As our entire membership hopefully knows by now -- as a result of both my messages in this column and my e-mails to our members -- our Council has embarked upon a two-year strategic planning effort to help define precisely those services our members most want from this Section, so that this Section for years to come can achieve its stated purpose of being resource tool for the bar as a whole, and to provide our members a forum for exchanging ideas in the areas of insurance and indemnity law.

As an update on that process, I recently participated with our State Bar of Michigan's Director of Research and Development and two other Council members in a focus group meeting with several of our members who graciously agreed to spend some of their time with us answering questions about the Section. This focus group meeting provided us with the basis for creating a survey that soon will be sent to each one of our members. The survey takes only a few minutes, and the responses will be very important to our future planning.

The strategic planning that the Council is undertaking leads to another source of change and growth in the near future, and that is leadership of the Section going forward. The Section was founded in 2007, and the founding members have all served in various capacities on the Council and/or as officers. It is imperative that we continue generating interest and involvement by our membership so that the Section can continue its growth.

Because several members expressed interest in participating, we increased the size of the Council to 21, including officers. Half of the Council positions are up for election each year, and the elections are “at-large,” so any member can become a candidate. Our goal is to give members as many options as possible to participate. In addition, our bylaws set term limits, so we will begin to have vacancies in Council seats starting next year. So, if you are interested in becoming a member of the Council, put your name forward in the next election.

The expansion of the Council provided an opportunity for interested members to participate and it is important to build on that. We are slowly generating new Council members but in the next short few years we will have reached the end of the informal line of succession for officer positions being filled by founding members. Under the bylaws, the normal progression is from treasurer to secretary, chair-elect, and then chair. This gives someone plenty of time to “learn the ropes” of the Section.

Another way an interested member can participate is to start a committee that focuses on a particular aspect of insurance or indemnity law. If you have an idea for a committee, just let one of our officers or Council members know. They are all identified on the last page of the Journal.
From the Chair
Continued from page 1

In addition to the strategic planning that we are performing this year, we will continue to publish the quarterly Journal (a publication that continues to receive very positive feedback) and we will provide another substantive program at the State Bar Annual Meeting, as well as, we hope, sponsor some other smaller programs that will give our members an opportunity to mingle and network.

As always, we want to hear from you and we want you involved. Our Section has made a good start, and now it’s time to build on that!

Editor’s Note
By Hal O. Carroll, Vandeveer Garzia, PC

The Journal of Insurance and Indemnity Law is a forum for the exchange of information, opinion, and commentary from any perspective on any topic related to the law of insurance and/or indemnity. In addition to being distributed to members, the Journal is also sent to state and federal trial and appellate judges, and selected legislators and members of the executive branch. The Journal welcomes articles or other contributions from any interested person.

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). If you have a proposal for publication, or would like to suggest a topic, please contact the editor, Hal Carroll, at hcarroll@VGpcLAW.com or at hcarroll@chartermi.net.

The Insurance Agent’s Duty—The Harts “Special Relationship” Test

By Adam Kutinsky, Kitch, Drutchas, Wagner, Valitutti & Sherbrook; adam.kutinsky@kitch.com

Michigan law has imposed a range of duties on insurance agents through the years, ranging from the most basic duty of an “order taker” for the insured, to the highest duty of fiduciary for the insurance company. Generally, these duties have arisen from three separate legal sources – statutes, contracts and common law. Coupled with the varying designations conferred on insurance agents as well as the infinite number of distinct factual scenarios leading to the purchase of insurance, Michigan law is somewhat convoluted on the issue of an insurance agent’s duties to a potential insured.

Nearly three decades ago, the Michigan Court of Appeals published a decision that adopted the general rule that an independent agent, who can write for several insurance carriers, is considered the agent of the insured and not the insurer. Mayer v Auto-Owners Insurance Company1 Yet, when considering other legal sources, this common law rule oversimplified a rather complex issue. To begin with, all licensed agents are governed by the Michigan Insurance Code, which imposes a fiduciary duty upon the agent to an insurance carrier when receiving premiums.2 Thus, as soon as an independent agent is appointed by a carrier, he or she instantly becomes the insurer’s agent when handling premiums, which contradicts the general rule that an independent agent is solely the agent of the insured.

Moreover, an independent agent usually signs a producer agreement with each carrier, thereby imposing additional duties on the agent owed to the carrier as well as limited binding authority. So, when considering all sources of Michigan law, even an independent agent is the agent of its insurance carriers, albeit for limited purposes. It follows, therefore, that the common law rule in Mayer may be construed as partially inconsistent with other sources of Michigan law.
Sixteen years after Mayer, the Michigan Supreme court published Harts v Farmers Insurance Exchange. Harts involved a captive agent that sold an auto policy to an insured without advising the insured to purchase uninsured motorist coverage. Following an accident with an uninsured driver, the insured sued the insurance agent for negligence. The Harts court found that the agent had no duty to advise the insured on whether to purchase uninsured motorist coverage, stating “an insurance agent whose principal is the insurance company owes no duty to advise a potential insured about any coverage.”

The Harts case also created the often-cited rule that an insurance agent is simply an “order taker” unless a “special relationship” is created between the parties. This special relationship abrogates the general “no duty to advise” rule but requires the insured to prove specific facts concerning the parties’ communications before the policy was issued.

