalized for injuries she sustained in the accident. She underwent treatment at a facility of Oxford Health Care, a unit of Aria Health Systems. Plaintiff also had two x-ray studies performed by Diagnostic Imaging, Inc.

Diagnostic Imaging submitted its bills to Progressive, but Progressive denied payment of them due to plaintiff's selected

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[6] At oral argument on the appeal, the parties appeared to agree that it is customary when an applicant purchases auto insurance through an online process to not have a CSF generated. As we note, infra, we do not resolve in this opinion whether that custom is permissible under the insurance statutes and regulations concerning the CSF, or whether an insurer's failure to obtain a CSF for an online customer could justify granting any relief to that customer.

[7] The specific date of the accident is listed three different ways in the state and federal complaints and the Law Division's opinion. The actual date does not affect our analysis.

health-first insurance option. In a letter to plaintiff and Diagnostic Imaging explaining that denial, Progressive wrote that she was ineligible for PIP benefits because she had "elected to have [her] health insurance as the primary source of coverage for medical costs." The x-ray invoices were then submitted, either by plaintiff or the provider, to Medicare, which paid them, apparently by mistake.[8]

Progressive also denied payment for the costs of plaintiff's ambulance ride and hospital stay at Aria Health System. Medicare likewise denied payment for these bills, because they had not been timely submitted, and also because Aria is not an approved Medicare provider.

Progressive ultimately did pay a portion of the Aria bill. Other Aria bills and the ambulance bill remained unpaid. Aria apparently wrote the remaining bills off as a loss.

Plaintiff pursued a bodily injury claim against the other driver who was involved in the accident. That driver had liability coverage with the insurer GEICO. Eventually, GEICO settled the bodily injury claim with plaintiff for an undisclosed amount.

Thereafter, Medicare placed a subrogation lien on plaintiff's tort settlement proceeds to recover what it had paid for the

[8] The federal and state complaints are contradictory as to who resubmitted the x-ray bills to Medicare.

Diagnostic Imaging bills, which it realized by that point had been paid in error. The present record does not indicate whether plaintiff has used the proceeds of her settlement with GEICO to satisfy the Medicare lien.

Plaintiff's Two Overlapping Federal and State Complaints

As we have already noted, plaintiff brought two separate lawsuits against Progressive[9] arising out of these common facts. She first filed a qui tam action in the United States District Court for the District of New Jersey on January 28, 2014. Her federal complaint, which was initially filed under seal, asserted claims as a "relator" on behalf of both the United States and the State of New Jersey.

The extensive twenty-three-page federal complaint detailed Progressive's course of conduct in issuing plaintiff a "health-first" policy, and later in rejecting her medical bills for payment and directing her to submit them inappropriately to Medicare. The federal complaint set forth two counts, claiming defendants' conduct violated the federal False Claims Act, 31 U.S.C.A. § 3729 to 3733, and New Jersey's False Claims Act, N.J.S.A. 2A:32C-1 to

[9] The federal lawsuit only names as defendants "Progressive Casualty Insurance Company" and "Progressive Garden State Insurance Company," which for simplicity we shall also refer to collectively as "Progressive."

-17.[10] As redress, the federal complaint sought a cease-and-desist order against Progressive, treble damages, civil penalties, attorneys fees, and other relief.

About a month later, on February 25, 2015, plaintiff filed this putative class action complaint under Rule 4:32 in the Law Division. This state court complaint is largely based on the same core facts as plaintiff's federal complaint. In fact, many of the factual allegations in plaintiff's thirty-three-page Law Division complaint are verbatim, or nearly verbatim, to allegations she asserted in her federal complaint.

The Law Division complaint alleges violations of the Consumer Fraud Act ("CFA"), N.J.S.A. 56:8-1 to -20; the Truth-in-Consumer Contract, Warranty and Notice Act, ("TCCWNA"), N.J.S.A. 56:12-14 to -18; and common-law claims of fraud, unjust enrichment, breach of contract, and bad faith. In essence, plaintiff contends that Progressive's website improperly induced her and other Medicare/Medicaid recipients to select the health-first option, and thereby sold them an illusory policy term. She asserts that the insurer sold her and others an auto policy that they were not lawfully allowed to purchase, allegedly for its own advantage.

