Opiates in Litigation
W. Ann ("Winnie") Maggiore, JD, NRP

Origins: Conflict of Interest
How opiates appear in litigation
OPIOID CRISIS
Ethical Issues – Failure to Disclose/Monitor Conflicts of Interest

• 1980s: MDs pushing for a more expansive role for opiate analgesics

• Some of these MDs had financial ties to pharmaceutical manufacturers

• 1997: American Pain Foundation
  – 2010: it disclosed 90% of its budget from came from Big Pharma

• 2000: Joint Commission introduces pain management standards
Continued...

- 2001: Pain as the “fifth vital sign” – later backtracks
- 2012: APF closed its doors and US Senate investigates opioid manufacturers for providing misleading information
- 2013: VA Opioid Safety Initiative
- 2016: Joint Commission standards promote access to non-drug pain therapy and introduces the PMP monitoring program
Opiates in Civil Litigation

• 2017: Multidistrict litigation
  – Nearly 200 pending opioid related cases consolidated into US District Court in Ohio
  – Alleged that manufacturers overstated benefits and downplayed risks
  – Aggressive marketing of drugs to MDs
  – Failure to monitor suspicious orders
Opiates in Civil Litigation

• *Oakey v. Doctor on Call, May Maple Pharmacy*
  – 19 yo female found dead in car on interstate highway rest area
  – Alleged MD prescribed without documented H&P, provided increased levels of opiates
  – Pharmacy failed to detect irregularities in Rx
Opiates in Civil Litigation

• Peterson v. Jones
  – 62 yo woman underwent hip arthroplasty via new anterior approach
  – Alleged injury to lateral femoral cutaneous nerve
  – PCP provided increasing dosages of Fentanyl patches
  – Pt husband testified that “all she does is lie in bed”
Opiates in Civil Litigation - States

- June 2018: NM Attorney General files suit against manufacturers/distributors
  - Improper marketing and distribution of opiates
  - Violations of Unfair Trade Practices Act
  - NM Medicare Fraud Act
  - NM Racketeering Act
  - NM Fraud Against Taxpayers Act
  - Negligence/negligence per se
New Mexico County Files Lawsuit Over Opioid Crisis

• A northwestern New Mexico county is the latest to file a lawsuit over the opioid crisis. **June 5, 2018, at 2:15 a.m.**

• **AZTEC, N.M. (AP) —** A northwestern **New Mexico** county is the latest to sue over the opioid crisis.

• Lawyers for **San Juan County** filed the challenge late last week against numerous pharmaceutical companies and distributors.

• The county is seeking relief for the costs of combatting a public nuisance that lawyers say stemmed from deceptive marketing campaigns that misrepresented the safety of long-term opioid use.

• According to the complaint, San Juan County reported 111 overdose deaths and more than 200 people visited the emergency room due to an overdose between 2010 and 2014.

• Santa Fe and Mora counties also sued, and the Navajo Nation filed a lawsuit in April, arguing that Native Americans suffer disproportionately from opioid dependency and abuse.
Opiates in Civil Litigation

- **Bevan v. Santa Fe County**
  - Estate of deceased plaintiff sued for inadequate medical care while incarcerated at Santa Fe Youth Development Program
  - Pt treated for heroin OD at hospital, cleared for incarceration
  - Pt went into respiratory/cardiac arrest that night
    - Autopsy found cause of death “toxic effects of heroin”
  - 8th Amendment violations
If you have experienced an increased addiction, committed illegal activity, or suffered an overdose due to opioids after being prescribed by a medical professional or facility, you may be eligible for compensation. **CONTACT AN ATTORNEY NOW**

There is no Fee Unless We Get You Money.
HOW THE ETHICAL AND LEGAL STANDARDS REGARDING OPIOID PRESCRIBING FIND THEIR WAY INTO CIVIL LITIGATION

W. Ann “Winnie” Maggiore, JD, NRP

The opioid epidemic has reared its ugly head in civil litigation in a number of ways. Physicians and dentists have been brought before licensing boards on charges of injudicious prescribing, after having taken mandatory CME courses in what constitutes appropriate pain management. But physicians and pharmacies have also been sued for improper prescribing, and dispensing, of opiate pain medications when a patient is harmed.

1. Ethical issues

The ethical facets of the opiate crisis are often understated and a look at the origins of widespread opiate addiction is instructive in realizing how we got where we are today. ¹ During the 1980s, physicians such as Russel Portenoy, M.D. began presenting seminars pushing for a more expansive role for opioid pain relievers, citing to a letter to the editor of the New England Journal of Medicine noting that less than 1% of patients treated with opioids became addicted. ² He cites his own retrospective review of 38 cases in which chronic non-cancer pain was treated with opioids, arguing that the evidence showed the effectiveness of opioids in treating such pain. ³ It was discovered that Portenoy had financial ties to more than 12 pharmaceutical manufacturers, some of whom produced opiates, and that these relationships were not disclosed during his numerous presentations. ⁴

In 1997 the American Pain Foundation was formed as an independent nonprofit organization advocating for the needs of patients suffering from chronic pain. However, in 2010,

the organization reported that 90% of its $5 million annual budget was received from pharmaceutical and medical device companies. One single manufacturer of opioid medications provided 53% of its funding.\(^5\) Shortly thereafter, in May of 2012, the foundation closed its doors.\(^6\) Within days, the U.S. Senate announced an investigation into manufacturers of opioid pain medications for promoting misleading information about the drugs’ safety and effectiveness.

The ethical violations reviewed show a failure of veracity, as well as a failure to adequately monitor and manage potential conflicts of interest.\(^7\) In the realm of providers and patients, the fiduciary responsibility arises when the provider is trusted to act in the best interest of the patient, and to not withhold information that would help the patient make an informed decision regarding treatment and potential risks.\(^8\)

The Joint Commission introduced pain management standards in 2000.\(^9\) In 2001, its standards mentioned pain as a “fifth vital sign” to be assessed in every patient.\(^10\) As opiate addiction and opioid related over-sedation continued to increase, the Joint Commission backtracked on some of its standards, withdrawing the concept of the fifth vital sign and turning to more global assessments of pain, noting that greater monitoring of opioid prescribing patterns was required. After 2016, the standards promote access to non-drug treatment modalities and championed the use of prescription drug monitoring programs.\(^11\) The CMS also began the use of patient satisfaction surveys, and facilities that received low scores in pain management increased

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\(^7\) Regis University. Ethics at a glance; veracity. [https://rrchp.regis.edu/HCE/EthicsAtAGlance/Veracity/Veracity.pdf](https://rrchp.regis.edu/HCE/EthicsAtAGlance/Veracity/Veracity.pdf).


\(^10\) Id.

their opiate prescribing. An ethics analysis revealed that the Joint Commission, the Federation of State Medical Boards, the FDA, and DEA all failed to adequately monitor conflicts of interest in the interest of protecting public safety.

In 2013, the Veteran’s Administration began its Opioid Safety initiative, seeking to help ensure safe and effective prescribing. The VA discovered that opioids were received by one in every four veterans who received prescriptions from the Nashville, Tennessee VA Medical Center. Two of the goals of the initiative are to review patient treatment plans for those receiving high dose opioid therapy and to offer alternative and complementary medicine options.

2. Examples of Opiate Issues in Civil Litigation (New Mexico)

In June of 2018, the New Mexico Attorney General filed suit against manufacturers and wholesale distributors of opioids, alleging that the companies improperly marketed and distributed these drugs nationwide. The suit sought injunctive relief as well as monetary damages through claims of public nuisance, violation of the NM Unfair Trade Practices Act, the NM Medicare Fraud Act, the NM Racketeering Act, the NM Fraud Against Taxpayers Act, negligence, and negligence per se. Defendants removed to federal court and the state moved to remand; that motion was ultimately granted. By September of 2017, multidistrict litigation consisting of nearly 200 pending opioid related cases were consolidated into the US District Court in Ohio. The common allegations are that the manufacturers of prescription opioid medications overstated the benefits while downplaying the risks of the use of the drugs, and

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12 Falkenberg K. Why rating your doctor is bad for your health www.forbes.com/sites/kaifalkenberg/2013/01/02why-rating-your-doctor-is-bad-for-your-health/#2bcbd3133c5.
16 In Re: National Prescription Opiate Litigation, MDL No. 2804.
aggressively marketed the drugs to physicians, and that distributors failed to monitor, detect, investigate, refuse, and report suspicious orders of prescription opiates.

State courts also see litigation involving prescribing of opioid medications; the following are a few cases from New Mexico:

In the case of *Oakey v. Doctor on Call and May Maple Pharmacy*, the family of a young woman who had been found dead of an opiate overdose on the side of an interstate highway sued both the physician who prescribed the opiates and the pharmacy who dispensed the medications. The civil Complaint in that case alleged that a physician had prescribed medications to the patient without taking a detailed medical history or performing a full history and physical, and continued to provide increasing levels of opiates. It further alleged that the pharmacy failed to detect irregularities in the prescriptions, which had likely been altered and duplicated.

In *Peterson v. Jones*, Mrs. Peterson sued her orthopedic surgeon, Dr. Steven Jones, who had performed a hip replacement using a new anterior approach that was designed to provide a shorter recovery time and reduced risk of nerve injury. Mrs. Peterson alleged injury to her lateral femoral cutaneous nerve during the surgery. At his deposition, her husband – a dentist – testified that after the surgery, his wife spent most of her time in bed, lethargic and unable to do any of the activities she had formerly enjoyed. A closer review of her medical records revealed that she had been receiving increasing dosages of Fentanyl “patches” from her primary care provider, ostensibly to treat pain from the nerve injury. Dr. Jones had been accused of injuring this patient, when instead she was simply over-sedated with too much opiate analgesic medication. It

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17 CV-2012-06141; the doctor’s portion of the case was settled; the case against the pharmacy was dismissed on summary judgment and subsequently appealed.
18 D-101-CV-2008-3473, First Judicial District, Santa Fe County, New Mexico. The case was tried to a jury and a defense verdict obtained; there was no appeal.
also came out at trial that Mrs. Peterson had sustained a back injury and had been treated for nerve impingement in California. The jury awarded a verdict in favor of Dr. Peterson.

In *Aimee Bevan v. Santa Fe County*, the estate of a deceased plaintiff sued for inadequate medical care while she was incarcerated at the Santa Fe Youth Development Program (YDP). She had been treated for heroin overdose at a local hospital and cleared for incarceration. Later that night, the patient stopped breathing. Non-medical staff began CPR and called 911, but the patient later died at the same hospital that had released her. The autopsy report determined the cause of death was “toxic effects of heroin.” The Complaint for wrongful death sought §1983 claims against the County for violation of the patient’s rights under the Fourteenth and Eighth Amendments. The court ultimately granted the County’s Motion for Summary Judgment.

In conclusion, the issue of opiate prescribing has both ethical and legal ramifications that have changed with modern medical and legal viewpoints.

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19 2017 WL 4480112 D.N.M.
Politicians have suggested that the opioid epidemic is one of the biggest problems facing America, and many seem to agree (see Figure 1). Overdose deaths involving opioids have grown exponentially since 2010, and the recent decline of prescriptions and availability of traditional opioids has led to a rise in deaths related to heroin and synthetic opioids such as fentanyl and tramadol (see Figure 2).

![Figure 1](image_url)
Hardly a day goes by where we don’t hear about another lawsuit being filed accusing pharmaceutical companies, distributors, hospitals, and pharmacies of fueling the country’s addiction to opioids. Plaintiffs, mostly consisting of state and local governments, seek reimbursement of funds spent investigating, responding to, and treating those affected by addiction. The largest multidistrict litigation on the issue, venued in Ohio Federal court, has been set on a litigation track, with the first set of bellwether plaintiffs to be tried in March of 2019 (case number 1:17-md-02804, in the U.S. District Court for the Northern District of Ohio). Plaintiff firms, purposefully seeking to avoid the MDL, are also filing suit in state courts, joining non-diverse sales reps, distributors, and physicians to defeat removal. Claims in these cases are based on allegations of Fraud, Negligent Misrepresentation, Negligence, Negligence Per Se (in available states), Constructive Fraud, Unjust Enrichment, Public Nuisance, and Unfair Trade Practices and Consumer Protection violations (State Court Litigation, presented by Marc J. Bern, Esq. at the Perrin Opioid Litigation Conference, June 28, 2018). In essence, the plaintiffs assert two theories of liability: 1) that pharmaceutical companies fraudulently hid the harmful and addictive nature of these drugs; and 2) that distributors failed to monitor and report prescription abuses.

Without any of these cases reaching a jury to date, it can be difficult to predict how jurors will react to these claims. To obtain a glimpse into jurors’ relevant attitudes and experiences, Litigation Insights, a national jury consulting firm, conducted a survey of mock trial participants in venues across the country.¹ The results suggest this is a topic that hits close to home for many

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¹ The pool consisted of 209 mock juror participants from Hennepin County (Minneapolis), Cook County (Chicago), Kanawha County (Charleston, WV), Seminole County (Orlando area), Los Angeles County, Harris County

Figure 2

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016

potential jurors, and jurors have strong opinions about who is to blame. Below, we examine the results of the survey and the likely implications for litigation in this arena.

**A Topic that Hits Close to Home**

Our survey results suggest that a sizeable number of potential jurors are likely to have had a personal experience with opioid addiction. Indeed, while only 1% of the sample admitted to having had difficulty stopping or cutting back on pain medications, one in five jurors (21%) had a family member or close friend experience addiction to prescription painkillers. Sadly, most all of these users graduated to non-prescription opioids such as heroin, suggesting that the leap from prescription opioids to street drugs was more akin to a small step. Shockingly, the destruction of such addiction was evident in the fact that one in five of the jurors (20%) had a friend or family member lose their life due to an opioid overdose, and just as many had a near-death experience.

In all, a third of the people surveyed indicated their lives had been personally affected by opioid addiction among friends, family, and their communities. And the problem was fresh in the minds of many jurors, as 22% indicated they were “concerned about a loved one’s current use of prescription painkillers.” Even many without direct personal experiences recognized the epidemic was prevalent in their communities. In fact, 20% of the sample indicated that opioid addiction was “very common” in their community, and an additional 27% believed it was “somewhat common.” As Figure 3 indicates, concern about the problem of opioid addiction was high, suggesting that jurors will be motivated to find a solution to the epidemic.

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(Houston), the Northern District of Maryland (Baltimore area), and the District of Minnesota. Jurors were recruited to match the demographics of the jury pools in these jurisdictions.
The Pharmaceutical Companies

Pharmaceutical companies and their “deep pockets” have become prime targets for this litigation, and the preliminary research suggests many jurors are already inclined to blame the industry. Without hearing any attorney argument or evidence, a whopping 71% of jurors agreed with the plaintiffs’ theory that “Pharmaceutical companies have oversold the benefits of prescription painkillers while downplaying the risks of addiction.” Only 9% disagreed, and remaining 19% were “unsure.” Despite this finding, however, FDA compliance remains a viable defense, as more than a third of the pool (37%) agreed that drug manufactures should not be liable as long as they followed FDA guidelines. Still, even though a third of the pool was unsure about whether companies should be on the hook for the types of damages sought by plaintiffs in this litigation, many were already inclined to side with those filing the suits (see Figures 4, 5, and 6).

Figure 4

Pharmaceutical companies should be required to pay for treatment and rehabilitation services for people who become addicted to their prescription painkillers.
Pharmaceutical companies should reimburse local governments for healthcare costs associated with opioid addiction, such as rehabilitation programs and emergency foster care services.

![Figure 5](image)

Since pharmaceutical companies are making the most money from opioid prescription painkillers, they should pay the most money to help treat the problem of opioid addiction in our communities.

![Figure 6](image)

Alarmingly for these defendants, the risk of punitive damages in these cases was evident in the fact that nearly half of the sample also agreed “Pharmaceutical companies want patients to get addicted to prescription painkillers so they can make more money by selling more pills,” and
more than half agreed “Pharmaceutical companies have hidden the risks of prescription painkillers from the public.” Indeed, 47% of the jurors clearly indicated that they wanted to see the companies “be punished for marketing prescription painkillers so heavily.” Like those with personal experiences, most jurors recognized that those addicted to pain medications were highly likely to turn to stronger opioids like heroin or fentanyl, suggesting that jurors may be inclined to hold pharmaceutical companies responsible not only for addictions to the drugs they manufacturer, but also for the aftermath of those addictions.

**Pharmacies and Distributors**

Whether to the benefit of the pharmaceutical industry or the detriment of other defendants, jurors were willing to spread the blame. Keeping in mind that those surveyed heard absolutely no attorney argument or evidence on the issue, the plaintiffs’ second theory of liability already held traction, with nearly 70% of the jurors agreeing that “Distributors of prescription painkillers should be held liable for failing to monitor and report suspicious drug orders” and almost the same number sought to hold insurance companies liable under the same failure-to-report theory. Jurors may even be inclined to hold pharmacies culpable merely for filling these prescriptions (see Figure 7).

**Doctors and Hospitals**

Though not often sued by plaintiffs in their cases against the pharmaceutical industry, jurors believe doctors hold some degree of responsibility in contributing to the epidemic, so corporate defendants may see some reduction in fault if they’re able to get them on the verdict form. Indeed, 62% of participants agreed that “Doctors should not be prescribing opioid painkillers as often as they do,” and 30% went so far as to agree that “Doctors should be held legally responsible when their patients become addicted to prescription painkillers.” Interestingly, nearly half of the sample (46%) indicated that pharmaceutical companies should not be held
liable for addictions so long as the companies warned doctors and patients about the risks of addiction, suggesting the possibility of a defense akin to the learned intermediary doctrine. However, just as many jurors already believe the companies “have hidden the risks of prescription painkillers from doctors,” indicating that this defense may not resonate as well with some jurors. If jurors are willing to hold the doctors responsible, however, this also opens the way to point blame toward the hospitals under the same “failure-to-report” theory that could expose distributors and pharmacies to liability (see Figure 8).

![Comparative Fault](image)

When a doctor prescribes too many painkillers, the hospital or facility employing the doctor should be held legally responsible for failing to monitor and supervise the doctor.

**Figure 8**

**Comparative Fault**

Plaintiff law firms have been reluctant to file suit on behalf of individual addicts or their families, in large part due to their belief that jurors will find these plaintiffs unsympathetic (although recent suits filed on behalf of “opioid babies” seek to avoid this dilemma). The results of our survey suggest that to be true to some extent; the degree to which jurors assign fault to the addict will likely depend upon the extent to which they feel he or she is culpable for becoming addicted in the first place. In our survey, an overwhelming number of jurors recognized the ease with which a person can become addicted, with 78% agreeing (31% of them strongly) that “It is way too easy for people to become addicted to prescription painkillers.” If jurors acknowledge this, they may be reluctant to place significant blame on an addict, essentially recognizing that they or a loved one could, too, one day become a victim. Still, in keeping with the theme that the opioid epidemic is a shared responsibility, jurors largely agree that the patient holds a great deal of responsibility for ensuring that he or she doesn’t become addicted to painkillers (see Figure 9).
Despite the lack of any verdict or known settlement in these cases, government municipalities and others continue to file lawsuits seeking compensation from the drug industry. Should these lawsuits proceed to trial, plaintiff attorneys will no doubt employ “reptile” tactics to capitalize on jurors’ personal fears of having a close friend or family member succumb to addiction. They will try to play upon jurors’ existing attitudes about big pharma and who is to blame for the epidemic, leaving defendants vulnerable to massive jury awards.

To prepare to defend these lawsuits, jury research – in the form of focus groups and mock trials – are imperative in formulating themes and narratives that will effectively combat the basic human instincts that favor the plaintiffs’ case. This research will also help develop juror profiles to aid defendants in identifying and removing jurors who are most inclined to agree with the plaintiffs’ position and award hefty damages.
Coverage Issues in Opioid Litigation

Ronald D. Kent and Justin A. Martin

I. Background

Along with the rise in opioid use and public awareness of an opioid epidemic, there is beginning a corresponding rise in opioid-related insurance coverage litigation.¹ Unsurprisingly, many opioid manufacturers and distributors have commercial general liability (“CGL”) insurance policies, and the opioid-related complaints against these policyholders are being tendered to insurers for a defense and indemnity.² Some of those tenders have prompted coverage litigation.

Several of these coverage cases have progressed to final judgments and published appellate decisions. These cases raise coverage questions such as whether the alleged conduct or resulting damages – depending on the controlling law – were accidental and unexpected, and thus an occurrence. Further, some cases put at issue whether there was alleged bodily injury within the meaning of the subject policies, as opposed to only economic loss. Yet others turn on the language of the policies’ products exclusion. This paper summarizes the recent case law.

II. Complaints by Cities, Counties and States, and the Conduct and Damages Alleged

In Travelers v. Actavis, there were two underlying complaints – one filed in California by the Counties of Santa Clara and Orange (“the California Complaint”), and one filed in Illinois by the City of Chicago (the Chicago Complaint).³ The California Complaint and the Chicago Complaint alleged that the counties and city had incurred, and continue to incur increased costs of care and services to their residents injured by prescription and illegal opioid use and addiction.⁴ The complaints further alleged that the pharmaceutical company defendants had engaged in a “common, sophisticated, and highly deceptive marketing campaign” designed to expand the market and increase opioid sales by promoting them for long-term chronic, non-acute and non-cancer pain – a purpose that defendants supposedly knew their opioid products were not suited.⁵ To this end, the California Complaint further alleged that “[t]he diversion of opioids into the secondary, criminal market and the increase in the number of individuals who abuse or are addicted to opioids have increased the demands on emergency services and law enforcement in California,” which has “taxed the human, medical, public health, law enforcement, and financial resources of the People.”⁶ The Chicago Complaint likewise

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³ Actavis, Inc., 16 Cal. App. 5th at 1030.
⁴ Id.
⁵ Id.
⁶ Id. at 1034.
claimed that the City’s “health plans have also paid costs imposed by long-term opioid use, abuse and addiction, such as hospitalizations for opioid overdoses, drug treatment for individuals addicted to opioids, intensive care for infants addicted to opioids, long-term disability and more.”

In *Liberty v. J.M. Smith Corp.*, the underlying complaint brought by the Attorney General of West Virginia alleged that drug distributors were contributing to the opioid epidemic by failing to identify, block and report excessive drug orders. It also alleged that the drug distributors contributed to the epidemic by failing to maintain sufficient controls that would flag suspicious orders, and lacked procedures to guard against illegal diversion of opioids in contravention of West Virginia law.

Similarly, in *Travelers v. Anda*, the underlying complaint was brought by the Attorney General of West Virginia, and claimed that the pharmaceutical distributors knowingly or negligently flooded the West Virginia market with commonly-abused drugs. The allegations stated that this resulted in myriad harms including crime, congested hospitals and emergency rooms, exhausted law enforcement resources, overcrowded jails and prisons, and court dockets over-crowded with prescription drug-related cases and crimes committed by addicts.

The Attorney General of West Virginia also brought the underlying complaint against pharmaceutical distributors in *Cincinnati Ins. Co. v. Richie Enters. LLC*. The complaint alleged that the distributors illegally distributed controlled substances by supplying physicians and drugstores with drug quantities in excess of legitimate medical need. It further claimed that as a result of this conduct, West Virginia was required to spend money combating the prescription drug abuse epidemic in the state.

### III. Was an Occurrence

A central issue in opioid litigation coverage cases is whether the conduct or damages alleged in the underlying complaints potentially constitute a covered “occurrence.” Because state insurance laws vary on the standard for determining an “occurrence,” courts have come to different conclusions when faced with substantially similar allegations and policy language.

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7 Id.
9 Id.
11 Id.
13 Id.
14 Id.
There were two sets of CGL insurance policies at issue in *Travelers v. Actavis*. One set, issued by St. Paul Fire and Marine Insurance Company (“St. Paul”), provided coverage for “damages for covered bodily injury or property damage” that are “caused by an event.” The term “event” was defined as an “accident, including continuous or repeated exposure to substantially the same general harmful conditions,” i.e. a fairly standard policy definition for an occurrence. The term “bodily injury,” in turn was defined as “any physical harm, including sickness or disease, to the physical health of other persons.”

Similarly, the second set of CGL policies, issued by Travelers Property Casualty Company of America (“Travelers”), provided a duty to defend against any “suit” seeking damages “because of ‘bodily injury’ or property damage” caused by an “occurrence.” An “occurrence” was defined in the same way as “event” was defined in the St. Paul policies. The Travelers policies defined “bodily” injury as “[p]hysical harm, including sickness or disease, sustained by a person; or … [m]ental anguish, injury or illness, or emotional distress, resulting at any time from such physical harm, sickness or disease.”

To begin its analysis, the California Court of Appeal compared the allegations of the underlying complaints with the terms of the insurance policy. The court noted that in the context of liability insurance, an accident is “an unexpected, unforeseen, or undersigned happening or consequence from either a known or an unknown cause.” Importantly, under California law, an accident “does not occur when the insured performs a deliberate act unless some additional, unexpected, independent, and unforeseen happening occurs that produces the damage.” Thus, an accident may exist if “any aspect in the causal series of events leading to the injury or damage was unintended a matter of fortuity.” However, “[w]here the insured intended all of the acts that resulted in the victim’s injury, the event may not be deemed an “accident” merely because the insured did not intend to cause the injury.”

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16 Id. at 1031.
17 Id.
18 Id.
19 Id.
20 Id.
21 Id. at 1038.
22 Id.
23 Id.
24 Id.
25 Id.
In turning to the specific allegations of the underlying complaints, the Court of Appeal noted that the claims were based on allegations that defendants engaged in deliberate conduct—“a common, sophisticated, and highly deceptive marketing campaign” aimed at increasing sales of opioids and enhancing corporate profits.26 These allegations, the Court noted, could only describe “deliberate, intentional acts.”27 In resolving Actavis’ argument that certain of the resulting injuries, such as an increase in heroin addiction, could be considered an “additional, unexpected, independent, and unforeseen happening” and thus an occurrence, the Court held that that they were not:

The complaints allege [defendants] knew that opioids were not suited to treatment of chronic long-term, nonacute pain and knew that opioids were highly addictive and subject to abuse, yet engaged in a scheme of deception in order to increase sales of their opioid products. It is not unexpected or unforeseen that a massive marketing campaign to promote the use of opioids for purposes for which they are not suited would lead to a nation “awash in opioids.” It is not unexpected or unforeseen that this marketing campaign would lead to increased opioid addiction and overdoses. [Defendants] allegedly knew that opioids were highly addictive and prone to overdose, but trivialized or obscured those risks.28 Accordingly, the Court found that the facts alleged in the underlying complaints suggested potential liability based only on defendants’ intentional conduct.29 Thus, the alleged resulting injury did not change the “event” or “occurrence” analysis.30

In addition to its substantive holding, Actavis is noteworthy procedurally. The California Supreme Court conditionally accepted review of the published Court of Appeal decision in Actavis.31 Subsequent to issuing its decision in a somewhat different “occurrence” case, Liberty Surplus Insurance Corp. v. Ledesma and Meyer Construction Co.,32 however, the Supreme Court dismissed its grant of review in Actavis.33 As a result, the Actavis Court of Appeal decision is now final and rather clearly constitutes the controlling law in California (and for policies construed under California law regardless of the coverage litigation venue).

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\textit{Liberty v. J.M. Smith}

In contrast, the court in J.M. Smith applied South Carolina law, and found that the injuries alleged were potentially an “occurrence” under the CGL policies at issue.34 The policies were issued by Liberty Mutual, and included a duty to defend against any suit seeking damages for injury or

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26 Id. at 1040.
27 Id.
28 Id.
29 Id. at 1044.
30 Id.
32 5 Cal. 5th 216 (2018).
33 Traveler’s Property Casualty Company of America v. Actavis, 427 P.3d 744 (Cal. 2018).
property damage resulting from an “occurrence.”  

Under the policies, an “occurrence” was defined as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions,” similar to the policies in Travelers v. Actavis. Since “accident” was not defined expressly in the policies, the Fourth Circuit Court of Appeals was tasked with determining the definition of “accident,” and whether it applied to the conduct or injuries alleged in the underlying complaint.

The court noted that, under South Carolina law, an accident means an “effect which does not ordinarily follow and cannot reasonably be anticipated from the use of those means, an effect which the actor did not intend to produce and cannot be charged with the design in producing.” Unlike California law, then, “accidents require that either the act or the injury resulting from the act be unintentional.”

Turning to the underlying complaint, the court pointed out that the State of West Virginia alleged that drug distributors’ failure to implement sufficient controls and systems breached the duties of care in marketing, promoting and distributing controlled substances. The drug distributors allegedly also breached their duty to guard against third-party misconduct such as that engaged in by so-called “pill-mills.” The court pointed out that the allegations contained “no demonstration of any intent to harm prescription drug users or, through them, the state.” Addressing the complaint’s public nuisance claim, the court likewise said that it alleged “that the defendants knew certain drugs were ones that were abused, and then continued to distribute them without effective – once again, preventable but unintentional harm.” “The simple fact that the alleged injurious action was repeated cannot on its own render the harm outside the policy’s coverage.”