Although Harts involved a captive agent, and premised the “no duty” rule upon the captive agent being the principal of the insurance carrier, several unpublished Court of Appeals cases after Harts expanded the “no duty without proving a special relationship” test to apply to independent agents as well. Significantly, these cases were silent on the distinction between a captive agent and an independent agent, thereby applying Harts to all insurance agents - essentially holding that no insurance agent, captive or independent, owes a duty to advise an insured on the adequacy of coverage absent proof of the Harts “special relationship.”

Nearly three decades ago, the Michigan Court of Appeals published a decision that adopted the general rule that an independent agent, who can write for several insurance carriers, is considered the agent of the insured and not the insurer.

This resulted in an apparent conflict with the older rule cited in Mayer that an independent agent is considered the agent of the insured and not the insurer - a rule that would impose a duty to properly counsel and advise the insured without proof of a special relationship. This particular conflict frequently arises in errors and omissions cases at the trial level on summary disposition. To my knowledge, neither the Michigan Court of Appeals nor the Michigan Supreme Court has addressed it specifically. However, recently, the Michigan Court of Appeals made reference to the conflict in some unpublished cases. The first case, National Association of Investors Corp v Dobson-McOmber Agency, Inc., et al involved a non-profit corporation that purchased a directors and officers policy from its longtime independent insurance agent. The plaintiff had apparently requested that its agent provide a presentation on the insurance coverage afforded under the policy. At the presentation, the agent failed to discuss the policy exclusions. After the policy was issued, a former board member sued the non-profit and the non-profit tendered the suit to the insurance carrier for coverage. Upon receipt of the lawsuit, the carrier denied coverage based upon the “insured v insured” exclusion in the D&O policy, which prompted the non-profit to sue its agent for negligence. The trial court applied the Harts special relationship test and granted the agent’s motion for directed verdict at trial.

The Court of Appeals reversed the trial court’s directed verdict and discussed several significant legal principles, including a short discussion of whether the Harts special relationship test applies to independent agents at all, stating: “it appears that the Harts case may not even apply to this case.” Although the court did not explicitly refuse to follow Harts, it implicitly challenged the prior cases that applied Harts to independent agents.

Within six months after issuing Dobson-McOmber, the Court of Appeals issued two additional unpublished decisions that applied Harts to independent agents. The first decision was Mauro v Lucido’s Insurance Agency, Inc. In Mauro, without discussing the distinction between a captive and independent agent, the Court applied the Harts rule to the facts of the case, stating: “Insurance agents generally have no duty to advise an insured.” However, Harts lists four situations when a “special relationship” between the agent and the insured may create a duty to advise the insured on the part of an insurance agent.

The third and most detailed decision is Nokielski v Colton. Colton involved an auto accident in which the driver of a vehicle, Colton, was sued for negligence. Prior to the car accident, Ms. Colton maintained an auto policy and an umbrella policy through the same insurance carrier. Subsequently, Ms. Colton switched her auto policy to a different carrier and left her umbrella policy in place with the original carrier. Unfortunately, the new auto policy only had limits of $100,000 per person/$200,000 per accident, which did not satisfy the umbrella policy condition that the primary layer of insurance provide at least $500,000 in coverage. This resulted in a gap in coverage for the accident of $400,000.

The Coltons sued their insurance agent (who was an independent agent) for failing to advise them to purchase at least $500,000 in primary coverage. The trial court applied Harts and ruled that no special relationship existed to create an exception to the general rule that insurance agents do not owe an
The Insurance Agent’s Duty . . .
Continued from page 3

affirmative duty to advise or counsel an insured about the adequacy or availability of coverage. Colton at 3. At the appellate level, the Coltons argued that Harts was inapplicable because it only applies to cases involving captive insurance agents and not independent agents.

The Court of Appeals discussed the captive versus independent agent distinction in its opinion and found that the Harts rule applies to both:

Although the defendant in Harts was a captive insurance agency, in our opinion, there is no reason that would preclude the Harts test from applying to both types of agents…The Harts Court did not specifically indicate that it only intended to address captive agents and not independent agents…we conclude (its reasoning) extends to both captive and independent insurance agents.9

The Colton case delved into an issue that has oftentimes been the subject of argument at the trial court level. However, since Colton was issued within months of Dobson-McOmber (which questioned the applicability of Harts to independent agents), its persuasiveness is somewhat tempered. Additionally, the unpublished nature of these cases brings to mind something stated by a local trial judge during motion call recently: “An unpublished case is nothing more than a letter from the court to the litigants.” Significantly, a publication request in Colton was denied by the appellate panel on February 16, 2011.

About the Author

Adam Kutinsky is a shareholder at Kitch and takes a leadership role in its insurance coverage and commercial litigation practice groups. He is also a CPCU® and may be reached at 313.965.6731 or adam.kutinsky@kitch.com.

