

7/63

Senator Crisco, Representative Fontana, members of the committee:

My name is Attorney Joe Foti. I am a partner in the law firm of Moore, O'Brien, Jacques & Yelenak in Cheshire, Connecticut. My firm represents plaintiffs in personal injury cases exclusively. I came here today to speak on behalf of the Connecticut Trial Lawyers Association in support of Senate Bill 763, an Act Concerning the Connecticut Unfair Insurance Practice Act.

Especially in cases where the risk to an insurance company is limited such as uninsured or underinsured cases, where defendants had no insurance or the insurance was insufficient to cover the injuries sustained and so the victim brings a claim under their own policy, insurance companies often take advantage of their limited risk to the detriment of their own insured.

A common statement made by insurance defense attorneys in uninsured/underinsured motorist cases is "The worst I can do is the policy." Where a case presents with good liability and extensive damages, insurance companies, for the most part, victimize their own insured by delaying and dragging out the litigation process. It is not unusual for a case to make its way to a trial management conference (which is normally held a week or two prior to jury selection) without the depositions of the plaintiff being taken or even performing an IME. It is not unusual to hear a defense attorney say that the company has yet to evaluate the case at that point. Most recently, a case was continued for trial because the defense attorney stated he needed to do an IME and the plaintiff's deposition, despite the fact that the underlying case had settled almost 8 months earlier. That was close to five (5) months ago and yet,

no deposition and no IME yet. Offers to mediate and/or arbitrate were fruitless. In the meantime, the plaintiff continues to need treatment, without medical insurance and cannot support his family. The most recent comment from defense in that case "I have just reviewed the file...what are you looking for? I don't think the case is worth more than he's already received." Yet he never heard from plaintiff at a deposition or even read a deposition from the underlying case.

With the current "offer to compromise" limiting interest to judgments vs. verdicts, there is little if any incentive for insurance companies to settle. In the clearest of cases, insurance companies seek "something off the policy" to settle. But at who's expense? The plaintiff's. The person who has faithfully paid his or her premiums and now looks to their own insurance company for help.

Examples of cases where we refused to "take something off the policy" or where companies refused or failed to properly review files or where companies employ IME doctors who are notoriously dispute injuries on behalf of insurance companies are seen regularly in our civil judicial system. With the incentive being a ceiling of policy limits as a backdrop, often, these cases are tried. I tried one such case in Litchfield Superior Court. Litchfield is known as a conservative Court often unfavorable to plaintiffs. With medical bills in excess of \$10,000.00 and no health insurance, and approximately \$75,000.00 in future medicals suggested by pain management doctors, a plaintiff was told she was permanently injured. A former world class bicyclist and who made the U.S. Olympic Team, she was given a permanent impairment of 15%. With a

tortfeasor settlement for the policy of \$100,000.00 there was an additional \$150,000.00 available to her through her underinsured carrier. Delay and denial lead to a \$700,000.00 verdict reduced to the policy limit of \$150,000.00. Clearly, the policy should have been paid without the years of delay.

Similar verdicts of \$283,320.00 reduced to coverage of \$80,000.00, or a \$206,000.00 verdict reduced to \$90,000.00 due to coverage, also illustrated cases where liability and injury were clearly over policy limits, yet the injured party had to overcome intense insurance tactics at trial where a jury of their peers had to do what the company would not do...justice.

One safeguard to try to prevent this type of injustice would be to subject the responsible insurance company to review. By requiring proof of "general business practice" this allows for injustice to permeate the system and puts a significant burden on the victim to prove a pattern or general business practice. Trying to depose insurance companies and obtain documents and files leads to motions to prevent such reviews as "privileged", including invoking an attorney/client privilege. HIPPA protections prevent the review of other victim's files to show patterns of abuse. Claims become nearly impossible to prosecute and yet the injustice continues. If an attorney, a doctor, or an accountant commits malpractice, it is judged by the act performed or not performed. The insurance industry should be held to the same standard everyone else is. It makes sense to hold a company accountable to the facts of that case. Remember, the victim is the plaintiff. He/she has already been injured and we need to ensure they are not victimized

again. If an unfair practice has been committed, it should be based upon the set of facts and circumstances existing in that case. It may be the company or it could be the firm employed to defend that particular case. In any event, requiring just treatment for each insured will lead to less litigation or at the very least less trials and a fairer system. It will no longer put the individual victim against a corporate wall. By allowing for judicial civil protection insurance companies will be less inclined to abuse the process and be required to use good faith in bringing a resolution to cases.