Building a Better Section

We completed the strategic planning process last year and since then we have been taking steps to implement it. The stated values in our two-year strategic plan is that the guiding principles of the section shall remain as they have from the inception of the section; namely, to provide an exchange of information and education across all areas of practice that are affected by insurance and indemnity issues and to do so in a way that fairly includes the viewpoints of both insurers and policy holders.

Our long-term plan calls for more of the Section’s business to be carried out by committees rather than directly by the Council so that the Council acts more as a governing body. To put that into effect we have now defined and staffed the committees that will be responsible for the work of the Section. There remains plenty of space on each of the committees for members to get involved and we encourage each of you to consider joining a committee. If you are interested in joining a committee to serve the Section and our membership, please contact me directly or any of the committee members identified below.

Membership Committee

Our membership continues to grow. At last count we had 561 members, including members in Connecticut (three), Illinois (seven), Massachusetts, Minnesota, Mississippi, Missouri (two), New Jersey, Ohio (two), Pennsylvania (two), Tennessee, Texas, Wisconsin, and Ontario.

We are pleased with the breadth of our membership in geographical terms and we want it to continue to be broad in terms of issues and orientation. The Section has a strong policy of being neutral as between insureds and insurers, and we want our membership to be diverse as well.

To encourage more membership growth, we have created a Membership Committee, consisting of Amy Iannone (chair), amy.iannone@bartonmalow.com, Dan Steele, dstelee@VGpcLAW.com, and Kathleen Lopilato, lopilato.kathleen@aons.com. We would like to arrange for a representative of our Section to speak to other sections or other groups of lawyers to explain what we do and how we can benefit them which will, hopefully in turn, increase the membership of our section. If you know of any sections or groups that might be interested in a short presentation on the benefits of membership in our Section, please contact any of the Membership Committee members.

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Along these lines, one of the goals for the Membership Committee is to create a comprehensive directory of our members which will include enough details about each member’s area of practice so that it is a valuable networking and reference tool for our membership. Finally, this committee will examine whether our Section should adopt a mentoring program for new or young lawyers interested in insurance and indemnity law.

Programs Committee

We will be reaching out to other sections to explore their interest in jointly presenting programs. In connection with that, our Program Committee is now fully staffed. If you are a member or leader in another section and you have any ideas for joint programs with our section and yours, please contact our Program Committee members: Elaine Pohl (chair) epohl@plunkettcooney.com, Loretta Pominville, lpominville@primeoneinsurance.com, Nicole Wilinski, nwilinski@plunkettcooney.com, Kimberly Roppel, kroppel@dickinsonwright.com, or Jill Krolikowski, jill@thegoodfirm.com.

Publications Committee

We also have a Publications Committee, which is in charge of putting together the Journal. The members are Hal Carroll (Editor), hcarroll@VGpcLAW.com and Larry Bennett, lbennett@gmhlaw.com. The Journal goes to judges and legislators in Michigan, so it is a good way to reach decision-makers with reasoned arguments. Like the Section itself, the Journal takes no sides but it accepts articles from all sides.

If you have an idea for an article or for a regular feature, contact either of the committee members.

Strategic Planning Process

The strategic planning process calls for us to work on a five-year plan for the growth of the Section, and to carry that out, we formed a committee consisting of the and Adam Kutinsky (chair) adam.kutinsky@kitch.com, Hal Carroll, Lauretta Pominville, and Elaine Pohl. The primary goal of adopting a “macro” five-year strategic plan is so that successive Councils can create and operate on one-year strategic plans with specifically stated goals and with the hope that this promotes a near seamless process for our membership when there is a leadership change.

As always, the Council welcomes any input you have and we encourage you to get involved.

**INSURANCE COVERAGE QUESTIONS OR REFERRALS?**

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One Word, Two Meanings: “Intentional” Under Worker’s Compensation Part Two Coverage

By Catherine L. Heise, Amerisure Insurance

Henry Ward Beecher said, “All words are pegs to hang ideas on.” As lawyers, we deal daily with the nuances and vagaries of language, always searching for le mot juste to polish our argument. The law sometimes even leads us into that semantic wonderland where one word, in the same situation, means two different things.

Such is the case with “intentional,” when encountered in the context of an employee alleging a tort against his or her employer in avoidance of the general immunity provided by the Workers Disability Compensation Act. Although these cases are uncommon in Michigan, an intentional act lawsuit against an employer may trigger a duty to defend or indemnify under Part Two, “Employers Liability Insurance,” of the employer’s Workers Compensation Policy.

The insuring agreement for Part Two states that the worker’s compensation insurer will pay “all sums you legally must pay” as damages for “bodily injury to your employees” that “arise out of and in the course of the injured employee’s employment by you.” This coverage, however, is limited by Exclusion 5 to Part Two, which states that the policy does not cover “bodily injury intentionally caused or aggravated by you.” (Emphasis added).

The tort liability exception to the general rule of employer immunity under the Workers Disability Compensation Act (“WDCA”) is governed by MCL 418.131(1), which states that:

The right to the recovery of benefits as provided in this act shall be the employee’s exclusive remedy against the employer for a personal injury or occupational disease. The only exception to this exclusive remedy is an intentional tort. An intentional tort shall exist only when an employee is injured as a result of a deliberate act of the employer and the employer specifically intended an injury. An employer shall be deemed to have intended to injure if the employer had actual knowledge that an injury was certain to occur and willfully disregarded that knowledge. The issue of whether an act was an intentional tort shall be a question of law for the court.

Actual and “Deemed” Intent

The “intentional” act exception to the immunity granted by the statute can thus be attained two ways. The third sentence of the section states that an “intentional tort shall exist only when an employee is injured as a result of a deliberate act of the employer and the employer specifically intended an injury.” The courts have construed this to mean that in order to state a claim against an employer for an intentional tort, the “employer must deliberately act or fail to act with the purpose of inflicting an injury upon the employee.”

The second way, as described in the fourth sentence of s 131(1), is more problematic. It states that an employer “shall be deemed to have intended to injure if the employer had actual knowledge that an injury was certain to occur and willfully disregarded that knowledge.” The Michigan Supreme Court has held that this standard is a “legislative recognition” of a “limited class of cases” where employer liability is possible “despite the absence of a classic intentional tort.” This second exception will be employed when there is “no direct evidence of intent to injure, and intent must be proved with circumstantial evidence.”

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In cases where the insured is a corporation, and under *Travis*, a corporation is vicariously liable only where “some employee…act[s] with the requisite intent to impute an intentional tort to a corporation.” 10 *Travis* stated that a plaintiff may establish a corporate employer’s actual knowledge by showing that a supervisory or managerial employee had actual knowledge that an injury would follow from what the employer deliberately did or did not do. 11 Once an injured worker establishes “actual knowledge” via a corporate employee, then the “actual knowledge” and “injury certain to occur” must flow from that knowledge in order to satisfy the requirements of the second sentence of the immunity exception.

An employer faced with a lawsuit that alleges “intentional” acts may naturally be concerned about whether the defense or indemnity obligation of its insurer is triggered, given the language of Exclusion 5, which precludes coverage for bodily injury “intentionally caused or aggravated” by the insured. 12 The duty to defend may even extend to actions that are groundless, false or fraudulent, so long as the allegations against the insured even arguably come within the policy coverage. 14

**“Deemed” Intent and the Duty to Defend**

The case of *Cavalier Mfg Co v Employers Ins of Wausau*, 15 dealt specifically with Part Two of a workers compensation policy issued to the plaintiff’s employer. Wausau had withdrawn its defense of the employer after the court ruled that the employee’s allegations, if proven, would establish an intentional tort. 16 *Id.* at 333. The policy had the standard exclusionary language cited above – it would not cover “bodily injury intentionally caused or aggravated” by the insured. The court clearly identified the issue: whether a statutory “intentional tort” meant the same thing as the policy’s exclusion for bodily injury “intentionally caused.” 17

The *Cavalier* court called the second part of the “intentional” tort definition a “legislatively created intent to injure,” and stated that the statute “defines intent to injure when in fact no such intent exists.” 18 The *Cavalier* court took due notice of the phenomenon of “identical words meaning different things,” but concluded that the policy exclusion related only to “true intentional torts.” 19 Construing the language of the exclusion strictly against the insurer, the court held that the statutory intentional tort was not “outside the ambit of coverage afforded by the policy.” 20 When the Court of Appeals revisited *Cavalier* in light of *Travis*, it still maintained that the exclusion required that the intent underlying the act causing injury must actually be to cause injury. 21

**Conclusion**

Employers and their insurers, therefore, should be aware that until the facts of the case establish that the employee’s injury was “intentionally caused,” the insurer’s duty to defend under a reservation of rights is most likely triggered. Facts developed through discovery may show that the insured employer acted only negligently or recklessly, in which case the entire case may be subject to a summary disposition. If the facts as developed show either a true intent to injure, or circumstantial evidence of intent, then exclusion 5 applies and the insurer may attempt to withdraw its defense of the employer. The point to remember, therefore, is that in the rare circumstance where an employee may allege intentional injury in a lawsuit, an employer should not fail to explore its right to a defense under its workers compensation policy.