Endnotes

2 MCL 500.1207.
4 Harts at 10.
5 National Association of Investors Corp v Dobson-McOmber Agency, Inc., et al., Unpublished per curiam opinion of the Court of Appeals, Issued June 29, 2010 (Docket No. 286295)
6 Mauro v Lucido’s Insurance Agency, Inc, Unpublished per curiam opinion of the Court of Appeals, Issued December 21, 2010 (Docket No. 294397).
7 Mauro at 3.
8 Nokielski v Colton, Unpublished per curiam opinion of the Court of Appeals, Issued January 4, 2011 (Docket No. 294143).
9 Colton at 4.
The next case to apply the rule is Harper v Tornado v Michigan Mutual Tornado Ins Co, in which the plaintiff sought to collect insurance on a building that had burned down. The building had been insured by the previous owner with a mutual company, but the rules of the company required that the company approve any new insured when property was transferred. The building burned down before the successor owner was approved as an insured, and the court held that there was no insurance.

The Supreme Court more recently applied the rule in American Bumper v Hartford Fire Ins Co. The court acknowledged that Michigan "recognizes that a completed loss is not covered under an after-acquired insurance policy." This reference to a "completed loss" must be read in the context of the Supreme Court's more general statement of the rule:

Under the loss-in-progress doctrine, an insurer is not liable if the loss was already in progress before the policy's coverage took effect. The doctrine is based on the rationale that insurance policies cover fortuitous events or risk of loss, not losses that are certain to occur. Once a loss has happened, or once it is in progress, the event is no longer fortuitous and the risk has already been realized.

These principles are not based on or limited by the terms of the policy. Fortuity and the loss in progress and known risk rules are related to two other insurance concepts – "adverse selection" and "moral hazard."
doctrines are related to two other insurance concepts—“adverse selection” and “moral hazard.” Adverse selection is the tendency of a person who knows he or she is more likely to suffer a loss to buy insurance. Moral hazard is the problem that one who has insurance will engage in riskier behavior—or intentional conduct—because he or she knows the insurance will make good the loss.

Adverse selection and moral hazard by applicants or policyholders provide perhaps the greatest threat to fortuitous underwriting by insurers. Adverse selection is the tendency of persons who are more likely to suffer a loss to purchase insurance on such risks. At its worst, adverse selection can mean an insurance applicant’s seeking a policy that will cover a loss he knows is certain to occur.9

Michigan has applied the moral hazard rule in several cases. Addressing the issue in the context of the insured’s failure to disclose a material fact, the Supreme Court said:

“It cannot be presumed that a breach of a condition which increases the moral hazard does the insurer no injury. Quite the contrary. Courts have uniformly avoided the policy upon breach of such conditions, upon the ground that an essential and material change of the contract was thus effected and the insurer prejudiced.”10

Policies may address the moral hazard problem in several ways. Many of the exclusions (the subject of a future article), are aimed at that problem. The most obvious, in a liability insurance policy, is the “expected or intended injury” exclusion (a/k/a the “intentional act exclusion). A property insurance policy will usually contain a provision that requires the insured to take steps to prevent certain types of loss. Also, a policy may contain a provision, usually in the Conditions section, that prevents coverage when the insured fails to disclose a material fact in the application. ■

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. His practice includes civil appeals and indemnity and insurance coverage disputes, where he represents insureds as well as insurers. He is a frequent author on insurance and indemnity topics. His email addresses are hcarroll@VGpcLAW.com and hcarroll@chartermi.net.

Endnotes

3 Gauntlett v Sea Insurance, 127 Mich 504; 86 NW 1047 (1901).
5 173 Mich at 463.
7 American Bumper at 459, citing Gauntlett.
8 American Bumper at 459.
9 Stempel, Law of Insurance Contract Disputes, Chapter 1, Core Insurance Concepts, § 1.05[b], page 1-65.
Sixth Circuit

No UIM Coverage in the Absence of an Endorsement to a Commercial Auto Policy

_Anton v National Union Fire Ins Co_
___F3d__ (6th Cir. 2011)(Case No. 09-2461)

GM executive’s wife operating a company car was not entitled to UIM benefits under the commercial auto policy issued by defendant for GM-owned vehicles because the policy did not include the Michigan endorsement for UM/UIM coverage. That the policy included endorsements for UM/UIM coverage in other states was irrelevant. This vehicle was registered in Michigan, which was also the place where the accident occurred.

Life Insurance Benefits Controlled by the Contract, Not Common Law

_Uunion Security Ins v Blakely_
___ F3d ___ (6th Cir 2011)(Case No. No. 09-4368)

Thomas Blakely died and left behind a life insurance policy with no named beneficiary. Conflicting claims were made by his girlfriend, identifying herself as a domestic partner, and his three children. The term “domestic partner” was not expressly defined in the insurance contract and so the trial court looked to federal common law and found the criteria satisfied. That holding was reversed on appeal because even though there was no specific contract definition of domestic partner, certain criteria in the contract should have directed the court’s analysis. “To determine the proper beneficiary of Thomas Blakeley’s life insurance policy, ERISA says to look first at the text of the policy. But the court below overlooked a key piece of the policy’s text and instead resorted to the common law to decide that Sondra Billet was the rightful beneficiary. This was error.” The case was remanded for further proceedings consistent with the opinion.

Michigan Court of Appeals - Published

Financial Transactions by BCBSM do not Violate the NHCCRA

_AG v Blue Cross Blue Shield of Michigan, et al._

This case was filed by the State of Michigan Attorney General (AG) against Blue Cross Blue Shield of MI (BCBSM) challenging the financial legality of certain conduct under the Nonprofit Health Care Corporation Reform Act, MCL 550.1101, et seq. (the Act). The Court of Appeals described the two issues taken up as: (1) whether BCBSM violated section 1207 of the Act when its subsidiary, the Accident Fund Insurance Company of America (the “Accident Fund”), purchased three for-profit insurance companies; and (2) whether Michigan courts defer to administrative agencies in the interpretation of Michigan statutes. The Court found that the transaction did not violate the Act and that the trial court erred by deferring to an administrative agency for the interpretation of a statute.