[10] The federal complaint invoked the District Court's supplemental jurisdiction over the state law claims under 28 U.S.C.A. § 1367.

As relief, the complaint seeks a variety of measures for the benefit of plaintiff and other similarly-situated Progressive policyholders in the putative class. Those measures include injunctive relief to compel Progressive to cease and desist from unlawful practices, treble damages, statutory penalties, disgorgement of profits, interest, counsel fees, and other relief.

The United States declined to intervene in plaintiff's federal action on March 11, 2015, and on March 17, 2015, the District Court accordingly unsealed the complaint. The State of New Jersey similarly declined to intervene in the federal case on August 3, 2015.

On June 22, 2015, Progressive moved to dismiss the federal complaint under Fed. R. Civ. P. 9(b) and 12(b)(6). The next day, on June 23, 2015, Progressive similarly filed a motion in the Law Division to dismiss the state court complaint under Rule 4:6-2(e)[11] for failure to state a claim.

The Substantially Divergent State and Federal Dismissal Motion Rulings

A. The Law Division Dismissal Ruling

[11] Progressive also moved to strike plaintiff's class action allegations as deficient under Rule 4:32-1. The motion judge did not need to and did not rule on that particular issue, nor do we.

Progressive's motion to dismiss the state court action was decided first. After hearing oral argument, the Law Division motion judge issued a written opinion on November 5, 2015, determining that plaintiff's claims were not viable as a matter of law.

In substance, the motion judge concluded that Progressive's online application process was adequate as a matter of law, and that it sufficiently provided applicants who are on Medicare or Medicaid with access to information apprising them that they are not eligible for the "health-first" option. The judge further ruled that plaintiff's complaint failed to allege any conduct by Progressive "that can be found to be wrongful or fraudulent."

In his written opinion, the judge noted that he was "initially concerned that an unsophisticated consumer might interpret [the term] 'health insurance' [on the application form] to include Medicare[.]" However, he noted that his concerns abated after reviewing the website's link to the Buyer's Guide and the explanatory PIP language that an applicant could have seen by clicking the applicable question mark on the computer screen.

Additionally, the judge found that Progressive had adhered to the terms of the New Jersey Fair Insurance Reform Act and its relevant regulations in designing its online application questions. The judge found that since "[t]he online application

process already has 42 questions; making the process longer or more complicated was not required as a matter of law."

Further, the motion judge rejected as legally untenable plaintiff's claim that Progressive should have explicitly asked in the online process whether an applicant was covered by Medicare or Medicaid. In this regard, he relied on Phillips v. Metlife Auto & Home, 378 N.J. Super. 101 (App. Div. 2005), which held that because an insurance company had provided a physical copy of the Buyer's Guide to customers, the insurer was not required to provide them with any further information about the lawsuit limitation option or "verbal threshold." Analogizing the insurer's practice validated in Phillips to this case, the judge concluded that Progressive's link to the Buyer's Guide, along with the PIP disclaimer appearing on the pop-up, "unambiguously advise[ed]" Medicare or Medicaid recipients to not select the health-first option. The judge did not comment on the optional nature of the pop-up.

The motion judge found it significant that N.J.S.A. 39:6A-4.3(f) provides a remedy for a situation when a policyholder improperly receives a health-first policy. Specifically, the statute requires insurers to pay medical benefits subject to "any deductible required by law . . . any copayment required by law and

additional deductible in the amount of $750." (quoting N.J.S.A. 39:6A-4.3(f)).

The judge disagreed with plaintiff's contention that auto insurers have an affirmative obligation to verify that applicants have eligible health insurance before issuing a health-first policy. He ruled that N.J.S.A. 39:6A-4.3(f) places the burden on the applicant, not on the insurance company, to ascertain his or her ineligibility for that option. He also found that an August 20, 1990 bulletin issued by the then-Department of Insurance (now known as the Department of Banking and Insurance) instructive. (citing New Jersey Insurance Bulletin 90-06, (August 20, 1990) hereafter "Bulletin 90-06"). That bulletin advised insurance companies that verifying an applicant's health insurance was voluntary. (citing Bulletin 90-06 at 8).

