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Greetings!

The Journal of Insurance and Indemnity Law is one of the greatest benefits to our membership, but our Section offers additional opportunities to our members to enrich the practice of Insurance and Indemnity Law. We would like to hear from you about what other educational opportunities we can offer or what other events you may find useful.

In that regard, you will likely be receiving a survey from us in the next several weeks and we would greatly appreciate any feedback. Please take the time to answer the questions.

Providing educational opportunities is especially important for the members who are new to this area of practice. There is a lot to learn in this area of practice and we want to give the members who are just starting out a good start on the process. In this issue, for example we have an article on how to “DICE” a policy (read each of its principal parts), how to critically read and analyze a policy provision, things to know about the “reservation of rights letter,” and an introduction to ERISA.

If there are any specific “introductory courses” you think we should offer, please let us know.

The section continues to grow and we are looking for ways to fulfill our strategic goals, which include providing educational resources and programs. We are always looking for ideas and participation on that front. Please feel free to email any of your Council members. Funding would not be an issue as we have quite a healthy surplus in the Section account.

Outreach to other Sections is also an important part of our Section’s work. We will be present at the Young Lawyers event in Novi at the Crowne Plaza on Saturday June 4, 2016. We have generously agreed to provide a gold sponsorship. We will also present a session at this event explaining the basic insurance policy structure and language. The article in this issue, “How to D.I.C.E. an Insurance Policy,” is a preview of the presentation.

Planning is also under way for the Annual Bar Meeting which will be held in September in Grand Rapids this year. If you would like to assist in planning, please contact Adam Kutinsky. We also have a committee reviewing changes to the Section By-laws which will be voted on at that meeting so please plan to attend.

Finally, we welcome these new members:

- JoAnn Ellen Cross
- Nicole M. McCarthy
- Lyle A. Peck
- E. Thomas McCarthy, Jr.
- Nicole Marie Walter
- Shelley Moore McCormick

Thank you for joining!  ■

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The Journal – now in its ninth year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The Journal – like the Section itself – takes no position on any dispute between insurers and insureds. But we welcome all articles of analysis, opinion, or advocacy for either position. All opinions expressed in contributions to the Journal are those of the author.

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.

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We Are Writing to Confirm Your OUR Reservation
Reservation of Rights Letters Pose Issues for Policyholders and Insurers
By Michael S. Hale, JD, CPCU, AAI & Melissa L. Hirn, JD

Introduction

This article examines some best practices in issuing reservation of rights letters and discusses where pitfalls often occur for insurers and policyholders. These issues typically arise with liability insurance claims rather than property or other first party claims.

The Reservation of Rights Letter

In most states, an insurer has an affirmative obligation to its insured to provide reasonable notice that it might deny coverage and that its actions in defending a lawsuit do not waive the rights to contest coverage. Principally, the reservation of rights letter provides the policyholder with fair notice of any coverage defenses and allows for the opportunity to obtain independent legal counsel for either the coverage dispute or the underlying lawsuit. The issues typically involved are the scope, timeliness and form of such reservation of rights letters and the consequences of not providing fair notice to the policyholder of any coverage defenses.

A notice of occurrence or claim form sent to the insurer, in most cases by the insurance agent, typically precedes the process of issuing reservation of rights letters. The notice of occurrence or claim form reflects such basic information as the policy number, the type of claim and the insured’s contact person. It is important to note that in Michigan, notice to the independent agent is not tantamount to notice to the insurer and separate duties exist to place the insurance company on notice.¹

Sometimes, claims forms are submitted as notice to the insurer of an occurrence, rather than a claim as is required by most commercial general liability insurance policies. This scenario does not typically create a duty of the insurer to reserve any particular rights because a claim is not being tendered. In this investigatory phase, the insurer is not obligated to issue a reservation of rights letter as a general matter. However, where in question, it may be a best practice for an insurer to utilize a non-waiver agreement with the insured during the investigation and negotiation of a claim. For example, if the insurer attempts to work out a nominal settlement with a third party even though coverage defenses may exist, it should consider using a non-waiver agreement.²

Key Principles from this Article

- Failure of an insurer to send a reservation of rights letter is not the death knell to an insurer on a liability claim but it could be its next door neighbor.
- An adequate reservation of rights letters should do more than cite the policy language or summarize the facts. Instead, it should provide an analysis of the facts and the policy contract and alert the insured to obtain coverage counsel. A general reservation is typically ineffective to preserve the insurer's rights.
- An insurer is obligated to provide timely and fair notice of any covered defenses under the laws of most states, including Michigan.
- Even if placed on notice of a claim, a true excess insurer is not obligated to issue a reservation of rights letter until coverage is triggered by the exhaustion or nonexistence of the underlying coverage.
- A denial letter from an insurer could still trigger a duty of the insured to cooperate and to immediately send any pleadings including any amended complaints.
- Conspicuously absent from many reservation of rights letters is a statement that the letter is not to be construed as an admission of any of the facts or circumstances set forth in the claim or pleading so as to prevent a policyholder from believing that coverage was denied because there was no merit to the underlying lawsuit.
- The applicable jurisdiction’s laws on reservation of rights should be understood and carefully followed.

In contrast, when a third party specifically demands monetary damages against an insured and a specific liability insurance claim is tendered to the insurer, such insurer has an affirmative obligation to either deny coverage, extend coverage with or without a reservation and/or to file a declaratory judgment action to ask a court of competent jurisdiction to decide whether coverage exists.
The Duty to Defend

Although presenting a detailed analysis of an insured’s duty to defend falls outside the main scope of this article, established case law in Michigan clearly provides that the insurer’s duty to defend is broader than its duty to indemnify. Insurers routinely face a challenge in the even a claim may or may not be covered by the policy(ies) it has issued.

In determining an insurer’s duty to defend, one common question concerns whether the insurer’s obligation in assessing the claim extends beyond the four corners of the complaint. If coverage even arguably exists, the court held that the insurance company did not give “reasonable” notice and so was estopped because it waited until after the judgment was obtained in the underlying case to assert a policy exclusion.

Certainly, an insurer cannot avoid extending coverage based on an inartfully or awkwardly worded complaint. The pivotal question is whether there is any possibility that coverage exists for any portion of the tendered lawsuit. It if does, Michigan law obligates the insurer to defend all of the counts in the complaint until such time as the claims can be confined solely to those not covered. If coverage even arguably exists, the insurer should defend the subject lawsuit under a reservation of rights and consider filing a declaratory judgment action. However, all too frequently insurers deny liability coverage in questionable cases without moving forward with a declaratory judgment action. Some insurers appear to adopt a “wait and see” approach as to whether the insured will initiate a lawsuit. This is dangerous territory in many ways and it is, in our view, the better practice to file a declaratory judgment action where the appropriate circumstances are presented. Although most insurers seldom welcome having to sue their customer, this action can show that the insurer is being proactive rather than responsive which, in light of the broad duty to defend obligation of the insurer, can be the more prudent approach.

Michigan Law on Insurer Reservation of Rights and Principles of Waiver

1. The notice must be timely. Notice to an insured that an insurer will provide a defense under a reservation of rights must be timely and specifically state the policy language on which the insurer bases its opinion that coverage may not be afforded under the policy.

Courts in Michigan have held that in assessing whether coverage applies, if a term at issue lacks a definition in the policy, an insurer might need to resort to looking at dictionary definitions. For example, in Auto-Owners Ins Co v All Star Lawn Specialists Plus, Inc, the issue of coverage turned on the definition of “attached,” a term not defined by the policy, and the court looked to the dictionary definition to determine the meaning of this word.

Although Michigan law sets no fixed time period for timely notice, each case presents a different set of facts as to whether the insured was prejudiced by the delay. Of course, an insurer cannot simply sit on its hands and wait until the 11th hour to file a declaratory judgment action because such a delay would be inconsistent with providing reasonable notice. Rather, where the insurer determines not to send a reservation of rights letter to the policyholder, it should promptly file a declaratory judgment action as soon as it knows of the coverage defense. In Meirithew v Last, the court held that the insurance company did not give “reasonable” notice and so was estopped because it waited until after the judgment was obtained in the underlying case to assert a policy exclusion.

Similarly, in Multi-States Transport, Inc v Michigan Mutual Ins Co, the Michigan Court of Appeals determined that a two year delay in filing a declaratory action or sending a reservation of rights letter was unreasonable. However, a four month delay might be reasonable.

2. An insurer is required to give fair and reasonable notice to its insured that the insurer is proceeding under a reservation of rights. What is “fair notice?”

In analyzing the question of whether fair notice was given, Michigan courts require the insurer to fairly inform the policyholder of the exact reasons that coverage is questionable. Principally, courts utilize the equitable estoppel theory to prohibit an insurer from raising defenses when the insurer acted in a manner that was inconsistent with providing specific denial information to the policyholder.

Michigan appears to look at the reasonableness of the notice when determining if the insurer provided “fair notice.” In Osburn Inc. v. Auto-Owners Ins Co, the court determined that the reservation of rights letter was not specific enough to inform the policyholder of the coverage defenses Auto-Owners might assert later. Thus, it did not give reasonable notice to the policyholder and the insurer was estopped from asserting the stated coverage defenses.

Decisions from other states have gone as far as to hold that the reservation of rights letter only provide “fair notice” if they are unambiguous and that any ambiguity will be construed against the insurer. In contrast, Michigan law appears to limit the contra proferentem doctrine to contracts rather than letters.

