

**AN OVERVIEW OF THE
MINNESOTA UNFAIR CLAIMS
PRACTICES ACT**

by

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I. INTRODUCTION

Minnesota's legislature passed an Unfair Claims Practices Act in 1984. (1984 Minnesota Laws, Chapter 555-codified at M.S. § 72A.20, 72A.23 and 72A.25.) Since 1984 the legislature has made several changes and additions to the Unfair Claims Practices Act. Those changes and additions are addressed below. Additionally, the legislature has renumbered M.S. §72A.20, Subd. 12a to M.S. § 72A.201.

In analyzing and reviewing Minnesota's Unfair Claims Practices Act it is important to recognize and keep in mind that the Unfair Claims Practices Act is an act designed to regulate the insurance industry. The three words most prominently used in the Unfair Claims Practices Act (or variations of those words) are: "prompt," "delay" and "reasonable."

The Unfair Claims Practices Act forbids an insurer from engaging in any unfair, deceptive, or fraudulent acts concerning any claim or complaint of an INSURED OR CLAIMANT including, but not limited to more than sixty some enumerated violations.

M.S. § 72A.20, Subd. 12 and M.S. § 72A.201 identify and set forth the prohibited practices.

II. STATUTORY REQUIREMENTS

Set forth below is an outline of the requirements and prohibitions of M.S. §72A.20, Subd. 12 and M.S. § 72A.201.

A. M.S. § 72A.20, SUBD. 12 UNFAIR SERVICE.

Prohibits the "causing or permitting with such frequency to indicate a GENERAL BUSINESS PRACTICE any unfair, deceptive, or fraudulent act concerning any claim or complaint of an INSURED OR CLAIMANT including, but not limited to, the following practices:"

1. Misrepresenting pertinent facts or coverage provisions;
2. Failing to acknowledge and act reasonably promptly upon communications with respect to claims;
3. Failing to adopt and implement reasonable standards for prompt claims investigation;
4. Refusing to pay claims without conducting a reasonable investigation;

5. Failing to affirm or deny coverage within a reasonable time;
6. Refusing to make good faith settlement attempts once liability has become reasonably clear;
7. Forcing INSUREDS to commence suit by offering substantially less than the amounts ultimately recovered in actions brought by INSUREDS;
8. Attempting to settle claims for less than a reasonable person would have believed they were entitled to by reference to advertising material accompanying an application;
9. Attempting to settle claims on the basis of an application which was altered without notice to or the knowledge or consent of the INSURED;
10. Making claims payments to INSUREDS or beneficiaries without providing them with a statement setting forth the coverage under which the payments are being made;
11. Making known to INSUREDS OR CLAIMANTS a policy of appealing from arbitration awards in order to compel settlements for less than an arbitration award;
12. Delaying investigation or claim payments by requiring INSUREDS, CLAIMANTS OR PHYSICIANS to submit preliminary and formal claim reports that are substantially similar,
13. Failing to promptly settle claims where liability has become reasonably clear under one portion of coverage in order to influence settlements under other portions of the coverage;
14. Failing to provide a reasonable explanation for a denial of a claim or for a compromise settlement offer.
15. Requiring an INSURED to provide information or documentation from more than five years prior to or five years after the date of a fire loss, except for proof of ownership of the damaged property.

NOTE. For a violation of M.S. § 72A.20, Subd. 12 there must be violations "with such frequency to indicate a general business practice". However, it should be noted that in *The Matter of The Great American Ins. Co.*, 412 N.W.2d 821 (Minn. App. 1987), the Minnesota Court of Appeals held that the Commissioner of Commerce was not required to show a "general business practice" in order to establish a violation of M.S. § 72A.20.

B. M.S. § 72A.201. REGULATION OF CLAIMS PRACTICES.

i. SUBD. 1 - ADMINISTRATIVE ENFORCEMENT

Provides that the commissioner may enforce through administrative action, including fines, a violation of M.S. § 72A.201 or a violation of M.S. § 72A.20, Subd. 12. The commissioner need NOT show a general business practice in taking administrative action for these violations.).

