STATE OF MINNESOTA

IN SUPREME COURT

A18-1081

Court of Appeals

Thissen, J.
Dissenting, Anderson, J., Gildea, C.J.

Alison Joel Peterson,

Respondent,

vs.

Filed: July 29, 2020
Office of Appellate Courts

Western National Mutual Insurance Company,

Appellant.

Teresa Fariss McClain, Robins Kaplan LLP, Minneapolis, Minnesota; and

Katherine S. Barrett Wiik, Best & Flanagan LLP, Minneapolis, Minnesota, for respondent.

John M. Bjorkman, Patrick H. O'Neill III, Larson King, LLP, Saint Paul, Minnesota, for appellant.

Beth A. Jenson Prouty, Jeffrey M. Markowitz, Arthur, Chapman, Kettering, Smetak & Pikala, P.A., Minneapolis, Minnesota, for amicus curiae American Property Casualty Insurance Association.

Dale O. Thornsjo, Lance D. Meyer, O'Meara, Leer, Wagner & Kohl, P.A., Minneapolis, Minnesota, for amici curiae The Insurance Federation of Minnesota and The National Association of Mutual Insurance Companies.

Jennifer E. Olson, Schwebel, Goetz & Sieben, P.A., Minneapolis, Minnesota; and

Michael L. Weiner, Yaeger & Weiner, PLC, Minneapolis, Minnesota, for amicus curiae Minnesota Association for Justice.

Timothy D. Johnson, Karly A. Kauf, Smith Jadin Johnson, PLLC, Bloomington, Minnesota, for amicus curiae United Policyholders.

S Y L L A B U S

1. Minnesota Statutes § 604.18 (2018) requires an insured to prove that, after conducting a full investigation and fairly evaluating the evidence, a reasonable insurer would not have denied the insured's claim for benefits, and the insurer knew, or recklessly disregarded information that would have allowed it to know, that it lacked a reasonable basis for denying the insured's claim for benefits.

2. The district court did not clearly err by determining that the insured proved that the insurer did not have a reasonable basis for denying the insured's claim for benefits and that the insurer knew, or recklessly disregarded, that it lacked a reasonable basis for denying the insured's claim for benefits.

Affirmed.

O P I N I O N

THISSEN, Justice.

Appellant Western National Mutual Insurance Company (Western National) challenges the district court's award of taxable costs for the denial of a first-party insurance claim in violation of Minn. Stat. § 604.18 (2018). After a multiday bench trial, the district court found that Western National did not have a reasonable basis for denying respondent Alison Joel Peterson's claim for insurance benefits and that the insurer acted in reckless disregard of its lack of a reasonable basis when it denied the claim. We affirm.

FACTS

Peterson purchased auto insurance from Western National. Her insurance policy included underinsured motorist coverage with a policy limit of $250,000.

On October 21, 2009, a motorist entered Peterson's lane and struck the right-front side of her Jeep Cherokee. The low-speed accident caused relatively minor damage to Peterson's vehicle and no part of Peterson's body struck any part of the interior of her vehicle on impact. Peterson experienced neck stiffness following the car accident. She declined medical assistance at the scene of the accident and went to work. But after work, she saw her chiropractor, complaining of a headache and body aches.

Peterson sued the driver of the car that hit her. In January 2014, while the litigation against the driver of the other car was pending, Peterson notified Western National that she anticipated her damages would exceed the limits of the other driver's insurance and that she would seek underinsured motorist benefits under her Western National policy. Peterson ultimately settled her claim against the driver of the other vehicle for $45,000 of the available $50,000 limits of liability. Western National consented to the settlement and waived its subrogation rights. Western National also paid Peterson $20,000 in no-fault benefits.

In July 2014, after the settlement with the at-fault driver, Peterson sent a settlement demand to Western National requesting payment of her underinsured motorist benefits. In her demand, Peterson requested her full policy limit of $250,000 and enclosed copies of her medical records and bills. Peterson also provided signed medical authorizations that allowed Western National to access her medical records.

The medical records that Peterson provided directly to Western National showed that, in the months following the accident, Peterson experienced frequent—often daily—headaches. Although Peterson had experienced and sought medical treatment for

intermittent headaches before the accident, her headaches after the car accident were more frequent and severe, and the pain originated in a different area of her head. Following the accident, Peterson's headaches started at the base of her skull and, when most severe, radiated to the top of her head, forehead, and temples. The medical records included a report from Peterson's chiropractor stating that her headaches before the accident were occasional, while after the accident, the headaches were more frequent, in a different location, and less responsive to chiropractic care.

According to the medical records provided to Western National, Peterson initially sought relief from her headaches through regular visits to her chiropractor. In April 2010, after six months without improvement to her daily headaches, Peterson went to see a medical doctor. From April 2010 to December 2012, Peterson attended physical therapy, used various over-the-counter and prescription pain medications, worked with chiropractors, received diagnostic testing, such as an MRI, underwent occipital nerve block treatment, and met with a headache specialist every three months. None of the treatments provided effective relief from Peterson's headaches. In December 2012, Peterson began receiving periodic Botox injections. The Botox injections reduced the average intensity of Peterson's headaches by 50 percent. The quarterly Botox treatment Peterson received was effective and cost more than $2,500 per treatment. Due to the cost of the procedure, Peterson also sought a second opinion from another neurologist, who suggested that she again undergo occipital nerve block treatment. Peterson did not receive any relief from the occipital nerve block treatment and resumed Botox treatments.

For nearly a year after Peterson's July 2014 claim for underinsured motorist benefits, Western National failed to either pay Peterson her benefits or expressly deny Peterson's claim. Western National made a number of requests to Peterson for additional medical documentation. Peterson promptly replied to each request. Often, Western National requested documents that Peterson had already provided. Peterson also re-signed medical authorizations even though she had provided the medical authorizations to Western National in early 2014.

On June 18, 2015, Peterson renewed her demand for underinsured motorist benefits. She received no decision from Western National. In fact, between July 2014 when Peterson submitted her claim and the summer of 2015, Western National never accepted that Peterson's headaches were caused by the 2009 car accident. Peterson filed a lawsuit on August 19, 2015, seeking payment of her underinsured motorist benefits.