In 1994, BCBSM formed the Accident Fund as a wholly owned for-profit Michigan stock insurance subsidiary, which in turn purchased the assets and acquired the liabilities of the State Accident Fund, a for-profit worker’s compensation insurer. Subsequently, the Accident Fund acquired three foreign insurance companies and BCBSM transferred $125 million to the Accident Fund as a capital contribution with no repayment obligation. The AG sued BCBSM, alleging that the acquisitions violated MCL 550.1207(1)(o), which prohibits BCBSM from acquiring any domestic, foreign or alien insurers, and that BCBSM’s contribution of $125 million violated the statutory restriction against the use of funds to operate or subsidize the Accident Fund.

BCBSM moved for summary disposition and the trial court initially denied the motion as to the two issues raised on appeal. Subsequently, the trial court concluded on reconsideration that the Act does not apply to transactions undertaken by the Accident Fund. The court then referred the matter to the Commissioner of the OFIR, under the doctrine of primary jurisdiction, to consider the propriety of using BCBSM funds to facilitate the Accident Fund’s purchase. The Commissioner found in favor of BCBSM, after which the AG filed a second complaint in the circuit court against not only BCBSM, but also the Commissioner and OFIR, asking the court to declare that the commissioner’s resolution was contrary to the statute. The trial court dismissed the lawsuit concluding that it lacked jurisdiction to hear the case as an original action.

On appeal, the Court of Appeals stated that MCL 550.1207(1)(o) does not apply to BCBSM’s wholly owned subsidiary, the Accident Fund. In particular, the Court of Appeals held that BCBSM was not the party that acquired the three corporations and BCBSM did not “otherwise acquire” the insurers within the meaning of the Act. Since there is nothing in the plain language of the statute to support the argument made
by the AG, and because the transactions about which the AG complained were not undertaken by BCBSM but were in fact undertaken by the Accident Fund, BCBSM did not directly or otherwise engage in any activity in violation of the Act.

Additionally, the Court of Appeals found that the trial court should not have relied upon the administrative agency to construe the statute governing the legality of the transaction. The doctrine of primary jurisdiction is applicable only where the issue presented requires an administrative agency’s superior knowledge and expertise in a regulatory area unfamiliar to the courts. Even then, the administrative agency’s determination is only to be provided respectful consideration and is not binding on the courts. As to the interpretation of statutes, the judiciary has sole authority.

Reformation of Insurance Contract Denied

Titan Insurance v Hyten


When the insured applied for her auto policy with Titan, she misrepresented on the application that she had a valid driver’s license. Her license was, in fact, suspended on that date but she anticipated its restoration at a court hearing scheduled two days later. At the hearing, the insured learned she had to complete a driver’s assessment before her license would be restored, which occurred several weeks later. Five months after submitting the application, the insured was involved in an auto accident. Titan petitioned for a reformation of the contract to reduce liability limits from $100,000/$300,000 per accident to the statutorily mandated coverage of $20,000/$40,000 (the law prohibits cancellation of an insurance where an innocent third party is involved).

Noting that reformation was an equitable remedy, and relying heavily on Titan’s failure to make any effort to investigate an easily ascertainable fact (e.g., the agent could have asked to see the insured’s license), the Court of Appeals upheld the lower court’s refusal to resort to equity to reform the contract. “Titan seeks the benefit of an equitable ruling that it may avoid liability to innocent third parties based on Hyten’s misrepresentation, notwithstanding its deliberate election to forego a risk assessment. ‘[E]quity aids the vigilant, not those who sleep on their rights.’” As to Titan’s claim of fraud in the application, the Court pointed out that Titan had failed to submit an affidavit stating that it would not have issued this policy to the insured if she had applied after her license was restored. Titan’s affidavit stated that the policy would not have issued at the time the license was suspended, a fact found to be irrelevant given restoration of the license at the time of the accident.

Pre-McCormick Verdict Sustained

Nelson v Dubose


Plaintiff went to trial on a serious impairment claim prior to the Supreme Court’s decision in McCormick v Carrier, 487 Mich 180 (2010). The jury returned a verdict of no cause for action and plaintiff lost her subsequent motion for JNOV.
The Court of Appeals declined to reverse under the change of law announced in McCormick. It first concluded that the jury was properly instructed under the standard jury instruction, which had never been modified to incorporate the Kreiner factors. As a result, the jury was accurately informed that serious impairment of a body function was “an objectively manifested impairment of an important body function that affects the plaintiff’s general ability to lead her normal life.” Second, the majority (Jansen, J. dissenting) rejected plaintiff’s argument that the verdict was contrary to the evidence under the criteria announced in McCormick. Two judges agreed that reasonable jurors could arrive at different conclusions based on the evidence. Consequently, the verdict was affirmed.