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**About the Author**

*Catherine L. Heise* is a Council member of the State Bar of Michigan Insurance and Indemnity Law Section. She is a corporate claims consultant at Amerisure Insurance Company.

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**Endnotes**

1. MCL 418.101 et seq.
2. ISO Workers Compensation Form WC 00 00 01A
3. *Id.*
4. *Id.* “Who is an Insured” means “you…if you are an employer named in Item 1 of the Information Page.”
5. Emphasis added.
Supreme Court Action

Supreme Court Clarifies Scope of Exceptions to Parked Vehicle Exclusion

As readers of this column are probably aware, no-fault benefits are generally not payable for accidental bodily injuries arising out of the ownership, operation or use of a parked motor vehicle as a motor vehicle, unless one of the three statutory exceptions to the Parked Vehicle Exclusion applies. The Michigan Supreme Court recently issued its decision in Frazier v Allstate Ins Co, docket number 142545, rel’d 12/21/2011, which clarifies the scope of the Parked Vehicle Exclusion and the statutory exceptions to it.

In Frazier, plaintiff was injured when she slipped and fell on a patch of ice while closing the passenger door of her vehicle. She had just finished putting some personal items into the passenger compartment and had stepped out of the way of the door when she closed it and fell. Both feet were “planted firmly on the ground outside of the vehicle,” and she was in no way reliant on the vehicle itself to maintain her balance.

The court examined whether the injury was sustained by Plaintiff “while occupying, entering into or alighting from the vehicle,” the third statutory exception to the Parked Vehicle Exclusion. After examining the dictionary definition of the term “alight,” (meaning ‘to dismount from a horse, descend from a vehicle, etc.’ or ‘to settle or stay after descending; come to rest’), the Supreme Court concluded that the alighting process “begins when a person initiates the descent from a vehicle and is completed when an individual has effectively ‘descended from a vehicle’ and has ‘come to rest’ – when one has successfully transferred full control of one’s movement from reliance upon the vehicle to one’s body,” which is “typically accomplished when ‘both feet are planted firmly on the ground.’” Accordingly, under the circumstance of this case, plaintiff had already completed the process of “alighting from” the vehicle. As a result, she was not entitled to no-fault benefits under the third exception to the statutory exclusion set forth in MCL 500.3106(1).

The court also observed that under the second exception to the Parked Vehicle Exclusion, MCL 500.3106(1)(b), injuries may be compensable under the No-Fault Insurance Act if the injury “was a direct result of physical contact with equipment permanently mounted on the vehicle, while the equipment was being operated or used . . . .” Plaintiff argued, both in the Circuit Court and in the Court of Appeals, that the vehicle’s door constituted “equipment.” Again, the Supreme Court examined the dictionary definition of the term “equipment” and simply noted that the car door, as well as the individual component parts of a vehicle, cannot constitute “equipment,” because the statute requires that any “equipment” be “mounted on the vehicle.” According to the Supreme Court, the fact that the Legislature chose to require that “equipment” be permanently mounted on the vehicle “indicates that the constituent parts of ‘the vehicle’ itself are not ‘equipment.’” Frazier, Slip Opinion at pages 2-3.

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Justice Marilyn Kelly, joined by Justice Cavanagh, dissenting on the basis that the jury’s determination that Plaintiff was alighting from her vehicle when she was injured should not be disturbed. Justice Hathaway dissented on the basis that there was no reason for the Michigan Supreme Court to “take any further action in this unique, fact-specific case that should have no precedential value.”

The outcome of Douglas v Allstate Ins Co has the potential for significantly clarifying the quantum of proofs necessary to support a claim for attendant care services. It also has the potential for limiting the rate of pay for attendant care services to pay rates, not agency rates, as referenced by Judge [now Justice] Zahra in his opinion in Bonkowski v Allstate Ins Co, 281 Mich App 154, 761 NW 2d 784 (2008).

Other Supreme Court Action – Leaves Granted

**Supreme Court to Address Scope and Compensability of Attendant Care Services**

On December 7, 2011, the Michigan Supreme Court granted leave to appeal in Douglas v Allstate Ins Co, Court of Appeals docket number 295484, unpublished decision rel’d 6/23/2011. Douglas involved a claim for no-fault benefits arising out of a catastrophic accident that occurred in July 1996, when the Plaintiff was struck by a motor vehicle while riding a bicycle. As a result, Plaintiff suffered a traumatic brain injury. Following a four-day bench trial, the lower court awarded attendant care benefits at the rate of seven hours per day for weekday aide care from May 31, 2004, through November 1, 2007, sixteen hours per day of weekend aide care during that same period of time and forty hours per week from November 1, 2007, through November 18, 2009, all at the rate of $40.00 per hour.

On appeal, the Court of Appeals vacated that portion of the judgment which permitted payment of attendant care benefits from November 7, 2006, through November 18, 2009, due to certain problems with the documentation that was submitted to the court, and remanded the matter back to the lower court for further fact finding. Specifically, the aid provider (plaintiff’s wife) apparently did not maintain records of the attendant care services that she was claiming in the lawsuit. At best, she submitted an “Affidavit of Attendant Care Services” for the preceding months. The court also observed that some of descriptions of her services, such as “breakfast lunch dinner” were “vague” and that, in other instances, the description of her services, on the forms, were blank. There was also evidence that Plaintiff’s wife was employed as a rehabilitation aide by plaintiff’s attending psychologist, Dr. Thomas Rosenbaum Ph.D., at his head injury rehabilitation program known as “TheraSupport.” However, the court did not appear to take plaintiff’s wife’s employment with Rosenbaum’s head injury program into consideration when calculating the hours of attendant care services to be awarded.

The Court of Appeals also determined that the $40.00 per hour rate, which is the rate charged by Dr. Rosenbaum’s agency, TheraSupport, was “within the range of evidence” under Sharp v Preferred Risk, 142 Mich App 499, 370 NW 2d 619 (1985).

In its order granting leave to appeal, the Michigan Supreme Court ordered the parties to brief the issue of whether the Court of Appeals erred in remanding the case for further proceedings (essentially giving Plaintiff a second bite at the apple) even though the Court of Appeals found that the lower court “clearly erred in awarding attendant care benefits to the plaintiff without requiring sufficient documentation to support the daily and weekly hours underlying the award.” The parties were likewise ordered to address “whether the activities performed by Katherine Douglas constituted attendant care under MCL 500.3107(1)(a) or replacement services under MCL 500.3107(1)(c).” Finally, the parties were ordered to brief whether the trial court “clearly erred” in awarding attendant care benefits at the rate of $40.00 per hour. The outcome of Douglas v Allstate Ins Co has the potential for significantly clarifying the quantum of proofs necessary to support a claim for attendant care services. It also has the potential for limiting the rate of pay for attendant care services to pay rates, not agency rates, as referenced by Judge [now Justice] Zahra in his opinion in Bonkowski v Allstate Ins Co, 281 Mich App 154, 761 NW 2d 784 (2008).

**Supreme Court to Address Whether Excess Replacement Service Expenses are Compensable in Third Party Automobile Negligence Action**

Also on December 7, 2011, the Michigan Supreme Court granted leave to appeal in Johnson v Recca, 292 Mich 238, __ NW 2d __ (2011). In Johnson, Plaintiff was involved in a motor vehicle accident while a pedestrian. The motorist who struck her was insured with Allstate. Because Plaintiff did not have a policy of no-fault insurance available to her in her household, she turned to Allstate for payment of her no-fault
benefits including household replacement service expenses. She likewise included a claim for household replacement service expenses in excess of the daily and yearly limitations set forth in MCL 500.3107(1)(c) in her automobile negligence claim against the other motorist. (MCL 500.3107(1)(c) limits payment of replacement service expenses to $20.00 per day for up to three years following the date of loss.) The tort defendant noted that the excess economic loss provision, found in MCL 500.3135(3), states:

“(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by [MCL 500.3101] was in effect is abolished except as to:

* * *

(c) Damages for allowable expenses, work loss, and survivor’s loss as defined in [MCL 500.3107 to MCL 500.3110] in excess of the daily, monthly, and 3-year limitations contained in those sections.”

 Defendant argued that household replacement service expenses are neither “allowable expenses,” “work loss” nor “survivor’s loss.” Therefore, excess household replacement service expenses are not compensable in a tort action. The Court of Appeals ruled that household replacement service expenses were simply a sub-species of “allowable expenses,” otherwise referenced in MCL 500.3107(1)(a). Therefore, household replacement service expenses, in excess of the $20.00 per day and three-year limitation set forth in MCL 500.3107(1)(c), are compensable.