After the lawsuit was filed, Peterson disclosed to Western National a report from one of her treating physicians, Dr. Thomas Schriefer. Based on his examination and Peterson's medical records, Dr. Schriefer opined that Peterson's chronic headaches were different than her prior headaches in location, intensity, and frequency, and were caused by the October 2009 car crash. He further stated his opinion that the headaches would last the rest of Peterson's life and that she would require Botox injections every three or four months for the rest of her life.

After Peterson filed the lawsuit, Western National retained counsel. It also hired a neurologist to conduct an independent medical examination. The independent medical examiner did not specialize in headache medicine and had never prescribed or administered

Botox for the alleviation of chronic headaches. After reviewing Peterson's medical records and conducting a physical exam, the independent medical examiner opined that Peterson had sustained a "soft tissue injury to her neck with resultant strain/sprain" from the accident and that "she . . . made a complete recovery." The independent medical examiner admitted, however, that the International Headache Society defines chronic headache attributed to whiplash as one arising within seven days after the whiplash injury and lasting longer than three months. The independent medical examiner also opined that, based on Peterson's "longstanding history of headaches, fatigue, anxiety, family history of depression, and the nature of the headache and its intractability," Peterson's chronic headaches were "most likely due to underlying psychological factors, most likely depression." But Peterson had never been diagnosed or treated for depression and nothing in the medical records suggested that she had been. Further, the independent medical examiner was not qualified to diagnose her with a psychiatric disorder.

The case went to trial. A jury awarded Peterson past and future damages totaling $1,414,090, including more than $900,000 for past and future health care expenses. Western National subsequently paid Peterson the underinsured motorist policy limits of $250,000.

Thereafter, the district court granted Peterson's motion to amend her complaint to seek taxable costs and attorney fees under Minn. Stat. § 604.18. A court trial on the section 604.18 claims was held in July 2017. Peterson and Western National each presented testimony from experts in handling first-party insurance claims. Western National's claims

adjusters who handled the claim and the counsel Western National retained to defend against the claim testified as well.

The district court ruled in Peterson's favor and awarded Peterson $100,000 taxable costs and $97,940.50 in attorney fees under Minn. Stat. § 604.18. Western National appealed the district court's decision and a divided court of appeals affirmed. *Peterson v. W. Nat'l Mut. Ins. Co.*, 930 N.W.2d 443 (Minn. App. 2019). We granted Western National's petition for review.

ANALYSIS

I.

Minnesota's Insurance Standard of Conduct statute provides:

> The court may award as taxable costs to an insured against an insurer amounts as provided in subdivision 3 if the insured can show:
>
> (1) the absence of a reasonable basis for denying the benefits of the insurance policy; and
>
> (2) that the insurer knew of the lack of a reasonable basis for denying the benefits of the insurance policy or acted in reckless disregard of the lack of a reasonable basis for denying the benefits of the insurance policy.

Minn. Stat. § 604.18, subd. 2(a).[1] Our job is to interpret the statute in a way that effectuates the intention of the Legislature. Minn. Stat. § 645.16 (2018). We determine the legal

[1] In addition to prejudgment and postjudgment interest and costs and disbursements allowed under law, the statute also provides that the court may award an insured the lesser of $250,000 or one-half the proceeds awarded that are in excess of an amount offered by the insurer at least ten days before trial. The court may also award "reasonable attorney fees actually incurred to establish the insurer's violation of [the statute]." Minn. Stat. § 608.04, subd. 3(a)(2) (2018). The statute further provides that "[a]ttorney fees must not exceed $100,000." *Id.* The district court awarded taxable costs under subdivision 3, and there is no dispute on appeal concerning the determination of taxable costs awarded by the district court. The only dispute is whether Western National violated subdivision 2 of the statute.

meaning of the section 604.18 insurance standard of conduct statute de novo. *See Thompson ex rel. Minor Child v. Schrimsher*, 906 N.W.2d 495, 498 (Minn. 2018).

When interpreting a statute, we generally turn first to the plain text of the statute and we do so here. When the words are clear, they are our best guide to what the Legislature meant. *City of Brainerd v. Brainerd Invs. P'ship*, 827 N.W.2d 752, 755 (Minn. 2013) ("When legislative intent is clear from the statute's plain and unambiguous language, we interpret the statute according to its plain meaning without resorting to other principles of statutory interpretation.") But section 604.18, subdivision 2, is an unusual statute in that the language of the two prongs of the statutory standard of conduct are drawn directly from a court case.[2] In *Anderson v. Continental Insurance Co.*, the Wisconsin Supreme Court authorized a cause of action in tort against an insurer for bad faith refusal to honor a claim. 271 N.W.2d 368, 371 (Wis. 1978). The *Anderson* court further held that, "[t]o show a claim for bad faith, a plaintiff must show *the absence of a reasonable basis for denying benefits of the policy* and the *defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim*." *Id*. at 376 (emphasis added); *accord* Minn. Stat.

After we granted review but before oral argument, Peterson moved under subdivision 3 to recover attorney fees that she incurred to prepare her response to Western National's petition for review. We will address the motion for fees in a separate order.

[2] In *Haagenson v. National Farmers Union Property & Casualty Company*, 277 N.W.2d 648 (Minn. 1979), we refused to recognize a common law tort claim for bad faith breach of an insurance contract. By enacting section 604.18, the Legislature created in statute such a claim. We recognize here that the Legislature adopted the elements for such a cause of action nearly word for word from a Wisconsin case, *Anderson v. Continental Insurance Company*, 271 N.W.2d 368 (Wis. 1978). *See Clapp v. Peterson*, 327 N.W.2d 585, 586–87 (Minn. 1982) (using existing case law as guidance when interpreting a statute that was "largely a codification of the common law").

