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From the Chair

Jason J. Liss
Fabian, Sklar, King & Liss

Our "E-Issue"

As I write this, we are in the midst of the COVID-19 pandemic and uncharted territory. One tangible sign of this is that this issue is coming to you electronically. At the moment, printing and mailing services are not available, and the State Bar offered to send this issue in electronic format as a temporary expedient. We plan to print and mail the hard copy as soon as we can, but for now, you can access all of the articles and regular features in this electronic issue.

I hope our members and their families are safe and as well as can be under these stressful and very challenging circumstances. I recently participated in a COVID-19 conference call set up by the State Bar for section leaders. Each participant was asked to identify the urgent questions facing each section's membership. This was the first in a series of meetings the State Bar intends to host with the hopes of developing an "Ask a Lawyer" event and/or a "Practicing During COVID" workshop to educate and assist lawyers with the practice of law under the unique challenges each practitioner faces during the current crisis.

Our January Program - Indemnification

Since the publication of our last issue of the *Journal*, our section hosted an educational program at the Birmingham Athletic Club in Bloomfield Hills on January 16, 2020 titled *Indemnification: Scope, Breadth & Application* presented by John Sier of Kitch Drutchas Wagner Valitutti & Sherbrook, P.C. Photos are elsewhere in this issue. Registration topped 100 and the attendance at this program far exceeded our expectations. To my knowledge, this was the most well-attended program during my time on the Council and, in addition to our own members attendees included members of the Business Law section and the local chapter of the CPCU society.

Our Annual Scholarship and Essay Topic

This past January and February, the members of the Council's Scholarship Committee worked hard to promote our section's annual $5,000 scholarship by visiting several of the State's law schools, engaging directly with the students and educating them about what they would need to do to be considered for the scholarship. To qualify, the applicants were required to submit a written article of original work up to 2,500 words analyzing the conflict between state and federal law that workers' compensation insurers face when considering reimbursement of claims for treatment involving medical marijuana. Perhaps I should not have been surprised by the enthusiasm the students we met with expressed for the topic.

I am happy to report that our hard work paid off and we received considerably more submissions this year than last. An important criterion upon which each submission will be judged is whether it is worthy of publication in the Section's *Journal*. As we did last year, I expect the scholarship to be announced and awarded to this year's winner at our Section's annual meeting in October and the winning submission published in our *Journal's* January 2021 edition.

In our continued effort to grow our membership through cross-pollination with other sections, our section will be a Silver Level sponsor for the Young Lawyers Section's annual summit scheduled for September 12, 2020 at Detroit Mercy School of Law.

Our next council meeting is currently scheduled for April 30, 2020. I am hopeful the current shelter-in-place order recently issued by Governor Whitmer will not be extended and we will be able to have our usual in-person council meeting as planned. If not, there is always Zoom and remote conferencing.

Again, I wish our members a safe, healthy and productive work-life balance for the duration of the shelter-in-place order and I look forward to seeing everyone after the order has been lifted. ■

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Editor's Notes

By Hal O. Carroll
www.HalOCarrollEsq.com

A Special Note of Appreciation

Producing each issue of the *Journal* requires the cooperation of many persons, and we always appreciate the efforts of the many contributors – authors at the input end and our printer at the output end.

But it is especially appropriate to acknowledge the efforts of the many contributors now, with the disruption caused by the Covid19 virus. In spite of that disruption, the authors and commentators sent in their contributions, including even one that specifically address the effect of the virus on coverage. And our printer has arranged to send the issue out electronically.

Thanks to everyone!

The *Journal* is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at HOC@HalOCarrollEsq.com. ■

Coronavirus (Covid-19) And Business Income Insurance: Can Businesses that are Forced to Close or Limit their Operations Recover their Income Losses?

By Rabih Hamawi, *Law Office of Rabih Hamawi, PC*

March 26, 2020—Over the past week, I have received many calls from business owners asking if they may recover Business-Income losses because they have been forced to temporarily suspend or limit their business operations due to COVID-19. The answer is simple: it depends.

It depends on the language in the insurance policy, which is the starting point in determining whether a business owner may recover business income losses.

A. Business income

Usually, a policy requires the following:

1. Loss of business income (not only loss of revenues, but verifiable loss of net income);
2. Due to the necessary suspension of business operations (which includes complete or partial suspension);
3. During the period of restoration (which generally starts after the event causing the complete or partial suspension of business operations);
4. Caused by a direct physical loss (usually tangible physical injury or damage to insured property);
5. At premises which are described in the Declarations Page (which means the specific location must be an insured location for business income purposes); and
6. The loss or damage must be caused by or result from a covered cause of loss that is not excluded under the policy (generally something like fire, vandalism, or windstorm).

For the purposes of COVID-19, only the fourth and sixth requirements above are generally at issue under the policy and Michigan law because damage caused by COVID-19 is not generally considered 1) a direct physical loss since there is no tangible physical injury to insured property; and 2) because damage caused by viruses is generally not considered a covered cause of loss.

So far, this means there is no business income coverage. But it isn't over yet. Let's examine the remaining parts of the policy.

B. Civil Authority

Most insurance policies include Civil Authority business income coverage, which requires the following:

1. A covered cause of loss;
2. Causing damage to property other than property at the described premises;
3. Resulting in a business income loss;

4. Due to civil-authority action; and
5. That prohibits access to the described premises due to particularized reasons as defined in the policy.

For the same reasons mentioned in the business income section above, the first requirement may create coverage issues. Likewise, there may be additional issues related to the second requirement: whether the damage must be physical tangible damage or whether it may be any type of damage, including those damages caused by a virus.

This may indicate there is no COVID-19 business income coverage under the Civil Authority section. Let's continue.

C. The "communicable disease" endorsement

Some insurance policies may include an endorsement called the "Communicable Disease" endorsement, where a business owner may recover business income losses due to COVID-19 if all of the following requirements are met:

1. A business income loss;
2. Due to a temporary suspension or shut down of business operations;
3. Ordered by a civil authority;
4. Due to an outbreak of a communicable disease; and
5. At the insured premises or at another premises.

If all of these requirements are met, then a policy may provide limited coverage up to the sublimit amounts stated in the endorsement for business income losses. In policies including this endorsement, the insurance company may pay for the following:

1. The cost of cleaning or disinfecting the business property;
2. The cost of replacing contaminated stock;
3. The cost of testing the insured premises;
4. The cost of necessary medical tests, doctor's care, hospitalization, blood work, or vaccines for infected persons;
5. The extra advertising costs to restore business reputation;
6. The cost to evacuate the insured premises; and
7. The cost to avoid or minimize the suspension of business operations, including business income losses.

The bottom line

Under most policies, a business owner isn't generally allowed to recover for COVID-19 business income losses. But policies including "communicable disease" or other similar endorsements may provide limited COVID-19 business income coverage. ■

About the Author

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Scenes from theJanuary 16, 2020 Indemnification: Scope, Breadth & Application Seminar

▲ Speaker John M. Sier of Kitch, Drutchas Wagner Valitutti & Sherbrook

▲ The Crowd

◀ Chair Jason Liss and Speaker John Sier

When the Agent Drops the Ball: Litigating the Agent Errors and Omission Action

By Douglas G. McCray, *McCray Law Office PLLC*

Introduction

Generally, persons seeking to obtain property or liability insurance will approach an agent, describe the risk and leave it in the agent's hands. Often, the process is short, involving a brief conversation (frequently over the phone), and the agent never meets the person seeking insurance or sees the property to be insured. An application *may* be completed and signed by the applicant. In practice, however, it is often the agent who fills out the form (purportedly based upon the applicant's statements), following which the blank signature page, only, is emailed to the applicant, who never sees the written version of his responses. The agent requests that a particular insurer provide what the agent has determined is the right coverage, provides that insurer with the signed form and waits for the policy (possibly issuing a binder). Eventually, the policy is issued and the agent moves on to the next sale, not thinking much more about the matter.

While the process is less than perfect, problems are rare. In part, this is because insurance is designed to protect against catastrophic but uncommon events. If a homeowner's policy lists the wrong address but there is no loss, the mistake does not matter. If a fire does occur the policy is usually "good enough" fit (i.e. a home is likely insured under a homeowner's policy, with limits close to its replacement cost). In such situations, the insurer may deny the claim based on arson or failure to comply with policy conditions, but these do not result in agent liability. For that reason, agent errors and omissions ("E&O") actions are less common than those against insurers. A viable agent E&O action only exists if: (1) the agent makes a mistake, either in procurement of the policy or the advice given the applicant; and (2) as a result, coverage is grossly deficient or absent.

This is important because the limitation period for malpractice is two years while that for negligence is three. Furthermore, the Court of Appeals has held that the period does not begin to run until the insurer denies the claim.

What is an Insurance Agent Errors and Omission Dispute (and how much time do I have to bring one)?

Ordinary Negligence Theory and the Accrual of the Claim

First and foremost, an agent E&O action is based upon ordinary negligence.[1] While litigants sometimes float professional negligence arguments, these have been rejected, largely because the requirements for becoming licensed as an agent are not comparable to those for professionals like "physicians, attorneys, surgeons and dentists" (*id*). This is important because the limitation period for malpractice is two years while that for negligence is three.[2] Furthermore, the Court of Appeals has held that the period does not begin to run until the insurer denies the claim.[3] Thus, if an agent procures a (deficient) policy in 2018, the loss occurs in 2019 and the denial comes on, say, January 1, 2020, the filing deadline will be January 1, 2023.

Misrepresentation Theory

What if this is not enough? Can one bring an action against an agent for misrepresentation or breach of a contract to procure insurance (both of which would have six-year limitation period[4])? *Zaremba Equipment v Harco Natl Ins Co (Zaremba I)* provides some insight. In that case, the court dismissed the insured's claim for misrepresentation as to the agent's failure to obtain "full replacement coverage" because the fact that such coverage was lacking would have been apparent if the insured had read the policy, so "reasonable reliance" was lacking.[5] However, the action was allowed to proceed on a misrepresentation theory with respect to the agent's miscalculation of the building's replacement cost, because that could not have been gleaned from the policy.

Breach of Contract Theory

The viability of breach of contract actions is less clear. In *Auto-Owners Ins Co v Michigan Mutual Ins Co*, the agent failed to properly insure a limousine company, so that no insurance existed when passengers were injured in a motor vehicle accident.[6] The passengers filed with the Assigned Claim Facility, which assigned the claims to Auto Owners.

Auto Owners, in turn, became the subrogee as to the passengers' rights against the agent. The court held that the passengers (and thus Auto Owners) had standing to sue the agent based on both negligence and the fact that the passengers were third party beneficiaries of the contract between the limousine company and the agent.[7] In contrast, outside of the third party beneficiary context most cases hold that E&O cases sound in tort, so the six-year limitation period now set forth in MCL 600.5807(9) is inapplicable.[8] Accordingly, as a general principle, those contemplating an E&O action would do well to file it within three years.

Overview of E&O Negligence Actions

As with any negligence action, the Plaintiff in an E&O case must establish four elements: "(1) a duty, (2) a breach of that duty, (3) causation, and (4) damages." In *Holton v A+ Insurance Associates, Inc*, the Court of Appeals summarized the duty owed: "Michigan law recognizes a cause of action in tort for an insurance agent's failure to procure requested insurance coverage, which includes an insurance agent's duty to advise an insured upon a showing of a special relationship."[9] The reference to the "duty to advise" is important, because while it is but a sub-category of the broader "duty to procure," most E&O cases deal with this topic. For that reason, it helps to divide such cases into two categories: (1) those addressing the "duty to advise"; and (2) other "duty to procure" cases. A second important distinction is whether the defendant is a "captive" (a.k.a. "exclusive") agent who works solely for a single insurance company or, alternatively, an "independent" agent (one who procures policies from a range of insurers).

At least with respect to captive agents, Michigan courts have long held there is no "affirmative duty to advise a client regarding the adequacy of a policy's coverage" but that such a duty "may arise when a 'special relationship' exists between the insurance company or its agent and the policyholder"

"Duty to Advise" E&O Actions and Harts v Farmers Insurance Exchange

At least with respect to captive agents, Michigan courts have long held there is no "affirmative duty to advise a client regarding the adequacy of a policy's coverage" but that such a duty "may arise when a 'special relationship' exists between the insurance company or its agent and the policyholder" (*see, e.g. Bruner v League General Ins Co*[10]). Prior to 1999, the most important factor in determining whether there was a "special relationship" was the existence of a "long-term standing relationship [with] some type of interaction on a question of coverage . . . ."[11] However, this changed with *Harts v Farmers Ins Exchange.*[12] *Harts* involved an agent's (Pietrzak's) alleged failure to advise the insured regarding the availability of uninsured motorist coverage. The trial court ruled against the plaintiff based on plaintiff's failure to establish a "special relationship" under *Bruner*.

