
NO. A09-1506

State of Minnesota
In Supreme Court

Western National Insurance Company,

Respondent,

vs.

Bruce Thompson, et al.,

Appellants.

REPLY BRIEF OF APPELLANTS

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INTRODUCTION

Contrary to the Respondent's argument, the Appellants have properly appealed the Court of Appeals decision that refusal of an unreasonable discovery request is a breach of contract. Despite that decision there is no coverage issue in this case. The Appellants have not argued the policy violates the No-Fault Act. The issue is not interpretation of the specific language in the policy that requires statements when reasonably requested. The issue for appeal is who decides the reasonableness of a refusal and the consequences of that determination.

The Court of Appeals decision would take away the responsibility to decide the reasonableness of a refusal from a neutral arbitrator and allow an insurer to arbitrarily void coverage even though it has not acted reasonably toward its insured. Affirmation of that decision would prevent mandatory arbitration of no-fault disputes. This appeal requires a determination that any dispute over the reasonableness of a refusal is within the jurisdiction of a neutral arbitrator, and therefore not a breach of contract, consistent with this Court's prior decision in *Weaver v. State Farm*, 609 N.W. 2d 878 (Minn. 2000).

I. AN ARBITRATOR'S FACTUAL DETERMINATION OF THE REASONABLENESS OF A REFUSAL IS CONSISTENT WITH THE NO-FAULT ACT.

The error in the Court of Appeal's decision and the Respondent's argument is apparent when considering how it would affect the rights and responsibilities of the parties to the insurance contract. It held an insurer is only obligated to act reasonably with regard to requests for independent exams because they are specifically mentioned in *Minn. Stat. 65B.56 subd. 1*. The conclusion the insurance industry can draw is that any request for formal discovery (except an IME) does not have to be reasonable. Without a

duty to act reasonably an insurer would have the ability to delay or prevent mandatory arbitration whenever there is any discovery dispute that didn't involve an IME.

EUO statements are only one form of discovery an insurer can pursue. If the decision remains law, every insurer in Minnesota could amend their policies from the current provisions requiring cooperation with all "reasonable" requests for statements in compliance with *Minn. Stat. 65B.56, subd. 1* to language that requires "absolute cooperation" with any discovery request as a condition precedent to receipt of benefits. Insurers could make demands for any type of information, whether reasonable or not, without the requests being subject to review by a neutral arbitrator. Any actual or perceived refusal could then subject the insured to the immediate denial of benefits.

It is not hard to envision that many claims would have to be litigated in the courts first. For example, if an insurer asked for a deposition statement and the claimant disputed the time or location that could be considered non-cooperation. If during the course of a deposition statement the insured/counsel objected to the relevance of any questions being asked this to could be deemed non-cooperation by the insurer and thereby a breach of contract. Likewise, an insurer could demand responses to interrogatories or requests for documents, and if the insured objected or failed to provide them within an arbitrary time frame, the insurer could deem it non-cooperation and a breach of contract.¹ The fact circumstances that could give rise to breach of contract claims would be as endless as the insurance industries willingness to make unreasonable requests. The formal litigation that arises from this would 1) burden the district courts

¹ For example, in this case the Respondent demanded the Appellants attend deposition statements and each bring with them State and Federal tax returns for at least two prior years, cell phone records for the month of the loss and photo identification. *A – 18*. Production of employment information is not required by the no-fault arbitration rules when a claimant is not making a claim for wage loss benefits at the time. *Minn.R.No-Fault.Arb.12*.

with factual disputes arising from no-fault discovery requests, and 2) favor the insurer with its far superior resources. Unless a claimant had both the resources and the determination to pursue expensive and lengthy formal litigation no-fault benefits would remain denied and the primary purpose of the No-Fault Act unrealized. Ultimately this would also require the claim to be shuttled back and forth between the courts and arbitrator to fully resolve, a practice this Court denounced in *Weaver* previously.²

The long and expensive history in this case presents a prime example of the burden of litigation that would be placed upon claimants. Here both Appellants by all accounts have cooperated fully with the Respondents investigation of their claims. Yet years after medical expenses were incurred they remain unpaid while the Appellants litigate their entitlement to benefits denied on a breach of contract theory. The No-fault Act with its requirements of reasonableness and mandatory arbitration fairly protected the rights of both parties resulting in quick and binding decisions by experienced and neutral arbitrators.³ If insurers were allowed to dictate what is an acceptable level of cooperation under the terms of their policies, claims would not be efficiently or fairly handled in this manner.

The Respondent writes in its brief about the public policy concerns inherent in conducting fraud investigation. It fails to explain how the public is served when an insurer can dictate unreasonable demands as a precondition for obtaining benefits, or when only one party to the contract must act reasonably. It fails to explain the public benefit of allowing an insurer to collect a premium for mandated coverage and then arbitrarily deny coverage forcing the insured to pursue expensive and time consuming

² *Weaver v State Farm*, 609 N.W. 2d 878, 881 (Minn. 2000).

