

The Journal of Insurance & Indemnity Law

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Hal O. Carroll, Journal Editor ■ www.HalOCarrollEsq.com ■ (734) 645-1404

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

From the Chair



Adam Kutinsky,
Dawda Mann

The resources offered by our section – such as this quarterly *Journal* and our educational programs – have led to consistent membership growth. Founded by Hal Carroll and Deb Hebert in 2008, our section now boasts nearly 1,000 members and an account balance of nearly \$35,000. Since we are flush with funds, the current council is tasked with the challenge of spending the money in furtherance of our section's goals.

One of the recent ideas for the funds is to create a scholarship for law students interested in the practice of insurance law. Before a scholarship may be established, however, the section must agree on who is eligible to receive it. So far, there are at least two requirements to apply. First, the person must be enrolled in law school, and second, the person must be interested in the practice of insurance law. The rest of the scholarship framework is up for discussion and we welcome the suggestions of section members.

A scholarship would serve two goals, one of which is to help students with the financial requirements of law school and the other is to cultivate interest in the practice of insur-

ance law. Requiring students to submit an essay along with their application would require applicants to think critically about the subject and how they see themselves practicing in the specialty once they are bar admitted.

The amount of funds devoted to the scholarship would initially be modest because this is our first time through the process. Once we successfully establish the scholarship, select the recipient, and put the money to use, we can consider increasing the amount for future applicants. There is also the consideration of equal opportunity to all of the State of Michigan's excellent law schools. At this time, the council does not know how much time and effort the scholarship program will require, so it is important not to be too ambitious. The goal of our section is to establish the scholarship by the end of the current term.

We would like to hear from you regarding your thoughts on our scholarship proposal.

Although additional programs will be offered, the section will definitely offer its annual program as the State Bar of Michigan annual meeting this year. We hope to see you there and would love to hear from you on ideas for subject matter.

—Adam Kutinsky

Editor's Notes



By Hal O. Carroll
www.HalOCarrollEsq.com

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. All opinions expressed in contributions to the *Journal* are those of the author. But we welcome all articles of analysis, opinion, or advocacy for any position.

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

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



Bad Faith: What It Is, and What It Is Not

By Drew W. Broaddus, *Secrest Wardle*

Introduction

More than thirty years after *Commercial Union Ins Co v Liberty Mut Ins Co*, 426 Mich 127; 393 NW2d 161 (1986), confusion still persists as to when the conduct of an insurer constitutes “bad faith” and what remedies are available. Frequently, the term “bad faith” is used to describe any denial of benefits by an insurer that a claimant considers improper.¹ But “[o]f course, not every disagreement or claim denial supports a cause of action for insurance bad faith.”² Under Michigan law the term has a specific meaning, although the precise contours of “bad faith” can vary depending upon the context, as this article will explain.

In almost every state, the law implies a duty of good faith and fair dealing in all insurance policies.³ The duty of good faith and fair dealing requires that neither party to a contract do anything to injure the other party’s right to receive the benefits of their agreement.⁴ But under Michigan law, this implied duty “is not itself a cause of action”; it cannot “override express contract terms” and “does not apply when the parties have clearly expressed their respective rights and obligations.”⁵ So the cause of action delineated in *Commercial Union* is somewhat of an anomaly under Michigan jurisprudence, as it is one of only a handful of recognized theories that “straddle the sometimes elusive boundary between tort and contract.”⁶

The Supreme Court defined “bad faith,” for the purposes of instructing the jury on remand, as “arbitrary, reckless, indifferent, or intentional disregard of the interests of the person owed a duty.”

Commercial Union involved an insurer’s handling of a liability suit brought by a third-party against the insured.⁷ However, when attorneys say an insurance claim has been denied in “bad faith,” they may also be referring to first-party claims,⁸ claims by third-party tort claimants against a tortfeasor’s insurer,⁹ and – although less frequently described as such – claims under the No-Fault Act.¹⁰ Therefore, this article will take a broader view of “bad faith” than what is defined in *Commercial Union*, so as to include these other situations where an insurer can be ordered to pay something above and beyond the value of the claim.

Bad Faith in Liability Claims

In *Commercial Union*, an excess insurer (Commercial Union) filed suit under an equitable subrogation theory¹¹ against a primary insurer (Liberty Mutual). Commercial Union alleged that Liberty Mutual’s failure to negotiate a settlement in a case against their mutual insured constituted bad faith, thereby causing Commercial Union’s excess policy to be exposed. The jury found no cause of action against Liberty Mutual, but the Court of Appeals reversed, ordering a new trial and finding that the trial court’s bad faith instructions were, in part, prejudicial and erroneous.¹² The Supreme Court affirmed the Court of Appeals and, instructing the trial court on remand, explained that “bad faith should not be used interchangeably with either ‘negligence’ or ‘fraud.’”¹³ The Supreme Court defined “bad faith,” for the purposes of instructing the jury on remand, as “arbitrary, reckless, indifferent, or intentional disregard of the interests of the person owed a duty.”¹⁴ “Good-faith denials, offers of compromise, or other honest errors of judgment are not sufficient to establish bad faith.”¹⁵ “Further, claims of bad faith cannot be based upon negligence or bad judgment, so long as the actions were made honestly and without concealment.”¹⁶ But because “bad faith is a state of mind,” the Supreme Court noted that “there can be bad faith without actual dishonesty or fraud.”¹⁷ “If the insurer is motivated by selfish purpose or by a desire to protect its own interests at the expense of its insured’s interest, bad faith exists, even though the insurer’s actions were not actually dishonest or fraudulent.”¹⁸

The *Commercial Union* court went on to identify the following twelve “supplemental factors which may be considered in determining whether liability exists for bad faith”:¹⁹

1. Failure to keep the insured fully informed of all developments in the claim or suit that could reasonably affect the interests of the insured,
2. Failure to inform the insured of all settlement offers that do not fall within the policy limits,
3. Failure to solicit a settlement offer or initiate settlement negotiations when warranted under the circumstances,
4. Failure to accept a reasonable compromise offer of settlement when the facts of the case or claim indicate obvious liability and serious injury,

5. Rejection of a reasonable offer of settlement within the policy limits,
6. Undue delay in accepting a reasonable offer to settle a potentially dangerous case within the policy limits where the verdict potential is high,
7. An attempt by the insurer to coerce or obtain an involuntary contribution from the insured in order to settle within the policy limits,
8. Failure to make a proper investigation of the claim prior to refusing an offer of settlement within the policy limits,
9. Disregarding advice or recommendations of an adjuster or attorney,
10. Serious and recurrent negligence by the insurer,
11. Refusal to settle a case within the policy limits following an excessive verdict when the chances of reversal on appeal are slight or doubtful, and
12. Failure to take an appeal following a verdict in excess of the policy limits where there are reasonable grounds for such an appeal especially where trial counsel so recommended.²⁰

The court noted that these “factors are not exclusive” and “[n]o single factor shall be decisive.”²¹

The *Commercial Union* Court was not the first to recognize bad faith in the insurance setting; the concept appears in Michigan jurisprudence at least far back as *City of Wakefield v Globe Indemnity Co*, 246 Mich 645; 225 NW 643 (1929). But *Commercial Union* was and remains the seminal decision defining the concept, at least in the context of liability claims.

Primary Carrier’s Duty to Excess Carrier

A sub-issue presented by *Commercial Union*, which still sometimes causes confusion today, relates to the duty owed to an excess carrier by a primary carrier. More specifically, why is any duty owed at all, where the primary and excess carriers have no contract between each other? This was addressed by the Supreme Court in another decision issued on the same day, *Commercial Union Ins Co v Medical Protective Co*.²² Here, the court explained that generally, a primary insurer owes no *direct* duty to an excess insurer to act in good faith and settle a claim within policy limits. However, an excess insurer may maintain a cause of action against a primary insurer, for the primary insurer’s bad-faith failure to settle within policy limits, under an equitable subrogation theory. “Since the insured would have been able to recover from the primary carrier for

a judgment in excess of policy limits caused by the carrier’s wrongful refusal to settle, the excess carrier, who discharged the insured’s liability as a result of this tort, stands in the shoes of the insured and should be permitted to assert all claims against the primary carrier which the insured himself could have asserted.”²³

Although the lead opinion suggested in footnote 5 that a primary insurer *might* owe a direct duty to an excess insurer in certain situations, four justices wrote separately to dispel that possibility and confirm that any such cause of action could *only* be pursued through equitable subrogation.²⁴ Those four justices otherwise concurred in the lead opinion. In other words, this was a 7-0 decision except for the narrow question about whether a direct duty could conceivably exist under other facts, which four justices emphatically said no to.²⁵

Collectability of the Insured

Four years later, in *Frankenmuth Mutual Ins Co v Keeley (On Rehearing)*, 436 Mich 372; 461 NW2d 666 (1990), the Supreme Court clarified that an insurer’s liability for bad faith failure to settle is limited by the collectability of its insured. The court did so by adopting Justice Levin’s dissent in *Frankenmuth Mutual Ins Co v Keeley*, 433 Mich 525; 447 NW2d 691 (1989). The approach adopted by the Court on rehearing was described as a compromise between the “prepayment rule” – which required an insured to have made some payment on the judgment²⁶ – and the “judgment rule” – which required an insurer to pay an excess judgment in instances of bad faith, regardless of the insured’s solvency or ability to pay any part of the judgment.²⁷ The compromise proposed by Justice Levin, and later adopted by the court, was to “accept the essence of the judgment rule by eliminating the need to show partial payment, but provide protection for insurers along the lines of the prepayment rule by precluding collection on the judgment from the insurer beyond what is or would actually be collectable from the insured.”²⁸

This approach, dubbed “the Michigan Rule,” has been described as a “minority view” and has been criticized on the grounds that

...[t]he injury to the insured is the continuing existence of the excess judgment. The cost of the cure of that injury is the amount required to satisfy the judgment. Payment of an amount measured by the probability of recovery from the insured personally, if less than the entire excess, does not eliminate the injury. The judgment holder is not restricted in executing on the judgment at any time by the probable assets of the debtor, determined at the time the judgment in the failure to settle case is entered against the insurer....²⁹

But regardless of its popularity elsewhere, the compromise approach adopted on rehearing in *Keeley* has not been questioned in subsequent Michigan case law.³⁰

First-Party Claims

Unlike some states, particularly California, Michigan has not recognized a claim for bad faith breach of an insurance contract in the first-party context, and Michigan courts do not seem to be poised to recognize any such tort-like first-party theories in the near future.³¹ For example, *Roberts v Auto-Owners Ins Co*, 422 Mich 594, 604 n 7; 374 NW2d 905 (1985) noted that the “mere denial of liability or refusal to pay, even [if] unreasonable and in bad faith, is not deemed outrageous” so as to support a claim for intentional infliction of emotional distress. Later, *Runions v Auto-Owners Ins Co*, 197 Mich App 105, 110; 495 NW2d 166 (1992) reiterated that the refusal to pay a claim cannot, as a matter of law, constitute extreme and outrageous conduct.³² And in *Kewin v Massachusetts Mutual Life Ins Co*, 409 Mich 401, 409; 295 NW2d 50 (1980) the court rejected a claim for “mental anguish” allegedly resulting from an insurer’s breach of contract.³³

However, first-party claimants whose claims are unreasonably drawn out are not without a remedy. Under MCL 500.2006(4), “[i]f benefits are not paid on a timely basis, the benefits paid bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or a person directly entitled to benefits under the insured’s insurance contract.”