The plaintiff contended that the Supreme Court "should reject *Bruner's* requirement of a special relationship" and reverse. Initially, the Supreme Court discussed the "default" lack of a duty to advise on the part of *captive* insurance agents at length, stating "[i]t is uncontested, indeed *it is essential to the cause of action pleaded by plaintiffs, that [the agent] was Farmer's agent*. As such, under the common law, he had a duty to comply with the various fiduciary obligations he owed to Farmers and to act for its benefit. . . . Moreover, *because he was farmers' agent*, he had no common law duty to advise plaintiffs" (citations omitted; emphasis added). Next, the court discussed certain policy reasons supporting "the general rule that insurance agents have no duty to advise the insured regarding the adequacy of insurance coverage." Finally, it stated: "Thus, under the common law, an insurance agent whose principal is the insurance company owes no duty to advise a potential insured about any coverage. Such an agent's job is to merely present the product of his principal and take such orders as can be secured from those who want to purchase the coverage offered" (emphasis added).

Having explained the default "no duty to advise" rule applicable to captive agents, the Supreme Court acknowledged earlier cases holding that such a duty could arise if a "special relationship" existed. However it rejected *Bruner*, holding instead that a "special relationship" existed if one or more of the following occurred: "(1) the agent misrepresents the nature or extent of the coverage offered or provided, (2) an ambiguous request is made that requires a clarification, (3) an inquiry is made that may require advice and the agent, though he need not, gives advice that is inaccurate, or (4) the agent assumes an additional duty by either express agreement with or promise to the insured" (footnotes omitted).[13] Finally, the court held that as the plaintiff could not establish any of the four "prongs," no duty existed.

"Duty to Advise" and Independent Agents

Harts is the law of the land with respect to "duty to advise" cases involving captive agents. Whether it applies to independent agents is unclear. There are at least two good reasons to believe it does not. First, *Harts* repeatedly emphasized that Pietrzak worked "exclusively for Farmers," "was Farmers' agent" etc., and limited its description of the default rule to agents "whose principal is the insurance company." Granted, the court elsewhere referenced the rule in connection with "an insurance agent" (without distinguishing). However, it also

noted that Pietrzak's status as a captive was "essential to the cause of action pleaded by plaintiffs." In light of the fact that the court discussed *captive* agents at such length, the argument that the court was announcing a rule applicable to *all* agents makes no sense.[14]

Second, "[t]he fiduciary duty that the insurance agent owes each party varies in relation to the agent's status as an independent or exclusive agent".[15] An independent agent's "primary fiduciary duty of loyalty rest[s] with [the applicant/insured], who c[an] depend on this duty of loyalty to ensure that [the agent is] acting in their best interests . . .[16] Logic dictates that the limited duty *Harts* indicated applied to captive agents is inconsistent with (and less than) an independent agent's obligation to obtain "most comprehensive coverage and [ensure] that the insurance contract properly addressed [the applicant's] needs."

On the other hand, *Harts* also cited the statutes governing licensing requirements for insurance agents and counselors and stated: [w]hat is clear from these provisions is that the Legislature has long distinguished between insurance agents and insurance counselors, with agents being essentially order takers while it is insurance counselors who function primarily as advisors." Later opinions have cited this language to argue that imposing a general duty to advise on an agent is inappropriate because agents are "order takers" and should not be required to perform the same function as an insurance counselor.[17] As of today, appellate panels have employed differing rationales to reach inconsistent results, and to the best of the author's knowledge there is no binding authority addressing the issue, which remains unresolved.

E&O Negligence Actions Based on the "Duty to Procure"

Many E&O disputes have more to do with what the agent *did* than what the agent *said*. Examples include procurement of policies that do not cover certain people or property, preparation of incorrect applications and certificates and negligent appraisals (resulting in deficient limits). In that regard, "Michigan law recognizes a cause of action in tort for an insurance agent's failure to *procure* requested insurance coverage . . . ." (*Holton, supra*). In this context, the language employed by courts in addressing "duty" is what one might expect in a negligence case. Specifically: "An agent employed to effect insurance must exercise such reasonable skill and ordinary diligence as may fairly be expected from a person in his or her profession or situation, in doing what is necessary to effect a policy, in seeing that it effectually covers the property to be insured, in selecting the insurer, and so on."[18] At a minimum, the agent must "procure the insurance coverage requested by an insured [and] strictly follow the insured's instructions which are clear, explicit, absolute, and unqualified."[19]

With respect to independent agents (who owe a fiduciary duty to the applicant), the agent's burden is significant. In *Genesee Foods Services v Meadowbrook*[20] the Court stated that the Plaintiffs: "could depend on this duty of loyalty to ensure that defendants were acting in their best interests, both in terms of finding an insurer that could provide them with the most comprehensive coverage and in ensuring that the insurance contract properly addressed their needs." The duty owed extends "to those who would foreseeably benefit from the insurance contract or who would be injured by the negligent failure to procure insurance," which depending on the circumstances may or may not include third parties.[21]

Damages and Comparative Negligence

Assuming an agent has breached either the duty to advise or more general duty to procure, the agent is "liable for any damages proximately caused by his negligence, up to the amount of the insurance he was employed to procure."[22] In *GHD Operating, LLC v Emerson Prew Inc*, the court stated: "[g]enerally, a negligent defendant is liable for all injuries resulting directly from his wrongful act, whether foreseeable or not, if the damages were the legal and natural consequences of his conduct and might reasonably have been anticipated."[23] Other cases reference "*any* damages resulting from the breach."[24]

Given that E&O actions are primarily rooted in negligence, it is not surprising that allocation of fault under Michigan's "comparative negligence" statutes[25] is an issue. Usually, this concerns the applicant's failure to read the policy, notwithstanding the "general duty to read the insurance policy and raise questions concerning coverage within a reasonable time after the policy has been issued."[26] If simply reading the policy would have avoided the deficiency in insurance, comparative negligence will decrease the plaintiff's recovery.[27] Conversely, if the applicant's negligence would not have prevented the deficiency, it cannot be used as an "offset." Thus, the appellate courts have held that comparative negligence" does not apply when the applicant: (1) causes the underlying property loss (*Holton*); (2) fails to realize an agent's certificate is incorrect (*Michigan Tooling*); or (3) does not catch an agent's "negligent appraisal" of a building's replacement cost (*Zaremba I* and *II*).

Avoiding E&O Actions: Strategies for Agents

From the agent's perspective, the best E&O case is the one that is never filed. In that regard, recurrent fact patterns in Michigan appellate opinions and the author's own cases provide some insight as to strategies an agent can use to avoid being on the wrong end of an E&O action. Some of these are:

1. If you prepare the application, do so based upon the applicant's statements, not guesses.
2. Have the applicant read the entire application before signing and initial each page.

3. If you email the application, email the entire document (not just the signature page).
4. If you have reason to believe residency issues exist, ask questions.
5. If you lack authority to issue the necessary policy (e.g. a rental for rental property), don't procure the wrong one (e.g. a homeowners) to make a sale - walk away.
6. If you decide to conduct an appraisal to determine the replacement cost limits, get it right.
7. If the applicant wants to save money by purchasing less coverage than you believe is needed, get a signed statement confirming they did so against your advice.
8. Make sure the applicant gets a copy of the policy, and tell them (in writing) to read it.
9. If you have reason to believe that anything about the risk may defeat coverage, even if not addressed in the application, ask still more questions.

This list is long, but it is not exhaustive.

Conclusion

An agent E&O case is often filed along with the action against the insurer, with the applicant seeking relief in the alternative (i.e. coverage exists, but if not it is the agent's fault).[28] Therefore, in addition to having a working knowledge of *Harts* and the other cases discussed above, the attorney should be familiar with the relevant type of insurance (e.g. fire insurance for a fire insurance policy). A basic understanding of the law relating to negligence and perhaps misrepresentation also helps. Especially in the "duty to advise" context, the action will usually involve conflicting statements about who said what, and grants of summary disposition as to the E&O action are probably the exception rather than the rule. Depending on the specific facts, it may or may not be necessary to involve experts on the agent standard of care and damages. In the end, if the matter does not settle or resolve through summary disposition, the prevailing party will likely be determined by whether the agent's story or the applicant's makes more sense in light of common sense and the available documents. ■

About the Author

Doug McCray *is the senior member at McCray Law Office PLLC (MLO). For 24-odd years, he has been involved in various types of insurance litigation. For the last 17, Doug has represented insureds (and applicants) against insurance companies and agents in the fire insurance context. He is listed as an author on several published articles addressing legal and scientific topics, and is a member of the Michigan State Bar Insurance and Indemnity Law Section council.*

Endnotes

1 *Stephens v. Worden Insurance Agency,* 307 Mich App 220 (2014).

2 See MCL 600.5805(8) (malpractice) and (2) (all actions to recover damages for the death of a person or for injury to a person or property). See also *Stephens*, *supra*, which addressed earlier versions of the referenced sub-sections.

3 *Stephens*, *supra*.

4 MCL 600.5807(9) (contracts); MCL 600.5813 ("all other personal actions"). An *insurer* can definitely sue an agent for breach of an agency contract (*see Hawkeye Cas. Co. v. Frisbee,* 316 Mich 540 (1947)).

5 280 Mich App 16 (2008) (*Zaremba* I), revisited 302 Mich App 7 (*Zaremba II*). *See also Schumitsch v. Pioneer State Mut. Ins. Co.,* Mich Ct. App 313046 (3-20-2014; unpublished) and *Hohensee v. Nasser Ins. Agency,* Mich Ct App 321434 (11-3-2015) (unpublished) (failure to read policy is fatal to misrepresentation claim if truth of matter can be gleaned from policy).

6 223 Mich App 205 (1997)

7 *See also Ahmad v. Wells Fargo Bank,* 861 F. Supp. 2d 818 (E.D. Mich. 2012) (stating, under heading entitled "Third party Beneficiary Breach of Contract," "[t]o sue as a third party beneficiary, the third party must show that the contract reflects the express or implied intention of the parties to the contract to benefit the third party"); and *Khalaf v. Bankers & Shippers Ins. Co.*, 404 Mich 134 (1978) (injured worker was third-party beneficiary of an agent's contract to procure liability coverage for a corporation; case implies that injured third party beneficiary could have proceeded against agent on the basis of negligence or breach of contract).

8 *See, e.g., Stephens*, *supra*; *Janndorhas Enterprises v. Walker Ins. Agency.*, Mich Ct App 320010 (4-16-2015; unpublished).

9 225 Mich App 318 (2003) (citation omitted).

10 164 Mich App 28 (1987).

11 Id (short relationship with little interaction; no "special relationship").

12 461 Mich 1 (July 30, 1999).

13 In a footnote, the *Harts* Court indicated that a request for "full coverage" would satisfy the second prong of the court's newly generated standard.

14 The Court of Appeals noted this in *Deremo v. TWC & Associates*, Mich Ct App 305810 (8-30-2012).

15 *Genesee Foods Services, Inc. v. Meadowbrook, Inc.*, 279 Mich App 649 (2007). In *Micheau v. Hughes & Havinga Ins. Agency,* Mich Ct App 307914 (5-21-2013) the Court of Appeals stated: "*Harts* neither holds nor implies that agents of the insured bear no fiduciary duties, even absent a "special relationship."

16 Id. *See also Deremo, supra* (citing *Genesee*).

17 *Harts*, *supra*; *Schumitsch v. Pioneer State Mut. Ins. Co.,* Mich Ct. App 313046 (3-20-2014; unpublished); Janovski v. SJ Ferrari In. Agency, Mich Ct App 326457 (5-24-2017).

18 *Micheau v. Hughes & Havinga Ins. Agency*, Mich Ct App 307914 (5-21-2013; unpublished), citing 3 Couch on Insurance, 3d, § 46:30, pp. 46-56 to 46-57).

19 *Zaremba Equip. v. Harco Nat'L Ins.*, 761 N.W.2d 151, 164, 280 Mich. App. 16 (Mich. App. 2008).

20 279 Mich App 649 (2008).

21 *Auto-Owners Ins. Co. v. Michigan Mutual Ins. Co.,* 223 Mich App 205 (1997) (duty to third party exists). *Compare Michigan Tooling Assoc. v. Farmington Ins. Agency*, Mich Ct App 249023 (12-7-2004; unpublished), reversed in part 708 NW 2d 370 (Mich 2006) (duty to prepare certificate in a "diligent and reasonably skillful workmanlike manner" exists with respect to those foreseeably injured if certificate is negligently prepared; Supreme court held injury to third party who never spoke with agent was not foreseeable).

22 *Century Boat Company v. Midland Ins. Co.*, 604 F. Supp. 472 (WD Mich 1985).

23 *GHD Operating, L.L.C. v. Emerson Prew, Inc.*, Mich Ct App 278857 (2-3-2009; unpublished).

24 *Stein, Hinkle, Dawe & Associates, Inc. v. Continental Cas. Co.*, 110 Mich. App. 410 (Mich. App. 1981).

25 (MCL 600 2957 and MCL 600.6304); *Holton*, *supra*.

26 *Harts*, note. 4.

27 *See, e.g., Zaremba I,* supra.

28 Both the agent and agency are typically listed, and the fact that the agency is vicariously liable for the agent's conduct is almost never an issue as long as it is pleaded correctly.

