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Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.
From the Chair

After a long, harsh winter, it finally is starting to look like Spring. As we all begin to come out of hibernation, our Section is looking forward to several upcoming opportunities to serve you. We are pleased to announce that our Annual Membership Meeting and Program will be held on Thursday, September 18, 2014, beginning at 9:30 in conjunction with the State Bar of Michigan’s annual meeting. This year’s meeting will take place in Grand Rapids at the DeVos Place. Details will follow, but please mark your calendars, as this promises once again to be our signature event for the year.

New Listserv

We have set up a new listserv so that we may be able to communicate better as a Section via electronic means. Please look for an electronic notice from me in the near future in your email inbox.

Searchable Directory

In addition, we continue to make strides on our Searchable Directory of members. Inside this issue of the Journal is an announcement with the details of how to sign up, and we encourage you to do so. You will recall that the purpose of the directory is to make the expertise of our Section members available to other members of the Section, and to other attorneys and any courts that might find our members’ expertise useful.

Section’s Position of Proposed Bar Restructuring

You may be following recent developments relating to the State Bar of Michigan and certain efforts to change the structure of the State Bar, including possibly making membership voluntary. Our Council recently voted to formally oppose certain proposed legislation to change the structure of the State Bar. Our opposition is posted on the State Bar’s website along with many other sections who took similar steps. We continue to follow developments in this area closely and I will keep you apprised of any further positions that our Council takes. If you have any input on this issue (or any others), please feel free to contact me.

Contributing to the Section

Every Section is as strong as its members’ participation. There are several ways that you, as a member, can participate in your Section:

• **Join a committee.** All sections do much of their work through committees. If you are a new member, this is a good way to jump start your networking. No experience required!

• **Recruit new members.** Tell other attorneys about the Section. Insurance and indemnity law touches on so many areas of practice that our Section has much to offer for most of the members of the State Bar.

• **Be an informal liaison.** If you are active in another section, raise the topic of joint activities.

• **Write an article.** If you have some expertise you would like to share, the Journal is a great place to do it. Remember, it goes to judges as well as Section members, so you will reach a wide audience.

• **Suggest a program.** Is there some topic that you think could be the focus of a program? Maybe a short program of a “homeward bound” type. Let us know.

― Elaine M. Pohl, Plunkett Cooney

Editor’s Notes


The Journal – now in its seventh year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. All opinions expressed in contributions to the Journal are those of the author. We welcome all articles of analysis, opinion, or advocacy. The Section itself takes no position on issues.

Copies of the Journal are mailed to all state circuit court and appellate court judges, all federal district court judges, and the judges of the Sixth Circuit who are from Michigan. Copies are also sent to those legislators who are attorneys.

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

State Bar of Michigan Insurance and Indemnity Law Section
Suggestions for Improving Your Chances When Applying for Leave to Appeal to the Michigan Supreme Court

By Frederick M. Baker, Jr., of counsel to Willingham & Coté*

As one who has practiced before the Michigan Supreme Court, and who for eight years was privileged to serve the court as a Commissioner, I have observed (and probably myself committed) some fundamental errors by appellate counsel, both experienced and inexperienced, at the critical application stage. Apart from mistakes that can be ascribed to lack of ability or effort, which no advice can remedy,¹ most errors can be traced to a failure to follow the two most basic rules of persuasive writing: Know your audience, and write for your audience.

When you apply for leave to appeal, your audience obviously is the court, as well as the commissioner who will prepare a report on which the court relies in its initial review of applications for leave to appeal. The commissioner’s report summarizes the case and performs a sort of analytical triage on the often imposing body of briefs, motions, exhibits, and transcripts that, like Marley’s chain, is forged below and follows a case as it wends its way up to the court. It is used to decide which cases need the more thorough monthly conference review by the full court that is required in the roughly one-quarter to one-third of the applications not disposed of under the court’s “order to enter” (OTE) procedure.²

Because the court and its staff are fully capable of extracting from the record what is required to perform its reviewing function, the inevitable errors and oversights of advocates usually are not fatal. But even with the best will, the court cannot remedy all deficiencies in the applications it reviews. It simply does not have the time. In 2012, the most recent year for which complete statistics are available, the court received 1978 case filings, and disposed of 2048 cases.³ Of those, only about 5% were grants of leave.⁴ To improve your chances of being among that tiny fraction of successful applicants, or, if you are the respondent, of persuading the court that the application should be denied, you must establish a relationship of trust and confidence with your reader. This article is intended to provide concrete suggestions for accomplishing that goal.

Stating the Issue

The best guides to advocacy are the rules governing it. Although intended primarily for use by counsel in preparing their briefs and arguing their case after leave has been granted, useful information can be found in the “Guide for Counsel In Cases To Be Argued In The Michigan Supreme Court,” which can be found on the court’s website.⁵ For an application, the rule that should guide every word you utter is MCR 7.302(A). Yet it is not an exaggeration to say that many applications seem to be written by advocates who think the rule does not apply to them.

The first subsection of that rule that an astonishing number of advocates disregard in multiple ways is 7.302(A)(1)(b). It requires the application to include “the questions presented for review related in concise terms to the facts of the case.” This requirement has three discrete components.

“The Questions Presented . . .”

First, you must determine what questions are presented for review. Yet most advocates fail to realize that not every claim of error that was presented in the court of Appeals is necessarily grant-worthy. Many applications are written with seeming obliviousness to how to identify and properly state the question presented. This often stems from the advocate’s failure to grasp a fundamental principle: the Supreme Court does not exist to correct error. You cannot state the question presented correctly without keeping this elemental fact in mind. Youare appealing from the only court in our system designed to correct error, the Court of Appeals,⁶ to a court whose only concern normally is whether, any error below notwithstanding, the question presented is sufficiently important to warrant a discretionary grant of leave to appeal.⁷ You simply cannot correctly frame the question presented in an application for leave to appeal to the Supreme Court without referring to the grounds for granting leave enumerated in MCR 7.302(B) (1)-(6). Yet a substantial proportion of applications contain statements of the issue merely asserting that one or both of the courts below “erred.”

Do not leave it to the reader to tease out whether your application presents an issue that presents one of the grounds that warrant a grant of leave! State the issue, and argue the issue, in such a way that you relate whatever error occurred below to one of the grounds for granting leave to appeal.⁸ This

* The author thanks Chief Commissioner Daniel Brubaker and John Yeager, Esq., for offering constructive comments and suggestions, but the opinions expressed are solely his own.
may seem obvious, but many applications do not even allude to the grounds for granting leave, let alone argue that one or more exists. The reason for this is often obvious: through the miracle of modern word processing, the application is often nothing more than a recaptioned and slightly revised version of the applicant’s Court of Appeals brief. That was an appeal by right, so, of course, it contained no discussion of the grounds for granting leave to appeal to the Supreme Court.

Always bear in mind that the application’s argument and analysis must be presented in terms of the rule prescribing the grounds for granting leave. If you have not even addressed those grounds, you have greatly reduced the already long odds of obtaining leave. In the absence of any guidance from you, it may not be readily discernible why your case is an appropriate one for the court to devote its scarce time and resources to deciding. Bear in mind, too, that the “default” disposition is to deny leave: By the time a case comes to the Supreme Court, at least four judges have done their best to decide it correctly. Certainly the court is unlikely to search for grounds that the applicant has not advanced. The effective advocate must argue the case in terms of the requirements that the court will apply in deciding the application.

### Most errors can be traced to a failure to follow the two most basic rules of persuasive writing: Know your audience, and write for your audience.

### “...Related in Concise Terms...”

The issue statement is to be “concise,” a term that appears three times in MCR 7.302(A)(1) because the court is jealous of its time. Yet issue statements commonly run on for two or three hundred words, forcing the reader to analyze the case to distill and correctly frame the issue. It is foolish to state the issue at such length that the reader is lost before completing it. Usually a disorganized issue statement reflects a mind that has not refined the question sufficiently to present a “concise” statement of the material facts and proceedings or a “concise” argument. See MCR 7.302(A)(1)(d) and (e). When the advocate considers every fact “material,” and so includes them all in the issue statement, the material facts are likely to be obscured in the resulting word thicket, and the first opportunity to make an ally of the reader is lost.

One understands the advocate’s dilemma, because, at least in some sense, a great many facts may be more or less material. At least two approaches can be used to resolve this dilemma.