A “cut and paste” approach to citing policy language alone will not likely afford the policyholder with reasonable notice. Michigan courts instead require at least some analysis beyond policy language as to why the insurer may
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decline coverage. The same conclusion is true where the reservation of rights letter only lists facts without an application of such facts to the policy contract.

This rule requiring insurer notification of coverage defenses seems, on first glance, to be inconsistent with the well-established Michigan law that an insured has a non-delegable duty to read the insurance policy and raise any questions concerning within a reasonable time after issuance of the policy. An insurer could argue that the insured is already on notice of key coverage provisions in the contract. Nonetheless, established law in Michigan provides that an insurer has an independent obligation to give the insured fair notice of its coverage position for a specific liability claim as soon as it knows of such a defense or defenses.

3. A general reservation alone is not adequate and the insurer must cite specific policy language. If an insurer has actual or constructive knowledge of a coverage defense, it has an obligation to present that to the insured. Furthermore, the insurer must timely notify the insured of its intention to disclaim liability. A letter of acknowledgement of receipt of a summons and complaint is not the same thing as a reservation of rights letter. It is surprising to read reservation of rights letters which inartfully cut and paste policy language without providing any real analysis of the facts to the coverages. From the standpoint of an insurer, this may be a self-piercing balloon.

Using complex insurance lingo or legalese is less than desirable. Again, the idea is to provide fair notice to the policyholder. The analysis should be presented clearly with as plain of language as possible.

Under Michigan law, the letter should state:

• That some or all claims against an insured may not be covered,

• That the insurer reserves the right not to indemnify the insured in the event a judgment is entered against it, and

• Should compare the allegations against the insured to the relevant portions of the policy.

Conspicuously absent from many reservation of rights letters is a statement that the letter is not to be construed as an admission of any of the facts or circumstances set forth in the claim or pleading so as to prevent a policyholder from believing that coverage was denied because there was no merit to the underlying lawsuit.

4. If the insurer does not issue a reservation of rights letter, it still preserves its rights in Michigan if it timely files a declaratory judgment action. In Riverside Insurance Company v Kolonich, the policyholder fought a declaratory judgment action that was filed by the insurer by asserting that the insurer had not initially sent any reservation of rights letter. The Court of Appeals disagreed, finding that the Michigan Supreme Court established case law did not require anything other than fair or reasonable notice, stating that a reservation of rights letter is not necessary where a declaratory judgment action is filed.

Should Umbrella / Excess Insurers Issue Reservation Letters?

In general, a true excess insurer issuing a policy designed to provide additional layers over a primary policy, is not required to issue a reservation of rights prior to the time that its policy limit is reached and it begins affording insurance coverage. A different analysis is likely required in the case where there is “primary” versus “excess” coverage in two policies on the same level, i.e. two commercial general liability policies, where an “other insurance” clause says that its coverage is “excess over any other valid and collectible insurance.”

May An Insurer Allocate Defense Costs Between Covered And Noncovered Claims?

Insurers often indicate in their reservation of rights letters that they are entitled to allocate defense costs between covered and non-covered claims. In Michigan this may only be possible where it is later determined that no coverage exists, and thus, no duty to defend given that the insurer is obligated to defend all counts until it can narrow down the entire complaint to being not covered.

In Budd Co v Travelers Indem Co, reimbursement was allowed where allocation between covered and non-covered claims could be established by the insurer.

Michigan Millers, made it clear that if there is going to be any argument that defense costs are recoverable after a determination by a court that there is no duty to defend, an insurer may not recover the defense costs it expended absent a reservation of that right. If the insurer intends to assert such a right of allocation, it must include this statement in the reservation of rights letter.

What Obligations Does The Policyholder Have?

The insured has clear contractual obligations to comply with all policy conditions before, during and after consideration of the claim by the insurer. It is clear that an insured has an affirmative obligation to cooperate with the insurer as detailed in virtually all liability insurance policies. These issues can involve navigating less than smooth waters and warrants the assistance of competent counsel. For example, if the insurer asks for additional documentation or information, it
It is surprising to read reservation of rights letters which inartfully cut and paste policy language without providing any real analysis of the facts to the coverages.

is incumbent upon the insured to provide such information or it could jeopardize coverage under the cooperation clause. If the information is not available or cannot be produced directly, the insured should document this and promptly notify the insurer.

Issues that most often arise in this area relate to an insured doing nothing further after it receives a denial letter from the insurer. If there are new developments such an amended complaint, such documents and information should be submitted to the insurer without delay. Most insurers will ask for such information in denial letters but this can be easily overlooked by the insured later on. Moreover, the insured must be careful to continue to comply with the terms and conditions of the policy after a denial letter, even if the insurer has not asked for additional information.

Should the policyholder respond to the reservation of rights letter? While there is no legal obligation to do so, such a response might be in order where the insurer has either stated incorrect facts, applied the wrong policy, or is missing key information. Further, where an insurer has requested additional information that does not exist or is outside the control of the policyholder, this should be reduced to writing. In any case, in responding to a reservation rights or denial letter, the policyholder should be cautious to work with legal counsel knowledgeable in insurance to be certain that unintended positions are not taken.

Who Should Author The Letter?

Anticipating litigation, it should be noted that the insurance company representative that drafts and signs the reservation of rights letter will likely be the one deposed. It is less than desirable to have the signer of the letter be other than the author as this demonstrates a decision made by someone who did not engage in the analysis.

The Laws of Other States Should Be Considered Where Applicable.

It is critical that the drafter of the reservation be acutely familiar with the laws of the jurisdiction in question, typically the state where the policy was issued to the insurer. This can be often overlooked.

At least one state requires that a reservation of rights letter be sent to an insured within thirty days after the insurer knows of a potential coverage defense. Other states require specific language to be included in the letter. In New Jersey, for example, the reservation must say that the insured is free to reject a defense. In Mississippi, the reservation of rights must say that the letter does not waive or invalidate any rights of either the insured or the insurer.

Conclusion

Reservation of rights letters present concerns to both policyholders and insurers. Michigan law requires that the insurer provide reasonable notice of coverage defenses to the policyholder. This usually involves more than simply sending a letter citing policy language and requires some analysis based upon the facts. Where filed promptly, declaratory judgment actions can substitute for the reservation of rights formal letter, at least in Michigan. The insurer should be particularly sensitive to the specific laws of the state where coverage could be interpreted.

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Endnotes

1 MCL 500.3008 [requiring authorized agent to bind insurer]; See also Mate v Wolverine Mut Ins Co, 233 Mich App 14; 592 NW2d 379 (1999).
2 See MacDonald v State Farm Mut Auto Ins Co, 14 Mich App 408, 413-4; 165 NW2d 665, 669 (1968).
5 Trimas Corp v Zurich American Ins Group, 469 Mich 881; 668 NW2d 909 (2003).


Meirthev v Last, 376 Mich 33; 135 NW2d 353 (1965).

Id. at 37-38.


Osburn Inc v Auto Owners Ins Co, unpublished opinion per curiam of the Court of Appeals, issued November 18, 2003, Docket No. 242313.


Allstate Ins Co v Harris, unpublished opinion per curiam of the Court of Appeals, issued January 16, 1998, Docket No. 199187.


City of Grosse Pointe Park, 473 Mich 188.

Cincinnati Ins Co v Hall, unpublished opinion per curiam of the Court of Appeals, issued June 14, 2011, Docket No. 297600.


1 Insurance Claims and Disputes 5th § 2:1 (citing US Fire Ins Co v Vanderbilt Univ, 82 F Supp 2d 788, 794 (MD Tenn 2000), aff’d, 267 F3d 465 (CA 6, 2001)).


Budd Co v Travelers Indemnity Co, 820 F2d 787 (CA 6, 1987).


29 Fla Stat § 627.426.

Concord Ins Co v Raber, 98 NJ Super 306; 237 A2d 289, 293-94 (App Div 1967);

Taylor v Fireman’s Fund Ins Co, 306 So2d 638, 640, 645 (Miss 1974).
Dicing an onion can make you cry. Taking apart an insurance policy may make you cry harder. And, like the onion, every policy has separate parts. Together they add up to a coherent whole, but to understand the whole policy, you have to handle each part separately.

Each type of insurance policy has its own unique structure. A liability policy is structured differently from a property policy for example, although they do have many similarities. Even within the same type of policy, one insurer may organize the parts in one order, while another might choose a different order.

Despite this, all policies of any particular type must do the same thing – define the coverage it provides, so it is possible to navigate the intricacies of any insurance contract by following a few steps.

The natural tendency for many practitioners is to jump into a coverage analysis by fast forwarding right to the exclusion section of a policy. This compulsion should be avoided if one wants to accurately understand what coverage is provided under the policy. A better way to approach any question of coverage is to examine the policy by thinking of the onion and follow the steps in “DICE.” DICE is an acronym for four steps to successful analysis of the policy.

D – Declarations
I – Insuring Agreement
C – Conditions
E - Exclusions

D is for Declarations

The Declarations of a policy are the page or pages most often found right at the beginning of the insurance documents. The Declarations provide the “who,” “what,” “when,” and “where” of the policy.