The Recent No-Fault Act Amendments Do Not Prevent Insurers from Obtaining Independent Medical Evaluations for Trial Purposes Performed by "Non-Matching" Medical Experts

By Christian C. Huffman, *Garan Lucow Miller*

Introduction

In *Muci v State Farm*[1] the Michigan Supreme Court held that MCR 2.311 of the Michigan Court Rules does not enable a court to refuse or render conditional the statutory right that the Legislature has granted to a no-fault insurer in MCL 500.3151 and MCL 500.3159 of Michigan's no-fault automobile insurance act[2] to require that the insured submit to an independent medical evaluation ("IME"). Rather, section 3151 and section 3159 alone govern, and "MCR 2.311 is not applicable to such examinations."[3]

The Michigan Legislature recently amended section 3151 as part of its comprehensive overhaul of the no-fault act.[4] In its current form, MCL 500.3151 now mandates that any IME performed pursuant to section 3151 must be conducted by a physician whose qualifications match the qualifications of the insured's treating physician:

> (1) If the mental or physical condition of [the insured] is material to a claim that has been or may be made for past or future [PIP] benefits, at the request of [the] insurer the [insured] shall submit to mental or physical examination by physicians. . . .
>
> (2) A physician who conducts a mental or physical examination under this section must be licensed as a physician in this state or another state and meet the following criteria, as applicable:
>
> (a) If care is being provided to the [insured] by a specialist, the examining physician must specialize in the same specialty as the physician providing the care, and if the physician providing the care is board certified in the specialty, the examining physician must be board certified in that specialty.
>
> (b) During the year immediately preceding the examination, the examining physician must have devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of medicine and, if subdivision (a) applies, the active clinical practice relevant to the specialty.
>
> (ii) The instruction of students . . .

> and, if subdivision (a) applies, the instruction of students is in the specialty.

This amendment, coupled with *Muci*'s statement that "MCR 2.311 is not applicable to such examinations,"[5] has caused some to believe that a no-fault insurer who is defending against a lawsuit brought by the insured cannot move pursuant to MCR 2.311 for court permission to obtain for trial purposes an IME performed by a physician whose qualifications do not precisely match the qualifications of the insured's treating physician.

Thus, so the argument goes, if an insured is treating with a chiropractor and a no-fault insurer refuses to pay personal protection insurance ("PIP") benefits for such treatment based upon an IME performed by a chiropractor under § 3151, if the insured files a lawsuit the no-fault insurer cannot request pursuant to MCR 2.311 that the court permit the no-fault insurer to obtain an additional IME performed by a neurosurgeon for use in defending against the lawsuit at trial. This, they assert, is because the neurosurgeon's qualifications do not match the treating chiropractor's qualifications, even though the neurosurgeon may in fact be more qualified than the treating chiropractor to formulate and explain to a jury expert medical opinions on issues such as, for instance, whether the insured has a herniated disc and, if so, whether the herniation was caused by the motor vehicle accident.

But the proponents of this argument misconstrue the holding of *Muci* and misunderstand the impact of the recent amendments to § 3151. The Supreme Court in *Muci* simply recognized that it did not have the constitutional authority to promulgate a court rule enabling a trial court to deny a litigant a statutorily created substantive right, such as the right of a no-fault insurer to obtain an IME for claim handling purposes by a physician meeting the requirements of § 3151.

Our Supreme Court *did not* hold that § 3151 and § 3159 operate to deny a no-fault insurer the ability to seek court permission pursuant to MCR 2.311 to obtain during discovery and present at trial evidence such as an additional IME by a physician possessing qualifications enabling the physician to render an opinion relevant to the litigated issues. And, nothing in the language of the newly amended § 3151 indicates a legislative intent to deny a no-fault insurer the ability to utilize MCR 2.311 to obtain an additional IME for trial purposes.

The Supreme Court's decision in *Muci*

Alina Muci filed a lawsuit against State Farm claiming that State Farm had wrongfully denied her PIP benefits. State Farm had not obtained an IME before the lawsuit was initiated. Thus, after Muci filed suit State Farm demanded that Muci submit to an IME pursuant to § 3151 and § 3159.

At the time that *Muci* was decided, § 3151 did not contain qualification-matching requirements. Rather, it simply provided that a no-fault insurer could mandate that an insured submit to an IME if their mental or physical condition was material to their claim for PIP benefits and was at issue:

> When the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, the person *shall* submit to mental or physical examination by physicians. . . . [Emphasis added.]

Moreover, § 3159, which has not been amended since the Supreme Court decided *Muci*, provides that the insured cannot refuse the no-fault insurer's request without demonstrating to a court "good cause" why the IME should not occur or should only occur subject to conditions:

> In a dispute regarding an insurer's right to discovery of facts about [the insured]'s earnings or about [the insured's] history, condition, treatment and dates and costs of treatment, a court may enter an order for the discovery. The order may be made only on motion for good cause shown and upon notice to all persons having an interest, and shall specify the time, place, manner, conditions and scope of the discovery. A court, in order to protect against annoyance, embarrassment or oppression, as justice requires, may enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

Ms. Muci refused to submit to State Farm's requested IME unless it was performed subject to several conditions. She claimed that because she had filed a lawsuit § 3151 and § 3159 no longer controlled the matter of her IME attendance. Rather, Ms. Muci argued that her filing of the lawsuit had rendered State Farm's ability to obtain an IME subject to the sole control of MCR 2.311, which provides, in pertinent part:

> **(A) Order for Examination.** When the mental or physical condition . . . of a party . . . is in controversy, the court in which the action is pending *may* order the party to submit to a physical or mental . . . examination by a physician (or other appropriate professional) . . . . The order may be entered only on motion for good cause with notice to the person to be examined and to all parties. The order must specify the time, place, manner, conditions, and scope of the examination and the person or persons by whom it is to be made, and may provide that the attorney for the person to be examined may be present at the examination. [Emphasis added.]

Thus, although the statute mandates that an insured must submit to an unconditional IME upon the request of a no-fault insurer unless the insured can show "good cause" for the IME to be refused or conditions imposed thereon, the court rule provides that the insurer has to move the court for permission to obtain an unconditional IME and show "good cause" for such request.

The Michigan Supreme Court held that MCR 2.311 irreconcilably conflicts with § 3151 and § 3159 in such a situation, stating:

> It is simply incorrect to argue that what can be done under § 3151 of the no-fault act is no different from what is required under MCR 2.311; after all, [MCR 2.311] requires pending litigation and the insurer to show good cause, and allows court-imposed conditions as a predicate to the examination while § 3151 does not have these requirements. Indeed, under § 3151 an insured must submit to a medical examination. In contrast, under MCR 2.311, whether an insured must submit to a medical examination is left to the trial court to decide. Therefore, the court rule and [§ 3151] conflict because that which is required under § 3151 is merely discretionary under MCR 2.311.[6]
>
> * * *
>
> We further note that the court rule conflicts with § 3159. While MCR 2.311 requires the party seeking the medical examination to demonstrate good cause, § 3159 requires the party seeking to impose conditions on a discovery order such as an order for a medical examination to show good cause.[7]

Having determined that MCR 2.311 conflicts with § 3151 and § 3159 when a trial court is asked to refuse or render conditional a no-fault insurer's statutory right to obtain an IME, the Michigan Supreme Court sought to resolve the issue of whether the court rule or the statutes control in such an instance.

In doing so the Supreme Court looked for guidance to its prior decision in *McDougall v Schanz*.[8] In that case the court had considered whether MRE 702 of Michigan's Rules of Evidence or MCL 600.2169 of Michigan's Revised Judicature Act of 1961[9] controls to determine what qualifications a physician must have to present expert testimony in a medical malpractice case regarding the standard of practice or care that should have been followed by a defendant-physician.

In that regard, § 2169 sets forth qualification-matching requirements for medical malpractice experts similar to those that the Legislature recently inserted into the no-fault act for physicians who perform IME's under § 3151. In relevant part, § 1629 provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the [defendant-physician] is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the [defendant-physician]. However, if the [defendant physician] is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the [defendant-physician] is licensed and, if th[e defendant-physician] is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in . . . the same health profession in which the [defendant-physician] is licensed and, if th[e defendant-physician] is a specialist, . . . in the same specialty.

The Supreme Court in *McDougall* held that because § 2169 "contains strict practice [and] teaching requirements" as a prerequisite to proffering expert testimony at a medical malpractice trial, it necessarily conflicts with the less stringent requirements for the introduction of expert testimony contained in MRE 702,[10] which in relevant part provides:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise . . . .

Having determined that an inherent conflict exists between § 2169 and MRE 702, the Supreme Court in *McDougall* recognized that its authority to promulgate court rules is constitutionally limited to dictating "matters of [court] practice and procedure," whereas the Legislature has sole authority

to "establish, abrogate, or modify the substantive law."[11] Thus, the court acknowledged in *McDougall* that "'[i]f a particular court rule contravenes a legislatively declared principle of public policy [in a statute], having as its basis something other than court administration . . . the [court] rule should yield.'"[12]

The court determined that § 2169 "reflects wide-ranging and substantial policy considerations relating to medical malpractice actions against specialists," thus rendering it substantive in nature and controlling over MRE 702.[13] In other words, the Supreme Court recognized in *McDougall* that § 2169's qualification requirements represent a legislative determination that a defendant-physician should not be held liable for medical malpractice based on the plaintiff's expert's assertion that the defendant-physician should have exercised a certain level of care in a specific situation unless the proffered expert possesses the same experience and knowledge with regard to such situations as the defendant-physician and, thus, has a credible basis to render an opinion regarding what the defendant-physician should have done in that situation.

Relying upon its earlier holding in *McDougall,* the Supreme Court in *Muci* similarly held that § 3151 and § 3159 represent a legislative determination that a no-fault insurer has a right to require an insured to submit to an IME in order to assess whether the insured was in fact injured in the motor vehicle accident[14] and, if so, whether the medical treatment the insured is seeking payment of PIP benefits for is reasonably necessary for the insured's care, recovery, or rehabilitation.[15] Thus, in light of the inherent conflict between the statutes and the court rule, the Supreme Court held that the statutes control to determine whether a no-fault insurer has the right to demand that the insured submit to an unconditional IME:

> [T]he provisions [of § 3151 and § 3159] concerning medical examinations, because they do not concern court administration, are substantive, not procedural, and are supreme over the court rule, just as the general court rule concerning experts' qualifications must, pursuant to *McDougall, supra* at 30–31, yield to statutory requirements concerning expert witnesses' qualifications.
>
> Thus, we conclude that the no-fault act comprehensively addresses the matter of claimant examinations. Accordingly, MCR 2.311 is not applicable to such examinations. [*Muci, supra* at 191 (emphasis added).]

In other words, the court held that the insured's filing of a lawsuit does not strip away the substantive policy considerations that caused the legislature to enact § 3151 and § 3159 and the court rules do not enable courts to utilize MCR 2.311 to contravene those substantive policy considerations under the auspices of "practice and procedure."

The Misinterpretation of *Muci*

There are those who read *Muci*'s statement that "MCR 2.311 is not applicable to such examinations" out of context, and misinterpret *Muci* as our Supreme Court having held that MCR 2.311 can *never* have any application in no-fault cases. These people thus believe that a no-fault insurer is limited to obtaining IME's solely pursuant to § 3151. Accordingly, now that § 3151 has been amended to provide that a physician performing an IME pursuant to § 3151 must possess the same qualifications as the insured's treating physician, those people believe that a no-fault insurer can *never* obtain an IME by a physician whose qualifications do not match the insured's treating physicians.

But such a belief is misplaced. Our Supreme Court in *Muci* considered only whether a no-fault insurer's statutory right to obtain an IME pursuant to § 3151 and § 3159 can be judicially stripped away or limited pursuant to MCR 2.311 simply because the insured has sued the no-fault insurer. That is, the court merely determined that it does not have the constitutional authority to promulgate a court rule dictating that a no-fault insurer has to seek trial court for permission to obtain an IME, and show good cause why the IME should be performed and no conditions imposed thereon, in direct contravention to the Legislature's substantive determination that the insured must submit to an unconditional IME unless the insured shows good cause why the IME should not be permitted or shows good cause why the IME should only be permitted subject to conditions.

But, importantly, our Supreme Court *did not* consider or rule upon the inverse issue – which is whether a no-fault insurer defending against a lawsuit brought by the insured may move a trial court pursuant to MCR 2.311 for permission to obtain an IME *in addition to* any IME that the no-fault insurer is statutorily entitled by § 3151 and § 3159 to obtain.

The no-fault insurer can.

Sections 3151 and 3159 do not limit an insurer's ability to request an IME pursuant to MCR 2.311

As an initial matter, it must be kept in mind that the recently amended § 3151 only provides that "*the [insured] shall submit* to a mental or physical examination by physicians" "[i] f the mental or physical condition of [the insured] is material to a claim" for personal protection insurance ("PIP") benefits. Accordingly, § 3151 merely dictates the circumstances under which the insured is required to undergo an IME requested by the insurer. Stated differently, § 3151 only limits the circumstances under which a no-fault insurer can *mandate* that the insured submit to an IME. It *does not* expressly or even impliedly preclude the insurer from obtaining an IME in some other, non-insurer mandated way, such as by obtaining court permission pursuant to MCR 2.311.

Similarly, § 3151 merely provides that "[a] physician who conducts a mental or physical examination *under this section* must" possess qualifications matching the insured's treating physicians' qualifications. Thus, the Legislature has not sought to dictate in § 3151 what qualifications an IME physician must possess when an IME that is not obtained "under [§ 3151]," but rather is obtained in some other way, such as pursuant to court permission under MCR 2.311 for the purposes of trial.[16]

Therefore, the text of § 3151 reveals no legislative intention that § 3151 serve as the only means by which an insurer can obtain an IME. Nor does anything in the text of § 3151 reveal any legislative intention that an IME physician necessarily possess qualifications identical to the insured's treating physician when the IME is not performed pursuant to § 3151, but rather is performed pursuant to MCR 2.311 for the purposes of litigation.