This section further provides that no individual violation constitutes a violation of M.S § 8.31 ("Private Attorney General Act").

ii. SUBD. 2 - CONSTRUCTION

Sets forth the Department of Commerce's policy in interpreting and enforcing the section, which includes taking into consideration all pertinent facts and circumstances. The facts and circumstances that may be considered include the magnitude of the harm to the claimant or insured and any actions by the insured, claimant or insurer that mitigate or exacerbate the impact of any violation.

iii. SUBD. 3 - DEFINITIONS

Defines the following terms:

1. Adjuster or Adjusters;
2. Agent;
3. Claim;
4. Claim Settlement;
5. Claimant;
6. Complaint;
7. Insurance Policy;
8. Insured;
9. Insurer;
10. Investigation;
11. Notification of Claim;

12. Proof of Loss;
13. Self Insurance Administrator;
14. Self-Insured or Self-Insurer.

iv. SUBD. 4 - STANDARDS FOR CLAIM FILING AND HANDLING

The following acts constitute UNFAIR SETTLEMENT PRACTICES:

1. Failing to acknowledge receipt of notification of claim from AN INSURED OR CLAIMANT within 10 business days and failing to promptly provide all necessary claim forms and instructions to process the claim, unless the claim is settled within 10 business days.

The acknowledgement must include the phone number of the company representative who can assist the insured or the claimant.

If an acknowledgement is made by means other than writing, an appropriate notation including at least the following information must be made in the claim file of the insurer and dated.

- a) The telephone number called, if any;
 - b) The name of the person making the telephone call or oral contact;
 - c) The name of the person who actually received the telephone call or oral contact;
 - d) The time of the telephone call or oral contact;
 - e) The date of the telephone call or oral contact.
2. Failing to reply, within 10 business days of receipt, to all other communications from AN INSURED OR CLAIMANT that reasonably indicate that a response is requested or needed.
 3. Failing to complete its investigation and inform the INSURED OR CLAIMANT of acceptance or denial of a claim within 30 business days unless the investigation cannot be reasonably completed within that time. In that event, the insurer shall notify the INSURED OR CLAIMANT

within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. (This provision can be superseded by policy language or by the provisions of another statute.)

4. Where evidence of suspected fraud is present, the requirement to disclose the reasons for failure to complete the investigation within the time period set forth in clause (3), above need not be specific. However, the insurer must make this evidence available to the Department of Commerce if requested.
5. Failing to notify AN INSURED who has made a notification of claim of all available benefits or coverages and of the documentation which the insured must supply.
6. Requiring AN INSURED to give written notice of loss or proof of loss within a specified time and later seeking to avoid its obligations if the time limit is not complied with unless the insurer's rights have been prejudiced by any such failure to comply and then only if the insurer gave prior notice to the insured of the potential prejudice. (This provision can be superseded by policy language or by the provisions of another statute.)
7. Advising AN INSURED OR CLAIMANT not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or adjuster is retained.
8. Failing to advise in writing AN INSURED OR CLAIMANT whose claim is known to be unresolved and who has not retained an attorney, of the expiration of a statute of limitations at least 60 days prior to that expiration. (If the insurer has received no communication from the INSURED OR CLAIMANT for a period of two years exceeding the expiration of the statute of limitations, such notice need not be given.)
9. Demanding information which would not affect the settlement of the claim.
10. Refusing to settle a claim of AN INSURED on the basis that the responsibility should be assumed by others. (This provision can be superseded by policy language or by the provisions of another statute.)
11. Failing, within 60 business days after receipt of a properly executed proof of loss to advise the insured of the acceptance or denial of the claim. (Every denial must be given to the insured in writing with a copy filed in the claim file and must make reference to the specific policy provision, condition or exclusion upon which the denial is based.)
12. Denying or reducing a claim on the basis of an application which was

altered or falsified by the agent or insurer without the knowledge of the INSURED.