In holding that the underlying complaint was potentially covered, and thus the insurer had a duty to defend, the court found that, although the defendants may not have been adequately careful about whose hands the drugs eventually reached, it did not preclude finding accidental injury where the resulting injury was not specifically intended by defendants.
C. Cincinnati Ins. Co. v. Richie Enters. LLC

In Richie, the court applied Kentucky law and found that there was an occurrence under the applicable policies. The CGL policies were issued by Cincinnati Insurance Co., and provided coverage for claims of bodily injury and property damage if that injury or damage is caused by an “occurrence.” Although the term “occurrence” was defined in the policy as an “accident,” the term “accident” itself was undefined.

The court relied on a Kentucky Supreme Court decision analyzing the meaning of “accident” in a similar CGL policy issued by Cincinnati Insurance Co. In that case, the Kentucky Supreme Court held that the term “accident” must be afforded its ordinary meaning, as the term is not ambiguous and has not acquired a technical meaning in the realm of insurance law under Kentucky law. Under Kentucky law, “the doctrine of fortuity is inherent in the ordinary meaning of the term ‘accident,’” and “[f]ortuity ‘consists of two central aspects’: intent and control.”

Turning to the facts of the case, the court analyzed whether the intent aspect of the fortuity doctrine was met. The drug distributors argued that the underlying complaint was filled allegations and theories of liability that were based in “negligence.” For example, the underlying complaint alleged the drug distributors “knew or should have known” that their products “were not being prescribed and consumed for legitimate medical purposes.” Further, they argued that they distributed their products in response to orders received from pharmacies, and it was a reasonable expectation that the pharmacies would dispense the medications to patients presenting valid prescriptions written by licensed physicians. In contrast, Cincinnati argued that the entire premise of the underlying complaint was that the drug distributors provided excessive amounts of prescription drugs, and because the result of that conduct was entirely foreseeable, the claims in the underlying complaint could not be considered unintentional. The Court found Cincinnati’s argument unpersuasive, and noted that while the underlying complaint included allegations of intentional conduct, it also included allegations of negligent conduct, which could not be ignored. Accordingly,

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47 Id. at *4.
48 Id.
49 Id.
50 Id.
51 Id.
52 Id.
53 Id.
54 Id.
55 Id. at *5.
56 Id.
57 Id.
the found that “with respect to the intent aspect of the fortuity doctrine, the alleged harm can properly be deemed ‘fortuitous,’ an ‘accident,’ and an ‘occurrence.’”\(^{58}\)

Next, the Court considered whether the outcome of defendants’ conduct was “a chance event beyond the control of the insured.”\(^{59}\) The distributors argued that the opioid epidemic was fortuitous because it was beyond its control and, instead, within the control of third persons.\(^{60}\) The distributors contended that they did not intend, and could have reasonably anticipated, that “a criminal collaboration among complicit pharmacies, physicians and patients would produce the ‘effect’ – the addiction and additional medical injuries of patients who procured illegal prescriptions.”\(^{61}\) In response, Cincinnati argued that the epidemic was not fortuitous, because its creation was within the distributors’ control.\(^{62}\) Noting that there were no allegations that the distributors “controlled” the pharmacies or the pharmacists who actually dispensed the drugs, the Court rejected this argument. It found that the fortuity required by Kentucky law was satisfied and thus there was a potentially covered occurrence.\(^{63}\)

### IV. Was Bodily Injury

Another issue in opioid coverage litigation can be whether there is bodily injury alleged within the meaning of the subject policies. The damages alleged in many of the underlying complaints involve purely economic loss, such as increased costs related to public health, medical care, law enforcement, court administration and incarceration.

The Court in *Actavis* broached the issue, but never directly reached it given its holding on whether there was an occurrence.\(^{64}\)

In *J.M. Smith Corp.*, Liberty Mutual raised the issue on appeal. The Court, though, did not address whether the underlying complaint alleged bodily injury as required for coverage under the policy.\(^{65}\)

In *Richie Enters. LLC*, the Court did address the bodily injury issue.\(^{66}\) The insurer argued that coverage did not exist under the policy because West Virginia was only seeking damages for its economic losses – namely, the money it had been required to spend because of the opioid epidemic.\(^{67}\) In response, the drug distributors argued that the underlying complaint sought damages for bodily

\(^{58}\) Id.
\(^{59}\) Id. at *6.
\(^{60}\) Id.
\(^{61}\) Id.
\(^{62}\) Id. at *7.
\(^{63}\) Id.
\(^{64}\) *Actavis*, 16 Cal. App. 5th 1221.
\(^{65}\) See *J.M. Smith Corp.*, 602 Fed. Appx. 115.
\(^{67}\) Id.
injury, as West Virginia’s action was based on the alleged epidemic, and thus the bodily injury of West Virginia citizens. The Court agreed with the drug distributors, and cited specific claims made by the state, such as the need to create a court-supervised fund to mitigate and address “increased susceptibility to death injuries and irreparable harm to the health of abusers and dependent users resulting from their exposure.” The state further claimed that “[w]ithout a court-approved medical treatment monitoring program, the relevant product users will not receive prompt medical care which could detect and prolong their productive lives, increase prospects for improvement and minimize disability.” The court stated that these claims showed “that in addition to seeking damages for economic harm, the State of West Virginia is seeking to recover damages on behalf of its citizens for bodily injury.”

□. **Application of Products Exclusions**

Another issue which has arisen in opioid coverage cases which is whether or not the CGL policies’ products exclusions apply to the damages allegedly caused by the opioid epidemic.

□. **Products Exclusion in Travelers v. Actavis**

As mentioned above, the court in *Travelers v. Actavis* held that the allegations were not potentially covered due to defendants’ intentional conduct. The court went on to hold that the underlying claims also fell within the CGL policies’ products exclusions. These particular products exclusions precluded coverage for bodily injury “arising out of” (Travelers Policies) or that “results from” (St. Paul Policies) “[a]ny goods or products … manufactured, sold, handled, distributed or disposed of” by the defendants. Further, the products exclusions excluded coverage for loss resulting from “[w]arranties or representations made” with respect to “fitness, quality, durability, performance, handling, maintenance, operation, safety, or use of such goods or products.”

The third party losses alleged in the underlying complaints fell into two categories. The first related to the use and abuse of opioid painkillers and included injuries such as overdose, addition, death and long-term disability. The second category related to the use and abuse of heroin, whose resurgence was allegedly triggered by the misuse of opioids. The court noted that under California

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68 Id. at *8.
69 Id.
70 Id.
71 Id.
73 Id.
74 Id.
75 Id. at 1045.
76 Id.
77 Id.
case law, the terms “arising out of” or “arising from” are applied broadly. Instead of importing a strict standard of causation, the terms can broadly link a factual situation with the event creating liability, and connote only a minimal causal connection.

Addressing the first category of injuries, the Court pointed out that the complaints alleged a direct connection between the statements and representations made by defendants in their purported campaign to increase sales of opioids, and the abuse, addiction, death, and other injuries caused by those products. Consequently, the products exclusions applied.

Turning to the second category of third party losses, the court noted that heroin is not a product made or distributed by defendants, “but that fact is not dispositive.” Actavis also argued that the products exclusions applied only to defective products, and no one was suggesting that the defendants’ opioids were defective. The Court, though, rejected these arguments. It held that the products exclusions extended to bodily injury arising out of warranties or representations made by defendants, and the complaints alleged a causal connection between those warranties and representations, and the resurgence in heroin use.

B. Products Exclusion in Travelers v. Anda

In Travelers v. Anda, the Eleventh Circuit similarly addressed whether claims made by the Attorney General of West Virginia against opioid distributors fell within the products exclusions in CGL policies issued by Travelers and St. Paul. In Anda, West Virginia claimed that the opioid distributors “knowingly or negligently flooded the West Virginia market with commonly-abused drugs,” which causes myriad harms such as increased crime, exhaustion of law enforcement resources, congested hospitals and emergency rooms and, and overcrowded jails and prisons. Although the district court did not reach the products exclusions, because it held that no “bodily injury” was alleged, the Eleventh Circuit did not reach the issue of whether the claims in the underlying complaint were “for” or “because of” bodily injury. Instead, the Eleventh Circuit affirmed the district court’s decision on the basis that the products exclusions in the policies precluded coverage for the opioid distributors.

78 Id.
79 Id.
80 Id. at 1046.
81 Id.
82 Id.
83 Id. at 1048-52
84 Id.
85 Id. at 1046.
87 Id. at 957.
88 Id. at 957-58.
89 Id. at 958.
Like the Court in *Travelers v. Actavis*, the Eleventh Circuit applied California law.\(^90\) The Court began by explaining the minimal causal connection needed to satisfy “arising out of” and “results from” under California law.\(^91\) The court turned to the allegations – that the distributors had so flooded the market with their products that West Virginia suffered from an opioid epidemic.\(^92\) In turn, as a result of that epidemic, West Virginia had suffered monetary losses that it sought to recover.\(^93\) The Court held that this causal connection between the distributors’ products and the injuries alleged was sufficient to meet the threshold set by California law.\(^94\) The Court further stated that its holding was consistent with a previous Eleventh Circuit ruling applying Florida law in the context of a products exclusion.\(^95\) Accordingly, the Eleventh Circuit affirmed the district court’s decision, and held that there was no coverage under the policies for the opioid distributors.\(^96\)

C. Jurisdictions Limiting Products Exclusions to Defective Products

In contrast to *Actavis*, some courts have found that products exclusions are limited to *defective* products.

In *Taurus Holdings, Inc. v. U.S. Fidelity and Guar. Co.*, for example, the Florida Supreme Court was faced with the question of whether the products exclusion in a gun manufacturer’s CGL policies applied to lawsuits filed by municipalities seeking to recover the cost of medical and other services incurred as a result of gun violence in their communities.\(^97\) The provision excluded from coverage “all bodily injury and property damage occurring away from the premises you own or rent and arising out of your product or your work.”\(^98\) The primary issue facing the Court was the meaning of “arising out of.”\(^99\) The gun manufacturer argued that a majority of courts around the country have interpreted products exclusions to exclude coverage only for *defective* products.\(^100\) Despite the fact that the court rejected this argument, and held that the products exclusion applied to the claims made against the gun manufacturers, the court recognized that the split of authority existed.\(^101\)

For instance, in *Viger v. Commercial Ins. Co. of Newark, N.J.*, the Third Circuit stated that “[w]hen the alleged failure to warn is unrelated to sale of a defective product,” product exclusions are

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\(^90\) *Id.*

\(^91\) *Id.*

\(^92\) *Id.*

\(^93\) *Id.*

\(^94\) *Id.* at 958-59.

\(^95\) *Id.* at 959.

\(^96\) *Id.*

\(^97\) *Taurus Holdings, Inc. v. U.S. Fidelity and Guar. Co.*, 913 So.2d 528, 530 (Fla. 2005).

\(^98\) *Id.* at 531.

\(^99\) *Id.* 532-38.

\(^100\) *Id.* at 537.

\(^101\) *Id.*
Although the court in Viger found that the product was defective, and thus coverage was precluded, the court noted that a failure to warn claim will fall outside of a products exclusion where it “is based on something other than a defect in the product sold by insured.”

In Chancler v. American Hardware Mut. Ins. Co., the Idaho Supreme Court held that an injury based on a failure to warn, as opposed to strict products liability, was outside of the relevant products exclusion. The action was brought by an individual who was injured when a modification to a crane purchased from the insured collapsed, and the insured had provided no safety information to the buyer regarding the modification. The insured tendered the complaint to its liability insurer, who asserted exclusions in the policy and refused to defend. The products exclusion precluded “bodily injury and property damage arising out of the named insured’s products or reliance upon representation or warranty made at any time with respect thereto.” The court determined that the products exclusion “was only intended to avoid claims based in strict products liability.” It noted that the products exclusion precluded coverage only for injury “arising out of the named insured’s products,” and that nowhere did it purport to exclude injuries arising out of negligent conduct. Although the injury occurred when the modification collapsed, the court opined that it was the insured’s failure to provide information that caused the injury. If the parties “intended to limit the liability of the insurer by excluding coverage for omissions and failure to warn when there is no affirmative duty to warn, the insurer could have so provided.” The products exclusion thus did not preclude coverage under the policy.

In American Trailer Service, the Minnesota Court of Appeals was faced with a similar situation. In that case, defendant was sued for failing to provide installation instructions for a fifth wheel assembly sold to a trucking company. The fifth wheel assembly broke after installation, and caused injury. The defendant tendered the complaint to its insurer, which refused to defend and indemnify based on the policy’s products exclusion. In analyzing the term “arising out of,” the court stated that under Minnesota law, it means “originating from, having its origin in, growing out of, or

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103 Id.
105 Id. at 544.
106 Id.
107 Id. at 545.
108 Id. at 546.
109 Id. at 548.
110 Id. at 549
111 Id.
112 Id.
114 Id. at 919.
115 Id.
116 Id.
flowing from.”117 “In other words, there must be a causal connection between the damage sustained and the product sold.”118 Noting that no illegal sale or defective product was alleged, it concluded that the products exclusion was not applicable because “liability arose out of its negligence in failing to provide assembly instructions and not out of the product sold.”119 The court opined that were negligence based on “defective design or workmanship,” the products exclusion would preclude coverage.120 Because the injury was not caused by a defective product, the Minnesota Court of Appeals held that the products exclusion did not preclude coverage.121

II. Conclusion

The growth and impact of the opioid epidemic has resulted in a rise in opioid-related liability insurance litigation, which has presented traditional coverage questions with respect to new fact patterns. As illustrated above, the question of whether there is a potential for coverage and whether insurers have a duty to defend depends on the specific allegations made, the policy language, what state law controls, and whether there are specific provisions, such as a products exclusion, which may preclude coverage.

117 Id.
118 Id.
119 Id.
120 Id. at 921
121 Id.
Appellant challenges the district court’s order denying its motion for a new trial, arguing that: (1) the district court erred in refusing to set aside the jury’s special-verdict finding that the respondent was not in breach of contract, (2) the district court erred in
refusing to set aside the jury’s special verdict finding that appellant was in breach of the implied covenant of good faith and fair dealing, (3) the district court’s instructions were substantially prejudicial, and (4) the district court’s evidentiary rulings were an abuse of discretion. We affirm.

FACTS

Appellant Western National Mutual Insurance Company (Western National) sold three workers’ compensation insurance policies to respondent Prospect Foundry (Prospect) between 2011 and 2014. Each policy included a plan where Prospect’s premiums could be returned as a dividend if a certain loss-ratio was met. The loss-ratio was determined on June 1 of the following year, ten months after the final date of each policy.

In the spring of 2013, Prospect’s president discussed the 2011-2012 policy’s claims with John Mares, Western National’s insurance agent. Prospect’s president later testified that Mares said there were still two open claims under the policy, but they would be closed by June 1. If these claims had closed before June 1, 2013, Prospect would have received a dividend for the 2011-2012 policy.

But Prospect did not receive a dividend and when Prospect’s president asked Mares why, Mares replied that Prospect’s loss-ratio was too high. Prospect looked into the matter and discovered that the two claims were still open. When asked why these claims did not close in time, Mares said the person in charge of adjusting the claims was on vacation.

In addition, Prospect believed that it was never paid a dividend for the 2012-2013 policy. Similarly, Prospect disputed Western National’s dividend calculation with respect
to the 2013-2014 policy. Western National also asserted that Prospect owed money for unpaid premiums.

Western National eventually sued Prospect for breach of contract. Prospect counterclaimed, alleging that Western National breached its contract and violated the implied covenant of good faith and fair dealing. Before trial, Western National objected to the district court’s proposed jury instructions concerning the implied covenant of good faith and fair dealing, proposing its own version of the instruction. The district court determined that Western National’s proposed instruction did not “accurately reflect the current state of the law” and instead supplied its own version of the instruction.

The jury found that, (1) Prospect did not breach its contracts with Western National; (2) Western National breached its contracts with Prospect, but Prospect was not entitled to damages; and (3) Western National violated the implied covenant of good faith and fair dealing, and Prospect was entitled to $53,300 in damages. Although the jury found that Prospect did not breach its contracts with Western National, when confronted with the special verdict’s question asking how much money Western National should be awarded in damages for Prospect’s breach, the jury answered $101,407.64.

The district court entered judgment in favor of Western National in the amount of $101,407.64 and in favor of Prospect in the amount of $53,300. Western National moved for a new trial and alternatively for judgment as a matter of law. Prospect moved to amend or correct the district court’s judgment, arguing that the jury did not intend to award Western National any damages.
The district court denied Western National’s motions but granted Prospect’s motion. The district court found that the jury appropriately followed the verdict form’s instructions by awarding a hypothetical judgment but the jury “did not intend for the Court to grant the amount to [Western National] in an award.” The district court vacated its judgment in favor of Western National and entered judgment only in favor of Prospect for $53,300. This appeal followed.

**DECISION**

Western National argues that the district court erred by declining to set aside the jury’s findings that Prospect did not breach its contracts and that Western National breached the implied covenant of good faith and fair dealing. “An answer to a special verdict question should be set aside only if it is perverse and palpably contrary to the evidence, or where the evidence is so clear as to leave no room for differences among reasonable persons.” *Moorhead Econ. Dev. Auth. v. Anda*, 789 N.W.2d 860, 888 (Minn. 2010) (quotation omitted). “The test is whether the special verdict answers can be reconciled in any reasonable manner consistent with the evidence and its fair inferences. If the answers to special verdict questions can be reconciled on any theory, the verdict will not be disturbed.” *Dunn v. Nat’l Beverage Corp.*, 745 N.W.2d 549, 555 (Minn. 2008) (quotations and citation omitted). “Review [of a special verdict] is particularly limited when the jury finding turns largely upon an assessment of the relative credibility of witnesses whose testimonial demeanor was observed only by the jury and the [district] court and the latter has approved the findings made.” *Kelly v. City of Minneapolis*, 598 N.W.2d 657, 662-63 (Minn. 1999).
Breach of Contract

Western National argues that the jury’s special verdict finding that Prospect did not breach its contacts was against the greater weight of the evidence, and the district court erred by not setting aside the verdict. Specifically, Western National argues that Prospect’s own statements acknowledge that it breached the insurance contracts. Generally, a party who first breaches a contract cannot use the other party’s later breach to avoid liability. *Space Ctr., Inc. v. 451 Corp.*, 298 N.W.2d 443, 451 (Minn. 1980). Here, the district court acknowledged evidence that Prospect stopped paying its premiums, but wrote that the jury found that Western National breached first by failing to close the two open claims and failing to pay Prospect its due dividend. On that basis, the district court concluded that the jury’s finding was consistent with the evidence and declined to set aside the jury’s answer on the special-verdict form.

Western National challenges the district court’s reasoning, arguing that there were three separate insurance contracts spanning policy terms from 2011-2014 and that it was only suing Prospect for breach of the last two contracts, not the first. Western National claims that it “was not in breach in respect to either the second or third insurance contracts

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1 Western National also argues that the jury intended to award it $101,407.64 in damages for its breach-of-contract claim against Prospect, and the district court erred by interpreting that award as hypothetical. However, the jury clearly found that Prospect did not breach its contracts with Western National. The third question on the special verdict form then asked how much money would compensate Western National for its damages “regardless of your answers to the previous questions.” Even though the jury responded with $101,407.64, based on the language of the question, we conclude that the jury intended to respond with what Western National would have won if it had prevailed on its breach-of-contract claim.
and sought only to enforce Prospect’s premium payment obligations under those policies,” and that “any claimed breach of the first [contract] is no justification for Prospect’s failure to pay the full amounts owed for the second and third policies.” Prospect counters that evidence introduced at trial demonstrated that Western National breached all three contracts. For instance, Prospect claims that it introduced evidence at trial that Western National did not pay Prospect promised credits for the 2012-2013 and 2013-2014 policies, that Western National did not pay the correct dividend for the 2012-2013 policy, and that Western National impermissibly changed the amount of premiums Prospect allegedly owed for the 2013-2014 policy—including demanding a new number the day before trial—in violation of the agreement.

We conclude that the record contains evidence demonstrating that Western National breached all three contracts. This court should set aside the jury’s special-verdict answers only if its decision cannot be reconciled on any theory. Dunn, 745 N.W.2d at 555. Because the jury’s verdict may be reconciled with Prospect’s evidence showing that Western National breached all three contracts, we will not set aside the jury’s special-verdict finding that Prospect was not in breach.²

² Western National also argues that the verdict should be set aside because the jury was never instructed that an initial breach by Western National could excuse subsequent breaches by Prospect. Again, we will not disturb a jury’s special verdict if it can be reconciled on any theory. Dunn, 745 N.W.2d at 555. Only when it is clear that findings cannot be reconciled should the verdict be set aside. Nihart v. Kruger, 291 Minn. 273, 276, 190 N.W.2d 776, 778 (1971). Because the jury’s verdict may be reconciled with the theory that Western National breached each contract prior to any subsequent breach by Prospect, we will not disturb the verdict.
Implied Covenant of Good Faith and Fair Dealing

The jury also determined that Western National breached the implied covenant of good faith and awarded Prospect $53,300 in damages. Minnesota law recognizes the implied covenant of good faith and fair dealing in most contracts, including insurance contracts. *Columbia Cas. Co. v. 3M Co.*, 814 N.W.2d 33, 36 (Minn. App. 2012), *review denied* (Minn. June 19, 2012). The implied covenant requires that “one party not unjustifiably hinder the other party’s performance of the contract.” *In re Hennepin Cty. 1986 Recycling Bond Litig.*, 540 N.W.2d 494, 504 (Minn. 1995) (quotation omitted). “To establish a violation of this covenant, a party must establish bad faith by demonstrating that the adverse party has an ulterior motive for its refusal to perform a contractual duty.” *Minnwest Bank Cent. v. Flagship Props. LLC*, 689 N.W.2d 295, 303 (Minn. App. 2004). “Actions are done in good faith when done honestly, whether it be negligently or not.” *Prairie Island Indian Cmty. v. Minn. Dep’t of Pub. Safety*, 658 N.W.2d 876, 889 (Minn. App. 2003) (quotation omitted).

The district court upheld the jury’s special verdict based on four main pieces of evidence. First, Prospect’s president testified that an agent for Western National told him that the two open claims would be resolved and closed, resulting in Prospect receiving a dividend. Second, Prospect’s president testified that the same agent told him that the two claims were not closed in time because the adjuster in charge of them was on vacation. Third, Prospect’s expert witness testified that one of the claims should have been closed before the policy period ended, something a claims supervisor at Western National also conceded at trial, and that the reserves on the other open claim were significantly
overstated. And fourth, Prospect’s president testified that he had trouble understanding how Western National arrived at its numbers, and even Western National’s vice president testified that his numbers were fluctuating and the calculations he approved yielded different numerical outcomes. While Western National’s witnesses disputed some of this evidence, the district court concluded that the jury found Prospect’s witnesses more credible.

We believe the district court did not err in upholding the jury’s special verdict. Again, we must determine if the jury’s special verdict can be reconciled in any reasonable manner with the evidence and fair inferences, and under any theory. Dunn, 745 N.W.2d at 555. This court’s review is also “particularly limited” in this instance, because the jury’s finding “turns largely upon an assessment of the relative credibility of witnesses . . . .” Kelly, 598 N.W.2d at 662. Here, the jury reconciled conflicting testimony in favor of Prospect’s witnesses, and given the evidence of Western National’s fluctuating numbers and questionable statements from its representatives, it was reasonable for the jury to conclude that Western National unjustifiably hindered the contracts and acted in bad faith. Given the evidence, we conclude that the district court did not err in refusing to set aside the jury’s special verdict.

**Jury Instructions**

Western National argues the district court’s jury instruction regarding the implied covenant of good faith and fair dealing was incomplete and unduly prejudicial. “The district court has broad discretion in determining jury instructions and we will not reverse in the absence of abuse of discretion.” Hilligoss v. Cargill, Inc., 649 N.W.2d 142, 147
If the instruction destroys the substantial correctness of the charge as a whole, causes a miscarriage of justice, or results in substantial prejudice, the error requires a new trial. *Lindstrom v. Yellow Taxi Co. of Minneapolis*, 298 Minn. 224, 229, 214 N.W.2d 672, 676 (1974). A new trial is also required if the instruction was erroneous and its effect cannot be determined. *Lieberman v. Korsh*, 264 Minn. 234, 242, 119 N.W.2d 180, 186 (1962).

The district court’s instruction read as follows:

Under Minnesota law, every contract includes an implied duty of good faith and fair dealing. Acting in good faith means a person acts honestly in performing this part of the contract, whether it be negligently or not.

Western National Mutual Insurance Company has a duty to act in good faith in the calculation of Prospect Foundry’s entitlement [to] dividend payments.

By contrast, Western National’s proposed instruction read:

Under Minnesota law, every contract includes an implied covenant of good faith and fair dealing requiring that one party not unjustifiably hinder the other party’s performance of the contract. Actions are done in good faith when done honestly, whether it be negligently or not. Actions are done in bad faith when a party’s refusal to fulfill some duty or contractual obligation is based on an ulterior motive, not an honest mistake regarding one’s rights or duties.

Western National argues that the district court’s instruction was misleading because it did not mention that the implied covenant requires that the violating party, with an ulterior motive in mind, unjustifiably hindered or obstructed the other party’s performance. But the district court determined that Western National’s instruction was too restrictive and cited to the Restatement (Second) of Contracts for the idea that “evasions of the spirit of
the bargain, lack of diligence and slacking off, willful rendering of imperfect performance, abuse of power to specify terms, and interference with or failure to cooperate in another party’s performance” also qualify as violations of the covenant. *See* Restatement (Second) of Contracts § 205 cmt. d (1981).³

The instruction preserved the substantial correctness of the charge and did not result in a miscarriage of justice such that it affected “the fairness, integrity or public reputation of judicial proceedings.” *State v. Kelley*, 855 N.W.2d 269, 279 (Minn. 2014) (quotation omitted). And while Prospect prevailed on its claim, that is insufficient to conclude that Western National was substantially prejudiced by the instruction. Because the district court’s instruction was not erroneous or prejudicial to Western National, we conclude that the district court did not abuse its discretion.

**Evidentiary Rulings**

Western National argues that it is entitled to a new trial because the district court improperly admitted the hearsay statements of its insurance agent, John Mares. The district court has broad discretion on evidentiary matters and this court will not disturb its ruling “unless it is based on an erroneous view of the law or constitutes an abuse of discretion.”

³ Minnesota’s appellate courts have not settled whether the state’s common law limits an implied-covenant claim only to the unjustifiable hindrance of performance or if this claim could include the behaviors in Section 205, comment d, of the Restatement (Second) of Contracts. *See Columbia Cas. Co.*, 814 N.W.2d at 40 (declining to determine whether a claim under the implied covenant of good faith and fair dealing is limited to unjustifiable hindrance). “Restatements of the law are persuasive authority only and are not binding unless specifically adopted in Minnesota by statute or case law.” *Williamson v. Guentzel*, 584 N.W.2d 20, 24 (Minn. App. 1998), *review denied* (Minn. Nov. 24, 1998). Minnesota has not adopted this part of the Restatement (Second) of Contracts in statute or in caselaw, but we find its guidance persuasive.
Kroning v. State Farm Auto. Ins. Co., 567 N.W.2d 42, 45-46 (Minn. 1997). “Entitlement to a new trial on the grounds of improper evidentiary rulings rests upon the complaining party’s ability to demonstrate prejudicial error.” Id. at 46 (quotation omitted).

Western National argues that the district court abused its discretion by permitting Prospect’s president to testify about statements made by Western National’s insurance agent, John Mares, that the two open claims would be closed, which would have entitled Prospect to a dividend. The district court determined that Mares was a broker for Western National and was therefore Western National’s agent. Because Mares was an agent, the court concluded that his hearsay statements were admissible as statements of a party opponent. See Minn. R. Evid. 801(d)(2). Western National argues that because Mares had no authority to determine when and how claim reserves were established, he was not an agent for the purposes of the hearsay analysis.