MCR 2.311 does not conflict with § 500.3151 and § 3159 when a no-fault insurer requests an IME for the purposes of litigation

As discussed above, the Legislature's imposition of qualification matching requirements upon physicians performing IME's pursuant to § 3151 are similar to the qualification matching requirements that the Legislature previously imposed for experts in medical malpractice cases in § 2169. But, it is significant to note that this is where the similarities between § 3151 and § 2169 end. Indeed, the text of the two statutes makes clear that what the Legislature intended in § 2169 is *very different* from what the Legislature intended when it amended § 3151.

Specifically, § 2169 provides that the proffered expert "*shall not give expert testimony . . . unless*" the proffered expert possesses qualifications matching those of the defendant-physician. Thus, as our Supreme Court noted in *McDougall,* when it enacted § 2169 the Legislature sought to "provide[] strict requirements for the admission of expert testimony in medical malpractice cases brought against specialists."[17]

Significantly, *nothing* in the language of § 3151 indicates that the Legislature similarly sought to provide "strict requirements" for what experts a no-fault insurer can present at trial in defense of a lawsuit brought by an insured.

Had the Legislature intended to prohibit a no-fault insurer from calling as an expert witness at trial an IME physician whose qualifications do not specifically match those of the insured's treating physician – such as a neurosurgeon, whose qualifications *exceed* those of a treating chiropractor in many respects - the Legislature obviously could have done so as it did in § 2169 with regard to claims of medical malpractice. Thus, the necessary inference is that the Legislature *did not* intend to impose such limitation on no-fault insurers when it amended § 3151.[18]

Instead, based on these textual indications, it is more reasonable to assume that the Legislature's intent in amending § 3151 was simply to indicate that a no-fault insurer's suspension of PIP benefits based upon an IME mandated by the insurer "under [§ 3151]" and performed by a physician possessing the qualifications required by that statute is presumptively "reasonable," thus insulating the no-fault insurer from court-ordered sanctions[19] for the suspension.

Indeed, *nothing* about the language of § 3151 reflects a legislative intent to deny an insurer that has suspended PIP benefits pursuant to an IME performed under § 3151 by a physician possessing the statutory qualifications, if later sued by the insured, the ability to present another physician at trial to proffer evidence in support of the proposition that the denial was reasonable.

Nor does anything about the language of § 3151 reflect a substantive policy decision by the Legislature to vest an insured a right *not* to have the insurer present such evidence.[20] Indeed, again, this is made clear by comparing the language that the Legislature used in § 3151 to the language that it used in § 2169.

The Legislature specifically stated in § 2169 that an expert "shall not give expert testimony on the appropriate standard of practice or care unless" the expert has the same qualifications "as the party against whom . . . the testimony is offered." This unambiguously vests the defendant-physician with the right *not* to have an expert who does not possess the statutorily-mandated qualifications testify against him. The Legislature used no similar language in § 3151. This, of course, is because when it amended § 3151 the Legislature's intention *was not* to handicap no-fault insurers at trial in defending against lawsuits for PIP benefits to which the insured may not be entitled, but rather simply to quasi-immunize no-fault insurers from the possibility of court-imposes sanctions in instances where no-fault insurers deny PIP benefits based on IME's.

Thus, while § 3151 and § 3159 are unquestionably "substantive," they *do not* "specifically address[]" the matter of what IME's can be obtained by a no-fault insurer for the purposes of litigation.[21] Nor do they "specifically address[]" what qualifications need be possessed by a physician performing an IME for the purposes of litigation.[22] Rather, § 3151 and § 3159 are simply "silent" on such matters. Accordingly, those issues are controlled by MCR 2.311 and MRE 702, since "the court rules control matters on which the no-fault act is silent."[23]

Nor do MCR 2.311 or MRE 702, when applied to a no-fault insurer requesting an IME for the purposes of litigation, exceed the realm of "practice and procedure" and impermissibly invade upon the "substantive" nature of § 3151 and § 3159.

Indeed, for a trial court to grant a no-fault insurer's request that an insured undergo an IME for use at trial pursuant to

MCR 2.311 and MRE 702 would not be "'contraven[ing] a legislatively declared principle of public policy'" that "'ha[s] as its basis something other than court administration.'"[24]

Rather, the trial judge's discretionary grant of a no-fault insurer's request pursuant to MCR 2.311 and MRE 702 would involve only "considerations [regarding] judicial dispatch of litigation,"[25] such as whether the requested IME physician possesses "specialized knowledge [that] will assist the trier of fact to understand the evidence or determine a fact in issue,"[26] and whether the qualifications possessed by the requested IME expert will render his testimony more than a mere "waste of time, or [the] needless presentation of cumulative evidence."[27]

Therefore, because MCR 2.311 and MRE 702 do not "inherent[ly] conflict" with § 3151 and § 3159 where a no-fault insurer requests trial court permission to obtain an IME for the purposes of defending against a lawsuit, MCR 2.311 and MRE 702 are not rendered inapplicable in such a situation.[28] Instead, MCR 2.311 and MRE 702 remain applicable to such a situation because "the court rules control matters on which the no-fault act is silent."[29]

Reading MCR 2.311 and MRE 702 in pari materia *with § 3151 and § 3159*

Because, as explained above, MCR 2.311 and MRE 702 do not "inherent[ly] conflict" with § 3151 and § 3159, the court rules must be construed and applied so as to avoid creating tension with the statutes.[30] That is, the statutes and the court rules "must be read together to produce a harmonious whole."[31]

That being said, we know from the Supreme Court's decision in *Muci* that MCR 2.311 cannot be utilized by a court to refuse or render conditional a no-fault insurer's right to require that the insured submit to an IME under § 3151 and § 3159, even though the insured has filed a lawsuit against the insured.[32]

Similarly, we know from the Supreme Court's holding in *McDougall* that MRE 702 cannot be utilized by a court to prohibit a no-fault insurer from introducing at trial the testimony of a physician who has performed an IME at the insurer's request under § 3151, and possesses the qualifications mandated by that statute. Rather, § 3151 reflects a "'declared principle of public policy, having as its basis something other than court administration'"[33] that an IME physician possessing the qualifications mandated by § 3151 is qualified to formulate a medical opinion concerning the mental or physical condition of the insured.

Moreover, we also know from the Supreme Court's decision in *Muci* that a no-fault insurer cannot utilize MCR 2.311 to obtain an IME *before trial* by an IME physician who does not possess the qualifications required by § 3151. Indeed, as aptly noted in *Muci*, MCR 2.311 "requires pending litigation."[34] Thus, the *only* way that a no-fault insurer can obtain an IME before litigation is commenced is "under [§ 3151.]" And, any physician who performs a "mental or physical examination" (i.e., an IME, as opposed to a record or film review) "under th[at] section *must*" possess the qualifications mandated therein.

Finally, we know that when a no-fault insurer requests an IME pursuant to MCR 2.311 for the purposes of trial, § 3151 and § 3159 *do not* apply to vest the insurer with any presumptive right to an unconditional IME. Rather, "the court rules [alone] control"[35] whether the insurer can obtain the IME, and whether conditions can be imposed thereon.

In that regard MCR 2.311 mandates that the no-fault insurer motion the court for permission to obtain the IME. And, before the court can properly exercise its discretion to allow the IME, the no-fault insurer *must* establish "good cause" for why it should be allowed to obtain the IME and why conditions should not be imposed thereon.[36]

The "good cause" requirement, as explained by the Supreme Court in *Muci*, requires "a particular and specific demonstration of fact" by the no-fault insurer, "as distinguished from stereotyped and conclusory statements."[37] Thus, the no-fault insurer will have to do more than make "stereotyped and conclusory" statements to the court that it needs the IME because the insured has put his or her physical or mental condition at issue by filing a lawsuit. This, of course, will be particularly true in cases where, unlike in *Muci*, the no-fault insurer has already obtained before trial an IME pursuant to § 3151 performed by a physician whose qualifications match the insured's treating physician.

Accordingly, the no-fault insurer will need to make a "particular and specific demonstration of fact"[38] to the court that the requested IME will not simply result in a "waste of time, or [the] needless presentation of cumulative evidence"[39] at trial, but instead will enable the insurer to obtain and present to the jury "specialized knowledge [that] will assist the trier of fact to understand the evidence or determine a fact in issue."[40] As just one example, this could be accomplished by appending to the motion an affidavit from the physician who performed the IME under § 3151 stating that in that physician's medical opinion the physician whom the insurer seeks to have perform the IME under MCR 2.311 is more qualified to formulate and provide a medical opinion to the jury regarding the specific issues in the case than a physician possessing only the qualifications of himself and the insured's treating physician.

By interpreting and applying the court rules in the above manner, a harmony is reached between the court rules and the statutes that respects both the Legislature's prerogative to statutorily implement substantive policy choices with regard to no-fault insurance, and the Michigan Supreme Court's prerogative to regulate courtroom practice and procedure.

Conclusion

Those who believe that the Michigan Supreme Court's decision in *Muci* and the Legislature's recent amendments to § 3151 preclude a no-fault insurer who is defending against a

lawsuit brought by the insured from receiving court permission pursuant to MCR 2.311 to obtain an IME by a physician who possesses qualifications other than those mandated by § 3151 are simply incorrect. Nothing in either the language of § 3151 nor the Supreme Court's decision in *Muci* supports such an assertion.

Accordingly, when served with a lawsuit by their insured, no-fault insurers should not hesitate to request such approval pursuant to MCR 2.311 where an additional IME may better equip the no-fault insurer to defend against the insured's lawsuit. Doing so will enable no-fault insurers to fulfill the legislative intent that PIP benefits not be paid to persons who did not suffer injuries arising out of a motor vehicle accident, or for treatment which is not reasonably necessary for the insured's care, recovery, or rehabilitation. Indeed, for no-fault insurers not to utilize MCR 2.311 to obtain additional IME's where appropriate would be anathema to the long-recognized legislative intent of containing the cost of no-fault insurance – an intent that was not only acknowledged by the Michigan Supreme Court in *Muci,*[41] but an intent that is *clearly* reflected in the Legislature's recent comprehensive amendments to the no-fault act.[42] ■

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Endnotes

1 478 Mich 178 (2007).

2 MCL 500.3101 *et seq.*

3 *Muci, supra,* 478 Mich at 191.

4 2019 PA 21 and 2019 PA 22.

5 *Muci, supra* 478 Mich 191.

6 *Muci, supra*, 478 Mich at 190-191.

7 *Muci, supra,* 478 Mich at 191 n 8.

8 461 Mich 15 (1999).

9 MCL 600.101 *et seq.*

10 *McDougall, supra,* 461 Mich at 24-25.

11 *McDougall, supra,* 461 Mich at 27. Const 1963, art 6, § 5, provides that "[t]he supreme court shall by general rules establish, modify, amend and simplify the practice and procedure in all courts of this state."

12 *McDougall, supra,* 461 Mich at 30-31, quoting Joiner & Miller, *Rules of practice and procedure: A study of judicial rule making*, 55 Mich LR 623, 635 (1957).

13 *McDougall, supra,* 461 Mich at 35.

14 MCL 500.3135(1) provides that a no-fault "insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of [the no-fault act]."

15 MCL 500.3107(1)(a) of the no-fault act provides that, in addition to other PIP benefits, a no-fault insurer is liable to pay for "[a]llowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.

16 *Rasch v City of East Jordan*, 141 Mich App 336, 338-339 (1985).

17 *McDougall, supra,* 461 Mich at 18.

18 To construe § 3151 as impliedly imposing an expert testimony requirement akin to § 2169 would violate the sacrosanct tenet of statutory interpretation that "Courts cannot assume that the Legislature inadvertently omitted from one statute the language that it placed in another statute, and then, on the basis of that assumption, apply what is not there." *Farrington v Total Petroleum, Inc,* 442 Mich 201, 210 (1993); *Robinson v City of Lansing*, 486 Mich 1, 25 (2010); *People v Monaco*, 474 Mich 48, 57-58 (2006); *Paselli v Utley*, 286 Mich 638, 643 (1938)("This court cannot write into the statutes provisions that the legislature has not seen fit to enact"); *City of Detroit v Redford Twp*, 253 Mich 453, 456 (1931)("Courts cannot attach provisions not found therein to an act of the Legislature because they have been incorporated in other similar acts"); *People v Underwood*, 278 Mich App 334, 338 (2008)("The omission of a provision in one statute that is included in another statute should be construed as intentional," "and provisions not included in a statute by the Legislature should not be included by the courts").

19 MCL 500.3148(1) provides, in pertinent part:

> [A]n attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits that are overdue. The attorney's fee is a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

20 Indeed, to read such a policy decision into § 3151 would not only impermissibly place into that statute language that the legislature included in § 2169 but omitted from § 3151, but would contravene the cost-containment aspect of the no-fault act that our Legislature intended. *Admire v Auto-Owners Ins Co*, 494 Mich 10, 29 (2013), citing *Griffith v State Farm Mut Auto Ins Co*, 472 Mich 521, 539 (2005); *Celina Mut Ins Co v Lake States Ins Co*, 452 Mich 84, 89 (1996); *O'Donnell v State Farm Mut Auto Ins Co*, 404 Mich 524, 547 (1979).