**PIP/Work Loss Benefits for Teachers**

*Copus v Meemic*  

This case involved a dispute over the proper computation of “work loss” benefits for a teacher who received her annual salary through payments spanning the entire calendar year rather than the school year. Defendant no-fault insurer argued that the statute only required compensation for the weeks the insured was unable to work due to injury as opposed to weeks the insured was unable to work because school was not in session. The Court of Appeals rejected the insurer’s argument: “[t]here is nothing ambiguous about MCL 500.3107(1)(b). It defines “work loss” as “loss of income from work an injured person would have performed . . . if he or she had not been injured.” The statute does not, as Meemic argued, “mandate any sort of temporal correlation between the work and the income.” Because the insured lost a full year’s salary due to her inability to perform any work during the academic year, she was entitled to a full year’s pay as work loss. Our no-fault act “seeks to compensate . . . for income lost as a consequence of work lost.”

**Michigan Court of Appeals - Unpublished**

Conclusory Statements Insufficient to Dismiss Lawsuit for Insurance Coverage

*Bahayou v Fire Insurance Exchange*  
Unpublished Per Curiam of December 2, 2010  
Docket No. 294165

This appeal arose from the plaintiff insured’s claim for fire and theft loss under a policy issued by the defendant. The trial court sua sponte dismissed the insured’s lawsuit after finding that the insurance company mailed the insured a notice of cancellation on April 25, 2007, which under MCL 500.2833, would make the effective date of cancellation ten days later on May 5, 2007. Since the alleged theft occurred after May 5, 2001, the Court determined that no policy was in effect at that time. The Court of Appeals reversed the trial court’s decision because the plaintiff’s complaint specifically alleged that the theft occurred before the policy was cancelled and because the plaintiff only assumed for argument purposes that the theft occurred after May 5, 2007. Plaintiff’s assumption, *arguendo*, did not constitute an admission, nor did the plaintiff concede that the theft occurred after policy cancellation. Since, under MCR 2.116(C)(8), the court was obligated to assume the facts alleged in the plaintiff’s complaint as true, summary disposition was inappropriate. The appellate court also found that dismissal would have been inappropriate under MCR 2.116(C)(10) because the parties did not provide supporting documentation for their respective positions. This opinion also includes a brief discussion concerning the protection that a reservation of rights letter affords an insurer faced with an estoppel argument.

**No Agency Liability**

*Mauro v Lucido’s Ins Agency,*  
Unpublished per curiam of December 21, 2010  
Docket No. 294397

Plaintiff insured sued his insurance agent for failing to revisit the policy limits of a builder’s risk policy and advise the insured to increase his limits as work on the insured’s million dollar home progressed. The Court upheld the trial court’s summary disposition order for the insurance agency “because the general rule that insurance agents have no duty to advise an insured on appropriate coverage applies.”

**Court Upholds Auto Liability Provision Limiting Coverage For Claims by Family Members**

*Fricke v Farm Bureau Mut Ins Co of Michigan*  
Unpublished per curiam of February 15, 2011  
Docket No. 295338

Insured husband and wife were fatally injured when the husband lost control of their car in a single car accident. Their auto policy with Farm Bureau had liability limits of $500,000, except that for members of the insured’s family, liability limits were the mandatory $20,000. When the wife’s estate made a claim against the husband’s estate, Farm Bureau offered the lower limits. The court agreed with Farm Bureau’s interpretation of the policy. Its terms were not ambiguous. And because the provision guaranteed the statutory minimum coverage, it was not contrary to public policy.

**Criminal Acts Exclusion Bars Liability Coverage For Inebriated Boater**

*Auto Club Group Ins v Smith*  
Unpublished per curiam of January 25, 2011  
Docket No. 294697

Insured husband and wife were sued for bodily injury claims arising out of a boating accident. Claimants alleged
that the insured husband was drunk and driving his boat in a reckless and careless manner. The insureds’ boatowners policy excluded coverage (1) for claims arising out of an act by the insured intended or reasonably expected to cause bodily injury or property damage, and (2) for claims arising out of a criminal act, whether or not criminal proceedings were commenced or resulted in a conviction. The Court of Appeals held that the exclusion was not ambiguous and that it excluded coverage for criminal acts regardless of whether the resulting injury was expected or intended. MCL 324.80176 makes it a felony to operate a boat under the influence of alcohol and the insured had previously pled nolo contendere in a criminal proceeding charging him with that offense as a result of this accident. “Therefore, we conclude that there was no genuine issue of material fact that the . . . claims clearly fell within the ‘criminal acts’ exclusion in the Auto Club policy.” And the exclusion applied to the claims against the insured wife as well, because coverage was barred regardless of who committed the criminal act.

About the Authors

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ERISA Decisions of Interest

United States Supreme Court Update

The United States Supreme Court is expected to issue its decision before the end of the term in a case concerning the standard for measuring harm to pension plan participants and beneficiaries resulting from alleged inconsistencies between a summary plan description and the full plan document. In the class action Cigna Corp v Amara, Case No. 09-804, argued on November 30, 2010, the plaintiffs argued that a showing of “likely harm” is sufficient to warrant recovery of benefits based on alleged inconsistencies; whereas the defendants argued that detrimental reliance was required. The court’s decision will determine the burden of proof applicable in pension benefit class action suits as well as have an impact on the level and type of information included in a summary plan descriptions. Stay tuned for further developments.