The declarations page will tell you the name and address of the “named insured” on the declarations. This may seem obvious, but there are important differences between having the status of a “named insured,” as opposed to being an “insured” by definition, or being an “additional insured.” The differences between how much and what kind of coverage there is for each of these three types of “insureds” can be complicated and it is important to be aware which category a particular person fits into. The named insured, identified in the declarations, is usually the one who pays for the policy and who, logically enough, has the most coverage. Coverage for an “additional insured” is typically limited in some fashion depending on the particular endorsement used to add the person or entity as an “additional insured.”

The declaration page will also set out the effective dates of the policy. The temporal scope of coverage is tied to the effective dates of the policy. Most policies that provide coverage for “bodily injury” or “property damage” require that the “bodily injury” or “property damage” occur during the policy term. Claims made policies have similar requirements that revolve around when the claim is made or when the claim is reported. The declaration page will also describe the location and number of buildings specifically insured if the policy is a property insurance policy. They also may list items of personal property or equipment specifically covered by a special coverage form. The declarations page will also list any additional interests to the proceeds of insurance such as mortgagors, security interests, etc.

Of course, the declaration page will also describe the policy limits – how much coverage there is. There is usually more than one limit, depending on the type of property loss or liability claim.

There are important differences between having the status of a “named insured,” as opposed to being an “insured” by definition, or being an “additional insured.”

The declarations page will also tell you what forms and endorsements are part of the policy. Every policy is made up of “forms”: usually a base policy and the various endorsements that may be added. Many types of coverage are added to the basic policy by endorsement. For example, common endorsements to an auto policy would likely include additional endorsements for uninsured/underinsured motorist coverage, no fault benefits, or some type of rental fee reimbursement. Endorsements are usually listed by their desig-
nation which is either a series of numbers or letters or combination of both numbers and letters. Other endorsements are used to limit coverages, or to define the “additional insureds” referred to above.

It is very important to review any exclusion carefully and to read the exclusion in its entirety. Not all exclusions apply in every circumstance.

I is for Insuring Agreement

The policy form will have one or more provisions, often in a separately titled section, that describe the broad grant of coverage that is being made. Other forms or endorsements, or coverage parts may expand or narrow the coverage provided by the base policy form. Different types of policies and endorsements have different grants of coverage. In a liability policy, the insuring agreement section will begin with a description of the types of claims or occurrences it covers.

The insuring agreement will also contain a promise to indemnify the insured for the loss. For example, a commercial general liability (“CGL”) policy may provide coverage for the insured’s legal liability to pay damages for “bodily injury,” “property damage,” “personal injury” and “advertising injury.” Another important promise typically included in the grant of coverage in a liability policy is the insurer’s promise to defend the insured against claims and suits. These promises to defend and indemnify are generally the core of any liability policy.

Liability policies also often provide many types of supplementary payments in addition to promises to indemnify or defend. Supplementary payments may include medical payments or the interest taxed against the insured in a lawsuit.

Property protection policies usually set out the types of property that are covered and the types of perils for which loss will be paid as part of the insuring agreement. Auto Physical Damage coverage in an automobile insurance policy might provide that the insurer “will pay for loss or damage to [the automobile scheduled on the declarations] and its equipment caused by (1) fire or lightning; (2) theft…” or other specified causes.

E is for Exclusions

Exclusions in the policy narrow the grant of coverage provided by the insuring agreement. Exclusions limit coverage for many reasons. Common exclusions address the types of risk that are traditionally not insurable, such as business risks, criminal acts, fraud or intentional conduct. Other exclusions address matters that are better insured by other types of insurance. A general liability (GL) policy, for example, will exclude liability for automobile accidents. Some exclusions address what is known as the “moral hazard” which is the hazard that a party will act irresponsibly or recklessly because they have acquired insurance coverage.

It is very important to review any exclusion carefully and to read the exclusion in its entirety. Not all exclusions apply in every circumstance. Many exclusions set out exceptions describing when the exclusion will not apply. Some endorsements that provide additional coverage may also remove certain exclusions entirely from the policy.

D is for Definitions

As we approach the end of the process, we can add another D and make our acronym past tense DICED. This D is for the definitions section that is found in most policies. This is where most – but not all – of the policy’s important terms are defined, subject, of course, to the endorsements.

A thorough coverage analysis requires a complete review of the entire policy and declarations, but it helps to think of the policy in terms of its components and the role that each one plays. To get a good start on your analysis, remember to just DICED it up.
One of the best ways to learn how to interpret an insurance policy clause is to study a poorly written one. The forms written by the Insurance Services Office (ISO) are generally of high quality, and have earned their status as the industry standard. If you are looking for a poorly drafted clause, you need to find a “manuscript” form – a form that is written by the insurance company itself.

The quality of the drafting that is done within an insurer varies greatly. That is why if you are representing someone seeking coverage, manuscript forms deserve special attention, because the drafter’s problem is the claimant’s opportunity.

But for the present, let’s look at the other benefit. There is a lot to be learned from bad writing. If you can learn what kinds of defects bad writing shares, you can avoid them if and when an insurer asks you to assist them in drafting a manuscript form. Knowing what not to do is a good first step in knowing what to do.

Drafting a policy clause is an art, even if it’s not Shakespeare. And unlike Shakespeare’s audiences, the drafter of a policy is drafting for hostile eyes. A misplaced comma or poorly chosen conjunction or preposition can be very expensive for the client.

Drafting a policy clause, like interpreting it, is pretty dry stuff. Humor is rare, although it sometimes happens, especially if a non-lawyer does the writing. One manuscript policy had a clause that said:

“If any clause in this policy is ambiguous, the parties may utilize parole [sic] evidence.”

Two things are wrong with this. First, it’s not necessary, because the law already calls for extrinsic evidence to resolve ambiguities. Second, the extrinsic evidence we use is called “parol,” not “parole.”

Anyway, let’s start with a real clause from a real manuscript policy and fix it step by step. A definition of “property damage” reads:

Property Damage – The term “Property Damage,” wherever used herein, shall mean damage to or destruction or loss of use of property of others, (excluding, however, damage to property in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

Step 1 – Remove the chaff

The first step is to remove unnecessary words.

Property Damage – The term “Property Damage,” wherever used herein, shall mean damage to or destruction or loss of use of property of others, (excluding, however, damage to property in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

For some drafters of policy language, the tendency to add repetition and curlies is strong. But there is no reason to say “property damage” twice. There’s also no reason to say “whenever used herein”; where else would it be used? There’s no need to say “shall mean.” “Shall” is the language of command and serves no purpose. Putting in unnecessary words adds nothing of value and runs the risk of adding something harmful.

In clean form, the clause now reads:

Property Damage means damage to or destruction or loss of use of property of others, (excluding, however, damage to property in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

Step 2 – Fix the core definition

The next step is to look for specific terms that can be improved.

A good principle is “Don’t define a word by using the word you are defining. Saying “Property Damage means damage . . .” is a circular definition and a per se drafting faux pas. If we replace “damage” with “physical injury” it avoids circularity. Inserting “physical” also makes clear that we are talking about tangible property, not the many kinds of intan-
gable property interests. Just to be sure, we can insert the word “tangible” in front of “property.”

There is a lot to be learned from bad writing. If you can learn what kinds of defects bad writing shares, you can avoid them if and when an insurer asks you to assist them in drafting a manuscript form. Knowing what not to do is a good first step in knowing what to do.

Step 3 – Clarify the exception

Also, the parenthetical phrase is not as clear as it could be because it is intended to remove from coverage property of “others” that is in the custody of the insured, but there is no reference to “others” in the parenthetical phrase.

Both of these can be fixed this way:

**Property Damage** means physical damage to or destruction or loss of use of the tangible property of others, (excluding, however, but not any property of others that is in the care, custody or control of the Named Insured), including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

In clean form, it now reads:

**Property Damage** means physical damage to or destruction or loss of use of the tangible property of others, but not any property of others that is in the care, custody or control of the Named Insured, including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

Up to the word “including,” it’s easier to read. Note that replacing “excluding, however” with “but not” also avoids the confusion of using “excluding” in one phrase and then following it immediately with “including.”

Step 4 – Separate the separate coverages

Avoiding run-on sentences is always good, and especially so in policy clauses. Here the policy uses the word “excluding” to introduce one phrase and then uses “including” to introduce the next. The problem is that it’s not clear if “including” means that the “included” property is include in the category of the “excluded” property or is included within covered property.

So the next target is the second half of the sentence, which begins with “including.” This applies to a separate category of property: property that the insured is buying “on time.” What it is trying to do is provide coverage only to the extent of what the seller is owed. But it does this in a sloppy way. The text reads:

including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

The idea is to limit coverage to the amount still owed to the seller, so as to protect the seller’s financial interest. Fair enough, but the language needs a lot of work. It’s a real mess.

This is qualitatively different from the first half of the clause, because here, it is both providing coverage and limiting the amount. So the first step is to make this a new sentence.

Second, the clause uses the phrase “title remains with the sellers,” but a “title-retaining contract” is only one kind of security interest and by far the least common. The coverage should not depend on whether the insured is in a “title-retaining” state or a “lien” state. This distinction, as to personal property is archaic since the advent of the Uniform Commercial Code. If the term is taken literally, the insured could well find itself without coverage depending on the formal structure of the purchase. So it’s better to use the generic term “security interest.” Before that, we need to drop the beginning phrase “including property.” This is a separate kind of coverage.