13. Failing to notify the insured of the existence of additional living expense coverage when AN INSURED under a homeowners policy suffers a covered loss and the damage to the dwelling is such that it is not habitable.
14. Failing to inform AN INSURED OR CLAIMANT that the insurer will pay for a repair estimate if the insurer requested the estimate and the INSURED OR CLAIMANT had previously submitted two estimates of repair.

v. **SUBD. 4a - STANDARDS FOR PREAUTHORIZATION APPROVAL**

If a policy requires preauthorization approval for non-emergency services or benefits, the decision to approve or deny the request must be communicated to the INSURED or the insured's HEALTH CARE PROVIDER within 10 business days of the preauthorization request provided that all reasonably necessary information needed to approve or deny the request has been made available to the insurer.

vi. **SUBD. 5 - STANDARDS FOR FAIR SETTLEMENT OFFERS AND AGREEMENTS**

The following acts constitute unfair settlement practices:

1. Making any payment, settlement or settlement offer which does not include an explanation of what it is for.
2. Making an offer to AN INSURED of settlement of one part of a claim contingent upon agreement to settle another part of the claim.
3. Refusing to pay any element of a claim by AN INSURED for which there is no good faith dispute.
4. Threatening cancellation, rescission, or non-renewal as an inducement to settle a claim.
5. Failing to issue payment of any settlement amount within 5 business days from receipt of the agreement by the insurer or from the date of performance by the CLAIMANT of any conditions set by such agreement, whichever is later, (notwithstanding any inconsistent provision of § 65A.01, Subd. 3).
6. Failing to inform the INSURED of the policy provision or provisions under which payment is made.

7. Attempting to settle an actual cash value claim with AN INSURED for less than the value of the property immediately preceding the loss, including all applicable taxes and license fees. (An insurer is not required in any case to pay an amount greater than the amount of insurance.)
 8. Attempting to settle a claim with AN INSURED under replacement value provisions for less than the sum necessary to replace the damaged item with one of like, kind and quality, including all applicable taxes, license and transfer fees (except where limited by policy provisions).
 9. Attempting to apply depreciation to items not adversely affected by age, use or obsolescence.
 10. Attempting to reduce a settlement offer for betterment unless the resale value of the item has increased over the pre-loss value by the repair of the damage.
- vii. **SUBD. 6 - STANDARDS FOR AUTOMOBILE INSURANCE CLAIMS HANDLING, SETTLEMENT OFFERS, AND AGREEMENTS**

The following acts constitute unfair settlement practices:

1. When an auto policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement with like, kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:
 - a) Comparable and available replacement auto, with all applicable taxes, license fees and other fees incident to the transfer of ownership paid, at no cost to the insured other than the deductible.
 - b) A cash settlement based upon the actual cost of purchase of a comparable auto including all applicable taxes, license fees, and other fees incident to transfer of ownership less the deductible. The cost must be determined by: (i) the cost of a comparable auto, adjusted for mileage, condition and options in the local market area of the insured if such an auto is available in the area; or (ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable auto is not available in a local market area; or (iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the INSURED.

2. If an auto policy provides for the adjustment and settlement of an auto partial loss on the basis of repair or replacement with like, kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:
 - a) To assume all costs, including reasonable towing costs, for the satisfactory repair of the vehicle including both obvious and hidden damage. (This assumption of cost may be reduced by applicable policy provision) or;
 - b) To offer a cash settlement sufficient to pay for satisfactory repair of the vehicle including repair of obvious and hidden damage and including reasonable towing costs.
3. Failing to inspect a damaged auto within 15 days after notification of claim. If not driveable, within 5 business days following receipt of notification of claim.
4. Requiring unreasonable travel of A CLAIMANT OR INSURED to inspect a replacement auto, to obtain a repair estimate, to allow an insurer to inspect an estimate, to allow an insurer to inspect repairs or to have an auto repaired.
5. Failing to notify AN INSURED of loss of use coverage and the manner in which the insured can apply for this coverage at the time of the insurer's acknowledgment of claim when such coverage exists.
6. Failing to include the INSURED'S deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured. When an insurer is recovering directly from an uninsured third-party by means of installment the insured must receive the full deductible share as soon as that amount is collected and before any part of the total recovery is applied to any other use. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery in which case deduction may be made only for a pro-rata share of the cost of retaining the attorney. An INSURED is not bound by any settlement of its insurer's subrogation claim with respect to the deductible, unless the INSURED receives the full amount of the deductible as a result of the subrogation settlement.