The first is to state the issue in terms of the facts, but not to include so much factual detail that the facts obscure the issue. This approach probably will require several attempts, and much critical revision. The effort is worth it, though, not only because it is an effective way to present the question so that an (as yet) uninformed reader can understand it readily, but also because the process of refining the issue statement to conform to this model forces the advocate to identify the few truly material, potentially dispositive facts. Eliminate adjectives, being sure to excise anything that criticizes the other party or the courts below. Revise and refine the issue to its essence as nearly as possible.

If you find that you cannot bear to leave out potentially significant facts, or believe that the issue truly cannot be stated without reference to a lengthy and complicated cluster of facts, consider the alternative model of prefacing a brief statement of the issue with an introductory factual statement, rather than attempting to include every fact in a run-on issue statement. Be considerate of your reader, who, unlike you, has not been living in the case for years, comes to it with no knowledge of its facts, and has none of your deep-seated conviction about its merits.

Thus, rather than presenting your reader with a run-on monstrosity of subordinate clauses peppered with semicolons (or, worse, not even peppered with semicolons), use the opportunity to state the issue to inform the reader by tightly organizing and concisely stating the foundational facts in a brief paragraph that will be comprehensible to the uninitiated reader before then providing a concise statement of the issue that comprises the most material facts. This alternate issue template can be highly effective when the issue arises in a truly complex factual setting.

### “...To the Facts of The Case.”

Finally, do remember that the issue must be stated in such a way that it is related in concise terms to the facts of the case. To follow this rule, you must identify and convey to your reader what facts of the case give rise to the (grant-worthy) issue presented. An issue stated without reference to the facts, such as, “did the courts below err in concluding that plaintiff was not entitled to relief under all of the circumstances presented,” is certainly stated in a way that is “related to the facts of the case,” but it does not identify those facts for the reader. Take the time to identify, and then properly state the issue in terms of the material facts. It not only will improve your reader’s understanding of the case, it will improve your own analysis, and thus your argument.

### Stating the Facts

Again stressing the word “concise,” MCR 7.306(A)(1)(d) requires the advocate to provide a “concise statement of the material proceedings and facts conforming to MCR 7.212(C) (6).” That rule, in turn contains a detailed list of requirements that will reward study and observance.
Despite these clear directives, many applicants simply summarize seriatim the testimony of every witness, leaving it to the reader to glean from a disorganized and indiscriminate welter of information what is significant. That approach not only obscures the material facts and proceedings in a thicket of peripheral and immaterial information, it also automatically violates the requirement that your statement of facts be “chronological.” It also makes it less probable that you will note the points on which the parties and witnesses disagree, as the rule also requires. More importantly, it foolishly alienates the reader at the beginning, when the statement of facts should be establishing a rapport and a bond of trust.

Perhaps some advocates fail to observe these requirements because they fear that leaving anything out will open them to criticism on the ground that they have omitted some unfavorable fact. The solution to that is not to violate the rule by including every fact, regardless of whether it is material. Although the impulse to be over-inclusive is understandable, it should be resisted. If you know your case, you know which facts are material. You should confine your statement of facts to those that have a bearing on the issues presented and contribute to understanding the case. Do the work necessary to organize the facts chronologically, being sure to provide accurate references to the record, transcript, and exhibits, and noting the points on which the witnesses did not agree.

If the proceedings are at all complex, and especially if the procedural posture of the case has a bearing on the issues presented, consider summarizing the proceedings separately from the summary of the material facts. Sometimes the procedural summary will be most helpful if it precedes the statement of material facts, and sometimes it will be more effective if it follows them. Consider carefully and choose the order that works best for presenting your case.

A well organized and concise statement of the material facts and proceedings that complies with both MCR 7.302(A)(1)(d) and 7.212(C)(6) will greatly enhance an application’s chances of success. Conversely, one that does not comply presents a golden opportunity that a respondent should always exploit: the chance (indeed, the obligation) to weaken any bond the application has forged with the reader by impairing the credibility of its statement of the facts. The respondent can do so and, at the same time, both forge a bond with the reader and shape the reader’s understanding of the case, by providing “a counter-statement of facts, pointing out the inaccuracies and deficiencies in the appellant’s statement of facts…” If you are the respondent, don’t waste this opportunity. If you are the applicant, do not give the respondent this opportunity. An applicant’s first tactical victory comes from providing a

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**Announcement**

**The Insurance and Indemnity Law Section’s Searchable Directory of Members Is Now Operational!**

All Section members are invited and encouraged to register in the directory and indicate their areas of expertise and the services they can provide.

The directory will be a resource for attorneys and court personnel in Michigan to assist them in finding Section members to assist in the handling and/or resolution of litigation.

When you register you can include the following information, in addition to information on how to contact you.

**Areas of Practice:**
- Indemnity Issues, Contract Drafting, Insurance In-House, Insurance Policy Drafting,
- Insurance Coverage (Liability, First Party Auto, Third Party Auto, Life, Health, Disability)
- ERISA
- Regulatory Matters
- Corporate/Transactional

**Services:**
- Consultation
- Litigation and Appeals
- Contract Review
- ADR (Neutral Evaluation, Facilitation, Mediation)

**Client Base (Percentage of work for insurers and insureds)**

**To JOIN the Searchable Directory**, go to [http://mistatebar.com/add-me](http://mistatebar.com/add-me), check the appropriate boxes, enter your personal data, and click on “enter.”

**To SEARCH in the Directory**, go to [http://mistatebar.com](http://mistatebar.com), click on “find a lawyer,” check as many of the boxes as apply. You can select by one or more of these: Areas of Practice, Client Base (percentage of clients who are insurers, and insureds), Services Provided (e.g., ADR, Contract Analysis, Litigation), Location (by county).

Then Click on “Apply”
that the meaning of the statute at issue was apparent from the discussion of the law’s purpose contained in a House Legislative Analysis. That advocate had not done his homework. As a result, he not only missed an opportunity to persuade the court to his position by relying on indications of legislative intent that are deemed permissible and persuasive guides to textualist interpretation, but almost certainly actually alienated, and deterred a majority of the court from embracing, the argument he advanced by basing it on authority that the court deems untrustworthy.

Examples could be multiplied, because the court’s decisions of the past decade and a half have transformed many substantive and procedural areas of the law. The point is simply that an applicant who seeks the court’s intervention must do the research necessary to be aware of and sensitive to the rules the court will apply in analyzing the merits of the argument advanced. An advocate always must be at pains to formulate any argument in terms, and support it with current authorities, that comport with the rules and modes of analysis that the court has made it plain it will henceforth apply.

Every Word Is Not a Pearl

Brevity is the soul of wit. We all know it, yet too many advocates make the mistake of regarding the 50-page limit of MCR 7.302(A)(1) and 7.212(B) as a goal, rather than a maximum. Remember that the court has 2000 applications to consider, and that yours is no more or less important than the rest. Assist the court to do right by your case in the limited time available by making your brief as short, plain, and simple as possible. That brevity will be appreciated.

Although 50 pages may be required in a case that has unusually complicated facts, an unusually large record, or an unusually large number of appealable issues, most applications can be presented – and would be better presented – in half as many pages. An advocate should strive to confine the application to the fewest pages consistent with a fair statement of the facts and the “concise” statement of the argument that is both required by MCR 7.302(A)(1)(e) and necessary to demonstrate that the case satisfies the criteria for granting leave to appeal. The court will not benefit from, or be receptive to, unnecessarily lengthy argument. The more concisely the argument is presented, the more persuasive and effective it is likely to be. Once you complete a draft of your argument, edit it ruthlessly and repeatedly to improve organization, eliminate repetition, delete excess words, recast passive sentences in the active voice, and so on. Shorten it as much as possible.

Avoid Personality

Appellate work can be a monastic occupation. Imagine that you are alone in a room with the record and the briefs. You may hear little else all day except the subvocalized voices of the advocates who wrote those briefs. Imagine what it is like to

Articulating How Your Case Fits Harmoniously Within Current Doctrine Is Essential to Successful Advocacy

Unless you have been sleeping under a tree for the last fifteen years, you know that great changes in Michigan law have occurred since 1999. Among other things, that is when the court began to embrace and employ a textualist approach to analyzing issues of constitutional, legislative, and contractual intent and meaning. This analytical approach has produced significant changes in both substantive and appellate procedural law. This article is not a primer on all changes that have occurred, but this particular change in the court’s analytical approach to deciding cases provides an example to illustrate my point.