The judge determined that, in light of the dynamic nature of a person's health insurance coverage over time, "there was no practical way the insurer could repeatedly check or verify" that its customers were continually insured by other means. Based on that finding of infeasibility, the judge thus concluded that insurers such as Progressive did not have a burden to "either initially and/or continue to monitor the eligibility of [their] insured to remain in the health first option[.]"

Lastly, the judge rejected plaintiff's argument that because Progressive did not receive a CSF from her in accordance with the usual procedures set forth in N.J.S.A. 39:6A-4.3(f) and N.J.A.C. 11:3-14.5(b), it committed an unlawful act giving rise to a CFA claim. The judge did agree with plaintiff that Progressive deviated from these provisions by not receiving the form. He also agreed that if Progressive had received the CSF, and thereby learned plaintiff's Medicare status, it would not have issued a health-first policy to her. However, the judge disagreed with the proposition that a departure from the insurance statute and regulation calling for CSF constituted an "unlawful act" under the CFA, or that it amounted to fraud, bad faith, or an unconscionable commercial practice.

The judge relied in this regard upon Myska v. New Jersey Manufacturers Insurance Company, 440 N.J. Super. 458, 485 (App. Div. 2015), certif. dismissed as improvidently granted, 224 N.J. 524 (2016), in which we held that the CFA "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." Because the Fair Insurance Act already specifies a remedy of the $750 deductible, in exchange

for an automobile insurer paying PIP medical benefits, the judge reasoned that CFA did not and could not apply to the situation.

The judge further ruled that plaintiff had not alleged with particularity any fraudulent act committed by Progressive. Instead, the judge characterized the State court action as "a dispute concerning PIP payment of medical expense benefits pursuant to an automobile insurance policy," in which a regulatory remedy already existed. The judge dismissed the complaint's remaining common-law claims, ruling that Progressive had not engaged in any wrongful conduct.[12]

The judge declined to resolve Progressive's separate argument that plaintiff could not proceed with this case because she has sustained no damages. However, the judge noted at oral argument that if plaintiff wished to specify her damages more fully, she would be "able to re-plead the matter . . . [and] we'll see where we go from there." The order of dismissal accordingly dismissed the complaint "without prejudice."[13]

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[12] The judge's opinion does not expressly state why plaintiff's TCCWNA claims were dismissed.

[13] We do not perceive that this "without-prejudice" facet deprives this court of appellate jurisdiction. Cf. Grow Co. v. Chokshi, 403 N.J. Super. 443, 457 (App. Div. 2008) (instructing that a negotiated "without prejudice" dismissal of a complaint may be a non-final order for purposes of appellate jurisdiction). Because the motion judge already has determined that plaintiff's claims are not viable as a matter of law, the dismissal order essentially

B. The Federal Court's Dismissal Ruling

Several months later, the federal district judge denied Progressive's motion to dismiss plaintiff's federal complaint. He issued a thirty-page written opinion on March 1, 2016 explaining his reasons for denying the motion.

In his own analysis, the district judge fundamentally differed from the Law Division's assessment of the viability of plaintiff's allegations of impropriety and fraud. Accepting plaintiff's factual assertions at the pleading stage as true, the district judge determined that she had pled viable allegations of deficiencies in both Progressive's online application process and its handling of her medical bills.

The district judge found that Progressive had at least three opportunities to prevent the sale of health-first auto policies to Medicare and Medicaid enrollees such as plaintiff and, even if such sales had occurred, to prevent the inappropriate submission of medical treatment claims to those government programs.

First, Progressive could have constructed its online application to prevent the mistaken purchase of health-first policies. According to the district judge, this "could have been

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operates as a final judgment. We discern no point in withholding review of this appeal in order to enable plaintiff to amend the complaint to amplify her damages claims, as liability already has been adjudged by the trial court in Progressive's favor.

accomplished through pop-up warnings, by requiring applicants to disclose the name of their health insurance carrier or provide a certification that they are not Medicare/Medicaid recipients, or by any number of other modifications to the online application process."