Sixth Circuit Court of Appeals Update

Since our last issue, the Sixth Circuit issued two published opinions; one of which upheld the well-known “plan documents” rule in a case involving a purported domestic partner, and one which provided guidance as to what type of conduct can be considered fiduciary activity.


This case presented the not uncommon scenario of a dispute over life insurance proceeds between the children of the deceased and the deceased’s purported fiancée where no beneficiary had been designated. In that situation, the policy provided that proceeds would be paid first to a surviving spouse, and if none, to a domestic partner, and thereafter to the deceased’s children. In this case, the deceased’s fiancée claimed entitlement to the proceeds as a “domestic partner,” arguing that state law should be applied to establish her status as such. The Sixth Circuit found that although “domestic partner” was not expressly defined in the policy’s general definition sections, the plan listed criteria for determining whether a domestic partner was an insurable life under the plan. As a result, the court held that beneficiary status must be determined by application of the plan documents rather than by state law and remanded for consideration of whether the fiancée satisfied the plan criteria to be considered a domestic partner. This case reinforces the well-established doctrine that the plan documents control with respect to determining beneficiary status.

Plaintiff here argued that the defendant’s expressly designated fiduciary status precluded it from engaging in contract negotiations with various hospitals that would raise the cost for participants in the employee-sponsored welfare benefit plan. The Sixth Circuit disagreed, finding that the defendant “was not acting as a fiduciary when it negotiated the challenged rate changes, principally because those business dealings were not directly associated with the benefit plan at issue here but were generally applicable to a broad range of healthcare consumers.” The court counseled that, to determine liability for breach of a fiduciary duty in an ERISA case, courts “must examine the conduct at issue to determine whether it constitutes ‘management’ or ‘administration’ of the plan, giving rise to fiduciary concerns, or merely a business decision that has an effect on an ERISA plan not subject to fiduciary standards.” In this case, the court noted that the “conduct at issue” clearly falls into the latter category.

Disability Benefits Can Be Terminated by Plan Amendment

Price v. Indiana Laborer’s Pension Fund, ___ F.3d ___, 2011 U.S. App. LEXIS 591 (6th Cir. 1/12/2011)

Under ERISA and the Internal Revenue Code, pension benefits will generally become vested. Neither law requires health and other welfare benefits to become vested, but the parties (i.e., employer and employee or union) can agree that the benefits be vested. In the absence of an explicit provision in the plan, the Sixth Circuit has recognized an inference (but not a presumption) that retiree health benefits will vest for the remainder of the retiree’s life. In this case, the Sixth Circuit held that disability benefits would be treated differently. Specifically, the Sixth Circuit held that a plan could be amended to limit the duration of disability benefits after an employee became disabled.

James Price began receiving disability benefits under a pension fund in 1990. At that time, the plan said benefits would be payable until Price’s early retirement age. In 2004, the Plan was amended to limit the payment of benefits until the end of 2006. Thus, the Plan cut off Price’s benefits in 2004. Price appealed, claiming that once he became disabled and entitled to benefits, the plan could not be amended to cut off his benefits before his early retirement age. The District Court agreed with Price and the Plan appealed.

The Sixth Circuit reversed, holding that there was nothing explicit in the Plan that provided Price’s benefits would be vested. To the contrary, the Plan explicitly provided that it could be amended, except no amendment could “result[r] in reduced benefits for any Participant whose rights have already become vested. . . .” The court concluded that this language only prohibited reduction in pension, and not disability, benefits. The court also deferred to the judgment of the Plan that it could be amended to reduce disability benefits. However, because the District Court analyzed the case under a de novo standard rather than giving deference to the Plan, the Sixth Circuit remanded the case for further consideration.

Western District of Michigan Court Update

Disability Required Loss of W-2 Income from Disability; Quitting, Even if “Forced-Out,” Bars Benefits


Brian Wernimont was injured in an automobile accident. At the time of the accident, he was a highly productive tax accountant. He was also a minority owner of his employer; in fact, much of his income was based on his ownership interest rather than his wages as an employee. After the accident, his productivity and performance slipped dramatically. After two years, his employer offered him continued employment only if he agreed to terms that would have significantly reduced his compensation as an owner. When Wernimont refused this offer, his employment was terminated. Wernimont sought disability benefits, which UNUM refused.

The court began by finding that in order to be “disabled” under the policy, Wernimont’s W-2 income must have decreased by 20%. Although Wernimont’s W-2 income for 2008 was 29% less than his W-2 income for 2007, the court found that the relevant analysis was his monthly income. Because Wernimont’s employment was terminated at the end of August of 2008, his 2008 income was based on only 8 months of work and thus his monthly W-2 income for 2008 was actually higher than that of 2007.

Second, the court noted that the decrease in income must have been “due to” the disability. Wernimont argued that the accident caused a decrease in his capacity to work; that decrease caused his employer to offer him continued employment only based on lesser compensation; that decrease caused him to decline the contract; and his declining the contract resulted in him losing his job and having a large decrease in income. The court responded:

Under a strict, sequential analysis of but for causation, Plaintiff’s argument would be compelling. But this is not a law school hypothetical, and this Court is not in the practice of stretching lines of causation beyond the intervening acts of third parties, much less the intervening acts of a party seeking relief. Here, Plaintiff elected to discontinue
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his employment... That election was not caused by sickness or injury, and it was that election alone which led to the 20% decrease in his monthly earnings.