The court’s focus on the text of a constitutional, statutory, or contract provision affects not only the standard of review, but also has changed the tools of interpretation, such as legislative bill analyses, formerly used to ascertain legislative intent. I once observed an oral argument in which the advocate urged
when those briefs contain mean-spirited bickering and name-calling by counsel who have such low regard for each other (or, worse, the courts below) that they cannot resist infecting their arguments with these feelings, inflicting them on the reader. Insults, accusations, sarcasm, and ad hominem attacks have no place in an application. They are unpersuasive. They are also unprofessional. Rise above your feelings. Exclude them from your brief. Remember the passage of the Lawyer’s Oath in which you promised to “abstain from all offensive personality,” and your ethical obligation under RPC 3.5(d) to refrain from undignified or discourteous conduct toward the court. Finally, remember that a reader who is forced to “listen” to these obnoxious, angry voices, rather than to the reasoned argument of professionals that the rules require, may well be unsympathetic to your cause. Behave yourself. You are practicing an honorable profession at the apex of the Michigan court system. Set aside personal animosity and comport yourself as the professional you are lucky to be. You owe that to your client, who is counting on you to present the best case possible.

Conclusion

I have tried to follow my own admonition, and keep this article reasonably short, so I have confined myself to the most important lessons gleaned from my experience as an advocate and the eight years I enjoyed the privilege of assisting the court to perform its singular mission in Michigan’s one court of justice. If anyone reads this, and I have succeeded in imparting even one useful suggestion to each person who does, I will have assisted not only the readers, but also the court and its staff in performing their endless, and endlessly satisfying, tasks. Good luck.

About the Author

The author served as a Michigan Supreme Court Commissioner from January 2005 through May 2013. Before that, he was a partner for 19 years in the Honigman firm’s Lansing office, in a litigation practice that included extensive appellate work. The over three dozen published decisions of state and federal courts in cases in which the author was counsel of record can be found at www.fbakerlaw.com. As an adjunct professor, he taught insurance law and conflict of laws at Cooley Law School, and both insurance and no-fault law at MSU Law School. He served on the full-time faculty of both Wayne Law School (as an instructor of legal writing, research and advocacy) and Cooley Law School (as an assistant professor, teaching contracts, civil procedure, and legal writing and research). He is now of counsel at Willingham & Cote, P.C., the firm where he began private practice after serving as a research attorney and law clerk to the late Chief Judge of the Court of Appeals, Hon. Robert J. Danhof. His email address is fbaker@willinghamcote.com

Endnotes

1 Except, perhaps, the motto of Boxer, the tireless and stalwart draft horse in George Orwell’s Animal Farm, “I will work harder.” Hard work and preparation will beat unprepared brilliance every time.

2 For a detailed description of the process the Court follows between the circulation of the commissioner’s report and the ultimate disposition of applications not disposed of under the OTE procedure, during which the Justices typically circulate memora- nda and request additional information and supplemental reports, see Oberg and Brubaker, Insights on the Michigan Supreme Court’s Consideration of Applications for Leave to Appeal, 87 Mich Bar J 30 (February 2008) (the authors are the Court’s current Deputy Chief Commissioner and Chief Commissioner, respectively).


4 According to the Court’s website, “[t]he Supreme Court receives about 2,000 applications each year and ‘grants leave’ in about 100 cases.” http://courts.mi.gov/education/learning-center/Pages/Michigan’s-Current-Court-System.aspxn (Last accessed March 3, 2014).


6 Obviously, the circuit court serves that function in appeals from the district courts, but I am speaking of the basic appellate model, of which the district/circuit/Court of Appeals appellate system is an analog.

7 For an excellent explication of why that distinction matters, see Halbert v Michigan, 545 U.S. 605, 617-618; 125 S. Ct. 2582; 162 L. Ed. 2d 552 (2005).

Because that distinction is so important, and because even the presence of some error may not warrant a grant of leave to appeal if your case does not present any of the grounds that prompt the Court to grant leave in such a tiny fraction of cases, you should analyze your case sensitively, realistically, and imaginatively, not only as you decide whether to seek leave to appeal, but also in deciding on what issues to seek leave to appeal, and what relief to request. If you think the Court may conclude that “mere error” not meriting a grant of leave has occurred in your case, consider whether you should suggest alternative relief in case the Court decides to deny leave to appeal.

For example, in a case in which the Court of Appeals has exercised its discretion to deny a delayed application for leave to

State Bar of Michigan Insurance and Indemnity Law Section 7
appeal, thereby leaving uncorrected the very sort of error that it exists and is designed to correct, would it be sufficient to obtain a remand for consideration as on leave granted? Remember that the Court is reluctant to grant leave in any case in which the Court of Appeals has not already fully considered the issue presented. The alternative of a remand to the Court of Appeals is a form of “error correction” in which the Court can and often does engage, because it does not entail the commitment of its limited resources that the requirements for granting leave are designed to accomplish.

Similarly, consider whether a remand for reconsideration in light of a decision of the Supreme Court (either one issued after the Court of Appeals decision or one the Court of Appeals did not consider), or another decision of the Court of Appeals that is controlling under MCR 7.215(C)(2) and 7.215(J)(1), would serve your client’s interests better than an unsuccessful application for leave to appeal. And so on.

In short, if you are concerned that the error in your case may not present the grounds for granting leave prescribed by MCR 7.302(B), consider whether grounds exist to request alternative relief that will get your case back before the Court of Appeals, which exists to correct error. Consider whether such relief should be requested in the alternative. And consider whether, and if so, how, to include or suggest that alternative in stating the issue. Do not rely on the Court to think of these possibilities – or make such judgments and decisions – for you, but do bear in mind that the commissioner’s report can – and often does – include alternative proposed orders. In an appropriate case, your application should include reasoned alternative requests for relief that the Court can consider in lieu of granting leave.

You must explain why the claim presented does (or, if you are the respondent, does not) (1) involve a substantial question as to the validity of a legislative act; (2) involve a question of substantial public interest and is against the state (or its agency/subdivision/officer); (3) involve a legal principle of major significance to the state’s jurisprudence; (4) satisfy the special grounds that must be present the grounds for granting leave prescribed by MCR 7.302(B), consider whether grounds exist to request alternative relief that will get your case back before the Court of Appeals, which exists to correct error. Consider whether such relief should be requested in the alternative. And consider whether, and if so, how, to include or suggest that alternative in stating the issue. Do not rely on the Court to think of these possibilities – or make such judgments and decisions – for you, but do bear in mind that the commissioner’s report can – and often does – include alternative proposed orders. In an appropriate case, your application should include reasoned alternative requests for relief that the Court can consider in lieu of granting leave.

For example, this issue statement, drawn from the facts of Bronson Methodist Hospital v Allstate Insurance Company, 286 Mich App 219 (2009), lv gtd 488 Mich 918 (2010), lv vacated 489 Mich 925 (2011), distills to a manageable length a complex question of statutory interpretation, leaving for the statement of the facts and the argument the factual development and statutory analysis necessary to unpack the issue in detail and fully explain its jurisprudential significance:

When the claimant hospital satisfied the timing requirements of MCL 500.3174 by filing its claim with the Assigned Claims Facility within a year of the first and last dates of service, and timely filing its “action” after the Facility appointed a servicing insurer, does the one year back rule of MCL 500.3145 bar recovery, in this case of first impression, because claimant rendered all of the services for which it seeks payment slightly more than a year before the “action” was filed, owing to the short delay that occurred before the Facility appointed the servicing insurer?

10 See “Avoid Personality,” infra.


The Court of Appeals held, in a published opinion following a decision of this Court holding that a lease must be construed “as written,” that, under the strict wording of the lease, the landlord may terminate the lease even for a non-material default. The Court of Appeals did not consider, however: (1) whether the landlord gave notice of default by registered mail, return receipt requested, as the lease required; and (2) whether, in light of extended negotiations while the default existed, during which the landlord did not invoke the power to terminate the lease, a question of fact existed whether the landlord’s notice of default adequately conveyed the landlord’s intent to terminate the lease, and thereby cause a forfeiture of the tenant’s several million dollars of leasehold improvements if the default was not cured. Under these circumstances:

Did the Court of Appeals clearly err in failing to consider whether, under all terms of the lease, and not just the term authorizing termination for any default, allowing the landlord to declare the lease terminated will result in a forfeiture so disproportionate to the materiality of the default that a material injustice to the tenant will result?