Recovery by the Insurer, and receipt by the INSURED of less than the total amount of deductible does not affect the INSURED'S right to recover any un-reimbursed portion from parties liable for the loss.

7. Requiring as a condition of payment of a claim that repairs to any damaged vehicle must be made by a particular contractor or repair shop, or that parts, other than window glass, must be replaced with parts other than original equipment parts.
8. Where liability is reasonably clear, failing to inform A CLAIMANT that the claimant may have a claim for loss of use of the vehicle.
9. Failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability.
10. Failing to pay any interest required by statute on overdue payment for a PIP claim.
11. If an auto policy contains either or both of the time limitations permitted by M.S. § 65B.55, Subd. 1 and 2, failing to notify the INSURED in writing of those limitations at least 60 days prior to the expiration of that time limitation. (M.S. § 65B.55, Subd. 1 allows an insurer to prescribe a period of not less than 6 months after the date of accident within which a person entitled to basic economic loss benefits must notify the insurer of the accident and the possibility of a claim for economic loss benefits; M.S. § 65B.55, Subd. 2 states that an insurer who provides coverage for basic economic loss benefits may contain a provision terminating eligibility for benefits after a prescribed period of lapse of disability and medical treatment, which period shall not be less than one year.)
12. If an insurer chooses to have AN INSURED examined as permitted by M.S. § 65B.56, Subd. 1, (IME) failing to notify the insured of all of the insured's rights and obligations under that statute including the right to request, in writing, and receive a copy of the report of the IME.
13. Failing to provide a complete copy of the claim file (excluding internal company memos; all material relating to any insurance fraud investigation, attorney work product materials; materials that fall within attorney-client privilege; and medical reviews within M.S. §145.64) to an INSURED who has submitted a claim for benefits as described in M.S. §65B.44. The insurer may charge a reasonable copying fee. (This clause supersedes any inconsistent provisions of sections 72A.49 to 72A.505 - The Minnesota Insurance Fair Information Reporting Act.)

14. On any claim for damaged window glass, failing to provide payment to the INSURED'S chosen vendor based on a competitive price that is fair and reasonable within the local industry at large.

This clause does not prohibit an Insurer from recommending a vendor to the INSURED or from agreeing with a vendor to perform work at an agreed-upon price, provided, however, that before recommending a vendor, the Insurer shall offer its INSURED the opportunity to choose the vendor. If the Insurer recommends a vendor, the Insurer must also provide the following advisory:

“Minnesota law gives you the right to go to any glass vendor you choose, and prohibits me from pressuring you to choose a particular vendor.”

15. Requiring an INSURED to have their motor vehicle glass and related products repaired at a particular place, shop or entity or otherwise limiting the ability of the INSURED to select the place, shop or entity to perform the repairs or replace the motor vehicle glass and related products and services.
16. Engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an INSURED to use a particular company or location to provide the motor vehicle glass repair or replacement services or products. (A warranty is not considered an inducement or incentive).

viii. SUBD. 7 - STANDARDS FOR RELEASES

The following acts constitute unfair settlement practices:

1. Requesting AN INSURED OR CLAIMANT to sign a release that extends beyond the subject matter that gave rise to the payment.
2. Issuing a settlement check or draft that implies or states that acceptance of the check or draft constitutes a final settlement or release of any or all future obligations arising out of the loss.

ix. SUBD. 8 - STANDARDS FOR CLAIM DENIAL

The following acts constitute unfair settlement practices:

1. Denying a claim without informing the INSURED of the policy provision, condition, or exclusion on which the denial is based.
2. Denying a claim without having made a reasonable investigation.
3. Denying a liability claim because the INSURED has requested that the

claim be denied.