21 *Muci, supra,* 478 Mich at 190.

22 *Muci, supra,* 478 Mich at 190.

23 *Muci, supra,* 478 Mich at 190.

24 *McDougall, supra,* 461 Mich at 31, quoting Joiner & Miller, *supra* at 635.

25 *Muci, supra,* 461 Mich at 30.

26 MRE 702.

27 MRE 403, which provides:

Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

28 *McDougall, supra,* 461 Mich at 24.

29 *Muci, supra,* 478 Mich at 190.

30 *McDougall, supra,* 461 Mich at 24.

31 *Fradco, Inc v Dep't of Treasury*, 495 Mich 104, 115 (2014). This is known as the doctrine of *in pari materia*, which recognizes that "'laws dealing with the same subject . . . should if possible be interpreted harmoniously.'" *SBC Health Midwest, Inc v City of Kentwood*, 500 Mich 65, 74 n 26 (2017), quoting Scalia & Garner, *Reading Law: The Interpretation of Legal Texts* (St. Paul: Thomson/West, 2012), p. 252.

32 *Muci, supra,* 478 Mich at 189-191.

33 *McDougall, supra,* 461 Mich at 30-31, quoting Joiner & Miller, *supra* at 635.

34 *Muci, supra,* 478 Mich at 190.

35 *Muci, supra,* 478 Mich at 190.

36 *Muci, supra,* 478 Mich at 190-191.

37 *Muci, supra,* 478 Mich at 192 (internal quotation marks omitted), quoting *Hertenstein v Kimberly Home Health Care, Inc*, 189 FRD 620, 624 (D Kan, 1999), quoting *Gulf Oil Co v Bernard*, 452 US 89, 102 n 16 (1981).

38 *Muci, supra,* 478 Mich at 192.

39 MRE 403, which provides:

Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

40 MRE 702.

41 *Muci, supra,* 478 Mich at 188 ("an important goal of the no-fault scheme" was "economy in the handling of claims to reduce transaction costs"); see also *Jarrad v Integon Nat'l Ins Co,* 472 Mich 207, 218 (2005)(recognizing "the Legislature's overarching commitment in the no-fault act, and its later amendments, to facilitating reasonable economies in the payments of benefits, thus causing the costs of th[e] mandatory auto insurance to be more affordable"); *Admire, supra,* 494 Mich at 29, citing *Griffith, supra,* 472 Mich at 539; *Celina Mut, supra,* 452 Mich at 89; *O'Donnell, supra,* 404 Mich at 547.

42 As just a few examples, the Legislature enacted MCL 500.2111f, which requires no-fault insurer's to reduce the premiums charged for PIP coverage by a minimum per-vehicle amount; amended MCL 500.3157 to implement a fee schedule in order to limit what PIP benefits can be sought for medical bills; enacted MCL 500.3181 through MCL 500.3189 to create a "managed care option"; enacted MCL 500.3107c and MCL 500.3107d to provide motorists with several less expensive alternatives to the previously mandated unlimited "allowable expense" PIP coverage; and significantly revised MCL 500.3109a with regard to coordination of PIP coverage with other health and accident coverage.

Joint Ventures – What Insurance Challenges Do Your Clients Face?

By Julia Baran, CIC, CRM, JD, Client Executive, *LSG Insurance Partners*

A joint venture ("JV") is often used for projects intended to have a limited lifespan, such as a construction project or a retail development. They are seen as a convenient, less formal way of putting together a team for short or shorter term projects. As is often the case, the ease of creating a JV may lead to trouble if proper thought and documentation are not used prior to the commencement of operations. This article will review certain insurance coverage issues that may arise with the use of a JV, and to unanticipated consequences or difficulties that an attorney can help his or her client avoid or minimize.

Knowledge is power and you can help your clients to get the best outcome by keeping these potential pitfalls in mind. You will want to include your client's insurance agent or broker early in the process of forming a JV to avoid pitfalls in the creation of their insurance program.

Whether the joint venture is created as a limited liability company ("LLC"), limited liability partnership ("LLP"), S Corporation or C Corporation, the insurance program will be a standard program, rated on the JV's exposures, etc. JVs commonly have a fixed term of existence. This limited-tenure feature should be proactively addressed in any insurance program. JVs can also be purely a creature of contract and not set up in a statutory form. It is especially important to anticipate the factors discussed below in the case of a contractually created JV. Note that issues of taxation, finance and/or regulatory matters relating to JVs will not be addressed in this article, but would have a significant impact on the structure and approach of a potential JV enterprise.

Counsel should walk the parties through the life cycle of the project, highlighting the parties' roles and the potential pitfalls.

It is important that clients recognize the importance of having a written contract for JVs, so that each of the parties to the JV has a clear road map regarding its rights and responsibilities in the enterprise. The parties must determine whether the JV will be created as an LLC, LLP, S Corporation, C Corporation or solely by contract. A key factor is the composition of ownership – does one party have more than 50% control, is ownership split 50/50 between two parties, or are there more than two (2) parties to the JV? Once this is decided, the JV can determine how to structure its insurance program. There three options**:** (1) insuring the JV entity, (2) adding the JV to a principal participant's insurance, and (3) looking to each participant's existing insurance.

It is important that clients recognize the importance of having a written contract for JVs, so that each of the parties to the JV has a clear road map regarding its rights and responsibilities in the enterprise.

Option 1: Insuring the Joint Venture as an Entity

Option 1- JV insures itself as a stand-alone entity in the form of an LLC, LLP, C Corporation or S Corporation. This is the most direct approach and occurs when the JV is set up as an LLC, LLP, S corporation or C corporation. The insurance program should protect all the parties to the JV from exposure to covered causes of loss that may be incurred by the JV. This approach underwrites and prices the program based upon the JV's exposures, inoculating participants from potentially riskier actions by the JV. Often a JV would be viewed as a type of start-up company, despite the parties of the JV having years of relevant experience.

The general liability policy therefore may be more difficult to issue due to the absence of operating history and current revenues. In addition, if this is a typical joint venture with a fixed term of existence (e.g. 3-year construction project), the participants will need to determine whether they must purchase "discontinued operations or completed operations" coverage to protect themselves for a given period of time after the project ends. This is a key consideration for structuring the insurance program because each state has some version of a statute of repose. If there is no coverage for discontinued products or continued operations once the JV is no longer operating, the former JV participants will potentially be exposed to post-termination claims and will need a means to respond in the event of a claim. It is critical to understand that discontinued-operations or completed-operations coverage must be purchased before operations cease. As a result, the carriers will want to carefully underwrite this exposure aspect.

Option 2: Add the JV to the Majority Stakeholder's Policy

Option 2 – If a JV participant has a majority role or financial stake in the JV project, that party may offer to add the other JV parties as named insureds on its policies in an effort to control the JV insurance program. In this situation, it is critical that the majority JV participant secure an agreement in writing in advance that the other participant(s) will contribute to the cost of the insurance. The parties need to agree to whom the claims payment would be made and/or allocated in the event of a covered loss. As noted above in Option 1, the JV participant that adds the JV as a named insured definitely will also want to consider securing completed products/discontinued operations coverage for a given period of time after the project ends. In this situation, it is that much more critical to the majority JV participant to get these matters memorialized in a written, signed agreement, as it is the majority participant's name and insurance program that would be directly affected.

The joint venture contract will need to identify to whom notice of cancellation and premium invoices will be sent, who is authorized to make changes or endorsements to the policy, and to what extent there are insured vs. insured exposures.

Option 3: Each Participant Has Insurance

Option 3 – Each JV participant is responsible for its own insurance in the JV enterprise, based on an allocation formulation agreed upon by the JV participants. The need for written agreement among the JV participants is paramount in this situation. The participants will need to be listed on the other JV's participants insurance programs as an "Additional Insured," so they will receive notice in the event of a cancellation, agree how claims would be handled amongst the parties and insurance companies, and how to purchase and maintain coverage post-project. Because there is no standard enterprise structure in place, the insurance companies will want to review the JV agreement before offering coverage options to determine how or if that structure will permit a proposed insurance program to respond appropriately to potential claims.

Once the basic JV enterprise structure is in place, it is time to consider how that structure is affected, or can affect the applicable insurance programs. Generally, insurance programs are priced and defined by the entity's size, or scope of business operations; but each enterprise creates its own unique circumstances that the insurance companies must evaluate in underwriting. For example, if the JV is a mining venture it will likely be more complex and expensive than a JV to develop a subdivision. Likewise, if researchers get together to launch a new drug or medical device, that would be more complex and expensive because of IT/intellectual property issues.

A purely contractual JV's insurance program will have more serious consequences than would a typical enterprise if the parties fail to proactively address "administrative" issues (especially if it is 50/50 split). The joint venture contract will need to identify to whom notice of cancellation and premium invoices will be sent, who is authorized to make changes or endorsements to the policy, and to what extent there are insured vs. insured exposures. In addition, since JVs frequently have a specific term of existence (e.g. 3 years, 6 years, etc.), the parties need to understand that there may be exposures that survive the term of the JV, and how with they will protect themselves once the JV ceases to exist, since the disbanded entity may have exposures for claims arising out of completed operations, workers compensation claims or employment practices, and so on.

General Liability Coverage

At this point, the JV participants need to consider the policies to be included in the JV insurance program. The first one to consider is general liability (GL) insurance. In most standard GL policies, coverage for joint ventures is excluded unless that joint venture is listed as a "named insured." However, before adding the JV or JV participants to a GL policy, the parties must take into account other issues, such as:

- In a standard GL policy, contractual liability coverage is first excluded and then given back under certain morel limited circumstances. You need to consider how those circumstances may apply to your situation.
- For the Products/Completed Operations exposure, you need to consider what happens once the JV is disbanded? Who will be responsible for this type of claim? This is a very highly litigated area of insurance policies.
- Broad-form Named Insured endorsement, that despite its title, does not automatically include JVs unless they are named on the policy.
- How will the JV deal with issues regarding separation of insureds; primary/non-contributory, fellow employee, waiver of subrogation. You cannot sue yourself, so how would potential conflicts among the parties be addressed?
- Will losses incurred by the JV have a negative impact on the insurance program for the participants' operations that are not part of the JV? Potentially, the loss history could affect the premiums and availability of insurance coverage, if the programs are not adequately sequestered from one another.

- In the event of cancellation, the notice is only required to go to the first named insured. What is that party's obligation to notify the others? What if the first named insured fails to pay the premium and the policy cancels for non-payment of premium?
- If there are material changes to the policy, the first named insured makes those changes, how do those changes impact the other JV participants; and what is that party's obligation to notify the others?

In the case of purely contractual joint ventures, the name in which the vehicle is title must match the named insured(s) of the auto policy intended to cover vehicles for a contractually created JV that have vehicles used in its operations.

Worker Compensation Coverage

Like a standard GL policy, a standard workers compensation/employer's liability ("WC") policy excludes coverage for JV enterprises unless that JV is listed as a "named insured." Since a WC policy assumes that all employees are covered and this line of coverage is very highly regulated and scrutinized by states, the structure of the policy and how it relates to the JV structure requires careful analysis. As with the GL policy, there are a number of consequences to making a JV a named insured in addition to those that are specific workers compensation issues:

- The contractual liability coverage issue is similar to the GL issue mentioned above.
- In certain states, the Alternate Employer Endorsement can be used to protect the parties. Different states take different approaches to the use of this endorsement for JVs. The form to use in those states that permit it is WC 00 03 19.
- If a state where the JV operations are being conducted does not allow an Alternate Employer Endorsement, would an assigned-risk WC policy address the potential WC exposure? Consider that assigned-risk WCs are less comprehensive and less flexible than standard WC policies. If a JV needs to use an assigned-risk policy, the parties need to be aware of the policy limitations. Typically, an assigned risk workers compensation policy covers only those employees in that state. If the JV is operating in multiple states that necessitate the use of an assigned-risk policy, then the JV will need to purchase as an assigned-risk policy in each of those states. This can be very administratively burdensome to the JV.
- Certain states will permit the use of a Joint Venture Endorsement. In those situations, the form to use is WC 00 03 05.
- What protections are available for claims by former employees once the project is complete? Consider for example, an asbestos-type claim that is discovered decades after the project was completed. How could this be handled and funded once the enterprise had been concluded?
- Will the JV operations have a negative effect on the experience modification factor of the insurance program for those operations that are not part of the JV? Each state may request an ERM 14 form (Experience Rating Ownership form) completed by the JV to determine whether or how much common ownership exists among the JV participants. The JV may not agree with a state's position regarding ownership. Dealing with this type of issue and getting it resolved with a state may be difficult, time consuming, and require financial and other disclosures that JV participants may be unwilling to share.
- Broad-form Named Insured which, as noted above, does not automatically include JVs. They must be named or scheduled on the policy.
- How will the JV deal with Issues regarding separation of insureds; primary/non-contributory, fellow employee, waiver of subrogation. You cannot sue yourself, so how would potential conflicts among the parties be addressed?
- In the event of cancellation, the notice is only required to go to the first named insured. What is that party's obligation to notify the others? What if the first named insured fails to pay the premium and the policy cancels for non-payment of premium?
- If there are material changes to the policy, the first named insured makes those changes, how do those changes impact the other JV participants; and what is that party's obligation to notify the others?