The district judge also noted that the "fine print" of the online application advises applicants they "should" select Progressive as their primary insurer if one or more drivers in their household are on Medicare or Medicaid. The judge stated that "Perhaps more accurate language would be to advise applicants that they 'must' select Progressive as the insurer if they are [covered] by Medicare or Medicaid."

Second, the district judge found that "it seems reasonable to assume that the online application process resulted in further post-application underwriting review and further communications between the [insurer] and purchasers of health[-]first policies[.]" Those added interactions would include "the issuance of a formal policy and declarations, the issuance of permanent insurance cards, premium notices, and renewal processes." The judge reasoned that "[e]ach of these communications or interactions presented a separate opportunity to ensure that health[-]first policies were not held by Medicare/Medicaid enrollees."

Third, the district judge ruled that plaintiff had raised viable allegations that Progressive's claims handling process for Medicare/Medicaid recipients with health-first policies was deficient. The judge observed that "nowhere is it explained why [Progressive's] adjuster did not ask the health providers submitting the claims the simple question of what other insurance [plaintiff] presented to the health care provider when the services were rendered." "Further, no reason is given why that same simple question was not asked of [plaintiff] at the beginning of the claims adjustment process."

The district judge rejected Progressive's argument that it was acceptable for Medicare to have paid some of plaintiff's medical bills because the auto insurer eventually reimbursed Medicare. As the judge noted, "[i]f that practice regularly occurred, [d]efendants would essentially be receiving an interest[-]free loan from the government on claims they are obligated to pay and were always obligated to pay."

For these and other stated reasons, the district judge declined to dismiss plaintiff's federal lawsuit, having ruled that she had fulfilled her pleading requirements. The federal case apparently is continuing to proceed in the discovery phase.

The Present Appeal

Fundamentally, plaintiff contends that the Law Division judge dismissed her complaint prematurely without affording her the appropriate indulgence mandated by Printing Mart and its progeny. She argues that the Law Division improperly assumed or decided various fact-laden issues. For instance, she argues the court made conclusive findings about the difficulty that would have been entailed in Progressive revising the online application process to make clearer to Medicare or Medicaid recipients their ineligibility for a health-first policy; the reasonableness of Progressive's failure to obtain a CSF before issuing to plaintiff the health-first policy; and the insurer's overall state of mind in structuring its online application and its claims handling processes.

Plaintiff further asserts that the Law Division erred in various facets of its legal analysis. She also points out that the Law Division never stated why it dismissed her TCCWNA claims.

Progressive, meanwhile, contends that the Law Division judge's analysis was sound in all respects. The insurer thus urges that we affirm the dismissal of the complaint.

II.

Well-established principles guide our appellate review of the Law Division's dismissal ruling. As the Supreme Court has instructed, a reviewing court assessing the dismissal of a

complaint under Rule 4:6-2(e) must "'search[] the complaint in depth and with liberality to ascertain whether the fundament of a cause of action may be gleaned even from an obscure statement of claim, opportunity being given to amend if necessary.'" Printing Mart, supra, 116 N.J. at 746 (quoting Di Cristofaro v. Laurel Grove Mem'l Park, 43 N.J. Super. 244, 252 (App. Div. 1957)); see also Banco Popular N. Am. v. Gandi, 184 N.J. 161, 165 (2005).

The review of a Rule 4:6-2(e) motion must be performed in a manner that is "generous and hospitable." Printing Mart, supra, 116 N.J. at 746. The court's role is simply to determine whether a cause of action is "'suggested'" by the complaint. Ibid. (quoting Velantzas v. Colgate-Palmolive Co., 109 N.J. 189, 192 (1988)).

A.

Guided by Printing Mart's indulgent pleading standards, we primarily consider whether plaintiff's Law Division complaint alleging CFA violations was pled with sufficient detail to survive a motion to dismiss. The motion judge conclusively determined that Progressive did not take any unlawful actions that could give rise to a claim under the CFA. We agree with plaintiff that this finding was premature and potentially erroneous.

The Supreme Court has held that, in order to state a claim under the CFA, a plaintiff must show three elements: (1) unlawful

conduct by a defendant; (2) an ascertainable loss; and (3) a causal relationship between the unlawful conduct and the ascertainable loss. "Each of these elements is rooted in the [CFA's] statutory text."[14] D'Agostino v. Maldonado, 216 N.J. 168, 184 (2013).