In its order granting leave, the Michigan Supreme Court ordered the parties to brief the issue of whether or not the “family joyriding” exception enunciated by the Michigan Supreme Court in Priesman v Meridian Mutual Ins Co, 441 Mich 60, 490 NW 2d 314 (1992) allowed Spectrum Health to recover payment of the medical expenses incurred by Craig Jr., or whether there was a simple “unlawful taking” of the vehicle, which would exclude Crain Jr. and his medical provider, Spectrum Health, from recovering any no-fault benefits. A decision is expected before the end of the Court’s current term on July 31, 2012.

In Progressive v DeYoung, Supreme Court docket number 143330, the court was again confronted with another “unlawful taking” situation. In DeYoung, the injured party was a named excluded driver on his wife’s no-fault policy with Progressive. She had repeatedly forbidden him from using her vehicle. Nonetheless, he took his wife’s vehicle without her consent and, while intoxicated, was seriously injured in a motor vehicle accident. Again, the insurer argued that the family member joyriding exception enunciated by the Michigan Supreme Court in Priesman, was inconsistent with the statutory language utilized in MCL 500.3113(a), and should be overruled.

**Material Misrepresentation and Residual Limits**

In Titan Ins. Co. v Hyten, Supreme Court docket number 142774, the Michigan Supreme Court will address the issue of whether or not an insurer can reform its residual bodily injury liability policy limits to the statutorily required minimum policy limits of $20,000.00/$40,000.00, in light of material misrepresentation contained in an application for insurance. In this case, the Court of Appeals had ruled that the status of the insured’s driver’s license was “easily ascertainable” by the insurer. Thus, even though there was no statute which created a duty, on the part of the insurer, to verify the status of one’s driver’s license, the Court of Appeals nonetheless ruled that the insurer was estopped from lowering its liability coverage limits. Again, a decision on this case is expected prior to the end of the Supreme Court’s current term on July 31, 2012.

Finally, in Admire v. Auto-Owners, Supreme Court docket number 142842, the Supreme Court is considering the issue of whether a No fault insurer was responsible for the entire cost of a modified van for a catastrophically injured claimant, or just the cost of the modifications themselves. Again, a decision is expected before the end of the Supreme Court’s current term on July 31, 2012.

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No-Fault Corner
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Court of Appeals Action

Cost of Medical Supplies

On February 16, 2012, the Court of Appeals issued a published opinion in *Bronson Methodist Hosp. v Home Owners Ins Co.*, __ Mich App __, NW 2d __ (Court of Appeals docket number 300566, rel’d 2/16/2012), which, for the first time, allows a no-fault insurer to obtain information regarding the cost of medical supplies purchased by a medical facility in order to determine whether its charges for those same medical supplies are “reasonable” under MCL 500.3107(1)(a).

In *Bronson*, one Gavin Powell was seriously injured in a motor vehicle accident in July 2009. He was treated at Bronson Methodist Hospital and incurred charges totaling $242,941.09, of which $61,237.50 was for “supply/implant” products. Another individual, Hector Serrano-Ruiz, was involved in an accident on July 17, 2009, and incurred medical expenses at Bronson Methodist Hospital totaling $143,477.76, of which $28,810.00 was for “supply/implant” products.

The no-fault insurers for each of these individuals, Auto-Owners Insurance Company and Home-Owners Insurance Company, sought information from the hospital regarding the hospital’s cost for the “supply/implant” products that were utilized by the hospital to treat the injuries suffered by these individuals. The hospital refused to provide that information and filed suit against the no-fault insurer. The lower court refused the insurer’s demand that it be provided with the cost information for the “supply/implant” products from the hospital.

On appeal, though, the Michigan Court of Appeals reversed and concluded that, “the actual cost of the durable medical equipment is certainly a piece of the overall ‘collage of factors’ affecting the reasonable rate of plaintiff’s charges.” Therefore, the cost of the actual “supply/implant” products utilized was a relevant factor, to be presented to the trier of fact, in order to demonstrate whether the medical provider’s charges were “reasonable” or whether the markup was excessive.

Legislative Action

Bill to Eliminate Lifetime Medical Coverage

The House of Representatives Committee on Insurance recently reported out a bill that would dramatically reform the Michigan No-Fault Insurance Act by, *inter alia* eliminating the lifetime, unlimited medical expense coverage that is currently required in the State of Michigan. However, as of the date this article is being prepared, the full House of Representatives has not acted on the bill. If and when the measure is passed by the House of Representatives and forwarded to the Senate for consideration, an analysis of the bill will appear in these pages.

Endnotes

1 See MCL 500.3106(1).
2 See MCL 500.3106(1) (c).
3 Frazier, Slip Opinion at pages 3-4.
Consumer Complaints in the Office of Financial and Insurance Regulation

By Sarah G. Wohlford, Office of Financial and Insurance Regulation

Among its many functions, the Office of Financial and Insurance Regulation (OFIR) assists consumers who have a complaint regarding a regulated entity.

OFIR encourages consumers to first contact the insurance company or agent directly, in order to attempt to resolve a dispute. If this cannot be accomplished, OFIR encourages consumers to ask the entity to provide a written response to the complaint. If a consumer cannot resolve the complaint on his or her own, then OFIR’s Consumer Services Division may be able to help.

Non-Health Coverage Complaints

A complaint submitted to the Consumer Services Division should include: a complaint letter; the name of the insurer and/or agent involved; any relevant policy and claim numbers; details of previous contacts regarding the dispute; and copies of all documents that will help verify or explain the dispute.

Once OFIR receives a complaint, the consumer is notified of the complaint process and a file number is assigned. OFIR then contacts the parties named in the complaint and sends them a duplicate copy of the complaint letter. OFIR then asks for a written response to the complaint letter, which OFIR reviews to determine if it: (1) complies with policy language; (2) complies with all applicable Michigan laws, rules and other directives of the Commissioner; (3) addresses the issues raised in the complaint; and (4) is reasonable in light of approved and accepted business practices.

OFIR then provides the complainant with a response detailing its findings and explaining the reason for the outcome, citing applicable laws and policy language where necessary. If additional information comes to light that could change the outcome of the complaint resolution, a complainant should submit it to OFIR.

While OFIR works diligently to resolve all consumer complaints, there are limitations to what OFIR can do. OFIR’s authority is limited to the entities it regulates. Entities that are not licensed by OFIR are not governed by the dispute resolution process. Similarly, OFIR only has authority over contracts issued in Michigan. If a contract was issued outside Michigan, that state’s regulatory authority should be contacted instead. Finally, OFIR has no authority over third party liability claims. OFIR cannot accept complaints from parties other than those involved in the contract (e.g., a health care provider).

Health Coverage Complaints

If a complaint involves health coverage, the process is different. If a complaint involves an adverse determination (i.e., a claim denial, coverage discontinuance; or refusal to provide authorization for a health care service), a policyholder is entitled to appeal through the health carrier’s internal grievance process. (Health coverage complaints that do not involve an adverse determination are handled in a manner similar to non-health coverage complaints.)

Health carriers are required to establish an internal grievance process. The process is initiated when a policyholder submits a written grievance to the carrier. If a policyholder submits a complaint to OFIR before going through the internal grievance process, OFIR will forward the complaint to the carrier and request a copy of the final decision.

The internal grievance process must completed within 35 calendar days, and entitles policyholders to appear before the carrier’s board of directors or designated grievance committee. Alternatively, policyholders may have the right to a management-level conference to complete the grievance. Carriers are required to notify a policyholder of the final determination in writing. Carriers must also notify policyholders of their right to an external review pursuant to the Patient’s Right to Independent Review Act (PRIRA).2

PRIRA requires a covered person to exhaust the carrier’s internal grievance process before seeking external review, unless the request is considered to be “expedited.” An expedited request is one in which the adverse determination “involves a medical condition of the covered person for which the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function as substantiated by a physician either orally or in writing.”

PRIRA provides for a preliminary review by the Commissioner in order to decide whether or not to accept the request for external review. If a request appears to involve issues of medical necessity or clinical review criteria, then the Commissioner must send the request to an independent review organization (IRO). If the request appears to involve contractual issues, then the Commissioner may review the request or send it to an IRO at his discretion.4 The Commissioner is required to review the IRO’s recommendation to ensure that it is not contrary to the terms of coverage.5

continued on the next page
After the Commissioner completes a review of the IRO's recommendation, the Commissioner issues a notice of decision. A decision is a final administrative remedy. However, PRIRA provides that "a person aggrieved by an external review decision may seek judicial review within 60 days from the date of the decision in state circuit court." PRIRA does not preclude a health carrier or a covered person from seeking other remedies available under applicable federal or state law.