§ 604.18, subd. 2 (stating that an insured must show "the absence of a reasonable basis for denying the benefits of the insurance policy" and "that the insurer knew of . . . or acted in reckless disregard of the lack of a reasonable basis for denying the benefits of the insurance policy"). In these unique circumstances, *Anderson* provides context to our understanding of the statute.[3]

Several things are clear from the plain text and structure of the statute. First, the burden rests with the insured to prove that the insurer violated the standard of conduct. Second, to prevail, the insured must establish two independent facts: (1) the insurer did not have a reasonable basis for denying the benefits of the insurance policy, and (2) the insurer either knew it lacked a reasonable basis for denying the benefits or it recklessly disregarded the fact that it lacked a reasonable basis for denying the benefits.

We further conclude—and both Peterson and Western National agree—that the first prong of the section 604.18 standard is an objective test. That is evident from the Legislature's use of the word "reasonable," which connotes an objective test. *See, e.g.*, *State v. McAllister*, 862 N.W.2d 49, 56 (Minn. 2015) (stating that the "reasonably

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[3] While unnecessary to our plain language analysis, we observe that the legislative history of section 604.18 is robust and clearly confirms our understanding of legislative intent. Among other things, the legislative history makes plain that the Minnesota Legislature adopted the statutory language from *Anderson*. For example, statements from both Senator Tarryl Clark, the chief author of the bill, and Senator Linda Scheid, the author of the amendment that included the "absence of a reasonable basis" language, provide insight that the bill was "adopting that specific test from that so-called *Anderson* case." Sen. debate on S.F. 2822, 85th Minn. Leg., Apr. 14, 2008 (audio recording) (statements of Sen. Clark and Sen. Scheid). The legislative history also suggests that the Legislature intended to adopt the standard from *Anderson*, but not necessarily the interpretation of that standard as applied in Wisconsin cases decided after *Anderson.* Sen. debate on S.F. 2822, 85th Minn. Leg., Apr. 14, 2008 (audio recording) (statement of Sen. Scheid).

foreseeable" standard under Minn. Stat. § 609.05, subd. 2 (2014), is objective); *Jacobs v. Rosemount Dodge-Winnebago S.*, 310 N.W.2d 71, 76 (Minn. 1981) (evaluating "reasonable time" under Minn. Stat. § 336.2-608(2) (1980) under an objective standard); *see also Anderson*, 271 N.W.2d at 377 ("The tort of bad faith can be alleged only if the facts pleaded would, *on the basis of an objective standard*, show the absence of a reasonable basis for denying the claim . . . ." (emphasis added)).

Consequently, we hold that the proper inquiry under the first prong of the section 604.18, subdivision 2 standard is whether a reasonable insurer under the circumstances would not have denied the insured the benefits of the insurance policy. In applying that standard, the factfinder should consider the level of investigation a reasonable insurer would have conducted under the circumstances of the case and how a reasonable insurer would have evaluated the claims in light of that investigation. The insurer's evaluation of the insured's claim must be fair. A fair evaluation means an evaluation that considers and weighs all of the facts and circumstances that a reasonable insurer would consider relevant. *Anderson*, 271 N.W.2d at 375, 377.

Western National argues for a different interpretation of the first prong of the section 604.18 standard of conduct. Drawing a comparison to the tests that courts apply for judgment as a matter of law under Minn. R. Civ. P. 50.01, summary judgment under Minn. R. Civ. P. 56.01, and sanctions under Minn. R. Civ. P. 11.03, Western National urges us to adopt the following rule of law: "unless all the evidence produced at trial points in only one way and reasonable minds could not differ as to whether the insured was entitled to the insurance benefits, there can be no finding of an 'absence of a reasonable basis' under

the statute." Stated another way, under Western National's test, if the insurer can identify any evidence to support its denial of the benefits of the insurance policy, even if there is substantial—even overwhelming—evidence to the contrary, it is not liable under section 604.18.[4]

We disagree. Western National's approach conflates the role of a judge when determining whether a claim fails as a matter of law and the role of an insurer in investigating, evaluating, and determining whether an insured's claim is covered under the policy for which the insured paid premiums. Because disputed issues of fact are to be determined by a jury and not by a judge, we apply a demanding test before we allow a judge to take an issue away from the jury and make a determination as a matter of law. *See Kenneh v. Homeward Bound, Inc.*, 944 N.W.2d 222, 228, 232 (Minn. 2020). We allow the judge to do so only when there is no dispute of material fact or inferences therefrom, Minn. R. Civ. P. 56.01, or no legally sufficient evidentiary basis for a reasonable jury to find for a party on an issue, Minn. R. Civ. P. 50.01(a). When there is a fact or inference upon which the factfinder could decide for the nonmoving party, the judge must leave the decision to the jury. *See* Minn. R. Civ. P. 50.01(a); 56.01. As Western National states, to grant

[4] Western National's proposed "directed verdict" rule of law has been adopted by a handful of courts around the country, most notably in *National Savings Life Insurance Co. v. Dutton*, 419 So. 2d 1357, 1362 (Ala. 1982), which held that, to make out a prima facie case of bad faith, the insured must be entitled to a directed verdict on his policy claim. But the Legislature quite explicitly adopted the *Anderson* standard when it enacted Minn. Stat. § 604.18 in 2008 and made no mention of the *Dutton* case even though it had been decided a quarter century earlier.

summary judgment or judgment as a matter of law, the evidence on an issue must all point in the same direction.

An insurer confronted by an insured's claim does not face the same constraints on its authority as a judge does when faced with a motion under Rule 50.01 or Rule 56.01. In fact, an insurer's obligation is quite different. When considering a motion for summary judgment or judgment as a matter of law, the judge *must* ignore all the evidence that points in favor of the moving party and focus solely on the evidence supporting the nonmoving party's position. In contrast, insurers who were paid a premium for the coverage set forth in the policy are expected to reasonably investigate all of the facts and fairly evaluate the claim in light of all of the evidence. They cannot ignore evidence that supports coverage; they must weigh all the evidence in the balance to determine whether coverage exists.