12 MCR 7.212(C)(6) requires:

(6) A statement of facts that must be a clear, concise, and chronological narrative. All material facts, both favorable and unfavorable, must be fairly stated without argument or bias. The statement must contain, with specific page references to the transcript, the pleadings, or other document or paper filed with the trial court,

(a) the nature of the action;
(b) the character of pleadings and proceedings;
(c) the substance of proof in sufficient detail to make it intelligible, indicating the facts that are in controversy and those that are not;
(d) the dates of important instruments and events;
(e) the rulings and orders of the trial court;
(f) the verdict and judgment; and
(g) any other matters necessary to an understanding of the controversy and the questions involved;…

13 7.212(C)(6)(“A statement of facts that must be clear, concise, and chronological...”).

14 See MCR 7.212(C)(6)(c).

15 Remember that the commissioner’s report, which is used to dis-
pose of most cases under the OTE system, also must state the facts. Most advocates are unaware that the Clerk currently will accept for filing a disk containing an electronic version of the application or response. Also, you should be aware that, probably by the time you read this, the Clerk’s office will have implemented e-filing. E-filed documents will be available system-wide to the entire Court and its staff, making it possible for all to go directly to the application, response, and any reply at will. This will mark a sea-change, in my opinion, in how the Court functions, by giving Justices and their clerks instant access to the entire application file.

You also should be aware that, once e-filing is implemented (it will be optional in the beginning, with the goal of eventually being mandatory in most cases, probably excepting prisoners and other in pro per parties), all hard copy application filings will be scanned into a searchable pdf format that will be available system-wide to the entire Court and its staff, even if the case was not e-filed.

You should be aware that, in Michigan a legislative analysis is a substantial part of the case presented by the pleading. Evidence offered in a cause, or a question propounded, is material when it is relevant and goes to the substantial matters in dispute, or has a legitimate and effective influence or bearing on the decision of the case.” (Emphasis added)

Black’s Law Dictionary (Online) (2d ed) defines “material” thusly: “Important; more or less necessary; having influence or effect; going to the merits; having to do with matter, as distinguished from form. An allegation is said to be material when it forms a substantive part of the case presented by the pleading. Evidence offered in a cause, or a question propounded, is material when it is relevant and goes to the substantial matters in dispute, or has a legitimate and effective influence or bearing on the decision of the case.” (Footnotes omitted).

The application must include “a concise argument, conforming to MCR 7.212(C)(7), in support of the appellant’s position on each of the stated questions.” MCR 7.212(C)(7), in turn, requires that the argument include “a statement of the applicable standard or standards of review and supporting authorities,” and “if a statute, ordinance, rule, judgment, or constitutional provision is involved, it must be reproduced in the brief or an addendum to it.”


Mitcham, supra. Though the Court has discretion to consider an issue that was not preserved below, if necessary to prevent a miscarriage of justice, “[m]ore than the fact of the loss of [a] money judgment in a civil case is needed to show a miscarriage of justice or manifest injustice. [and] such inherent power is to be exercised only under what appear to be compelling circumstances….” Napier v Jacobs, 429 Mich 222, 232-234 (1987). In short, do not count on the Court to remedy the deficiencies of your brief, or your failure to preserve an issue for appeal.

Whitman v City of Burton, 493 Mich 303, 311-312 (2013), contains a typical statement of the standard of review reflecting this analysis:

This case involves the interpretation and application of a statute, which is a question of law that this Court reviews de novo. When interpreting a statute, we follow the established rules of statutory construction, the foremost of which is to discern and give effect to the intent of the Legislature. To do so, we begin by examining the most reliable evidence of that intent, the language of the statute itself. If the language of a statute is clear and unambiguous, the statute must be enforced as written and no further judicial construction is permitted.

Effect should be given to every phrase, clause, and word in the statute and, whenever possible, no word should be treated as surplusage or rendered nugatory. Only when an ambiguity exists in the language of the statute is it proper for a court to go beyond the statutory text to ascertain legislative intent. [Footnotes omitted, emphasis added.]

Compare the references twenty years ago, in People v Fields, 448 Mich 58, 67-68 (1995), to “legislative history,” and citing a House Legislative Analysis as a source of such history, to the Court’s discussion two years ago, in People v Williams, 491 Mich 164, 178 (2012), of the proper approach to statutory analysis and determining legislative intent. The Williams majority criticized the dissent because it “would have this Court interpret the robbery statutes in accordance with an unstated legislative intent rather than the plain meaning of the words chosen. This approach to statutory interpretation has been consistently criticized and rejected. So too has this Court rejected the dissent’s resort to unauthoritative legislative analyses in order to displace statutory language.” (Footnotes omitted).

Among the authorities cited in the Williams Court’s discussion were Frank W Lynch & Co v Flex Technologies, Inc, 463 Mich 578, 587 (2001) (stating that “in Michigan a legislative analysis is a
feeble indicator of legislative intent and is therefore a generally un-persuasive tool of statutory construction’), and In re Certified Question from the United States Court of Appeals for the Sixth Circuit (Kenneth Henes v Continental Biomass), 468 Mich 109, 115 n 5 (2003) (discussing why a legislative analysis, as opposed to other forms of legislative history, is a poor aid in statutory interpretation and thus ‘should be accorded very little significance by courts when construing a statute.’). [Emphasis added.]

27 See, e.g., People v Gardner, 482 Mich 41, 57-58 (2008), where the Court said:

As we have stated, construing an unambiguous statute by relying on legislative history “[a]t the very most . . . allows the reader, with equal plausibility, to pose a conclusion of his own that differs from that of the majority,” (citations omitted) Further, ‘not all legislative history is of equal value . . . .’ In re Certified Question, 468 Mich 109, 115 n 5; 659 NW2d 597 (2003). Some historical facts may allow courts to draw reasonable inferences about the Legislature’s intent because the facts shed light on the Legislature’s affirmative acts. For instance, we may consider that an enactment was intended to repudiate the judicial construction of a statute, or we may find it helpful to compare multiple drafts debated by the Legislature before settling on the language actually enacted. Other facts, however, such as staff analyses of legislation, are significantly less useful because they do not necessarily reflect the intent of the Legislature as a body. [Emphasis added.]

28 This article is not intended to provide instruction on matters of style, but for the reader who desires an excellent summary of the rules for plain and effective persuasive writing, I recommend Joseph Kimble, Writing for Dollars, Writing to Please, Carolina Academic Press (2012), which distills the author’s over 30 years of labor in the vineyard of plain language and effective writing.

Significant Insurance Decisions

By Deborah A. Hebert, Collins, Einhorn, Farrell; Deborah.hebert@ceflawyers.com

Michigan Court of Appeals – Published

Standard Mortgage Clause Enforced

Wells Fargo Bank, N.A. v Null

___ Mich App ___ (2014)
Docket No. 312485

The “standard mortgage” clause in this homeowner’s policy protected the mortgagee’s interest in the property after a fire loss, even though coverage was not triggered for the homeowner because he no longer used the home as his “residence premises.” A prior action (see January 2014 issue) determined lack of coverage for the homeowner. In this action, the court interpreted the standard mortgage clause as a separate contract between the insurer and the mortgagee, guaranteeing coverage for a “valid claim of the mortgagee” regardless of whether the policyholder lacked coverage under the insuring agreement or under an exclusion.

Insurance Agent did not have Duty to Advise Policyholder on Coverage

Estate of Richardson v Grimes

Unpublished Court of Appeals Opinion of January 21, 2014 (Docket No. 312782)

Husband and wife policyholders purchased their auto and homeowner’s insurance through defendant agency for many years. The first auto policy provided liability limits of $100,000/$300,000. That limit was never increased for the ensuing policy periods. In 2009, by which time the policyholders owned assets worth $2.7 million, policyholder wife was involved in an accident resulting in fatal injuries to the other driver. The estate’s claim settled for $675,000, of which $100,000 was paid by the auto insurer. In this opinion, the Court of Appeals found no basis for the policyholders’ malpractice claim against the agency because insurance agencies

Property Coverage Afforded for Collapsed Roof

Hani and Ramiz, Inc. v North Pointe Ins Co

Unpublished Court of Appeals Opinion of December 12, 2013 (corrected 2/4/14)
(Docket No. 316453)

Grocery store owner has coverage for the collapse of his roof weighed down by the accumulation of snow and ice. It was later discovered that trusses had been treated with a flame-retardant chemical that caused the lumber to weaken over time and contributed to the collapse. North Pointe asserted the collapse exclusion, but the Court found that the exclusion did not apply because of the exceptions for specified causes of loss, which included “abrupt collapse of . . . part of a building” due to “decay hidden from view,” and also, damage caused by “weight of snow and ice.”