Provider Complaints

As noted above, OFIR generally cannot accept complaints from parties other than those involved in the relevant insurance contract. However, in certain circumstances, OFIR will pursue complaints from participating providers of Blue Cross Blue Shield of Michigan, health maintenance organizations, alternative finance and delivery systems, and Delta Dental Plan of Michigan, if the provider is party to a participation agreement with one of the listed entities. OFIR may also pursue complaints from providers acting as the authorized representatives of patients covered by a Michigan licensed health carrier.

Failure to pay clean claims in a timely manner is among the reasons why a provider may submit a complaint to OFIR. Public Act 316 of 2002 (codified at MCL 500.2006) governs clean claim payments.

Endnotes

1 This article reflects the views of its author and should not be construed as an official agency statement, position, interpretation, or guidance.
2 MCL 550.1901 et seq.
3 MCL 550.1913(1)(a)-(b).
4 MCL 550.1911(6)-(7).
5 MCL 500.1911(15).
6 MCL 500.1911(16).
7 MCL 500.1915(1).
8 MCL 550.1915(1).
9 MCL 550.1915(2)-(3).
settles a claim that alleges both active and passive fault, it is barred from obtaining common law indemnity.9

**Active vs Passive Fault.** Obviously, the distinction between active and passive fault is important here. This odd terminology roughly translates to a distinction between direct and vicarious liability, although it is broader than that.6 The underlying principle is that the party whose “liability arises only by operation of law” is entitled to indemnity because that is “passive fault.” From the perspective of public policy, this is because “liability should fall upon the party best situated to adopt preventive measures.”7 If both the potential indemnitor and indemnitee are passively negligent, then indemnity is not owed at all.8

**Implied Contractual Indemnity**

Implied contractual indemnify is thought of as a hybrid theory, halfway between common law and contractual indemnity. In real life, the theory almost never comes into play. A plaintiff seeking indemnity may include a count in implied contractual indemnity, but it almost never goes anywhere.

Implied contractual indemnity does not fit easily into the pattern of the other two. Common law indemnity is all equity and no contract; fault is critical to the obligation – the indemnitor must be at fault and the indemnitee must be free of active fault. Express contractual indemnity is all contract and no equity. Fault is irrelevant unless the parties choose to make it relevant in the contract.

**Pleading.** The rule of pleading is different from common law indemnity. For common law indemnity, the allegations of the principal complaint alone control. For implied contractual indemnity, however, the allegations of the potential indemnitee’s third party complaint must also be considered.

To determine whether a third-party plaintiff has stated a cause of action for indemnity based on an implied contract, the court must look to the third-party complaint as well as the original complaint.9

The official formulation of the theory calls for a “special relationship” or a course of conduct.

An implied contract to indemnify arises only if there is a “special relationship between the parties or a course of conduct whereby one party undertakes to perform a certain service and impliedly assures indemnification.”10

“**Special Relationship.**” The phrase “special relationship” is part of the standard formulation, but it does not appear to play any part in the analysis. To put it another way, the actual cases where the implied contractual indemnity theory has been applied arise out of a course of conduct. Perhaps a “special relationship” can be inferred from that course of conduct, but if so, “special relationship” is a conclusion and not a premise. It may be a vestigial remnant of the case that is seen as the progenitor of the rule. In that case there was arguably a bailment that preceded the fault, and perhaps the phrase was a reference to that.11 If “special relationship” referred to a relationship recognized in law that has an independent factual basis, like a bailment, that would make some sense. In any event, in the actual cases, the phrase does not appear to play a real part in applying the theory.

**Course of Conduct - Actual Cases.** In reality, the cases in which the implied contractual indemnity theory has actually been applied fit into a narrow pattern. The owner of a factory buys a piece of equipment and asks the manufacturer to leave off a guard, promising to position the equipment in such a way that the guard will not be needed. The factory owner fails to keep its promise, an employee is injured and sues the equipment manufacturer. The manufacturer is entitled to indemnity under the implied contractual indemnity theory.12

**Comment.** In this author’s opinion, implied contractual indemnity might well be explained better by applying promissory estoppel theory.

The elements of promissory estoppel are (1) a promise, (2) that the promisor should reasonably have expected to induce action of a definite and substantial character on the part of the promisee, and (3) that in fact produced reliance or forbearance of that nature in circumstances such that the promise must be enforced if injustice is to be avoided.13

These elements fit the actual cases described above quite well, although no court has applied a promissory estoppel analysis.

**Conclusion**

The indemnity that most often comes into play is express contractual indemnity, and it is fair enough that express contractual indemnity gets most of the attention. In future columns, we’ll discuss it in more detail.

But common law indemnity and implied contractual indemnity have their places as well, and it is worth having some familiarity with the first two steps of the trilogy. The pleadings requirements are especially worth remembering because it is possible to trip up at that stage. ■

**Endnotes**

1 Portland v Citizens Telephone Co, 206 Mich 632, 636; 173 NW 382 (1919.)

continued on the next page
Common Law
Continued from page 11

6 The list is extensive and, upon request, the author will provide a list of which faults he thinks are passive and which are active.

Directors & Officers Liability Insurance

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

Authors’ Note: This article is the second in what is intended to be a regular series on the subject of professional liability insurance in the Journal. This piece discusses directors and officers (D&O) liability insurance, which is meant to provide coverage for management exposures to businesses and their officers and directors.

Directors and officers liability insurance, also known as “D&O” insurance, is a form of management liability insurance. It is unique, but still falls in to the general category of professional liability coverage and shares many of the same traits, including claims made coverage triggers, extended reporting periods, payment of defense costs and indemnity, and strict claim reporting requirements.

Management liability is a constantly evolving risk for organizations and includes litigation concerning regulated and non-regulated securities, management fraud, non-disclosure, merger and acquisition transactions, fiduciary responsibility, SEC investigations, and direct shareholder claims.

Today, D&O insurance generally protects against management exposures to business entities, and not just their directors and officers. The original purpose of D&O coverage was to facilitate unfettered but sound business judgments by management, who would know they were protected from a direct shareholder claim even if the organization were to become insolvent and unable to fulfill its indemnity obligations to management. As the types of claims being brought have evolved, so has the coverage provided, which has resulted in some changes that make the policy broader than the protection for organization leaders.

D&O coverage may be purchased by for-profit enterprises, both private and public, as well as non-profit businesses, and is generally characterized by a unique coverage form split into separate parts or “sides”. The first part provides direct coverage to directors and officers when the organization is not legally obligated to indemnify them for a loss (side A), the second part reimburses the insured organization when it is legally obligated to indemnify its directors and officers for loss (side B) and a third optional part (entity coverage) provides coverage for securities related and other types of claims when the company itself is a defendant (side C).

To avoid stacking of coverage, side A is usually limited to losses for which the entity does not or cannot provide indemnity to the management insureds. In other words, if there is management liability, but no right to indemnity from the organization, side A will cover the loss. Conversely, if there is management liability and the director or officer insured is entitled to indemnity from the organization, side B is triggered.

Side C or “entity coverage,” which is usually optional, provides direct insurance coverage to the organization as opposed to coverage for the organization’s indemnity obligations to its management. Although Side C is optional, and most prudent organizations purchase it, entity coverage may not always be
in the directors and officers interest because it could erode the limits available to them.

D&O policies are written on unique forms developed by each individual carrier, which requires insureds to take an active role in negotiating the appropriate policy based upon the intended risk management goals. As indicated above, the original purpose of D&O insurance was to protect the individual directors and officers of the corporation from suits in which they are personally named. This same purpose is usually a good starting point for evaluating the appropriate coverage to obtain.

Especially for non-profit organizations, as in health care, for which securities law and derivative suits are unlikely, D&O coverage has become as sort of gap liability policy covering risks that property, personal injury and professional liability policies do not cover. Typical coverages added for entities and employees in addition to the directors and officers include antitrust, civil rights, criminal defense costs, and employee benefit errors and omissions. Often the D&O policy by endorsement furnishes employment practices liability coverage relied upon by the organization; in fact, the primary reason many smaller organization buy D&O insurance is to get access to cost-effective EPL coverage.

As might be expected of a policy designed to fill gaps, the insurer does not want to expand liability beyond the gaps – as a result, D&O liability insurance is characterized by very limiting definitions and exclusions to coverage. These exceptions achieved by definition or exclusion are for any claim involving bodily injury, a claim for payment of fraudulently obtained gain, knowing violations of the law, claims by one insured against another insured, and punitive damages, including multiplied damages such a for antitrust judgments. Moreover, even if a claim is covered, the corresponding trigger may be limited. A classic example is that although defense costs for criminal or regulatory violations may be covered, those costs may not be payable unless formal charges like an indictment or regulatory complaint are brought. Typically today when dealing with corporations, the government and the corporation will try to settle before those formalities are invoked and while the costs at the pre-indictment phase are very substantial and prevent formal action ever being taken, they are not covered because the trigger has not been met.