Under the CFA, an unlawful conduct or practice is defined as:

> 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 or real estate, or with the subsequent performance of such person as aforesaid, whether or not any person has in fact been misled, deceived or damaged thereby . . .
>
> [N.J.S.A. 56:8-2].

The Supreme Court broadly interpreted the scope of the CFA in an insurance context in Lemelledo v. Beneficial Mgmt. Corp. of Am., 150 N.J. 255 (1997). In Lemelledo, the Court addressed whether the CFA applied to defendants who engaged in offering credit insurance through "loan packing." Id. at 260. The trial court dismissed the complaint for failure to state a claim under

[14] On the present appeal, only the unlawful conduct prong of the CFA is at issue. The motion judge found that the CFA's elements of ascertainable loss and causation would need discovery to adjudicate, and he did not base his dismissal on those elements.

which relief can be granted. Id. at 263. The Court disagreed and reinstated the plaintiff's CFA claims.

The Court in Lemelledo underscored the CFA's purpose, observing that the statute is "intended to protect consumers 'by eliminating sharp practices and dealings in the marketing of merchandise and real estate.'" Ibid. (quoting Channel Cos. v. Britton, 167 N.J. Super. 417, 418 (App. Div. 1979)). The Court further noted that the Legislature intended the CFA to apply "broadly in order to accomplish its remedial purpose, namely, to root out consumer fraud." Id. at 264.

With that backdrop in mind, the Court ruled in Lemelledo that although the "payment of insurance benefits is not subject to the CFA," the sale of insurance, such as the sales practices at issue in that case, would be covered by the CFA as a means to "root out fraud in its myriad, nefarious manifestations." Id. at 265-66.

By way of guidance, the Supreme Court in Lemelledo addressed whether the CFA could apply to an industry, such as the insurance business, already regulated by non-consumer state administrative agencies. See id. at 267. Accord Gonzalez v. Wilshire Credit Corp., 207 N.J. 557, 586 (2011); Real v. Radir Wheels, Inc., 198 N.J. 511, 522-24 (2009). Generally, the Court held that such regulation by an administrative agency is not an entirely dispositive factor in determining whether the CFA will apply.

Lemelledo, supra, 150 N.J. at 268. "Instead, a court must look to whether a 'real possibility' of conflict would exist if the CFA were to apply to a particular practice, regardless of the number of agencies with regulatory jurisdiction over that practice." Ibid.

As a starting point to the CFA analysis, Lemelledo instructs that it should be initially "assumed that the CFA applies to the covered practice" at issue. Ibid. This initial assumption is based in the "sweeping legislative remedial purpose" inherent in the CFA, and the expectation that in filing appropriate lawsuits under the CFA "consumers will act as private attorneys general." Ibid. (internal quotations omitted). To find that non-consumer statutes and regulations preempt the CFA, a court must determine that "a direct and unavoidable conflict exists between application of the CFA and application of the other regulatory scheme or schemes." Id. at 270 (emphasis added).

Following Lemelledo, our courts have applied the CFA to regulate insurance sales practices, although they have been disinclined to apply the CFA to conduct involving the payment of insurance benefits. See, e.g., Myska, supra, 440 N.J. Super. at 484. In Myska, the trial court had dismissed a putative CFA class action because the harms alleged by the plaintiffs were insufficiently discrete and because insurance regulations

preempted the CFA claim. Id. at 471. On appeal, we acknowledged that insurance-related fraud claims could potentially proceed under the CFA, but were restricted "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-purpose." Id. at 485.

We ruled that the plaintiff in Myska had failed to allege how the defendants' insurers had "fraudulently procured their agreement for coverage." Ibid. (emphasis added). Without the allegation of fraudulent intent, the plaintiffs' complaint in Myska ultimately boiled down to "whether they filed and supported a claim for a specified amount of benefits under their respective policies—issues which fall outside the scope of the CFA." Ibid.