4. Denying a liability claim because the INSURED has failed or refused to report the claim unless an independent evaluation indicates no liability.
5. Denying a claim without including the following information: (i) the basis for the denial; (ii) the name, address, and telephone number of the claim representative to whom the INSURED OR CLAIMANT may take any questions or complaints about the denial (iii) the claim number and the policy number; and (iv) if the denied claim is a fire claim, the INSURED'S right to file with the Department of Commerce a Complaint regarding the denial, and the address and phone number of the Department of Commerce.
6. Denying a claim because the INSURED OR CLAIMANT failed to exhibit the damaged property unless (i) the insurer within a reasonable time made a written demand to inspect the property and (ii) the demand was reasonable under the circumstances.
7. Denying a claim by an INSURED OR CLAIMANT based on the evaluation of a chemical dependency claim reviewer selected by the insurer unless the reviewer meets the specific qualifications set out in Subd. 8a.

If an insurer selects chemical dependency reviewers to conduct claim evaluations, the insurer must annually file a report containing the specific evaluation standards and criteria used in the evaluations with the commissioner. This report must be filed at the same time as the annual statement is submitted under M.S. §60A.13.

This report must include: the number of evaluations performed on behalf of the insurer during the reporting period; the types of evaluation performed; the results; the number of appeals of denials based on these evaluations; the results of these appeals; and the number of complaints filed in a court of competent jurisdiction.

x. SUBD. 8a - CHEMICAL DEPENDENCY CLAIM REVIEWER QUALIFICATIONS

- a.) The personnel file of a chemical dependency claim reviewer must include documentation of the competency of the reviewer in the following areas: i.) knowledge of chemical abuse and dependency; ii.) chemical use assessment, including client interviewing and screening; iii.) case management, including treatment planning, knowledge of social services, appropriate referrals, record keeping, reporting requirements, confidentiality rules; and iv.) individual

and group counseling, including crisis intervention.

- b.) Adequate documentation of competency in the areas referred to above includes:
- 1.) a Bachelor of Arts degree with a major or concentration in social work, nursing, sociology, human services, or psychology, is a licensed registered nurse, or is a licensed physician; has completed 30 hours of classroom instruction in each of the areas listed in paragraph a.), clauses i.) and ii.); and has successfully completed 480 hours of supervised experience as a chemical dependency counselor, either as a student or as an employee; or
 - 2.) successful completion of: 60 hours of classroom training in chemical abuse and dependency; 30 hours of classroom training in chemical use assessment, including client interviewing and screening; 160 hours of classroom training in case management, including treatment planning, knowledge of social services, appropriate referrals, record keeping, reporting requirements, confidentiality rules; and individual and group counseling, including crisis intervention; 480 hours of supervised experience as a chemical dependency counselor either as a student or as an employee; or
 - 3.) certification by the Institute for Chemical Dependency Professionals of Minnesota, Inc., as a chemical dependency counselor or as a chemical dependency counselor reciprocal, through the evaluation process established by the Certification Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1986;
 - 4.) successful completion of three years of supervised work experience as a chemical dependency counselor before January 1, 1988; or
 - 5.) a licensed physician, who has 480 hours of experience in a licensed chemical dependency program.

After January 1, 1993, chemical dependency counselors must document that they meet the requirements of 1.), 2.) or 3.) in order to comply with this section.

xi. SUBD. 9 - STANDARDS FOR COMMUNICATIONS WITH THE DEPARTMENT

The following acts constitute unfair settlement practices:

1. Failure to respond within 15 working days after receipt of any inquiry regarding a claim to the commissioner.
2. Failure, upon request, to make specific claim files available to the commissioner
3. Failure to include in a claim file all written communications and transactions from or to the insurer as well as all notes and work papers relating to the claim. (All written communications and notes referring to verbal communications must be dated by the insurer.)
4. Failure to submit to the commissioner, when requested, any summary of complaint data reasonably required.
5. Failure to compile and maintain a file on all complaints. (The file must contain adequate information so as to permit easy retrieval of the entire file. The file must indicate what investigation or action was taken by the company. The complaint file must be maintained for at least four years after the date of the complaint.)

xii. SUBD. 10 - SCOPE

This section does not apply to worker's compensation insurance.

xiii. SUBD. 11 - DISCLOSURE MANDATORY

An insurer must disclose coverage and limits of a policy within 30 days after written request by A CLAIMANT.

xiv. SUBD. 12- PREJUDGMENT INTEREST

Once a judgment is entered against an insured, the principal amount of which is within the applicable policy limits, the insurer is responsible for their insured's share of the costs, disbursements, and prejudgment interest as determined under M.S. § 549.09, included in the judgment even if the total amount of the judgment is in excess of the applicable policy limits.