In the past, Minnesota distinguished between insurance agents and insurance brokers for principal-agent analysis. See Eddy v. Republic Nat’l Life Ins. Co., 290 N.W.2d 174, 176 (Minn.1980) (stating that the essence of the difference between agents and brokers is that an insurance agent acts on behalf of a particular insurance company, whereas an insurance broker acts on behalf of the prospective insured). However, a Minnesota statute now states that “[a] person performing acts requiring a producer license . . . is at all times the agent of the insurer and not the insured.” Minn. Stat. § 60K.49, subd. 1 (2016); see also Graff v. Robert M. Swendra Agency, Inc., 800 N.W.2d 112, 118 n.5 (Minn. 2011) (stating that although Minnesota law previously recognized a distinction between agents and brokers, that distinction “appears to have been superseded by statute.”). One such act
is negotiating insurance. Minn. Stat. § 60K.32 (2016). And negotiating insurance is specifically defined as “conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.” Minn. Stat. § 60K.31, subd. 12 (2016).

Western National and John Mares’s brokerage company had an agency agreement giving him some authority to act and speak on Western National’s behalf. Specifically, the agreement gave brokers the authority to provide “all usual and customary services of an insurance agent on all insurance contracts placed by the Agent with the [Western National].” A Western National employee testified that all communications between Western National and Prospect flowed through John Mares’s company and that one of the services the company provides is communicating about claims between policyholders and Western National. The scope of this relationship was supported by Prospect’s expert witness who testified to his understanding that policyholders take what an insurance agent tells them as a communication from the insurance company itself.

Based on this evidence, we conclude that the district court had sufficient grounds to treat John Mares as being “authorized by [Western National] to make a statement concerning” the open claims to Prospect, or—at minimum—was making a statement concerning a matter within the scope of the agency or employment, either of which would qualify as a party-opponent statement. See Minn. R. Evid. 801(d)(2)(C)-(D). The district
court did not abuse its discretion by admitting testimony about statements made by Western National’s agent.

**Affirmed.**
NO. A17-0992

State of Minnesota
In Court of Appeals

Western National Mutual Insurance Company,
Appellant,

vs.

Prospect Foundry, LLC,
Respondent.

RESPONDENT’S BRIEF AND ADDENDUM

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STATEMENT OF ISSUES

(1) Did the Trial Court correctly deny Western’s motion for judgment as a matter of law in light of the Jury’s Special Verdict finding on Prospect’s claim for breach of the implied covenant of good faith and fair dealing?

Trial Court held: In the affirmative. See Add. 27-29.

**Apposite Authorities:**

Hanks v. Hubbard Broadcasting, Inc., 493 N.W.2d 302, 309
The Restatement (Second) of Contracts § 205

(2) Did the Trial Court correctly find that evidence supported the Jury’s finding of no breach of contract by Prospect?

Trial Court Held: In the affirmative See Add 23-25.

**Apposite Authorities:**

Hauenstein v. Loctite Corp., 347 N.W.2d 272, 275 (Minn. 1984)
Nihart v. Kruger, 190 N.W.2d 776, 778 (Minn. 1971)
Space Center, Inc. v. 451 Corp., 298 N.W.2d 443, 451 (Minn. 1980)

(3) Did the Trial Court property deny Western’s motion for new trial based upon the evidence and record in this case and the Jury’s Special Verdict findings?

Trial Court Held: In the affirmative. See Add 13-22.

**Apposite Authorities:**
Minn. R. Evid. 801(d)(2).
Minn. Stat. § 60K.49
STATEMENT OF THE CASE

This case involves the payment of premiums, and the return of premiums in the form of dividends and credits, under workers compensation policies issued by Appellant, Western National Insurance Company, to Respondent, Prospect Foundry, LLC for the years 2011-2012 ("2011 policy"), 2012-2013 ("2012 policy"), and 2013-2014 ("2013 policy"). Under the policies, ten months after each policy year closed (here June 1), the parties would look at open claims and reserves and determine a loss ratio. If the loss ratio was low enough, Prospect would be entitled to a return of premium in the form of a dividend. For years, Prospect called the insurance agent in April or May, and the agent would let them know the amount of the expected dividend, if any. Invariably, Prospect received a dividend consistent with that communication. A similar call occurred in April 2013 for the 2011 policy, but come June, Prospect didn’t receive its expected dividend. Prospect was told that contrary to the agent’s earlier representations, one claim wasn’t closed, and the reserves on another were not reduced until three days later, on June 4, 2013. Therefore, according to Western, Prospect was not entitled to the dividend. No reasonable explanation was provided for the failure to timely adjust the two claims.

Prospect worked with Western for years in an attempt to resolve the dispute, but kept receiving changing information from Western, including ever-changing “audited” premium numbers. Those ever-changing numbers hindered Prospect’s ability to determine its premium and made it impossible to perform under the policies. During these negotiations, and due to Western’s changing positions, Prospect became arrears in its premiums. In an attempt to resolve the matter, in October 2015 Prospect made a good
faith calculation of the dividend and premiums owed, and sent a check to Western for $86,653.64. Western held that check without cashing it for three months, and then sued Prospect for breach of contract, returning the check on January 26, 2016. Prospect counterclaimed for breach of contract and the implied covenant of good faith and fair dealing.

The matter was tried in Hennepin County District Court before the Honorable Michael Browne. On January 18, 2017, the jury returned a special verdict finding that Prospect had not breached the insurance contracts, but as instructed, regardless of the finding of liability, entered $101,407.64 as the amount that would fairly and adequately compensate Appellant for its damages. Conversely the jury found that Western did breach the insurance contracts, that the breach directly caused Prospect Damages, but entered $0.00 as the amount that would fairly and adequately compensate Prospect for breach of contract. Finally, the jury found that Western had breached the implied duty of good faith and fair dealing, the breach directly caused damages, and that $53,300 would fairly and adequately compensate Prospect. On January 24, 2017, The Trial Court initially entered judgment in favor of Appellant for $101,407.64 and Respondent in the amount of $53,300. After post-trial motions, on June 15, 2017, the Court amended the judgment, removing the judgment in favor of Appellant. Appellant filed this appeal on June 28, 2016.
STATEMENT OF FACTS

I. The Workers Compensation Policies Issued to Prospect

At issue in this case are three workers compensation insurance policies issued by Appellant to Prospect for the periods of August 1, 2011 to August 1, 2012 (the “2011 policy”) (Ex. 200); August 1, 2012 to August 1, 2013 (the “2012 policy”) (Ex. 201); and August 1, 2013 to August 1, 2014 (the “2013 policy”) (Ex. 202). On the special verdict form, which on this issue was agreed to by the Appellant, the three policies were treated together as one, and not separated. Add.7, T. 627, Ins. 17-19 (when addressing the special verdict form, Mr. Martin, counsel for Appellant, stated: “All right. Then, I guess we can do that collectively. I’m okay with referencing 2011-2014.”).1 T.627. Each of the policies included a plan where premiums could be returned in the form of a dividend if a certain loss-ratio was met. (Dividend Plan B for the 2011-12 policy, and Dividend Plan A for the 2012-13 and 2013-14 policies) (Ex. 200, at PROSPECT 00244; Ex. 201, at PROSPECT 00281; Ex. 202, at PROSPECT 00317). The loss ratio was determined ten months following the last date of each policy (June 1) and was based upon the audited premium paid, less certain fixed expenses, divided by adjusted incurred losses. (Id.; T.117-119 ; T.380-381; T.397-398). It is noteworthy that Western had issued Prospect workers compensation insurance going back to at least 2009. T.379-380.

Mr. Carlson, Prospect’s President, had oversight over premiums and dividends relating to the workers compensation policies issued by Western. T.376, 379. Mr.

1 In fact, the policies were treated so interchangeably by Appellant, that it didn’t even put the 2013-2014 policy (Exhibit 202) into the record before resting its case in chief, a fact that Respondent pointed out it its motion for directed verdict. T.365-368.
Carlson’s education included working in public accounting and earning a Certified Public Accountant designation. T.377. In the two years leading up to the 2011 policy, the first at issue here, in April or May of each year, Mr. Carlson would work with the insurance agent of Western, and discuss the open claims to make sure they were properly reflected on the claim close date. T.381. Furthermore, before coming to Prospect, Mr. Carlson was in charge of workers compensation insurance for prior employers going back at least eighteen years. Id. In those years he would work with the insurance agent in the months before the closing date to make sure all parties agreed on the valuation. T.382. In each of those years, he dealt with the insurance agent, and what the insurance agent told him with respect to loss reserve and payment of dividends would come to pass. T.382-383.

II. **The 2011 Policy and Western’s Breach by Failing to Close the Eiola Claim and Reduce Reserves on the Anderson Claim**

The process surrounding the claim close date of June 1, 2013 (for the 2011 policy) began like it had for every other year, with Mr. Carlson having a discussion with the agent in April or May of 2013. T.385. At that time, Mr. Carlson was told there were two open claims (the Jason Eiola and Robert Anderson claims) that would be closed by June 1, 2013. T.387. Shortly after June 1, when no dividend was returned, Mr. Carlson asked the agent why, and the agent who reported that the loss ratio was too high. Id. When Mr. Carlson reviewed the loss runs, he discovered that the two claims that he was told would be closed were, in fact, still open as of June 1, 2013. Id. When he followed up, he discovered that the two claims were not closed or the reserves reduced, until June 4, 2013. T.388.
How these two claims were treated is important because they would determine whether Prospect was entitled to a dividend. The final audited premium for the 2011 policy year was $799,666. Ex. 203A at PROSPECT 00127; T.393-393. Subtracting out the Special Compensation Fund Assessment of $49,153, the WCRA Assessment of $9,626, and the Terrorism insurance fee of $3,171, results in a net premium of $737,716. Id., at PROSPECT 00125,00127; T.393-394. Without applying the reductions for the Eiola and Anderson claims, Prospect’s incurred losses were $385,020, (with $127,757 relating to the Eiola and Anderson claims) yielding a loss ratio of just over 52%. See Ex. 203; T.394-395. However, the hold-backs and reserves for these claims were reduced by $67,300 as of June 4, 2013, leaving $59,758.91, and then to zero as of December 31, 2013. Ex. 203A at PROSPECT 00130, T.395-397. Had the reserves for the Eiola and Anderson claims been properly closed on June 1, 2013, Prospect would have been owed a dividend of $95,903. T.397, Ex. 203.

A. The Eiola Claim

In fact, had just the Eiola claim been closed on time (and even Western conceded that the reserve was too high on Eiola (Appellant’s Brief at 6, citing to T.332)), Prospect would have been entitled to a dividend. T. 400-402. Western points to the testimony of one of its supervisors, Ms. Beese, that it was reasonable to keep a reserve open for the Eiola claim of $10,000 because of the possibility of future medical treatment. Appellant’s Brief at 6. However, that position is entirely inconsistent with the evidence submitted in Western’s own claims records that show that there was a stipulated resolution of the Eiola claim on March 25, 2013, including medical for his shoulder, and
that an April 12, 2013 entry in Western’s claims notes state that they can probably close the file. T.219-222, Ex. 233 at April 12, 2013 entry. An additional entry for April 3, 2013 in a separate Eiola claim file (thumb) also reflects the March 25, 2013 award, with a “pay by” April 8, 2013 date. T.223, Ex. 232 at April 3, 2013 entry. It goes on to state “Award paid and NOBP filed Review for closure next diary date.” E.232 at April 4, 2013 entry.

The fact that these entries are contained in Mr. Eiola’s file in early to mid-April is important. Mr. Ellefson, Western’s Vice President, acknowledged that Western had an internal policy to adjust claims within five days of receiving data that warrants change. T. 225. Incredibly, Ms. Brophy, the claims handler assigned to handle Prospect’s claims was completely unaware of this five-day adjustment requirement:

Q: Mr. Ellefson had testified earlier. You weren’t here for that, but Mr. Ellefson testified that Western National had a policy that claims should be adjusted, workers’ compensation claims should be adjusted within five days of receipt of data on the claim that warrants a change. Are you aware of a policy like that?

A: No.

Q: You were never told that policy?

A: No.

Q: So, you didn’t institute that policy?

A: I’m unaware of that policy.

T.312. Ms. Brophy’s supervisor, Margaret Beese, testified that she was surprised by the fact that Ms. Brophy was unaware of the five-day policy to adjust claims. T.344. Ms.
Brophy was also unaware of what Mr. Ellefson testified was a “generally good practice” of indicating the amount of any change in reserves in claim notes. T.238, 318. Finally, Ms. Brophy testified that she was never informed by Western that resolution of claims in a quick manner is important to policyholders because it could affect their entitlement to dividends. T.313.

The loss reserves for Mr. Eiola were reduced to $0 on June 4, 2013, and no explanation was provided as to why June 4 was any different than June 1, other than the fact that on June 4 the claims handler received a call from the insurance agent about the separate Anderson claim. See Ex. 203A at PROSPECT 00130, T.388-389; Ex. 208 at WN000075, entry for June 4, 2013; T.262. Even the supervisor at Western, Margaret Beese, admitted that at least $7,500 that had been reserved on the Eiola claim should have been reduced before the June 1 cutoff date. T.350.

Prospect’s expert, Mike Baumann, an insurance agent from Arthur Gallagher & Company, testified that the Eiola claim should have been closed before June 1, 2013. T.513. The evidence here clearly supported the jury finding that the Eiola claim should have been closed as of June 1, 2013, entitling Prospect to a premium dividend.

B. The Anderson Claim

The Anderson claim is a bit different because, unlike Eiola, it was not completely settled prior to the claim close date of June 1, 2013. Mr. Anderson had work-related issues with each of his thumbs. Because of this, Western had set high reserves relating to each thumb. However, Mr. Anderson had surgery on his left thumb in June of 2012, a full year before the claim close date, and he returned to work on June 26, 2012, and had a
full release on that thumb as of August 13, 2012. T.226-228, Ex. 208 at WN000078, February 8, 2013 entry. Western’s Vice President, who was handling negotiation of the outstanding dividend, did not follow up with the claims handler to determine if the partial permanent disability reserve still being held as of February 8, 2013 was appropriate. T. 230-231. Prospect’s expert, Mike Bauman, testified that the reserve was quite high. T.514-515. Additionally, the claim notes show that Mr. Anderson had surgery on his second thumb on February 6, 2013, and returned to work on February 18, 2013. T.233, Ex. 208 at WN000077-78, February 26, 2013 entry. What is important is that in April 2013, nearly two months before the claim close date, Western’s claims handler, Janet Brophy, had conversations with the agent about whether the reserves could be lowered and whether Prospect would accommodate Mr. Anderson. Ex. 208 at WN000077. Ms. Brophy indicated that if an accommodation could be made, it would affect her assessment of reserves. T.314; Ex. 208 at WN000077, April 22, 2013 entry. In April or May of 2013, the president of Prospect gave that very assurance:

Q: An just so there’s no question, Mr. Carlson, in April or May of 2013, were you contacted by Marsh McLennan and asked the question whether Mr. Anderson there would be a position for him even with restrictions?

A: Yes.

Q: And what was your response to that?

A: Yes. Basically, my response - - he had been a long-term employee. He was second generation, and he had his third generation working there. Out of loyalty, yes, we would have found a home no matter what, either in a supervisory position or some sort of former fashion to meet restrictions or ongoing.
T.496-497.

Prospect’s expert, Mike Baumann, testified that the reserves for Mr. Anderson, were quite high and should have been lower. T.514-515. He further testified that it would have been reasonable for an agent to represent that the claim be closed, or that the reserves be significantly reduced. T.516. Again, the evidence clearly supports a finding that significant reductions should have been made to the Anderson Claim reserves that were not timely made by Western.

C. The Representations of Western’s Actual Agent

Appellant argues that it was error for the Court to allow Prospect’s President, Darrin Carlson, to testify about representations that were made by the Marsh McLennan Insurance Agency, and specifically John Mares, and that the communications of Mr. Mares should not be binding on Western. However, Western conveniently ignores several important facts. First, Western and Marsh McLennan had an agency agreement imbuing Marsh and John Mares with actual authority. Ex.251. The agreement (executed by Marsh’s predecessor, Russell-Jeatran-Fleming Agencies, Inc.) specifically enumerates the agent’s authority as including authority to “Provide all usual and customary services of an insurance agent on all insurance contracts placed by the Agent with the Company.” Id. at pg. 1. Western’s Vice President, Eric Ellefson, testified that all of the communications between Prospect and Western flowed through the agent, that Marsh placed all of the policies at issue in the case, and that one of customary services that an
insurance agent provides is communications about claims between the policyholder and
the insurance company. T.166-167.

Prospect's expert witness, Mike Baumann an insurance agent from Arthur J.
Gallagher & Company, confirmed this evidence. At trial, the following testimony was
uncontroverted:

Q: Do you make communications about claims to policyholders?
A: Yes. We do communicate information regarding claims on behalf of
the carrier to the policyholder.

Q: Do you understand whether policyholders, whether or not they rely
on those communications?

* * *

A: It is my understanding that my client takes what I tell them about my
conversations with the insurance company as to be a communication
that is from the insurance company.
T.506-507.

Given this authority to communicate on behalf of Western, the communications of
Marsh are particularly important here. Mr. Carlson, the President of Prospect, had been
handling workers compensation insurance for at least eighteen years. T.381. In those
years, he worked with similar dividend plans, and would have communications with the
insurance agents two or three months before the claim close dates to discuss which claims
would be closed and which would be reduced. Id. The insurance agent would represent
what the valuations would be, and what the proper reserves would be. T.382. In all the
years he had been doing this, Mr. Carlson had been able to, and did, rely on the
representations of the insurance agent, including policies with Western in 2009 and 2010.
T.380, 382-384. Mr. Carlson testified that the Marsh agent told him that the Eiola and Anderson claims would be closed. T.386-387.\textsuperscript{2} Given the history of interaction between Prospect and Western through that insurance agent, it was a further breach of the policies for Western to fail to close the Eiola and Anderson claims as represented by their agent in fact.

III. **The 2012 Policy and Western’s Breach, and Hindrance of Prospect, by Failing to Provide Promised Premium Reductions and Paying the Promised Dividend**

Western claims that the only evidence of its breach is its failure to close the Eiola and Anderson claims and provide a dividend under the 2011 policy. However, the evidence at trial also demonstrated breach of the 2012 policy. Specifically, Prospect was promised a credit of $18,053 based upon the reclassification of a number of Prospect’s workers. T.403-404. Importantly, when Western agreed to the $18,053 credit, it was part of a normal back and forth between the policyholder and Western, and the reduction was not conditioned on any global settlement. T.413-414. In fact, Mr. Ellefson specifically testified: “Q: At the time you offered the $18,000(sic), did you tell him [Mr. Carlson] that it was contingent on a global settlement? A: Not at that time.” T.214. Additionally, during his testimony, Mr. Ellefson was confused on whether Western was even seeking the $18,053 as part of their breach of contract claim. At one point he states that they

\textsuperscript{2} Western points out that Mr. Mares doesn’t recall any conversation until after the claim close date. See T.553-554. However, the Jury clearly found that testimony was not credible given Mr. Carlson’s over eighteen year history of discussing claims a month or two before the claim close date (T.381-382), and Mr. Ellefson’s acknowledgement and evidence in the claims notes of the agent contacting Western in April 2013 requesting a change in reserves. T.235; Ex. 208 at WN0000077, April 22, 2013 Entry.
were seeking it: “Q: So, it’s amounts that you’re seeking right now? A: Yes.” T.212. However, when presented with his claim summary, Exhibit 250, he stated it was being deducted, and not part of the claim. T.257. Regardless, it hasn’t been paid to Prospect.

Prospect has also not been paid the dividend owed to it for the 2012 policy. Mr. Carlson testified that he calculated that dividend to be $106,051, and that Western had agreed to that amount. T.403, Ex. 203. Yet Western changed its position and now claims that the dividend owed for 2012 is only $102,441. Ex. 250. What is clear, is that because of the dispute over the dividend owed in 2011, and premiums owed for 2013, the 2012 premium dividends have not been paid to Prospect in breach of the 2012 policy.

These failures also hindered Prospect’s ability to perform. Because Western’s numbers and approved credits and dividends kept changing, and Prospect was never provided with the dividends or credits it was owed, Prospect could not determine a premium that was owned consistent with the documents it was provided, and that would be acceptable to Western.

IV. The 2013 Policy and Western’s Breach by Failing to Provide Promised Premium Reduction and Changing Final Audited Premium Number

Much like the 2012 policy, Prospect and Western discussed employee classifications and agreed to a $22,000 credit for 2013. Again, at the time that credit was agreed upon, Western did not condition the credit to Prospect’s agreeing to a global settlement. T.413-414, Ex. 203; T.212-213, Ex. 235. However, months later Western withdrew the credit, claiming it was an unrequired concession. Ex.215.
Similarly, the amount Western claimed it was owed in premiums for the 2013 year changed right before trial. Throughout their discussions in attempting to resolve the payment disputes prior to litigation, the parties consistently represented that for purposes of calculating dividends, the audited premium amount for 2013 would be $570,265, and after deducting appropriate assessments, the audited earned premium for calculating loss ratio would be $530,609. Ex. 203, T.177-180. In fact, Mr. Ellefson himself went through the premium calculations and personally signed off on those figures. Ex. 253; T.185-187. Yet a day before trial, Western provided a hand written document claiming that the audited premium should have been $616,373. T.177-178, Ex. 254. Mr. Ellefson admitted that he never told Prospect that the premium numbers they were using were wrong, or that the dividend that it would be entitled to for the 2013 policy, based on this handwritten number, would be higher. T.188-189, 410. Furthermore, when asked to identify the foundational documents that would support the new handwritten number, he stated: “I don’t know where it would be in all of this information.” T.258. These constantly changing positions again made it impossible for Prospect to perform as evidenced by Western’s refusal to accept a tendered payment of $86,653.64, as will be discussed below.

V. Settlement Discussions and Western’s Ever-Changing Positions

Western spends much of the fact section of its brief going through the various settlement offers it made prior to litigation. Appellant’s Brief 9-11. Most of that discussion is irrelevant, and demonstrates one significant fact: Western’s numbers were unsupported and kept changing. As pointed out in the immediately-preceding section,
Western's premium calculation for the 2013 policy year changed the day before trial, despite the fact that an earlier number had been reviewed and specifically signed-off on by Western's Vice President, Eric Ellefson. Ex.253.

Prospect's President, Darrin Carlson, testified that the reason he couldn't reach agreement with Western is that its numbers were never supported and kept changing. T.389-390. Despite this fact, Prospect calculated what it felt it owed and actually sent a check in October 2015 to Western for $86,653.64. Ex.203, 214, T.215, 414. In the letter acknowledging receipt of the check, Western asserted the total amount owed was $208,336.64, yet asserted a different, higher number at trial. Ex.214; 250. Western also held on to the check for three months and didn't return it until its Counsel sent a letter on January 26, 2016 with this lawsuit. T.415-416. The Court instructed the Jury in this case as follows:

A contract is breached when there is a failure without legal justification to perform an important part of the contract. This breach occurs when one party fails to carry out part of the contract that required immediate performance or fails to carry out a term of the contract by preventing or hindering the term being completed.

T.670. Here, Western's constantly changing positions and numbers hindered Prospect's ability to perform, and the facts support legal justification for Prospect's failure to pay premiums when Western rejected its good faith effort to pay outstanding premiums.

Western makes much of the fact that Mr. Carlson purportedly admitted at trial to owing a balance to Western for unpaid premiums. Appellant's Brief 13. However, whether or not Mr. Carlson testified to amounts owed, it does not relieve Western's
burden of proving that Prospect breached the contract, a burden it failed to meet.
Because Western’s numbers kept changing, right up to the day before trial, Western
hindered Prospect and made it impossible for Prospect to perform under the policies.
Furthermore, Western mischaracterizes the testimony of Prospect’s expert, Mike
Baumann as stating that a fair amount owed by Prospect would be $125,000. Id. Mr.
Baumann’s testimony concerned the amount that could have gotten the case resolved
short of litigation. Mr. Baumann’s exact testimony was as follows: “Q: So you’d say that
the better number would have been 125? A: In a compromise situation, yes.” T.546
(emphasis supplied). He also went on to expressly state that, in his professional opinion,
Prospect was not treated fairly with respect to both the Eiola and Anderson claims.
T.545.

**LAW AND ARGUMENT**

VI. The Trial Court Properly Denied Appellant’s Motion for JNOV on Breach of
Contract and the Implied Duty of Good Faith and Fair Dealing

A. Standard of Review

A reviewing court may only set aside a jury’s answer to a special verdict question
if the answer is “perverse and palpably contrary to the evidence or where the evidence is
so clear to leave no room for differences among reasonable people.” Hanks v. Hubbard
Beauty & Barber Supply Co., 441 N.W.2d 565, 567 (Minn. App. 1989). That is, if an
answer to a special verdict question “can be reconciled in any reasonable manner
consistent with the evidence and its fair inferences,” the answer must stand. Reese v.
Henke, 152 N.W.2d 63, 66 (Minn. 1967); see also Hauenstein v. Loctite Corp., 347 N.W.2d 272, 275 (Minn. 1984) (noting that “[i]f the answers to special verdict questions can be reconciled on any theory, the verdict will not be disturbed”). Only where no such reconciliation is possible may an appellate court change a jury’s answer to a special verdict question as a matter of law. Orwick v. Belshan, 231 N.W.2d 90, 94-95 (Minn. 1975). On appeal, the reviewing court must give the verdict the benefit of every reasonable inference in its support. See Kellerman v. Nelson, 265 Minn. 525, 532, 122 N.W.2d 604, 608-09 (Minn. 1963).

B. The Trial Court Properly Upheld the Jury’s Verdict

Question No. 1 on the Special Verdict form asked whether Prospect breached “the applicable worker compensation insurance contracts with Plaintiff?” and the jury answered “no.” The instruction before Question No. 3 states: “ANSWER THE FOLLOWING QUESTION REGARDLESS OF YOUR ANSWERS TO THE PREVIOUS QUESTIONS:” and Question No. 3 asks “What amount of money will fairly and adequately compensate Plaintiff for its damages?” The Jury answered $101,407.64, the exact same number that Defendant presented to the Jury as the amount that would be owed had Western properly closed the Eiola claim, reduced the reserve in Anderson, and issued the dividends and credits owed. See Ex. 205. The jury’s position was consistent with the evidence that Prospect was legally justified in its actions, and Western hindered Prospect from performing under the policy by rejecting Prospect’s tendered payment of $86,653.64.
1. **The Time for Western to Accept Prospect’s Offer of Payment was Before the Jury Found No Breach**

Western spends a significant amount of time pointing to what it claims are judicial admissions of amounts it claims it was owed by Prospect. The time to accept those amounts was prior to trial when, Prospect made an attempt to pay what it calculated Western was owed. Instead, Western ignored that offer and sought more than $240,000 at trial. It is not a coincidence, and is consistent with the evidence, that the Jury identified a number in the Special Verdict form that Prospect identified at trial as the amount that would adequately compensate Appellant had they met their burden of proof to show a breach of contract. But Western did not.

2. **Prospect Substantially Performed and Western’s Breach Excused Prospect**

The trial court and jury by implication properly found that Prospect had substantially performed under the applicable contracts, and that Western’s breach relieved Prospect from Performing. See Add.22-25. The Jury’s finding on Question No. 1 of no breach by Prospect is consistent with the evidence that Prospect substantially performed under the parties’ contracts by tendering a check of $86,653.64 to Western. (See Exs. 214 & 216). “Under the doctrine of substantial performance, minor or technical breaches of a contract are excused . . . because the performance that was rendered was so similar or close to that required under the contract that the failure to perform exactly results in an immaterial breach . . .” 14 Williston on Contracts § 44:52 (4th ed.). If the Jury’s finding as to no breach by Prospect “can be reconciled on any theory, the verdict will not be disturbed.” Hauenstein, 347 N.W.2d at 275 (Minn. 1984).
“It is well settled that we will set aside an answer to a special verdict question only when it is perverse and palpably contrary to the evidence.” Id. Also, a judge’s findings cannot contradict and must be consistent with the facts as determined by the jury in a special verdict form. See Milner v. Farmers Inc. Exchange, 748 N.W.2d 608, 620 (Minn. 2008).

“The evidence must be considered in the light most favorable to the prevailing party” and in this case, it is Prospect. Stumme v. Village Sports & Gas, 243 N.W.2d 329, 330 (Minn. 1976). Again, as argued about, the trial court specifically instructed the jury that there is only a breach where there is no legal justification for non-performance, and that it is a breach of contract to prevent or hinder performance. See T.670. The verdict was consistent with the instruction and a finding that Prospect was legally justified in not paying, and hindered from paying, premiums by Western’s constantly changing numbers, and failure to issue credits and dividends.