The text that comes before “including” covers damage to the property of others, but this part imposes a limit on coverage where the damaged property belongs to the insured, but the seller has a financial interest to the extent of the outstanding debt. If that property is damaged or destroyed the seller will sue for the financial loss. This contains language that tries to limit the coverage to the amount the seller has lost. Splicing the different concepts together in one sentence is a bad idea. In fact, it’s not clear that they even belong in the same clause. It’s odd to put a coverage limitation in a definition. Fair enough, but the language needs a lot of work. It’s a real mess.

The coverage limit should be a whole new sentence, not tacked onto the previous one. Rewriting the whole second part, it would begin like this:

For property owned by the Named Insured that is subject to a security interest resulting from the Named Insured’s purchase of the property, the coverage provided by this policy shall not exceed . . . . .

The next question is what it should not exceed, i.e., how much will the insurer pay. Right now, it says the insurer’s obligation is limited to “the payments outstanding.” But the
sum of the payments outstanding is almost certainly greater than the amount of the remaining debt, since each payment includes interest. So the sum of the payments outstanding will exceed the amount of the debt.

Probably, if the seller tries to get this windfall, the court will find a way to keep it from happening, but that’s no excuse for writing it poorly. So the limit should be set at whatever the seller’s actual financial interest is.

For property owned by the Named Insured that is subject to a security interest resulting from the Named Insured’s purchase of the property, the coverage provided by this policy shall not exceed the principal balance of the indebtedness remaining to be paid to the seller.

After all of these repairs are made, this is what we end up with.

Property Damage means physical damage to or destruction or loss of use of the tangible property of others, but not any property of others that is in the care, custody or control of the Named Insured. For property purchased by the Named Insured and which is subject to a security interest resulting from the Named Insured’s purchase of the property, the coverage provided by this policy shall not exceed the principal balance of the indebtedness remaining to be paid to the seller.

This clause is more direct and easier to understand and therefore and more “user-friendly” than the existing version. It accomplishes this by a step by step process. There are other ways to accomplish what the insurer wants. But the technique of fixing a bad clause is still valid: drop the unnecessary words, look closely at the definitions, watch out for conjunctions, and put separate concepts in separate sentences.

About the Author

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A Basic Introduction to ERISA Benefits Litigation

By K. Scott Hamilton and Kimberly J. Ruppel, Dickinson Wright PLLC

Litigation under the Employee Retirement Income Security Act (“ERISA”), 29 USC §1001 et seq, can be confusing and perplexing to even seasoned insurance lawyers if they do not regularly practice in that area of the law. This article is a very basic introduction to the most fundamental principles of ERISA litigation, focusing on those aspects of ERISA that are most important in litigating medical, disability, or life insurance matters.

What is ERISA?

ERISA is a comprehensive federal statute designed to provide nationally uniform rules and regulations for establishing and maintaining pension plans and employee welfare benefits plans. It displaces, or pre-empts, almost all state laws and causes of action, so that employers and insurers are governed by only one comprehensive set of federal requirements, rather than the laws of several different states. ERISA provides a framework for filing and resolving benefit claims that is designed to be efficient, inexpensive and prompt. By providing employers certain protections and uniform regulation, it is intended to encourage employers to establish employee welfare benefit plans for their employees.

ERISA’s civil enforcement mechanism gives insureds (ie, “participants” and “beneficiaries”) the right to sue for denied benefits. It provides that a “civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”

Application of ERISA in an insurance dispute has extreme, and often outcome-determinative, effects on the litigation. Whether or not a claim is governed by ERISA is therefore one of the first issues that should be addressed in any insurance action involving a claim for benefits.
When Does ERISA Apply to a Claim for Insurance Benefits?

ERISA applies to any “employee welfare benefit plan,” which is “any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.”

An ERISA plan is usually a “group” policy of insurance under which a class or classes of employees are insured. However, the insurance policy need not necessarily be a group policy for it to constitute an ERISA plan. An ERISA plan can, and often does, consist of an individual disability insurance policy or policies.

Thompson v American Home Assurance Co, 95 F3d 429 (6th Cir. 1996), established a 3-part test to determine whether a plan or policy satisfies the definition of an “employee welfare benefit plan.” It is:

(i) Apply the “safe harbor” regulations established by the Department of Labor to determine if the plan or policy is exempt from ERISA. An insurance policy is not governed by ERISA only if all of the four “safe harbor” criteria in the regulation are met.

(ii) See if there is a “plan” by inquiring whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, the class of beneficiaries, the source of financing and procedures for receiving benefits; and

(iii) See if the employer “established or maintained” the plan with the intent of providing benefits to its employees.

Thompson, 95 F3d at 434-35.

Under the 3-part test, whether an ERISA plan exists is a question of fact to be determined in light of all the circumstances from the point of view of a reasonable person.

How Does Litigating of ERISA-Governed Claims Differ From Litigating Non-ERISA Claims?

A court deciding an action under §1132(a)(1)(B) must determine whether the benefit decision was proper based upon (1) the contents of the “administrative record” given (2) the appropriate standard of review. A denial of benefits challenged under §1132(a)(1)(B) is reviewed by the court de novo (i.e., with no deference to the insurer’s decision) unless the plan or policy gives the decision-maker discretion to determine eligibility for benefits. In that case, an “arbitrary and capricious” standard of review will apply, and the insurer’s decision must be upheld “if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence,” even though the court may have reached a different conclusion.

The differences between litigating ERISA and non-ERISA insurance benefit claims are numerous and profound. The most important are discussed below.

All state law claims are pre-empted

ERISA provides that it “shall supersede any and all State laws insofar as they may . . . relate to any employee benefit plan . . .” Thus, ERISA precludes an insured from bringing traditional state law claims such as breach of contract, fraud, intentional infliction of emotional distress and similar causes of actions that are often associated with an insured’s action for denied benefits. An insured’s exclusive remedy for denied benefits is the statutory remedy in 29 USC §1132(a)(1)(B).

There is complete, or “field,” pre-emption which allows removal regardless of the claims actually pleaded

Complete or field pre-emption is the doctrine that when Congress so regulates an area of federal concern with a statutory framework that governs the relationships of the parties subject to the regulation, it is intended to displace or supplant any other governmental regulation (including any state law), and the federal statutory framework becomes the sole and exclusive body of law in that “field.” With ERISA, Congress so dominated the field of employee welfare benefits and pension plans that ERISA pre-empts any other state remedy concerning a claim for such benefits.

Complete pre-emption derives from 29 USC § 1132(a), which is ERISA’s civil enforcement provision. Under the “Mottley well-pleaded complaint rule,” a complaint filed in state court cannot be removed unless, based upon its “well-pleaded” allegations, it asserts a federal claim.

However, the “Supreme Court has recognized some areas of federal legislation that are so comprehensive that they constructively convert state law claims that come within their scope into claims ‘arising under’ federal law, creating a ‘com-
plete preemption exception’ to the well-pleaded complaint rule.” Metropolitan Life Ins Co v Taylor. “extended this exception to state law claims that fell within the scope of ERISA’s civil enforcement provision, 29 USC §1132(a). Taylor held that a suit for benefits, even “though it purports to raise only state law claims, is necessarily federal in character by virtue of the clearly manifested intent of Congress. It, therefore, ‘arise[s] under the . . . laws . . . of the United States,’ 28 USC § 1331, and is removable to federal court by the defendants, 28 USC § 1441(b).”

Thus, even if a plaintiff’s complaint alleges only state law claim, such as breach of contract, and is devoid of any reference to ERISA (or any other federal statute), it can nonetheless be removed to federal court.

ERISA precludes an insured from bringing traditional state law claims such as breach of contract, fraud, intentional infliction of emotional distress and similar causes of actions that are often associated with an insured’s action for denied benefits. An insured’s exclusive remedy for denied benefits is the statutory remedy in 29 USC §1132(a)(1)(B).

The court’s decision must be based only on the contents of the “administrative record”

The Supreme Court has recognized that courts must limit “the record for judicial review to the administrative record compiled during the internal review” of a benefits claim. What is the “administrative record” the court reviews in a §1132(a)(1)(B) action? Typically, the administrative record is all the information and materials that were available to the plan administrator when it decided the benefits claim, and is usually simply the claim file. That information often includes: The claimant’s medical records, office examination notes, test results, independent medical examination reports, peer review reports, correspondence between the claimant and the plan administrator, the insurance policy, the summary plan description, the employer’s welfare benefits plan, the claims analysts notes, reports by any reviewing consultant or medical provider and surveillance report or records.

Evidence outside the administrative record cannot be considered by the Court. Thus, affidavits, depositions and other testimony or documents cannot be added in the course of litigation.

There is usually no, or very limited, discovery

It follows from the limitation of review based only on the administrative record that ERISA cases do not involve the same level of discovery as other litigation matters. The seminal Sixth Circuit case that established the procedural framework for ERISA matters is Wilkins v. Baptist Memorial Healthcare Systems. Rather than proceed to trial, the court is to rule on the propriety of the benefits decision based upon the administrative record that was before the claim administrator at the time the decision was made, by applying the appropriate standard of review. Therefore, most often, there are no depositions, interrogatories or other discovery requests, aside from voluntary production of the administrative record.

Discovery may be allowed with respect to challenges to due process during the administration and processing of the claim, or if plaintiff makes a showing of bad faith by the insurer, or whether the insurer’s decision was infected by its own self-interest.