³ Appellant's Appendix, A 65-66.

litigation. This Court has previously determined there is a quid pro quo in the no-fault system that payment of benefits is conditioned upon cooperation.⁴ Allowing an insurer and not a neutral arbitrator to determine the level of cooperation necessary to qualify for benefits destroys this concept.

If the Court of Appeals decision remains law, what will most likely follow is an increase in insurer's use of unreasonable demands for all types of discovery as a tactic to avoid informal arbitration and deny payment of claims by alleging breach of contract. This tactic would move claims out of informal arbitration and back into the litigation system that favors the resources, experience and personnel insurers have available to fight claims. It would not give insurers a new tool to investigate fraud, but a new tool to deny claims, or at least obstruct collecting benefits by increasing the costs associated with qualifying for them. This was an outcome that existed before the No-Fault Act was passed. It was an outcome the act sought to eradicate when it made the prompt payment of medical expenses a priority and implemented mandatory arbitration.

The present no-fault system works. It is informal, efficient, inexpensive and imminently fair to both parties. The Respondent under this system had at its disposal all of the tools necessary to investigate the Appellant's claims. To the extent it needed more information the arbitrators had the authority to order it.⁵ The arbitrator not the insurer should decide what is reasonable under the facts of each case. An insurer is not harmed in any way when it is required to act reasonably. Both parties mutually benefit from the minimal delay and minimal expense inherent in an informal arbitration system based upon reasonableness.

⁴ *Neal v State Farm*, 529 N.W. 2d 330, 333 (Minn. 1995).

⁵ Minn.R.No-Fault.Arb. 12.

II. COOPERATION WITH AN ALLEGED FRAUD INVESTIGATION IS NOT A CONDITION PRECEDENT TO PAYMENT OF NO-FAULT BENEFITS

The Respondent has misstated its obligations to pay claims and prevent fraud. State law doesn't elevate an insurer's obligation to guard against fraudulent claims to a superior position over its statutory obligation to investigate and promptly pay claims for medical benefits. These obligations are mutually exclusive under Minnesota Law.

The primary purpose for passage of the No-Fault Act was to relieve the severe economic distress of uncompensated accident victims and encourage appropriate medical care through prompt payment of claims.⁶ There is no mention of fraud investigation as being one of the primary purposes for passage of this act.⁷ While this statute does refer to over compensation and duplicative payments to claimants it does so in the context of the tort liability system and not with reference to no-fault benefits per se.⁸

The Respondent points to the anti-fraud language in *Minn. Stat. 60A.954, Subd. 1* seemingly for support of its position an insurer's obligation to investigate fraud is somehow a condition precedent to payment of no-fault benefits. That statute makes no mention of no-fault policies in general or no-fault claims for benefits in particular. It merely details the fact an insurer is obligated to have a policy in place to guard against fraud from all types of insurance claims. Certainly if the legislature had intended the effect the Respondent argues it would have included in the No-Fault Act a provision

⁶ Minn. Stat. 65B.42, Subd. (1) – (5).

⁷ Id.

⁸ Minn. Stat. 65B.42, Subd. (2), (5).

requiring an insurer to implement a fraud policy together with language describing how the operation of such a policy would affect the payment of benefits.

The amicus brief of the Insurance Federation argues that because the No-Fault Act does not specifically proscribe the inclusion of fraud-combating policy language as a condition precedent to coverage it should be enforced.⁹ But as the amicus brief of the Minnesota Association for Justice pointed out it is well established in Minnesota law that policy provisions that restrict mandated coverage are unenforceable.¹⁰ The Respondent was contractually obligated to pay medical benefits for both Appellants, or submit any dispute concerning payment to mandatory arbitration. The legislature's requirement the Respondent maintains a general fraud policy in place does not restrict this mandated coverage. If that were the legislature's intention it would have clearly stated so in the no-fault statute, or at least conditioned coverage upon it.

The policy language doesn't require a deposition statement as a condition precedent to obtaining benefits. It only mentions a EUO in the context of a claimant "seeking coverage" and that had already been established in this case.¹¹ The policy does contain a section dealing with fraud, but it also does not require a deposition statement as a condition precedent to obtaining benefits.¹² Also, the Respondent refers numerous times to its obligation to maintain a fraud policy. However, it did not include this alleged document in its submissions to any tribunal that heard these claims. This Court and the Appellants have no actual knowledge of the actual contents of this policy, or its

⁹ Amicus Brief of Ins. Federation at P. 11.

¹⁰ Amicus Brief of Mn. Assoc. for Justice at P. 2.

¹¹ Respondent's Appendix RA – 10.

¹² Respondent's Appendix RA – 11.

requirements. If the Respondent does in-fact have an anti-fraud policy, it could not operate as a condition precedent because it was not noticed to the Appellants and no-fault coverage was not predicated upon such a policy.