Western’s witness, Eric Ellefson, testified at length about how Western calculated the dividends and premiums allegedly owed under the various policies, yet those calculations were ever-changing, including handwritten edits just one day before the start of the trial. (See Ex. 254). “The damages recoverable for a breach of contract ‘are such as either arise naturally from the breach itself or such as may reasonably be supposed to have been contemplated by the parties when making the contract as the probable result of the breach.’” Pillsbury Co. v. Nat’l Union Fire Ins. Co. of Pittsburg, Pennsylvania, 425 N.W.2d 244, 248 (Minn. App. 1988). Again, Western’s hindrance of Prospect’s performance is evident by the fact that the Jury in the Special Verdict Form used
Prospect’s net calculation of $101,407.64 to answer Question No. 3, and not any amount asserted by Western. Western’s actions made it impossible for Prospect to determine an amount due that was acceptable to Western, and also consistent with the documents provided. That fact, coupled with the Jury’s finding that there was no breach of contract by Prospect, demonstrates that Western is not entitled to any award of damages.

An additional, independent basis exists to find no breach of contract by Prospect consistent with the Jury’s special verdict form. Western’s breach of contract claim, including its alleged damages against Prospect, arises from the 2013 policy. (See Trial Exhibit 202). However, Western never offered for admission, nor obtained admission of, the actual Insurance Policy (Ex. 202) before the close of its case in chief. See T.366-369 (motion for directed verdict based upon Western’s failure to submit Exhibit 202). Western’s breach of contract claim required that the Insurance Policy be introduced into the record and provided to the Jury because “[a]n insurance policy must be construed as a whole, and unambiguous language must be given its plain and ordinary meaning.” Midwest Family Mut. Ins. Co. v. Wolters, 831 N.W.2d 628, 636 (Minn. 2013). The Jury could not be expected to apply the terms of a policy that it was not even provided in Plaintiff’s case in chief. Western’s failure to provide the Insurance Policy to the Jury supports the Jury’s finding of no breach by Prospect and an award of no damages.

3. **Western’s New Argument on Pre-existing Breach is Incorrect as a Matter of Law and Fact**

Western now argues for the first time the inapplicability of the doctrine that pre-existing breach excuses a subsequent breach because here Western is arguing for
recovery under the 2013 policy, and Western’s breach concerned the 2011 policy. Western is incorrect as a matter of fact and pursuant to applicable law.

First, issues not raised by a party in the lower court cannot be considered for the first time on appeal. Krogness v. Best Buy Co., 524 N.W.2d 282, 286 (Minn. App. 1994) (citing Thiele v. Stich, 425 N.W.2d 580, 582 (Minn. 1988). Upon review, the appellate court must limit its consideration to “only those issues which the record shows were, or had to be, presented and considered by the trial court in deciding the matter before it.” Thompson v. Barnes, 200 N.W.2d 921, 926 (Minn. 1972). This rule applies with equal force whether the question is of law or fact. See Trovatten v. Minea, 213 Minn. 544, 7 N.W.2d 390 (Minn. 1942); see also Chicago M & St. P Ry v. Sprague, 140 Minn. 1, 167 N.W. 124 (Minn. 1918). “Where the parties fail to fully litigate an issue below, [the appellate court] cannot determine it on appeal.” Fryhling v. Acrometal Products, Inc., 269 N.W.2d 744, 747 (Minn. 1978). This is the first time Western has argued that its breach related only to 2011 policy, and Prospect breached the 2013 policy.

Even if considered, Western’s argument fails. Western agreed to treat the three policies at issue together for purposes of the special verdict form and determination of the parties’ claims. The Special Verdict Form treats the three policies together, and when addressing the special verdict form, Mr. Martin, counsel for Appellant, agreed, stating: “All right. Then, I guess we can do that collectively. I’m okay with referencing 2011-2014.” T.627. If a party fails to object to a special verdict form prior to the submission to the jury, such failure “constitutes a waiver of any objection which a party may have.”
Theilbar v. Juenke, 189 N.W.2d 493, 498 (Minn. 1971) (citing Raymond v. Baehre, 184
N.W.2d 14 (Minn. 1970)). Even where “[t]he form of the special verdict . . . is fatally
defective,” failure to timely object within the district court constitutes a waiver by the

Additionally, ample evidence was presented at trial that Western breached not
only the 2011 policy, but also the 2012 and 2013 policies. Specifically, as described in
the Statement of Facts, Sections III and IV above, Western has failed to issue Prospect
the dividends that are owed under the 2012 policy, and has also failed to issue the
$18,053 and $22,000 credits that the parties agreed upon for both 2012 and 2013.
Therefore, Western’s preexisting breach of these policies excuses Prospect.

Finally, Western’s argument on the Court’s alleged failure to instruct on the issue
of a pre-existing breach does not require reversal. First, the jury was instructed that there
can be legal justification for non-performance, and a breach can exist if one party
prevents or hinders performance. See T.670. Furthermore, regardless of what theory a
jury employs to reach its verdict, the trial court (and appellate court) should uphold the
verdict if it is consistent with any legal theory. Minnesota courts have previously stated
that it is not the function of the court “to determine on what theory the jury arrived at its
verdict.” Nihart v. Kruger, 190 N.W.2d 776, 778 (Minn. 1971); see also Flatin v. Lampert
Lumber Co., 215 N.W.2d 783, 785 (Minn. 1974). Instead, upon review, courts may only
“examine the record to decide whether the verdicts are consistent on any theory.” Nihart,
190 N.W.2d at 778. Regarding jury instructions, so long as the “general charge fairly and
correctly states the applicable law," a new trial will not be granted. Smith v. Kahler Corp., 211 N.W.2d 146, 153 (Minn. 1973) (quoting Pogalz v. Miller, 188 N.W.2d 877 (Minn. 1971)).

C. The Verdict Finding Western’s Breach of the Implied Duty of Good Faith and Fair Dealing is Consistent with the Evidence

Western spends a significant amount of its brief confusing the law on the implied duty of good faith and fair dealing with statutory insurance bad faith, trying to argue Prospect must prove some affirmative dishonesty. That is not the standard. Under the law as articulated by the Restatement (Second) of Contracts, there is no requirement of a finding of any actual malice or scienter to find a breach of the covenant of good faith and fair dealing. The Restatement (Second) of Contracts § 205 (“Restatement”). Western further states that because Western did nothing to prevent or [hinder] Prospect’s ability to perform the contract, Western did not act in bad faith. Appellant’s Brief at 21. Western is attempting to narrow the scope of what constitutes a violation of the covenant of good faith and fair dealing to intentional bad acts or only the hindrance of the other’s parties’ performance of the contract. This is simply not the law. Section 205 of the Restatement (Second) of Contracts articulates a multitude of examples:

Subterfuges and evasions violate the obligation of good faith in performance even though the actor believes his conduct to be justified. But the obligation goes further: bad faith may be overt or may consist of inaction, and fair dealing may require more than honesty. A complete catalogue of types of bad faith is impossible, but the following types are among those which recognized in judicial decisions: evasions of the spirit of the bargain, lack of diligence and slackling off, willful rendering of imperfect performance, abuse of a power to specify terms, and interference with or failure to cooperate in the other party’s performance.
Restatement (Second) of Contracts § 205.

Among the types of conduct recognized are a lack of diligence, evasion of the spirit of the bargain and abuse of power to specify terms. Related to these types of breaches, in applying Minnesota case law, the United States District Court, District of Minnesota, found in *White Stone Partners* that the Minnesota Supreme Court would require a party to exercise good faith in exercising an unlimited discretionary power over a term of the contract if necessary to effectuate the parties’ intent and to save a contract from being held to be illusory. *White Stone Partners, LP v. Piper Jaffray Cos., Inc.*, 978 F. Supp. 878, 882 (D. Minn. 1997) (emphasis added). The *White Stone Partners* Court concluded that Minnesota courts would examine contracts that grant a party discretion with respect to a particular term on a case-by-case basis to determine if the contract is illusory unless an implied covenant of good faith is applied.

holding "Good faith, at a minimum, excludes actions that violate community standards of
decency, fairness, or reasonableness.") (Resp. Add. 8); Crosstown Holding Co. v.
Marquette Bank, N.A., No. A04-1693, 2005 WL 1154271 at *4 (Minn. App. May 17,
2005) ("the types of bad faith recognized in judicial opinions are evasion of the spirit of
the bargain and abuse of a power to specify terms") (Resp. Add. 14).

Furthermore, under this doctrine, "a party to a contract cannot avoid its duties
under the contract by . . . disabling itself from performance." See Space Center, Inc. v.
451 Corp., 298 N.W.2d 443, 449 (Minn. 1990). "A person may not escape liability
under an agreement upon a condition by preventing the happening of a condition."
Miller v. O.B. McClintock Co., 297 N.W. 724, 728 (Minn. 1941); Carlson Real Estate

Here, Western had complete discretion with respect to Western’s obligation under
the Policy to look at and close open claims and reserves by the claims closing date, and in
issuing credits based upon employee classifications. As an example of that discretion,
Western has stated that "[t]here is no set time for the reviewing and revising of reserves
except that Western has a policy that calls for adjustments within five days of data having
been supplied on a claim warranting such changes." See Pl.’s Mem. In Support of Mot.
Limine (Doc. # 23) at pg. 4. However, at trial, the claims handler in this matter, Janet
Brophy, said she was completely unaware of any policy that required her to close claims
within a certain period of time. This lack of a set time, and an unshared and unspecified
"policy" illustrates the complete discretion that Western holds over the terms and
obligations under the Policy related to the claims closing date, and an actual failure to follow its own internal policies here.

Additionally, with respect to the 2012 and 2013 policies, the parties discussed employee classifications and agreed to credits, only to have those credits called "concessions" and withdrawn. See Statement of Facts, Sections III and IV, above. Therefore, Western was required, as the party with complete discretion, to not act to deprive Prospect of their rights under the contracts in such a way that evades the spirit of the transaction or denies Prospect the expected benefit of the contract. White Stone Partners, 978 F. Supp. at 882-84 (D. Minn. 1997). Furthermore, knowing of its own failure to close and reduce claims, and issue appropriate credits, Western none-the-less rejected Prospect’s payment and knowingly brought a breach of contract action against Prospect seeking a total recovery of amounts owed without conceding the dividends and credits that was rightfully owed to Prospect. Western’s constantly changing numbers and failure to issue credits and dividends hindered Prospect’s ability to determine what was owed, and provided legal justification for any alleged non-payment by Prospect.

Western relies on Prairie Island Indian Community v. Minnesota Dep’t of Public Safety, 658 N.W.2d 876 (Minn. App. 2003) for the proposition that if acts of a party are honest, it precludes a finding of a breach of the duty. However, the issue in Prairie Island was the failure to maintain material as confidential, and the Court found that the agency responsible for working with the Native American communities had actively resisted efforts of outsiders to obtain information, and only released the information when it was
ordered to do so. In essence, the court found there was not even negligence. Furthermore, and more importantly, Western’s actions here are not mere negligence. Its own claims handler testified that she was completely unaware of the Western’s internal policy to close claims within five days. Additionally, Western at trial for the first time admitted that the reserves were “overstated on the Eiola claim by $7,500” (T.350), and the claim file itself indicated on April 12, 2013 that “[t]he Stip closes all future right shoulder claims including medical” (Trial Exhibit 233)(emphasis supplied). Additionally, the parties negotiated credits based upon employee classifications that were later withdrawn. Statement of Facts, Sections III and IV. Despite this evidence, Western sought recovery from Prospect without crediting them the appropriate amounts.

Even more troubling was Mr. Ellefson’s testimony at trial that Prospect was due a credit of approximately $18,056 (See Trial Exhibit 203, T.214) for the 2012 policy due to adjustments in claim rating, but on cross examination he could not recollect if that credit was being included in Western’s damage demand or not. T.212, T.257. Furthermore, despite the identity of the nature of a $22,000 credit owed to Prospect for the following year, Mr. Ellefson could not articulate a reasonable basis why that credit was not being included to reduce part of Western’s claimed damages. (See Trial Exhibit 203, T.271).

Western also cites to Cox v. Mortgage Electronic Registration Systems, Inc., 685 F.3d 663 (8th Cir. 2012). However, Cox supports Prospect’s claim. First, Cox recognizes that “a plaintiff alleging a claim for breach of the implied covenant of good faith and fair dealing ‘need not first establish an express breach of contract claim —
premiums include, but are not limited to, lost company time . . .” See Defendant’s Rule 26.01(a) Disclosures attached as Exhibit 2 to the March 8, 2017 Yetka Affidavit, Doc. # 86. Finally, at trial, Mr. Carlson testified that he was the President of Prospect, and was in charge of dealing with the issues raised by Western’s actions. He further testified that based upon his salary and benefits, and taking into account time off and hours worked, that the cost to Prospect of his time was $205 per hour. T.424. He further testified that dealing with this issue, he had spent twenty-five hours each in 2013 and 2014, fifty hours in 2015, one hundred-twenty hours in 2016, and forty hours in 2017, not including trial time, for a total of $53,300. T.423-425. These damages were referenced in the Answer and Counterclaim and Rule 26(a) Disclosure, and addressed specifically at trial.

VII. The Trial Court’s Evidentiary Findings Were Consistent with the Law and a New Trial is not Warranted

In an attempt to sway this Court, Western invokes “Occam’s Razor” and speculates on what may have caused the Jury to decide the way it did. It speculates (without any evidence) on anti-insurance company bias, the settlement negotiations that Western chose to submit, and allegedly erroneous rulings by the trial court. However, using Occam’s Razor, the most likely explanation is that Western failed to meet its burden of proof, while Prospect met its burden.

A. Standard of Review

Generally, the decision to grant a new trial lies “within the sound discretion of the trial court and will not be disturbed absent a clear abuse of discretion.” Halla Nursery, Inc. v. Baumann-Furrie & Co., 454 N.W.2d 905, 910 (Minn. 1990) (citing Lindstrom v.
Yellow Taxi Co. of Minneapolis, 214 N.W.2d 672, 677 (Minn. 1974)). "On appeal from a denial of a motion for a new trial, the verdict must stand unless it is manifestly and palpably contrary to the evidence, viewed in a light most favorable to the verdict."


Minnesota trial "courts have considerable latitude in selecting language used in the jury charge and in determining the propriety of a specific instruction." Blatz v. Allina Health Sys., 622 N.W.2d 376, 389 (Minn. App. 2001) (citing Alholm v. Wilt, 394 N.W.2d 488, 490 (Minn. 1986)). Reviewing courts, when determining "whether an instruction constitutes error" must read the instructions "as a whole, keeping in mind the evidence of the case." Id. (citing Lindstrom 214 N.W.2d at 676). "If the charge as a whole properly states the law," the reviewing court cannot reverse "simply because the objecting litigant preferred other language." Id. (citing Alholm, 394 N.W.2d at 490). "Errors in jury instructions are not grounds for a new trial unless the error is prejudicial." Id. (citing Lewis v. Equitable Life Assurance Soc'y of the United States, 389 N.W.2d 876, 885 (Minn. 1986).

B. The Instruction on the Implied Covenant of Good Faith and Fair Dealing was Consistent with the Law and Facts in this Case

The Court's instruction in this case was consistent with the application of the law to the facts and testimony. As described in greater detail above, the Restatement (Second) of Contracts 205 (adopted by Minnesota in, for example, In re Hennepin Cnty. 1986 Recycling Bond Litig., 540 N.W.2d 494, 503 (Minn. 1995) and Cox v. Mortgage...
Electronic Registration Systems, Inc., 685 F.3d 663, 671 (8th Cir. 2012)), states the breach of the implied duty can include: "evasions of the spirit of the bargain, lack of diligence and slacking off, willful rendering of imperfect performance, abuse of a power to specify terms, and interference with or failure to cooperate in the other party's performance." These concepts have been articulated in Cox v. Mortgage Electronic Registration Systems, Inc., 685 F.3d at 663 (8th Cir. 2012), White Stone Partners, LP v. Piper Jaffray Companies, Inc., 978 F. Supp. 878, 882 (D. Minn. 1997) and Cardot v. Synesi Group, Inc., No. A07-1868, 2008 WL 4300955 at * 8 (Minn. App. Sept. 23, 2008) (Resp. Add. 1), each demonstrating that a breach of the implied covenant in Minnesota goes beyond simply unjustifiable hindrance or obstruction of performance, or a finding of willfulness or malice. A breach can be found where one party abuses its power to specify terms, or has discretionary control and improperly fails to exercise that control thereby depriving the other party of the fruits of the contract. The unjustifiable hindrance language would not have changed the outcome here because there is ample evidence of Western bindering Prospect, and the Court provided an instruction on breach of contract that addressed hindrance. T.670. Furthermore, requiring the proof of affirmative dishonesty would have served to simply confuse the Jury here, and would have been an improper statement of the law. The Court appropriately tailored the instruction to the facts of this case, consistent with the law.

C. The Court Properly Overruled Improper Hearsay Objections.

The uncontroverted testimony from Prospect's expert, Mr. Baumann, was that it was well within Marsh & McClennan's authority to communicate regarding the relevant
policy on behalf of Western. T.506-507. Western’s own Vice President, Eric Effefson, agreed that a customary service of an insurance agent is to communicate with policyholders about claims. T.166-167. It was those communications from Marsh’s Mr. Mares to Mr. Carlson that were allowed, and were not hearsay because, as statements of Western’s authorized agent, they are statements by a party-opponent. Minn. R. Evid. 801(d)(2)(C&D). (See Trial Exhibit 251).

To the extent there was any question about Mr. Mares status after reviewing the agency agreement, by statute, Minnesota addresses the issue of who an insurance agent or broker is legally representing, depending on what act they perform. Minnesota Statute § 60K.49, Subd. 1 states in relevant part:

Subdivision 1. Agent of insurer. A person performing acts requiring a producer license under this chapter is at all times the agent of the insurer and not the insured. (Emphasis added).

The “acts” referred to in Section §60K.49, are enumerated in Minnesota Statute §60K.32 that reads:

A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority under sections 60K.30 or 60K.56. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier. (Emphasis added)

Finally, “negotiate” is specifically defined in the statutes as well. Minnesota Statute §60K.31, Subd. 12, reads:

Subd. 12 Negotiate. “Negotiate” means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits,
terms, or conditions of the contract if the person engaged in that act either sells insurance or obtains insurance from insurer for purchasers.

Here, there is no dispute that Marsh and McLennan sells and obtains insurance from insurers for purchasers. There is also no dispute that the communications relating to the closing of claims and reduction of reserves was advice about the particular Western policies issued to Prospect concerning substantive benefits, terms and conditions of the policies. Therefore, by statute, Marsh and McLennan, and Mr. Mares, were the agents for Western for purposes of those communications.

The Minnesota Supreme Court has specifically recognized the agency statute. It has further alluded that the distinction between an agent acting on behalf of an insurer versus a broker acting on behalf of a policyholder for certain communications has been eliminated by the statute. See Graff v. Robert M. Swendra Agency, Inc., 800 N.W.2d 112, 118 n.5 (Minn. 2011) (“This distinction [between agent and broker], however, appears to have been superseded by statute.”).

Furthermore, this issue was made moot by the fact that Western called Mr. Mares to testify. The jury was allowed to consider Mr. Mares testimony in light of Mr. Carlson’s and make their own determination on credibility. The jury’s determination should not be reversed.

Western also takes issue with instruction CIV JIG 12.35 that was provided by the Court on adverse inferences for failure to call a witness. While not specifically emphasized at closing, Western failed to call, or even subpoena, Cassandra Rudy (Coppet), despite being the first witness listed in Western’s Answers to Interrogatories as
a person with knowledge of this case. Plaintiff’s Answers to Interrogatories, Interrogatory No. 2, pg. 2-3, attached the March 8, 2017 Affidavit of Christopher Yetka as Ex. 3 (Doc # 86). This is important because there is no doubt that Western had the ability to call Ms. Rudy given the existence of an Agency Agreement between Western and Ms. Rudy’s employer, Marsh & McLennan. (See Trial Exhibit 251). Furthermore, as Western points out “Prospect could have called Ms. Rudy” and did not.” (Plaintiff Brief in Support of Motion for New Trial, Doc. #69 at pg. 15). Therefore, any negative inference could have gone either way, and there can be no prejudice to Western.

D. The Verdict Here was Consistent with the Evidence

The evidence discussed in detail above demonstrates that the verdict was consistent with the evidence presented at trial. But a point in Western’s Brief requires further response. At page 28 of Appellant’s brief, Appellant argues “Prospect’s counsel agreed in final argument that if Prospect breached, then Western was entitled to recover up to $200,460.” Brief at 28, citing to T.687. However, that is a misleading statement of the closing argument. Western pulls out one number mentioned in closing (and only applicable if the Jury found breach) without referencing the numerous deductions that counsel subsequently asserted had to be applied including $95,958 in unpaid dividend for 2011 (T.687), an $18,000 credit in 2012 (T.687), and a $22,000 credit in 2013 (T.688).

Additionally, Counsel for Western passingly refers to “a host of evidentiary rulings” referenced in its post-trial motion as “erroneous and unduly prejudicial” yet does not specifically cite to or argue a single one. This Court should treat those arguments for what they are: unworthy of mention in Appellant’s brief.
Finally, Appellant mentions that they jury deliberated for an hour and a half, and states that it is evidence of a rush to judgment. An alternate, and appropriate, interpretation would be that the facts were so clear to the Jury, that they were able to reach agreement and a verdict quickly. The Jury’s award should not be upset.

CONCLUSION

The Jury’s Special Verdict was consistent with both the facts and law as contained in the instructions in this matter. The trial court property entered judgment consistent with the Jury’s verdict. Finally, no errors were committed requiring reversal or a new trial. To find otherwise would further reward Western for conduct that the jury has already found violated the implied covenant of good faith and fair dealing that attaches to all contracts.

Respectfully submitted,

Dated: November 22, 2017

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ATTORNEYS FOR RESPONDENT,
PROSPECT FOUNDRY LLC
STATE OF MINNESOTA
IN COURT OF APPEALS

Western National Mutual Insurance Company, A17-0992

Appellant,

vs. RESIDENT’S CERTIFICATE
PROSPECT FOUNDRY, LLC, OF COMPLIANCE WITH

Respondent. RULE 132.01(3)

Christopher Yetka, Attorney for Respondent, hereby certifies to the Court of
Appeals as follows:

1. The Respondent’s Brief was prepared with Microsoft Word Office Version 2010.

2. The word count for Respondent’s Brief is 9,728 and within the scope of Rule

132.01(3). The brief is printed with Times New Roman 13 point font characters.

Dated: November 22, 2017 BARNES & THORNBURG, LLP

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(2) Hanson Constr. & Specialty Cabinets, LLC v. Waylein,

(3) Crosstown Holding Co. v. Marquette Bank, N.A,
David E. Albright, Apple Valley, MN, for appellant.

Jodi L. Johnson, Thomas P. Kane, Hinshaw & Culbertson, LLP, Minneapolis, MN, for respondent.

Considered and decided by HALBROOKS, Presiding Judge; HUDSON, Judge; and COLLINS, Judge.

UNPUBLISHED OPINION

COLLINS, Judge.

"1 Appellant challenges the district court's grant of summary judgment in favor of respondent, arguing that the district court erred by concluding that appellant's claims are barred by a waiver and release provision, and that there are genuine issues of material fact that preclude summary judgment. We reverse and remand.

FACTS

Synesi Group, Inc.\(^1\) is an inactive Minnesota corporation that currently has no assets. Synesi was formed in 1999 for the purpose of generating licensing revenue through two patents, U.S. Patent # 6922720 and U.S. Patent # 7020692 (the patents) relating to the securing, bonding, insurance, and underwriting of Internet transmissions. Stephen Cardot is one of the founders of Synesi, and he, along with two other individuals, authored the patents and filed provisional patent applications in September 1999, although the patents were not granted until July 26, 2005, and March 28, 2006. Cardot was also Synesi's president and chief executive officer (CEO) from its inception until March 2003.

In 2001, Marcellus Knoblach of the Marcellus P. Knoblach Revocable Trust (Knoblach) became involved with Synesi. Knoblach provided financing to Synesi, and during Cardot's tenure as president and CEO, Knoblach loaned Synesi approximately $2,000,000. Knoblach also owned stock in Synesi, and, by the summer of 2002, Knoblach had become Synesi's largest shareholder.

On May 15, 2001, Cardot entered into an “Assignment of Interest Regarding U.S. Patents” (the first assignment) with Synesi, transferring “any and all right, title, interest or claim he has or may have” regarding the patents in

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\(^1\) Synesi Group, Inc.
exchange for Synesi’s agreement to pay him a royalty of “one-third of one percent (.333%) of [Synesi’s] gross revenue for a period of twelve (12) years.”

Approximately two months later, Cardot entered into an “Amendment to Assignment of Interest Regarding U.S. Patents” (the amended assignment) with Synesi. The amended assignment reaffirms the first assignment but provides that Synesi’s obligation to pay royalties did not apply to its first $2,000,000 in gross revenue. It also provides that, if substantially all of Synesi’s assets or the majority of its stock were sold to a third party, Cardot would agree to offer to sell his right to receive royalties for .333% of the gross sales price or $1,700,000, whichever is greater.3

On December 9, 2002, Cardot entered into an “Intellectual Property Agreement” (the IP agreement) with Synesi. The IP agreement reaffirms the first assignment and the amended assignment and provides that its purpose is to “enhance the opportunity for [Synesi] to be able to continue ongoing operations by clarifying and reaffirming existing assignment and royalty obligations and by supplementing such assignments, thereby aiding the company in attracting additional investment or increasing the marketability of [Synesi’s] products and services.” Further, the IP agreement provides that Cardot received “consideration in the form of potentially increasing the value of [his] stock holdings in [Synesi] or potentially increasing the possibility that [he] will obtain royalties or a buy out of [his] royalties,” as set forth in the amended assignment. In exchange, Cardot “assign[ed] and reaffirm[ed] the assignment to [Synesi] of any and all intellectual property ... including but not limited to ideas, inventions, software, writings, discoveries, developments, plans, strategies, lists, information and data” regarding the patents and Cardot’s involvement with Synesi.

*2 Cardot resigned as president and CEO of Synesi in March of 2003, and entered into a “Severance Agreement and Release” (the severance agreement) on March 17. At that time, the parties agreed that Synesi owed Cardot $97,166 in past-due wages. The severance agreement provided that in satisfaction of this obligation, Synesi would convert half of this amount into “a warrant ... to purchase an aggregate of 48,583 shares of [Synesi’s] common stock ... at $1.00 per share,” and that the balance would be paid “pursuant to the terms of a one-year 6% promissory note in the amount of $48,583.12.” The severance agreement also provides that, in exchange for Cardot’s agreement to waive any claims that he may have against Synesi, Synesi would issue Cardot two warrants to purchase 500,000 shares of common stock at a price of one dollar per share.

Also on March 17, 2003, Synesi and Knoblauch entered into numerous agreements regarding loans that Knoblauch had made to Synesi. Under these agreements, Synesi granted Knoblauch a “first priority perfected security interest” in Synesi’s intellectual property and in its interest and rights in the patents and the patent applications. The agreements provide that, in the event of a default, including a failure by Synesi to pay its loan obligations when due, Knoblauch would have the right to, among other actions, take possession of Synesi’s interest and rights in the patents without a judicial proceeding and sell or otherwise transfer the patents. In exchange, Knoblauch made loans to Synesi in the amount of $1,596,113 and $424,446, both of which were due and payable in full on December 17, 2003. When these agreements were entered into, Cardot was still a member of the board of directors and executed a “Written Action of the Board on March 10, 2003, approving the Amended, Restated and Consolidated Secured Convertible Term Promissory Note Due December 17, 2003 for $1,596,113.60.” The written action incorporated by reference all of the other March 17, 2003 agreements.

Over the next two and one-half years, Knoblauch continued to make loans to Synesi, and, ultimately, Knoblauch had loaned a total of $3,583,355 to Synesi. Although it is not entirely clear from the record what happened between Cardot’s departure and the initiation of this lawsuit, it appears that by December 2004 Synesi was in default on its loan obligations to Knoblauch. Knoblauch agreed to grant Synesi a forbearance until February 28, 2005, which the parties later extended to March 31, 2005, and then extended a second time to August 1, 2006.

By letter dated September 18, 2006, Synesi’s board of directors notified the shareholders that the company was in default on its loan obligations to Knoblauch, that Knoblauch was unwilling to negotiate any further forbearances, and that Knoblauch had requested that Synesi voluntarily agree to the foreclosure of assets pledged to Knoblauch as collateral—namely, the interest and rights in the patents—unlike to the board of directors had refused. The letter also informed the shareholders that Synesi had no funds and did not have the ability to cure the default. On October 2, 2006, Knoblauch sent a “Notice to Assembly Collateral” to Synesi requesting that the company make the collateral available to TranSurety, LLC, the company to which Knoblauch had assigned its rights to the collateral. The board of directors unanimously voted to not cooperate with Knoblauch’s request without a court order, and it notified the shareholders of that decision.
*3 On November 17, 2006, Cardot wrote to Synesi advising the company that he was “rescinding [his] assignment of patent rights to [Synesi]” and that he “expects that Synesi will return the patent rights forthwith.” In December 2006, TranSurety removed the patents from Synesi.