Commercial Auto Coverage

Challenges similar to those found in the WC policy will also be found in commercial auto policies. It is important to keep in mind that commercial auto policies are less broad than personal auto policies, and those distinctions may significantly impact the treatment and outcome of an auto claim. The coordination that needs to occur between the JV entities and its employee/drivers auto insurance policies must be taken into account. Commercial auto policies are also highly regulated at the state level.

In the case of purely contractual joint ventures, the name in which the vehicle is title must match the named insured(s) of the auto policy intended to cover vehicles for a contractually

created JV that have vehicles used in its operations. Commercial auto policies do not specifically exclude coverage for JV enterprises, but you must carefully review who is included the definition of the named insured. Just as with the GL and WC policies discussed earlier, there are a number of consequences to insuring a JV's commercial autos. Some are general, some are specific to commercial auto coverage, and some are specific to the state where the vehicles are registered:

- The contractual liability coverage issue is similar to the GL issue mentioned above.
- Broad-form Named Insured does not include JV's, they must be named (aka specifically scheduled or listed) on the policy.
- How will the JV deal with Issues regarding separation of insureds; primary/non-contributory, fellow employee, waiver of subrogation. You cannot sue yourself, so how would potential conflicts among the parties be addressed?
- In the event of cancellation, the notice is only required to go to the first named insured. What is that party's obligation to notify the others? What if the first named insured fails to pay the premium and the policy cancels for non-payment of premium?
- If there are material changes to the policy, the first named insured makes those changes, how do those changes impact the other JV participants; and what is that party's obligation to notify the others?
- Many states require that Uninsured/Underinsured Motorist ("UM/UIM") coverage forms be completed and on file, and each state takes its own approach to this coverage. Internally, the JV needs to determine how it will administer the UM/UIM coverages.

Umbrella or Excess Liability Coverage

The last coverage type to be considered is umbrella/excess liability coverage. Differences between umbrella liability policies and excess liability policies are beyond the scope of this article. While these policies play similar roles in an insurance program, there are differences that need to be taken into account that are a topic for a different day.

There is no standard form for either umbrella or excess liability policies. Each insurance company has its own version, which necessitates careful reading of the policy and its exclusions and endorsements. Both umbrella and excess policies are intended to provide additional liability limits to the primary insurance program. If the GL, WC and auto are included as scheduled underlying policies in the umbrella/excess policy, then each of those policies have access to those additional limits. The umbrella/excess policies will look to these underlying policies to determine how or if a JV enterprise has access to its limits. As noted above, this why determining whether a JV is included as a named insured on the GL, WC or auto is essential to properly insuring the JV.

In the situations described in Options 2 and 3 above, if there is true umbrella policy form and JVs are not specifically excluded on the umbrella policy, you may have coverage where you otherwise may not with an excess liability policy and/or based upon the underlying GL. An excess liability policy should be "follow form": whatever is covered or not covered in the underlying (or primary) GL or WC policy will be treated the same way in the excess liability policy.

Final Thoughts for Counsel

Counsel should be aware that if the JV is a named insured on the client's policy, the client sharing its limits (i.e. diluting its protections) with the JV's other participants.

Counsel must read and understand the forms, endorsements and exclusions included on each policy from the perspective of each JV participant to determine what insurance coverage counsel's client has and whether that coverage is sufficient.

As counsel to a JV or on the JV participants, you have the opportunity to protect your clients against unintended consequences! Take advantage of the knowledge and insurance company access that your client's insurance agent or broker can provide early in the process of forming a JV to create the most robust insurance program for your JV client. ■

About the Author

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No-Fault Corner

Recent Department of Insurance and Financial Services' Orders and Bulletins and How They Impact on the Upcoming Nofault Reform Amendments

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As noted in my prior articles, we will soon begin seeing changes in the Michigan NoFault Act. For policies issued or renewed on or after July 2, 2020, the new PIP choice provisions will begin phasing in, along with the increases in the residual bodily injury/tort liability limits. Due to the haste in which the nofault reform measures were drafted, there are countless examples of sloppy draftsmanship in both SB 1 and HB 4397, which became 2019 PA 21 and 22, respectively. Although the Legislature has promised a number of technical amendments, so far nothing has been introduced in the Legislature, aside from two bills which would revert the nofault motorcycle priority scheme to where it was from 1973 to 1980.

With all eyes on the State Capital, it was easy to overlook the fact that the Department of Insurance and Financial Services (DIFS) has been charged with implementing a number of key provisions contained within the NoFault Reform Act, including a Utilization Review Unit and an Anti-Fraud Unit. As we approach the July 2, 2020, implementation date, we need to take a look at some of the orders and bulletins issued by the Insurance Director, through the Department of Insurance and Financial Services (DIFS), to see how DIFS has been working behind the scenes to give guidance to both insurance carriers and policyholders alike.

DIFS Orders

19-048M, Issued September 20, 2019

PA 21 and 22 were filed with the Michigan Secretary of State on June 11, 2019. The new law made significant changes to the nofault priority scheme, set forth in MCL 500.3114 and MCL 500.3115. Under the old law, so-called "strangers to the insurance contract," including occupants of motor vehicles who did not have insurance of their own in their household, whether individually or through a spouse or family member, would turn to the insurer of the owner, registrant or operator of the motor vehicle they were occupying. Similarly, under the old law, non-occupants of motor vehicles who did not have insurance of their own in their household, whether individually or through a spouse or domiciled relative, would turn to the insurer of the owner, registrant or operator of the motor vehicle involved in the accident for their nofault benefits.

After June 11, 2019, the so-called "strangers to the insurance contract" now file their claims with the Michigan Automobile Insurance Placement Facility (MAIPF), which operates the Michigan Assigned Claims Plan (MACP). Although the statute purported to change the priority provisions effective June 11, 2019, there were insurance policy forms which remained in effect which still defined these "strangers to the insurance contract" as "insureds," entitled to benefits under the applicable insurance contract. The question then became which controlled – the statute or the insurance contract?

After many months of uncertainty, with different insurance carriers taking different positions and the Legislature seemingly unable to arrive at a common-sense solution (by simply postponing the effective date of the priority changes), the Director of Insurance stepped in on September 20, 2019, and issued Order number 19-048. This Order effectively preserves the old priority system until the insurer files new policy forms, reflecting the change in the priority system. The author believes that most insurers will simply opt to incorporate the new nofault priority scheme when it submits the new policy forms to DIFS to take into account the new PIP choice provisions and corresponding premium rate reductions. Some carriers, though, have opted to take a two-step approach by filing one set of revised policy forms, reflecting the new priority system and making a partial premium reduction, with a second set of filings to follow, effective for policies issued or renewed on or after July 2, 2020, which will reference the new PIP choice provisions and further premium reductions. In either event, the old priority system remains in effect until the new policy forms are issued and, in the case of personal lines insurance, are approved by DIFS.

In an effort to take advantage of the new priority system without revising its policy forms, some insurers were taking the position that their "conformity to law clause" automatically converted the insurance policy to reflect the new priority scheme. DIFS Order 19-048 expressly prohibits an insurer from relying on any "conformity to law clause" to change its policy forms.

Bottom line: Whether you are representing a "stranger to the insurance contract" or defending a claim filed by such an individual, it is imperative that you obtain a copy

of the policy form that was in effect at the time of the accident, to see whether or not the policy form still reflects the old priority system or the new priority system. It will also be important to pay attention to the effective date of that policy. For example, if a policy is renewed on June 1, 2020, for a six-month period of time, it will still reflect the old priority scheme (assuming that the insurer decided not to do a "two-step" filing) which means that the so-called "strangers to the insurance contract" would be entitled to lifetime, unlimited benefits under that old policy form until the policy is renewed on December 1, 2020.

DIFS Order 19-049

On September 22, 2019, Detroit Free Press columnist Mitch Albom wrote an article about the plight of a three-year-old girl who was crossing the street when she was struck by an uninsured motorist. Because her parents did not have a policy of insurance in their household, and because the owner, registrant and operator of the motor vehicle were uninsured, her family was forced to file a claim for nofault benefits through the Michigan Assigned Claims Plan (MACP), which is administered by the Michigan Automobile Insurance Placement Facility (MAIPF). The new law provided that for claims payable by the MACP, there was a $250,000 cap in "allowable expense" coverage. This cap was effective on June 11, 2019. Because this little girl's accident occurred after that date, her benefits were seemingly capped, by statute, at $250,000. The problem here, though, is that the girl's inpatient hospitalization bill at Children's Hospital was $140,000, meaning that she only had $110,000 left on her benefit package before her nofault benefits would be exhausted.

Two days later, Governor Whitmer directed her Insurance Director to essentially postpone the effective date of the MACP $250,000 allowable expense cap to July 2, 2020. The Director's legal basis for doing so is dubious at best, and her action was challenged by the Michigan Automobile Insurance Placement Facility in the Court of Claims. The MAIPF moved for a temporary restraining order, to be followed by a preliminary injunction, which would preclude DIFS Orders 19-948 and 19-049 from going into effect. However, Court of Appeals Judge Michael J. Kelley, sitting in the Court of Claims, denied the motion for a temporary restraining order and preliminary injunction. Thus, these two orders remain in effect, and for accidents occurring through July 1, 2020, those individuals who would have gone to the MAIPF anyway for their nofault benefits will continue to receive lifetime, unlimited benefits – just like the three-year-old girl mentioned in Mitch Albom's article.

DIFS Bulletins

The following is a summary of the various bulletins issued by DIFS since June 11, 2019, that impact on the Michigan NoFault Insurance Act:

2019-11 Medical Expense Fee Schedules

This Bulletin supersedes Bulletin 2018-13 which, in turn, superseded Insurance Bulletin 1992-3, regarding a nofault insurer's obligation to defend and indemnify their insureds in "balance bill" disputes with medical providers. This Bulletin clarifies that the medical expense fee schedules will begin for medical services rendered on or after July 1, 2021. In the meantime, nofault carriers are reminded that they are only obligated to pay a "reasonable charge" and that a healthcare provider "can charge no more than that." Healthcare providers are also reminded that for services rendered on or after June 11, 2019, they now have a direct cause of action against the nofault insurer for payment of any "balance bill." The intent is to dissuade a provider from suing the patient directly over a 'balance bill."

2019-15 Self-Insurance Pools

This Bulletin, issued on September 27, 2019, makes it clear that group self-insurance pools, such as the Michigan Municipal Risk Management Authority and self-insurers do not issue "insurance policies." Therefore, the PIP coverage choices found in MCL 500.3107c do not apply to them. These entities continue to provide lifetime, unlimited benefits to their members.

2019-17 Attorney liens

As amended, MCL 500.3148(1) provides that it is improper for an injured claimant's attorney to claim a lien over payment of nofault benefits unless (1) the payment is authorized by the NoFault Act and (2) the payment is "overdue." Notwithstanding this language, DIFS Bulletin 2019-17 states that:

> "[The amended statute] does not prohibit an injured person from contracting with an attorney to assist in the recovery of nofault benefits. An attorney may, in the course of his or her representation, hold in trust any funds paid to a Claimant via a two-party check."

This Bulletin was issued in response to the practice of the insurance carriers to issue checks solely to the injured person for, say, work loss or household replacement service expenses, even though their attorney attempts to claim a lien on any such payments. Although this Bulletin seems to resurrect a claim for an attorney's charging lien on claims for work loss benefits and household replacement service expenses, by virtue of the reference to "any funds paid to a Claimant via a two-party check," it seems that an extension of this Bulletin to cover undisputed medical expense payments due and owing to a provider, would defeat the entire purpose behind the Legislative amendment to MCL 500.3148(1). This provision, after

all, which was designed to preclude an injured person's attorney from claiming a lien on payment of undisputed medical expenses.

2019-21 Out-of-State residents

Under the old law, insurers doing business in Michigan were forced to file a certification under MCL 500.3163(1), which would require them to provide Michigan nofault benefits to any of their insured out-of-state residents who were injured while traveling in the State of Michigan. Effective June 11, 2019, out-of-state residents are now barred from recovering Michigan nofault insurance benefits unless they own a motor vehicle registered and insured in Michigan. This Bulletin clarifies that for losses occurring prior to June 11, 2019, an insurer which has filed a certification pursuant to MCL 500.3163(1) will still be obligated to provide lifetime, unlimited benefits to out-of-state residents injured in a motor vehicle accident in Michigan. However, for accidents occurring on or after June 11, 2019, "the certifications have no effect and cannot be relied upon by a non-resident to claim coverage from an insurer that previously filed a certification." For accidents occurring after June 11, 2019, an out-of-state resident's only recourse is a tort action against the other motorist who caused the accident (assuming that the out-of-state resident does not own a Michigan registered and insured motor vehicle).