Also presumably because of the gap coverage nature, empirically there seem to be more technical denials and reservation of rights with D&O than any other type of insurance. Notice is a big issue and it is not unusual for the D&O carrier to deny coverage based on technicalities in a way that other insurers do not. For example, D&O carriers may deny coverage for a regulatory matter based upon “late notice” after determining that a plaintiff brought a personal injury claim 4 years earlier, despite the fact that the personal injury claim would not have been covered by the D&O policy. Because the personal injury plaintiff alleged the same wrongdoing as the government alleged in its claim, the D&O carrier claims that it was entitled to notice of the prior claim. Truly, an insured looking to assure coverage needs to be very aggressive in reporting anything that sounds like it could be a matter within the scope of D&O coverage.

In summary, the D&O policy is something much broader than coverage for directors and officers of businesses. While it always includes directors and officers, the policy by option – an option that most sizable corporations think they must elect – extends coverage to the corporation and all of its employees. While the policy’s original intent focused on securities liability, today it is a source of many coverages, so that even many organizations that have little securities law risk buy entity coverage to cover risks that are difficult to cover in any other way. Because of the technical way in which D&O policies are written and sensitivities of the policy issuers to being stuck with more coverage than they intended, more often than other types of liability policies there tends to be a clash of expectations and intentions between the insurer and insured.

About the Authors

Greg Drutchas and Adam Kutinsky co-chair the insurance coverage practice at the Kitch Drutchas Wagner Valitutti & Sherbrook. Greg Drutchas is the former chair of the Insurance Law Committee and Adam Kutinsky is an officer of the State Bar of Michigan Insurance & Indemnity section and a CPCU*. They may be reached at (313) 965-7900 or greg.drutchas@kitch.com
Sixth Circuit

When is an accident an accident?


The Sixth Circuit had recent occasion to review another accidental death and dismemberment insurance claim with compelling facts. Just nine days after delivering their second child, the plaintiff’s wife died as a result of a pulmonary embolism, which she sustained in connection with her recovery from surgery to repair a leg fracture. While bedridden, evidently a blood clot formed and fatally travelled to the decedent’s lungs. The policy at issue expressly excluded coverage for death caused by “circulatory malfunction.” The parties agreed that a pulmonary embolism is a circulatory malfunction. However, the plaintiff argued that the *cause* of the circulatory malfunction - relating to the broken leg - was accidental, so that coverage should not be excluded. Expressing sympathy over the circumstances, the court nonetheless rejected the plaintiff’s argument and upheld the plan’s interpretation. From the insurer’s perspective, this case is an example of a policy containing clearly drafted exclusions, and from the insured’s perspective, this case demonstrates that an accident is not always an accident when it comes to insurance proceeds.

Letting Employees Chose Among Pension Investment Options Doesn’t Always Protect Employer if it was a Bad Option


Many employer sponsors of 401(k) plans allow their employees to decide where to invest his or her retirement funds. Usually, the plan provides a variety of investment options. And if the employer is publicly traded, employer stock is usually one of those options. Many employers also think that if each employee makes his or her own investment choices, then the employer is insulated from fiduciary liability exposure. See ERISA 404(c). While this may be correct in some cases, it is not always true—especially when the company stock drops in value and the company files for bankruptcy protection.

This class action case arose out of the General Motors bankruptcy. State Street was the fiduciary for two GM 401(k) plans. Employees participating in either plan controlled how their accounts were invested and could change their allocations on any business day. Among several funds, employees could invest in GM common stock, and the plaintiffs alleged that some $1.45 to $1.9 billion in plan assets was so invested. As information about GM’s shaky financial condition became public, the plaintiffs alleged that State Street had a fiduciary duty under ERISA to stop allowing plan participants to invest their retirement funds in GM stock.

The Sixth Circuit allowed the case to proceed. Since the case was at the pleading stage, the question was really whether the plaintiffs had made sufficient allegations to proceed, not whether those allegations were actually proven.

The Court had little trouble agreeing that the plaintiffs had sufficiently alleged State Street had breached its fiduciary duty. Under ERISA, a fiduciary must operate prudently and solely in the interests of plan participants. It must monitor and screen investment alternatives to ensure that imprudent options are not offered to plan participants. When an investment becomes imprudent, the fiduciary must divest the plan of that imprudent option, even if it is the participants and not the fiduciary that makes the investments, and even if the terms of the plan require that investment option.

One other issue: several circuits -- including the 6th Circuit -- have adopted a rule sort of akin to the business judgment rule. This rule says that a fiduciary’s decision to remain invested in employer securities is presumed reasonable, although subject to rebuttal if the plaintiff can show the fiduciary’s decision was imprudent. Although the 6th Circuit had adopted this rule, this case holds that the presumption does not apply at the pleadings stage.

United States District Court

Failure to Verify Dependent Status Results in Recovery of Overpaid Benefits


Many employee benefit plan participants were accustomed to the initial enrollment of dependents and then never giving a second thought to notifying the employer or plan administrator if, for example, a child outgrew the coverage eligibility, or if marital status changed so that an ex-spouse was no longer eligible for coverage (or was eligible for coverage under COBRA). With the rising cost of health insurance, more and
As part of its dependent eligibility audit, on four occasions, the defendant asked the plaintiff to provide documentation in the form of income tax returns and proof of residency of his various dependents. The plaintiff did not provide the requested information for four of his claimed dependents and as a result, the defendant deducted payments from the plaintiff’s paycheck as reimbursement for benefit payments that were made on those dependents’ behalf. Although the plaintiff provided a divorce judgment indicating that he was obligated to provide health benefits for one of his daughters until she turned 18, the tax returns he supplied did not list that daughter as a dependent. As a result, the court agreed that the defendant did not act arbitrarily or capriciously by determining that the daughter was ineligible for coverage after she turned 18 due to the plaintiff’s failure to follow plan procedure and verify her eligibility. The court also held that the plaintiff failed to exhaust his administrative remedies with respect to the three remaining audits, which were never appealed internally before filing suit.

**Beneficiary Designations - Put It in Writing**


In another case involving competing claims to life insurance proceeds following a change in marital status, a judgment of separate maintenance was entered just one month before the husband’s death due to a motorcycle accident. Although the stipulated judgment of separate maintenance expressly extinguished the rights of either party to any life insurance proceeds from a policy or annuity covering the life of the other party, here the wife submitted deposition testimony from three individuals who testified that the husband indicated his desire to “re-designate” his wife as his beneficiary on his life insurance policy.

Because the wife was still the designated beneficiary, the court initially held that the insurance company was obligated to pay her the proceeds in compliance with the terms of the ERISA plan. However, the Court then applied the rationale of *Sweebe v Sweebe*, 474 Mich 151 (2006) (involving waiver of insurance proceeds in a divorce judgment), and held that the plain language of the judgment of separate maintenance waived the spouse’s right to retain the proceeds of the life insurance policy. As a result, the court ordered that the funds must be relinquished to the estate. In response to the wife’s submission of deposition testimony regarding the decedent’s intention, the court found that the decedent did not substantially comply with the plan requirements that a designation or change of beneficiary must be in a signed writing.

As we have previously reported, most ERISA claim denials are reviewed by a court under an “arbitrary and capricious” standard; that is, the denial will be upheld unless the claimant proves not only was the denial wrong, but it was so wrong that it was arbitrary and capricious. Further, in most cases, the court will only review evidence that was presented to, considered by, or perhaps available to the plan when it denied the claim; the court will generally not take new evidence or even allow discovery. Many claimants believe that these are significant burdens to overcome, but every now and then, a case comes along where the claimant wins -- even with these burdens. This was such a case.

After reviewing the facts in the case, the court found the review and denial was arbitrary and capricious. The court found that the plan did not acknowledge or discuss evidence presented by the plaintiff and simply adopted the conclusory statements of its “physician reviewer” who similarly failed to discuss the plaintiff’s treating physician’s diagnosis or the plaintiff’s test results. (Further, the physician reviewer only reviewed records and did not actually examine the plaintiff.) While the Plan is not required to adopt a claimant’s position, it must at least give reasons for why it is rejecting that position. There was also some suggestion that a key piece of medical evidence supporting the claim was improperly removed from the file (or, at the very least, the Plan knew plaintiff had sent it to the plan twice, but the Plan made no real attempt to get it.)

The Court has an interesting discussion on two other issues. First, although an ERISA claimant must normally exhaust any appeal procedure provided by the plan before filing suit, the Court held that exhaustion would have been futile in this case and thus excused.