Michigan Court of Appeals - Unpublished
generally have no duty to advise of the adequacy of insurance and there was no evidence of any special relationship between this agency and these policyholders.

CGL Exclusions for Mold and Loss of Use Expenses Bar Coverage

*Hastings Mutual Ins Co v Mosher Dolan Cataldo & Kelly, Inc.*
Unpublished Court of Appeals Opinion of January 23, 2014
(Docket No. 296791)

In what appears to be the last of several appellate decisions in this defective construction case, the Court of Appeals addressed CGL exclusions as follows: (1) mold exclusion in the policy in effect at the time the home became uninhabitable barred liability coverage for the general contractor, (2) the “loss of use” exclusion (n) excluded coverage for costs and expenses such as those incurred for packing and storing property removed from the home and for alternative living arrangements because those costs arose out of the need to vacate property due to defects in the insured’s work, and (3) pollution and impaired property exclusion (m) did not apply. Because the claims against the insured were not covered, the contractor was obligated to reimburse Hastings Mutual for the defense costs incurred on its behalf.

**Action for UM Benefits barred by PIP Litigation**

*Graham v State Farm Mutual Automobile Ins Co*
Unpublished Court of Appeals Opinion of February 18, 2014
(Docket No. 313214)

Motion for publication pending

After suing State Farm for PIP benefits and dismissing that action with prejudice, plaintiff policyholder filed a separate lawsuit against State Farm for UM coverage. The court found the second lawsuit barred by the doctrine of *res judicata*. Both actions arose out of the same operative facts and were related in time, space, origin and motivation. Specifically, both actions involved the same motor vehicle collision, the same injuries, and the same insurer and policyholder. Because the first action was decided on the merits, the second action was barred.

**No Remedy for Lack of UM Endorsement**

*Leggett v Tabacchini*
Unpublished Court of Appeals Opinion of February 20, 2014
(Docket No. 311600)

After her auto accident, plaintiff policyholder discovered that she did not have uninsured motorist coverage. Claiming that she had requested “full coverage” for her vehicle, she sued both the insurance agent and her insurer for breach of contract and fraud. The breach of contract claim was barred by the six-year statute of limitations, which commenced the date the policyholders’ malpractice claim against the agency because insurance agencies generally have no duty to advise of the adequacy of insurance and there was no evidence of any special relationship between this agency and these policyholders.
auto policy was issued without a UM endorsement rather than the date of the auto accident. The fraud claim was dismissed for lack of supporting evidence.

**Personal UIM Coverage Denied Where Policyholder is Driving Employer's Vehicle**

*Micallef v AAA Auto Club Group of America, Inc.*
Unpublished Court of Appeals Opinion of February 20, 2014 (Docket No. 313068)

Plaintiff's personal auto policy did not provide UIM coverage for injuries sustained in an accident while the insured was operating a vehicle provided by his employer. The policy expressly stated that its UIM coverage "does not apply to bodily injury sustained by an insured person . . . while occupying a motor vehicle furnished by an insured person's employer and operated in the course of that insured person's employment unless the motor vehicle is your car. . . ." The court found no ambiguity with the term "furnished", which means to provide or supply. There was no dispute that plaintiff was driving a vehicle supplied by his employer for plaintiff to test drive in his capacity as a vehicle test engineer.

**After suing State Farm for PIP benefits and dismissing that action with prejudice, plaintiff policyholder filed a separate lawsuit against State Farm for UM coverage. The court found the second lawsuit barred by the doctrine of res judicata. Both actions arose out of the same operative facts and were related in time, space, origin and motivation.**

**Policy Cancellation One Day Prior to Accident Upheld**

*Micou v Progressive Michigan Ins Co*
Unpublished Court of Appeals Opinion of March 13, 2014 (Docket No. 311937)

Plaintiff's auto policy was cancelled for non-payment one day prior to his involvement in an accident. First party benefits were denied. A recorded telephone call between a Progressive employee and the policyholder establishing that the policyholder was granted an extra day to make payment failed to result in an extension of coverage because the payment was not made by the close of business. Theories of equitable estoppel and mutual mistake/impossibility did not apply because the recorded telephone conversation clearly stated the terms of continued coverage, which were not met.

**Failure to Plead Coverage B Offenses Results in Lack of CGL Coverage**

*Battery Solutions, Inc. v Auto-Owners Ins Co*
Unpublished Court of Appeals Opinion of March 18, 2014 (Docket No. 311168)

Plaintiff policyholder was not covered under Section B, personal and advertising injury coverage for a customer's claims of for breach of contract, interference with a contractual relationship, intentional and/or negligence misrepresentation, negligent performance of a contract, and unfair/deceptive business practices. Plaintiff had agreed to dispose of its customer’s lithium batteries in a particular manner, but instead provided the batteries to a company in China. When the batteries reappeared in the market place, plaintiff's customer faced claims by the battery manufacturer and in turn, sued plaintiff. Because plaintiff was not sued for any of the offenses listed in the definition of “personal and advertising injury,” there was no coverage for the claims.

Blue Cross Blue Shield “Access Fees” Revisited and Upheld

*County of Bay v BCBSM*
Unpublished Court of Appeals Opinion of December 17, 2013 (Docket No. 307447)

*City of Battle Creek v BCBSM*
Unpublished Court of Appeals Opinion of February 11, 2014 (Docket No. 311872)

In both of these cases, the Court of Appeals rejected public entity challenges to Blue Cross Blue Shield’s collection of “access fees” charged for its administration of self-insured health care plans. The legitimacy of these fees was addressed in *Calhoun County v Blue Cross Blue Shield Mich*, 297 Mich App 1 (2012), in which the Court determined that the fees were authorized by the terms of the BC/BS contract and were sufficiently specific to support enforcement. These two cases were not factually distinguishable from *Calhoun County.*
Insurance Coverage for Cyber Risks is Changing

By Douglas Young, Wilson Young PLC

The recent Target Corp. data breach has highlighted the need for insurance coverage attorneys, in-house attorneys, risk managers and their clients to recognize cyber risk and the potential for insurance coverage for this risk. The magnitude of this risk is great and becoming greater. The Target data breach, which is reportedly the second largest cyber data breach in U.S. retail history, recently gave hackers credit card information for 70 million Target customers. This has resulted in state and federal investigations into possible consumer-protection law violations and over 40 potential class action lawsuits. Business Insurance has reported that Target has $100 million of cyber insurance, including its retentions, and $65 million of Directors and Officers (D&O) insurance. Unfortunately, however, Target’s cyber and D&O insurance may be insufficient to cover the damages and costs for this massive data breach.

Target is not alone. A 2007 TJ Maxx cyber data breach has been reported to have cost TJX Cos. $256 million. These costs include settlements with state and federal regulators, class action litigants, credit card companies, banks, credit monitoring services for potentially affected parties and legal fees. It has been estimated that the cost of a data breach can approach $188 per record breached for breaches of up to 100,000 records. If these yardsticks are any indication, Target’s costs could exceed its insurance coverage by more than $100 million, not including the negative publicity costs and lost sales during the Holiday season, considering this data breach was publicized one week before Christmas.

Lawyers and risk managers for small and medium-sized companies must understand this risk and appropriately understand cyber insurance to assist in the risk mitigation or risk transfer strategy of their client. If they fail to heed this call, they will do a disservice to their clients and increase the potential for an errors and omissions claim. While it is not unusual for clients to involve their legal counsel after a problem has arisen, this is an opportunity to proactively manage risk. Clients, lawyers and risk managers must first recognize this exposure and then decide whether they wish to retain this risk or purchase cyber insurance coverage to transfer all or a portion of this risk to one or more insurance carriers.

Data/Privacy Breaches Will Soon Be Excluded In Most Coverage Forms

Retailers Target and Nieman Marcus are just two of the latest victims. It is reported that data breaches “are on the rise with unprecedented frequency, sophistication, and scale.” Many companies have previously decided not to purchase cyber insurance coverage, either believing that the risk was not that great or that this risk was already covered by their Commercial General Liability (CGL) insurance. These companies must now understand that the Insurance Services Office’s (ISO) May 2014 endorsements are modifying its standard-form CGL primary, excess and umbrella insurance coverage forms to expressly exclude claims arising from the access to or disclosure of personal, business or financial data.