There is no trial on the merits, nor traditional summary judgment motions

Again, because a court deciding an §1132(a)(1)(B) claim is deciding whether the benefit decision was proper based only on the administrative record, it follows that the court need not (and cannot) take testimony or consider other evidence that was not before the insurance benefit decision-maker. Therefore, neither a bench nor jury trial is permitted.

Similarly, the court must determine whether the decision-maker rendered a proper decision based upon the court’s de novo review of the administrative record, or based on whether the decision was supported by “substantial evidence” and principled reasoning. The standard is not whether there is an absence of any genuine issue of material fact such that one party is entitled to judgment as a matter of law. Therefore, summary judgment motions are inapplicable in ERISA actions.

The proper procedural vehicle for resolving claims in the Sixth Circuit, as well as in most other jurisdictions, is for the parties to move for judgment on the administrative record. Courts often have the parties file cross-motions (the plaintiff would file a “Motion to Reverse the Administrative Decision,” and the defendant a “Motion to Affirm the Administrative Decision”), and the court then renders judgment based on those motions. That procedure was originated in Wilkins v. Baptist Healthcare System, Inc and that case gives a good description of the applicable procedure.

The insured must exhaust administrative remedies before filing an ERISA claim

Although ERISA does not set out an express exhaustion requirement, the Sixth Circuit has held that the “administrative scheme of ERISA requires a participant to exhaust his or her administrative remedies prior to commencing suit in federal court.” Exhaustion is not necessary if the insured can make a “clear and positive indication of futility” in using the insurer’s internal appeal processes before suing under §1132(a)(1)(B).
This means that if an insured who is denied benefits is given the opportunity to appeal the denial through the insurer’s process for doing so, yet fails to appeal, that failure may be fatal to a suit under §1132(a)(1)(B).

Rather than proceed to trial, the court is to rule on the propriety of the benefits decision based upon the administrative record that was before the claim administrator at the time the decision was made, by applying the appropriate standard of review. Therefore, most often, there are no depositions, interrogatories or other discovery requests, aside from voluntary production of the administrative record.

The prevailing party is usually entitled to attorney’s fees

Unlike the usual “American Rule” under which each litigant bears his or her own attorney’s fees, 29 USC §1132(g)(1) provides that “[i]n any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney’s fee and costs of action to either party.”

Secretary of Dept of Labor v King provides the analytical framework for deciding a motion for attorney fees under §1132(g). In exercising its discretion, a district court should consider the following factors:

1. The degree of the opposing party’s culpability or bad faith;
2. The opposing party’s ability to satisfy an award of attorney fees;
3. The deterrent effect of an award on other persons under similar circumstances;
4. Whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolved significant legal questions regarding ERISA; and
5. The relative merits of the parties’ positions.

A district court’s denial of fees is usually not an abuse of discretion if no single factor “weighs heavily” in favor of awarding fees.

Conclusion

Litigating ERISA-governed insurance benefit claims is radically different from “traditional” insurance benefits litigation. ERISA brings into the mix several principles and procedures that may seem foreign, if not bizarre, when viewed from the perspective of typical litigation. The above is only a brief summary of the many differences.

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Endnotes

2 29 USC §1132(a)(1)(B).
3 29 USC §1002(1).
4 See Agrawal v Paul Revere Life Ins Co, 205 F3d 297, 300 (6th Cir. 2000); Massachusetts Cas Ins Co v. Reynolds, 113 F3d 1450, 1453 (6th Cir. 1999).
5 Reynolds, 113 F3d at 1453.
6 The “safe harbor” regulations are set out in 29 CFR §2510.3-1(j).
10 29 USC §1144(a).
13 CC Mid West, Inc v McDougall, 990 F Supp 914, 917 (ED Mich. 1998).
15 CC Mid West, 990 F Supp at 917.
16 481 U.S. at 63-4, 67.
18 150 F3d 608 (6th Cir. 1998).
20 150 F3d 609 (6th Cir. 1998)
22 Fallick v Nationwide Mut Ins Co, 162 F3d 410, 419 (6th Cir. 1998).
23 775 F2d 666 (6th Cir. 1985),
24 775 F.2d at 669.
25 Schwartz v Greger, 160 F.3d 1116, 1121 (6th Cir. 1998).
Selected Insurance Decisions

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

Michigan Supreme Court Orders And Decisions

Leave granted to consider Total Pollution Exclusion

Hobson v Indian Harbor Ins Co
Supreme Court No. 151447
December 9, 2015

The parties have been directed to address: “(1) whether the Total Pollution Exclusion Endorsement is ambiguous, and (2) whether there was a discharge, dispersal, seepage, migration, release, or escape of a pollutant that caused the plaintiffs’ injuries.”

Leave granted on transportational function

Kemp v Farm Bureau General Ins Co of Mich
Supreme Court No. 151719
February 5, 2016

The parties have been directed to address: “(1) whether the plaintiffs injury is closely related to the transportational function of his motor vehicle, and thus whether the plaintiff’s injury arose out of the ownership, operation, maintenance, or use of his motor vehicle as a motor vehicle; and (2) whether the plaintiff’s injury had a causal relationship to his parked motor vehicle that is more than incidental, fortuitous, or but for.”

Michigan Court Of Appeals – Published Decisions

No homeowner’s coverage for sexual misconduct

Home-Owners Ins Co v Smith
___ Mich App ___ (2016)
Docket No. 322694
Released January 12, 2016

Homeowner’s policy does not cover sexual misconduct claim by seven-year old girl against the named insured’s 16-year-old son. The incident was not an “occurrence” within the meaning of the insuring agreement and was otherwise excluded under the “expected or intended injury” exclusion because the son admitted that he acted with intent, and because a reasonable 16-year-old should have expected the nature of the harm inflicted. Summary disposition should have been granted for the insurer in this declaratory judgment action.

Resolution of PIP action has res judicata effect on subsequent UM action

Garrett v State Farm Mut Auto Ins Co
___ Mich App ___ (2016)
Docket No. 323705
Released February 23, 2016

Plaintiff commenced a prior action against State Farm for PIP benefits and the action resolved by way of both parties’ acceptance of the case evaluation award. Plaintiff subsequently commenced a tort action, in which she also asserted a claim against State Farm for UM benefits. The panel members followed Adam v Bell, 311 Mich App 528 (2015) and dismissed the UIM claim on the basis of res judicata but stated they did not agree with the decision and declared a conflict as allowed by MCR 7.215(J)(2). On March 14, 2016, the Court of Appeals issued an order declining to convene a conflict panel.

Michigan Court Of Appeals - Unpublished

Settlement with tortfeasor negates UIM claim

McAuliffe v Auto-Owners Ins Co
Docket No. 323349
Released December 10, 2015

Plaintiff’s insurance policy provided $500,000 in UIM benefits but excluded coverage for “any person who settles a bodily injury claim without our written consent.” The insured’s attorney wrote a letter to Auto-Owners advising of the tender of the tortfeasor’s $100,000 policy limit and followed up multiple times, but never obtained consent to proceed. Because the settlement went forward without Auto-Owners’ consent, UIM coverage was denied. The record did not support a finding of coverage based on equitable estoppel because there was no “support for the conclusion that the insurer, by its silence, intentionally or negligently induced plaintiffs to believe that it was consenting to the settlement at issue.”

Uninsured plaintiff has no actionable tort or UM claim

Rayfield v Stewart
Docket No. 322764
Released December 15, 2015

Plaintiff was injured in an auto accident and filed a residual tort liability suit against the tortfeasor and a UM claim against American Reliable Insurance. But plaintiff was uninsured – he
never renewed his auto policy with American Reliable. Plaintiff had no UM coverage and was also barred from filing suit for residual liability.

Law enforcement liability policy covers excessive force claims

Charter Twp of Shelby v Argonaut Ins Co
Docket No. 324447
Released December 22, 2015

The insuring agreement for this law enforcement insurance policy covered the Township’s liability for damages caused by wrongful acts committed during the course and scope of law enforcement activities. The Court of Appeals found that the insurer had a duty to defend and indemnify the Township on claims that certain police officers engaged in wrongful arrest, excessive force, false imprisonment, and violation of civil rights under 42 USC 1983. The claims were all based on alleged wrongful acts committed in the course of law enforcement activities. And the exclusions for knowing violations of the law and for malicious or criminal acts did not defeat coverage because those claims were not specifically asserted in the underlying complaint.

Health Insurer allowed to discontinue coverage

Pung v Blue Cross Blue Shield
Docket No. 327793
Released January 5, 2016

Plaintiff was insured with the defendant under a health insurance policy. When defendant decided to discontinue private nursing care as part of the covered services for its “small group market,” plaintiff sued to enjoin. The dispute was over which statute controlled: MCL 500.3712(2), allowing the discontinuance as long as the service was discontinued for the entire small group market, or MCL 500.2213b(4), preventing the discontinuance unless the service was also discontinued for the large group market. The court held that the first statute applied and allowed the discontinuance.