The amicus brief of the Insurance Federation was apparently offered for two reasons. One was to remind this Court that historically EUO provisions were and apparently still are a necessary part of fire insurance contracts in which they are recognized as a condition precedent to recovery. But as Judge Howard correctly pointed out in his decision, a fire insurance policy does not “implicate Minnesota’s No-fault Act or its mandatory arbitration provisions” referencing *McCullough v. Travelers Companies*, 424 N.W. 2d 542 (Minn. 1988). If this were a claim under a fire insurance policy, the requirements for cooperation might necessarily be different. The fact the Insurance Federation has found other fire claims cases in Minnesota and elsewhere that applied its theory on EUO’s doesn’t change the logic of Judge Howard’s decision on this point.

Second, the brief introduces for the first time an annual report on insurance fraud by the Department of Commerce in an apparent attempt to move this Court into viewing insurance fraud as the most pressing issue in the no-fault system. This report has no apparent relevance to the payment of no-fault claims. It contains self-serving and unverifiable **estimates** of the cost of all types of insurance fraud nationwide by an insurance industry trade group.¹³ These unverifiable estimates statistically have nothing to do with no-fault claims in Minnesota.

The report does contain some verifiable statistics. During the entire year of 2009 there were 924 referrals of potential fraud to that department. Of that amount it closed

¹³ The organization lists 30 insurance companies on its board of directors on its website www.insurancefraud.org.

750 cases for lack of evidence or merit. Of the remaining open cases only 29 were referred for prosecution.¹⁴ These resulted in court ordered restitution of \$3,618,035.00 consistent with the statistics of the prior two years.¹⁵ The report does not indicate if any of the cases subject to prosecution in 2009 involved no-fault benefits. However, the report did contain a list of “Noteworthy Insurance Fraud Cases”. In the only no-fault related case reported as noteworthy a woman in Minnesota received \$3,187.00 as a result of a false claim in 2007.¹⁶

The hard statistics in this report don’t support the Federation’s statement in its brief that “The very nature of No-Fault claims invites fraud by unscrupulous individuals” unless they were referring solely to the 2007 prosecution highlighted in that report. It certainly doesn’t support the conclusion that public policy requires deposition statements as a condition precedent to obtaining benefits to root out fraudulent claims.

The Appellants will concede that there could have been more than \$3,187.00 in reported or actual fraud involving no-fault claims in Minnesota since 2007. But the no-fault insurer has the responsibility to investigate suspicious claims without placing the financial and legal burden upon their own insured. The Respondent doesn’t have the legal right to hold no-fault benefits hostage, or deny them merely because it wants the Appellants to cooperate with it as it carries out its sole obligation to investigate any allegedly fraudulent claim. Further, the Respondent had all of the necessary tools it needed to investigate suspicious claims beginning with the application for benefits and authorizations it requires, the discovery allowed by the arbitration rules, its ability to

¹⁴ Amicus Brief of Ins. Federation – Appendix P. 11.

¹⁵ Id. at P. 12.

¹⁶ Id. at P. 10.

gather all medical information from any providers within 7 years of an accident, the vast number of adjusters, field operatives, claims analysts, lawyers and doctors on its payroll and its ability to obtain when necessary any discovery allowable by the District Courts. Public policy is not served if the insurer can simply ignore its responsibility to investigate claims with all of these tools at its disposal and unreasonably deny a no-fault claim because the insured does not want to share in the burden of its investigation.

CONCLUSION

The Respondent has the sole responsibility to investigate any alleged fraud. It has the tools to do so. It also had the opportunity to convince two neutral arbitrators of its need to conduct formal discovery. Even though the requests were ultimately found to be unreasonable in these cases it still can investigate the claims and take action after the fact to recoup any monies it can prove were unlawfully obtained by any party.¹⁷ Further, if the Respondent had a reasonable suspicion that the medical provider was perpetrating fraud, it arguably had a duty to warn the Appellants so they would not continue to remain victims of that provider. The record accurately reflects no such warnings were ever provided to the Appellants in the request for statements or otherwise.

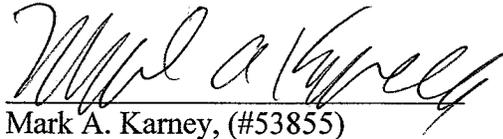
Judge Howard was correct when he determined reasonableness is the heart of the no-fault system. This Court's prior decision in *Neal*¹⁸ places a duty on both parties to act reasonably. Neutral arbitrators must decide the reasonableness of any refusal so that disputes can be subject to mandatory arbitration and thereby maintain the purpose and intent of the No-Fault Act.

¹⁷ Minn. Stat. 65B.54, Subd. (4).

¹⁸ *Neal*, 529 N.W. 2d at 333.

Respectfully submitted by,

Dated: October 8, 2010

A handwritten signature in cursive script, appearing to read "Mark A. Karney". The signature is written in black ink and is positioned above a horizontal line.

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CERTIFICATION OF BRIEF LENGTH

I hereby certify that this brief conforms to the requirements of Minn. R. Civ. App. P. 132.01, Subd. 1 and 3, for a brief produced with a proportional font. The length of this brief is 2723 words, including headings, footnotes and quotations and excluding the Table of Contents and Table of Authorities. This brief was prepared using Microsoft Word 2007.

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