Here, we must analyze the legal sufficiency of plaintiff's complaint as to three separate CFA issues: (1) whether other insurance laws preempt plaintiff's cause of action under the CFA; (2) whether Progressive's failure to request the identity of plaintiff's health insurance provider could constitute an "unlawful act" under the CFA, and (3) whether Progressive's failure to obtain a CSF from plaintiff could give rise to a CFA claim. Progressive argues, and the Law Division judge found, that the

terms of insurance statutes and regulations preclude a CFA claim here.

Plaintiff's CFA claims do not manifestly undermine the discrete regulatory remedies set forth in N.J.S.A. 39:6A-4.3(f) and N.J.A.C. 11:3-37.8. Those insurance provisions call for the immediate payment of PIP medical expenses, with a $750 deductible, and an opportunity for the insurance company to increase the Medicare or Medicaid recipient's auto premium, retroactively. In this manner, the insurance laws prescribe that the auto insurers coverage can be made available when a policyholder mistakenly obtains a health-first policy.

The insurance laws do not address, however, what consequences an auto insurer faces if it misleadingly induced an ineligible Medicare or Medicaid recipient to sign up for a health-first policy. The remedies available to a consumer under the CFA conceivably might be complementary to, rather than "unavoidably in conflict with" the measures set forth in N.J.S.A. 39:6A-4.3(f) and N.J.A.C. 11:3-37.8 in cases where a deceptive practice in violation of the CFA liability has been proven. Here, such deceptive practices have only been alleged and are hotly contested by the defense.

Because the parties have yet to engage in discovery that would focus on these questions of alleged improper intent and

"steering" on the part of Progressive, we conclude that it is premature under Printing Mart to resolve these questions from the face of plaintiff's Law Division complaint. Instead, the substantive issues can be revisited at a later time on a motion for summary judgment, after the facts relating to Progressive's design and operation of its online application process are explored in greater depth.

Indeed, the federal district judge's opinion denying Progressive's parallel dismissal motion in that court highlights a number of facets of Progressive's process that, if proven by plaintiff, conceivably could support a theory of improper intent on the part of the insurer. These include the three opportunities identified by the district court judge in which Progressive could have discovered an applicant's Medicare or Medicaid status. Although we do not necessarily adopt here the federal judge's reasoning, his opinion at the very least raises legitimate points of analysis and concern. This strengthens our view that we should act with caution in terminating plaintiff's parallel state court case too swiftly.

To be sure, Progressive's counsel has presented to us several potential grounds for rejecting the claims of plaintiff that the insurer was deliberately engaged in improper practices designed to enrich its coffers. For instance, defense counsel has argued

that it would not be in Progressive's financial interest to issue health-first policies that could generate lower premiums. Whether that is actually true — and whether there are any offsetting business considerations that come into play — implicates factual matters that are not suitable for conclusive determination on the face of the complaint.

On the whole, we are persuaded that the state-of-mind questions associated with the insurer's business practices and motivations, as well as the parties' knowledge and expectations, should be deferred to a later stage of this case, after discovery has been conducted.

Applying a Printing Mart approach, we are also reluctant at this early phase of the case to conclude definitively, as the Law Division judge did, that Progressive's online application sufficiently alerts Medicare and Medicaid recipients of their ineligibility for the health-first option. As we understand it, the website does not automatically activate the cautionary "pop-ups" about Medicare and Medicaid; whenever an applicant answers "Yes" to the pivotal inquires about other health insurance. Instead, an applicant must have the motivation and curiosity to click one of the many question marks that appear on the screen.

We have previously held, albeit in a more extreme context, that a commercial business's website constructed with "submerged"

language that is not readily visible to a customer can be legally deficient. See Hoffman v. Supplements Togo Mgmt., 419 N.J. Super. 596, 598 (App. Div. 2011), certif. granted, 209 N.J. 231 (2012).[15] In addition, as the district judge noted, the cautionary language on the website uses the mild phraseology that the applicant "should" select Progressive rather than "must."

Under the precepts of Printing Mart, plaintiff should be afforded the opportunity to pursue these matters, at least until a fuller record is developed suitable for summary judgment motions or a trial.