Second, when a court overturns a benefit denial, it will generally remand the claim back to the plan administrator for further consideration unless the claimant is “clearly entitled” to benefits. The court found that this plaintiff was “clearly entitled” to benefits and thus declined to remand. That may not be noteworthy. But in considering remand, the court used language such as “This Court declines to give the plan administrator a second bite at the apple.” Those comments seem inconsistent with the US Supreme Court’s 2010 opinion in *Conkright v. Frommart*, 160 S.Ct. 1640 (2010) where the majority rejected the concept of applying “one strike and you’re out” to a review of a plan administrator’s “second bite at the apple.” (The *Peshke* Court did not cite *Conkright.*)

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If a Plan Excludes Out-of-Network Providers, the Benefit Is Not Covered Even if No In-Network Providers Provide the Benefit.


This is another case involving claims by the parents of autistic children that health plans cover their children’s autism treatment. But unlike other cases, this decision denied the claim.2

The child had been receiving treatment for his autism. But in 2008, Boyle’s employer switched to a self-funded plan that excluded benefits for treatment by out of network providers. The child’s provider was out-of-network. And so the Court upheld the denial.

The court also rejected Boyle’s argument that his out-of-network claim should be paid because there was no in-network provider that provides this same treatment. Although he tried to provide the court with proof that no in-network provider provided the treatment, the court refused to consider the evidence because it had not been previously presented to the Plan. (Generally, a reviewing court will only review evidence that was previously submitted to the plan. See discussion in Peshke, above.) But even if the evidence had been previously submitted, it appears unlikely that the court would have allowed it to overcome the plain language of the Plan – particularly since there was evidence in the administrative record that identifies in-network providers.

About the Authors

Mike Shpiece is Of Counsel at Kitch Drutchas Wagner Valitutti & Sherbrook in Detroit. He specializes in Employee Benefits, Insurance and Health Care law. He is also an Adjunct Professor of Law at the Wayne State University Law School.

Kimberly J. Ruppel is a Member in Dickinson Wright’s Troy office. Ms. Ruppel is a commercial litigator who specializes in ERISA and insurance litigation. Her practice includes defending and counseling companies in areas such as life, health and disability benefit claims, breach of fiduciary duty allegations, plan interpretation, coordination of overlapping policy benefits, and breach of provider and supplier contracts.

Endnotes
1 The firm of one of the co-authors represented the defendant in this matter.
2 The firm of the co-authors has represented BCBS of Michigan in similar matters.

Published Court of Appeals Decisions

“Occupying” a motor vehicle for UIM coverage

Westfield Ins Co v Ken’s Service
___ Mich App ___ (2012)
(Docket No. 300941)

In this UIM dispute, the policyholder’s employee sought benefits under his employer’s commercial auto policy as an occupant of the insured tow truck. The policy afforded up to a $1,000,000 in UIM coverage for any person “occupying a covered ‘auto.’” The term occupying was defined in the policy as “in, upon, getting in, on, out or off.” At the time of the accident, the employee had parked the tow truck on the shoulder of the road and had exited the cab. He then spent several minutes attaching a cable to the disabled vehicle to pull it out of a ditch. When the employee was struck by a passing car, he was standing alongside the bed of the tow truck, with two feet on the ground, while one hand was operating the levers on the control panel and the other hand was grasping the rail of the flat bed for support. There was no dispute that the employee was not in, or getting in, on, out or off the tow truck. As to whether the employee was “upon” the truck, the court agreed with the insurer and concluded that he was not upon the truck within the meaning of the policy definition of “occupying.”
Unpublished Court of Appeals Decisions

CGL indemnity coverage for a bodily injury claim

Secura Ins Co v Farm Bureau Ins Co of Michigan
Unpublished per curiam, December 22, 2011, app lv pending
(Docket No. 298106)

This case arises out of a construction site accident, which resulted in a lawsuit by the injured worker against the general contractor. In an earlier declaratory judgment action brought by Secura as the insurer for an involved subcontractor, it was declared that Secura’s policy covered that subcontractor’s contractual indemnity liability to the general contractor. Secura had breached its contract in refusing to pay the defense costs of the general contractor and those costs were awarded as damages for the breach.

The liability case went to trial and resulted in a no-cause verdict. Afterward, Secura filed suit against the injured worker’s employer and its liability insurer (Farm Bureau) to recoup the cost of defending the general contractor. Secura argued that its coverage was excess to the Farm Bureau policy and alternatively, argued unjust enrichment. The court held that Secura was barred by res judicata from litigating primary/excess coverage because it could have done so in the prior declaratory judgment action. The court also declined to apply principles of equity because there was no finding of fault in the underlying case that would support an equitable reallocation of the defense costs.

Exclusions for damage to property on which the insured is working

Looking Good Lawns v Secura Ins Co
Unpublished per curiam, January 10, 2012
(Docket No. 301805)

The insured lawn service company applied the wrong herbicide to its customers’ lawns, causing the grass to die along with the weeds. Its Business Owners Policy insurer declined coverage for the resulting claims. That decision was upheld by the Court of Appeals under the exclusion for damage to “that particular part of real property on which you or any contractor or subcontractor working directly or indirectly on your behalf is performing operations, if the ‘property damage’ arises out of those operations,” and also under the exclusion for damage to “that particular part of any property that must be restored, repaired or replaced because ‘your work’ was incorrectly performed on it.” The court went on to further hold that the herbicide exception to the pollution exclusion did not create coverage where it was expressly excluded by an altogether different exclusion.

Fraud claims do not arise out of an “occurrence”

Frankenmuth Mut Ins Co v Mitch Harris Building Co, Inc
Unpublished per curiam, January 31, 2012, reconsideration pending (Docket No. 300481)

In this case, a condo owner sued the defendant developer for defects and deficiencies in her unit and in the common elements. Her claims were ultimately narrowed down to claims of fraud, misrepresentation, fraud in the inducement, and silent fraud. The court ruled that the developer’s liability insurer, Frankenmuth, had no further duty to defend because none of the remaining claims arose out of an “occurrence.” The essential elements of those claims required an intentional or reckless act, and thus were not accident-based. An insurer’s duty to defend ends when the claims against the policyholder are confined to theories outside the scope of coverage.

Joint venture is not insured

Ibrahimovic v Medmarc Casualty Ins Co,
Unpublished per curiam, January 19, 2012
(Docket No. 298469)

Plaintiff hired two different attorneys to handle two separate claims - a workplace accident and an auto accident. They shared the same office and administrative services but were not formal partners. Plaintiff later sued for legal malpractice and the question arose as to whether the attorneys were a joint venture because the applicable liability policy did not cover the insured’s liability arising out of a joint venture. The court enforced the policy definition of “who is an insured,” which excluded any person or organization involved in a joint venture. The case was remanded for further proceedings because there was a question of fact about whether a joint venture had been formed.

This opinion also addresses the effect of an insurer’s failure to reserve specific coverage defenses while defending under a reservation of rights. The rule is that failure to reserve does not create coverage where coverage is not otherwise afforded, with two exceptions. One is where the coverage facts could and should have been resolved in the underlying action and were not. The other is where the insurer’s actions create some inequity that outweighs the inequity of forcing the insurer to assume a risk it never agreed to assume.

UM three-year limitations period enforced

Mopkins v Nat’l Indemnity Co
Unpublished per curiam, December 13, 2011
(Docket No. 299621)

Plaintiff, an employee of the policyholder, waited more than three years to file his claim for uninsured motorist benefits under the employer’s commercial auto policy. He argued

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that the three-year limitations period in the contract should not apply because the insurer failed to produce the policy on request and failed to advise him of the time limitation. He did not claim that insurer actively misled him. The court was “not willing to impose on defendant” an “equitable duty to disclose” and further noted that plaintiff had asked for the policy with two years yet remaining on the limitations period but never followed up with that request.

UIM limits based on insurance available for the underinsured vehicle

Brainerd v Home-Owners Ins Co
Unpublished per curiam, February 23, 2012
(Docket No. 301675)

Plaintiff’s decedent was fatally injured in a motor vehicle accident while a passenger in a vehicle insured by Home-Owners. The tortfeasor’s policy had liability limits of $500,000, but due to the fact that multiple persons were injured in the accident, the decedent’s estate only received $230,000. The Home-Owners policy afforded occupants UIM coverage up to $500,000 per person/occurrence. Plaintiff was denied coverage, however, because the total limits of all available liability insurance was equal to the Home-Owners limit. Plaintiff argued that the Home-Owners policy did not provide for “set-offs” but the court reviewed the policy as a whole and determined that based on the declarations of the policy, and the “Limit of Liability” provisions in the UIM endorsement, coverage was limited “to the amount by which the underinsured-motorist coverage limits exceed the total limits of all bodily injury policies available to the owner of the underinsured vehicle [not the injured person, emphasis added].” The Court rejected the claim that “available” was ambiguous in this context.