We also disagree with Peterson's approach to the first prong of the section 604.18 standard. Peterson suggests that the insured prevails in establishing the absence of a reasonable basis for denying benefits if she can demonstrate that the insurer did not conduct a reasonable investigation or fairly evaluate the results of that investigation. But that is a subjective test that focuses on the conduct of the actual insurer that denied the claim.[5] Once

[5] Western National argues that consideration of a poor or incomplete investigation is improper under Minn. Stat. § 604.18, subd. 2(a)(1), because the Insurance Industry Trade Practices Act (commonly referred to as the Unfair Claims Practices Act), Minn. Stat. §§ 72A.01–.52 (2018), already provides a remedy for an insurer's refusal to pay claims without conducting a reasonable investigation and for failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement. We disagree. Nothing in the Unfair Claims Practices Act, which creates an administrative remedy for certain statutorily defined improper conduct, *see* Minn. Stat. § 72A.201, states that the Legislature intended that the administrative remedy be the *exclusive* remedy. Indeed, the Unfair Claims Practices Act expressly recognizes that "[o]ther prohibitions and penalties may be found

again, the proper objective test under the first prong of the section 604.18, subdivision 2 standard of conduct is whether a reasonable insurer, having conducted a full investigation and a fair evaluation that considers and weighs all of the facts, would have denied the insured the benefits of the insurance policy.

We next turn to the second prong, which is the mens rea element of a claim that the insurer breached the statutory standard of conduct under section 604.18: "that the insurer knew of the lack of a reasonable basis for denying the benefits of the insurance policy or acted in reckless disregard of the lack of a reasonable basis for denying the benefits of the insurance policy." Minn. Stat. § 604.18, subd. 2(a)(2); *see generally Anderson*, 271 N.W.2d at 374-376 (explaining that the facts showed purposeful conduct by the insurance company designed to evade providing the insured the benefits of the policy). The plain language of the statute tells us that this subjective inquiry concerns whether the insurer knew, or recklessly disregarded information that would have allowed it to know, that it lacked an objectively reasonable basis for denying the claim. The *Anderson* court explained this inquiry as follows: "[T]he knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless disregard of a lack of a reasonable basis for denial or a reckless indifference to facts or to proofs submitted by the insured." *Id.* at 377. Further, "[i]t is appropriate, in applying the test, to determine

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in . . . other state laws." Minn. Stat. § 72A.01. Further, because we conclude that the actual investigation conducted by the insurer is not dispositive under the objective first prong of the section 604.18 standard of conduct, the argument is beside the point. As we make clear in the next part of this opinion, however, the reasonableness and thoroughness of the insurer's actual investigation and evaluation of an insured's claim is relevant to the second, subjective, mens rea prong of the section 604.18 standard.

whether a claim was properly investigated and whether the results of the investigation were subjected to a reasonable evaluation and review." *Id.* The insurer's actual investigation and evaluation are relevant to this prong of the analysis. In sum, the second prong of the statutory insurer standard of conduct requires an insured to prove that the insurer knew, or recklessly disregarded or remained indifferent to information that would have allowed it to know, that it lacked an objectively reasonable basis for denying the insured's claim for benefits

II.

Having interpreted section 604.18, subdivision 2, and determined the legal standard to be applied in cases brought under the statute, we turn to the facts of this case. The questions of whether a reasonable insurer, having conducted a full investigation and fair evaluation of the results of the investigation under the circumstances, would have denied the insured the benefits of the insurance policy, and whether the insurer knew, or recklessly disregarded information that would have allowed it to know, that it lacked an objectively reasonable basis for denial, are questions of fact, which we review for clear error. *See* Minn. R. Civ. P. 52.01 (instructing that "[f]indings of fact, whether based on oral or documentary evidence, shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge the credibility of the witnesses"); *Johnson v. Johnson*, 84 N.W.2d 249, 254 (Minn. 1957) ("It is not within the province of this court to determine issues of fact. . . . This is true even though this court might find the facts to be different if it had the factfinding function.").

Turning to the first prong of the section 604.18, subdivision 2 standard of conduct, we must decide whether the district court erred by determining that a reasonable insurer, who had the information that Western National had, would have denied Peterson's claim for benefits. Based on the district court's extensive findings, and our own thorough review of the record, we conclude that the district court did not clearly err.

First, there is substantial evidence in the records that were available to Western National that supported Peterson's claim that her headaches were the result of the 2009 accident. The district court's finding that Peterson was involved in a car accident on October 21, 2009, and suffered a soft tissue whiplash injury is well supported by the record. Peterson complained to her chiropractor on the day of the accident of achiness and stiffness and noted on her intake form that she had a headache. As the district court found, Western National had Peterson's medical records beginning at the latest in July 2014 and the records show that she suffered chronic—and sometimes severe—headaches over the several years following the accident.[6] The medical records Western National received demonstrated that Peterson sought many treatments to resolve her chronic headaches, but that none of the treatments provided long-term relief until she received the Botox treatments starting in December 2012. The medical records disclosed that the Botox treatments reduced

[6] Western National's claims adjuster stated that she lacked Peterson's medical records. The district court found that Peterson provided Western National with "extensive copies of her medical records" in July 2014. Based on our review of the record, the district court's finding is correct with the exception of biofeedback records that were provided in the fall of 2014 in response to Western National's request. But, Peterson first provided Western National with signed medical release forms in early 2014, which enabled Western National to obtain Peterson's medical records on its own initiative.

Peterson's headache burden by 50 percent. Peterson's expert, who the district court found most credible, testified that the medical records included a "mountain . . . of evidence" supporting Peterson's claim for benefits.

The district court further credited the testimony of Peterson's expert, in which he stated that the medical records demonstrated that this was not a "run of the mill soft tissue injury" (a conclusion notably echoed in a September 2015 letter from Western National's lawyer). Western National's claims adjuster acknowledged that Peterson suffered a soft tissue injury in the accident, that soft tissue injuries can cause headaches, and that the medical records provided evidence that Peterson was suffering from chronic daily headaches. She also admitted that, during the course of her analysis of the file, she learned that Botox is an accepted treatment for chronic headaches. Moreover, there is no evidence that Western National consulted with any medical professional for a year and half after Peterson filed her claim.