We also are not entirely confident at this juncture that Progressive's website link to the Buyer's Guide adequately meets the objectives of our consumer protection laws. In Phillips, supra, 378 N.J. Super. at 101-04, the key case relied on this point by the motion judge, the applicant was actually supplied by the insurer with a printed copy of the Buyer's Guide. Here, no such printed copy was furnished to plaintiff, an online customer. Instead, Progressive's website only displayed a digital link to the Guide, without any words on the computer screen explaining to Medicare or Medicaid recipients interested in the health-first

[15] The Court did not hear argument in or decide the Hoffman matter, as the case was dismissed by stipulation of the parties in November 2012.

option why they should consult the Guide before making that election.

The reasonableness of the website's design and its navigation methods comprises a fact-laden subject that ought to be developed through discovery. For instance, the parties may choose to retain experts in website design, psychology, marketing, or other disciplines that potentially could provide useful insights in evaluating the reasonableness of Progressive's application process and the feasibility of the alternative designs suggested by plaintiff.

The motion judge prematurely decided that it would be unduly burdensome for Progressive to insert additional questions on the application form asking whether the applicant is a Medicare or Medicaid recipient. It is not manifestly clear to us that including such an additional question or two to the forty-two existing questions would be asking too much. That point itself is a fact-laden issue that should be reserved for further proofs and potential expert opinion.

Additionally, Progressive's apparent custom to not obtain a CSF from online customers such as plaintiff implicates concerns that are best not resolved before a factual record is developed. N.J.S.A. 39:6A-23 specifies the written notice requirements that obligate insurers to provide prospective

consumers with the Buyer's Guide and the CSF. Specifically, the statute requires:

> No new automobile insurance policy shall be issued . . . unless the application for the policy is accompanied by a written notice identifying and containing a buyer's guide and coverage selection form. . . .
>
> The coverage selection form shall identify the range of premium rate credit or dollar savings, or both, and shall provide any other information required by the commissioner by regulation.
>
> The applicant shall indicate the options elected on the coverage selection form which shall be signed and returned to the insurer.
>
> [N.J.S.A. 39:6A-23(a) (emphasis added)].

The statute also establishes that the CSF "shall be prima facie evidence of the named insured's knowing election or rejection of any option." N.J.S.A. 39:6A-23(e) (emphasis added).

The pertinent administrative regulations specify the timeline for ascertaining when a policy should become effective. Specifically, "[f]or 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." N.J.A.C. 11:3-15.7 (emphasis added).

The Law Division judge here concluded that, despite Progressive's failure to receive a CSF from plaintiff, that omission would not constitute an unlawful practice under the CFA. He largely based that determination on the Bulletin 90-06, supra, regulatory guidance which treats verifying an insured's coverage as optional. However, as plaintiff points out, Bulletin 90-06 does not discuss the CSF. Even if it did, that advisory document cannot replace statutory and regulatory obligations that carry the force of law.

That said, even if the Bulletin does not legally nullify an auto insurer's obligation under the statute and regulation to obtain a completed CSF from a new customer, the Bulletin might still bear upon fact-laden issues in this case such as the insurer's state of mind and proximate cause. For instance, we do not know from the undeveloped record why Progressive apparently does not generate a CSF to be completed and returned by its online customers. We do not know whether Progressive actually relied in good faith on the Bulletin in its business practices in issuing policies to plaintiff or other online customers without a CSF. These factual issues warrant development before this aspect of plaintiff's consumer fraud claims is adjudicated. We decline to resolve these questions relating to the CSF in a vacuum.

Progressive has argued through its counsel that it would be unrealistic and overly burdensome to require it to ascertain and evaluate each applicant's actual health insurer at the time the auto policy is issued, because that health coverage can change as time passes. Although that point is well taken, it is premature to decide at this pleading stage definitively whether the lack of such a CSF is always inconsequential. Nor is it appropriate to decide yet whether it would be imposing an excessive burden on auto insurers to insist that they have a copy of the CSF before approving or rejecting a policy for an online applicant. This is yet another issue that merits further factual development.