MCL 500.2006(4) “divides insurance claims ‘not paid on a timely basis’ into two categories.”³⁴ “For cases where ‘the claimant is the insured or an individual or entity directly entitled to benefits under the insured’s contract of insurance,’ the interest rate is 12% per annum.”³⁵ “However, for ‘third party tort claimant[s],’ the interest rate is 12% per annum ‘if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law.’”³⁶ The distinction is important because if “the claimant is the insured or an individual or entity directly entitled to benefits under the insured’s contract of insurance, and benefits are not paid on a timely basis, the claimant is entitled to 12 percent interest, *irrespective of whether the claim is reasonably in dispute.*”³⁷

Underinsured Motorist Claims

A currently “hot topic” is whether a claim for underinsured motorist (UIM) benefits is more analogous to a first-party claim or a third-party tort claim, within the meaning of MCL 500.2006(4). In *Nickola v MIC Gen Ins Co*, the Court of Appeals refused to impose 12% interest on an arbitration award in a UIM case because the insurer’s liability was reasonably in dispute.³⁸ The panel found that “while plaintiff is seeking

UIM benefits that are provided under the policy, he is doing more than merely making a simple first-party claim....”³⁹ “In order for plaintiff to succeed on his UIM claim, he essentially has to allege a third-party tort claim against his own insurer....”⁴⁰ The insurer “stands in the shoes of the alleged tortfeasor, and plaintiff seeks benefits from defendant that arose from the alleged tortfeasor’s liability.”⁴¹

A primary insurer owes no direct duty to an excess insurer to act in good faith and settle a claim within policy limits. However, an excess insurer may maintain a cause of action against a primary insurer, for the primary insurer’s bad-faith failure to settle within policy limits, under an equitable subrogation theory.

“This third-party tort claim is different in nature from a typical claim for first-party benefits, as it will often require proof of the nature and extent of the injured person’s injuries, the injured person’s prognosis over time, and proof that the injuries have had an adverse effect on the injured person’s ability to lead his or her normal life.”⁴² “In addition, such a third-party tort claim is designed to compensate a claimant for past and future pain and suffering and other economic and noneconomic losses rather than compensation for immediate expenses” that are generally associated with a first-party claim.”⁴³ “In other words, plaintiff’s UIM claim is tied to a third-party tort claim for damages that, in many respects, is ‘fundamentally’ different from a typical first-party claim.”⁴⁴

But on May 25, 2016, the Michigan Supreme Court directed the clerk to schedule “mini-oral argument” on the plaintiff’s leave application in *Nickola*.⁴⁵ The order directed the parties to file supplemental briefs addressing, among other things, “whether an insured making a claim for underinsured motorist benefits may be considered to be a ‘third party tort claimant’ under MCL 500.2006(4)...”⁴⁶ The Supreme Court heard the “mini-oral argument” on January 10, 2017.⁴⁷

Third-Party Tort Claimants

In certain situations, a third-party tort claimant may pursue a claim directly against a tortfeasor’s insurer. However, a judgment against the insured is generally a precondition to any such claim. This is because MCL 500.3030 otherwise bars direct actions by an allegedly injured party, against an alleged tortfeasor’s insurance company.⁴⁸ But in *Security Ins Co of Hartford v Daniels*, 70 Mich App 100; 245 NW2d 418 (1976), the Court of Appeals indicated that an action by the injured person against a tortfeasor’s insurer could be brought, once there has been a determination of liability in the underly-

ing suit. The panel noted that “[a]lthough Daniels was barred from joining the insurance companies in the original action, if he were to succeed in that action, he would be entitled to litigate the coverage issue in a subsequent action against the insurance companies.”⁴⁹ While that decision is not precedentially binding,⁵⁰ the Supreme Court later cited it as “instructive” in explaining that “an injured person’s interest in the resolution of the policy coverage question stems from the availability of a postjudgment garnishment action against the insurer in which the coverage question would be litigated.”⁵¹

Once the third party has standing, as noted above MCL 500.2006(4) only allows third-party tort claimants to recover 12% interest “if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law.”⁵² The Court of Appeals has noted that under the second sentence of § 2006(4), “[i]t is immediately apparent that four elements must coexist in order for this provision to apply [to a third-party tort claimant]: (1) that satisfactory proof of loss be received by the insurer; (2) that the liability of the insurer for the claim not be reasonably in dispute; (3) that the insurer refused payment of the claim; and (4) that the refusal to pay was in bad faith.”⁵³

A currently “hot topic” is whether a claim for underinsured motorist (UIM) benefits is more analogous to a first-party claim or a third-party tort claim, within the meaning of MCL 500.2006(4).

No-Fault Claims

Much like first-party claims under the first sentence of MCL 500.2006(4), an insurer’s delay in handling a first-party no-fault claim is dealt with through a 12% penalty interest provision. MCL 500.3142(2) states that “[p]ersonal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained,” and MCL 500.3142(3) states that “[a]n overdue payment bears simple interest at the rate of 12% per annum.” Also like § 2006(4)’s first sentence, § 3142(3) is not truly a “bad faith” provision; the Court of Appeals has held that 12% interest can be imposed under the No-Fault Act “irrespective of the insurer’s good faith in not promptly paying the benefits” if the “insurer refused to pay benefits and is later determined to be liable, irrespective of the insurer’s good faith in not promptly paying the benefits.”⁵⁴ “[A]n insurer’s good faith in withholding payment of benefits is relevant in awarding attorney fees under the act, but is irrelevant to liability under the penalty interest statute.”⁵⁵

The only relief non-prevailing insurers have obtained, in terms of avoiding no-fault penalty interest, has come in cases where there was some problem with the sufficiency of the proof of the loss sustained.⁵⁶ For example, if an expense is otherwise compensable but not factually supported until some point during litigation, interest awards can be reduced or denied.⁵⁷ In *English v Home Ins Co*, 112 Mich App 468, 476; 316 NW2d 463 (1982), a prevailing plaintiff was denied penalty interest as follows:

Under § 3142 an insured may recover 12% interest on personal protection benefits if the benefits are not paid within 30 days after an insurer receives reasonable proof of the fact and amount of loss sustained. In the instant case, the trial court found that defendant was justified in making a thorough investigation to determine if plaintiff’s losses were related to the automobile accident. The trial court found, in effect, that plaintiff failed to present reasonable proof of the fact and amount of benefits to which he is entitled. Since the trial court’s findings of fact are not clearly erroneous, interest under § 3142 was properly denied.

As noted above, insurers’ delays under the No-Fault Act are also remedied through the fee-shifting language of MCL 500.3148(1). This subpart is more akin to a “bad faith” type of provision, as the claimant must show not only that benefits are “overdue” under § 3142(2), but also that the insurer “unreasonably refused to pay the claim or unreasonably delayed in making proper payment.”⁵⁸ “[W]hether the defendant’s denial of benefits is reasonable under the particular facts of the case is a question of fact.”⁵⁹ “[W]hen considering whether attorney fees are warranted under the no-fault act, the inquiry is not whether coverage is ultimately determined to exist, but whether the insurer’s initial refusal to pay was reasonable. ... [A] delay is not unreasonable if it is based on a legitimate question of statutory construction, constitutional law, or factual uncertainty.”⁶⁰ Even after the claimant has prevailed, before awarding attorney fees the trial court must still “examine the circumstances as they existed at the time the insurer made the decision, and decide whether that decision was reasonable at that time.”⁶¹

A situation even more akin to “bad faith” that can arise under the No-Fault Act – albeit very rarely – involves misleading statements by an insurance adjuster regarding what benefits are available. When this happens, the claimant *may* have a fraud claim against the no-fault carrier per *Cooper v Auto Club Ins Ass’n*, 481 Mich 399; 751 NW2d 443 (2008). But the court in *Cooper* went to great lengths to explain, among things, (1) that such claims “must be pleaded with particularity” and proved “by clear, satisfactory and convincing” evidence, (2) that the reliance element of fraud will be particularly difficult

to establish given the “obvious adversarial position” of the adjuster during the claims handling process, and (3) that courts must be careful to “distinguish between misrepresentations of fact, i.e., false statements of past or existing facts, and mere negotiation of benefits, i.e., the mutual discussion and bargaining preceding an agreement to pay PIP benefits.”⁶²

Conclusion

The phrase “bad faith” is often used colloquially to describe any decision by an insurance company that a claimant or their attorney disagrees with. But the phrase has a specific meaning in insurance law, developed primarily in the liability coverage setting. Outside of that context, there are multiple situations where insurers can face extra-contractual exposure short of bad faith. A clearer understanding of what is (and what is not) bad faith can streamline settlement discussions, reduce unnecessary motion practice, and generally benefit both sides of the bar. ■

About the Author

Drew Broaddus is a partner at Secrest Wardle's Grand Rapids office, and he is the Chair of the firm's Appellate and Insurance Coverage Practice Groups. He has been named to the list of Rising Stars in Super Lawyers Magazine for 2012-2016. He was named by *dbusiness Magazine* to the list of Top Lawyers in 2017, and has received an AV Preeminent® Peer Review Rating by Martindale-Hubbell. Since joining Secrest Wardle in 2010, Mr. Broaddus has obtained excellent results in several dozen appeals covering a wide range of practice areas. He can be reached at dbroaddus@secrestwardle.com.