Cardot, acting pro se, filed this lawsuit against Synesi on August 1, 2006, claiming that Synesi had failed to pay him the $48,583 due on the promissory note for past wages. Cardot later hired an attorney to represent him and, in January 2007, moved the district court for leave to amend the complaint. The district court granted the motion, and Cardot filed an amended complaint adding a claim seeking to rescind his assignment of his interest and rights in the patents. The amended complaint asserts that Cardot is entitled to a rescission of the three assignment agreements, that is, the first assignment, the amended assignment, and the IP agreement (collectively, the three assignments) on the grounds that Synesi: (1) materially breached its contractual duties, including the duty of good faith and fair dealing; (2) fraudulently induced Cardot into entering into certain agreements; and (3) frustrated the purpose and hindered the performance of the three assignments. Synesi moved for summary judgment, which the district court granted, and Cardot appeals.

**DECISION**

When reviewing a grant of summary judgment, this court determines whether there are any genuine issues of material fact and whether the district court erred in its application of the law. *State by Cooper v. French*, 460 N.W.2d 2, 4 (Minn.1990). There is no genuine issue of material fact when the record, taken as a whole, would not permit a rational fact-finder to find for the nonmoving party. *DLH, Inc. v. Russ*, 566 N.W.2d 60, 69 (Minn.1997). We review the record in the light most favorable to the nonmoving party. *Fabio v. Bellomo*, 504 N.W.2d 758, 761 (Minn.1993). All factual inferences and ambiguities must be resolved in favor of the nonmoving party. *Wistrom v. Duluth, Missabe & Iron Range Ry.,* 636 N.W.2d 611, 613 (Minn.App.2001).

**I.**

As an initial matter, Synesi argues that Cardot’s brief is “devoid of appropriate citation to the district court’s record,” and thus, violates Minn. R. Civ.App. P. 128.02, subd. 1(c) (requiring that statements of material fact in a party’s brief be accompanied by references to the record). Although some of Cardot’s factual assertions are not accompanied by specific references to the record reproduced in his appendix, others are, and, generally speaking, it is apparent what portions of the record Cardot is referring to. Further, contrary to Synesi’s assertion, all of the documents in Cardot’s appendix are in fact included in the district court file.

**II.**

The severance agreement that Cardot entered into contains a “Waiver and Release” provision, which states, in pertinent part:

[Cardot] hereby unconditionally waives, releases, acquits and forever discharges [Synesi] and any entity affiliated with [Synesi], including, but not limited to, its ... owners, officers, agents, directors, shareholders, lenders, employees and other representatives ... from any and all past, present or future claims, demands, obligations, actions, damages and expenses of any nature ... which [Cardot] now has or in the future may have. This release includes, but is not limited to, all claims on account of or in any way growing out of the employment or other relationship between the parties hereto, including, but not limited to ... fraud or misrepresentation, breach of a covenant of good faith and fair dealing, ... breach of contract, ... claims arising out of or in connection with any intellectual property or other rights or property assigned by [Cardot] to [Synesi], and any other claims for unlawful employment practices.

*4 ...*

It is the intention of the undersigned parties that the release shall be effective as a full and final accord and satisfaction, and as a bar to all actions, causes of action, obligations, ... claims, liabilities and demands of whatsoever nature, known or unknown, suspected or unsuspected. The undersigned parties hereby acknowledge that they or their attorneys may hereafter discover claims or facts in addition to or different from those that they now know or believe exist with respect to the subject matter of this Agreement, but that it is their intention hereby to fully, finally and forever settle and release all of the disputes and differences, known or unknown, suspected or unsuspected, which do now exist, may hereafter exist, or may heretofore have
existed, without regard to the subsequent discovery or existence of differen[t] or additional facts.

The district court noted that the waiver “specifically states that Cardot is releasing all claims of breach of contract, breach of a covenant of good faith and fair dealing, and fraud or misrepresentation,” including all of Cardot’s claims arising out of the three assignments of the patents. Accordingly, the district court concluded that “Cardot released these claims that he now brings before this Court,” and thus, “all of Cardot’s claims fail because [they] were extinguished by the terms of the Severance Agreement.”

Minnesota law “presumes that parties to a release agreement intend what is expressed in a signed writing,” and any party seeking relief from a release bears the burden of establishing facts sufficient to avoid that presumption. Sorenson v. Coast-to-Coast Stores, Inc., 353 N.W.2d 666, 669-70 (Minn.App.1984), review denied (Minn. Nov. 7, 1984). In the absence of fraud, misrepresentation, or other inequitable conduct, a plainly-worded release is effective even as to unknown claims or claims that the releasing party did not specifically know it was releasing. See id. (holding that franchise-termination agreement discharged claims and causes of action of which party did not necessarily know or intend to release).

Cardot argues that the district court erred by concluding that his claims are barred by the severance agreement. He asserts that there are genuine issues of material fact as to whether he is entitled to an avoidance of the severance agreement, on the grounds that Synesi materially breached the severance agreement, and the severance agreement was obtained by fraudulent inducement and misrepresentation. We will address each assertion in turn.

A. Material breach
Cardot contends that there are genuine issues regarding whether Synesi’s failure to pay him $48,583 in past due wages pursuant to the promissory note was a material breach of the severance agreement, entitling him to a rescission of the severance agreement, including the waiver-and-release provision. Synesi argues that non-payment of the $48,583 in past due wages does not amount to a material breach and, therefore, Cardot is not entitled to a rescission of the severance agreement. We agree.

“5 Rescission is the unmaking of a contract ... which not only terminates the contract but abrogates it and undoes it from the beginning.” Johnny’s, Inc. v. Njaka, 450 N.W.2d 166, 168 (Minn.App.1990). As a general rule, rescission “is justified only by a material breach or substantial failure in performance.” Cloverdale Foods of Minn., Inc. v. Pioneer Snacks, 580 N.W.2d 46, 49 (Minn.App.1998). A material breach occurs when a party refuses to perform a substantial part of the contract. Liebch v. Abbott, 265 Minn. 447, 451-52, 122 N.W.2d 578, 581-82 (1963). In other words, a breach is material when “one of the primary purposes” of the contract is violated. See Steller v. Thomas, 232 Minn. 275, 282, 45 N.W.2d 537, 542 (1950); see also 15 Samuel Williston & Richard A. Lord, A Treatise on the Law of Contracts § 44:55 (4th ed.2000) (stating that material breach “goes to the root or essence of the contract”).

The “primary purpose” of the severance agreement or, in other words, its “root or essence,” is the waiver, and the severance agreement expressly provides that the consideration for that waiver was the issuance of two warrants entitling Cardot to purchase 500,000 shares of common stock. Cardot has not claimed, and there is nothing in the record to suggest, that Synesi failed to perform its contractual obligation to issue the two warrants. Because the failure to pay the $48,583 in past due wages does not constitute a material breach, rescission of the severance agreement, including the waiver provision, is not appropriate. See Anderson v. Kammeter, 262 N.W.2d 366, 374 (Minn.1977) (stating that nonmaterial breach of contract does not justify rescission).

Cardot also argues that the severance agreement is not supported by adequate consideration. His argument is based on the assertion that the $48,583 promissory note was the sole consideration for the severance agreement, and the severance agreement purports to release any claim he might have against Synesi for failing to pay the promissory note. But, as previously noted, the consideration for the severance agreement was the two warrants to purchase 500,000 in common stock, not the $48,583 promissory note. Furthermore, the severance agreement expressly provides that the waiver provision “shall not apply to any failure by [Synesi] to pay amounts due [Cardot] under and pursuant to the [promissory note].” Thus, contrary to Cardot’s assertion, the severance agreement does not purport to release claims against Synesi for failing to satisfy the promissory note.

There are no genuine issues of material fact regarding whether Cardot is entitled to rescind the severance agreement on the ground that Synesi materially breached the severance agreement.
B. Fraud
To establish a claim of fraud, Cardot must demonstrate that: (1) Synesi made a “false representation of a material past or present fact susceptible of knowledge;” (2) Synesi “either knew it to be false or asserted it as [its] own knowledge without knowing whether it was true or false;” (3) Synesi intended Cardot “to act in reliance” on the representation; (4) Cardot “was induced to act in reliance on the representation;” and (5) Cardot “suffered damages which were the proximate cause of the representation.” See Rognlien v. Carter, 443 N.W.2d 217, 220 (Minn.App.1989), review denied (Minn. Sept. 21, 1989).

*6 The district court concluded that Cardot’s fraud claim failed because “Synesi has not alleged that the misrepresentation relates to a past or present fact, but rather to an expectation regarding future events.” The district court explained:

In this case, Cardot’s claims are what he perceives to be as misrepresentation as to expectations of future events and not representations known to be false by Synesi.... Cardot alleges that Synesi failed to pursue revenue opportunities, drove away financing opportunities and conspired with other entities to convert Synesi’s assets. Synesi denies these allegations and argues that these are not representations that were known to be false by Synesi at the time the Agreements were entered into.... All of Cardot’s claims relate to his expectation of what was going to happen in the future.... In addition, the alleged misrepresentations ... all relate to alleged activity that occurred after Cardot entered into the Assignments and after Cardot was out of the office.

The district court concluded, therefore, that “Cardot has no basis in either the law or facts of this case to support his claims of fraudulent inducement and misrepresentation.”

Cardot argues that the district court mischaracterized his allegations as relating only to expectations of future events. He maintains that his allegations pertain to Synesi’s present intent at the time that the parties entered into the severance agreement. Specifically, he claims that, when the severance agreement was executed in March 2003, the parties had agreed, as the IP agreement signed several months earlier establishes, that moving forward, Synesi would seek to “potentially increase[ ] the value of [Cardot’s] stock holdings ... or potentially increase[e] the possibility that [Cardot] will obtain royalties or a buy out” regarding his interest and rights in the patents. Contrary to this stated intent, Cardot argues that Synesi’s true intent was to prevent the company from generating any revenue on the patents, and thereby to prevent him from realizing royalty payments or any other benefit regarding the patents.

Indeed, a fraud claim can be predicated on a promise to perform at a future date. Hayes v. Northwood Panelboard Co., 415 N.W.2d 687, 690 (Minn.App.1987), review denied (Minn. Jan. 28, 1988). Granted, a subsequent intent to break such promise or the mere fact that the promise was not fulfilled does not constitute fraud. Benson v. Rostad, 384 N.W.2d 190, 195 (Minn.App.1986). But a fraud claim will lie if there is “affirmative evidence” to show that, at the time the promise was made, the promisor had no intention to perform. See Hayes, 415 N.W.2d at 690.

We agree with Cardot that the allegations do not relate simply to “expectations of future events,” as the district court determined, but rather to Synesi’s true intent at the time the severance agreement was executed. Synesi maintains that summary judgment was nonetheless appropriate because the allegations Cardot relies on involve only speculation, conclusory statements, and bare assertions.

*7 To withstand summary judgment, a nonmoving party cannot rely upon “mere general statements of fact” but rather must demonstrate that “specific facts are in existence which create a genuine issue for trial.” Hunt v. IBM Mid Am. Employees Fed. Credit Union, 384 N.W.2d 853, 855 (Minn.1986). “Speculation, general assertions, and promises to produce evidence at trial are not sufficient to create a genuine issue of material fact for trial.” Nicollet Restoration, Inc. v. City of St. Paul, 533 N.W.2d 845, 848 (Minn.1995). And affidavits that are based on “information and belief” and contain only unverified opinions and allegations are insufficient to withstand summary judgment. See Urbaniaik Implement Co. v. Monsrud, 336 N.W.2d 286, 287 (Minn.1983) (stating that affidavit opposing summary judgment is not adequate if it only recites argumentative and conclusory allegations).

The critical issue here involves a question of what Synesi’s true intent was when the parties executed the
severance agreement. Generally speaking, intent is a fact question. See Sackett v. Storm, 480 N.W.2d 377, 379 (Minn.App.1992), review denied (Minn. Mar. 26, 1992). And “[s]ummary judgment is notoriously inappropriate for determination of claims in which issues of intent, good faith and other subjective feelings play dominant roles.” Pfizer, Inc. v. Int'l Rectifier Corp., 538 F.2d 180, 185 (8th Cir.1976) (citing White Motor Co. v. United States, 372 U.S. 253, 259, 83 S.Ct. 696, 700, 9 L.Ed.2d 738 (1963)). Here, Cardot alleges that Synesi “secretly chased away one investor in autumn 2002,” and “thereafter insulted and otherwise discouraged a myriad of investors and license seekers until Synesi’s demise in November 2006.” In particular, Cardot claims that Synesi refused to pursue one opportunity in which a company had allegedly offered to “assume hundreds of thousands of dollars of [Synesi’s] debt, pay $85,000 in cash and a 3% royalty” to license the patent rights, and that Synesi refused to consider debt-financing opportunities under terms that were more favorable than those offered by Knoblauch. Although these allegations are not direct evidence that Synesi’s true intent was to prevent any revenue from being generated on the patents, they are circumstantial evidence that tend to support an inference to that effect. And when reviewing summary judgment, we must resolve all reasonable inferences in favor of the nonmoving party. Fabio, 504 N.W.2d at 761.

We conclude that there is a genuine issue of material fact regarding whether the severance agreement was obtained by fraud, and, therefore, the district court erred by determining that the waiver provision in the severance agreement barred Cardot’s claims.

III.

The district court also based its decision on the alternative ground that, regardless of the waiver provision in the severance agreement, Synesi is entitled to summary judgment because Cardot’s claims fail as a matter of law.

A. Fraud

Cardot argues that the district court erred by granting summary judgment on his claim seeking to rescind the IP agreement because, like the severance agreement, it too was obtained by fraud. Cardot’s fraud claim regarding the IP agreement is based on the same allegations as his fraud claim regarding the severance agreement-namely, that, although Synesi represented that it would seek to generate revenue on the patents, Synesi’s true intent was to prevent the company from generating any such revenue. Because we have already concluded that there are fact issues concerning these allegations of fraud, summary judgment on Cardot’s claim seeking to rescind the IP agreement based on the same allegations was, likewise, improper.

B. Breach of contract

Synesi’s obligation under the three assignments was to pay Cardot royalties on revenue generated through the patents. Cardot contends that Synesi “intentionally plac[ed] itself in a position where it could not perform,” namely, “by putting itself in a position where it could never obtain revenues from which to pay royalties to Cardot.” Under such circumstances, Cardot claims, Synesi’s conduct violated the “implied covenant of good faith” and constituted a breach of the three assignments. He concludes, therefore, that fact issues exist as to whether Synesi breached its contractual obligations entitling him to a rescission of the three assignments.

In Minnesota, “every contract includes an implied covenant of good faith and fair dealing.” In re Hennepin County 1986 Recycling Bond Litig., 540 N.W.2d 494, 502 (Minn.1995) “[C]ourts employ the good faith performance doctrine to effectuate the intentions of parties, or to protect their reasonable expectations.” Steven J. Burton, Breach of Contract and the Common Law Duty to Perform in Good Faith, 94 Harv. L.Rev. 369, 371 (1980). The implied covenant of good faith and fair dealing applies when one party exercises discretion, thereby controlling the other party’s benefit. Id. at 369. “‘Bad faith’ is defined as a party’s refusal to fulfill some duty or contractual obligation based on an ulterior motive, not an honest mistake regarding one’s rights or duties,” Sterling Capital Advisors, Inc. v. Herzog, 575 N.W.2d 121, 125 (Minn.App.1998).

Under the implied covenant of good faith, “a party to a contract cannot avoid its duties under the contract by ... disabling itself from performance.” Space Center, Inc. v. 451 Corp., 298 N.W.2d 443, 449 (Minn.1980); see also Miller v. O.B. McClintock Co., 210 Minn. 152, 159, 297 N.W. 724, 728 (1941) (“A person may not escape liability under an agreement upon a condition by preventing the happening of the condition.”). Here, Cardot alleges that Synesi acted in bad faith by rejecting potential investors and licensing and sales opportunities. Similar to the fraud issue addressed above, Cardot’s claim that Synesi breached the duty of good faith focuses on the allegations as to Synesi’s true intent or motive when it decided to not pursue certain investment and business opportunities. As we have already concluded, there are unresolved issues of material facts regarding these allegations, which have at
least some tendency to support an inference that, as Cardot claims, Synesi acted in bad faith. Likewise, we conclude that there are material fact issues that preclude summary judgment on Cardot’s claim that Synesi breached the three assignments by putting itself in a position where it would be unable to perform its contractual obligation of paying royalties to Cardot.

*9 On a related matter, Synesi argues that it is protected under the business-judgment rule from a determination that it breached the three assignments. Synesi claims that the three assignments, the severance agreement, and the “dealings with prospective investors were part of normal business activity conducted in good faith; accordingly Synesi cannot be held liable and its actions ... are protected under the business judgment rule.” But the business-judgment rule is irrelevant to the issues here; this is not a shareholder-derivative action involving a challenge to whether Synesi made sound business decisions, but rather an action on a contractual dispute. Moreover, as Synesi points out, the business-judgment rule applies to normal business activity conducted in “good faith.” Even if the business-judgment rule were relevant, Synesi would not be protected by the rule if Cardot is ultimately able to prove his bad-faith claim.

Finally, Synesi argues that Cardot’s appeal should be dismissed as moot for failure to brief a dispositive ruling by the [district] court. Synesi claims that the dispositive ruling relates to Cardot’s failure to join an indispensable party—namely, TranSurety. Although Synesi moved the district court for a dismissal on the ground that Cardot failed to join TranSurety, the district court did not rule on that motion and instead granted summary judgment. Because the indispensable-party issue was not decided by the district court, we decline to address it on appeal. See Thiele v. Stich, 425 N.W.2d 580, 582 (Minn.1988).

Reversed and remanded.

All Citations

Not Reported in N.W.2d, 2008 WL 4300955

Footnotes

* Retired judge of the district court, serving as judge of the Minnesota Court of Appeals by appointment pursuant to Minn. Const. art. VI, § 10.

1 The company, which was originally named Portogo, Inc., changed its name to Synesi Group, Inc. in 2005. For clarity, we will at all times refer to the company as Synesi.

2 The other two individuals who authored the patents, neither of whom is a party to this litigation, likewise assigned their interests in the two patents to Synesi through separate assignment agreements.

3 In the district court, Cardot also claimed that Synesi’s conduct constituted a “frustration of the purposes” of the three assignments. Cardot has conceded to us that he “withdraws this claim” because “[i]t doesn’t affect the outcome of this case.”

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the evidence of damages did not correspond to work performed; and (5) it was unfair to require appellants to defend two causes of action when one would be decided by the court and the other by the jury. We affirm.

FACTS

In March 2002, appellant John Worlein met with Donald Hanson (Hanson) of respondent Hanson Construction and Specialty Cabinets, LLC (Hanson Construction), about a remodeling project for Worlein’s home. Worlein provided Hanson with a drawing and a material list prepared by Freeborn Lumber. Hanson told Worlein that Hanson would need a much more detailed plan to give an exact cost for the project. Worlein provided Hanson with one or two more plans, but, according to Hanson, they were not sufficiently detailed.

On April 2, 2002, Hanson submitted an initial estimate for the project to Worlein in the amount of $321,759, which included approximately $74,000 for materials to be purchased from Freeborn Lumber. Worlein responded that he had been hoping to keep the cost down in the range of $250,000. On April 18, 2002, Hanson submitted a revised estimate to Worlein in the amount of $284,578, which again included approximately $74,000 for materials to be purchased from Freeborn Lumber. Both estimates were prepared based on the material list provided by Freeborn Lumber. Worlein was satisfied with the revised estimate and orally stated to Hanson that they would go ahead with the project. The parties did not enter into a written contract.

Hanson Construction began work on the project in the spring of 2002. After completing the project in August 2003, Hanson Construction brought this action against Worlein alleging that he had failed to pay the full amount owed for labor and materials.

Hanson testified at trial: During the project, Worlein made changes to the project, sometimes bypassing Hanson and dealing directly with subcontractors. Hanson did not put the change orders in writing because the changes were happening so fast and because he was under the impression that cost was not an issue to Worlein. Hanson generally discussed the project and the costs of changes with Worlein every morning, and Worlein would give his approval. Hanson became concerned about the increasing cost of the project and periodically expressed that concern to Worlein. Worlein always said not to worry and assured Hanson that he would get paid. Worlein never
stopped Hanson from doing anything and never expressed any concern about cost. Hanson provided specific, detailed testimony about the changes Worlein made.

*2 Hanson submitted the following invoices to Worlein:
July 21, 2002: $45,990
October 21, 2002: $84,298.16
December 9, 2002: $89,987.07
January 21, 2003: $31,704.92

Along with each invoice, Hanson provided a spreadsheet showing itemized expenses and the differences between the actual expenses and the initial and revised estimated expenses. Worlein paid the invoices in a timely manner.\(^2\) On June 30, 2003, Worlein paid Hanson an additional $20,000 without an invoice. As of June 30, 2003, the total amount that Worlein had paid Hanson was $270,694.92. Worlein also made the following payments directly to Freeborn Lumber:

The payments to Freeborn Lumber totaled $93,292.65. The payments to Hanson and Freeborn Lumber totaled $363,987.57.

The spreadsheet attached to the December 9, 2002 invoice showed the total project cost at $410,946.40. The spreadsheet attached to the January 21, 2003 invoice showed a total project cost of $418,976.64. A final spreadsheet, prepared by Hanson after the project was completed, showed a final total project cost of $444,958.70. The total project cost included the amounts paid to Freeborn Lumber. The total amount that Worlein paid to Hanson and Freeborn Lumber was $80,971.13 less than the final total project cost of $444,958.70. Along with the final spreadsheet, Hanson sent Worlein a four-page letter itemizing and explaining cost overruns.

Worlein testified that he understood that if a project cost exceeded the amount allowed on the estimate, the additional cost would be billed to him. He also understood that if an item was added to the project, it would increase the total cost. Worlein understood that the changes he requested would result in additional costs but was surprised by the amount.

Worlein agreed that some costs exceeded allowances. Worlein admitted that he approved changes to the project, including leaded glass doors, mirrors on upstairs doors, a septic tank, speakers and wiring, a pool, a shower system, a glass shower, using cherry trim instead of oak trim, and using wider-than-standard baseboards. Worlein testified that he did not agree to have a Wirsbo heating system installed in the turret, but he otherwise agreed to project changes.

The jury found by special verdict that a contract existed between Hanson Construction and Worlein; Worlein breached the contract by failing to pay sums owed under it; and Worlein owed Hanson Construction $65,000. The district court issued an order adopting the jury's special verdict and granting judgment for Hanson Construction against Worlein in the amount of $65,000 plus costs and disbursements. The district court denied Worlein's posttrial motion for amended findings of fact, a JNOV, or, alternatively, a new trial. This appeal followed.

**DECISION**

I.
*3 Statutory construction is a question of law, which this court reviews de novo. Ryan Contracting, Inc. v. JAG Invs., Inc., 634 N.W.2d 176, 181 (Minn.2001). The object of statutory interpretation is to ascertain and effectuate legislative intent. Minn.Stat. § 645.16 (2004).

"A person who meets the definition of a residential remodeler as defined in section 326.83, subdivision 16, or a residential building contractor as defined in section 326.83, subdivision 15, must be licensed as a residential building contractor or residential remodeler." Minn.Stat. § 326.84, subd. 1 (2004). "The commissioner may adopt rules to administer and enforce sections 326.83 to 326.98." Minn.Stat. § 326.98 (2004). The commissioner has adopted the following rule:

Contracts between a contractor and a customer for the performance of a licensee's services must be reduced to writing and must contain the following:

A. a summary of the work to be performed;

B. a description of materials to be used or a list of standard features included; and

C. the total contract price, or a description of the basis on which the price will be calculated.

The licensee shall provide to the customer a copy of all written contracts between the licensee and its customer, including, but not limited to, proposals, quotations, change orders, and purchase orders at the time the document is executed.


Worlein argues that Hanson violated Minn. R. 2891.0030, and, therefore, any contract and change orders agreed upon by the parties should be held unenforceable. But the legislature has prescribed specific penalties for violations of chapter 326 and other prohibited conduct by licensees and has granted the commissioner enforcement authority. Minn.Stat. § 326.91, subd. 1 (2004).

The commissioner may by order deny, suspend, or revoke any license or may censure a licensee, and may impose a civil penalty as provided for in section 45.027, subdivision 6, if the commissioner finds that the order is in the public interest, and that the ... licensee ...:

(5) has violated or failed to comply with any provision of sections 326.83 to 326.98 or any rule or order under sections 326.83 to 326.98[.]

Id. Minn.Stat. § 45.027, subd. 6 (2004), authorizes the commissioner to impose a civil penalty not to exceed $10,000 per violation.

We decline to expand the penalties for violating Minn. R. 2891.0030 expressly provided by the legislature. See Ullom v. Indep. Sch. Dist. No. 112, 515 N.W.2d 615, 617 (Minn.App.1994) (stating that this court cannot add to a statute what the legislature may have inadvertently overlooked or purposely omitted); cf. Schermer v. State Farm Fire & Cas. Co., 702 N.W.2d 898, 904 (Minn.App.2005) (explaining that private party does not have cause of action against insurer for violation of the Unfair Claims Practices Act (UCPA) because the UCPA's comprehensive administrative-enforcement scheme is more appropriate to investigating and regulating insurer's business practices), aff'd, —— N.W.2d —— (Minn. Sept. 14, 2006); Mut. Serv. Cas. Ins. Co. v. Midway Massage, Inc., 695 N.W.2d 138, 142 (Minn.App.2005) (discussing factors that must be considered when determining whether a cause of action can be inferred from a statute), review denied (Minn. June 14, 2005).

*4 Citing a case involving fee-splitting by attorneys, Worlein argues that enforcement of a contract in this case violates public policy. In that case, the supreme court stated:

The purpose of these rules governing fee-splitting agreements is to protect the client's best interests throughout his/her representation. Each client has a right to choose the attorney that he/she prefers and to be knowledgeable about the specifics of his/her case, especially those terms regarding the payment of fees. To allow attorneys to proceed with fee-splitting arrangements without the client's written agreement or knowledge would put the client at a severe disadvantage in the lawyer-client relationship.

... Legal commentators have noted reasons why fee-splitting agreements often require a division of labor or responsibility to be consistent with public policy: An agreement to pay a referral fee is often viewed as unenforceable as against public policy. It is thought likely to increase the overall fee charged, to ignore the rights of the client to choose his own lawyer, and to encourage neglect and unethical conduct in the referring attorney, besides being unfair to the one who has done all of the work.
Christensen v. Eggen, 577 N.W.2d 221, 225 (Minn. 1998) (quotation omitted). The policy concerns noted in Christensen are not present in this case. Hanson Construction contracted with Worlein to complete a remodeling project, and brought suit to obtain payment for the work it performed.

II.

Worlein argues that any contract is unenforceable based on a lack of good faith and fair dealing by Hanson. A contract is the result of a bargained-for exchange where both sides exercised good faith and fair dealing. In re Hawesepin County 1986 Recycling Bond Litig., 540 N.W.2d 494, 502 (Minn. 1995) ("[E]very contract includes an implied covenant of good faith and fair dealing...."); Cederstrand v. Lutheran Bhd., 263 Minn. 520, 530, 117 N.W.2d 213, 220 (1962) (stating that a contractual promise must be the product of a bargain); Restatement (Second) of Contracts § 17, 205 (1981). Good faith, at a minimum, excludes actions that violate community standards of decency, fairness, or reasonableness. Restatement (Second) of Contracts § 205 cmt. a. Subterfuge, evasion, and “abuse of a power to specify terms” are some examples of bad faith. Id. cmt. d. The existence of bad faith is a factual question. Gendreau v. Foremost Ins. Co., 423 N.W.2d 712, 714 (Minn. App. 1988).

Worlein suggests that Hanson acted improperly by labeling documents as invoices when what the documents represented were draws. Hanson explained that the amounts on the invoices did not necessarily include all work completed on the project but rather he was drawing money to cover his costs. An invoice is defined as “[a] detailed list of goods shipped or services rendered, with an account of all costs; an itemized bill.” The American Heritage Dictionary of the English Language 949 (3d ed. 1992). Even if labeling the documents as invoices was technically incorrect, the record does not show that the documents were misleading.

Worlein requested and approved numerous changes and that when Hanson expressed concern to Worlein about the increasing project cost, Worlein indicated that cost was not an issue.

It is the jury’s function to determine witness credibility. Melina v. Chaplin, 327 N.W.2d 19, 20 (Minn. 1982). Appellate courts afford great deference to the fact-finder’s determination of weight of testimony and credibility of witnesses. Hasnudeen v. Onan Corp., 552 N.W.2d 555, 557 (Minn. 1996). Whether an enforceable contract existed was a factual question properly resolved by the jury.