2019-22 Attendant care 56 hour cap

This Bulletin clarifies the effective date of the 56 hour per week attendant care cap set forth in MCL 500.3157(10). Prior to that date, some insurance were taking the position that this 56 hour per week cap applied to any services rendered after June 11, 2019, despite the statutory language set forth in MCL 500.3157(14), which made it clear that this limitation applies only to care "rendered after July 1, 2021." In fact, the author was involved in a debate with a fellow defense attorney at the recent Insurance Alliance of Michigan Claims Seminar in late September 2019 over this very issue. This Bulletin makes it clear that the 56 hour per week cap takes effect for services "rendered after July 1, 2021" and encourages claimants to file a complaint with DIFS if they believe that their attendant care benefits were improperly limited by the insurer before that date.

2020-01 Medicare opt-out – Qualified health coverage

This Bulletin directs health insurers and health plans to develop a document to indicate whether a person's coverage is "qualified health coverage," for purposes of the Medicare opt-out provisions set forth in MCL 500.3107d. The document needs to list the full names and dates of birth of all individuals covered under the policy or plan, and contain a statement as to whether or not the coverage constitutes "qualified health coverage" such as Medicare, or that the health coverage does not exclude coverage for motor vehicle accidents and has an annual deductible of $6,000 or less per covered individual. These forms will be required by insurers if the insured decides to opt out of the "allowable expense" coverage because they are Medicare recipients, and members of their household otherwise have "qualified health coverage."

2020-03 Choice of coverage limits

After numerous revisions, this Bulletin contains the final draft of the Michigan Choice of Bodily Injury Liability Coverage Limits, and the selection of personal injury protection medical coverage amounts for both commercial lines insurers and personal lines insurers. Although insurers are required to use the DIFS Bodily Injury Choice Forms, insurers have the option of using the DIFS forms when it comes to the PIP choice provisions. If the insurer chooses to utilize their own forms, they must still be approved by DIFS.

If you want to see what your new PIP choices election form will look like when your policy comes up for renewal on or after July 2, 2020, you may want to take a look at these forms.

2020-05 Opting out of allowable expense coverage

This Bulletin answers many of the questions posed by Medicare recipients, regarding their ability to "opt out" of the "allowable expense" portion of their nofault policy. This Bulletin clarifies that Medicare enrollees who choose to opt out of the nofault "allowable expense" coverage will still be covered by Medicare, subject to any co-insurances, co-payments and deductibles that may be imposed by Medicare. This Bulletin further advises that the enrollee will be responsible for many services that Medicare does not cover, including "transportation to and from medical appointments, vehicle modifications, case management services, residential treatment programs, long-term and custodial care, and replacement services." The Bulletin also notes that if the Medicare enrollee opts for lower "allowable expense" coverage (say $250,000 or $500,000), Medicare will pay for any medical expenses incurred by the injured Claimant once the PIP coverage limits have been exhausted.

Obviously, it will be necessary to keep a close eye on not only the Legislature but also DIFS as we near the July 2, 2020, implementation date. In the meantime, please be safe as we work our way through these uncertain times. ■

Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*

Michigan Court Of Appeals – Published

Automatic termination provision enforced

Tackoor v Wheelock
___ Mich App ___ (2020)
Docket No. 345854

Esurance issued an auto policy that "provided for automatic termination upon the insured's sale, assignment, gifting or transfer of a vehicle covered under the policy." The insured sold a covered auto to his granddaughter, who obtained a new title but failed to purchase insurance. She was involved in an accident two weeks later and submitted a claim to Esurance, which denied coverage based on the automatic termination provision. The trial court found that the policy cancellation failed to comply with the requirements of Michigan's insurance code, MCL 500.3204 through 3264, but the Court of Appeals held that those statutory provisions did not apply where the termination occurred automatically based on a condition described in the contract.

Rescission "balancing of equities" factors

Pioneer State Mut Ins Co v Wright
___ Mich App ___ (2020)
Docket No. 347072
Supreme Court app lv pending

In a published opinion addressing the rescission of an insurance contract following an innocent third-party claim, the Court of Appeals adopted the "balancing of equities" factors identified by Justice Markman in his concurring opinion in *Farm Bureau Gen Ins Co of Michigan v ACE Am Ins Co*, 503 Mich 903 (2018). These factors include (1) the extent to which the insurer could have discovered the fraud before the innocent third party was injured, (2) the relationship between the innocent party and the culpable insured, (3) the innocent third party's responsibility for the injury-causing event, (4) alternate avenues for recovery, and (5) whether enforcement of the policy would merely relieve the culpable insured of what would otherwise be the insured's liability to the innocent third party.

Michigan Court of Appeals – Unpublished Decisions

Insureds bound by UM policy rather than coverage requested

Loney v Sleever
Docket No. 345655
Released January 16, 2020
Supreme Court app pending

Plaintiffs claim they asked Geico to issue an auto policy with the same UM and UIM coverage provided in their policy with a prior insurer. The policy that issued listed UM coverage only, and the definition of an uninsured motor vehicle did not include underinsured vehicles. So when the insured was involved in an accident with a driver having only the statutory minimum coverage, he sued Geico for breach of contract. The court found no breach; the plain terms of the contract provided UM coverage only. The court also rejected the insured's claims of promissory estoppel, fraud, and negligent misrepresentation. Regardless of what Geico's agent may have said about the coverage to be provided, the contract that issued was unambiguous. The insureds were neither deceived nor misled.

UTPA penalty interest does not apply to sanctions award

Andreson v Progressive Michigan Ins Co
Docket No 345864
Released December 19, 2019
Supreme Court app pending

In this case, plaintiffs obtained a judgment against the at-fault driver in an amount that entitled them to full UIM benefits under their policy with defendant. They moved for penalty interest under the UTPA as to both the damages recovered and the substantial costs and attorney fees awarded under the offer of judgment rule. The court held that the UTPA allowed penalty interest against "benefits," which did not include offer of judgment sanctions. The court also held that plaintiffs had no actionable claim for bad faith. Plaintiffs failed to present any evidence of "tortious conduct independent of defendant's breach of the parties' insurance contract."

CGL endorsement bars coverage for injuries to subcontractor employees

Estate of Messenger v Atain Ins Co
Docket No 344690
Released December 26, 2019

This coverage action arises out of a construction site accident resulting in the death of a subcontractor's employee. Plaintiff estate sued the general contractor, whose general liability insurer, Atain Insurance, denied coverage under an endorsement titled Employees, Subcontractors, Independent Contractors, Temporary Workers, or Volunteers. It expressly barred coverage for bodily injury to an "employee of any subcontractor . . . performing work or services for any insured arising out of and in the course of employment by or service to any insured for which any insured may be held liable as an employer or in any other capacity." Because there was no dispute that the decedent was an employee of the insured's subcontractor, fatally injured in the course of performing services for the insured, the exclusion applied.

Subrogation claim governed by product liability limitations statute

State Farm Fire & Cas Ins Co v Gen'l Electric Co
Docket No. 345992
Released January 2, 2020
Supreme Court app lv pending

After paying its homeowner-insured's claim for property damage caused by a General Electric humidifier that malfunctioned, State Farm sued General Electric in subrogation. General Electric argued that the one-year statute of limitations applied under the UCC and the economic loss doctrine. The court disagreed. The resulting fire caused damage to other property, not just the humidifier, so the claim was governed by the statute of limitations for product liability actions.

Duty to defend based on potentially covered claim

City of Bad Axe v Pamar Enterprises and Secura Supreme Ins Co
Docket No 345810
Released January 14, 2020, recon den 2/26/20

Secura's insured, Pamar Enterprises, contracted with MDOT for road and sewer work on M-53. The contract required Pamar to insure and indemnify MDOT and others, including the City of Bad Axe, for any property damage arising out of its work. Several homeowners sustained water damage to their homes as a result of a rain event during the project. They sued Pamar and later, the City, claiming that one or both were responsible. Secura defended Pamar but refused to defend the City for what it described as the City's own negligence in failing to maintain the sewers. The court found a duty to defend given that the complaint alleged alternative theories of liability implicating the City. The City was also an additional insured under the policy.

Duty to defend based on potentially covered claim

Hanover Ins Co v Lubienski
Docket No. 346942
Released March 24, 2020

Coverage under plaintiff's professional liability policy was triggered by a claim of undue influence against defendant insured. The policy afforded coverage for liability arising out of a "wrongful act," defined in the policy as "any actual or alleged negligent act, error, omission or misstatement committed in your professional services . . . ." Although undue influence can involve an intentional act, "there was no allegation [in the complaint] . . . that defendant had a specific intent to unduly influence the decedent or undertook a specific intentional action to do so." Plaintiff insurer had a duty to defend and could not recoup defense costs against this insured.

Sixth Circuit Court of Appeals

Homeowner fails to comply with notice and reporting requirements

Keathey v Grange Ins Co
Case No 19-1242
Decided March 19, 2020

Grange Insurance properly rejected plaintiff-homeowner's claim for water damage to her new home. The claim, made less than three months after the purchase, allegedly involved frozen water pipes and over $130,000 in repairs. But the repairs were all paid for in cash with no receipts, and the work was largely completed prior to the submission of the claim. Plaintiff had no photos of the frozen pipes or the resulting damage and no documentation of repairs. Plaintiff failed to comply with the notice and reporting requirements of the contract.

Federal District Court – Eastern District of Michigan

Number of occurrences for self-insured retention.

Livonia Pub Sch v Selective Ins Co of the Se
Case No. 16-10324
Decided February 13, 2020

The insured school system and the insurer disputed whether one or two policy years were triggered for defense coverage. The underlying complaints, filed on behalf of three students, alleged that school employees committed acts of physical and emotional abuse "on multiple occasions in the 2010-2011 and/or 2011-2012 school year(s)." The insured had contracted to pay a self-insured retention for each occurrence, for each policy year. The court found there were three occurrences (one occurrence for each student) under

the 2010-2011 policy and three occurrences under the 2011-2012 policy. That meant the insured had to pay six SIRs in its own defense before the insurer became obligated to pay any defense costs.

After the underlying matters settled, the insured argued that because there was never proof of abuse in the 2010-11 school year, the court should modify its order as to the number of occurrences. The court did not do so. It found that, as to the duty to defend, the number of occurrences must be determined at the time suit is filed, not in hindsight based on what the evidence proved. Reference in the complaint to "multiple occasions in the 2010-2011 and/or 2011-2012 school year(s)" was inherently ambiguous and the ambiguity should be resolved in the insured's favor.

Potentially covered claims trigger duty to defend

Great American Fidelity Ins Co v Stout, Risius, Ross, Inc
Case No 19-11214
Decided February 14, 2020

Great American issued a professional liability to defendant Stout, a financial advisory firm. When Stout was sued by clients for overvaluing stock, Great American defended under a reservation of rights and filed this action for declaratory judgment to determine whether coverage was barred for all claims under one of the policy exclusions. The exclusion applied to any claim based on or arising out of a violation of ERISA or the Securities Act of 1933, or any related rule or regulation. The court rejected Stout's claim that the exclusion was ambiguous but went on to conclude that some of the claims against Stout could be covered and thus warranted a continued defense. The exclusion applied to claims "based on or arising out of" a violation of ERISA. Claims of common law fraud and negligent misrepresentation may arise out of the same facts but the liability claim is based on and arises out of the common law, not ERISA.

No homeowners coverage for assault claim

Allstate Vehicle and Property Ins Co v Todaro
Case No. 19-11833
Decided March 5, 2020

Allstate issued a homeowners policy to the Montoyas. Their daughter attacked defendant Todaro on a school bus, holding her down in a seat and repeatedly punching her in the face. Todaro incurred several injuries to her jaw and head. The liability part of the policy provided coverage for claims of bodily injury caused by an occurrence, defined as an accident, and expressly excluded coverage for bodily injuries intended or reasonably expected by the insured. The court granted Allstate' motion for summary judgment, finding there was no coverage for the parents or for the daughter. Tondaro's injuries were not caused by an accident and were also subject to the exclusion.

Carbon monoxide is a pollutant

Housing Enterprise Ins Co v Hope Park Homes, Ltd
Case No 18-14022
Decided March 17, 2020

Defendant property owner was sued by tenants for injuries they suffered from carbon monoxide poisoning as the result of a furnace malfunction in the home they rented. Plaintiff is defendant's liability insurer, but it denied coverage based on the pollution exclusion in its policy and filed this declaratory judgment action. The exclusion applied to claims of "bodily injury . . . arising out of the actual, alleged, or threatened discharge, dispersal, seepage, migration, release, or escape of pollutants . . . at or from any premises, site, or location which is, or was at any time, owned by . . . any insured, unless the bodily injury or property damage arises from the heat, smoke, or fumes of a fire which becomes uncontrollable or breaks out from where it was intended to be located."

A pollutant was defined, in relevant part, as "any solid, liquid, gaseous, thermal, or radioactive irritant or contaminant, including acids, alkalis, chemicals, fumes, smoke, soot, vapor, and waste. The court agreed with the insurer that carbon monoxide fit the definition of a pollutant – it's "a gas that was either an irritant, a contaminant, a chemical, or a fume." And it was a contaminant according to the ordinary dictionary meaning of that term, which is a substance that makes something "unfit for use." The court found a question of fact, however, as to the cause of the exposure, that is, whether the release was attributable to an uncontrollable fire.