Finally, the Court held that Wernimont's coverage ended on his last day of employment, and his earnings decreased after that date, i.e., after his coverage ended.

Although the Court's analysis may be consistent with the strict terms of the policy, one can't help but wonder if the result is consistent with the purpose of disability insurance coverage and the expectations of the parties. Assuming Mr. Wernimont was, in fact, disabled, his total income was going to decrease significantly as the result of his disability. And isn't that what disability insurance is intended to protect against?

As everyone knows, the Michigan Supreme Court released its decisions in McCorkmick v Carrier, 487 Mich 180, __NW2d__ (2010) and Regents v Titan Ins Co, 487 Mich 289, 791 NW2d 897(2010) on July 31, 2010, and as a result, noticeably changed the course of No Fault jurisprudence in this state. Specifically, in McCorkmick, the Supreme Court overruled its earlier decision in Kreiner v Fischer, 471 Mich 109, 683 NW2d 611 (2004) and in Regents, the Court overruled its earlier decision in Cameron v ACIA, 476 Mich 55, 718 NW2d 784 (2006). As a result of this court action, many no-fault practitioners expected other no-fault cases, decided by the former Taylor Court majority, to fall by the wayside as well. With Judge Mary Beth Kelly's defeat of incumbent Justice Alton Davis in the November 2, 2010 general election and with the appointment of Judge Brian Zahra, of the Michigan Court of Appeals, to replace Judge Maura Corrigan (who resigned to head up the Department of Human Services in Governor Snyder's administration), it remains to be seen if this new court will accept the invitation to re-examine case law precedent from the Kelly Court of 2009-2010.

What follows is analysis of some issues of interest to No Fault practitioners, currently pending before the Michigan Supreme Court, followed by an analysis of two recent published decisions from the Court of Appeals, which may set the stage for future Supreme Court action.

Supreme Court Recap

Housing Accommodations – Incremental Cost

Readers will recall that the Supreme Court's 2005 decision in Griffith v State Farm, 472 Mich 521, 697 NW2d 895 (2005) has been under attack almost since the day it was released. Opponents argue that Griffith unduly restricts the type of no-fault benefits recoverable for a catastrophically injured claimant. In 2010, the case of Wilcox v State Farm, (no. 138602) was pending before the Supreme Court and many observers believed that Wilcox, in all likelihood would overrule Griffith. In fact, the parties had been ordered to brief this very issue. Oral argument took place on November 4, 2010, two days after Justice Alton Davis was defeated in his bid to retain the seat that he had been appointed to months earlier. Five days later, on November 9, 2010, the Supreme Court vacated its earlier order granting the application for leave to appeal. Justice Cavanagh, joined by former Chief Justice Kelly and Justice Hathaway, dissented, arguing that the Court's decision to deny the application leaves in place an “allocation of costs” approach, whereby a no-fault insurer was responsible only for the incremental costs of modifying a home as opposed to paying for the entire cost of housing accommodations. This approach, they argued, was inconsistent with the purpose of the No-Fault Act.

We still may not have the last word from the Supreme Court on this issue. The application for leave to appeal in Ward v Titan Ins Co, 287 Mich App 552, 791 NW 2d 488 (2010) is still pending before the Michigan Supreme Court. In Ward, the
Court of Appeals held that the lower court had erred when it awarded claimant the full amount of housing costs that he incurred, as opposed to the difference between the standard apartment that he had been living in prior to the accident, and the cost of a handicapped-accessible apartment. Essentially, the Court of Appeals ruled that the no fault insurer was responsible only for the incremental increase in the costs of housing. The Supreme Court issued an order in late September 2010, holding the application for leave to appeal in Ward v Titan in abeyance, pending its decision in Wilcox. The application in Wilcox has now been vacated, but as of the date this report was prepared, the Supreme Court has yet to make any decisions on the application in Ward.

Providers and Attorney Fees

On February 2, 2011, the Michigan Supreme Court granted leave to appeal in Miller v Citizens Ins Co, 288 Mich App 424, ___ NW 2d ___ (2010). In Miller, the Court of Appeals ruled that counsel representing the injured party was entitled to take a one-third attorney fee from medical expenses he recovered for a medical provider from the No fault insurer, even though there was no attorney-client relationship between the provider and counsel. In its order granting leave to appeal, the Supreme Court ordered the parties to brief to the following issues:

1. Whether a medical care provider that is not a party to the agreement with Plaintiff’s counsel may be liable for all or a portion of counsel’s fee and the basis for such liability, if any;
2. If there is such liability, the manner in which the amount of the liability is to be determined.

As those of who practice regularly in this area will attest, there has been ongoing dispute between medical providers and attorneys representing injured claimants over whether the claimant’s attorney is entitled to take his or her attorney fee from the amount of medical expenses paid by the insurer, particularly when those expenses are not disputed by the no-fault insurer. Hopefully, the Michigan Supreme Court will clarify this area once and for all.