III.

The district court’s decision to deny remittitur or a new trial based on excessive damages will not be disturbed absent an abuse of discretion. Hanson v. Chicago, Rock Island & Pac. R.R. Co., 345 N.W.2d 736, 739 (Minn. 1984). A party seeking remittitur or a new trial on the basis of excessive damages must establish that the amount of damages exceeds the highest amount permitted by the evidence, such that the award only can be the product of passion or prejudice. Kinikin v. Heupel, 305 N.W.2d 589, 596 (Minn. 1981); Sandt v. Hyen, 301 Minn. 475, 476, 224 N.W.2d 342, 343 (1974).

Worlein argues that the damages award should be reduced to $14,500. But Hanson presented detailed evidence regarding the costs of numerous changes in the project and the difference between the revised estimate cost and the actual project cost.

Subtracting from the total project cost the total payments that Worlein made to Hanson and Freeborn Lumber leaves a balance due of $80,971.13, which is greater than the amount of the $65,000 jury verdict. The district court did not abuse its discretion in denying remittitur.

IV.

Worlein argues that the district court erred in denying a new trial or JNOV. Ordinarily, appellate courts will not disturb the district court’s decision to grant or deny a new trial absent a clear abuse of discretion. Halla Nursery, Inc. v. Baumann-Furrie & Co., 454 N.W.2d 905, 910 (Minn. 1990) (noting that if district court’s decision to grant new trial is based on error of law and not exercise of
issues are for the fact-finder to resolve. *Tolzmann v. McCombs-Knutson Assocs.*, 447 N.W.2d 196, 198 (Minn.1989). Viewed in the light most favorable to the verdict, the evidence supports the jury’s determination of damages. The district court did not err in denying Worlein’s motion for a new trial or JNOV.

V.

Worlein argues that the district court erred in allowing Hanson Construction to proceed under two theories, breach of contract and unjust enrichment. Hanson Construction argues that Worlein waived this issue by failing to raise it as an affirmative defense. Because the complaint did not make it clear that Hanson intended to proceed under two alternative theories, Worlein did not waive this issue by failing to raise it as an affirmative defense.

*7 The doctrine of election of remedies requires a party to adopt one of two or more coexisting and inconsistent remedies which the law affords the same set of facts. The purpose of the doctrine is not to prevent recourse to any particular remedy but to prevent double redress for a single wrong.

However, if inconsistent remedies are sought and it is doubtful which one will bring relief, a party may claim either or both alternatively until one remedy is pursued to a determinative conclusion. Therefore, a party should not be bound by an election unless he has pursued the chosen course to a determinative conclusion or has procured advantage therefrom, or has thereby subjected his adversary to injury.

Worlein argues that Hanson Construction did not recover under unjust enrichment. *Under Christensen*, the district court did not err in allowing Hanson Construction to proceed under both theories.

Worlein argues that Hanson Construction should not have been allowed to proceed under an unjust-enrichment theory because it failed to pursue the legal remedy of a mechanic’s lien action. But because Hanson Construction did not recover under an unjust-enrichment theory, Worlein’s argument does not present a justiciable controversy. *See In re Schmidt*, 443 N.W.2d 824, 826 (Minn.1989) (explaining that appellate courts decide only...
actual controversies and will not issue advisory opinions or decide moot issues).

Worlein also argues that he was prejudiced by the district court's late decision, after Hanson Construction had finished presenting its case, to submit the issue of damages to the jury. But following Hanson Construction's opening statement, Worlein's counsel raised a concern about the jury possibly becoming confused about the amount of money involved. The district court responded:

As I see it, it's going to turn if the jury does, in fact, find a contract exists and that the changes were agreed to and were part of the contract then the jury may well be asked to find the numbers. If the jury finds that there is no contract, then it will be up to the Court on an equitable basis to determine whether or not there has been any unjust enrichment or should be order by the Court of damages for unjust enrichment.

This pretrial statement by the district court provided Worlein notice that the issue of damages would be submitted to the jury if the jury found that a contract existed. Worlein did not seek a continuance and has not shown any prejudice as a result of insufficient notice that the issue of damages would be presented to the jury. See Phelps v. Blomberg Roseville Clinic, 253 N.W.2d 390, 394 (Minn.1977) (concluding that district court did not err in declining to suppress expert testimony based on late disclosure when party did not seek a continuance and failed to show prejudice). Therefore, even if the notice was insufficient, Worlein is not entitled to reversal.

*8 Affirmed.

All Citations

Not Reported in N.W.2d, 2006 WL 2807018

Footnotes

1 Rosemary Linderman Worlein was initially named as a defendant, but she was dismissed from the action by district court order.

2 For the October 21, 2002 invoice, Worlein paid $84,000, and for the December 9, 2002 invoice, Worlein paid $89,000, rather than the invoice amounts.

   July 29, 2002: $325.40
   September 16, 2002: $45,977.76
   October 31, 2002: $8,009.09
   December 12, 2002: $26,354.11
   April 1, 2003: $12,626.29

3 Hanson Construction argues that this issue is not properly before this court because it was not raised before the district court. Worlein's argument in his new-trial motion that there could be no oral contract because Hanson acted in a deceptive and misleading manner was sufficient to preserve this issue for appellate review.
2005 WL 1154271
Only the Westlaw citation is currently available.

NOTICE: THIS OPINION IS DESIGNATED AS UNPUBLISHED AND MAY NOT BE CITED EXCEPT AS PROVIDED BY MINN. ST. SEC. 480A.08(3).

Court of Appeals of Minnesota.
CROSSTOWN HOLDING COMPANY, et al.,
Appellants,
v.

No. A04-1693.

May 17, 2005.

Hennepin County District Court, File No. CT 02-5980.

Attorneys and Law Firms
Richard T. Ostlund, Randy G. Gullickson, Janel M. Dressen, Anthony Ostlund & Baer, P.A., Minneapolis, MN, for appellants.
Charles F. Webber, Karla C. Robertson, Faegre & Benson, LLP, Minneapolis, MN, for respondents.
Considered and decided by SHUMAKER, Presiding Judge; DIETZEN, Judge; and PORITSKY, Judge.

UNPUBLISHED OPINION
GORDON W. SHUMAKER, Judge.

*1 This lawsuit arose after appellant Crosstown Holding Company’s attempt to purchase three branch banks from respondent Wells Fargo failed, and the latter instead sold the bank to First Federal Savings Bank. Crosstown claimed this was the result of improper actions by one of Wells Fargo’s employees, and sued for damages for (a) breach of contract; (b) breach of the covenant of good faith and fair dealing; (c) misrepresentation; (d) negligent misrepresentation; (e) promissory estoppel; (f) unjust enrichment; and (g) civil conspiracy. The district court granted summary judgment to respondents on all claims. Crosstown also asserts the court erred in failing to rule on its motion for leave to file a second amended complaint. We affirm.

FACTS
Appellant Crosstown Holding Company (Crosstown) sued after its attempts to purchase three branch banks from respondents failed and respondents sold the banks to another company. Crosstown argues that improper activities by one of respondents’ employees caused the deal to fail and appeals from summary judgment in favor of respondents. Additionally, Crosstown asserts that the district court erred in not addressing appellants’ motion for leave to amend its complaint.

Respondent Wells Fargo is a banking and financial services company. Respondent Marquette Bank is a Minnesota corporation that owns a number of banks in Minnesota. In October 2001, Wells Fargo acquired Marquette Banks. In order to gain federal regulatory approval for this acquisition, Wells Fargo agreed to sell some Marquette branch banks, including three branches in Rochester, Minnesota.

Crosstown contacted Wells Fargo and expressed an interest in bidding on the Rochester branches. In order to receive a bid package from Wells Fargo, each bidder was required to sign a confidentiality agreement. Crosstown signed the confidentiality agreement on November 1, 2001, and received a bid package shortly thereafter.

The bid package set forth the process that would be used for the sale of the Marquette branch banks. The bidding companies were invited to review the materials provided on each of the branches and submit “non-binding indications of interest” or, in other words, a preliminary bid. Potential purchasers were asked to submit their preliminary bids by noon on November 7, 2001. Wells Fargo intended then to review the bids and determine which potential purchasers would be allowed to move forward in the process by conducting limited due diligence on the purchase of the branches.

Crosstown submitted a timely bid of $19,406,555 for the Rochester branches. Crosstown’s bid was the highest of the three received for the Rochester branches, and Crosstown was the only company invited to perform due diligence on the Rochester branches. Steve McConley, a vice-president of Wells Fargo’s Corporate Development Department, notified Crosstown that its bid was very impressive and Wells Fargo would proceed to due
diligence "with you and you alone."

*2 After Crosstown was given permission to complete further due diligence on the Rochester banks, Wells Fargo introduced Crosstown's CEO to Michael Bue. Bue was a Marquette employee and president of the Rochester branches and was also in charge of the due diligence that was conducted at the Rochester branches.

Bue wanted to ensure that he would have a job with the purchaser of the Rochester banks. In efforts to ensure future employment with the purchaser of the banks, Bue entered into a contract with Robert Edelman, a Milwaukee investment banker, to find a "strategic partner" to buy the Rochester branches. Edelman knew of First Federal bank in Wisconsin, and contacted it about an opportunity to buy the Rochester branches. Wells Fargo does not dispute that it was not part of Bue's job to solicit possible purchasers of the Rochester branches.

Edelman contacted Wells Fargo on behalf of First Federal on November 20, 2001. Wells Fargo allowed First Federal to bid. First Federal signed the confidentiality agreement on November 21, 2001, and was sent the bid package shortly thereafter. Based on its preliminary bid, Wells Fargo then decided to invite First Federal to perform due diligence at the Rochester branches. On December 5, 2001, Wells Fargo informed Crosstown that another party also was being allowed to conduct due diligence on the Rochester branches.


Crosstown sued for damages for breach of contract, breach of covenant of good faith and fair dealing, misrepresentation, negligent misrepresentation, promissory estoppel, unjust enrichment, and civil conspiracy. The district court granted summary judgment to respondents on all claims.

**DECISION**

On an appeal from summary judgment, we ask two questions: (1) whether there are any genuine issues of material fact and (2) whether the district court erred in its application of the law. *State by Cooper v. French*, 460 N.W.2d 2, 4 (Minn.1990).

A motion for summary judgment shall be granted when the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that either party is entitled to a judgment as a matter of law. On appeal, the reviewing court must view the evidence in the light most favorable to the party against whom judgment was granted.

*Fabio v. Bellomo*, 504 N.W.2d 758, 761 (Minn.1993) (citation omitted). No genuine issue of material fact exists "[w]here the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party."

*DLH, Inc. v. Russ*, 566 N.W.2d 60, 69 (Minn.1997).

1. *Breach-of-Contract Claim*

*3 Crosstown claims that the district court erroneously concluded that no contract existed between the parties. Whether a contract exists is generally an issue for the factfinder," but if, taking the record as a whole, a rational trier of fact could not find for the nonmoving party, summary judgment is appropriate. *Gresser v. Hotzler*, 604 N.W.2d 379, 382 (Minn.App.2000).

The district court determined that no contract existed on which Crosstown could base its claim, stating that both parties signed an agreement that neither party would be bound *until* they both executed a written agreement. Crosstown asserts three separate breach-of-contract theories: (1) respondents breached their contract to conduct a fair and evenhanded bidding process; (2) respondents breached their contract to exclusively negotiate with Crosstown for the sale of the Rochester branches; and (3) Wells Fargo breached their contract to keep Crosstown's bidding information confidential.

a. *Contract to conduct fair bidding process*  
Crosstown argues that Wells Fargo had a duty to conduct a fair and evenhanded bidding process, but failed to do so and, thus, breached its contract with Crosstown. The evidence Crosstown points to for the existence of a contract for a fair bidding process is a "fair reading" of the confidentiality agreement and bid package. The
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confidentiality agreement states that none of the parties "shall have any obligation with respect to an Acquisition except pursuant to written agreements, if any, entered into after the date hereof." A signed agreement is not required for formation of a contract. Aratex Servs., Inc. v. Blue Horse, Inc., 497 N.W. 2d 283, 285 (Minn.App. 1993), review denied (Minn. May 11, 1993). However, when the parties understand that a written contract is a condition precedent to their being bound, there can be no binding contract until the written agreement is executed. Powell v. MVE Holdings, Inc., 626 N.W. 2d 451, 462 (Minn. App. 2001).

Additionally, the first page of the bid package provided from Wells Fargo states:

The acceptance by a bidder of the offering procedures set forth in the Memorandum does not constitute an agreement in the principle or letter of intent with respect to the terms of any possible transaction between the bidder and the Companies. The Companies further expressly reserve the right, at any time, to modify any of the terms, conditions or procedures of the offering or to terminate discussions and request the return of this Memorandum.

The bid package contained specific instructions and materials on how an interested company should go about submitting a preliminary bid to allow it to move forward in negotiations. In Minnesota, an agreement to negotiate in good faith in the future is not enforceable because it does not constitute the parties' complete and final agreement. Mohrenweiser v. Blomer, 573 N.W. 2d 704, 706 (Minn.App. 1998), review denied (Minn. Feb. 19, 1998). In this case, the parties expressly agreed not to be bound without a written contract; the package of materials was an offer solely to make an offer of potential future negotiations; and the package expressly withheld the right to modify the procedures at any point in time. Therefore, no contract for a fair bidding process existed.

b. Exclusivity Agreement

*4 Crosstown's second theory is that Wells Fargo breached its contract to negotiate exclusively with Crosstown for the sale of the Rochester branches. Crosstown claims that when it was notified on November 9, 2001 that respondents had decided to go forward "with you and you alone," this created a duty to negotiate exclusively with Crosstown as an oral modification of a contract. The general common-law rule is that a written contract can be varied or rescinded by oral agreement of the parties, even if the contract provides it shall not be varied or rescinded orally. Larson v. Hill's Heating & Refrigeration, 400 N.W.2d 777, 781 (Minn.App. 1987), review denied (Minn. April 17, 1987). However, this implies that there was a contract in existence to modify. As stated in the section above, the only documents Crosstown had received at the point when the statement was made were the confidentiality agreement and the bid package. These documents created only an offer to make a preliminary offer and expressly reserved the right to change the terms and procedures at any time. Therefore, based on the express language of the two documents Crosstown had received, no contract existed. Because no contract existed between Crosstown and Wells Fargo at the point the "promise" was made, there could not be an oral modification of the alleged contract.

c. Confidential Information

Finally, Crosstown asserts that Wells Fargo breached its contract to keep Crosstown's preliminary bid information and identity confidential. Crosstown suggests that Bue supplied First Federal with Crosstown's confidential preliminary bid offer and that First Federal then structured its bid to be slightly higher than Crosstown's. Crosstown suggests that because Bue worked for Marquette at the time this information was allegedly shared, Marquette and Wells Fargo are vicariously liable.

Crosstown signed a confidentiality agreement in order to receive the bid package from Wells Fargo. By signing the confidentiality agreement, Crosstown agreed to keep confidential any discussions with Wells Fargo as well as any information Wells Fargo supplied Crosstown regarding the potential purchase of the divested branches. Nowhere in the confidentiality agreement does Wells Fargo agree to keep any of the information it received confidential. Because the confidentiality agreement does not require Wells Fargo to keep any information confidential, this claim for breach of contract fails.

2. Good Faith and Fair Dealing

Crosstown asserts that the district court erred when it determined Crosstown did not have a valid claim for breach of duty of good faith and fair dealing. A duty of good faith and fair dealing is read into every contract in Minnesota. In re Hennepin County 1986 Recycling Bond Litigation, 540 N.W.2d 494, 502 (Minn.1995). When it
exists, a duty of good faith prevents a party from unjustifiably hindering another party's performance of the contract. Id. Additionally, the types of bad faith recognized in judicial opinions are evasion of the spirit of the bargain and abuse of a power to specify terms. White Stone Partners, L.P. v. Piper Jaffray Cos., Inc., 978 F.Supp. 878, 881 (D.Minn.1997). But, a party to a contract does not act in bad faith by asserting or enforcing its legal or contractual rights. Sterling Capital Advisors, Inc. v. Herzog, 575 N.W.2d 121, 125 (Minn.App.1998).

*5 The district court determined that no contract existed, and, as such, Crosstown did not have a valid claim for breach of duty of good faith and fair dealing. Minnesota does not recognize a claim for breach of the implied covenant of good faith and fair dealing separate from the underlying breach of contract claim. Medtronic, Inc. v. Convacare, Inc., 17 F.3d 252, 256 (8th Cir.1994). Therefore, because the district court correctly determined that no contract existed between the parties, the claim for breach of the covenant of good faith and fair dealing fails.

4. Negligent-Misrepresentation Claim
Crosstown argues that Wells Fargo was not entitled to summary judgment on the negligent-misrepresentation claim. Negligent misrepresentation occurs when someone, in the course of business, profession, or employment, or in a transaction in which he has a pecuniary interest, supplies false information for the guidance of another in their business transactions and that person justifiably relies on the information. Hurley v. TCF Banking & Savs., 414 N.W.2d 584, 586 (Minn.App.1987). And persons making representations are negligent when they have not discovered or communicated certain information that the ordinary person in his or her position would have discovered or communicated. Safeco Ins. Co. of Am. v. Daim Bosworth Inc., 531 N.W.2d 867, 870 (Minn.App.1995), review denied (Minn. July 20, 1995). However, when adversarial parties negotiate at arm’s length, there is no duty imposed such that a party could be liable for negligent representations. Id. at 871.

*6 Here, the district court determined that the parties were sophisticated businesses negotiating at arm's length, and, thus, Crosstown did not have a valid claim for negligent misrepresentation. Crosstown argues that the district court's reliance on Safeco was misplaced. Crosstown suggests that in Safeco the defendant was not supplying information for the guidance of the plaintiff but was negotiating with the plaintiff as part of a commercial transaction, which is why no negligent misrepresentation was found. Crosstown contends that the present situation differs from Safeco because Wells Fargo was providing information for the guidance of Crosstown. However, Crosstown was completing due diligence in contemplation of an approximately $20 million purchase from Wells Fargo. Wells Fargo was not attempting to provide "guidance" to Crosstown regarding the contemplated purchase of the Rochester branches; it was attempting to sell the Rochester branches for the highest price offered. Therefore, because the parties were sophisticated businesses negotiating at arm's length for the sale of banks, Wells Fargo did not owe a duty to
Crosstown such that it could be liable for negligent representations, and the district court's grant of summary judgment is correct.

5. Promissory Estoppel
Crosstown contends that the district court erroneously weighed the evidence when it granted summary judgment in favor of Wells Fargo on the promissory estoppel claim. Promissory estoppel implies a contract in law where no contract exists in fact. *Dell v. Univ. of Minnesota*, 578 N.W.2d 779, 781 (Minn.App.1998), review denied (Minn. July 16, 1998). The doctrine of promissory estoppel is applicable when (1) a promise has been made; (2) the promisor should have reasonably expected the promise to induce action by the promisee; (3) the promisee does in fact act; and (4) justice requires enforcement of the promise. *McNeill & Assoc., Inc. v. ITT Life Ins. Corp.*, 446 N.W.2d 181, 185 (Minn.App.1989), review denied (Minn. Dec. 1, 1989).

We will begin with the last element of promissory estoppel, because it is dispositive of this claim. The last element of the promissory estoppel claim is whether justice requires that the promise be enforced. This element is a question of law the court must decide. *Fairmon v. Winona State Univ.*, 540 N.W.2d, 879, 883 (Minn.App.1995), review denied (Minn. Feb. 9, 1996). Numerous considerations enter into a judicial determination of injustice, including the reasonableness of the promisee’s reliance and a weighing of public policies in favor of both enforcing bargains and preventing unjust enrichment. *Id.* A promise of a possible benefit is too uncertain to require special judicial action to avoid injustice. *Id.* at 884.

Here, Crosstown argues that Wells Fargo promised that it would go forward in due diligence “with you and you alone.” Crosstown does not dispute that the parties had never reached a final contract. The promise was that Crosstown was to complete due diligence on its own, not that it would automatically receive the Rochester branches. Additionally, Wells Fargo had stated, in both the confidentiality agreement and the bid package which Crosstown received, that the process of the acquisition would be in the sole discretion of Wells Fargo and that Wells Fargo would be able to reject any offers and terminate any discussions at any time. Therefore, at best, the promise from Wells Fargo indicated that a benefit would possibly be given to Crosstown. Because this benefit is too uncertain, justice does not require the enforcement of the “promise.” The district court’s grant of summary judgment was proper, and we need not address the other elements of this claim.

6. Unjust Enrichment
"Crosstown argues that the district court erred when it granted summary judgment on the unjust-enrichment claim. To establish a claim for unjust enrichment, the claimant must show that another party knowingly received something of value to which he was not entitled and that the circumstances are such that it would be unjust for that person to retain the benefit. *Schumacher v. Schumacher*, 627 N.W.2d 725, 729 (Minn.App.2001). However, an unjust-enrichment claim does not lie merely because one party benefits from another’s efforts or obligations. Rather, it must be shown that a party was unjustly enriched in the sense that the term “unjustly” could mean illegally or unlawfully. *Custom Design Studio v. Chloé, Inc.*, 584 N.W.2d 430, 433 (Minn.App.1998), review denied (Minn. Nov. 24, 1998).

Here, Crosstown argues that Wells Fargo was unjustly enriched when it sold the Rochester branches to First Federal for a higher price than Crosstown offered. Essentially, Crosstown’s theory is that Wells Fargo acted unlawfully when it misused Crosstown’s confidential bid information as well as when Wells Fargo reneged on its promise to move forward exclusively with Crosstown. The product of this “unlawful” action was a “windfall of several million dollars” when Wells Fargo sold the Rochester branches to First Federal at a higher price than what Crosstown had offered. Crosstown has not shown that Wells Fargo was not entitled to seek out the highest bidder for the Rochester branches. Nor has it shown that it would be unjust for Wells Fargo to keep the money it received when it sold the branches to First Federal. Therefore, because Crosstown has failed to show a genuine issue of material fact supporting its claim for unjust enrichment, the district court’s grant of summary judgment was proper.

7. Conspiracy Claim
Crosstown argues that the district court erred when it granted summary judgment on the conspiracy claim. A conspiracy is a combination of persons to accomplish an unlawful purpose or a lawful purpose by unlawful means. *Harding v. Ohio Cas. Ins. Co.*, 230 Minn. 327, 337, 41 N.W.2d 818, 824 (1950). To constitute a conspiracy, the minds of the alleged conspirators must meet upon a plan or purpose of action to achieve the contemplated result. *Bukowski v. Juraneck*, 227 Minn. 313, 318, 35 N.W.2d 427, 429 (1948).

In this case, Crosstown alleges that Marquette and Wells...
Fargo engaged in concerted efforts with First Federal and Edelman to remove Crosstown from its promised position of sole bidder and to sell the Rochester branches to First Federal. Although a conspiracy can be proved by circumstantial evidence, *Nathan v. St. Paul Mut. Ins. Co.*, 251 Minn. 74, 81, 86 N.W.2d 503, 509 (1957), Crosstown fails to show how the purchase of the banks was an unlawful purpose, or that the actions taken by Marquette and Wells Fargo were unlawful, or that the minds of the alleged conspirators were united in a common plan or result. Therefore, because Crosstown failed to prove the existence of any conspiracy, this claim is without merit, and the district court's grant of summary judgment was proper.

8. *Crosstown's Motion to Amend*

The district court has broad discretion to grant or deny leave to amend a complaint, and its ruling will not be reversed absent a clear abuse of discretion. *Fabio*, 504 N.W.2d at 761. Whether the district court abused its discretion in ruling on a motion to amend may turn on whether it was correct in an underlying legal ruling. *Id.* at 761-62.

After a response is served, a party can amend its pleadings only by leave of the court, "and leave shall be freely given when justice so requires." *Minn. R. Civ. P.* 15.01. Generally, an amendment will be allowed, except when there is prejudice to the other party, substantial delay will result, or the amendment does not state a cognizable claim. *Emsw r v. Indep. Sch. Dist. No. 704*, 399 N.W.2d 593, 597 (Minn.App.1987), *review denied* (Mar. 25, 1987). Additionally, the district court may consider the stage of the proceedings when deciding whether or not to allow an amendment. *Id.*

Crosstown argues that the district court abused its discretion when it denied Crosstown's motion for leave to amend its complaint. Crosstown moved to amend its complaint to include Bue, Edelman, and First Federal as parties, and to assert additional claims. The district court heard Crosstown's motion jointly with Marquette's and Wells Fargo's motion for summary judgment. It appears that, because the district court granted Marquette's and Wells Fargo's motion for summary judgment on all of the claims, it denied Crosstown's motion to amend. However, the district court's reasoning is unclear because it did not provide any explanation or order addressing Crosstown's motion. Because the district court has wide discretion to grant or deny motions to amend and because the district court may consider the stage of the proceedings when making its decision, we affirm the district court's denial of the motion based solely on the timing of the motion and do not reach the merits of the motion.

**Affirmed.**

**All Citations**

Not Reported in N.W.2d, 2005 WL 1154271

Footnotes

- Retired judge of the district court, serving as judge of the Minnesota Court of Appeals by appointment pursuant to Minn. Const. art. VI, § 10.
Introduction

Given today’s technology driven business and social climates, it should come as no surprise that the risks and costs of a data breach are continuing to increase. While the threat of a data breach is pervasive and here to stay, industry data reinforces the importance of cyber-resilience. It is critical that businesses of all shapes and sizes embrace the reality of this brave new world and take reasonable and cost-effective steps to effectively manage this risk.

Notably, in its 2018 report, the Ponemon Institute stated that the average cost of a data breach has increased from $3.62 to $3.86 million. (Pg. 3, 2018 Cost of a Data Breach Study: Global Overview, Ponemon Institute (July 2018)). Moreover, the average cost of a breach for organizations that do not deploy security automation is $4.43 million, while the cost for companies that fully deploy security automation is $2.88 million. (Id. at 4). The Ponemon Institute further reports that the average global probability of a material breach occurring in the next 24 months is nearly 28 percent. (Id. at 3). Clearly, this data is a sobering reminder of the likelihood of a cyber-event as well as the serious financial consequences of such an event.

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1 The report states that this data pertains to “[a] breach that involves a minimum of 1,000 lost or stolen records containing personal information.” Id. at n.3.
Importantly, according to the Ponemon report, companies that successfully contain a breach within 30 days saved more than $1.10 million as compared to those companies that did not. Id. at 4. Of course, it is impossible for a modern-day company to guarantee that it will not be victimized by a data breach. Fortunately, industry data confirms the benefits of cyber resilience.

**Industry Best Practices Require Cyber Resilience**

The negative business impact caused by a cyber-attack are well known, and industry data reflects that cyber-attacks can lead to lost business, negatively impact a company’s reputation, and inevitably cause a business to incur substantial costs. Fortunately, an organization that takes reasonable steps to prepare for and manage this risk will lessen the negative business impact of a cyber event.

In order to comply with industry best practices, a business should – on an on-going basis – develop and implement strategies in several key areas. Of course, a business must adopt appropriate technological safeguards. A business should ensure that a sufficient firewall is in place, routinely conduct penetration testing, and ensure that anti-virus and malware software is properly and timely updated. A company should also map its business data and prioritize and segment that data. A properly experienced IT forensics firm can serve as an effective consultant in this area.

Employee training is another area that is critical when it comes to cyber resilience. A company must address, with its employees, passwords, relevant employment policies, how to spot a phishing attack, and other issues in order to create a culture of cyber awareness. It is
also advisable for a business to provide employees with the ability to encrypt confidential business material. A company should also instruct its internal IT personnel to provide timely notice of any perceived or potential security threats, as well as response strategies.

It is also critical that a business evaluate insurance coverage options. Moreover, general counsel or outside counsel should be tasked with evaluating contracts to ensure that a company has appropriate indemnification provisions and other contractual protections. While every business is always interested in minimizing costs, the retention of legal counsel who can provide cyber resilience consultation can trigger the protection of the attorney-client privilege and help to ensure that resilience activities are current, thorough and state-of-the-art.

Finally, best practices indicate that a client should develop and implement an emergency response plan. An emergency response plan will address several areas and must be designed to discontinue and contain a cyber-attack, determine how the cyber-attack occurred, recover lost information, and restore business operations. As discussed in further detail, below, the restoration of business operations is a critical aspect of the emergency response plan.