This new CGL endorsement provides in part:

“This insurance does not apply to . . . [d]amages arising out of . . . [a]ny access to or disclosure of . . . confidential or personal information, including patents, trade secrets, processing methods, customer lists, financial information, credit card information,

Editor’s note: Portions of this article originally appeared in the March 2014 edition of Michigan Agent, a publication to the members of the Michigan Association of Insurance Agents (MAIA).
health information or any other type of nonpublic information."

This endorsement further excludes "the loss of, loss of use of, corruption of . . . electronic data." It also adds an exclusion to the Personal and Advertising Injury Liability coverage part for "Personal and advertising injury" arising out of any access or disclosure noted above. Finally, it excludes as damages any "notification costs, credit monitoring expenses, forensic expenses, [or] public relations expenses" incurred because of the data breach.

Cyber Liability Exposure

These ISO policy changes will make cyber risk insurance coverage even more important for companies that desire to transfer this risk. It is currently estimated that only 31% of companies have a dedicated cyber insurance product. For the 69% of companies without cyber insurance, they must recognize that they now may have a significant uninsured exposure under the 2014 ISO endorsement exclusions for data breaches and the resulting damages. This uninsured exposure is quite large when viewed in light of the $5.4 million average cost of a data breach to U.S. businesses.

In addition, a vast majority of states have statutes that expressly deal with the notification requirements to the potentially affected parties following a data breach, and these requirements cost an average of $565,000. These notification costs alone could seriously harm many companies. In Michigan, for example, the failure to notify customers of a data breach can result in a fine of $250 per notification failure, up to a maximum fine of $750,000.

It also must be understood that data breaches do not necessarily have to involve credit card information or the purchase of goods. Any company that possesses or acquires a customer's personally identifiable information ("PII") or protected health information ("PHI") has this exposure. Thus, all companies that store their trade secrets, processing methods, customer lists and financial information on a computer system will also have this first party exposure as well.

The Cyber Liability Policy

The recent data breach cases illustrate the data security challenges that will continue to be faced by companies in today's electronic world. Attorneys and risk managers must understand and be able to explain to their clients both the retained exposures of operating a company without cyber risk insurance coverage and the potential advantages of purchasing such coverage.

A cyber liability policy can provide protection against both first and third party claims, including post-breach notification and mitigation costs. These costs, if uninsured, have the potential to be catastrophic for companies of any size. Thus, insurance coverage may be required. However, this insurance coverage and the forms used by different insurers can vary dramatically. Thus, not only is it vital for attorneys and risk managers to understand cyber liability insurance policies, but it is also paramount that the different choices within these policies are explained to the decision-makers and they are afforded the ability to choose a cyber risk insurance product that best suits the company's needs.

Conclusion

Companies, attorneys and risk managers alike must come to the realization that cyber risk insurance is becoming a necessity in today's internet world. Companies that consciously forgo this insurance coverage must recognize the significant exposure that they are choosing to retain. These companies must analyze the average cost of $188 per record breached multiplied by the number of customers for whom they possess PII or PHI.

For a company of any size, cyber liability exposure can be extreme. Additionally, each company must weigh its own first party losses that it will suffer in the event its business proprietary information was destroyed or published to the world as a result of a cyber attack. As the threat of cyber attack continues to increase, attorneys and risk managers must assist the company in the formula of a strategy to deal with this threat. For many companies, cyber risk insurance coverage may become as common as comprehensive general liability insurance or property insurance coverage.

About the Author

Douglas Young is council member of the Insurance and Indemnity Section. He is a Member of Wilson Young PLC and has a law practice focused on insurance matters. He represents individual and corporate policyholders in a wide variety of insurance coverage disputes with insurance carriers. He also represents companies in the formulation of comprehensive risk transfer strategies involving self-insured retentions and captive insurance companies.

Mr. Young would like to acknowledge the assistance of Ted Degenhart, Law Clerk at Wilson Young PLC, in the preparation of this article. Mr. Young can be reached at dyoung@wilsonyoungplc.com and (313) 983-1235.

Endnotes


The Certificate of Insurance and Senate Bill 715

Hal O. Carroll, Law Office of Hal O. Carroll*

The certificate of insurance is one of those peculiarities of insurance practice that confuse many lawyers who do not practice in this area. The idea is simple enough, but the way the certificate is used is what causes the confusion.

The starting point is the situation where a general contractor hires a subcontractor. The general wants to be sure the sub has insurance, just as the Michigan Secretary of State wants to be sure a driver has insurance. So the general, like the Secretary of State, asks the sub for a certificate to prove the policy has been issued to the person who claims to be insured. Nothing complicated here.

There is even a standard form for each. For the contractor scenario, the usual form is a one-page form that says “Certificate of Liability Insurance” at the top. The subcontractor’s insurance broker prepares it and puts his or her name in the box at the top, and then fills in the boxes showing which policies apply and the policy limits of each. The purpose is to provide information to the general about the insurance that covers the sub. The form itself even says that in the upper right corner:

“This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policies below.”

The “certificate holder” in our scenario is the general contractor, and form has a box in the lower left corner for the general’s name. Above that box is another one, entitled “Descriptions of Operations, Vehicles, Special Items.” This is where the broker can insert a description of the project that the general and the sub are working on.

Bill 715 is a solution in search of a problem, and seems to be a reflection of the peculiar and pervasive philosophy that for every social ill, there needs to be a regulation promulgated by wise and distant savants, each regulation nudging society a bit closer to perfection.

Again, there is nothing complicated here.

But, humans being what they are, this simplicity gets mucked up. The general wants more than just to know that the sub is insured. The general also wants to be insured under the sub’s policy. Members of this Section of the State Bar know that to add an insured means amending the policy and amending the policy can only be done by an endorsement. There are several different types of “additional insured” endorsements.

But what often happens in practice is that the broker types something like this in the box for “Descriptions of Operations, Vehicles, Special Items”: “General Contractor XYZ is an additional insured.”

* As with all articles in this publication, the views expressed are solely those of the author. The Insurance and Indemnity Section has not taken a position on Senate Bill 715.
There is something to be said for government stepping aside and permitting contractual acts between consenting adults, even when the adults don’t always get it right, and the courts have to sort things out.

The problem is that this is ineffective as a matter of contract law. First, the law is clear that the certificate is not part of the policy. “The certificate is no part of the insurance contract.”1 Second, the certificate is not issued by the insurer, so the insurer can’t be bound by it. The broker issues it, and the broker is the agent of the insured, not the insurer. “[T]he independent insurance agent or broker is considered an agent of the insured rather than an agent of the insurer.”2 It is possible to have an endorsement that refers to the certificate to define additional insureds, but if so, the power to change the policy comes from the endorsement, not the certificate.

Asserting “additional insured” language in an endorsement is so common that it is the norm, and insurance coverage practitioners deal with it on a regular basis, along the lines of the preceding paragraph.

Enter Senate Bill 715. This bill seeks to remedy the situation described above. It does this by requiring, first, that every certificate have the language they already have in the upper right hand corner to the effect that the certificate is for information only and doesn’t change the policy.

This bill would do several things. First, it prohibits issuing a certificate that purports to amend the policy or extend the policy’s coverage.

Second, it prohibits anyone from “prepar[ing] or issu[ing],” or “demand[ing] or requir[ing]” a certificate “that contains any false or misleading information concerning an insurance policy.” The bill does not define “false or misleading,” but probably someone is an additional insured when they are not would qualify, because that is not true.

The bill has penalties, to be assessed in an administrative action. The penalties can be as low as $500 or as high as $2500, depending on the state of knowledge of the wrongdoer. The director can also get an injunction to prohibit the miscreant from further misdeeds.

It’s interesting that the House and Senate Legislative Analyses do not identify a problem that the bill is required to address. They say a few words about the economic cost of enforcing the bill, but not about why it is needed. Perhaps they had the scenario above in mind.

So, is SB 715 a good thing? It’s true that certificates are routinely issued with that ineffective text about additional insureds. This must certainly happen many thousands of times a year. But whenever push comes to shove over the effect of this language about additional insureds, the attorneys and courts involved handle it routinely and without anyone being led astray. Attorneys and judges all understand the law, or quickly learn it.