Supreme Court Reluctantly Accepts Expansion of Coverage for Benefits Arising From Theft of Motor Vehicle

On January 13, 2011, the Michigan Supreme Court issued an Order denying the Application for Leave to Appeal in Henry Ford Health System v Esurance Ins Co, 288 Mich App 593, ___ NW 2d ___ (2010). In Henry Ford, the Court of Appeals overturned a jury verdict in favor of Defendant insurer and ruled, as a matter of law, that the no-fault insurer was obligated to pay no-fault benefits to the passenger in a motor vehicle insured by Esurance Insurance Company, which had obviously been stolen. The Court of Appeals determined that under the ambiguous language of MCL 500.3113(a), the injured claimant would need to be involved in the “unlawful taking” of the motor vehicle before being disqualified from recovering benefits under MCL 500.3113(a). A mere “unlawful use” of the vehicle, without an involvement in the actual taking of the vehicle was insufficient. In a concurring opinion, Justice Markman (joined by Chief Justice Young, and Justices Maura Corrigan and Mary Beth Kelly) noted that affording coverage in these situations:

“[G]oes far beyond the scope of what an insurer reasonably bargains for when it enters into a policy with the owner of a vehicle, and responsible citizens will inevitably pay these costs through higher premiums. If the coverage in these cases is what is intended by the Legislature, I must defer to its judgment; if, however, it is not, the Legislature should take clear notice that no-fault benefits are now recoverable even by persons who ‘fault’ pertains to theft, car jacking, and shootouts with the police, rather than ‘fault’ pertaining only to negligent or careless driving of a motor vehicle.”


The Supreme Court is clearly signaling its intent that if a change is to be made to the exclusionary provision set forth in MCL 500.3113(a), it is up to the legislature, not the court, to make such changes.

Named Excluded Driver

On December 17, 2010, the Michigan Supreme Court granted the Application for Leave to Appeal in Progressive Michigan Ins Co v Smith, 287 Mich App 537, 791 NW 2d 480 (2010). The Supreme Court docket number is 141255. In Smith, the Court of Appeals reversed a grant of summary disposition in favor of the No Fault insurer, and determined that because Progressive did not incorporate the exact statutory warning of MCL 500.3009(2) into the certificate of insurance, it could not deny liability coverage for an accident arising out of the use of the insured motor vehicle by the named excluded driver. The statutory warning is reproduced below:

“Warning—when a named excluded person operates a vehicle all liability coverage is void—no one is insured. Owners of the vehicle and others legally responsible for the acts of the named excluded person remain fully personally liable.”
In this case, the insurer substituted the word “responsible” for “liable” in the certificate of insurance and on the face of the policy. Judge Markey dissented, noting that the terms “liable” and “responsible” were synonymous.

In granting leave to appeal, the Supreme Court ordered the parties to brief the issue of “whether the legislature intended to include the final sentence of MCL 500.3009(2) in the required notice provisions of the insurance documents described in that provision.”

Licensure of Adult Foster Care Facilities

On February 13, 2011, the Supreme Court partially reversed the decision of the Michigan Court of Appeals in its unpublished decision in Healing Place v Farm Bureau, (no. 286050, rel’d 8/5/2010). In doing so, the Supreme Court re-affirmed the importance of making sure that medical care facilities are properly licensed to provide the services being rendered for the injured claimant. The Court of Appeals had reversed the Oakland County Circuit Court’s grant of summary disposition in favor of the no-fault insurer, which had ruled that the services provided to the injured claimant were akin to those provided by adult foster care facilities. However, this facility (The Healing Place) was not so licensed. The Supreme Court relied upon the dissent authored by Judge Wilder, who noted that “the injured claimant required supervision on an ongoing basis but did not require continuous nursing care.” Under MCL 400.703(4), the services should have been provided by an adult foster care facility. Again, the facility (headed by the late Roman Frankel) was not so licensed, and therefore the services were unlawfully rendered were under MCL 500.3157.

Court of Appeals Recap

Bystander Entitled to Recover No-Fault Benefits

In Boertmann v Cincinnati Ins. Co., __ Mich App __, __ NW 2d __ (decision rel’d 3/8/2011, docket number 293835), the Michigan Court of Appeals held that an individual who was not physically involved in a motor vehicle accident could nonetheless recover benefits as a result of witnessing the death of her son. In Boertmann, Plaintiff was operating a motor vehicle insured by Cincinnati Insurance Company. She was driving behind her son, who was operating a motorcycle. Plaintiff witnessed the collision between her son’s motorcycle and another motorist and, as a result of this collision, her son was killed. Plaintiff then began suffering symptoms of post-traumatic stress disorder, including nightmares and recurrent images and thoughts of the accident. Her physical symptomatology included insomnia, fatigue, nausea, nosebleeds, loss of sleep, loss appetite, nightmares and severe headaches.

Defendant argued that pursuant to the Court of Appeals’ decisions in Williams v Citizens, 94 Mich App 762, 290 NW 2d 76 (1980) and Keller v Citizens, 199 Mich App 714, 502 NW 2d 329 (1993), plaintiff was not entitled to recover no-fault benefits, as she was not physically ‘involved’ in the motor vehicle accident. Ruling that plaintiff was entitled to recover no-fault benefits, the Court of Appeals drew a distinction between hearing an accident (Keller and Williams) and actually witnessing the accident itself. The court also noted that in Keller, Plaintiff’s injury was as a result of her son’s death. In this case, though, the injuries (according to plaintiff’s psychologist) were the result of witnessing the fatal collision, which resulted in her son’s death. Arguably, this is a distinction without a difference, and it remains to be seen if the insurer files an application for leave to appeal with the Michigan Supreme Court.

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