**Planning for Business Interruption**

Clearly, best practices identify several areas that companies must address in order to effectively manage the risk of a data breach. Taking steps to ensure business continuity is an important part of this process. A recent report from the Business Continuity Institute evaluates the main threats faced by organizations, how professionals view those threats, and
what steps organizations are taking in light of such threats. Not surprisingly, the report identifies non-physical threats as the most significant, and identifies the risks of a cyber attack and data breach as topping the list. (Pg. 6, Horizon Scan Report 2018, Business Continuity Institute (January 2018)). The report further states that malicious attacks via the internet are the number one trend impacting business continuity. (Id. at 8). Companies must have resiliency in place in order to minimize the duration and impact of business interruption.

Why must an organization plan for business interruption? Insurance will not cover all the costs associated with a cyber-attack. Moreover, business interruption often leads to lost clients and customers who are not easily - and sometimes not ever - replaced. For these reasons, and many others, it is in a company’s best interests to develop, implement and maintain a business continuity plan. An effective business continuity plan should include four components.

First, in order to initiate this process, a company should perform a business impact analysis. During this process, it is critical that an organization evaluate the functions that are critical to its business operations as well as those that are time sensitive. The company must also identify the resources that support these functions.

Of course, the creation of a team that is responsible for business continuity is critical. The team must be properly trained and must regularly evaluate and - when necessary - update the business continuity plan. Moreover, a cyber-attack can disrupt communications, access to data as well as production and this disruption can, in turn, impact production and client communication, among other business functions. Accordingly, a sound business
interruption plan will need to include, as a team member, a technical expert who will assist with the recovery of information, the restoration of communications and other business continuity efforts.

Second, a company must develop strategies that will facilitate the recovery of its critical business functions as soon as possible. During this process, a company should identify and evaluate any gaps that may exist between its current ability to recover and what would be required for the recovery of its critical business functions. The business continuity team should evaluate all reasonable recovery options and, along with management, identify and then implement the preferred strategies.

Third, the company should develop and document the specific plan. During this process, it is critical to map out a specific plan and identify the group responsible for execution. A company should also evaluate the potential need to relocate certain business functions, which may be necessary, depending upon the nature and extent of the incident. Following this process, the company should draft and obtain c-suite or management approval of the specific business interruption procedures.

Finally, it is critical that a company regularly test its business continuity plan in order to determine whether changes or updates are necessary. In the event that plan testing identifies any deficiencies, those should be discussed, evaluated and accounted for in a revised plan.
**Business Interruption Insurance**

Of course, a business always has the option of purchasing business interruption insurance that may provide coverage for certain losses incurred during a disruption of business operations that result from a cyber-attack. Such insurance can provide coverage for lost earnings or profits as well as operating expenses if the loss falls within the scope of the applicable coverage. It is critical for a business to evaluate the specific terms of an insurance policy to determine whether that policy will truly address that company’s needs and to avoid a surprise that can occur if a business misunderstands the nature or extent of its coverage. For example, business interruption coverage may only be triggered upon the complete cessation of business operations and may not extend to a mere diminution of business.

**Conclusion**

An effective business continuity plan must identify and account for any event that may potentially impact business operations. The implementation of the business continuity plan is a reaction to a cyber-attack, and the key goal is to maintain a company’s financial viability and going concern during the immediate aftermath of an attack.
Commercial general liability (CGL) policies are sometimes referred to as “litigation insurance.” These policies typically obligate the insurer to defend any suit seeking potentially covered damages that the insured may be legally obligated to pay. Since 1986, standard CGL policy forms have defined suit to include a civil proceeding and an arbitration proceeding, and in 1988, any other alternative dispute resolution proceeding was added to the definition.

In the context of a CGL insurer’s duty to defend, the definition of suit seems straightforward enough. However, the issue of whether an insurer has any obligations before a suit is filed can engender disputes between insurers and insureds, particularly because not all jurisdictions are in agreement regarding the scope of an insurer’s pre-suit obligations.

Consider, for example, the lurid facts of Sanders v. Phoenix Insurance Co., 843 F.3d 37 (1st Cir. 2017). A divorce attorney (Doe) had an intimate relationship with a client (Sanders), who later committed suicide. Sanders’s estate (Estate) blamed Doe for the death. It served Doe and his law firm with a pre-suit demand letter, as required by M.G.L. ch. 93A. Under Massachusetts law, plaintiffs are required to send such a letter at least thirty days before bringing suit for unfair or deceptive acts or practices in the conduct of any trade or commerce. The purpose of the demand letter requirement is to avoid litigation by giving the recipient the opportunity to respond with a reasonable settlement offer; if the recipient does not make a reasonable offer of settlement, it becomes liable for treble damages and attorneys’ fees.

Doe received the letter. He forwarded it to his professional liability carrier. The carrier denied coverage on various grounds, including the absence of an actual, filed suit for damages. Fearing reputational damage if his name was exposed in public court documents, Doe then entered into pre-suit settlement discussions with the Estate. After mediation, the case settled, and Doe resolved the case without suit being filed. As part of the resolution, Doe agreed with the Estate to a negotiated sum $500,000 and assigned the Estate his rights against the insurer with respect to its failure to defend or indemnify him.

The insurer argued successfully in the district court and the First Circuit that Doe had no such rights under Massachusetts law. The Policy provides that it must only furnish counsel to defend the insured in the face of a suit. [The insurer] has no obligation to provide a defense in the absence of a suit. Sanders, 843 F.3d at 37. Because Sanders’s claim was
resolved prior to litigation, the courts found, Doe’s policy was not triggered, and no coverage obligations arose.

Interestingly, in reaching this conclusion, both courts rejected a prior district court decision, Cytosol Labs., Inc. v. Federal Insurance Co., 536 F. Supp. 2d 80 (D. Mass. 2008), which found a pre-suit MGL ch. 93A demand letter did trigger a duty to defend:

Although not a formal lawsuit, [Cytosol’s failure to respond adequately to the letter] would significantly affect its ability to defend itself in a subsequent action involving these same issues. In addition, [the claimant] stands ready to file suit, and the only reason [it] has not sued Cytosol is because of a tolling agreement [Tolling Agreement]. Accordingly, a duty to defend is triggered, and this court has jurisdiction to consider this dispute.

Id. at 90. How could two courts applying the same policy language to the same type of pre-suit demand letter get to such seemingly divergent results?

**DISCUSSION**

I. **The CGL Policy Language**

A. **The Requirement of A “Suit”**

The standard CGL policy insuring agreement, Form CG 00 01 12 07, begins as follows:

We will pay those sums that the insured becomes legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies. We will have the right and duty to defend the insured against any suit seeking those damages. However, we will have no duty to defend the insured against any suit seeking damages for bodily injury or property damage to which this insurance does not apply. We may, at our discretion, investigate any occurrence and settle any claim or suit that may result.

The policy defines suit as follows:

Suit means a civil proceeding in which damages because of bodily injury, property damage, or personal and advertising injury to which this insurance applies are alleged. Suit includes:

a. An arbitration proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent;

b. Any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent;
As with all policy provisions, this language defines and limits the parties’ obligations. So, for the most part—with limited exceptions—an insurer has no duty to defend its insured unless there is some adversary legal proceeding, falling within the policy definition of “suit.” (Of course, there are occasions when an insurer may choose to become involved, prior to the filing of a “suit,” even though it has no clear legal duty to do so. For example, a carrier may conclude that both the carrier and the policyholder would benefit from pre-suit settlement. By getting involved early, the carrier may be able to prevent the claim from escalating. It may be able to avoid unnecessary and potentially large attorney fee expenditures to litigate a covered claim with a high likelihood of liability. In general, however, the decision as to whether to become involved in this way is left to the discretion of the carrier and its claims personnel.

Tying an insurer’s obligation to the existence of a “suit” in this way makes sense in that it provides insurers with a definable event that triggers their policy obligations. Tying an insurer’s obligation to the existence of a “suit” may also make sense from the perspective of defining and underwriting risk. Underwriters, who are charged with evaluating and pricing risks, can readily access information as to the number and extent of suits, or damage awards against a company, or within a relevant industry group or segment. By manipulating and analyzing this data, they can reach a pricing formula that accurately and fairly reflects the exposure of a particular insured to future “suits” of similar kinds. Using these numbers, they can fairly agree to transfer and assume some of that risk.

By contrast, when demands are resolved informally (prior to suit being filed) it is much harder for underwriters to identify, valuate and price the exposures presented. These claims are not tested through litigation. They are not usually reduced to a judgment or settlement through an adversary process. They may be negotiated and resolved based on abstract concepts of “fairness,” with an eye toward the preservation of ongoing business relationships, or the avoidance of negative publicity, or other matters that difficult to estimate monetarily, and are not properly the concern of insurers.

Finally, pre-suit settlements tend to be private. They may or may not be reported, and particularly in cases where the carrier has not been properly notified they may be infected by collusion between the insured and the injured party. *Griabaldo, Jacobs, Jones & Assoc. v. Agrippina Versicherunger A.G.*, 3 Cal.3d 434, 449 (1970) (noting concern to prevent collusion as well as to invest the insurer with the complete control and direction of the defense or compromise of suits or claims.)

B. **The Requirement of “Damages”**

In addition to the requirement of a “suit,” there is also a second requirement that must be met to trigger an insurer’s obligations under the policy insuring agreement: the suit must be one for “damages” to which the policy applies. In most policies, the term “damages” is not defined. Although the term is generally understood to include compensatory monetary relief, other types of relief may also constitute “damages.” For example:

- *Injunctive Relief.*
Some jurisdictions, such as California, have found that damages requires a payment of money, and does not include injunctive relief. See Columbia Cas. y Co. v. Gordon Trucking, Inc., 758 F. Supp. 2d 909 (N.D. Cal. 2010). In other jurisdictions, the term damages may include injunctive relief. See, e.g., School Union No. 37 v. United Nat’l Ins. Co., 617 F.3d 554, 563 (1st Cir. 2010); Omega Flex, Inc. v. Pac. Empls. Ins. Co., 78 Mass. App. Ct. 262, 267 (2010). Moreover, a legal proceeding that seeks injunctive relief and other relief has been found to trigger an insurer’s duty to defend. See Country Mut. Ins. Co. v. Bible Pork, Inc., 2015 IL App (5th) 140211.

- Statutory Damages, Fines or Penalties.

When fines or penalties are involved, some courts deem it to be against public policy to shift such costs to insurers. See, e.g., Carney v. Coull Bldg. Inspections, Inc., 847 N.Y.S.2d 895 (2007); State Farm Fire & Cas. Co. v. Martinez, 26 Kan. App. 2d 869, 875 (2000). In other cases, the question of whether statutory damages or penalties constitute covered damages may depend on whether the specific damages, fines or penalties at issue are compensatory or punitive in nature and, if the latter, whether applicable public policy precludes coverage for punitive relief. See Standard Mut. Ins. Co. v. Lay, 2013 IL 114617 (statutory damages available under the federal Telephone Consumer Protection Act of 1991 are covered because they are remedial in nature and not punitive); Ulta Salon v. Travelers Property Cas. Co. of Am., 2011 WL 2279527 (Cal. App. 2011) (civil penalties sought pursuant to the California Safe Drinking Water and Toxic Enforcement Act of 1986 for failure to warn of a harmful toxin not covered because not damages because of bodily injury).

- Plaintiff’s Attorney Fee Awards.

Many, but not all, courts have found that a plaintiff’s attorney fee award constitutes damages. See Mid-Continent Cas. Co. v. Petroleum Solutions, Inc., No. 4:09-0422, 2016 WL 5539895 (S.D. Tex. Sept. 29, 2016) (attorneys’ fee award under the Texas Product Liability Act against an innocent seller qualified as damages because of property damage but seller’s attorneys’ fees incurred in successfully prosecuting its claim against the manufacturer did not constitute damages); Church Mut. Ins. Co. v. Exec. Bd. of the Mo. Baptist Convention, No. 03-4224-CV-W-SOW, 2005 WL 1532948, at *10 (W.D. Mo. June 24, 2005) (award of attorneys’ fees and costs is indistinguishable from a damages award for [insurance] coverage purposes). Some courts find that plaintiff’s attorney fee awards are court costs, which are covered as part of the insurer’s duty to defend, rather than damages. See Prichard v. Liberty Mut. Ins. Co., 84 Cal. App. 4th 890 (2000).
II. **The Insured's Pre-Suit Duties**

For obvious reasons, CGL policies require insureds to notify their insurers promptly of any "suit," seeking "damages," that may be covered under a policy. The purpose of these provisions is to allow insurers to involve themselves in the resolution of such "suits," and to efficiently manage their own and their insured's financial exposures.

Toward this end, most policies contain language like the following, captioned "Duties In The Event Of Occurrence, Offense, Claim Or Suit:"

b. If a claim is made or "suit" is brought against any insured, you must:

(1) Immediately record the specifics of the claim or "suit" and the date received; and

(2) Notify us as soon as practicable.

You must see to it that we receive written notice of the claim or "suit" as soon as practicable.

c. You and any other involved must

(1) Immediately send us copies of any demands, notices, summonses, or legal papers received in connection with the claim or "suit,"

(2) Authorize us to obtain records and other information

(3) Cooperate with us in the investigation or settlement of the claim or defense against the "suit," and

(4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply.

In addition to notice of suits and claims, CGL policies require insureds to notify their insurers as soon as practicable of an "occurrence" or an offense which may result in a claim. ISO CGL form CG 00 01 04 13, for example, states as follows:

a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:
(1) How, when and where the "occurrence" or offense took place;

(2) The names and addresses of any injured persons and witnesses; and

(3) The nature and location of any injury or damage arising out of the "occurrence" or offense

Finally, most CGL policies make clear that there is no coverage for voluntary payments, i.e., payments incurred by an insured without the assent of an insurer: No insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

II. Risks of Ignoring Pre-Suit Policy Language

A. Risks To Insureds — Untimely Notice

In some cases, insureds fail to provide timely notice to an insurer of an occurrence, claim or suit. Many such delays are innocent: the insured was simply unaware of its coverage, or did not anticipate that the suit would proceed, or simply forgot to provide notice.

In some cases, however, insureds may intentionally delay in notifying their insurers of a claim, particularly a claim that has not yet ripened into a formal lawsuit. For example, an insured might not want to immediately cede the handling of a civil claim to its insurer, because of concerns for potential collateral consequences — negative publicity, impact to reputation, unwanted regulatory attention, even criminal liability. Recognizing that insurance is, fundamentally, a financial relationship — an insurer's principal goal is to address and resolve the monetary impacts of a claim — an insured might not trust the insurer to manage these other aspects with proper sensitivity. By intentionally delaying in notifying its insurer of a claim, the insured may hope to keep the insurer at arm's length until the risk of regulatory or reputational harm have died down, or other collateral aspects of the matter have been addressed.

Courts treat the consequences of late pre-suit notice in a variety of ways. In most jurisdictions, an insurer cannot deny coverage based on the timing of the insured's notice unless the insurer can demonstrate that it was prejudiced by the late notice. See, e.g., Sherwood Brands, Inc. v. Great Am. Ins. Co., 13 A.3d 1268, 1270 (Md. 2011); Stresscon Corp. v. Travelers Prop. Cas. Co. of Am., 2013 COA 131, ¶ 26 (Colo. Ct. App. 2013); Ansul, Inc. v. Emp’rs Ins. Co., 2012 WI App 135, ¶ 24 (Wis. Ct. App. 2012). In some instances, the prejudice requirement is statutory. See, e.g., Mass. Gen. Laws ch. 175, § 112; Md. Code Ann., Ins. § 19-110; Wis. Stat. § 631.81. But in a few jurisdictions, lack of timely notice is a valid coverage defense, regardless of prejudice. See, e.g., Travelers Indem. Co. of Ill. v. United Food & Comm’l Workers Int’l Union, 770 A.2d 978, 991 (D.C. 2001); Fireman’s Fund Ins. Co. v. Care Mgmt., 361 Ark. 800 (Ark. 2010). And in other jurisdictions, prejudice may be considered only if the insured has a reasonable justification for the delay. See County Mut. Ins. Co. v. Livorski Marine, Inc., 856 N.E.2d 338 (Ill. 2006). Even in jurisdictions that require prejudice as a basis for denial of coverage, prejudice will often be found if the insurer is deprived of the opportunity to investigate or defend.
A delay in notice may also leave the insured liable for the costs incurred in defending a matter prior to the date notice was given. While courts are split regarding whether an insurer is liable for pre-tender defense expenses, a majority of courts find that pre-tender defense expenses are not covered. These courts reason that "a tender of defense is a condition precedent to the creation of a duty to defend," Towne Realty, Inc. v. Zurich Ins. Co., 548 N.W.2d 64, 68 (Wis. 1996), and the insurer "can only be liable for damages which 'naturally flow' from its breach of a contractual duty," and no such duty exists until the insured puts the insurer on notice of a claim. Towne at 68 (citation omitted, emphasis in original). See also Elan Pharm. Research Corp. v. Employers Ins. of Wausau, 144 F.3d 1372 (11th Cir. 1998) (requiring the insurer to pay costs incurred before tender would render the "contractual terms necessary to trigger ... [the insurer's] performance under the policy meaningless.")

There is, however, a substantial minority view that insurers should be required to pay pre-tender defense expenses. These courts reason that there is nothing in the CGL policy that ties an insurer’s duty to defend to notice. Instead, the duty to defend arises when an underlying suit is brought against the insured with allegations that are arguably within the scope of the insurance policy's coverage . . . an insurer’s duty to defend is triggered when the underlying claim is brought and thus pre-exists any obligation on the part of the insured as to notice or compliance with the voluntary payment provision of an insurance contract. Episcopal Church v. Church Ins. Co., 53 F. Supp. 3d 816, 828 (D.S.C. 2014).

As another court reasoned, to hold that the duty to defend could not possibly arise before notice or tender would:

confuse events which give rise to the duty to defend (an underlying suit is brought against the insured with allegations that are arguably within the insurance policy's indemnification provisions) and events which give rise to an insurer's breach of that duty (awareness of the need for defense and an unjustified refusal to defend) . . . . [T]he duty to defend pre-exists any obligation on the part of the insured as to notice or compliance with the voluntary payment provision of an insurance contract . . . . The duty arises when the underlying claim is brought and thus pre-exists the insured's obligation to notify its insurer of that suit.

Liberty Mut. Ins. Co. v. Black & Decker Corp., 383 F. Supp. 2d 200, 205 (D. Mass. 2004) (quoting Aetna Cas. & Surety Co. v. Dow Chem. Co., 44 F. Supp. 2d 847, 857 (E.D. Mich. 1997)). Jurisdictions that require insurers to cover pre-tender defense expenses typically hold that the insurer must establish prejudice to forfeit the coverage to which the insured would otherwise be entitled. See Weaver v. State Farm Mut. Auto. Ins. Co., 936 S.W.2d 818, 821 (Mo. banc 1997). According to the Weaver court, a notice condition is not a technical escape-hatch by which to deny coverage in the absence of prejudice nor to evade the fundamental protective purpose of the insurance contract to assure the insured and the general public that liability claims will be paid up to the policy limits for which premiums were collected. Weaver, 936 S.W.2d at 820. See also Smith & Nephew, Inc. v. Federal Ins. Co., 2005 WL 3434819 (W.D. Tenn. 2005) (a prejudice analysis should apply to both the existence of a duty to defend after late notice, as
well as to whether that duty includes pre-tender costs); TPLC, Inc. v. United Nat’l. Ins. Co., 44 F.3d 1484 (10th Cir. 1995) (finding insurer cannot avoid paying pre-tender defense costs absent a showing of prejudice); Griffin v. Allstate Ins. Co., 29 P.3d 777 (Wash. 2001).

The bottom line, in many jurisdictions, is that timely notice may be crucial at a minimum, to avoid prejudice to an insurer when a pre-suit dispute becomes a filed lawsuit. It is less common for insurers to be able to establish prejudice from late notice of an occurrence, particularly because insurers often contend that their duty to defend does not arise until a suit is filed. But even before a lawsuit is filed, there may be compelling pragmatic reasons for an insured to give prompt notice of an occurrence or claim that could become a suit. First, as noted above, the insurer may agree to provide defense counsel to investigate and attempt to resolve the claim before litigation is filed. Second, as discussed below, there are instances in which pre-suit demands may trigger an insurer’s duty to defend. Providing prompt notice maximizes the potential that if a pre-suit demand is deemed to be a suit for purposes of CGL coverage, the insurer will be required to pay for pre-suit defense expenses.

B. Risks To Insureds - Voluntary Pre-Suit Payments.

Sometimes as in the Sanders case, above policyholders facing potential litigation want to minimize their risk and exposure by engaging in pre-suit settlement discussions, and even pre-suit settlement agreements. In such cases, the preferred practice is for the insured to notify the insurer. In some cases (as noted above) the insurer may agree to become involved notwithstanding the lack of a clear legal duty to do so if it believes its interests are aligned with the insured’s, and early involvement could head off a larger future liability that is likely to be covered under the policy.

On the other side of the coin, most, if not all, CGL policies include a consent to settle provision that prohibits an insured from settling claims without the consent of the insurer. The standard form of these provisions is quoted above. It provides:

No insured will, except at that insured’s own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

A more elaborate clause was construed in First Commonwealth Bank and First Commonwealth Financial Corporation v. St. Paul Mercury Insurance Company, 2014 U.S. Dist. LEXIS 141538 (Oct. 6, 2014). It provides:

[i]he Insureds agree not to settle or offer to settle any Claim, incur any Defense Costs or otherwise assume any contractual obligation, admit any liability, voluntarily make any payment or confess or otherwise agree to any Damages or judgments with respect to any Claim covered by this Policy without the Insurer’s written consent, which shall not be unreasonably withheld. The Insurer shall not be liable for any settlement, Defense Costs, assumed obligation, admitted liability, voluntary payment, or confessed or agreed Damages or judgment to which it has not consented. ☐
If a policyholder enters into a pre-suit settlement agreement or voluntarily makes payments to a claimant, most jurisdictions hold that the carrier will not be liable for such settlement. Though there are some circumstances in which an insurer's conduct may result in waiver or estoppel of the insurer's ability to rely upon the consent to settlement provision including notice, failure to notify insured of the consent to settle requirement, breach of the policy or duty of good faith and fair dealing, and failure to intervene such circumstances are beyond the scope of this article.

It should also be noted that there are a few jurisdictions, Arizona included, that have broadly interpreted the term "legally obligated to pay" and have required carriers to indemnify policyholders for pre-suit payments and/or voluntary settlements. Thus, in Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co., 225 Ariz. 194, 197, 236 P.3d 421, 424 (Ariz. Ct. App. 2010), aff'd, 226 Ariz. 419, 250 P.3d 196 (2011), soil settlement caused cracks and other damage to 50 new homes. After multiple complaints from October 1999 throughout 2000 from customers, the developer, Desert Mountain Properties, incurred average costs of $200,000 per home to correct the soils issues and repair the damage. Id. On May 16, 2001, Desert Mountain sent notice of a claim to Liberty Mutual for coverage for already incurred repair costs of $640,000 and additional necessary repairs. Liberty Mutual requested additional information before making a coverage determination. Desert Mountain informed Liberty Mutual that it needed to proceed with repairs over the summer months when residents would be away so as to avoid relocation costs. Liberty Mutual again requested the additional information and informed Desert Mountain that it was not authorizing the repair work. Desert Mountain provided some, but not all, of the requested documents by the end of June 2001. Id. at 198, 425.

Desert Mountain, believing it had an obligation to repair the damages, continued to make additional repairs. Eventually, in February 2003, Liberty Mutual denied Desert Mountain’s claim for coverage citing, among other provisions, the policies’ voluntary payments provision. Desert Mountain sued Liberty Mutual, and a jury found in favor of Desert Mountain on its contract claim. Id. at 199, 426.

On appeal, Liberty Mutual argued that because none of the homeowners sued Desert Mountain over the soil settlement problems, Desert Mountain was not legally obligated to make the repairs. Id. at 200, 427. Liberty Mutual also argued that it agreed to pay monetary damages for [Desert Mountain’s] legal obligations for causing property damage; it did not underwrite a warranty program for [Desert Mountain] to rectify its defective work. Id.

Liberty Mutual relied upon California cases holding that an insurer's duty to indemnify an insured for sums the insured becomes legally obligated to pay as damages only extends to amounts a court has ordered the insured to pay. Id. citing County of San Diego v. Ace Prop. & Cas. Ins. Co., 37 Cal.4th 406, 33 Cal.Rptr.3d 583, 118 P.3d 607, 617 (2005) (‘damages' has legally and traditionally always been understood as limited to money ordered by a court); Certain Underwriters at Lloyd's of London v. Superior Court, 24 Cal.4th 945, 103 Cal.Rptr.2d 672, 16 P.3d 94, 105 (2001) (‘insurer's duty to indemnify the insured for all sums that the insured becomes legally obligated to pay as damages' is limited to money ordered by a court).
The Arizona Court of Appeals rejected the California courts reasoning as the minority view, and reasoned that a legal obligation to pay means any obligation enforceable by law, including, for example, an obligation created by statute, contract or common law. Desert Mountain Properties, 225 Ariz. at 201, 236 P.3d at 428 (Ariz. Ct. App. 2010). The Arizona Court of Appeals held that coverage for sums an insured becomes legally obligated to pay as damages may be triggered even in the absence of a civil lawsuit against the insured or a court order requiring the insured to make payment. Id.

The Arizona Court of Appeals also rejected the idea that interpreting the legally obligated to pay language as it did would result in carriers being obligated to pay meritless claims: But the insuring clause imposes no indemnification obligation when an insured pays to settle a meritless claim; if a claim lacks merit, the insured by definition is under no legal obligation to pay. Id.

Liberty Mutual next argued that the policy voluntary payments provision precluded coverage because the insured voluntarily incurred repair costs without Liberty Mutuals consent. Id. at 206, 433. The Arizona Supreme Court previously held that the purpose of voluntary payments provision is to protect the insurer's right to a fair adjudication of the insured's liability and to prevent collusion between the insured and the injured person. The court held an insured's breach of the clause ordinarily would relieve a prejudiced insurer of liability under the policy. Id. citing Arizona Property & Casualty Insurance Guaranty Fund v. Helme, 153 Ariz. 129, 136, 735 P.2d 451, 458 (1987). In Desert Mountain Properties, The Arizona Court of Appeals found that Liberty Mutual did not establish prejudice because it did not contest that the repairs were reasonable and necessary, or that the insured's voluntary payment affected Liberty Mutual's ability to settle or defend the claims. Desert Mountain Properties, 225 Ariz. at 206, 236 P.3d at 428 (Ariz. Ct. App. 2010).

Consequently, and contrary to the majority of jurisdictions, the Arizona Court of Appeals held: (1) a carrier's duty to indemnify an insured for settlement payments prior to a suit, and (2) a carrier can only rely upon the voluntary payments provision if its ability to defend or settle the claim was prejudiced by the voluntary payment.

B. Risks To Insurers - Assuming Pre-Suit Obligations

As stated previously, a carrier may sometime have incentive to step up to provide a defense to its insured or even to resolve a potential claim, prior to suit being filed. However, a carrier that does this may also face risks of its own. Among other things:

- The carrier may have difficulty recovering from its reinsurers. See, e.g., American Empl. Ins. Co. v. Swiss Reinsurance America Corp., 275 F.Supp.2d 29 (D. Mass. 2003) (denying reinsurance cover for carrier that entered global pre-suit settlement of environmental claims, including at twenty-seven sites where the carrier had no information and [was] thus unable to assess alleged damages)

- The carrier may find the insured arguing later that its provision of pre-suit defense does not exhaust limits of a cost-erosive policy
• Or the carrier may find itself barred from seeking recovery of the pre-suit expenses from other, jointly liable carriers, on a theory of equitable contribution, because the pre-suit expenses constitute voluntary payments, and equity will not aid a volunteer. See Hartford Ins. Co. v. Ohio Cas. Ins. Co., 145 Wn. App. 765 (2008) (an insurer who acts as a volunteer in making payment on behalf of its insured will lose the right to recover contribution from other insurers on the loss).

EXCEPTIONS TO GENERAL "SUIT" RULE

I. Costs Incurred "In Anticipation of Litigation"

The foregoing cases demonstrate some risks to both insurers and insureds in undertaking defense or settling a case prior to suit. On the other hand, divergent authority exists. For example, one significant line of cases finds pre-suit costs may be recoverable if they were reasonably incurred to legitimately protect the insured in anticipation of a suit being filed. See, e.g., LM Ins. Co. v. Canal Ins. Co., 2012 U.S. Dist. LEXIS 89792 (E.D. Ky. Jun 28, 2012).

Thus, for example, in Liberty Mutual Insurance Co. v. Continental Casualty Co., 771 F.2d 579 (1st Cir. 1985), an insured installed glass panels in the John Hancock Tower in Boston, Massachusetts. The panels failed. Numerous glass panels were blown from the building onto the streets below. The insured notified its carrier that the owner considered it to be in breach of contract, and the insured planned to present the carrier with any claims that might be filed for personal injury or property damage. Nonetheless, the insured continued to work with the owner to try to fix the problem. This caused a delay of several years in the filing of lawsuits.