In sum, we conclude that the Law Division prematurely decided that all of plaintiff's CFA claims lack merit before allowing the record to be developed appropriately. The court did not consider plaintiff's CFA claims in the "generous and hospitable" manner required by Printing Mart, supra, 116 N.J. at 746. We accordingly vacate the dismissal of those claims.[16]

[16] Nothing in this opinion forecloses Progressive, after an appropriate period of discovery, from moving for partial summary judgment to dismiss plaintiff's CFA claims if she is unable to substantiate that she has suffered an ascertainable loss due to the insurer's conduct. See Thiedemann v. Mercedes-Benz USA, LLC, 183 N.J. 234, 238 (2005) (upholding a dismissal on summary judgment when a plaintiff failed to demonstrate ascertainable loss to support a CFA claim).

B.

We reach a similar determination with respect to plaintiff's remaining claims of fraud, unjust enrichment, breach of contract, bad faith, and TCCWNA violations. Viewing those allegations in the complaint indulgently as we must under Printing Mart, these alternative legal theories likewise are best evaluated on a full record after discovery. The fraud and bad faith allegations in particular hinge, at least in part, upon proofs relating to Progressive's state of mind. See Gennari v. Weichert Co. Realtors, 148 N.J. 582, 606 (1997). Moreover, the contract breach issues themselves are closely intertwined with respect to the salient facts tied to the parties' respective knowledge, intentions, and expectations. And, as plaintiff correctly points out, the motion judge, perhaps inadvertently, did not address the TCCWNA claims in his detailed opinion.

We accordingly restore these other pleaded claims for further exploration in the trial court, without prejudice to future dispositive motion practice occurring after discovery is completed.

C.

As a final subject, we briefly comment on some procedural concerns that we have raised, sua sponte, with counsel. Now that

we are restoring plaintiff's complaint and remanding it to the Law Division, the parties will again be poised to litigate the overlapping facts and legal issues simultaneously in the federal court and our state court. Up until this point, no motion has been made in the Law Division to stay this parallel case.[17] Nevertheless, the duplicative nature of the overall litigation clearly raises the specter of potential inconsistent factual and legal determinations, not to mention the arguably wasteful expenditure of scarce judicial resources.

No effort apparently has been made yet to ascertain whether all of plaintiff's claims can be combined in one forum, specifically by way of the supplemental jurisdiction of the federal court under 28 U.S.C.A. § 1367. Nor has any motion been made to dismiss without prejudice or stay the Law Division case under "single controversy" principles. See, e.g., J-M Mfg. Co. v. Phillips & Cohen, LLP, 443 N.J. Super. 447, 454-57 (App. Div. 2015), certif. denied, 224 N.J. 527 (2016) (dismissing, in a somewhat different procedural context, a New Jersey class action where a related federal qui tam action for fraud had already gone to verdict).

[17] Apparently, Progressive included such an alternative argument with its dismissal motion in the federal court, but the district judge chose to allow the federal case to proceed nevertheless, while the present dismissed state court action was on appeal.

In its pre-argument brief addressing these concerns at our request, Progressive cited to other instances in which federal courts have exercised supplemental jurisdiction over both qui tam claims pled under the federal False Claims Act and related class action claims pled under state law. Plaintiff asserts that those cases do not reflect the prevailing custom, representing that it is not unusual for federal qui tam cases and topically-related state court class actions to be litigated in two forums simultaneously.

We need not resolve these forum concerns at this moment. However, we instruct that they be addressed by the Law Division promptly on remand. More specifically, plaintiff shall be afforded thirty days to move, if she wishes, for leave to amend her complaint in the federal action to include, by way of supplemental jurisdiction, all of the additional state-law claims included in her present Law Division action. We do not, of course, presume how the district court would rule on such a motion, especially given the amount of time that already has been expended in the federal case. In any event, the Law Division may properly take into account whether plaintiff has attempted to invoke the supplemental jurisdiction of the federal court, in deciding whether single controversy or other principles weigh against

allowing the Law Division case to proceed at the same time the federal action is ongoing.

At the very least, if the Law Division judge decides to allow this case to continue into the discovery phase, the judge and counsel should consider coordinating discovery with the discovery in the federal action.

We suggest that the Law Division convene a case management conference within forty-five days of this opinion, at which opportunity the court and counsel may explore these and other forum and procedural concerns.

III.

For these reasons, the trial court's order of dismissal is vacated, and the case is remanded to the Law Division for further proceedings. We do not retain jurisdiction.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE APPELLATE DIVISION