Endnotes

- 1 See, for example, *State Farm Lloyds v Nicolau*, 951 SW2d 444, 454 (Tex 1997) (Hecht, J., dissenting).
- 2 Cross, *Returning to “Go” (but Not Collecting \$200): Reexamining Insurance Bad Faith in Light of Modern California Law on Summary Judgment, and the Genuine Dispute Doctrine*, 40 Tort Trial & Ins Prac LJ 1051, 1054 (2005).
- 3 Richmond, *Insurance Bad Faith and Insurers' Duty to Communicate with Insureds Regarding Settlement*, 49 Tort Trial & Ins Prac LJ 499 (2014).
- 4 *Id.*
- 5 Pappas et al, *Michigan Business Torts* (ICLE 2d ed 2003), § 10.1.
- 6 *Id.* Generally, an insurance policy is treated “in the same manner as any other species of contract.” *DeFrain v State Farm Mut Auto Ins Co*, 491 Mich 359, 367; 817 NW2d 504 (2012). A breach of a contract – even in bad faith – typically does not give rise to a tort claim. *Rinaldo's Const Corp v Michigan Bell Telephone Co*, 454 Mich 65, 84-85; 559 NW2d 647 (1997). See also *Kewin v Massachusetts Mut Life Ins Co*, 409 Mich 401, 419; 295 NW2d 50 (1980). Yet “there is a persistent tort-like quality to third-

party bad faith claims.” *Schwartz v Twin City Fire Ins Co*, 492 F Supp 2d 308, 327 (SDNY 2007).

- 7 See *Great Am Ins Co v E.L. Bailey & Co, Inc*, 841 F3d 439, 446 (6th Cir 2016).
- 8 See *Stryker Corp v XL Ins Am*, 735 F3d 349, 359-360 (6th Cir 2012), discussing MCL 500.2006(4).
- 9 *Stryker*, 735 F3d at 359-360; MCL 500.2006(4).
- 10 MCL 500.3142(3); MCL 500.3148(1).
- 11 “[E]quitable subrogation is a legal fiction through which a person who pays a debt for which another is primarily responsible is substituted or subrogated to all the rights and remedies of the other. It is well-established that the subrogee acquires no greater rights than those possessed by the subrogor, and that the subrogee may not be a mere volunteer. ... When an insurance provider pays expenses on behalf of its insured, it is not doing so as a volunteer.” *Auto-Owners Ins Co v Amoco Prod Co*, 468 Mich 53, 59; 658 NW2d 460 (2003) (citations omitted).
- 12 *Commercial Union*, 426 Mich at 131.
- 13 *Id.* at 136.
- 14 *Id.*
- 15 *Id.* at 136-137.
- 16 *Id.* at 137.
- 17 *Id.*
- 18 *Id.*
- 19 *Id.* These factors have not been significantly modified by Michigan Courts in the thirty years since. See *Great Am Ins Co*, 841 F3d at 446.
- 20 *Commercial Union*, 426 Mich at 138-139.
- 21 *Id.* at 137.
- 22 426 Mich 109, 118; 393 NW2d 479 (1986).
- 23 *Id.*
- 24 *Id.* at 126 (Boyle, J., concurring).
- 25 *Id.* See also *Keeley*, 433 Mich at 561 (Levin, J, dissenting).
- 26 “The underlying rationale” of the prepayment rule “is that where an insured does not pay any money in satisfaction of an excess judgment, the insured is not harmed and thus may not collect damages.” *Econ Fire & Cas Co v Collins*, 643 NE2d 382, 385 (Ind App 1994).
- 27 *Keeley*, 433 Mich at 553-565 (Levin, J., dissenting). The “judgment rule” was and remains the majority rule. See *Miller v Kenney*, 180 Wash App 772, 799; 325 P3d 278 (2014).
- 28 *Keeley*, 433 Mich at 565 (Levin, J., dissenting).
- 29 *Med Mut Liab Ins Soc of Maryland v Evans*, 330 Md 1, 25; 622 A2d 103 (1993).
- 30 See *Tibble v Am Physicians Capital, Inc*, unpublished opinion per curiam of the Court of Appeals, issued October 28, 2014 (Docket No. 306964).

- 31 Pappas, Michigan Business Torts at § 10.10, citing *Kewin*, 409 Mich at 401.
- 32 See also *Wendt v Auto-Owners Ins Co*, 156 Mich App 19, 25; 401 NW2d 375 (1986).
- 33 “[A] disability income protection insurance policy contract is a commercial contract, the mere breach of which does not give rise to a right to recover damages for mental distress. The damages recoverable are those damages that arise naturally from the breach, or which can reasonably be said to have been in contemplation of the parties at the time the contract was made. Absent proof of such contemplation, the damages recoverable do not include compensation for mental anguish.” *Kewin*, 409 Mich at 419.
- 34 *Stryker*, 735 F3d at 359-360.
- 35 *Id.*
- 36 *Id.*
- 37 *Nickola v MIC Gen Ins Co*, 312 Mich App 374, __; 878 NW2d 480, 486 (2015) (emphasis added).
- 38 *Id.* See also Heller & Mayer, *Time to Reconsider Strict Liability Penalty Interest in Coverage Disputes Arising under Third Party Liability Policies*, 9 Journal of Insurance & Indemnity Law 2 (No. 1, Jan 2016).
- 39 *Nickola*, 312 Mich App at __; 878 NW2d at 487.
- 40 *Id.*
- 41 *Id.*
- 42 *Id.* (citation omitted).
- 43 *Id.* (citation omitted).
- 44 *Id.*
- 45 *Nickola v MIC Gen Ins Co*, 499 Mich 935; 878 NW2d 886 (2016).
- 46 *Id.*
- 47 Michigan Courts, *Case Search* <http://courts.mi.gov/opinions_orders/case_search/pages/default.aspx?SearchType=1&CaseNumber=152535&CourtType_CaseNumber=1> (accessed February 22, 2017).
- 48 MCL 500.3030 states: “In the original action brought by the injured person, or his or her personal representative in case death results from the accident, as mentioned in section 3006, the insurer shall not be made or joined as a party defendant, nor, except as otherwise provided by law, shall any reference whatever be made to such insurer or to the question of carrying of such insurance during the course of trial.” (Emphasis added.)
- 49 *Security Ins Co*, 70 Mich App at 105.
- 50 The Court of Appeals is not bound to follow its own published decisions issued before November 1, 1990. MCR 7.215(J)(1).
- 51 *Allstate Ins Co v Hayes*, 442 Mich 56, 69 n 13; 499 NW2d 743 (1993).
- 52 *Stryker*, 735 F3d at 359-360. See also *Nickola*, 312 Mich App at __; 878 NW2d at 487 (“...the second sentence of Subsection (4), which applies to third-party tort claimants, imposes penalty interest on the insurer only if the claim is not reasonably in dispute”).
- 53 *Medley v Canady*, 126 Mich App 739, 743; 337 NW2d 909 (1983).
- 54 *Morales v State Farm Mut Auto Ins Co*, 279 Mich App 720, 730; 761 NW2d 454 (2008), quoting *Williams v AAA Michigan*, 250 Mich App 249, 265; 646 NW2d 476 (2002).
- 55 *Davis v Citizens Ins Co of America*, 195 Mich App 323, 329; 489 NW2d 214 (1992).
- 56 See *Shields v Government Employees Hosp Ass’n, Inc*, 490 F3d 511, 518-519 (6th Cir 2007).
- 57 See *Id.* See also *Moore v Secura Ins*, 482 Mich 507, 518-519; 759 NW2d 833 (2008), where the jury found that work loss benefits were compensable and overdue but only awarded one week of penalty interest.
- 58 *Moore*, 482 Mich at 517.
- 59 *Ross v Auto Club Group*, 481 Mich 1, 7; 748 NW2d 552 (2008).
- 60 *Bonkowski v Allstate Ins Co*, 281 Mich App 154, 171; 761 NW2d 784 (2008), quoting *Shanafelt v Allstate Ins Co*, 217 Mich App 625, 635; 552 NW2d 671 (1996). “[A]n insurer’s initial refusal to pay no-fault benefits can be deemed reasonable even if it is later determined that the insurer was required to pay those benefits.” *Tinnin v Farmers Ins Exch*, 287 Mich App 511, 516; 791 NW2d 747 (2010).
- 61 *Brown v Home-Owners Ins Co*, 298 Mich App 678, 691; 828 NW2d 400 (2012).
- 62 *Cooper*, 481 Mich at 414-416 (citations omitted).



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Property Insurance 101



Anti-Concurrent Causation – Not a Foregone Conclusion

Jason Liss, *Fabian, Sklar & King, PC*

Many lawyers practicing in the property area of insurance law believe that under the anti-concurrent causation rule there is no coverage for a loss which results from a combination of a covered and an excluded cause of loss. While this may be considered by some as the general rule in Michigan, it is not a forgone conclusion and careful review of the policy of insurance may provide a basis to avoid the rule's application to bar coverage for a loss.

The concurrent causation doctrine was first addressed in Michigan in *Vanguard Ins Co v Clarke*,¹ a tragic case implicating the liability coverage of a homeowner's policy. The case involved the wrongful death of a mother and her son from carbon monoxide poisoning as a result of the insured husband's alleged negligence in running his car's engine in an attached garage. Though the insured's alleged negligence was a covered cause of loss, the policy excluded coverage for incidents arising from the operation and use of a motor vehicle.