Coinsurance penalty for undervalued property

PrimeOne Ins Co v Grand Trumbull, LLC
Case No 19-10276
Decided March 18, 2020

PrimeOne issued a commercial policy to defendant that included up to $1,3000,000 in coverage for damage to defendant's commercial building. But if the property was underinsured, meaning insured for less than 90% of its true value, the policy imposed a coinsurance penalty by which the two parties would share in the cost or repairs. Defendant made a claim for actual cash value, rather than a claim for replacement cost, which was an option under the policy. The property was not underinsured based on its ACV but it was underinsured based on the cost of replacement. PrimeOne sought to apply the coinsurance penalty but the court granted summary judgment

for the insured on the ground that the claim was for ACV and the property was not underinsured for that coverage.

Insurer's notice of lawsuit required action

Cherry v American Country Ins Co
Case No 18-13883
Decided March 27, 2020

Plaintiff was seriously injured in a motor vehicle accident and obtained a $1.25 million default judgment against the at-fault driver and vehicle owner, American Country's insureds. Plaintiff then commenced this action against American Country to recover policy limits of $1 million. American Country defended on the ground that the insureds never formally tendered the complaint or otherwise sought a defense. The court held that although American Country was not obligated to pay policy limits under MCL 257.520(f)(1) (because this policy was not a certified policy), American Country did know of the accident prior to the filing of the lawsuit, and received several notices of the lawsuit from plaintiff prior to the default. Based on Michigan case law holding that an insurer may not ignore claims and lawsuits even if the insured fails to tender them for a defense, the court found that American Country was not excused from coverage and held that plaintiff was not barred from pursuing garnishment of the policy in the Wayne County Circuit Court action in which the judgment was entered.

Commercial policy does not cover damage to the building leased by the insured

DLSH Properties v Samsung Fire & Marine Ins Co
Case No 19-11227
Decided March 31, 2020

DLSH, through an assignment of defendant's insured, submitted a claim for property damage discovered at the property plaintiff had leased to the insured. But the two policies in effect when the damage occurred did not cover damage to the property leased by the insured. Coverage at that location was limited to personal property. ■

Legislative Update

By Patrick D. Crandell,
Collins, Einhorn, Farrell PC

Coronavirus Changes the Conversation

Coronavirus is shaking up our daily lives – I'm writing this from and you're probably reading it at home. Remote offices are becoming the norm, and the Legislature is no exception. While the House and Senate continue to meet, much of their staff now work remotely. And they are shifting focus to address impacts from the virus – which means legislative agendas are taking a backseat. This will change the legislative landscape over the next few months – I'll report on it in the next issue. But, before we get there, here are bills that moved since the last update.

Bills in Process

- **Reimbursable chiropractic services –** HB 4449 removes certain chiropractic services from the list of non-reimbursable personal injury protection benefits ***House Insurance Committee adopted H-1 Substitute on 4/18/19; Referred to House Committee on Ways and Means on 6/20/19; Passed by the House (102-5) on 12/10/19; Referred to the Senate Insurance and Banking Committee on 12/11/19; Reported to the Committee of the Whole on 3/12/20***
- **Travel insurance –** HB 4508 amends the Insurance Code to change the definition of "travel insurance" and to add a new chapter to regulate the sale of that insurance ***Passed by the House (105-2) on 2/25/20; Referred to the Senate Insurance and Banking Committee on 2/26/20***
- **Agent and broker fees –** HB 5174 amends the insurance code to modify the fees that personal and surplus lines agents or brokers can charge in addition to commission ***Passed by the House (108-0) on 12/11/19; Passed by the Senate (37-0) on 3/5/20; Signed by the Governor on 3/17/20 (PA 62'20 with immediate effect)***
- **Health and life insurance reserves –** HB 5241 removes a provision that currently exempts certain health and life insurers from establishing reserves using a principle-based valuation (per the NAIC *Valuation Manual*) ***Passed by the House (103-2) on 12/4/19; Passed by the Senate (36-0) on 1/15/20; Signed by the Governor on 1/27/20 (PA 15'20 with immediate effect)***

- **Internationally active insurers –** HB 5242 amends the Insurance Code to authorize the Director of the Department of Insurance and Financial Services to act as or appoint a group-wide supervisor for an internationally active insurance group (required for NAIC accreditation) ***Passed by the House (103-2) on 12/4/19; Passed by the Senate (36-0) on 1/15/20; Signed by the Governor on 1/28/20 (PA 16'20 with immediate effect)***
- **Internal audit functions –** HB 5243 amends the Insurance Code to require an internal audit function (IAF) for certain insurers and defines the organization of and duties for an IAF ***Passed by the House (103-2) on 12/4/19; Passed by the Senate (36-0) on 1/15/20; Signed by the Governor on 1/28/20 (PA 17'20 with immediate effect)***
- **Insurers' privacy policies –** SB 172 modifies the requirements for insurers to provide privacy policies to customers ***Passed the Senate (35-2) on 11/5/18; Referred to the House Insurance Committee on 11/5/19; Referred to the House Ways and Means Committee on 3/5/20***
- **Surprise Billing Protections –** SB 570 amends the Public Health Code to add Article 18 (Surprise Billing Protections), requiring nonparticipating providers to accepts as payment for certain health care services either the average amount negotiated with a health benefit plan or 150% what Medicare covers (whichever is greater) ***Reported out of the Senate Insurance and Banking Committee and Referred to the Committee of the Whole on 1/23/20***
- **Discipline for violations –** SB 571 amends the Public Health Code to include violations of SB 570 and 572 as grounds for discipline ***Reported out of the Senate Insurance and Banking Committee and Referred to the Committee of the Whole on 1/23/20***
- **Consent for billing for non-emergency services –** SB 572 amends the Public Health Code to permit nonparticipating providers to bill patients for nonemergency services not covered by the patient's health insurance, only if the patient consents in writing and certain conditions are met ***Reported out of the Senate Insurance and Banking Committee and Referred to the Committee of the Whole on 1/23/20***
- **Fine for violations of SB 571-** SB 573 amends the Public Health Code to prescribe a fine for violating SB 571 ***Reported out of the Senate Insurance and Banking Committee and Referred to the Committee of the Whole on 1/23/20***

New Bills

And new bills continue to roll out (1700 in the House and 853 in the Senate), with the following new referrals to the House and Senate Insurance Committees:

- **Short-term policies –** HB 5316 permits extensions and renewals of and additional coverage for short-term health insurance policies
- **Physician certification –** HB 5329 amends prohibition on insurers requiring allopathic or osteopathic physicians to hold certain certifications before the insurer issues payment
- **No-fault IME board –** HB 5331 creates a no-fault independent medical examination board, proscribes its composition, duties and powers
- **IME – good cause –** HB 5332 requires a good cause showing to request an independent medical exam for a personal protection benefit claim, amends the requirements for the physician conducting the exam and the exam process
- **Mental health disorder –** HB 5429 requires health insurers to provide coverage for mental health and substance use disorder services (including behavioral health treatment) at a no less favorable level than for physical illness
- **Gender and sexual identity –** HB 5430 prohibits insurers from refusing to issue or denying coverage based on a person's gender, gender identity or sexual orientation
- **Expansion of health insurance coverage –** HB 5431 requires health insurance policies to cover: ambulatory services, emergency services, hospitalization, pregnancy and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services (including oral and vision care)
- **Pre-existing conditions –** HB 5432 prohibits health insurers from denying coverage for preexisting conditions or cancelling coverage based on the insured's health
- **PIP benefits for minors –** HB 5677 eliminates choice of levels of personal protection benefits for minors and requires unlimited coverage
- **Assigned claim benefits –** HB 5678 modifies limits regarding when certain individuals are entitled to assigned claim benefits
- **Disclosure of ratings based on territories –** SB 821 amends the insurance code to require automobile insurers to disclose any rating based on territories, and requires the Department to assess that rating process and to publish the insurer's territorial rating information on the Department's website ■

ERISA Decisions of Interest

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Sixth Circuit

Court Reverses Denial of Benefits Where Claimant Was Under "Regular Attendance of a Physician"

Reversing the district court, the Sixth Circuit held in *Bruton v. America United Life Ins. Corp*., - Fed. Apx. -, 2020 WL 398539 (6th Cir., Jan. 23, 2020), that the plaintiff was entitled to LTD benefits.

Plaintiff Bruton was an information technology manager who developed severe back and leg pain. The plan in which he was a participant required that to be "totally disabled": an insured must be unable to perform the material and substantial duties of his "Regular Occupation" (meaning a "person's occupation as it is recognized in the general workplace and according to industry standards," rather than "the specific job tasks he does"), and that he be "under the regular attendance of a physician" for his disabling condition.

The plan defined "Regular Attendance" to mean the insured "1) personally visits a Physician as medically required according to standard medial practice, to effectively manage and treat his Disability; 2) is receiving the most appropriate treatment and care that will maximize his medical improvement and aid in his return to work; and 3) is receiving care by a Physician whose specialty or clinical experience is appropriate for the Disability."

The district court affirmed the administrator's denial of benefits under *de novo* review, finding that Bruton failed to follow standard medical practice to manage his pain because he received increasingly large doses of opiates despite normal clinical findings; that he failed to undergo an MRI that his physician recommended; that he failed to pursue aquatic therapy that his physical therapist recommended, and that failed to follow-up with a referral to a rehabilitation specialist.

The Sixth Circuit reversed, holding that the "Regular Attendance" requirement "does not empower an administrator to micromanage a claimant's medical care – instead, it exists merely to prevent malingering and fraud." It characterized the defendant's argument as being "the failure to pursue *any* treatment recommended by *any* medical professional with *any* level of confidence that the treatment would lead to medical improvement puts the applicant outside the realm of 'total disability' – even in circumstances when a patient declined treatment that is prohibitively expensive, or experimental, or risky, or painful." The Sixth Circuit's own "march through the [administrative] record reveal[ed] that he received extensive treatment from medical professionals," including "over a dozen visits with his primary care provider and multiple visits with specialists." The court discounted Bruton's failure to follow up with the recommended medical options because "the record offers little evidence that Bruton would have improved his health outcome had he pursued them."

Exhaustion of Administrative Appeal Not Required if Plan Does Not Specify Procedures for Appealing Denial of Benefits

Wallace v Oakwood Healthcare, Inc, et al
(6th Cir, March 31, 2020) (published).
Case No. 18-2316, --Fed--

The Sixth Circuit made clear in *Wallace* that the judicially-created exhaustion requirement - - *i.e*., that plan participants and beneficiaries who are denied benefits must administratively appeal before filing a claim in federal court - - does not apply if the plan fails to identify the procedures for appeal. The Court succinctly stated that "we hold today that for a plan fiduciary to avail itself of this Court's exhaustion requirement, its underlying plan document must – at minimum – detail its required internal appeal procedure."

The plaintiff was a nurse with long-term disability benefits through a plan established and maintained by her employer, Oakwood Healthcare, Inc. Hartford Life and Accident Insurance Company initially insured the plan until December 31, 2012, when Oakwood switched its insurer to Reliance Standard Life Insurance Company. She contracted an illness in September 2012 that forced her to take a medical leave from October 2012 to April 2013. While on leave, Oakwood changed insurers. After returning to work in April 2013, she stopped working in May 2013 and did not return.

She applied for benefits with Reliance Standard, which denied her claim based on the plan's "pre-existing condition" provision. The denial letter said she could request review of her claim, and that her "failure to request review within 180 days . . . may constitute a failure to exhaust the administrative remedies available under" ERISA and affect her ability to sue under ERISA. However, Reliance Standards' plan document described neither any appeal procedures, nor any exhaustion requirement.

The plaintiff did not ask Reliance Standard to review the denial, but instead filed a claim in federal court under ERISA, §502(a)(1)(B), in early 2019. Reliance Standard moved to dismiss, arguing the failure to exhaust barred Plaintiff's action. The district court denied the motion on the ground that the plan document did not require exhaustion. The Sixth Circuit affirmed the denial, but on different grounds.

The Sixth Circuit explained that although "ERISA itself does not include an explicit exhaustion requirement," the Court "has read such a requirement into the statute." Moreover, ERISA regulation C.F.R. §2560.503-1(1) provided that in the "case of the failure of a plan to establish or follow claim procedures consistent with the requirements of this section, a claimant *shall be deemed to have exhausted the administrative remedies available under the plan* and shall be entitled to pursue any available remedies under Section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." (italics in original).

In addition, 29 C.F.R. §2560.503-1(h)(1) and 29 U.S.C. §1133 require plans to establish procedures for claimants to have a reasonable opportunity for a full and fair review of decisions denying their claim.

The court noted that Reliance Standard's "plan document contains no information about the review procedures or remedies available for denied claims." It then held:

> Specifically, we do not decide whether, as the district court found, a plan document must explicitly and affirmatively require exhaustion. At a minimum, a plan document must detail claim review procedures and remedies and must not mislead an employee into believing that there are no administrative remedies or that those remedies must need not be exhausted. Defendant's plan document did just that, which this Court cannot condone.

The court rejected the insurer's argument that it was not necessary for the plan to detail appeal procedures because those procedures were explained to plaintiff in the denial letter, holding that "one of ERISA's central goals is to enable beneficiaries to learn their rights and obligations at any time," and that plans must be "established and maintained pursuant to a written instrument" from which beneficiaries can find their rights "on examining the plan documents." That is not satisfied by a denial letter. ■