Bill 715 is a solution in search of a problem, and seems to be a reflection of the peculiar and pervasive philosophy that for every social ill, there needs to be a regulation promulgated by wise and distant savants, each regulation nudging society a bit closer to perfection.

But, philosophy aside, consider the practical effects. Bill 715 will not void any certificate issued in violation of its precepts, so any litigation that relates to them will go on as before. And even if it did void the “additional insured” language in a certificate, that is in effect what courts already do. In that sense SB 715 can claim the virtue of being harmless because it’s ineffective.

But it does raise the specter of extensive, expensive and pointless administrative litigation to assess “civil fines” against the brokers who “prepare and issue” these certificates and the general contractors who “demand and require” them. The civil fines can themselves be annoying, but defending against an administrative proceeding adds another layer of expense.

But there is a countervailing philosophy to perfection by regulation. There is something to be said for government stepping aside and permitting contractual acts between consenting adults, even when the adults don’t always get it right, and the courts have to sort things out. Courts have been doing that for a while now, after all.

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. Mr. Carroll practices extensively in the area of insurance coverage and indemnity law, and was designated a “Super Lawyer®” again in 2013. He also consults with businesses and insurers on the drafting of contracts, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His website is www.HalOCarrollEsq.com and his email address is HOC@HalOCarrollEsq.com.

Endnotes

1 Chrysler Corp v Hardwick, 299 Mich 696, 700; 1 NW2d 43 (1941)

SENATE BILL No. 715

December 5, 2013, Introduced by Senators CASPERSON, HUNE, ROBERTSON and SMITH and referred to the Committee on Insurance.

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
(MCL 500.100 to 500.8302) by adding chapter 22A.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

CHAPTER 22A

SEC. 2270. AS USED IN THIS CHAPTER:

(A) "CERTIFICATE OF INSURANCE" MEANS A DOCUMENT, REGARDLESS OF HOW TITLED OR DESCRIBED, THAT IS PREPARED BY AN INSURER OR INSURANCE PRODUCER THAT IS A STATEMENT OR SUMMARY OF AN INSURED'S PROPERTY OR CASUALTY INSURANCE COVERAGE. CERTIFICATE OF INSURANCE DOES NOT INCLUDE A POLICY OF INSURANCE, INSURANCE BINDER, POLICY ENDORSEMENT, AUTOMOBILE IDENTIFICATION CARD, CERTIFICATE ISSUED UNDER A GROUP OR MASTER POLICY, OR EVIDENCE OF COVERAGE PROVIDED TO A LENDER IN A LENDING TRANSACTION INVOLVING A MORTGAGE, LIEN, DEED OF TRUST, OR OTHER SECURITY INTEREST IN OR ON ANY REAL OR PERSONAL
PROPERTY.

(B) "DIRECTOR" MEANS THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES.

(C) "INSURANCE" MEANS ANY OF THE LINES OF AUTHORITY IN CHAPTER 6.

(D) "INSURANCE PRODUCER" MEANS THAT TERM AS DEFINED IN SECTION 1201.

SEC. 2271. A PERSON SHALL NOT DO ANY OF THE FOLLOWING:

(A) ISSUE OR DELIVER A CERTIFICATE OF INSURANCE THAT PURPORTS TO AFFIRMATIVELY OR NEGATIVELY ALTER, AMEND, OR EXTEND THE COVERAGE PROVIDED BY AN INSURANCE POLICY REFERENCED IN THE CERTIFICATE OF INSURANCE.

(B) PREPARE OR ISSUE A CERTIFICATE OF INSURANCE THAT CONTAINS ANY FALSE OR MISLEADING INFORMATION CONCERNING AN INSURANCE POLICY REFERENCED IN THE CERTIFICATE OF INSURANCE.

(C) DEMAND OR REQUIRE THE ISSUANCE OF A CERTIFICATE OF INSURANCE FROM AN INSURER, INSURANCE PRODUCER, OR POLICYHOLDER THAT CONTAINS ANY FALSE OR MISLEADING INFORMATION CONCERNING AN INSURANCE POLICY REFERENCED IN THE CERTIFICATE OF INSURANCE.

SEC. 2272. A PERSON SHALL NOT ISSUE OR DELIVER A CERTIFICATE OF INSURANCE UNLESS IT CONTAINS THE FOLLOWING OR SIMILAR STATEMENT:

"THIS CERTIFICATE OF INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY. IT DOES NOT CONFER RIGHTS UPON A PERSON REQUESTING THE CERTIFICATE OF INSURANCE BEYOND WHAT AN INSURANCE POLICY EXPRESSLY PROVIDES. THIS CERTIFICATE OF INSURANCE DOES NOT EXTEND, AMEND, OR ALTER THE COVERAGE, TERMS, EXCLUSIONS, OR CONDITIONS AFFORDED BY AN INSURANCE POLICY REFERENCED IN THIS
CERTIFICATE OF INSURANCE.".

SEC. 2273. EXCEPT AS OTHERWISE PROVIDED IN AN INSURANCE POLICY, A CERTIFICATE OF INSURANCE DOES NOT REPRESENT AN INSURER’S OBLIGATION TO GIVE NOTICE OF CANCELLATION OR NONRENEWAL TO A PERSON.

SEC. 2275. A PERSON IS ENTITLED TO NOTICE OF CANCELLATION, NONRENEWAL, AND ANY SIMILAR NOTICE CONCERNING A POLICY OF INSURANCE ONLY IF THE PERSON HAS NOTICE RIGHTS UNDER THE TERMS OF A POLICY OF INSURANCE OR AN ENDORSEMENT TO A POLICY OF INSURANCE. THE TERMS AND CONDITIONS OF A NOTICE DESCRIBED IN THIS SECTION ARE GOVERNED BY THE POLICY OF INSURANCE OR ENDORSEMENT. A CERTIFICATE OF INSURANCE DOES NOT ALTER THE TERMS AND CONDITIONS OF THE NOTICE.


(A) PAYMENT OF A CIVIL FINE OF NOT MORE THAN $500.00 FOR EACH VIOLATION. HOWEVER, IF THE PERSON KNEW OR REASONABLY SHOULD HAVE KNOWN THAT HE OR SHE WAS IN VIOLATION OF THIS CHAPTER, THE DIRECTOR MAY ORDER THE PAYMENT OF A CIVIL FINE OF NOT MORE THAN $2,500.00 FOR EACH VIOLATION. AN ORDER OF THE DIRECTOR UNDER THIS SECTION SHALL NOT REQUIRE THE PAYMENT OF CIVIL FINES EXCEEDING $25,000.00. A FINE COLLECTED UNDER THIS SUBDIVISION SHALL BE TURNED OVER TO THE
STATE TREASURER AND CREDITED TO THE GENERAL FUND OF THIS STATE.

(B) THE DIRECTOR MAY APPLY TO THE CIRCUIT COURT OF INGHAM COUNTY FOR AN ORDER OF THE COURT ENJOINING A VIOLATION OF THIS CHAPTER.
Sixth Circuit Update

**En Banc** rehearing Of Disgorgement Decision

*Rachow v. Life Insurance Company of North America,*

(6th Cir. 2014)

2014 U.S. App. LEXIS 3158, Case no. 12-2074

You may recall in the last issue that we reported on the Sixth Circuit’s decision to uphold an award for disgorgement of profits as damages for a breach of fiduciary duty claim. As anticipated, the previous decision and judgment was vacated and the Court will proceed with an *en banc* rehearing. We will report on future developments.

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Deferential Review Is Extremely Deferential

**McClain v. Eaton Corp. Disability Plan**

740 F.3d 1059 (6th Cir. 2014)

In this relatively uncomplicated disability benefits case, the Sixth Circuit took the opportunity to discuss just how deferential judicial review should be under the arbitrary and capricious standard. Acknowledging the familiar refrain that this standard is the “least demanding form of judicial review” but “not, however, without some teeth,” the court cautioned that this standard must be clearly distinguishable from *de novo* review. The court explained that “an ‘extremely deferential review,’ to be true to its purpose, must actually honor an ‘extreme’ level of ‘deference’ to the administrative decision.”