While the trial court concluded that the sole proximate cause of the loss was from the operation and use of a motor vehicle, and therefore excluded, the Court of Appeals disagreed, concluding there was a confluence of causes, one covered and the other excluded. After surveying jurisdictions nationally, the Court of Appeals adopted the theory of concurrent or dual causation set forth in *State Farm Mutual Auto Ins Co v Partridge*,² a California case, and held "we believe that the theory of dual causation is clearly viable and should be recognized in this jurisdiction ... If an occurrence is caused by a risk included within the policy, coverage is not vitiated merely because a separate excluded risk constitutes an additional cause of the occurrence."³

However, the Michigan Supreme Court reversed, holding "no sound jurisprudential or policy reason exists to introduce a legal theory or doctrine that departs from the literal interpretation of an unambiguous insurance contract ... Because the tragic event at issue here clearly 'arose out' of the operation and use of an automobile ... the exclusion stands."⁴ Following the Supreme Court's *Vanguard* decision, the anti-concurrent causation rule has been applied in numerous Michigan first party insurance cases to defeat coverage.⁵

Those who consider anti-concurrent causation to be the default rule in Michigan should be cognizant that a particular policy's language and architecture may overcome the rule. Undoubtedly, many standard policies contain language which unequivocally invoke the anti-concurrent causation rule. The following example is typical and can commonly be found as a

preamble to a subset of exclusions in many Michigan policies:

We will not pay for loss or damage caused directly or indirectly by any of the following. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss.

While the intent of this clause is decidedly anti-concurrent causation, it can be contrasted with language found in other Michigan policies adopting the "efficient proximate cause" doctrine. The efficient proximate cause doctrine operates to extend coverage in circumstances where the cause which sets the chain of events in motion, i.e. the "efficient" proximate cause, is covered under the policy even though an excluded cause has contributed to the loss.⁶ The intent of the following language found in some Michigan policies clearly embraces the efficient proximate cause doctrine to permit coverage even if there is an excluded concurrent cause:

We do not cover loss to property ... when:

- a) there are two or more causes of loss to the covered property; and
- b) the predominant cause(s) of loss is (are) excluded ...

While these two examples appear clear in their intent, many Michigan policies contain inconsistent exclusionary language applicable to different subsets of exclusions. This inconsistency may be a key to overcoming an adversary's assertion of the anti-concurrent causation rule.

The exclusions section in many property policies are divided into discrete subsections, each with its own fairly standard preamble and set of exclusions. One standard policy architecture juxtaposes one set of exclusions subject to the anti-concurrent causation preamble identified above, with another set of exclusions having an entirely different preamble, thereby calling into question its intent:

We will not pay for loss or damage caused by or resulting from any of the following ...

Does the fact that a policy contains multiple, incongruent preambles for different classes of exclusions preclude application of the anti-concurrent causation doctrine to the subset of exclusions subject to the preamble not containing explicit anti-concurrent causation language?

This issue was addressed by the Sixth Circuit Court of Appeals in *Iroquois on the Beach, Inc v Gen Star Indem Co* (*infra* note 5). In that case, the insured's building was concurrently damaged by water and wind. Because of the nature of the water loss, the insurer denied coverage based on a policy exclusion for loss or damage "caused by or resulting from ... Continuous or repeated seepage or leakage of water, or the presence or condensation of humidity, moisture or vapor, that occurs over a period of 14 days or more."

The insured argued that the anti-concurrent causation doctrine was inapplicable to the loss because the "caused by or resulting from" preamble applicable to the set of exclusions containing the subject exclusion conflicted with the unequivocal anti-concurrent causation preamble applicable to a separate set of policy exclusions. With little analysis of fundamental tenants of contract interpretation, citing *Vanguard, supra*, the *Iroquois* court simply rejected the insured's argument, concluding that the addition of an anti-concurrent causation clause would be surplusage since the default rule in Michigan is that a loss is not covered when it is caused by a combination of a covered risk and an excluded risk.⁷

A practitioner confronted with the standard policy architecture described above has a basis to argue against an adversary's assertion of the anti-concurrent causation rule and reliance on *Iroquois, supra*, by pitting the conflicting preambles against one another, advocating for a strict application of the canons of contract interpretation⁸ and pointing out that the court in *Iroquois* made no attempt to harmonize the two conflicting preambles. Nor did the court attempt to explain why the drafter's use of two distinctly different preambles was not itself a manifestation of an intent to express two distinctly different meanings. At least one commentator has expressed that the standard ISO forms⁹ containing the identical architecture at issue in *Iroquois, supra*, manifests an intent that the first set of exclusions is subject to anti-concurrent causation, while the second set of exclusions is not.¹⁰

Accordingly, in order to overcome an application of the anti-concurrent causation rule, the practitioner must comprehensively review the particular policy at issue and provide the court with a thoughtful analysis of the policy language in order to overcome an adversary's rote citation to *Vanguard, supra*, in an attempt to argue there is no coverage for concurrent causation in Michigan. ■

About the Author

Jason J. Liss is an attorney with *Fabian, Sklar & King, P.C.*, a firm specializing in the representation of policyholders in residential and commercial property insurance disputes. He is a Certified Fire and Explosion Investigator (CFEI), qualified by the National Association of Fire Investigators (NAFI), and an appointed alternate on the Technical Committee on Fire Investigator Professional Qualifications, a peer committee comprised of public

and private sector industry professionals responsible for writing NFPA 1033: Standard for Professional Qualifications for Fire Investigator. Mr. Liss is a council member of the Insurance and Indemnity Law section of the State Bar of Michigan and serves on the Executive Board of the Michigan Association for Justice. Mr. Liss can be reached at jliss@fabiansklar.com.

Endnotes

- 438 Mich 463 (1991) (overruled in part on other grounds by *Wilkie v. Auto-Owners Ins. Co.*, 469 Mich 41 (2003)).
- 10 Cal. 3d 94, 514 P.2d 123 (1973), superseded by statute as stated in *Wincor Nixdorf Inc. v. Discover Prop. & Cas. Ins. Co.*, C.D.Cal., June 14, 2013.
- 181 Mich. App. 36, 48, 448 N.W.2d 754, 758 (1989), vacated (Oct. 25, 1990), rev'd, 438 Mich. 463, 475 N.W.2d 48 (1991).
- 438 Mich. at 475.
- See, e.g., *Sunshine Motors, Inc. v. New Hampshire Ins. Co.*, 209 Mich. App. 58, 530 N.W.2d 120 (1995); *Pioneer State Mut. Ins. Co. v. Splan (On Remand)*, unpublished opinion per curiam of the Court of Appeals, issued March 18, 2003 (Docket No. 220477); *Commerce Ctr. P'ship v. Cincinnati Ins. Co.*, unpublished opinion per curiam of the Court of Appeals, issued May 9, 2006 (Docket No. 265147); *Iroquois on the Beach, Inc. v. Gen. Star Indem. Co.*, 550 F.3d 585 (6th Cir. 2008); *Telerico v. Nationwide Mutual Fire Insurance Company*, 2012 WL 3609882 (E.D. Mich. 2012).
- See 7 Couch on Ins. § 101:45 (3d ed.)
- 550 F.3d at 588-589.
- A policy's terms may not be considered in isolation for purposes of determining its meaning; rather, the policy must be read as a whole and meaning given to all of its terms. *Singer v. American States Ins.*, 245 Mich. App. 370, 374 (2001). Every word, phrase, and clause must be given effect so as to avoid an interpretation which renders any part of it surplusage or nugatory. *Wells Fargo Bank, N.A. v. Cherryland Mall Ltd. Partnership*, 295 Mich. App. 99, 111 (2011), remanded on other grounds 493 Mich. 859 (2012). If after considering the policy as a whole, the court concludes that the common and ordinary meaning of the term at issue reasonably may be interpreted in more than one way, then the term is deemed to be ambiguous and it must be strictly construed against the insurer and in favor of coverage for the insured. *Celina Mut. Ins. Co. v. Citizens Ins. Co.*, 136 Mich. App. 315, 320-321 (1984); *Reurink Bros. Star Silo, Inc. v. Maryland Casualty Co.*, 131 Mich. App. 139, 146 (1983).
- ISO stands for Insurance Services Office, which is a company providing insurance related services to the industry, including standard policy forms.
- Krauss, George E., et al., *The National Underwriter Company, Commercial Property Coverage Guide*, pp. 90-92, 99 (6th ed.2015).

“Other Insurance” Clauses in Property and Liability Insurance Policies: Frequently Misunderstood Provisions

By Rabih Hamawi, *Law Office of Rabih Hamawi*

Most property and liability insurance policies contain “other insurance” clauses that insurers insert to restrict or limit their liability if another insurance policy affords coverage for the “same loss.”¹ These clauses intend to preclude insureds from over or double insuring their properties, to conform to the principle of indemnity, and to reduce moral hazards by preventing profiting from losses.

Unfortunately, insurers sometimes misunderstand their own “other insurance” clauses, and occasionally assert their applicability to a given factual situation when inappropriate, mainly because the competing policies don’t insure the “same loss.” This flawed interpretation has resulted in substantial penalty-interest awards against insurers for unreasonable delay or denial of claim payments.

Analyzing a potential “other insurance” issue is often a three-step process:

1. Do the competing policies insure the “same loss”;
2. What type of “other insurance” clause do the competing policies contain; and
3. What contract-construction principals do courts utilize to resolve conflicting clauses.

Definition of “Same Loss”

The first step in analyzing whether there is a potential “other insurance” issue is determining if the competing policies insure the “same loss.” Michigan courts have interpreted the “same loss” requirement consistently;² they will enforce an “other insurance” clause when and if the competing policies satisfy a four-trigger requirement:

1. They insure the same property;³
2. They insure the same insurable interest;⁴
3. They insure against the same risks or perils;⁵ and
4. The insurance proceeds are payable to the same parties.⁶

If any one of these four requirements is missing, then the competing policies don’t insure the “same loss,” and there is no “other insurance” problem. Consequently, the primary insurance policy must fully pay the insured’s loss.