That is not to say that no evidence supports Western National's position that Peterson's headaches were not caused by the 2009 accident. Western National points to a few reasons to justify its denial of Peterson's policy benefits despite the evidence in the medical records. First, Western National cites the medical records showing that Peterson suffered from episodic headaches prior to the accident. The district court, however, considered those records and found that no evidence substantiated the position that Peterson's postaccident headaches were a mere continuation of the headaches she had experienced before the accident:

> [Peterson's] medical records established that after [the accident, Peterson] suffered from chronic severe daily headaches, unlike any headaches she had experienced prior to the accident. Before the accident, [Peterson] had occasional headaches in the front of her head which responded to over-the-counter analgesics. She did not seek or receive medical treatment for any of her pre-accident headaches. After the accident, [Peterson's] headaches were in the back of her head, and they were more frequent and debilitating than any headaches she had experienced before.

The district court's finding is supported by the record evidence.

The district court also credited the opinions of Peterson's expert that a reasonable insurer would have determined that the headaches had changed in intensity, frequency, and location and that it is unreasonable for an insurer to use as a pretext a supposed preexisting condition supported by bits and pieces of a medical record to deny a claim without investigating and evaluating whether the accident exacerbated or changed the condition. Based on our thorough review of the record, we cannot say that the district court clearly erred by finding that Peterson's preaccident headaches were not a sufficient basis for a reasonable insurer to deny Peterson's claim.

Western National also based its denial of Peterson's claim on the relatively minor damage to Peterson's car resulting from the accident. Yet the adjuster testified at deposition that her only investigation of the vehicle damage was to review the cost of repair and some photos of the damage. The district court credited Peterson's expert, who testified that Western National's equation of minor motor vehicle damage with minor injuries to Peterson was not a reasonable basis for denying Peterson benefits, particularly in the face of the medical records that showed that Peterson suffered chronic daily headaches

following the accident. Again, based on our review of the record, we cannot say that the district court clearly erred by finding Peterson's expert credible on these points.

Lastly, Western National asserts that it had a reasonable basis for refusing to pay Peterson's claim for benefits because it relied on an independent medical examiner's opinion and the advice of experienced litigation counsel. We disagree.[7]

Of course, we do not hold that it is never reasonable for an insurer to obtain and consider an independent doctor's opinion when determining whether to deny an insured's claim for benefits. On the other hand, it is not always reasonable to rely on an independent doctor. In this case, the district court credited and relied on the testimony of Peterson's expert who opined that a reasonable insurer would have discounted the independent medical examiner's opinion in evaluating Peterson's claim. Here, Western National's independent medical examiner's opinion directly contradicted the contrary evidence in the

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[7] Western National does not argue that it did not deny Peterson's claim for benefits. Certainly, Western National made no decision on Peterson's claim for over a year after it received notice of the claim and before Peterson filed her lawsuit to compel coverage. *Cf. Anderson*, 271 N.W.2d at 372 (stating that the insurer never denied the claim but rather passed the claim back and forth with a claims adjusting company and ultimately took no action on the claim before the insured sued for coverage). At the same time, Peterson does not identify the precise date when Western National may have constructively denied benefits or make any argument about constructive denial—a legal concept we have never addressed. Accordingly, the issue of whether it is even appropriate to consider the advice of legal counsel or the independent medical expert—information that emerged only after Peterson was forced to file a lawsuit to recover benefits—in assessing a claim under Minn. Stat. § 604.08, subd. 2, is not squarely before us. Because we conclude that the district court did not clearly err by finding that a reasonable insurer would not have denied Peterson's claim for benefits, even if we consider the opinion of Western National's independent medical expert and the advice of its litigation counsel, we express no opinion on the issue of whether and when Western National had constructively denied the claim by the time the lawsuit was filed.

medical records prepared by Peterson's treating physicians. While an independent medical examiner may disagree with a treating physician, the independent medical examiner Western National employed was not a headache specialist. The independent medical examiner had never ordered or administered Botox as a treatment for a headache patient, he believed (contrary to medical opinion) that headaches from a soft tissue injury would not last more than six weeks, and he asserted that Peterson's headaches were likely psychological in origin despite the absence of any evidence in the record to support that conclusion. The district court did not clearly err by finding that Western National's untempered reliance on the advice of this independent medical examiner was inconsistent with how a reasonable insurer would act.

We also conclude that, in this case, Western Mutual cannot hide behind the advice of outside litigation counsel. Western National did not retain outside litigation counsel until Peterson filed suit. After his initial review of the medical records, litigation counsel noted that the case presented more than a "run of the mill" soft tissue case. He also noted that there were few documented headache complaints in the three years before the accident and that, after the accident, the headache complaints were consistent. He then went to work to develop a defense for his client which had, at that time, already made a determination that Peterson was not entitled to underinsured motorist benefits.

Western National argues that reliance on the advice of an insurer's litigation counsel that the insurer could prevail at a jury trial should weigh against a finding of liability under section 604.18, subdivision 2. That argument conflates two distinct inquiries. Whether an insurer may possibly convince a jury at trial—an outcome that depends on a variety of

factors, including the potential credibility of witnesses and the evidentiary rulings that may preclude the jury from considering certain facts—is not the inquiry under section 604.18, subdivision 2. The inquiry under the statute is whether a reasonable insurer, having conducted a full investigation and a fair evaluation that considers and weighs all of the facts before it, would have denied the insured the benefits of the insurance policy in the first place. Accordingly, the advice of Western National's litigation counsel is not dispositive of Peterson's claim.