“Full credit bid” terminates mortgagee’s interest in property insurance

Howard v American Security Ins Co
Docket No. 323118
Released January 12, 2016

After Plaintiff’s home was substantially damaged by fire, his homeowners insurer issued checks for the dwelling loss, payable both to the plaintiff and to the mortgagee as allowed by the mortgage payee clause in the insurance policy. Afterward, the mortgagee purchased the property in foreclosure on a full credit bid and the mortgage was extinguished. When plaintiff refused to sign the insurance checks, the mortgagee asked the insurer to issue new checks made payable solely to the mortgagee. The insurer did so. Michigan courts follow the “full credit bid rule,” which means that the mortgagee’s entitlement to insurance proceeds for property damage ends when the mortgagee extinguishes the mortgage debt by placing a full credit bid at a foreclosure sale. Plaintiff’s common law conversion claims against both the mortgagee and the insurer were sustained. Claims for statutory conversion, however, were reversed.
Resident relative per this UM policy does not include step-grandchild

_Lei v Progressive Ins Co_
Docket No. 325168
Released February 16, 2016 (lv app pending)

Seventeen-year old Yuan Lei lived part of the time with her mother and step-father Brian Goetz, in a home owned by Brian's mother, Merilyn Goetz. Merilyn died three months before Yuan's auto accident but her policy with Progressive remained in effect. That policy provided UM coverage for relatives, defined as “a person residing in the same household as you and related to you by blood, marriage, or adoption, and includes a ward, stepchild, or foster child. . . .” The majority decided that this policy definition of a relative did not include step-grandchildren (Beckering, J dissenting).

One-year limitations period for property claim

_J & N Koets, Inc v Auto-Owners_
Docket No. 326955
Released March 10, 2016

Property owner's suit against homeowners insurer for the cost of remediating skunk odor was too late because it was filed beyond the statutory one-year limitations period of MCL 500.2833(1)(q). Plaintiff filed suit five years too late.

Injuries did not result from the motoring function of a motor vehicle

_Employers Ins Co of Wausau v Hearthstone Senior Services_
Docket No. 324776
Released March 15, 2016

Injuries sustained by the resident of an assisted living facility when she was allegedly left on the facility-owned minibus for 12 hours after a trip to Meijer did not arise out of the motoring function of the insured vehicle but was the result of the facility's negligent supervision of the resident after the minibus was no longer being used in its motoring capacity. The facility's commercial auto policy did not cover the claim.

UM exclusion for occupancy of non-covered owned vehicles

_Polite v Tyler_
Docket No. 325811
Released March 29, 2016

Farm Bureau's UM policy excluded coverage for “any person injured while occupying an auto owned by you or any family member, if the auto is not insured for UMC [uninsured motorist coverage] by this policy.” The insured owned three vehicles, only two of which were insured with Farm Bureau. The third vehicle was insured under an antique vehicle policy issued by another insurer. Plaintiff was injured by an uninsured motorist while occupying the antique vehicle, and thus could not collect UM benefits under the Farm Bureau policy.

Federal District Court Decisions - Michigan

Replacement costs may be recoverable if insurer delayed repairs

_Dabaja v State Farm & Cas Co_
E.D. Case No. 14-cv-13222
Released March 15, 2016

The court agreed that plaintiff was only entitled to replacement cost value for her property damage if she complied with the conditions of the policy by completing repairs within the required time. But the court found a question of fact about whether the insurer prevented timely completion by delaying approval of the repair estimates, which would open the door to a claim of equitable estoppel.

Flood damage coverage did not include added asbestos damage

_Katz v Safeco Ins Co_
E.D. Case 15-cv-10405
Released March 23, 2016

Plaintiff homeowner sustained damage to her home and personal property as a result of the flooding that occurred throughout southeastern Michigan in the summer of 2014. Her homeowner's insurer paid the limits of coverage for damage caused by the "escape of water from a sump," but denied additional coverage for damage caused by the removal of tiles containing asbestos. Because her policy excluded coverage for losses or injuries attributable to asbestos, no additional coverage was available.

Insured v Insured exclusion in D&O policy

_Indian Harbor Ins v Zucker_
W.D. Case No. 14-cv-1017
Released March 31, 2016

The D&O policy issued to this insured, a bank holding company, contained an “insured v insured” exclusion, barring coverage for certain types of internal and derivative disputes. The Court applied the exclusion to bar coverage for the company's officers when they were sued by the company's trustee in a bankruptcy action. “[T]here is a direct connection between the debtor/company/insureds and the Liquidation Trust, which was created by agreement of the Debtors and Creditors' Committee.” Because the lawsuit was essentially an intracompany claim, the exclusion applied.


Since January 1, 2016, the Michigan Supreme Court has released a very important (and unanimous) Opinion regarding the timeframes for initiating and maintaining a claim for no-fault benefits. We also have a number of published and unpublished decisions from the Michigan Court of Appeals that impact on various provisions of the No-Fault Insurance Act, including a case that provides a new twist on previously unnoticed statutory provision.

**Supreme Court Action**

The Supreme Court clarifies that there are two ways to initiate a claim for no-fault benefits – giving “written notice of injury” within one year after the accident, or where “the insurer has previously made a payment of personal protection insurance benefits for the injury,” which does not contain any time limits.

\[\text{Jesperson v ACIA} \]
\[\_ \text{Mich \_\_ NW2d \_} \]
Supreme Court docket no. 150332, rel’d 3/21/2016

In Jesperson, Plaintiff was involved in a motor vehicle accident on May 12, 2009. The accident was not reported to his insurer, AAA, until June 2, 2010, more than one year post accident. Despite the late notice, AAA began paying personal protection insurance benefits. After terminating benefits, Jesperson amended his then-pending tort suit to include a claim against AAA, seeking payment of additional PIP benefits.

Shortly before trial was scheduled to begin, AAA filed its motion for summary disposition, arguing that because plaintiff had failed to comply with the one-year notice provision, set forth in MCL 500.3145(1), his claim for additional no-fault benefits was barred. The trial court agreed with AAA and dismissed plaintiff’s cause of action.

The Court of Appeals affirmed the decision of the circuit court in a 2-1 decision. The Court of Appeals majority ruled that, because defendant’s first payment of no-fault benefits did not occur until more than one year post accident, plaintiff was not entitled to additional PIP benefits. Judge Servitto dissented, arguing that defendant had waived any statute of limitations defense by failing to properly plead it.

On further appeal, the Supreme Court reversed the decision of the Court of Appeals, and in a unanimous decision, the court ruled that Plaintiff could maintain his cause of action for additional no-fault benefits, notwithstanding the fact that he failed to comply with the one-year written notice provision in MCL 500.3145(1). In doing so, the Supreme Court carefully reviewed the statutory language of MCL 500.3145(1), which states:

“An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.”

The Supreme Court noted that, while the “written notice” provision has a time limit (one year), the “payment” provision – “unless the insurer has previously made a payment of personal protection insurance benefits for the injury” - did not. Therefore, because Plaintiff complied with the provisions of MCL 500.3145(1) (because the insurer “previously made a payment of personal protection insurance benefits for the injury,” notwithstanding the late notice), Plaintiff was permitted to pursue his claim for additional PIP benefits.

**Supreme Court declines an opportunity to revisit tort threshold.**

\[\text{Hall v Miko} \]
\[\_ \text{Mich \_\_ NW2d \_} \]
Supreme Court docket no. 152217, Order rel’d 4/1/2016

Since the Supreme Court issued its decision in McCormick v Carrier, 487 Mich 180, 795 NW2d 517 (2010), practitioners have wondered how long the McCormick’s court analysis of the tort threshold would remain in effect, given the membership changes in the Michigan Supreme Court since 2010. One year after McCormick was decided, the Michigan Supreme Court turned down an opportunity to revisit McCormick in Brown v Blouri, 489 Mich 959, NW2d (2011). In Brown, Chief Justice Young indicated that he would defer to the Legislature to determine whether or not McCormick was properly decided. Justice Markman indicated that, after the lower courts had an opportunity to analyze Plaintiff’s injuries in light of the McCormick standards, the Supreme Court should then consider whether or not McCormick or the Supreme Court’s earlier decision in Kreiner v Fischer, 471 Mich 109, 683 NW2d 611 (2004) properly analyzed the applicable
tort threshold. Justice Cavanagh wrote a concurring opinion, arguing that his opinion in McCormick properly applied the statutory language.

In Hall, the Supreme Court again declined to revisit the tort threshold issue, even though, according to Justice Markman’s dissent, application of the McCormick standards was outcome-determinative. As noted by Justice Markman:

“I would grant leave to appeal to consider defendants’ argument that this Court should overrule McCormick v Carrier, 487 Mich 180 (2010), and reinstate Kreiner v Fischer, 471 Mich 109 (2004), which itself was overruled by McCormick. Defendants concede that Plaintiffs satisfy the No-Fault Act’s ‘serious impairment’ threshold for tort liability as construed by McCormick, and Plaintiffs concede that Plaintiff Tracy Moore probably would not be able to satisfy the ‘serious impairment’ threshold as construed by Kreiner. Therefore, this would seem to be an appropriate case to assess both McCormick and Kreiner, which as both parties recognize set very different thresholds for tort liability, and to determine which is most compatible with MCL 500.3135.”

Thus, it appears that the court may not be willing to revisit the threshold issue for the foreseeable future. If a change is to be made, it will probably come from the Legislature.

The Supreme Court noted that, while the “written notice” provision has a time limit (one year), the “payment” provision—“unless the insurer has previously made a payment of personal protection insurance benefits for the injury”—did not.

Court Of Appeals Action – Published Opinions

Occupant of one’s owned, uninsured parked vehicle entitled to benefits because vehicle was not being “driven or moved on a highway.”