Interestingly, this “same loss” requirement is litigated more often in “other insurance” clauses involving property-insur-

ance disputes. In the last 100 years,⁷ Michigan courts have rarely applied “other insurance” clauses in property-insurance disputes because the policies didn’t insure the “same loss.” Typically, the Michigan cases have involved situations where the competing policies insured separate and distinct insurable interests but one of the insurers asserted proration was required. For example, the following disputes didn’t satisfy the “same loss” requirement:

1. Policies separately insuring a land-contract vendor and a land-contract vendee;⁸
2. A policy issued jointly to two brothers versus a separate policy insuring an individual brother;⁹
3. An owner’s builders-risk policy versus a general contractor’s builders-risk policy;¹⁰
4. Policies separately insuring a landlord and a tenant;
5. Policies separately insuring a condominium association versus a unit owner.¹¹

Types of “Other Insurance” Clauses

If the competing policies insure the “same loss,” then the second step in analyzing an “other insurance” problem is to determine what type of clause the competing policies contain. Generally, insurers may either insert their own “other insurance” clauses, usually those the Insurance Services Office approves and adopts on the forms that it writes, or they may draft their own manuscript clauses to address certain risks or unacceptable insurance classifications. The types of “other insurance” clauses inserted could vary depending on whether the insurance policy is a liability or a property policy.

Liability Insurance Policies

In liability policies, like commercial general liability, professional liability, pollution liability, or automobile liability policies, there are often four types of “other insurance” clauses that may limit an insurer’s liability if two or more policies insure the “same loss.”

1. A pro-rata clause: an insurer usually pays its loss’s share in the proportion its policy limits relates to the aggregate coverage available under all applicable insurance policies;¹²

2. An excess clause: an insurer pays a loss only after other primary insurance is exhausted;
3. An escape clause: an insurer doesn't pay for any loss if other insurance coverage is available.¹³
4. An excess-escape clause: an insurer pays for the loss's amount exceeding the limits of other insurance available, but it doesn't pay where the amount of other insurance coverage available equals or exceeds its own.

Property Insurance Policies

In property insurance policies, especially those insuring fire as a basic peril, like most homeowners or dwelling policies, Michigan law requires admitted¹⁴ insurers to only insert pro-rata "other insurance" clauses.¹⁵

Although some admitted insurers ignore Michigan law, and instead, insert only excess or escape clauses in their fire insurance policies, Michigan courts will void any policy provisions that contradict Michigan law, and would add any missing statutory provisions, like a pro-rata clause, into any non-conforming fire insurance policy.¹⁶

When the dispute involves non-admitted insurers,¹⁷ and the policies include excess clauses, for example, instead of pro-rata clauses, courts still apply a pro-rata formula, relying on contract-interpretation principals, because a literal application of the excess clauses would leave the insured without any available insurance.¹⁸

Construction of "Other Insurance" Clauses

Where the competing policies aren't true "other insurance" (not concurrent) because they don't insure the "same loss" (same property, same insurable interest, same risks or perils, and insurance proceeds are payable to the same parties), there is no "other insurance" issue, and the primary insurer must fully pay the insured's loss.¹⁹

But when "other insurance" clauses conflict because the policies do insure the "same loss" but have differing provisions, courts nationally follow one of two methods to resolve the conflict:

1. The majority view, including Michigan, reconciles the conflicting clauses by discerning the parties' intent, usually requiring the insurer with the pro-rata clause to cover all losses up to its policy limits;²⁰
2. The minority view finds the conflicting clauses to be "mutually repugnant," rejecting them completely, and then prorating the loss among all insurers.²¹

Thus, where two policies have pro-rata clauses insuring the "same loss," insurers must contribute equally to the insured's loss.²² For example, a building is insured for \$1,000,000, with insurer A providing \$700,000 in coverage, and insurer B providing \$300,000 in coverage. If the building suffers a loss of \$200,000, and the two policies include pro-rata clauses, then insurer A pays \$140,000 (70 percent of \$200,000) and insurer B pays \$60,000 (30 percent of \$200,000).

Where two policies insure the "same loss," and one policy has an excess clause and the other policy has a pro-rata clause, the policy with the pro-rata clause is primary and the other policy is excess.²³ If one policy has an escape clause and the other has a pro-rata clause, then the escape clause will not apply and the policy with the pro-rata clause pays the entire claim. Finally, if one policy has an escape clause and the other has an excess clause, then an analysis of the parties' intent will resolve the conflict.²⁴

The Primary Insurer's Payment Obligation

"Other insurance" clauses only affect insurers' rights among themselves, and should not adversely affect the insured's right to recovery under each clause or concurrent policy. Therefore, insurers may never allocate a loss to the insured, and paying the insured's claim must take priority over any loss-allocation disputes among concurrent insurers.²⁵ The primary insurer must fully indemnify the insured for the loss, then seek contribution from the other insurer or insurers.²⁶ Alternatively, the primary insurer may also institute a declaratory judgment action.²⁷

Conclusion

"Other insurance" clauses apply when the two or more policies insure the "same loss." The "same loss" is satisfied when the two or more policies insure 1) the same property; 2) the same insurable interest; 3) the same risks or perils; and 4) the insurance proceeds are payable to the same parties. If the policies insure the "same loss," then analyzing the type of the "other insurance" clause inserted would permit the court to properly declare the insured's rights under the competing policies. But when a literal application is impossible because it would leave the insured without any available insurance, Michigan courts reconcile the conflict by pro-rating the loss between the insurers. Finally, when there is an "other insurance" dispute, a primary insurer can't simply ignore the claim; it has only two options: 1) fully pay the insured's claim, and then seek contribution from the other insurer or insurers, or 2) file a declaratory-judgment action. ■

About the Author

Rabih Hamawi is a principal at Law Office of Rabih Hamawi, P.C. and focuses his practice on representing policyholders in fire, property damage, and insurance-coverage disputes with insurers and in errors-and-omissions cases against insurance agents. He has extensive expertise in insurance coverage and is a licensed property and casualty, life, accident, and health insurance producer and counselor (LIC). He earned the Chartered Property and Casualty Underwriter (CPCU), Certified Insurance Counselor (CIC), and Certified Risk Manager (CRM) designations. His email address is rh@hamawilaw.com.

Endnotes

- 1 *Lubetsky v Standard Fire Ins Co*, 217 Mich 654; 187 NW2d 260 (1992); *Root v Hamilton Mut Ins Co*, 116 Mich App 596; 323 NW2d 298 (1981); *McCoy v Continental Ins Co*, 326 Mich 261; 40 NW2d 146 (1949).
- 2 *Id.*
- 3 *Lubetsky*, 217 Mich at 656.
- 4 *American & Foreign Ins Co v Allied Plumbing & Heating Co*, 36 Mich App 561; 194 NW2d 158 (1971); *Dietzel v Patrons' Mut Fire Ins Co of Michigan*, 232 Mich 415; 205 NW 149 (1925).
- 5 *Lubetsky*, 217 Mich at 655-56.
- 6 *Id.*; *Root v Hamilton Mut Ins Co*, 116 Mich App 596; 323 NW2d 298 (1981).
- 7 Only some of the published cases are included in this article.
- 8 *McCoy v Continental Ins Co*, 326 Mich 261; 40 NW2d 146 (1949); *Smith v American Ins Co*; 177 Mich 123; 143 NW 54 (1913); *State Farm Fire & Cas Co v Farmers Ins Exchange*, 80 Mich App 567; 264 NW2d 62 (1978); *Tyler v Pacific Indem Co*, 2012 WL 300883 (ED Mich, Feb 1, 2012).
- 9 *Dietzel v Patrons' Mut Fire Ins Co of Michigan*, 232 Mich 415; 205 NW 149 (1925).
- 10 *American & Foreign Ins Co v Allied Plumbing & Heating Co*, 36 Mich App 561; 194 NW2d 158 (1971).
- 11 Concurrent coverage maybe created by extrinsic documents, not part of the insurance policies themselves, like condominium association by-laws, or the master deed.
- 12 Some older policies include pro-rata clauses that allocate the loss between insurers by equal shares, and not policy limits.
- 13 *St Paul Fire & Marine Ins Co v American Home Assur Co*, 444 Mich 560; 514 NW2d 113 (1994).
- 14 Admitted insurers are those that are licensed and authorized to do business in Michigan.
- 15 MCL 500.2833(k).
- 16 *Randolph v State Farm Fire & Cas Co*, 229 Mich App 102; 580 NW2d 903 (1998).
- 17 Non-admitted insurers are not licensed in Michigan and do not contribute to the state's guaranty fund, which protects policyholders in case a non-admitted insurer declares bankruptcy.
- 18 *Travelers Property Casualty Company of America v XL Insurance America, Inc*, unpublished opinion of the Court of Appeals, issued [Mar 16, 2017] (Docket No. 329277 and 329293).
- 19 *American & Foreign Ins Co v Allied Plumbing & Heating Co*, 36 Mich App 561; 194 NW2d 158 (1971).
- 20 *St Paul Fire & Marine Ins Co*, 444 Mich at 560.
- 21 *Lamb-Watson Inc v Oregon Auto Ins Co*, 219 Or 110; 314 P2d 110 (1959).
- 22 *Interstate Fire & Cas Co v Hartford Fire Ins Co*, 548 F Supp 1185 (ED Mich, 1982).
- 23 *St Paul Fire & Marine Ins Co v American Home Assur Co*, 444 Mich 560; 514 NW2d 113 (1994).
- 24 *Pacific Ins Co v Cordova Chemical Co of Michigan*, unpublished opinion per curiam of the Court of Appeals, issued [June, 14, 2005] (Docket No. 248778). *State Farm Fire & Cas Co v Liberty Ins Underwriters, Inc*, 613 F Supp 2d 945 (W D Mich, 2009), *aff'd*, 398 F Appx 128 (CA 6, 2010).
- 25 *Auto-Owners Ins Co v Southern Michigan Mut Ins Co*, 123 Mich App 39; 333 NW2d 168 (1983).
- 26 *Reliance Ins Co v Liberty Mutual Fire Ins Co*, 13 F3d 982 (CA 6, 1994).
- 27 *Auto-Owners Ins Co v S Michigan Mut Ins Co*, 123 Mich App 39; 333 NW2d 168 (1983); *State Farm Fire & Cas Co v Farmers Ins Exchange*, 80 Mich App 567; 264 NW2d 62 (1978).