With respect to the disability claim, the plaintiff here asserted that she was no longer able to work due to a back injury suffered on the job. She purchased the highest level of disability coverage, which was designed to replace 70% of her monthly income. After paying benefits for 24 months under the “own occupation” definition of the Plan, the claims administrator applied the “any occupation” definition to review the claim. One of the plaintiff’s treating physicians indicated that she was capable of working part-time at a sedentary occupation with frequent rest breaks, but she had no ability to work full-time. After a transferable skill assessment identified suitable positions that the plaintiff was capable of performing, the claims administrator terminated payment of monthly benefits. During the administrative appeal, the plaintiff provided medical records from another doctor, who also indicated that she was capable of working with appropriate restrictions and limitations. The decision that the plaintiff was not totally disabled from any occupation was upheld.

The plaintiff argued that, even if she was capable of working part-time, the income from the jobs identified by the claims administrator would place her below the poverty line. According to the plaintiff, this would frustrate the purpose of the disability plan that she purchased, which was to provide her with 70% of her pre-disability wages. The court was not persuaded. Applying the extremely deferential standard of review, the court concluded that, because the plaintiff’s doctors indicated that she was capable of doing “some” work, the claims administrator was reasonable in determining that she was not totally disabled from doing “any” work as provided by the Plan.

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File Review Of A Claim Based On Mental Illness Was Insufficient Basis For Denial

*Javery v Lucent Technologies, Inc. Long Term Disability Plan*

741 F3d 686 (6th Cir. 2014)

The plaintiff stopped working at his job as a software engineer due to back pain associated with a diagnosis of degenerative disc disease. He claimed that he was unable to perform the physical or mental aspects of his job due to the pain he experienced when sitting, and the side effects of his prescription medications. After his claim was denied, he filed suit and the district court remanded to the plan administrator for further review of the mental component of the plaintiff’s claim. Additional records were provided regarding the plaintiff’s psychiat...
ric care, including two lengthy inpatient hospital admissions. The plaintiff also provided the Social Security Administration's determination that he was disabled under the federal system. After considering the new information, the plan administrator concluded that the lack of ongoing psychiatric treatment did not support the presence of a mental disorder of such severity so as to preclude the plaintiff from working. The plan administrator also concluded that the additional records did not support functional impairment from a physical or neurological perspective. The claim was again denied, and the plaintiff reinstated suit.

On appeal, the Plan argued that the plaintiff should be judicially estopped from proceeding because he had filed for bankruptcy, but failed to advise the bankruptcy court of his disability claim. The court was not persuaded that the plaintiff had acted with intent and found that any omission of the disability claim was the result of inadvertent or careless error.

The court also found that, although the district court might have given more deference to the plan administrator than was warranted under a de novo standard of review, the district court appropriately remanded the claim for further fact finding that was necessary to supplement the incomplete record.

With respect to the ultimate disability determination, the court reversed the trial court’s decision and found in favor of the plaintiff. The parties agreed that the plaintiff’s job requirements were technically and intellectually demanding and required sitting for prolonged periods. The court found that the medical evidence indicated that a combination of extreme pain, mental illness, and the effects of pain medication caused difficulties in concentrating, handling stress, decision-making, and sitting for an extended length of time. The court gave more weight to the plaintiff’s treating providers in contrast to the file reviews performed by the Plan’s consultants, which were criticized for not providing a solid rationale for their respective conclusions. In particular, the court noted that file reviews are questionable in terms of evaluating claims based in part on mental illness, or where the claim administrator disputes the credibility of a claimant’s complaints. The court also found that one of the file reviewers overlooked or failed to appreciate the nature of some of the medical records, and the other review was very limited in scope. Ultimately, the court held that the plan administrator did not offer a sufficient explanation to contradict the conclusions of the plaintiff’s treating physicians, and remanded with instructions to enter judgment in favor of the plaintiff.

Notably, this disability claim was evaluated under the one year “own occupation” period. Presumably, the claimant will be permitted to submit updated medical records and information from after that period in support of any claim of ongoing disability.

Dispute over MPPAA Mass Withdrawal Subject to Arbitration

Knall Beverage, Inc. v Teamsters Local Union No. 293 Pension Plan, 744 F.3d 686 (6th Cir. 2014)

Some employers with unionized employees are contractually required to provide those employees with pension benefits by contributing to a “multi-employer fund.” These funds are governed jointly by the union and employers. A collective bargaining agreement may typically require the employer to contribute a set amount (e.g., $1/hour) based on the amount of work done by the unionized employees. However, in 1980, Congress passed the Multiemployer Pension Plan Amendments Act (MPPAA). That law added an additional obligation to employers: if an employer is no longer required to contribute to a multi-employer pension plan, that employer must also pay the fund that employer’s share of the fund’s unfunded vested benefits. This “withdrawal liability” can amount to millions of dollars. (In this case, the three employers had liability of $1.5 million, $2.5 million, and $4.2 million.)

When an employer stops contributing, the fund calculates the amount of the withdrawal liability. If the employer disagrees with the fund’s calculation (or even if the employer disagrees that it has withdrawn), the employer must follow a statutory procedure for contesting its liability, including arbitrating the dispute. Only after the employer has completed arbitration, can the employer go to court – and even in court, there is a presumption, rebuttable only by a clear preponderance of the evidence, that the findings of fact made by the arbitrator were correct. And the employer must pay the withdrawal liability assessed by the fund throughout this process under the “pay now, dispute later” rule of MPPAA.

Generally, when an employer withdraws, the fund calculates the amount of liability and a payment schedule and, unless the employer disagrees, that is that. However, if all of the fund’s contributing employers withdraw from the fund, then the fund can allocate additional liability to employers that have withdrawn within the past three year so that all unfunded vested benefits are fully funded.

That is what happened in this case. Knall and two other employers withdrew from the fund and paid their withdrawal liability. But within three years, the remaining employers entered into an agreement that each would withdraw. (The
authors suspect there may be an interesting “back story” involved.) Knall and the two other employers went to court, claiming that the withdrawal of the other employers was a “sham” (MPPAA provides that “sham” transactions are to be ignored) and that the fund could not assess the additional liability. The Sixth Circuit held that the mandatory arbitration requirement applied even to disputes involving “mass withdrawals” and “sham” transactions.

Other Decisions of Note

The following are recent decisions which your authors determined do not warrant a full write-up. Only certain aspects of the decisions are mentioned.

Dispute over Termination of Retiree Health Coverage must go to Trial

Past issues have described case involving attempts by employer to terminate retiree benefits. This is a similar case. The court denied both cross motions for summary judgment and does a good job of reviewing the case law.

Denial of Disability Benefits Reversed

This case is interesting because the Court reversed the denial of a claim for disability benefits even while reviewing the denial under the “arbitrary and capricious” standard. It demonstrates that sometimes a claimant can win even under this deferential standard.

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Economics of Law Practice Survey

All SBM Members Asked to Participate in the 2014 Economics of Law Practice Survey

The State Bar of Michigan Economics of Law Practice Survey only happens once every three years, but the survey results get used daily throughout the state in courtrooms, law firms and by lawyers in all occupational areas. The 2014 survey will begin May 1, and SBM asks every member to participate. This year’s survey has been revamped and streamlined so that it should take no more than five minutes to complete.

In the 2008 Michigan Supreme Court decision Smith v. Khouri, the court referenced the SBM Economics of Law Practice Survey as the primary resource for trial courts in determining attorney fees. It provides the benchmark for more than 50 specific fields of practice by geographic location.

The survey is designed to capture information relevant to the various occupational areas of Michigan attorneys. Private practitioners will be asked questions about their specific practice areas, and those in non-private practice occupations, such as those working in government service, in-house counsel, non-profit organizations, academia, legal services and more, will be asked for information about salaries, benefits, hours worked and job satisfaction.

When members participate in the survey, their privacy will be fully protected and their replies will remain strictly confidential. Results will be reported in the aggregate only—no individual results will be identifiable. The State Bar will not have access to any respondent’s financial information, and attorneys will not be asked to provide a P-number or any other identifying information to take the survey. The survey will be conducted by a third-party vendor on an independent website. However, to help members find the survey, a link to the survey will be provided on the State Bar website.

To sweeten the pot and make participation in the survey a little more fun, participants will be eligible to enter a drawing for prizes, including an iPad, two $250 gift cards, and two $150 donations to the Access to Justice Fund in the name of the prize winners.

For those unable to take the survey online, a paper survey can be requested by calling SBM Director of Research and Development Anne Vrooman at (517) 346-6410. Preliminary survey results will be available at no cost online in the mid-summer.