Shinn v State of Michigan Secretary of State ___ Mich App ___ NW2d ___

Court of Appeals’ docket no. 324227, rel’d 3/27/2016

In Shinn, Plaintiff had gone for a walk with her baby. Upon returning to her house, she opened the door to her own uninsured motor vehicle, which was parked along the curb outside of her house, and was seated partially inside the vehicle. Another motorist, insured with American Country Insurance Company, rear-ended Plaintiff’s vehicle. Because Plaintiff did not have a policy of insurance in her household, she applied for no-fault benefits with American Country Insurance Company (the insurer of the vehicle that rear-ended her parked vehicle) and the Michigan Assigned Claims Facility. The lower court granted summary disposition in favor of American Country, on the basis that it did not occupy any of the orders of priority for payment of Plaintiff’s benefits, as she was an “occupant” of her own uninsured motor vehicle. The lower court likewise granted summary disposition in favor of the Michigan Assigned Claims Facility and its assigned insurer, Farmers Insurance Exchange, on the basis that Plaintiff’s own, uninsured motor vehicle was “involved” in the accident, by virtue of the fact that she was occupying same.

On appeal, the Court of Appeals affirmed the grant of summary disposition in favor of American Country. This was not at all surprising, since it is a basic rule of no-fault that whenever one is an occupant of a motor vehicle, one never, ever turns to the insurer of the other motor vehicle involved in the accident for payment of no-fault benefits. See MCL 500.3114.

However, the Court of Appeals reversed the summary disposition ruling in favor of the Michigan Assigned Claims Plan insurer, Farmers Insurance Exchange, and determined that Plaintiff was entitled to no-fault benefits. In doing so, the Court of Appeals recognized that in Heard v State Farm, 414 Mich 139, 324 NW2d 1 (1980), the Supreme Court recognized that, when dealing with parked motor vehicles, a parked vehicle is considered “involved in the accident” only if one of the three statutory exceptions to the Parked Vehicle Exclusion, set forth in MCL 500.3106(1) is satisfied. The court also recognized that under MCL 500.3113(b), a person cannot recover no-fault benefits if:

“The person was the owner or registrant of a motor vehicle or motorcycle involved in an accident with respect to which the security required by §3101 or 3103 was not in effect.”

However, in an interesting twist, the Court of Appeals noted that, at the time Heard was decided, MCL 500.3101(1) required that the “security [required under the No-Fault Act] shall be in effect continuously during the period the registration of the motor vehicle.” However, in 1987, the Michigan Legislature amended the No-Fault Act to remove the “continuous coverage” requirement. In its place, the Legislature added the following language:

“Security is only required to be in effect during the period the motor vehicle is driven or moved on a highway.”

Because Plaintiff’s parked motor vehicle, though uninsured, had not been “driven or moved on a highway” at the time of the accident, she was not in violation of MCL 500.3101(1). Therefore, she was entitled to no-fault benefits through the Michigan Assigned Claims Plan.
MACP-assigned insurer not permitted to conduct an independent investigation into potential eligibility for no-fault benefits, despite statutory language which implies that MACP-assigned insurers can investigate claims involving not-so-obvious eligibility issues.

Bronson Healthcare Group Inc v Titan Ins Co
_Mich App _, _NW2d _
Court of Appeals docket no. 324847 rel’d 3/15/2016

In Bronson, Claimant French was a passenger in an uninsured motor vehicle owned and operated by Capp. Because her healthcare provider, Bronson, was unable to identify any insurance in French’s household, and because the Capp vehicle was apparently uninsured, Bronson filed a claim for no-fault benefits with the Michigan Assigned Claims Plan, which assigned the claim to Titan Insurance Company. Titan subsequently received Bronson’s claims submissions on September 24, 2013, but did not issue payment, because French’s eligibility to recover benefits through the Michigan Assigned Claims Plan had not yet been established.

French was ultimately deposed on July 10, 2014, at which time her eligibility to recover benefits was established. French testified that she was not living with any relatives at the time of this occurrence, and that she did not own or use a motor vehicle. She also testified that she was not married, and did not have use of Capp’s uninsured motor vehicle for more than thirty days. Three weeks after French’s deposition, Titan tendered payment of the medical expenses, because French’s eligibility to recover no-fault benefits through the Michigan Assigned Claims Plan had been confirmed. However, Titan refused to pay penalty interest or attorney fees. Bronson filed a motion for penalty interest and attorney fees, which was denied by the circuit court.

On appeal, the Court of Appeals reversed the decision of the circuit court. The Court of Appeals noted that under its earlier decision in Williams v AAA of Michigan, 250 Mich App 249, 646 NW2d 476 (2002), a bill for medical services and a statement from the hospital constitute “reasonable proof of the fact and of the amount of loss sustained” as required by MCL 500.3142(2). Therefore, because the claims submission in September 2013 should have constituted “reasonable proof of the fact and of the amount of the loss sustained,” Titan was obligated to pay that claim within thirty days. The Court of Appeals also noted that the Michigan Assigned Claims Plan has a statutory obligation to make “an initial determination of a Claimant’s eligibility for benefits under the Assigned Claims Plan, and unless the Claimant is “obviously ineligible,” the MACP must assign the claim to an appropriate insurer, which “shall make prompt payment of loss in accordance with this Act.” See MCL 500.3173(a) and MCL 500.3175. Therefore, Titan’s failure to pay the medical expenses within thirty days triggered the obligation to pay no-fault penalty interest. The court also noted that Titan’s defenses were frivolous under MCL 600.2591, thereby entitling Bronson to an award of costs and attorney fees as well.

The author respectfully submits that the court’s holding is suspect. After all, what if discovery had revealed that French was Capp’s girlfriend, and that she had extensive use of Capp’s uninsured motor vehicle for a period of time greater than thirty days, thereby rendering her an “owner” of Capp’s uninsured motor vehicle accident under MCL 500.3101(2)(k) (i). In that case, French would not have been eligible to recover no-fault benefits through the Michigan Assigned Claims Plan because she would have been disqualified from recovering benefits pursuant to MCL 500.3113(b), as extended to MACP insurers by MCL 500.3173. Readers are cautioned against extending the court’s rationale beyond the scope of the court’s opinion, which is addressed only to MACP-assigned insurers.

Court Of Appeals rejects plaintiff’s arguments that chiropractic expenses which fall outside the scope of chiropractic, as it existed on January 1, 2009, are nonetheless compensable as “allowable expenses.”

Measel v Auto Club Group Ins Co
_Mich App _, _NW2d _
Court of Appeals docket no. 324261, rel’d 2/9/2016

In Measel, Plaintiff was involved in a motor vehicle accident in August of 2012. She commenced treatment at Complete Care Chiropractic and incurred medical expenses for the “new patient examination,” which included an examination of her extremities, as well as expenses for therapeutic massages and ultrasound treatment. Her health insurance carrier rejected the charges. She then submitted them to her no-fault carrier, AAA, which refused to pay the expenses associated with the new patient examination, the ultrasound treatments and the massage therapy treatments, as they were outside the scope of chiropractic services as of January 1, 2009, pursuant to MCL 500.3107b(b). The district court and the circuit court ruled that the no-fault carrier was obligated to pay those expenses, notwithstanding the clear and unambiguous language in MCL 500.3107(b).

The Court of Appeals reversed and, in doing so, carefully examined the Legislature’s decision to enlarge the scope of chiropractic services allowable under Michigan law (see 2009 PA 223) while, at the same time, restricting the compensability of those services under the No-Fault Insurance Act to only those services that were considered to be “lawful” as of January 1, 2009. See 2009 PA 222. After examining the Supreme Court’s decision in Attorney General v Beno, 422 Mich 293, 393 NW2d 544 (1985), as well as its earlier decision in Hofmann v ACIA, 211 Mich App 55, 535 NW2d 529 (1995), the Court of Appeals concluded that the services that were billed for as a part of the “new patient examination,” as well as the ultrasound and massage therapy treatments, fell outside...
of the scope of chiropractic as it existed on January 1, 2009. Therefore, the no-fault insurer had no obligation to pay for said services.

Court Of Appeals Action – Unpublished Opinions

Insurer of out-of-state resident not obligated to pay Michigan no-fault benefits where purported out-of-state resident was injured in a pedestrian-motor vehicle accident.

Dahlmann v GEICO,
Court of Appeals docket no. 324698
unpublished decision rel’d 3/22/2016

In Dahlmann, Plaintiff was injured while a non-occupant of her motor vehicle as the result of a “road rage” incident. The owner of the vehicle that struck her was insured with Frankenmuth Insurance Company. Plaintiff had been a resident of the State of Virginia, but was living in Michigan temporarily while her husband was overseas. Although she maintained a Michigan driver’s license, many of her belongings were left behind in Virginia, as her husband was stationed out of Norfolk. Her vehicle was insured under a Virginia policy issued by GEICO.

GEICO denied Plaintiff’s claim for no-fault benefits on the basis that Plaintiff was a Michigan resident, not a Virginia resident. As such, she was obligated to comply with MCL 500.3101. The circuit court ordered GEICO, the Virginia insurer, to pay the appropriate benefits, as opposed to Frankenmuth, which insured the Michigan-registered motor vehicle that actually struck Plaintiff.

The Court of Appeals reversed. The majority engaged in a lengthy analysis of Plaintiff’s domicile and, applying the rationale of its earlier decision in Tienda v Integon National Ins Co, 300 Mich App 605, 834 NW2d 908 (2013) concluded that Plaintiff was domiciled in Michigan, not in Virginia. Therefore, just as in Tienda, the Virginia insurer was not responsible for paying Michigan no-fault insurance benefits. Rather, Frankenmuth was responsible for paying the benefits.