Insurance & Indemnity Law Section Mission

Issues arising out of insurance contracts and indemnity agreements affect a broad range of practice areas. In addition, insurance is a regulated industry, and state and federal regulations present specialized questions. The membership of the Insurance and Indemnity Law Section of the State Bar of Michigan consists of those who have expertise in this area of practice, as well as those whose expertise lies in other practice areas that are affected by insurance and indemnity issues. The mission of the Section is to provide a forum for an exchange of information, views and expertise from all perspectives on both insurance coverage issues and indemnity issues, and to provide information and assistance to other persons or organizations on matters relating to insurance and indemnity. Membership is open to all members of the State Bar of Michigan.

Insurance and Indemnity 101



Useful Citations

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

Everyone who practices in the area of insurance coverage sooner or later develops a set of useful citations. There are two criteria for including a citation in your personal set. First are those that you will use a lot. Second are those that you won't use very often but they are hard to find, so you should save them just in case. For those who are new to the area, here is a starter set.

Interpretation – General Principles

In *Frankenmuth Mutual Insurance Co v Masters*, 460 Mich 105; 595 NW2d 832 (1999), the Supreme Court listed these “well established Michigan principles of construction”: “An insurance policy must be enforced in accordance with its terms. . . . We will not hold an insurance company liable for a risk it did not assume. . . . In interpreting ambiguous terms of an insurance policy, this Court will construe the policy in favor of the insured. . . . However, we will not create an ambiguity where the terms of the contract are clear. . . . Where there is no ambiguity, we will enforce the terms of the contract as written.” *Frankenmuth* at 111. . . . “Furthermore, this Court will interpret the terms of an insurance contract in accordance with their ‘commonly used meaning.’ . . . We will take into account the reasonable expectations of the parties.” *Frankenmuth* at 112. “Where the meaning of a term is not obvious from the policy language, the ‘commonly used meaning’ controls.” *Frankenmuth* at 113-114.

Reasonable Expectation of Insured No Longer Valid

In *Wilkie v Auto-Owners*, 469 Mich 41; 664 NW2d 776 (2003) the court held that the principle that the policy would be interpreted consistently with the reasonable expectation of the insured was “invalid as an approach to contract interpretation.” *Id.* at 52.

Rules of Contract Interpretation Apply

“The rules of contract interpretation apply to the interpretation of insurance contracts. The language of insurance contracts should be read as a **whole** and must be construed to give effect to every word, clause, and phrase.”

McGrath v Allstate Ins Co, 290 Mich App 434, 439; 802 NW2d 619 (2010) (citations omitted)

Parol Evidence Not Permitted

“[W]here the terms of a contract are unambiguous, their

construction is for the court to determine as a matter of law . . . and the plain meaning of the terms may not be impeached with extrinsic evidence.”

“We must look for the intent of the parties *in the words used in the instrument.*”

Zurich Insurance Co v CCR and Co (on rehearing), 226 Mich App 599, 604; 576 NW2d 392 (1997), appeal dismissed 572 NW2d 13, appeal denied 583 NW2d 902 (affidavit of intent not permitted)

Interpretation: Two-Step Analysis

The interpretation of a policy is a two-step process.

“To determine what the parties agreed to, the court applies a two-part analysis. In the first part, the court must decide if the occurrence section of this policy includes a particular act. If so, the court then must decide if coverage is denied under one of the policy's exclusions.”

Fire Insurance Exchange v Diehl, 450 Mich 678, 683; 545 NW2d 602 (1996), citing *Heniser v Frankenmuth Mutual Insurance Co*, 449 Mich 155, 172; 534 NW2d 502 (1995)

Burden of Proof

The burden of proof shifts at each step of the analysis.

“It is without dispute that the “insured bears the burden of proving coverage, while the insurer must prove that an exclusion to coverage is applicable.”

Heniser v Frankenmuth Mutual Insurance Co, 449 Mich 155, 161 note 6; 534 NW2d 502 (1995), quoting from *Arco Industries Corp v American Motorists Ins Co*, 448 Mich 395, 425-425; 531 NW2d 168 (1995) (concurring opinion of Boyle, J.)

Endorsement Prevails Over Main Policy

“When a conflict arises between the terms of an endorsement and the form provisions of an insurance contract, the terms of the endorsement prevail.”

Hawkeye Security Insurance Co v Vector Construction Co, 185 Mich App 369, 380; 460 NW2d 329 (1990).

General and Specific Terms (Ejusdem Generis)

“The doctrine of *ejusdem generis* provides that, where a rule or law contains general words followed by the specific enumeration of particular persons or things, those general words are to be construed as applicable only to the same kinds of

persons or things as those previously specifically enumerated.”

SOCIA v DNR, 176 Mich App 434, 441; 440 NW2d 649 (1989). The rule applies to written instruments as well: *In Re Scheyer's Estate*, 336 Mich 645, 650; 59 NW2d 33 (1953) (will), *Hansen v Facione*, 294 Mich 473; 293 NW2d 723 (1940) (deed restriction), *Sobel v Piston Ring Sales, Inc*, 294 Mich 211; 292 NW 863 (1940) (contract).

Interpretation in Context (Noscitur a Sociis)

“[T]his Court applies the doctrine of *noscitur a sociis*, which ‘stands for the principle that a word or phrase is given meaning by its context of setting.’”

In re complaint of Rovas against SBC Mich, 482 Mich 90, 114; 754 NW2d 259 (2008):

“When reading an exclusionary clause, we read the contract as a whole to effectuate the overall intent of the parties.”

Hayley v Allstate Ins Co, 262 Mich App 571, 575; 686 NW2d 273 (2004).

Ambiguity

An ambiguity will be found if two contractual provisions irreconcilably conflict or a term is equally susceptible to more than one meaning.

Coates v Bastian Bros, Inc, 276 Mich App 498, 503; 741 N.W.2d 539 (2007).

“An insurance contract is ambiguous when its provisions are capable of conflicting interpretations.” *Farm Bureau v Nik-ke*, 460 Mich 558, 566, 596 NW2d 915 (1999).

Ambiguity – If Unambiguous, Interpretation is a Matter of Law

“[W]here the terms of a contract are unambiguous, their construction is for the court to determine as a matter of law . . . and the plain meaning of the terms may not be impeached with extrinsic evidence.”

Zurich Insurance Co v CCR and Co (on rehearing), 226 Mich App 599, 604; 576 NW2d 392 (1997), citing *Mt. Carmel Mercy Hospital v Allstate Insurance Co*, 194 Mich App 580, 588; 487 NW2d 849 (1992).

Ambiguity: Interpretation is a Question of Fact

If the court finds that a provision is ambiguous, its interpretation becomes a matter of fact to be resolved by the trier of fact based upon the evidence. If the trier of fact is not able to make a decision based on the evidence, then it must apply the rule “contra proferentem” and interpret the provision against the drafter.

Klapp v United Ins Group Agency, Inc, 468 Mich 459, 468; 663 NW2d 447 (2003). ■

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. Mr. Carroll practices extensively in the area of insurance coverage and indemnity law, and was designated a “Super Lawyer®” again in 2016. He also consults with businesses and insurers on the drafting of contracts, represents insureds and insurers in declaratory actions, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His email address is HOC@HalOCarrollEsq.com.



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Insurance Coverage Counsel

Practice Attorney Spotlight



Noreen L. Slank

- Over 35 years of extensive experience in appellate work, insurance coverage work, and professional liability defense (especially medical and legal)
- Past chair of the indemnity law committee of the Insurance and Indemnity Section and the State Bar of Michigan's Appellate Practice Section
- Co-editor of Michigan Insurance Law and Practice, and Torts: Michigan Law & Practice (2d)
- Highly respected in the legal industry having earned numerous accolades and recognitions

You can contact Noreen at noreen.slank@ceflawyers.com or 248-351-5444.

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248-355-4141

www.ceflawyers.com

4000 Town Center, 9th Floor

Southfield, Michigan 48075-1473



Opening Pandora's Box: Legal Malpractice and the "Suit Within a Suit" Doctrine

By Sandra J. Lake, *Speaker Law Firm*

The difficulties in prevailing on a claim of legal malpractice are numerous. Questions regarding when the attorney-client relationship ends, when the claim of legal malpractice accrues, whether the attorney judgment rule applies to bar the claim, and when expert testimony is needed to establish a breach of duty on the part of the attorney are just a few of the issues that arise. Perhaps the most arduous issue, however, is proving that but for the attorney's malpractice, the client would have prevailed and/or achieved a better outcome in the underlying action.

There is a significant difference, however, in proving that the client would have prevailed completely in the underlying action, as opposed to proving that a better outcome could have been achieved. The latter is arguably a much less stringent standard. Thus, knowing when this less stringent standard applies is crucial, and often misunderstood.

The "Suit Within a Suit" Doctrine

There are four basic elements required to prove a claim of legal malpractice: (1) the existence of an attorney-client relationship, (2) the acts alleged to have constituted the negligence, (3) that the negligence was the proximate cause of the injury, and (4) the fact and extent of the injury alleged.¹

Often the most difficult element to prove in a legal malpractice case is that of proximate causation, particularly where the claim is that the malpractice resulted in an inability to pursue the underlying action. After all, how does one prove that, but for the alleged negligence of the defendant-attorney, the client would have prevailed on the question of liability; let alone determine the amount that would have ultimately been awarded by the trier of fact? To limit the potentially speculative nature of such a claim, the Michigan appellate courts have recognized the "suit within a suit" doctrine, also known as the "case within a case" doctrine.

Initially discussed by the Michigan Court of Appeals as a matter of first impression in *Basic Food Industries, Inc v Grant*², the "suit within a suit" doctrine holds that a plaintiff-client in a legal malpractice case bears the burden of proving that he or she would have prevailed in the underlying action had the defendant-attorney not been negligent.³ Thus, not only does the client have to prove that his or her attorney committed acts of negligence, but also that had the underlying case proceeded

in the absence of negligence, the client would have succeeded and been awarded the relief requested. In other words, the client is "faced with the difficult task of proving two cases within a single proceeding."⁴

How Does the "Suit Within a Suit" Standard Differ from Standard Proximate Causation?