Ultimately, after considering all the evidence that Western National had before it, Peterson's expert opined that a fair, honest, and reasonable insurer would not have denied Peterson benefits to compensate her for the injuries she had suffered in the accident. The expert reached that conclusion because "the overwhelming weight of the evidence, competent evidence, credible evidence was that this accident created a chain of events that ultimately led to [Peterson] having to submit to a painful Botox treatment regimen." The district court credited and relied on the opinion of Peterson's expert. *See Gianotti v. Indep. Sch. Dist. 152*, 889 N.W.2d 796, 803 (Minn. 2017) (stating that appellate courts defer to the factfinder's weighing of competing and conflicting expert testimony). Consequently, we conclude that the district court did not clearly err by determining that a reasonable insurer who conducted a proper investigation and a fair evaluation of the evidence would not have denied Peterson the benefits of her insurance policy.

We next turn to the second prong of the section 604.18, subdivision 2 standard of conduct and consider whether the district court clearly erred by finding that Western National knew, or recklessly disregarded information that would have allowed it to know,

that it lacked an objectively reasonable basis for denying benefits to Peterson. We conclude that the district court did not clearly err.

First, for many of the same evidentiary reasons set forth in detail above, the district court found that Western National exhibited a reckless indifference to facts and proofs submitted by Peterson. It found that Western National failed to evaluate "any of the evidence favorable to [Peterson's] claim." The district court's finding is supported by the testimony of Peterson's expert who opined that Western National's insurance adjuster ignored clear evidence in Peterson's medical records that supported her claim for insurance benefits. The district court also credited the expert's testimony that Western National did not investigate Peterson's claim with an open mind, but rather "developed an early opinion that [Peterson's] claim was of no value based on its view that the property damage to [Peterson's] vehicle was minor, and from then on, that opinion was etched in stone." Based on our review of the record, we cannot conclude that any of these findings are clearly erroneous.

In addition, the district court's findings show that Western National did not properly and thoroughly investigate Peterson's claim for benefits. For instance, the district court found that Western National's claims adjuster repeatedly asked for medical records that Peterson had already supplied and failed for months to use medical release forms Peterson had signed and supplied to obtain the documents. As a result, the analysis of the claims file dragged on for well over a year without resolution. The district court also found that the claims adjuster's presentation to Western National's claims board was imbalanced and misstated certain important facts. These findings are well supported in the record.

Western National contends that, at most, the record shows that its handling of Peterson's claim was negligent and argues that recklessness must require something more than negligent claims handling. But that misses the purpose of the quality-of-investigation inquiry for the second prong of the section 604.18, subdivision 2 standard. The narrative of *how* an insurer handled a claim provides a factfinder with insight into the insurer's mens rea, which is precisely what the second prong of the section 604.18 standard of conduct is about. The pattern of persistent and extended investigative failures in this case is additional probative evidence—additional to Western National's indifference to substantial medical records supporting Peterson's claim—about whether Western National recklessly disregarded information that would have demonstrated to a reasonable objective insurer that Western National should not have denied Peterson benefits.

Accordingly, the district court's determination that Western National recklessly disregarded information that would have allowed it to know that an objectively reasonable insurer would not have denied Peterson insurance benefits is not clearly erroneous.

CONCLUSION

For the foregoing reasons, we affirm the decision of the court of appeals.

Affirmed.

D I S S E N T

ANDERSON, Justice (dissenting).

Because I conclude that the court misinterprets the plain language of Minn. Stat. § 604.18, subd. 2 (2018), and that the insurer, appellant Western National Mutual Insurance Company (Western National), did not act unreasonably by denying a claim for a lifetime of Botox injections to treat headaches that respondent Alison Joel Peterson suffered following a minor car accident, I respectfully dissent.

I begin with the statutory language. Minnesota's Insurance Standard of Conduct statute provides that a district court may award certain taxable costs to an insured against an insurer if the insured can show (1) "the absence of a reasonable basis for denying the benefits of the insurance policy" and (2) "that the insurer knew of the lack of a reasonable basis" or "acted in reckless disregard of the lack of a reasonable basis." Minn. Stat. § 604.18, subd. 2(a).

We have not previously interpreted this statute, colloquially known as the "bad-faith" standard of conduct, as applied to insurance carriers. Statutory interpretation is a question of law, which we review de novo. *City of Oronoco v. Fitzpatrick Real Estate, LLC*, 883 N.W.2d 592, 595 (Minn. 2016). We interpret statutory language to "ascertain and effectuate" the Legislature's intent. Minn. Stat. § 645.16 (2018). "If the meaning of a statute is unambiguous, the plain language of the statute controls." *Wilson v. Mortg. Res. Ctr., Inc.*, 888 N.W.2d 452, 458 (Minn. 2016). And absent ambiguity, "the letter of the law shall not be disregarded under the pretext of pursuing the spirit." Minn. Stat. § 645.16.

Some discussion of basic insurance principles is helpful. The dispute here arises from a contract between Peterson and her insurance carrier, Western National. This is first-party coverage, and the policy contractually agreed to by Peterson and Western National governs the rights and obligations between the two parties if the contract (in this case, the policy of insurance) is breached.

Minnesota law is quite clear that, absent statutory remedies, no matter how wrongful, malicious, or irresponsible a contractual breach might be, the insured recovers only those benefits owed by the policy, not additional damages for the wrongful conduct by the insurer.[1] *See Haagenson v. Nat'l Farmers Union Prop. & Cas. Co.*, 277 N.W.2d 648, 652 (Minn. 1979) (holding that "[a] malicious or bad-faith motive in breaching a contract does not convert a contract action into a tort action" even after the jury found that the insurer's refusal to pay the insured's claim under the insurance contract was intentional, malicious, and in bad faith (citation omitted) (internal quotation marks omitted)).