In a concurring opinion, Judge Gleich took issue with the domicile analysis. Instead, she observed that, whether or not Plaintiff was a Michigan resident was immaterial because her injury did not arise out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle by an out-of-state resident, as required by MCL 500.3163(1). Rather, because she was a pedestrian, the only motor vehicle “involved in the accident” was the Michigan-registered vehicle insured by Frankenmuth.

The author respectfully suggests that Judge Gleich’s analysis is the proper analysis. Generally speaking, MCL 500.3163(1) does not apply to those situations where the out-of-state resident is not operating a motor vehicle. In this case, the plaintiff was clearly a non-occupant of her motor vehicle at the time she was injured. If the plaintiff had been an occupant of her motor vehicle at the time of the injury, though, she very well may have been disqualified from recovering benefits based on her failure to comply with MCL 500.3101.

Used car dealer still deemed to be an “owner” of a motor vehicle involved in the accident because it still retained title to the vehicle.

Citizens Ins Co v Auto-Owners Ins Co
Court of Appeals docket no. 325402
unpublished decision rel’d 3/17/2016

In Citizens, the underlying claimant and her two daughters were injured in a motor vehicle accident. They were driving a vehicle that they had just purchased from Wise Auto, a used car dealer. The underlying claimant and her two daughters filed a claim for no-fault benefits with the Michigan Assigned Claims Plan, which assigned the claim to Citizens Insurance Company.

Citizens subsequently determined that the used car dealership, Wise Auto, still retained the title to the vehicle. Citizens also determined that Auto-Owners Insurance Company insured other vehicles owned by Wise Auto. Therefore, Citizens filed suit against Auto-Owners Insurance Company, demanding reimbursement. The circuit court ruled in favor of the assigned claims insurer, and Auto-Owners appealed.

The Court of Appeals affirmed, noting that the used car dealership still remained the “owner” of the motor vehicle occupied by the three injured claimants, because it held the legal title to the motor vehicle. The Court of Appeals rejected Auto-Owners’ argument that the injured claimant was actually leasing the motor vehicle because the sales document at issue never used the words “lease,” “lessee,” “lessor,” “rent,” “lease-to-own” or “lease with the option to buy.” Because title never transferred, the used car dealership remained the “owner” of the vehicle.

Court of Appeals reverses summary disposition in favor of plaintiff, finding that there existed a genuine issue of material fact regarding the involvement of a motor vehicle in a single motorcycle accident.

Wojcik v Automobile Club Ins Co
Court of Appeals docket no. 325328
unpublished decision rel’d 3/10/2016

Plaintiff was operating a motorcycle, and witness Clarke was a passenger. While rounding a curve on a gravel road, plaintiff lost control of his motorcycle, and plaintiff and his passenger both sustained serious injuries. Plaintiff had no memory of the accident. His passenger, though, gave inconsistent accounts about how the accident occurred. Specifically, Clarke failed to tell the investigating police officer about any involvement of a motor vehicle. Instead, she indicated that
her host operator simply lost control of the motorcycle, due to the loose gravel road. However, after making her own claim for no-fault benefits, Clarke changed her testimony and indicated that the accident occurred when a motor vehicle “rapidly pulled up behind [Plaintiff’s] motorcycle and then attempted to pass us by pulling around to our left.” Despite these factual inconsistencies, the Wayne County Circuit Court granted summary disposition in favor of plaintiff, and defendant appealed.

The Court of Appeals reversed the decision of the circuit court and remanded the matter back for a trial on the merits. The court recognized that it was up to the jury, not the trial court, to judge Clarke’s credibility. The court noted that Clarke’s credibility was suspect, noting that, “this is particularly true given that Clarke has a motive to lie insofar as she has filed her own no-fault suit. Plaintiff is Clarke’s ‘very good friend,’ and whether she and Plaintiff obtain benefits from Defendant will depend on the “involvement of a motor vehicle in the accident.”

Self-insurer of rental vehicle not obligated to afford Michigan no-fault insurance benefits

Heichel v GEICO Indemnity Co
Court of Appeals docket no. 323818
unpublished decision rel’d 3/1/2016

In Heichel, Plaintiff motorcyclist was struck by a motor vehicle rented from Enterprise Rent-A-Car in Pennsylvania. EAN Holdings LLC owned the vehicle and registered in North Carolina. In 2010, EAN Holdings LLC was certified as a qualified self-insurer by the Michigan Secretary of State under MCL 500.3101(4). EAN denied coverage, arguing that the Michigan Supreme Court’s decision in Parks v DALLIE, 426 Mich 191, 393 NW2d 833 (1986) abdosed EAN of liability for the motorcyclist’s no-fault claim. Therefore, GEICO and State Farm, as the insurer of two motor vehicles owned by the motor vehicle operator and his wife, became responsible for payment of the motorcyclist’s PIP benefits.

After examining the Supreme Court’s holding in Parks, to the effect that “a vehicle that does not need to be registered in Michigan cannot trigger the application of the priority provisions set forth in MCL 500.3114,” the Court of Appeals concluded that, because the EAN-owned vehicle had not been traveling in the State of Michigan for more than thirty days, it was not required to be registered in the state. Therefore, it was not required to carry Michigan no-fault insurance coverage. Therefore, GEICO and State Farm were obligated to afford coverage.

The author cautions against an overly broad reading of this case. Although EAN is a certified self-insurer under MCL 500.3101(4), it is not among the list of certified “insurers” under MCL 500.3163(1). As the Supreme Court noted in Parks, supra, self-insured entities are simply not recognized as “an insurer authorized to transact automobile liability insurance and personal and property protection insurance in this state.”

Medical provider who failed to intervene in claimant suit nonetheless bound by jury verdict in favor of no-fault insurer

Michigan Head & Spine Inst PC v State Farm
Court of Appeals docket no. 324245
unpublished decision rel’d 1/21/2016

Michigan Head & Spine filed suit against State Farm, seeking to collect payment of medical expenses incurred by Claimant Garley. Claimant Garley had filed his own separate lawsuit against State Farm, which was removed by State Farm to federal court. Garley’s case against State Farm ultimately went to trial. The jury concluded that even though Garley had sustained bodily injury, State Farm owed Garley nothing. In fact, the jury specifically indicated, on the Verdict Form, that “We think all bills related to the accident have been paid and no more money is owed.” Although Michigan Head & Spine Institute (MHSI) was advised of the pendency of Garley’s federal court action, it refused to intervene, and instead insisted on pursuing its own independent cause of action against State Farm in the circuit court. After the jury verdict in the federal district court matter, State Farm moved for summary disposition, which was granted by the circuit court.

The Court of Appeals affirmed the decision of the circuit court, based on res judicata grounds. The court recognized that MHSI’s expenses had been incurred prior to the trial date in the federal court action. Therefore, they could have been brought in the context of that litigation. The court observed that Garley was fully capable of protecting the interests of MHSI. If MHSI felt that its interests were not being adequately protected, it could have intervened in Claimant’s lawsuit, which again it had full knowledge of. Having failed to do so, however, MHSI was bound by the jury’s verdict in favor of State Farm.

Plaintiff counsel’s “charging lien” rejected where insurer settles with provider, which had retained its own counsel

Kalla v Progressive Michigan Ins Co
Court of Appeals docket no. 323416
unpublished decision rel’d 1/14/2016

Plaintiff’s medical provider, St. Peter’s Medical Center, retained separate counsel and filed its own lawsuit against Progressive Michigan Insurance Company, which was subsequently settled. Plaintiff’s counsel then asserted a “charging lien” against Progressive, arguing that she was entitled to a one-third attorney fee, based upon the no-fault insurer’s settlement with St. Peter’s Medical Center in the separate
lawsuit. Both the circuit court and the Court of Appeals rejected Plaintiff counsel’s argument that she was entitled to a so-called “charging lien,” based upon the following:

- Plaintiff failed to demonstrate the existence of an attorney-client relationship between herself and St. Peter’s Medical Center, and without the existence of an attorney-client relationship between herself and St. Peter’s Medical Center, Plaintiff could not exert a charging lien for her fees;
- Even if she had a valid charging lien against St. Peter’s Medical Center’s recovery in the district court action, she could not enforce the charging lien by filing a motion to do so in the circuit court action, where St. Peter’s Medical Center was not a party;
- In order for an attorney’s charging lien to attach to a client’s recovery, the recovery must be the result of an attorney’s services – in this case, Plaintiff’s counsel acknowledged that she was unaware of the district court action, or its settlement. Therefore, any settlement was not as a result of her efforts;
- Plaintiff’s counsel was in violation of the Michigan Court Rules and the Michigan Rules of Professional Conduct, as she claimed that she had a contingent-fee agreement with St. Peter’s Medical Center, but the agreement was not in writing, contrary to MCR 8.121(F) and MRPC 1.5(c).

With regard to this latter point, the Court of Appeals noted that Plaintiff’s counsel was requesting that the Court exercise its equitable powers. However, noting that, “one who seeks the aid of equity must come with clean hands” (See Rose v National Auction Group Inc, 466 Mich 453, 646 NW2d 455 (2002)) Plaintiff’s counsel had “unclean hands” because she was asking the court to enforce a fee agreement “that is specifically prohibited by both the Court Rules and the Rule of Professional Conduct.”