Arguably, the "suit within a suit" proximate cause requirement is substantially heightened from the level of proximate cause required in other legal malpractice cases, which only require a showing that had the client been properly represented, a more favorable result would have been achieved.⁵

If you are confused as to the difference between these two standards, you are not alone. So how are they different? Case law has provided little guidance in terms of specifics. The difference seems to be the degree of success that could have been achieved in the underlying action but for the alleged malpractice. The Michigan Court of Appeals refers to the "suit within a suit" standard as requiring a showing that the client would have prevailed "completely" in the underlying action.⁶

The prevailed "completely" standard is contrasted with a lesser showing that but for the attorney's negligence, a better outcome could have been achieved or, in the context of a criminal case, that a lighter sentence would have been imposed.⁷ In a case in which the "suit within a suit" standard does not apply, the client need only prove those damages directly and proximately caused by the attorney's negligence.⁸ In other words, the injury alleged may not be that there was an adverse judgment, but rather, that the amount of the judgment or settlement was less than what could have been obtained had there not been negligence.⁹

When Does the "Suit Within a Suit" Standard Apply?

Due to the restrictive nature of this standard, the *Basic Food* Court limited its application to three distinct situations. The court held this standard only applies to cases where:

1. An attorney's negligence prevents the client from bringing a cause of action (such as where the statute of limitations has run),
2. The attorney's failure to appear causes judgment to be entered against the client, or

3. The attorney's negligence prevents an appeal from being perfected.¹⁰

Use of this standard is supposed to be strictly limited to the above situations. As stated by the court in *Basic Food Industries, Inc v Grant*:

We believe that the "suit within a suit" requirement should, as a matter of sound public policy, be limited to the types of cases we have described above. Requiring the plaintiff in all cases to show that he would have prevailed completely in the former action as a condition precedent to recovery in a subsequent malpractice action is a harsh requirement that would preclude otherwise meritorious claims. If the attorney's negligence results in a verdict against his client that is larger than what would have been returned in the absence of his negligence, then the attorney should be held liable for the increased amount of the judgment.¹¹

Application of the "Suit Within a Suit" Doctrine

The "suit within a suit" doctrine has been applied within the restrictions set forth in *Basic Food* in several published opinions. Examples include: an attorney's failure to timely file an application for disability retirement benefits,¹² the filing of a claim under the Whistleblowers' Protection Act after the expiration of the statute of limitations,¹³ an attorney's failure to exercise reasonable skill and care in answering interrogatories which led to the dismissal of the client's case,¹⁴ and failure to file a brief on appeal and respond to a motion to dismiss in the Court of Appeals.¹⁵

There are also several published opinions where the court properly declined to apply the "suit within a suit" doctrine, including: allegations of failure to conduct necessary discovery,¹⁶ failure to advise the client of a hearing on a motion to terminate parental rights resulting in the client's lost opportunity to resolve the matter via settlement,¹⁷ and failure to subpoena business records and protect the client with respect to an ongoing foreclosure of the marital home in a divorce matter.¹⁸

Fortunately, it appears the published authority in Michigan has handled this issue consistent with the limitations set forth in *Basic Food*. There are some unpublished decisions, however, that have applied the "suit within a suit" standard to cases that do not fall within the three situations set forth in *Basic Food*. In *Nolan v Chapman*,¹⁹ for example, the client sued her attorney alleging that the attorney failed to give her proper advice as to the effect of settling a third-party auto negligence case with respect to her ongoing worker's compensation benefits. As a result of settling the third-party case, the client's worker's compensation benefits were subsequently reduced. On appeal, the client claimed that the trial court erred in granting the attorney's dispositive motion, which averred

that the client could not prove that she would have obtained a better outcome had she not settled.

In discussing the causation standard applicable, the Court of Appeals in *Nolan* stated that the "suit within a suit" standard applied. This case does not, however, meet any of the three situations stated in *Basic Food*. Thus, the "suit within a suit" standard should not have been applied. Fortunately for the client in that case, however, the Court of Appeals actually applied standard proximate cause in holding that the trial court erred in dismissing the case on the basis of proximate causation. The Court of Appeals held that, "[i]n such cases, the legal malpractice jury is charged with determining whether, had the evidence been admitted, the underlying jury would have awarded plaintiff larger damages."

Similarly, in *Messenger v Heos*,²⁰ the clients sued their attorney for legal malpractice after the jury issued a finding of no cause of action in the underlying medical malpractice case. The clients alleged numerous acts of negligence, including: failure to properly investigate the claims, failure to secure and confirm expert witness testimony, and failure to call witnesses live instead of using videotaped testimony. The trial court dismissed the legal malpractice claim upon findings that the claims were barred by the attorney judgment rule and that the clients could not establish that the attorney's alleged malpractice resulted in their claimed damages.

On appeal, the court in *Messenger* affirmed the grant of summary disposition in favor of the attorney on the basis of the attorney judgment rule. The Court of Appeals further held, albeit in dicta, that it agreed that dismissal was appropriate on the basis of proximate causation. The Court of Appeals stated that the "suit within a suit" standard applied and that the clients could not show that they would have prevailed in the underlying action but for the alleged negligence of their attorney.

The *Nolan* and *Messenger* cases both held that the "suit within a suit" standard applied to allegations that do not fall within the three situations set forth in *Basic Food*. The lesson to be taken from these cases is when discussing application of the "suit within a suit" doctrine, stick to the published authority.

What Does it Mean to Prevail "Completely?"

Once you have determined that the "suit within a suit" requirement applies to your case, you must next determine how it is to be applied. Although appellate case law has not provided a definition of what it means to prevail "completely" in a matter, obviously, this must mean something different than merely the lost opportunity to achieve a better outcome.²¹

The "suit within a suit" concept is easy enough to understand when the issue in the legal malpractice case is whether the client would not have prevailed in the underlying action due to a legal deficiency. For example, in *Manzo v Petrella*,²²

the client's Whistleblowers' Protection Act ("WPA") claim was dismissed as a result of being filed outside the statute of limitations. In the subsequent legal malpractice case, the attorney argued that the client could not establish the "suit within a suit" requirement where the WPA claim was not viable as a matter of law.

The Court of Appeals in *Manzo* agreed with the defendant-attorney, holding that because the client had not engaged in "protected activity" as defined by the WPA, the client would not have prevailed in his underlying WPA action. Specifically, the Court of Appeals held that the WPA only protected the employee with respect to reports made to a "public body" and further held that his report to a hospital's professional standards and conduct committee was not a report to a "public body." Accordingly, the attorney was entitled to dismissal, as the client could not establish that he would have prevailed in the underlying action.

Thus, in cases such as *Manzo* where the issue is one of law, the "suit within a suit" doctrine is straightforward. But, what does it mean to prevail "completely" where the main point of contention in the underlying action would have been, for example, the fact and extent of damages? This question has not been answered and remains problematic for the client in proving his or her case of legal malpractice.

Does the Legal Malpractice Plaintiff Have to Prove Collectability?

One other issue that has been raised with respect to the issue of proximate causation and damages is whether the plaintiff-client in the malpractice case must be able to prove that he or she would have been able to actually collect damages in the underlying action in order to prevail in the legal malpractice case. This issue was addressed by the Court of Appeals in *Teodorescu v Bushnell, Gage, Reizen & Byington*,²³ where the court held that the plaintiff did not bear the burden to prove collectability. Rather, the issue of collectability is an affirmative defense that must be raised by the defendant. It is the defendant-attorney's burden to prove that any award that could have been achieved in the underlying action was uncollectable or partially uncollectable.

Conclusion

From a plaintiff-client's standpoint, legal malpractice cases are difficult to prove, and even more so if the underlying action was not pursued as a result of attorney negligence. If your client is in the unenviable position of having to prove his or her "suit within a suit," be sure to fill your legal armory with experts and documentary evidence that show not only that the attorney breached the standard of care, but also that the underlying action was legally and factually viable. ■

About the Author

Sandra J. Lake is an attorney with *Speaker Law Firm, PLLC*, an appellate boutique law firm representing clients in the Michigan and federal appellate courts. Ms. Lake focuses her practice on legal and medical malpractice, Michigan no-fault law, premises liability, insurance coverage, contract, and bar exam appeals. Ms. Lake can be reached at slake@speakerlaw.com.

Endnotes

- 1 *Law Offices of Lawrence J Stockler, PC v Rose*, 174 Mich App 14, 25; 436 NW2d 70 (1989).
- 2 *Basic Food Industries, Inc v Grant*, 107 Mich App 685, 690; 310 NW2d 26 (1981); lv den 413 Mich 913 (1982).
- 3 *Id.*
- 4 *Id.* at 691.
- 5 *Ignotov v Reiter*, 425 Mich 391, 396; 390 NW2d 614 (1986).
- 6 *Basic Food* at 694; *Schlumm v Terrence J O'Hagan, PC*, 173 Mich App 345, 359-360; 433 NW2d 839 (1988).
- 7 *Basic Food* at 690; *Schlumm* at 359.
- 8 *Basic Food* at 693.
- 9 *Id.* at 694.
- 10 *Id.* at 693.
- 11 *Id.* at 694.
- 12 *Bowden v Gannaway*, 310 Mich App 499; 871 NW2d 893 (2015).
- 13 *Manzo v Petrella*, 261 Mich App 705; 683 NW2d 699 (2004).
- 14 *Law Offices of Lawrence J Stockler, PC v Rose*, 174 Mich App 14; 436 NW2d 70 (1989).
- 15 *Charles Reinhart Co v Winiemko*, 444 Mich 579; 513 NW2d 773 (1994).
- 16 *Basic Food* at 690.
- 17 *Ignotov* at 396.
- 18 *Teodorescu v Bushnell, Gage, Reizen & Byington*; 201 Mich App 260; 506 NW2d 275 (1993).
- 19 Unpublished opinion per curiam of the Court of Appeals, issued April 23, 2015 (Docket No. 319830).
- 20 Unpublished opinion per curiam of the Court of Appeals, issued December 9, 2008 (Docket No. 279968).
- 21 See *Basic Food, supra*, at 694, discussing that the "suit within a suit" requirement is harsh compared to the standard of proof in legal malpractice cases to which this requirement does not apply.
- 22 261 Mich App 705; 683 NW2d 699 (2004).
- 23 201 Mich App 260; 506 NW2d 275 (1993).