xv. SUBD. 13- IMPROPER CLAIM OF DISCOUNT

- a.) No insurer or community integrated service network shall intentionally provide a health care provider an explanation of benefits or similar document claiming a right to a reduced fee, price or other charge when they do not have an agreement with the provider for the reduction with respect to the patient involved.
- b.) Notwithstanding paragraph a.), the insurer or community integrated service network may claim the right to a discount based upon a discount agreement between the health care provider and another entity, but only if: 1.) the agreement expressly permitted the entity to assign its right to receive the discount; 2.) the assignment complies with any relevant requirements for assignments contained in the discount agreement; and 3.) the insurer or community integrated service network has complied with any relevant requirements contained in the assignment.
- c.) When an explanation of benefits or similar document claims a discount permitted under paragraph b.) above, it shall prominently state the name of the entity from whom the assignment was received. (This paragraph does not apply if the entity that issues the explanation of benefits or similar document has a provider agreement with the provider.)
- d.) No insurer or community integrated service network that has entered into an agreement with a health care provider that involves discounted fees, prices, or other charges shall disclose the discounts to another entity, with the knowledge or expectation that the disclosure will result in claims for discounts prohibited under paragraphs (a) and (b).

III. CASE LAW

Several Minnesota cases have interpreted the provisions of the Unfair Claims Practices Act. Pertinent cases include the following:

- 1. Morris v. American Family Mut. Ins. Co., 386 N.W.2d 233 (Minn. 1986);
- 2. Great West Cas. Co. V. Barnick, 542 N.W.2d 400 (Minn. App. 1996);
- 3. Glass Service Co., Inc. v. State Farm Mut. Auto. Ins. Co., 530 N.W.2d 867 (Minn.App. 1995) review denied;
- 4. Pillsbury Co. v. National Union Fire Ins. Co., 425 N.W.2d 244 (Minn. App. 1988),

5. In The Matter of The Great American Ins. Co., 412 N.W.2d 821 (Minn. App. 1981).
6. State ex rel. Hatch v. American Family Mutual Ins. Co., 609 N.W.2d 1 (Minn. App. 2000) review denied;

Morris v. American Family is a significant case with a holding very favorable to the insurance industry. In Morris, the Minnesota Supreme Court reversed the Minnesota Court of Appeals and held that a private person does not have a cause of action for a violation of the Unfair Claims Practices Act. In so holding, the Minnesota Supreme Court not only reversed the Court of Appeals but was directly contrary to an article written by the then Commissioner of Commerce, Michael A. Hatch, in the Minnesota Trial Lawyers Association publication, Minnesota Trial Law.

In this article, Commissioner Hatch argued that the Unfair Claims Practices Act not only permitted a private cause of action against the insurer, but also allowed for punitive damages. The holding also disregarded testimony by Commissioner Hatch in 1984 before committees of both the House and Senate in which Commissioner Hatch testified that a private cause of action had already been created.

The Morris case has been consistently upheld and widely cited in denying private persons and corporations private causes of action based upon alleged violations of the Unfair Claims Practices Act. See State Farm Mutual Automobile Ins. Co. v. Cincinnati Ins. Co., 651 N.W.2d 542 (Minn. App. 2002); Glass Service Co., Inc. v. Progressive Special Ins. Co., 603 N.W.2d 849 (Minn. App. 2000); Doe v. Norwest Bank Minnesota, NA, C.A. 8 (Minn.) 1997, 107 F.3d 1297; TGA Development, Inc. v. Northern Ins. Co. of New York, C.A.8 (Minn. 1995), 62 F.3d 1089; American Commerce Ins. Brokers, Inc. v. Minnesota Mut. Fire & Cas. Co., 535 N.W.2d 365 (Minn.App. 1995); Glass Service Co., Inc. v. State Farm Mut. Auto. Ins. Co., 530 N.W.2d 867 (Minn.App. 1995) review denied; O'Reilly v. Allstate Ins. Co., 474 N.W.2d 221 (Minn.App. 1991); and Pillsbury Co. v. National Union Fire Ins. Co. of Pittsburgh, PA, 425 N.W.2d 244 (Minn. App. 1988) review granted, appeal dismissed.