Notice of settlement with tortfeasor required for UIM coverage

Hegyi v Auto Club Ins Group
Unpublished per curiam, December 15, 2011
(Docket No. 298539)

Plaintiff policyholder was injured in an auto accident and settled with the tortfeasor for the $20,000 in liability limits under the tortfeasor’s policy. He then applied to his own insurer for underinsured motorist benefits, which were denied because of his failure to provide the required 30-day notice of settlement. Both the trial and appellate courts agreed that plaintiff’s failure to comply with the “consent to settle” condition barred coverage. Plaintiff argued that he never received the endorsement containing the notice requirement but the insurer produced evidence that the endorsement had been sent to plaintiff’s address in the same package as the renewal notice in 2005, 2006 and 2007, and none of the packages was ever returned. Plaintiff’s mere denials were not sufficient to rebut the presumption of receipt under the “mailbox rule.”

Plaintiff argued that he never received the endorsement containing the notice requirement but the insurer produced evidence that the endorsement had been sent to plaintiff’s address in the same package as the renewal notice in 2005, 2006 and 2007, and none of the packages was ever returned. Plaintiff’s mere denials were not sufficient to rebut the presumption of receipt under the “mailbox rule.”

Coordination of UM policies: “escape” and “excess” clauses

Beddingfield v Vaughn
Unpublished per curiam, January 19, 2012, app lv pending
(Docket No. 300471)

Plaintiff was a passenger in a vehicle struck by an uninsured vehicle. The policy covering the vehicle in which she was a passenger was insured with Farm Bureau under a policy that included UM coverage up to $500,000. Plaintiff’s own auto policy with State Farm included UM coverage up to $100,000. Coordination was the issue. Farm Bureau’s “other insurance” clause was a true escape clause, stating that if there was UM coverage available to an occupant under a different policy, “this coverage will not apply.” State Farm’s policy was excess for the policyholders injured in vehicles other than an insured auto. The Court of Appeals relied on case law holding that excess coverage is not readily available coverage and concluded that the “other insurance” clauses conflicted, and thus did not apply and that the coverage had to be coordinated between both policies on a pro rata basis.

Limited mold coverage

Williams v Home-Owners Ins Co
Unpublished per curiam, December 20, 2011
(Docket No. 301158)

A power outage caused the sump pump in plaintiffs’ home to fail, which in turn caused water to enter the basement and
create the conditions for mold, which developed later. Plaintiff's homeowners policy excluded coverage for such water intrusions except that it contained a “sump pump” endorsement that gave back coverage up to $5,000 for this type of water event. The policy also contained a “mold endorsement” granting coverage for mold damage if caused by a “covered cause of loss,” but only up to the limits afforded for that covered cause of loss. The court agreed with Home-Owners that the mold coverage available for this claim was limited to $5,000, because the cause of loss—the sump pump failure—was only insured up to that limit. Plaintiffs alleged a factual question as to the cause of the water damage but never produced any evidence of what that other cause might be.

Homeowner's policy: sufficiency of proof of loss

Pearson v Flood Professionals, Inc
Unpublished per curiam, January 24, 2012
(Docket No. 298359)

In this case, the court reversed summary disposition on the adequacy of a proof of loss required by homeowner's policy because there was a question of fact about whether the insured's proofs were satisfactory. The insurer had extended the deadline for submission more than once and had allowed the insured to submit multiple forms of proof. “The issue regarding satisfactory proof of loss in light of the facts and circumstances of this case presented an issue for the trier of fact.” Judge Beckering's concurring opinion is noted for those interested in examining this issue more closely.

Calculating property loss for the innocent coinsured when the home is not rebuilt

Hicks v Auto Club Group Ins Co (On Remand)
Unpublished per curiam January 24, 2012, app lv pending
(Docket No. 295391)

This case was remanded by the Supreme Court after it adopted the dissenting opinion in an earlier Court of Appeals opinion, the result of which was to reinstate coverage for an innocent coinsured wife. As reported in the last issue of this Journal, the wife was not a participant in her husband's scheme to exaggerate their property loss after a fire in their home. On remand, the Court of Appeals was directed to address issues not previously considered, relating to the proper calculation of the loss and whether all or only half of the loss was to be paid by the insurer.

In this current opinion, the Court of Appeals unanimously held that because the wife was the only name on the purchase contract for the house, she had the insurable interest in the property, not her husband, and could thus collect the full amount available under the policy. As to that coverage, Auto Club relied on the provision in its policy stating that it would only pay ACV until the repairs or replacement were completed, at which time it would tender the difference to pay RCV. Because this house was never rebuilt, Auto Club argued that it owed “actual cash value” only. The Court, however, looked to MCL 500.2827 and Cortez v Fire Ins Exch, 196 Mich App 666 (1992) and held “when the replacement cost exceeds the policy limits, an insurer cannot withhold replacement cost proceeds even if the insured did not repair or replace the insured property.”

No “bad faith” actions in Michigan and thus no attorney fees

Travier v Auto Club Group Ins Co
Unpublished per curiam February 23, 2012
(Docket No. 301122)

Auto Club took nearly a year to adjust plaintiff's claim for a fire loss, in part because of a police investigation into arson. The claim was not paid until after the insured had filed suit. At issue was whether the insured was entitled to attorney fees for the insurer's alleged “bad faith” in delaying payment on the claim. The court declined to carve out an exception to the “American Rule” for what the insured described as bad faith because “Michigan does not recognize an independent tort for bad faith in the handling of insurance claims.” The American Rule applied and the court thus rejected the “argument that Auto Club's allegedly dilatory handling of her claim entitles her to attorney fees.”

Accurate disclosure statement required for stop loss policy

Evangelical Presbyterian Church v American Fidelity Assurance Co
Unpublished per curiam, January 12, 2012
(Docket No. 299625)

Plaintiff policyholder is a religious organization with an employee benefit plan that is partially self-insured. The insured pays benefits up to a certain amount and then relies on a “stop loss” policy to pay any excess. In applying for coverage each year, the insured is required to prepare a disclosure statement identifying every covered plan member who received a certain amount in benefits the preceding 12 months, and must also identify every covered plan member known to have a diagnosis that might lead to reimbursements. For the policy year in question, the disclosure statement failed to identify two plan members who should have been disclosed. The insurer thus denied requests for excess benefit reimbursements for these members. In an opinion upholding the denial of coverage, the Court of Appeals held that the insurance agent who assisted the policyholder in preparing the renewal application was an agent of the policyholder, not the insurer, and that the

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plain language of the policy and the disclosure statement both conveyed that the statement was incorporated into the policy, which unambiguously provided that reimbursements would not be paid for persons improperly omitted from disclosure.

The “renewal rule” is an exception to the general requirement that policyholders must read their policies, and is derived from principles of equity and estoppel. “When a policy is a renewal, the insured is not obligated to read the entire policy to ensure that the terms have not changed.” Rather, it is the obligation of the insurer to call to the insured’s attention any changes that reduce coverage.

Umbrella policy barred coverage for claim by family member

*Home-Owners Ins Co and Auto-Owners v Leikert*
Unpublished per curiam, January 26, 2012, lv app pending (Docket No. 301571)

Defendant husband and wife purchased an umbrella liability policy from Auto-Owners. The policy excluded coverage for “personal injury to you or a relative,” except “to the extent that insurance is provided by an underlying policy listed in Schedule A.” Policyholder wife was injured in a motorcycle accident in which she was the passenger on the motorcycle operated by her husband. She sued her husband and obtained a default judgment. The liability insurer for the motorcycle paid its policy limits, after which the policyholder wife looked to the Auto-Owners umbrella policy to cover the remaining liability of the husband. Auto-Owners denied coverage because the motorcycle policy was not listed in Schedule A. That decision was upheld by both the trial and appellate courts because “[i]t is undisputed that [policyholder wife] falls within the definition of ‘you or a relative’ . . . . Consequently, the exclusion applies to preclude coverage except to the extent that insurance is provided by an underlying policy listed in Schedule A.” Because the exception to the exclusion plainly requires the policy to be listed on Schedule A, the [policyholders] cannot rely on the policy that they had with Progressive Insurance,” which was not scheduled.