Eventually, the owner filed suit. One carrier defended, but a second carrier did not, arguing that there was no legal obligation to defend prior to filing of suit. The court found these costs recoverable in the circumstances of this particular case.

Under the circumstances of this particular case, we hold that the pre-suit services were correctly considered as part and parcel of the defense against the liability suits. John Hancock made its initial claim no later than June 1, 1973, and Continental was notified of it immediately thereafter. The extent of the window problem was so great that it was almost certain that a suit would be filed. Indeed, John Hancock and Robertson, as well as others involved in the construction of the Hancock Tower, entered into an agreement to delay the filing of any suits until after further efforts were made to solve the immediate problems posed by the defective curtain wall. Without this agreement, the suit would have been filed much sooner, in which case the technical issue now before us probably would not have arisen.

Finally, both the exhibits and the testimony of witnesses strongly suggest that most, if not all, of the pre-suit services would have been performed after suit was filed had they not been performed before and that the
insurance experts felt that Robertson had little choice but to retain counsel and prepare to defend itself when it did. Under these particular circumstances, we conclude that it was not error to allow the jury to evaluate the pre-suit services and charges for their reasonableness.

Ten years later, in *High Voltage Engineering Corp. v. American Employers Insurance Co.*, 1995 Mass. Super. LEXIS 501 (1995), the court concluded that "there is no per se rule limiting the defense costs to those incurred after the actual filing of suits." It found that:

in some narrow circumstances, an insurer may be held liable for presuit costs. [such as] where (1) the third party made its initial claim against the insured before the third party actually filed suit, (2) the insured immediately notified the insurer of the third party's claim, (3) the nature of the claim created a near certainty that a suit would be filed, (4) the pre-suit services would have been performed after the suit was filed had they not been performed before, and (5) after the insurer's refusal to defend, the insured had little choice to retain counsel and prepare to defend itself when it did . Under these narrow circumstances, "the presuit services were correctly considered as part and parcel of the defense against the liability suits." *Id.*


Likewise, in *Arch Insurance Co. v. Scottsdale Insurance. Co.*, 2010 U.S. Dist. LEXIS 115256 (W.D. Wash. 2010), a crane collapsed during construction of a tower in Bellevue, Washington. The general contractor (LCL) notified its carrier (Arch) of the accident, and the likelihood of litigation. Arch appointed counsel, and undertook various pre-suit expenses: storing the remains of the crane, retaining experts to examine the crane in preparation for litigation, making efforts to settle, and advocating for LCL during investigations. *Id.* at * 12. It also tendered to the crane operator's insurer (Scottsdale) as an additional insured. Scottsdale declined to defend, on various grounds.

In the ensuing coverage litigation, the court determined that Scottsdale did, in fact, owe LCL a defense, and the duty extended to the pre-suit costs Arch had incurred:

Having found that LCL is an additional insured with respect to the Scottsdale policy, the Court now turns to the scope of fees and costs that Arch may recover. Scottsdale argues that pre-suit costs are not recoverable because Scottsdale is not responsible for expenses that were incurred by LCL or Arch prior to the filing of the first suit. However, there is no authority to support this proposition. The duty to defend is broad and encompasses those expenses that are reasonably related to the defense of a covered claim. In *Nordstrom v. Chubb*, [820 F. Supp. 530, 536 (W.D. Wash. 1992), aff'd on other grounds, 54 F.3d 1424 (9th Cir. 1995),] this court specifically held that "[n]o right of allocation exists for the defense of non-covered claims that are 'reasonably related' to the defense of covered claims." Therefore, where the duty to defend
necessarily encompasses certain pre-suit expenses, those expenses will not be allocated as distinct.

The issue of whether costs are reasonably related to the defense of covered claims is a factual inquiry. In this case, Plaintiff Arch has explained that its pre-litigation costs were incurred in storing the remains of the crane, retaining experts to examine the crane in preparation for litigation, making efforts to settle, and advocating for LCL during investigations. Scottsdale does not plead sufficient evidence to raise an issue of fact as to whether the pre-suit costs were reasonably related to the defense of covered claims.

Scottsdale further asserts that Arch may not recover pre-suit expenses because Arch voluntarily paid these costs. An insurer who acts as a volunteer in making payments loses the right to recover contribution from other insurers. An insurer is considered a volunteer if the insurer has no right or interest of its own to protect and is under no obligation to pay. However, payments made by an insurer under the threat of civil suit are not considered voluntary, nor is the existence of a possible defense to coverage sufficient to render an insurer's actions voluntary.

In this case, given the situation of the crane collapse, Arch operated under the near certainty that claims and litigation would follow. As LCL was Arch's insured, it cannot be said that Arch had no obligation to make expenditures to facilitate the defense of its insured.


II. Emergency Response By Insured

A second line of cases, embodied in Leebov v. United States Fidelity and Guaranty Co., 401 Pa. 477 (1960), arises when insureds argue that the insured must take some emergency action to prevent a suit from arising.

In Leebov, a contractor purchased a liability policy from USF&G. That policy said the insurer agreed "to pay on behalf of the Insured all sums which the Insured shall become obligated to pay by reason of the liability imposed upon him by law for damages because of injury to or destruction of property, including the loss of use thereof, caused by accident and arising out of the hazards hereinafter defined." While Leebov was excavating along a hillside before construction of a warehouse, a landslide began, and a porch on a house atop the hill collapsed.

Leebov ceased operations, drove his trucks to the hillside, pounded stakes to hold his trucks in place. He summoned a shoring expert and notified USF&G what was happening. USF&G sent its safety engineer to the scene, who approved of what had been done. Leebov
spent $13,000 to repair the damage and prevent further loses. The homeowner whose porch was
destroyed filed suit, USF&G refused to defend, and Leebov defended and settled for $1,700.

The court noted that if Leebov "had not taken immediate and substantial measures to
remedy the perilous situation, disastrous consequences might have befallen the adjoining and
nearby properties. In that event USF&G would have been required to pay considerably more.
The court observed that would be a "strange kind of argument and an equivocal type of justice to
say the USF&G must pay $100,000 if the damage had been allowed to happen, and a not
much smaller sum that would have avoided that foreseeable disaster"

Similarly, in Broadwell Realty Services, Inc. v. Fidelity & Casualty Co., 218 N.J. Super. 516, 528 A.2d 76 (1987) the Department of Environmental Protection (DEP) sent a directive letter to the insured, Broadwell. Broadwell leased property to a lessee who operated a franchise service station on the property. The letter stated that hazardous substances had escaped from an underground storage tank on the insured's land and migrated to adjacent land. The letter stated that failure to take immediate cleanup action it would result in treble damages and placement of a claim and lien upon all of its real and personal property.

The court held that the costs of preventive measures taken by Broadwell on its own
property in response to the DEP directive were designed to abate the continued flow of
contaminants on to adjacent lands and were recoverable under the policy. The court found that
the interceptor trenches dug on Broadwell's property and the observation / recovery pumping
wells installed on its property would have been covered if installed on the third party's property.
The court reasoned that "It would be folly to argue, under such circumstances, that the insured
would be required to delay taking preventive measures, thereby permitting the accusation of
mountainous claims at the expense of the insurance carrier. In other words the insured need not
calmly await further catastrophe. Abatement measures designed to prevent the continued
destruction of adjacent property are plainly compensable under the policy. Id. at 526-27
[citation omitted]. The measures were taken to discharge a legal obligation to DEP or at the very
least to prevent what would have been an avoidable legal obligation to pay damages to a third
party.

Similarly, in State of California v. Allstate Ins. Co., 45 Cal. 4th 1008, 1015, 90 Cal. Rptr. 3d 1, 8, 201 P.3d 1147, 1153 (2009) the State constructed and operated a hazardous waste disposal site known as the Stringfellow Acid Pits. The State directed construction of open, unlined evaporation ponds to contain the hazardous waste, channels to divert rainwater around
the site, and a barrier dam at the bottom of the site. The facility was opened in 1956 and closed in
1972 after groundwater contamination was discovered. More than 30 million gallons of liquid
industrial waste were deposited in the Stringfellow ponds during operation. The policies
contained sudden and accidental pollution exclusions.

Severe rainstorms struck the area, a state of emergency was declared. Concerned about
rising levels in the site's evaporation ponds, Anderson, the executive officer of the Regional
Water Quality Control Board had additional storage ponds dug on the site and started pumping
water to the new ponds. As heavy rain continued, the main pond was again full. The Board
placed sandbags on top of the dam and pumping continued, though it was limited when one of
the two pumps broke. When a crack was observed in the face of the dam, Anderson ordered wastes released through a spillway to prevent an uncontrolled release of up to 20 million gallons. The controlled release was stopped several days later, but restarted three days after that when the dam began to give way. It was stopped again four days later when the danger of collapse had passed.

The court agreed with the insurers that in one obvious sense the 1978 discharges were not accidental: the wastes were intentionally released at Anderson's direction. But this was done only to prevent a larger, uncontrolled discharge of wastes if, as threatened, the dam broke. That, the State argued, would have been an accidental discharge. The court held that to the extent the conditions threatened a sudden and accidental release of wastes from the Stringfellow site, the qualified pollution exclusion does not bar coverage for liability arising from the State's intentional releases performed to prevent such a greater accidental release.

Similarly, in Goodyear Rubber & Supply v. Great Am. Ins. Co., 545 F.2d 95, 96 (9th Cir. 1976) the court held (under Oregon law) that liability for salvage costs covered under property damage liability policy, where salvager had acted to prevent further damage from fire, a covered source of damage. It would be a strange kind of justice, and a stranger kind of logic, that would hold the defendant to be liable for as much as $450,000 if the barge and its contents had been consumed by fire, but free of liability for a much lesser amount because of the fortuity of rescue. Id., 545 F.2d at p. 96.

But if the situation is not an emergency, failure to get consent will bar coverage. In Jamestown Builders v. Gen. Star Indem. Co., 77 Cal. App. 4th 341, 344, 91 Cal. Rptr. 2d 514, 515 (1999) Jamestown developed 300-home housing tracts Many of the new homeowners were dissatisfied with the construction, complaining the houses were not watertight. These complaints began slowly but intensified as more homeowners demanded that Jamestown fix the problems and compensate them for damages. Jamestown was faced with a "deluge of problems." It paid approximately $1,240,000 for repairs and damages. It investigated and repaired all known water intrusion related problems. No lawsuits were filed against it. The developer never tendered any of these damage claims to General Star during this period. Jamestown argued it did not give notice to General Star because it was "inordinately preoccupied with the magnitude of the remedial work". The court did not accept this argument, and held that the voluntary payment provision precluded coverage for those payments.

III. Demands Equivalent To Suits

There are also certain types of demands that do not meet the classic definition of a suit, but courts have found to be the function equivalent of suits for purposes of triggering a CGL insurer's duty to defend. Along these lines, for example, numerous courts have found that environmental PRP letters, administrative cleanup orders, and state administrative environmental proceedings are suits. In addition, some courts have found that pre-suit claims made pursuant to construction notice and opportunity to repair statutes constitute suits for purposes of the duty to defend.

A. Statutory Notice and Opportunity to Repair Notices.
Under Florida law, a claimant must follow certain procedural requirements before bringing a lawsuit for a construction defect. See Fla. Stat. § 558.004. Chapter 558 requires the claimant to serve written notice of claim on the contractor, subcontractor, supplier, or design professional, as applicable, before filing suit. See id. The respondent, in turn, must serve a written response that offers to: (1) remedy the alleged construction defect at no cost to the claimant; (2) compromise and settle the claim by monetary payment; (3) compromise and settle the claim by a combination of repairs and monetary payment. The respondent also may respond with a statement disputing the claim or informing the claimant that any monetary payment will be determined by the recipient's insurer. See id.

The court in Altman Contractors, Inc. v. Crum & Forster Specialty Insurance Co., 232 So. 3d 273, 277 (Fla. 2017), held that Florida’s Chapter 558 process is a “suit” within the meaning of the commercial general liability policy. Although the chapter 558 notice and repair process if not a “civil proceeding under the policy terms because the recipient's participation in the chapter 558 settlement process is not mandatory or adjudicative,” the court explained, it does fall within the CGL policy’s definition of “suit” because the CGL definition of “suit” includes “[a]ny other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with our consent.” See id. at 278. Similarly, the court in Melssen v. Auto-Owners Insurance Company, 285 P.3d 328 (Colo. App. 2012), found that notice under Colorado’s right to repair statute also constituted a “suit” because it was alternative dispute resolution, and the insurer waived its right to consent.

Applying Utah law, the court in Cincinnati Insurance Co. v. AMSCO Windows, 593 F. App’x 802 (10th Cir. 2014), found that a notice under Nevada’s notice and opportunity to repair statute did not constitute a “suit” because noncompliance [with the civil pre-litigation process] does not result in any adverse judgment or obligation but rather imposes limited consequences in subsequent litigation. Id. at 809. Moreover, the insurer did not consent to the insured participating in the process and the statute does not provide for compulsory arbitration. See id. at 809 (discussing Nev. Rev. Stat. § 40.649).

Had the policies been governed by Nevada law rather than Utah law, the result may have been different, as the Nevada notice and opportunity to repair statute provides that an insurer “must treat the claim as if a civil action has been brought against the contractor” and “must provide coverage to the extent available under the policy of insurance as if a civil action has been brought against the contractor.” See Nev. Rev. Stat. § 40.649. Similarly, the California construction defect right to repair statute, California Civil Code § 910, states that such notice “shall have the same force and effect as a notice of commencement of a legal proceeding.” Relying on that provision, the court in D.R. Horton Los Angeles Holding Co., Inc. v. American Safety Indemnity Co., 2012 U.S. Dist. LEXIS 1881 (S.D. Cal. Jan. 5, 2012), found that a Section 910 notice triggered an insurer’s duty to defend.

B. Environmental Remediation Demands and Proceedings.

Although jurisdictions are split on this issue, most courts have found that PRP letters, environmental cleanup letters, and administrative environmental proceedings trigger a CGL
insurer's duty to defend, even in the absence of a lawsuit. Courts finding a duty to defend typically find that the term "suit" is ambiguous, and a "coercive" environmental demand from a regulator triggers the duty to defend. See, e.g., Aetna Cas. & Sur. Co. v. Commonwealth of Ky., 179 S.W.3d 830 (Ky. 2005); R.T. Vanderbilt Co. v. Cont'l Cas. Co., 870 A.2d 1048 (Conn. 2005); Johnson Controls, Inc. v. Emp's Ins. of Wausau, 665 N.W.2d 257 (Wis. 2003); Compass Ins. Co. v. City of Littleton, 984 P.2d 606 (Colo. 1999). In contrast, courts finding no duty to defend typically interpret "suit" to require a lawsuit or ADR proceeding as required by the policy. See, e.g., Foster-Gardner, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 959 P.2d 265 (Cal. 1998); Lapham-Hickey Steel Corp. v. Prot. Mut. Ins. Co., 166 Ill. 2d 520, 532 (1995).

IV. Arbitration /ADR

Another proceeding that some parties view as "equivalent to" suits are arbitration and other forms of alternative dispute resolution proceedings. Since these are technically not a lawsuit, standard coverage forms have been changed to adapt to their increasing use. Since 1985, the Commercial General Liability coverage form, CG 00 01 04 13 has defined "suit" to include "an arbitration proceeding alleging such damages to which you must submit or submit with our consent." Since 1988, the definition has also included other alternative dispute resolution proceedings. The current language, in effect since 1996, reads:

"Suit" means a civil proceeding in which damages because of "bodily injury", "property damage" or "personal and advertising injury" to which this insurance applies are alleged. "Suit" includes:

a. An arbitration proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent; or

b. Any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with our consent.

It should be noted, however, that liabilities arising out of arbitration and ADR proceedings will only give rise to coverage if the insured submits with [the insurer's] consent. An insured that is considering the resolution of liabilities through arbitration or ADR should seek out the consent of its insurer, or risk a subsequent denial of coverage.

V. Crisis Management Coverage

Another exception to the general "suit" requirement is crisis management coverage. This coverage goes beyond the traditional provision of a litigation defense. It pays expenses which the insured incurs to address negative publicity caused by a crisis event, such as such as a serious accident, an explosion, an act of violence, a contamination or product recall incident or in connection with cyber policies, a breach of an insured's network. Some endorsements also pay expenses required to provide immediate support to victims and their families, such as funeral expenses, psychological counseling, travel, and temporary living costs. Features that can vary by policy include whether the insured has a choice of the crisis communications firm or must
choose from a pre-approved list of firms, the duration of coverage (until the crisis is over - which raises the question of who determines this and by what standard; or the limit exhausted), and whether the limit of coverage is a sublimit of other coverage or a separate limit.

Typically these endorsements tie back to the scope of coverage in the policy. If it is a general liability or umbrella liability policy, the endorsement will require that the crisis arise from bodily injury, property damage and personal and advertising injury. It may add coverage for imminent threat of such injury or damage. It may add some defined type of incident such as sexual misconduct to this scope. Or it may limit the scope of the coverage to death or serious bodily injury to more than one or two or three or more persons. The endorsements cover fees and expenses charged by a crisis management firm in providing public relations and media management services. Some endorsements also include fees and expenses of the insured's employees, some do not. The endorsements may also provide coverage for emergency transportation and psychological services to provide relief or support to persons affected by the crisis.

The endorsements often have very precise timing requirements. The endorsement may require telephone notice within 24 hours. It may also require written notice as soon as practicable with a description of how, when and where the covered crisis took place, the names and addresses of any affected parties and witnesses, and the location and nature of the injury or damage. It may require a claim for reimbursement - if the insured's own expenses are covered and if the insured seeks to recover those - within a specific time frame, for example 90 days. And it may require backup documentation for expenses that exceed a certain threshold level, for example $50.

These endorsements often are found on umbrella policies, so remember to check the umbrella policy for such coverage if it is not found in the primary policy.

**ALTERNATIVE POLICY LANGUAGE**

The discussion above focuses on language used in the insuring agreement of ISO Form CGL policies. But in some contexts - for example, where insureds assume liability through captives or specialized risk retention groups - policies may be drafted more broadly, to avoid the "suit" requirement and "legally obligated to pay" language. The following manuscript language represents one risk retention group's approach to this issue:

[Risk Retention Group] hereby agrees, subject to the limit of liability and all other limitations, terms, exclusions and conditions hereinafter mentioned, to indemnify the Insured for all sums which the Insured shall be obligated to pay by reason of liability imposed upon the insured by law or assumed under contract or agreement by the Insured for damages on account of

[1] personal injury [defined to mean bodily injury (including death at any time resulting therefrom), mental injury, mental anguish, shock, sickness, disease, disability, false arrest, false imprisonment, wrongful eviction, detention, malicious prosecution, discrimination,
humiliation, and all libel, slander, or defamation of character or invasion of rights of property],

[2] property damage or

[3] advertising liability

anywhere in the universe, resulting from an occurrence; provided, however, that the aggregate limit, the per occurrence limit,

Note the absence here of a “suit” requirement, and the broad language providing indemnity for all sums the insured is “obligated to pay” by reason of liability imposed “by law” not just sums the insurer is “legally obligated to pay as damages.” The unique structure of captive and risk retention arrangements make such broader language possible.

POST-SUIT DUTIES

One final note. The discussion above centers on carriers’ obligation (or lack of obligation) before “suit” is filed. But an analogous issue arises after suit is over, and a judgment or settlement has been secured. Can the carrier in those circumstances simply pay its limits and walk away? Or does the carrier have to continue defending through “final judgment,” i.e., resolution of JNOV and post-trial motions? What if the carrier is only liable for part of the verdict, say, in a pro rata long-tail context? Can it pay that part and leave the insured to continue defending post-trial motions, etc., as to the un-covered part?

What about after final judgment? Does the carrier have to fund an appeal, if the insured wants one? Authority is mixed. Many states require the carrier to fund an appeal only if there a “reasonable chance” it will prevail. Davis, 434 Mass. at 146; Sullivan, 33 Mass. App at 157 n.4; Med. Prof’l Mut. Ins. Co. v. Newton-Wellesley Hosp., 1999 Mass. Super. LEXIS 529; see P. Gioioso & Sons. Inc. v. Liberty Mut. Ins. Co., 2018 Mass. App. Unpub. LEXIS 79 (Mass. App. 2018). Buy what if the carrier and the insured disagree about whether the appeal is “reasonable” does the carrier have to seek a declaratory judgment and argue publicly that its insured’s appellate argument is frivolous? While the appeal is still pending and the insured’s dispute with a plaintiff is still going on?
Pre-Suit Duties

Moderator: Eric Hermanson
Panelists: Micalann Pepe, Seth Lamden, Tim Thornton
Hypothetical (ish) -

1. Insured is divorce lawyer.
2. Claimant is insured’s client.
3. Claimant and insured are romantically involved.
4. Insured learns Claimant has committed suicide.
5. Insured learns Claimant’s Estate has hired a lawyer.
7. Insured tenders to carriers (CGL, PL) - what response?
8. Successful pre-suit mediation.
9. Insured’s attorney sends insurer bill for services. Response?
10. Insured tenders settlement for payment. Response?
Duty to Notify
Duties In The Event Of Occurrence, Offense, Claim Or Suit

Must notify as soon as practicable if “occurrence” or an offense may result in a claim.

Notice should include:

- How, when and where the "occurrence" or offense took place;
- The names and addresses of any injured persons and witnesses; and
- The nature and location of any injury or damage...
Duties In The Event Of Occurrence, Offense, Claim Or Suit

If claim or "suit" is brought against any insured, you must:

1. Immediately record the specifics of the claim or "suit" and the date received;
2. Notify us as soon as practicable.
Duty to Defend
The “Suit” Requirement

01
Pay amounts the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which this insurance applies.

02
Have the right and duty to defend the insured against any “suit” seeking those damages.

03
No duty to defend the insured against; ...to which this insurance does not apply.
May investigate and settle any claim or “suit” that may result ...
“Suit” means a civil proceeding in which damages because of “bodily injury,” “property damage,” or “personal and advertising injury” to which this insurance applies are alleged.
“Suit” includes

An arbitration proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent;

Any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent;
Duty To Indemnify
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<td>Pay amounts the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which this insurance applies.</td>
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<td>No duty to defend the insured against; ...to which this insurance does not apply. May investigate and settle any claim or “suit” that may result ...</td>
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Conflicting Outcomes

Sanders v. Phoenix Ins. Co., 843 F.3d 37 (1st Cir. 2017):

“The Policy ... provides that it must only furnish counsel to defend the insured in the face of a suit .... [The insurer] has no obligation to provide a defense in the absence of a suit.” 843 F.3d at 37.

• No duty to defend means no duty to indemnify.

• NB: Some courts would have rested on “legally obligated to pay,” or “as damages”
Conflicting Outcomes


“Although not a formal lawsuit, .... Cytosol's failure to respond adequately to the letter would significantly affect its ability to defend itself in a subsequent action involving these same issues .... Accordingly, a duty to defend is triggered .....”
Does *Sanders* Makes Sense?

Insurer’s perspective?

- Historical rationale
- Contractual rationale (policy language)
- Policy rationale (avoidance of collusive results)
Does *Sanders* Makes Sense?

Insured’s perspective?

- Chapter 93A akin to a CERCLA demand letter?
- “No duty to defend means no duty to indemnify” rule is at odds with policy language and is illogical when the basis for no duty to defend is something other than no potentially covered allegations.
- Regardless of whether the ruling is correct, does it reflect a smart approach for an insurer? Good customer service?
Consequences to Insured: Giving Pre-Suit Notice

There is rarely a good reason not to provide pre-suit notice, but there are a lot of reasons for which it happens:

- Inadvertance
- Unaware of policy requirements
- Unaware of legal risk
- Unaware that the circumstances could become a suit
- Desire to protect loss experience/concern about nonrenewal.
- Exploring business resolution
- Confidentiality
Consequences to Insured: Failing to Give Pre-Suit Notice

• Potential breach of policy condition. Prejudice standard?

• Hard to get an insurer to agree to a pre-suit settlement if the insurer hasn’t opened a claim file.

• Unlikely that insurer will voluntarily cover pre-suit legal expenses before claim file is opened.
Consequences to Insurer: Responding to Pre-Suit Notice

- What are the potential advantages to pre-suit involvement?
  - Ability to investigate
  - Control direction of defense
  - Settlement Opportunities
  - Waiver
  - May be on the hook anyway, in some jurisdictions

- What are the potential disadvantages to pre-suit involvement?
  - Voluntary assumption of obligations
  - Waiver, estoppel exposure
  - Inability to challenge insured’s activities
Consequences to Insurer: Failing to Respond to Pre-Suit Notice

- If there is no duty to defend
  - Lost opportunity to settle and investigate

- If there is a duty to defend
  - Lose right to control litigation
  - Lose right to get notice
  - Lose ability to investigate claim
  - May lose right to dispute amount of settlement, be bound by findings of facts essential to a judgment
  - Lose ability to assert conditions like cooperation
  - Lose right to seek reimbursement of uncovered defense expense
  - If an unreasonable refusal to defend, bad faith exposure
Common Issues
What Should Count as a “Suit”?

• CERCLA PRP Letters and Administrative Actions
  • Literal approach
  • Functional equivalent approach
• Builder right-to-repair statutes
• EEOC Notices
• MGL Chap 93A demand letters
• Conventional demand letter
• Criminal prosecution
• Arbitrations and mediations
“Legally Obligated To Pay As Damages”

• Spirtas v. Nautilus Ins. Co.

• Desert Mountain Properties v. Liberty Mutual Ins. Co.
“Legally Obligated To Pay As Damages”

- Builders Mutual Ins. Co. v. Dragas Management
- Permasteelisa CS Corp. v. Columbia Cas. Co.
Emergency Response Actions

- Voluntary Payment provision say incur no obligation or make any payment
- Product Recall exclusion
- Leebov case
- McNeilab, Inc. v. North River - contaminated Tylenol case
Crisis Management Coverage

- Found in some GL and some commercial umbrella forms or by endorsement
- Address negative publicity
- Tied back to scope of coverage grant
- Sublimit
- Timing requirements, notice requirements
- Approved lists of firms to help
Common Issues: Consent to Settle Provisions

• “No insured will, except at that insured’s own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.”

• Most jurisdictions enforce this language.

• Some have deviated in fact-specific instances.

• Is prejudice to the insurer required?
Variant (Manuscript) Language
[Risk Retention Group] hereby agrees, subject to the limit of liability and all other limitations, terms, exclusions and conditions hereinafter mentioned, to indemnify the Insured for all sums which the Insured shall be obligated to pay by reason of liability imposed upon the insured by law or assumed under contract or agreement by the Insured for damages on account of
personal injury [defined to mean “bodily injury (including death at any time resulting therefrom), mental injury, mental anguish, shock, sickness, disease, disability, false arrest, false imprisonment, wrongful eviction, detention, malicious prosecution, discrimination, humiliation, and all libel, slander, or defamation of character or invasion of rights of property],

property damage or

advertising liability

anywhere in the universe, resulting from an occurrence ....
Further Discussion
Post-Suit Duties

- Once suit is concluded, can insurer pay limits and walk away?
- Or does insurer’s duty to “defend any suit” included duty to appeal?
- Majority approach: insurer has duty to appeal only when “reasonable grounds” exist to believe insured’s interests will be served.

Post-Suit Duties

• What are “reasonable grounds” warranting appeal?

Post-Suit Duties

- Duty to appeal (variant approaches) -
  - *Palmer v. Pacific Indemn. Co.*, 74 Mich. App. 259 (1977): Insurer “will be expected to proceed with an appeal, if requested by an insured, if [the insurer] writes a broad ‘duty to defend’ clause into its insurance contracts.”
  - *Hawkeye Security Ins. Co. v. Indemn. Ins. Co.*, 260 F.2d 361 (10th Cir. 1958) (“We very much doubt whether defendant, under the clause of the contract we have set out, would be liable for failing to take an appeal,” unless refusal was in bad faith).
Post-Suit Duties

Duty to appeal (variant policy language) -

• ISO Form Policies: defense obligations end “when we have used up the applicable limit of insurance in the payment of judgments or settlements.”

• But see City of Hartsville v. South Carolina Mus. Ins. & Risk Fin. Fund, 382 S.C. 535 (S.C. 2009) (variant language; insurer agrees to “indemnify [for] all costs and expenses incurred in the investigation, adjustment, settlement, defense and appeal of any claim or suit...”).

• Compare Scottsdale Ins. Co. v. City of Hazleton, 2009 WL 1507161 (M.D.Pa. 2009) (insurer has “right, but no duty, to appeal any judgment....”).
QUESTIONS?