The holding in Morris is also consistent with a line of breach of contract cases including Olson v. Ruglowski, 277 N.W.2d 385 (Minn. 1979); Haagenson v. National Farmers Union Property & Cas. Co., 277 N.W.2d 648 (Minn. 1979); and Minnesota-Iowa Television Co. v. Watonwan TV Improvement Assoc., 294 N.W.2d 297 (Minn. 1980). These cases held that punitive damages are not recoverable for a breach of contract except in exceptional cases where the breach is accompanied by an independent willful tort.

After the passage of the Unfair Claims Practices Act, there was a great concern throughout the insurance industry that an alleged violation of the Unfair Claims Practices Act would be seen by the courts as creating an independent willful tort which would allow a plaintiff to include a claim for punitive damages in a lawsuit against an insurer for breach of an insurance contract. However, the above-referenced case law has established that there is no private cause of action for any alleged violation of the Unfair Claims Practices Act.

The Minnesota Court of Appeals, in Great West Cas. Co. v. Barnick, held that an insurer is not obligated to pay prejudgment interest on a policy limits settlement reached prior to commencement of any lawsuit.

In Glass Service Co., Inc. v. State Farm Mut. Auto. Ins. Co., the Court of Appeals relied on Morris when denying Glass Service a private cause of action based on an alleged violation of the Unfair Claims Practices Act. The Court stated that it was not coercion and/or inducement to provide their insureds with a preferred vendor list and to inform their insureds that if they choose their own vendor they may be liable to pay the difference between the insureds' chosen vendor's price and the reasonable charges allowed by the policy. In this case, Glass Service Co., required the insureds to sign an invoice stating that they agreed to pay for work the insurance company was not required to cover.

In Pillsbury Co. v. National Union Fire Ins. Co., the Court of Appeals, relying in part on the Morris case, held that an insured's claim for punitive damages for bad faith denial of an insurance claim, defamation and coercion had been properly dismissed by the trial court. The Pillsbury Court again acknowledged that punitive damages are not recoverable in actions for breach of contract, except in exceptional cases where a breach of contract constitutes or is accompanied by an independent willful tort. The Court also determined that a bad faith denial of an insurance claim does not constitute an independent willful tort absent exceptional circumstances and that an alleged bad faith breach of an insurance contract is insufficient to support a claim of punitive damages.

In The Matter of The Great American Ins. Co., the Court of Appeals held that the Commissioner of Commerce was not required to show a "general business practice" in order to establish a violation of either § 72A.20 or § 72A.201 of the Unfair Claims Practices Act. Based upon the facts set forth in that case, the Court held that there was substantial evidence that the insurer had violated the Unfair Claims Practices Act and upheld a \$5,000 civil penalty imposed upon the insurer by the Commissioner of Commerce.

State ex rel. Hatch v. American Family Mutual Ins. Co., stands for the proposition that while the commerce commissioner has authority to bring actions against insurance companies for unfair trade practices, such power is not exclusive. The authority given to the Commissioner of Commerce to investigate and prosecute claims against insurance companies does not mean that the Attorney General is

precluded from doing so. The Court of Appeals recognizes that the Attorney General was authorized by statute to bring suit for alleged violations of consumer protection laws and insurance trade practice regulations against an insurer concerning the insurer's payment of claims to its insureds for storm damage. In so holding, the Court of Appeals stated that if the legislature intended that the commerce commissioner should have exclusive authority over insurance matters, the legislature would have explicitly stated so in the statute.

IV. CONCLUSION

The insurance industry in the State of Minnesota has indeed been fortunate as a result of the holding in Morris v. American Family which refused to recognize a private cause of action for a violation of the Unfair Claims Practices Act. But, due to the wide ranging powers of the Commissioner of Commerce and also the Attorney General in enforcing the provisions of the Unfair Claims Practices Act, all claims people who deal with either first party or third-party claims must be thoroughly familiar with the provisions of and the ramifications of Minnesota's Unfair Claims Practices Act.