No coverage where complaint never tendered to insurer

*Kamen v Spectrum HR, LLC*
Unpublished per curiam, December 1, 2011 (Docket No. 299585)

Plaintiff sued Spectrum HR, her former employer, for wrongful discharge. At the time, Spectrum was insured by Lexington Insurance Company under a policy that covered certain employment-related claims. After obtaining a default against the defunct Spectrum HR, plaintiff attempted to garnish the Lexington policy. Lexington defended on the ground that the insured never tendered the claim. The trial court denied Lexington’s motion for summary disposition, after which the matter was submitted for decision on stipulated facts. There was evidence that Aon, Spectrum’s insurance agent, had received the complaint filed by plaintiff and had passed it along to Lexington shortly after suit was filed. But that agent withdrew the claim a few days later, stating that it was at the policyholder’s direction. Most of this opinion revolves around evidentiary issues, including hearsay. The coverage ruling is that the insurance agent was the agent of the policyholder and because the claim was never tendered to Lexington for coverage, its policy was not available to satisfy the default judgment.

Renewal rule not applicable to policies issued after move to new state

*Ruzak v USAA Ins Agency, Inc (On Remand)*
Unpublished per curiam of December 1, 2011, lv app pending (Docket No. 288053)

This is the third Court of Appeals opinion generated in this case. In this opinion, the court considered the “renewal rule” as applied to an auto policy issued to a policyholder after he moved to a different state. The “renewal rule” is an exception to the general requirement that policyholders must read their policies, and is derived from principles of equity and estoppel. “When a policy is a renewal, the insured is not obligated to read the entire policy to ensure that the terms have not changed.” Rather, it is the obligation of the insurer to call to the insured’s attention any changes that reduce coverage. But when the insured moves to a new state and receives a policy for that state, the new policy is not a renewal and the renewal rule thus does not apply. It is not reasonable for an insured to expect that policy terms will remain the same from state to state.
Construction Defect Claims as Occurrences: Part III

By James A. Johnson, johnsonjajmf@hotmail.com ©2012

“You can guard against the high percentage of risk but you can’t guard against risk itself.”

Introduction

One of the most litigated issues in insurance law is whether construction defect claims constitute “occurrences” under the Commercial General Liability (CGL) policy. This article answers the question in the affirmative and explains the nascent majority view. This paper should be read in conjunction with Construction Defect Claims as Occurrences Part I and Part II in the January and July 2011 issues of the Journal of Insurance and Indemnity Law.

Currently the majority view is that construction defects constitute “occurrences” with the Supreme Courts of Tennessee, Indiana, Florida, Alaska, Wisconsin, South Dakota, Mississippi, Georgia, Texas, South Carolina, Minnesota, and Kansas. These states all find in favor of policyholders. Moreover, Colorado, Arkansas, Hawaii, and South Carolina have passed statutes that essentially mandate that construction defects are “occurrences.”

Analysis

In determining if construction defects are “occurrences,” the analysis should focus on whether the faulty workmanship and resulting damage was expected or intended by the insured. If the faulty workmanship in a construction project and the resulting damage were unexpected and unintended by the contractor, it follows that the resulting construction defects and any related property damage were caused by an “occurrence.”

The rules of insurance policy interpretation dictate that construction defects are “occurrences.” Under the rules of insurance interpretation, such as contra proferentem, the reasonable expectations doctrine, and the principle that requires construing the policy as a whole, there is no question that construction defects are “occurrences.” All of the policy provisions should be analyzed, including the business risk exclusions to determine if the policy covers the claim at issue. Contractors do not intend for their workmanship to be faulty or defective. Nor do they generally expect that their work will result in property damage.

Thus, when construction work is done defectively it generally is an “accident.” If construction defects were not “occurrences” the business risk exclusions, which purport to exclude coverage for certain risks inherent in doing business, would be superfluous. The drafters of the Commercial General Liability policy did not intend to provide illusory coverage to contractors. And, contractors who purchase CGL insurance expect that liability claims will be covered under CGL policies they purchase. This expectation is reasonable because contractors are in the construction business.

Insurance companies maintain that allowing coverage for construction defects convert CGL policies into performance bonds because such claims are reasonably foreseeable and therefore not “accidents.” This counsel maintains that permitting recovery for construction defect claims does not convert the Commercial General Liability into performance bonds. Performance bonds are issued to the owner to ensure that the construction will be completed. CGL policies insure the contractor against third party claims and lawsuits. Thus, performance bonds and liability insurance provide financial security to different entities and requires a separate and independent analysis of the facts.

In applying the expected or intended language the majority of courts have adopted the subjective test. These courts have reached their conclusions by applying the definition of “occurrence” to the facts of the case. And, then determined it was undisputed that the insured did not expect or intend to do the work defectively or cause the resulting damage.

Case Law


OHIO – Erie Ins. Exchange v Colony Dev. Corp., 736 NE 2d 941, 947 (Ohio App.1999) – property damage caused by contractor’s negligence in constructing and designing a condominium complex reasonably falls within the policy’s definition of property damage caused by an occurrence i.e., an accident.

MASSACHUSETTS – Quincy Mutual Fire Ins, Co v Abernathy, 469 NE 2d 797, 800 (Mass. 1984) - an injury is nonaccidental only where the result was actually, not constructively intended.

LOUISIANA – Great American Ins Co v Gaspard, 608 So2d 981, 985 (La. 1992) – the subjective intent of the insured is the key and not what the average or ordinary reasonable per-

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son would expect or intend; Williams v City of Baton Rouge, 731 So2d 240, 253 (La. 1999) – the subjective intent of the insured will determine whether an act is intentional.

ALABAMA – USF & G Co v Armstrong, 479 So 2d 1164, 1167 (Ala 1985) – the legal standard to determine whether the injury was either expected or intended is a purely subjective standard.

NEW HAMPSHIRE – High Country Assoc v New Hampshire Ins Co, 648 A2d 474, 478 (NH 1994) – property damage to condominium units caused by defective workmanship is an “occurrence” within the meaning of the CGL policy.

Conclusion

When you apply the rules of policy interpretation such as contra proferentem, the reasonable expectations doctrine together with construing the policy in its entirety, the ineluctable conclusion is that construction defects are occurrences. Contractors do not expect or intend to do their work defectively. Moreover, construction defects must be “occurrences” in order for business risk exclusions to have any purpose. Also, the subcontractor exception would be superfluous.

In the final analysis, the test should be subjective whether the damage was actually expected or intended by the insured and not whether the damage was reasonably foreseeable. If construction defects were not “occurrences” under CGL policies, the coverage would be illusory. Therefore, construing CGL policies as a whole leads inexorably to the conclusion that construction defects are “occurrences.”

About the Author

James A. Johnson of Southfield, Michigan is a trial lawyer. Mr. Johnson concentrates on insurance coverage under the Commercial General Liability policy. He is an active member of the Michigan, Massachusetts, Texas and Federal Court Bars. Mr. Johnson can be reached at 248-351-4808 or www.JamesAJohnsonEsq.com

Endnotes


2 Sheehan Const. Co., Inc v. Continental Cas. Co., 935 NE 2d 160 (Ind. 2010) modified on other grounds, 2010WL1535322 (Ind.2010) – if faulty workmanship is unexpected and without intention or design and not foreseeable from the viewpoint of the insured, then it is an accident within the meaning of a CGL policy.

3 United States Fire Ins Co v JSUB, 979 So 2d 871, 883 (Fla 2007) – defective soil work done by subcontractor that caused damage to homes was an occurrence under CGL policies.

4 Fejes v Alaska Ins Co, 984 P 2d 519, 523 (Alaska 1999) – improper or faulty workmanship constitutes an accident.

5 American Family Mut Ins Co, 673 NW 2d 65, 70 (Wis 2004) – settlement of soil after building was completed that caused the building’s foundation to sink was property damage caused by an occurrence within the meaning of the CGL policies general grant of coverage.

6 Corner Construction Co., v U.S. Fid. & Guar. Co., 638 NW 2d 887, 894-95 (SD 2002) – construction defects resulting in ventilation problems constituted an accident and such damage is covered by the policy at issue.

7 Architex Assn Inc v Scottsdale Ins Co., 27 So 3d 1148, 1162 (Miss 2004) – the term “occurrence” cannot be construed in such a manner as to preclude coverage for unexpected or unintended property damage resulting from negligent acts or conduct of a subcontractor, unless otherwise excluded or the insured breaches its duties after loss.

8 American Empire Surplus Lines Ins v Hathaway Dev Co, 707 SE 2d 369, 372 (Ga 2011) – an occurrence can arise where faulty workmanship causes unforeseen or unexpected damage to other property.

9 Lamar Homes, Inc v Mid-Continent Cas Co, 242 SW 3d 1, 9 (Tex 2007)- no basis exist in the definition of “occurrence” to distinguish between damage to the insured’s work and damage to a 3rd party’s property from an occurrence as defined in the CGL policy.


11 Wanzale Const, Inc v Employers Ins of Wausau, 679 NW 2d 322 (Minn 2004).

12 Lee Builders, Inc v Farm Bureau Mut Ins Co, 137 P3d 486, 493 (Kan 2006).


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