The legislative creation of a bad-faith remedy applicable to a contract for insurance implicates, at least in part, the *Haagenson* rule. Statutes in derogation of the common law

[1] Third-party claims, unlike the first-party insurance dispute here, do implicate good-faith considerations. In the typical third-party claim, the insured is a defendant in a litigation matter in which the insurer has agreed to indemnify and defend the insured. *See Short v. Dairyland Ins. Co.*, 334 N.W.2d 384, 387–88 (Minn. 1983). In the usual circumstances presented with a third-party claim, the insurer would owe a "fiduciary duty to the insured to represent his or her best interests." *Id.* at 387. The insurer's duty of good faith in those cases includes "an obligation to view the situation as if there were no policy limits applicable to the claim, and to give equal consideration to the financial exposure of the insured." *Id.* at 387–88. One reason for imposing that duty is the potential exposure to the defendant for damages exceeding the policy limits. That rationale does not apply in the first-party contractual dispute context.

are generally "strictly construed." *Do v. Am. Family Mut. Ins. Co.*, 779 N.W.2d 853, 858 (Minn. 2010). Therefore, a reviewing court must "carefully examine the express wording of the statute to determine the nature and extent to which the statute modifies the common law." *Staab v. Diocese of St. Cloud*, 813 N.W.2d 68, 73 (Minn. 2012). We "do not presume that the Legislature intends to abrogate or modify a common law rule except to the extent expressly declared or clearly indicated in the statute." *Id.*; *see also Ly v. Nystrom*, 615 N.W.2d 302, 314 (Minn. 2000) ("We have . . . long presumed that statutes are consistent with the common law, and if a statute abrogates the common law, the abrogation must be by express wording or necessary implication.").

I agree with the court and the parties that the statute is not ambiguous. But I conclude that a plain reading of the statute leads to the conclusion that the summary judgment standard urged by Western National is the correct standard to apply here.

The Legislature has placed the burden on the insured to show the "absence of a reasonable basis" for denying a claim. Minn. Stat. § 604.18, subd. 2(a)(1). Although we have not interpreted that phrase, Minnesota courts routinely consider "reasonableness." For example, in the context of summary judgment motions in civil cases, *see* Minn. R. Civ. P. 56.01, district courts are asked to determine whether a genuine dispute of material fact exists by evaluating whether "reasonable persons might draw different conclusions from the evidence presented." *Montemayor v. Sebright Prods., Inc.*, 898 N.W.2d 623, 628 (Minn. 2017) (citations omitted) (internal quotation marks omitted). Similarly, when presented with a request for judgment as a matter of law, we ask whether "reasonable persons could draw only one conclusion from the evidence presented." *DLH, Inc. v. Russ*,

566 N.W.2d 60, 70 (Minn. 1997). I would apply our usual and customary approach to reasonableness determinations and adopt the summary judgment standard when applying Minn. Stat. § 604.18, subd. 2.[2]

I also part ways with the court in its analysis of the sufficiency of Peterson's showing under the statutory requirements. Whether the standard is the historical and traditional "reasonableness" approach that we have used with summary judgment or judgment as a matter of law motions that I would prefer, or the expansive approach taken by the court here, Peterson's claim of bad faith under Minn. Stat. § 604.18, subd. 2, fails as a matter of law. Western National's conduct was the product of reasonable first-party interactions during a claim dispute, and Peterson failed to meet her burden of proof.

As to the first element, Peterson was required to prove that a reasonable basis did not exist for Western National to deny her claim for benefits. *See* Minn. Stat. § 604.18, subd. 2(a)(1). Peterson did not meet her burden because Western National's denial of benefits was grounded in a reasonable evaluation, even though a jury ultimately reached a different conclusion. In addition, the claim was based on a new medical treatment, which caused more difficulty for claim evaluation and, in turn, rendered Peterson's efforts to show "unreasonableness" on the part of Western National more challenging.

When the district court interpreted Minn. Stat. § 604.18, subd. 2, in this case, it added requirements for insurers that are not part of the claim enacted by the Legislature.

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[2] Perhaps it is so, as the court states, that the summary judgment standard is the minority rule. But it is a better fit given the Minnesota statutory framework and the differences in common law between Minnesota and jurisdictions that adopt a rule akin to that adopted by the court here.

The court now affirms those new requirements. Section 604.18 does not require an insurer to conduct a reasonable *investigation*; it requires a reasonable *basis* for the insurer to deny a claim. As Western National notes, the district court erred by analyzing settlement and investigation issues under the bad-faith provisions of Minn. Stat. § 604.18, rather than more properly under Minn. Stat. §§ 72A.01–.52 the Minnesota Unfair Claims Practices Act.[3] The investigation and claims adjustment process that Peterson experienced was hardly a model of customer service, but Peterson must prove that Western National did not have a reasonable basis for denying her underinsured benefits claim. Although delays and confusion created by Western National during the claims adjustment process were no doubt annoying and perhaps violations of Minn. Stat. § 72A.20, legally they are irrelevant here. Throughout the claims process and litigation proceedings, Western National consistently had at least three reasonable bases to deny Peterson's claim: (1) the lack of a causal connection, established by competent medical evidence or even common knowledge, tying Peterson's car accident injury to her Botox treatment for headaches; (2) an expert opinion from its independent medical examiner who opined that Peterson's headaches were not caused by the collision; and (3) an evaluation from its claims board, as well as independent outside counsel, that Peterson had already been fully compensated for her injuries related to the car accident.

[3] Although the Minnesota Unfair Claims Practices Act does not include a private cause of action against insurers, it provides administrative review of certain insurance practices, such as refusing to pay claims without conducting a reasonable investigation. *See Morris v. Am. Family Mut. Ins. Co.*, 386 N.W.2d 233, 234–35 (Minn. 1986); *see also* Minn. Stat. § 72A.20, subd. 12.

Finally, a jury verdict, following trial, finding that Peterson's claim for benefits under the policy had merit and that Western National was wrong in denying that claim does not, by itself, establish that Western National acted unreasonably.

The second element of the statute, which Peterson also fails to establish, requires proof that Western National "knew of the lack of a reasonable basis for denying the benefits of the insurance policy or acted in reckless disregard of the lack of a reasonable basis for denying the benefits of the insurance policy." Minn. Stat. § 604.18, subd. 2(a)(2).

Here, it is useful to explain in greater detail the reasonable bases for Western National's denial of Peterson's underinsured motorist claim. Western National sought advice from two of its experienced claims adjusters, an internal claims review board, a board-certified neurologist, and an experienced personal-injury attorney. All agreed that, under the policy, she was not entitled to underinsured motorist benefits. Because Western National sought advice from competent and experienced professionals on whether to settle the claim or proceed to trial, Peterson's claim that Western National "knew" that a denial of underinsured motorist benefits was unreasonable, or "acted in reckless disregard," fails as a matter of law. *See Christian Builders, Inc. v. Cincinnati Ins. Co.*, 501 F. Supp. 2d 1224, 1232 (D. Minn. 2007) (noting that insurers are supposed to "[h]ire a competent and experienced defense attorney" that they trust, and should "rely on the advice [of the attorney] . . . and take seriously what that attorney says about the settlement value of the case"); *State v. Jacobson*, 681 N.W.2d 398, 404 (Minn. App. 2004) (stating that in some cases, Minnesota has "recognized that good-faith reliance on the advice of professionals" is a valid defense), *aff'd*, 697 N.W.2d 610 (Minn. 2005).

In holding otherwise, the court relies on the district court's credibility determinations, which it made during the hearings on Peterson's section 604.18 claim.[4] I respectfully suggest that doing so loses sight of the principal issue here—not whether some witnesses were more credible than others but rather was it "reasonable" for Western National to deny Peterson's underinsured motorist claim. The fact that the district court relied on a plaintiff's insurance industry expert should not lead this court to conclude that it was unreasonable for Western National to rely on a different expert who reached a different conclusion. The district court may not disregard the existence of conflicting expert opinions related to causation and damages expressed at trial simply because the court chose to weigh the evidence after the trial and in the same manner as the jury in its findings. *See Peterson v. Am. Family Mut. Ins. Co.*, 160 N.W.2d 541, 544 n.2 (Minn. 1968) (discussing third-party bad faith and stating that "[w]e do not believe the test of bad faith

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[4] Because this issue was not litigated in these proceedings and is not before us, I do not consider the propriety of the district court's decision to hold a trial and take witness testimony to determine Peterson's section 604.18 claim. But it is worth noting that the express language of the statute directs the parties to file motions under Rule 119 of the General Rules of Practice rather than holding a trial to determine an insurer's alleged bad faith. *See* Minn. Stat. 604.18, subd. 4(b) (2018) ("An award of taxable costs under this section shall be determined by the court in a proceeding subsequent to any determination by a fact finder of the amount an insured is entitled to under the insurance policy, and shall be governed by the procedures set forth in Minnesota General Rules of Practice, Rule 119."). Rule 119 motions, like summary judgment motions and motions for judgment as a matter of law, are adjudicated by the district court in the first instance, and the procedure the district court adopted here is awkward at best. The court's reliance on a deferential standard of review in affirming the district court is also troubling; again, although the issue is not before us, we have often applied a de novo review standard when interpreting procedural rules. *See In re S.M.E.*, 725 N.W.2d 740, 742 (Minn. 2007) (noting that the court "interpret[s] procedural rules de novo"). I conclude that Peterson's bad-faith claim under Minn. Stat. 604.18 does not survive under any standard of review, deferential or otherwise.

should be determined by hindsight" (citation omitted) (internal quotation marks omitted)). Importantly, "[a] mere mistake in judgment does not, standing alone, constitute bad faith." *Id.*

Western National convened a claims board, which concluded that Peterson's claim was satisfied by the compensation she had already received. Outside counsel, a veteran and experienced trial lawyer, had represented a *plaintiff* with similar claims that involved the use of Botox and advised Western National of the large verdict in that case and specifically explained why the cases were dissimilar; his consistent assessment was that Peterson's claim was satisfied by what she had already been paid. That Western National chose to litigate and lost does not mean that the insurer acted in reckless disregard of a reasonable basis for Peterson's claim; it simply means a jury decided for Peterson, not for Western National. Put another way, the right to a jury trial is not restricted to insureds; the insurance carrier is entitled to a jury trial on disputed issues of fact as well.

Finally, there are significant consequences to the novel interpretation of the bad-faith statute advanced by the court here. In many respects, this is a classic disputed personal-injury claim—disputed issues of causation, damages, inconsistent medical evidence, and arguments about the qualifications and opinions of medical experts testifying at trial. The burden of proof fell on Peterson, who was required to causally connect the low-speed accident (resulting in minimal vehicle damage) to her continuing debilitating headaches. And, indeed, there was some evidence presented to suggest that the cause of her injuries was not related to the 2009 accident, including (1) Peterson's prior automobile accidents with reported injuries and regular chiropractic treatment; (2) conflicting evidence

from Peterson's own medical records; and (3) the expert opinion of an independent medical evaluator who concluded that there was no causal relationship between the 2009 accident and Peterson's continuing headaches.[5] Additionally, because this was an underinsured motorist claim, not only was Peterson required to establish that she suffered injuries, but she was also required to prove that she was entitled to damages in excess of what she had already been paid—$45,000—which was a less-than-limits settlement of her claims with the tortfeasor's insurance carrier.

If Peterson's bad-faith claim does not fail as a matter of law, then *any* personal injury verdict in an uninsured or underinsured motorist case that substantially exceeds the last offer from the carrier (or, as here, the amount paid in settlement by others) carries with it the seeds of a bad-faith claim. This is contrary to what the statutory language passed by the Legislature specifically provides, contrary to our common law rule that we do not permit bad-faith damages in breach-of-contract cases, and upsets existing claims management and litigation practice without legislative authority.

Respectfully, I dissent.

GILDEA, Chief Justice (dissenting).

I join in the dissent of Justice Anderson.

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[5] It is worth noting that, at the initial trial, Peterson did not challenge the admissibility of the testimony of Western National's independent medical examiner. It is troubling that today the court proposes that reliance by Western National on the testimony of an independent medical examiner was unreasonable as a matter of law when that same expert testified at trial without objection by Peterson. The absence of an objection by Peterson to the independent medical examiner's testimony is an implicit concession of reasonableness on the part of Western National; it is the equivalent of the dog that did not bark. *See* Arthur Conan Doyle, Silver Blaze, *in* The Complete Sherlock Holmes, Vol. 1 415 (Barnes & Noble Classics 2003).