ERISA
Case
Summary

ERISA Decisions of Interest

K. Scott Hamilton, *Dickinson Wright PLLC*, khamilton@dickinsonwright.comKimberley J. Ruppel, *Dickinson Wright PLLC*, kruppel@dickinsonwright.com

Sixth Circuit Update

Discovery Rule Starts the Statute of Limitations Clock

Patterson v. Chrysler Group, LLC
845 F.3d 756 (6th Cir. 2017)

This case exemplifies the importance of complying with ERISA requirements in a divorce proceeding and in the subsequent pension benefit claim process. Had the plaintiff's first of four attorneys followed proper procedure, the outcome of this case would likely have been dramatically more favorable to the plaintiff.

Plaintiff and her former husband were divorced on September 27, 1993. The judgment of divorce provided that plaintiff was entitled to half of her former husband's pension benefits which accrued during their marriage, with full rights of survivorship. Benefits were due to plaintiff when they became payable to the former husband.

On April 1, 1994, plaintiff's former husband began receiving retirement benefits; plaintiff did not. On December 14, 1994, plaintiff's attorney submitted the judgment of divorce to the plan administrator in an attempt to obtain her benefits. In response, on January 18, 1995, a plan representative advised plaintiff's attorney that the judgment of divorce lacked the information required to qualify as a "qualified domestic relations order" ("QDRO"). A written sample of a proper QDRO was provided along with the written denial of plaintiff's claim. Plaintiff took no further action at that time.

By way of background, the statutory framework of ERISA contains an "anti-alienation" provision, such that pension benefits ordinarily cannot be assigned or alienated from the plan participant, even in the face of a court order. The exception to this rule is that benefits may be assigned pursuant to a QDRO, which must satisfy statutory requirements by: creating or recognizing an alternate payee and that payee's right to receive benefits; identifying the alternate payee and other specified clerical information; and not requiring the plan to provide benefits not otherwise provided or at an increased amount. (*See*, 29 USC § 1056(d)).

Approximately twelve years later, after Plaintiff's ex-husband passed away, she again contacted the plan to claim her benefits. The plan again denied her claim because the judgment of divorce did not contain the requisite information. After engaging her fourth attorney, plaintiff's judgment of

divorce was corrected by a *nunc pro tunc* order which finally contained the clerical information required of a QDRO. The new order was submitted to the plan on March 3, 2014 and her claim again denied by the plan on June 24, 2014. Plaintiff filed suit on February 12, 2015, challenging the denial.

The district court initially found in favor of the plaintiff on a number of grounds, including that the 2014 *nunc pro tunc* order triggered a six year statute of limitations such that plaintiff's claim was not time-barred. The Sixth Circuit disagreed, finding that if a parties' claim could be revived by the issuance of a *nunc pro tunc* order, then no claim would ever truly be time-barred. Instead, the Court applied the "discovery rule" and held the statute of limitations began to run when plaintiff was first put on notice of the denial of her claim, which was January 18, 1995, well more than six years before filing suit. The Court of Appeals was not swayed by plaintiff's argument that the plan should have done more to help her particularly because the plan provided her a sample QDRO and an explicit reason for the denial. Further, the court was not impressed by plaintiff's 20 year delay in filing suit. The district court's judgment was reversed and remanded with instructions to dismiss plaintiff's claim as time-barred.

Exhaustion Not Required for Statutory
Claims Under ERISA*Hitchcock v Cumberland Univ 403(b) DC Plan*
-- F3d --, (6th Cir, 3/14/17) Case No. 16-5942

The plaintiffs were participants in a defined contribution pension plan that Cumberland University provided its employees. The plaintiffs sued the university alleging claims for (1) wrongful denial of benefits under §1132(a)(1)(B), (2) violation of ERISA's anti-cutback provision in §1054(g), (3) failure to give statutory notice contrary to §1132(a)(3), and (4) breach of fiduciary duty under §1104. The district court dismissed the third count for failure to state a claim, and dismissed all of the other counts for failure to exhaust administrative claims procedures.

The plaintiffs appealed dismissal of the anti-cutback and fiduciary duty claims for failure to exhaust. The Sixth Circuit reversed, holding that exhaustion of administrative remedies is not required for claims of statutory violations of ERISA. Noting "that the circuits are split on the issue of whether participants or beneficiaries of an ERISA plan 'must exhaust internal

plan remedies before suing plan fiduciaries on the basis of an alleged violation of duties imposed by the statute” (quoting *Mason v Cont'l Grp*, 474 US 1087 (1986)), the Sixth Circuit joined the Third, Fourth, Fifth, Ninth, Tenth, and DC Circuits in holding that “there is no exhaustion required for ERISA claims alleging statutory, rather than plan-based, violations.”

The court explained that “this statutory claim exception to the exhaustion requirement does not apply to ‘plan-based claims “artfully dressed in statutory clothing,” such as where a plaintiff seeks to avoid the exhaustion requirement by recharacterizing a claim for benefits as a claim for breach of fiduciary duty.’”

The Sixth Circuit described the test to determine whether a claim is a statutory claim that it is not subject to exhaustion. “[T]he relevant inquiry is what forms the basis of [Plaintiff’s] right to relief: the contractual terms of the pension plan or the provisions of ERISA and its regulations.” (quoting *Stephens v Pension Guar Corp*, 755 F3d 959, 967 (DC Cir 2014)). In *Hitchcock*, the “rights [the] Plaintiffs assert – the right to receive accrued benefits which have not been decreased by an illegal amendment, and the right to have a fiduciary discharge his or her duties in accordance with the statute – are granted to them by ERISA, not by the Plan’s contractual terms . . . and [t]hus, Plaintiffs assert statutory claims, which are not subject to the exhaustion requirement.”

The statutory framework of ERISA contains an “anti-alienation” provision, such that pension benefits ordinarily cannot be assigned or alienated from the plan participant, even in the face of a court order. The exception to this rule is that benefits may be assigned pursuant to a QDRO, which must satisfy statutory requirements ...

Denial of Benefits Was Supported By “Substantial Evidence” and Therefore Proper Under De Novo Standard of Review

Gilewski v Provident Life and Acc Ins. Co
(6th Cir, March 22, 2017), Case No. 16-2028 (unpub)

The long-term disability (“LTD”) plan in Gilewski did not vest discretion in the insurer to make benefits decisions, and Provident Life “did not dispute that the plan administrator’s decision . . . [was] not entitled to deference.” Under *de novo* review, the Sixth Circuit affirmed the district court’s holding that “Provident’s decision to terminate Gilewski’s long-term disability benefits was supported by substantial evidence in the administrative record.”

The plaintiff’s psychiatrist, Dr. Gerald Shiener, submitted attending physician statements saying that major depression

disabled the plaintiff. However, those statements “did not contain any analysis or content to help enlighten or explain in any detail why Dr. Shiener believed Gilewski could not work,” and he “submitted photocopies of the exact same statements with only the date changed for over a year.” The statements “simply said that Gilewski was depressed, unable to work and his prognosis was uncertain.”

An independent medical examination by psychiatrist Dr. Calmeze Dudley concluded that “he was able to return to work without restrictions.” Two other psychiatrists who reviewed the plaintiff’s file agreed.

The Sixth Circuit affirmed the district court’s decision upholding the denial of benefits. First, it held that there was substantial evidence to support the conclusion that the plaintiff was not disabled because Dr. Shiener’s “attending physician statements and reports” were “incompatible with Gilewski’s self-reported activity level and abilities in 2012 and 2013, as well as with the other medical opinions” of the doctor who either examined him or reviewed his medical records.

The court also rejected the plaintiff’s claim that Provident Life should have consulted a vocational expert about his ability to return to his occupation, noting that “[v]ocational expert testimony ‘is the special creature of social security,’ and has no relevance to long-term disability claims like the one here where the question is whether Gilewski is able to return to his former position based on the medical evidence.”

Lastly, the court rejected the plaintiff’s assertion that Provident Life decided his benefit claim under a conflict of interest because it both decides entitlement and pays the claim, holding that “Gilewski has demonstrated no circumstances indicating a need to give the conflict significant weight” in reviewing Provident Life’s decision.

Foot Amputation Was Caused, In Part, By Diabetes And Therefore Not Covered By Plan

Collins v Unum Life Ins Co of America
(6th Cir, March 9, 2017), Case No. 16-3918 (unpub)

The plaintiff broke his ankle falling in a parking lot in January, 2012. Over a year later, in February, 2013 his foot had to be amputated, and he filed a claim for benefits under a plan that excluded “accidental losses caused by, contributed by, or resulting from . . . disease of the body.” Unum denied his claim for benefits, determining that his history of poorly-controlled diabetes contributed to the severity of his injury and the need to amputate his foot. The Sixth Circuit affirmed the district court’s holding that Unum’s decision that the amputation was caused, in part, by diabetes was supported by substantial evidence and therefore was not arbitrary or capricious.

The plaintiff’s attending physician “circled ‘No’ in response to Unum’s inquiry of whether he thought ‘the loss [was] caused

The Sixth Circuit described the test to determine whether a claim is a statutory claim that it is not subject to exhaustion. “[T]he relevant inquiry is what forms the basis of [Plaintiff’s] right to relief: the contractual terms of the pension plan or the provisions of ERISA and its regulations.”

in any way by illness or disease.’” However, the podiatrist who treated his broken ankle repeatedly noted his long-standing history of diabetes, and the plaintiff saw another podiatrist for “diabetic foot care” and neuropathy. Two pathologists reviewed the plaintiff’s medical records, and one concluded that “[t]o a reasonable degree of medical certainty both the underlying illness and the injury were necessary for the development of the joint pathology that led to amputation.”

The Sixth Circuit rejected the plaintiff’s claims that (1) Unum had a conflict of interest because it both decided and paid any claim, (2) Unum’s reviewing physicians did not give sufficient consideration to his attending physician’s statement that diabetes did not contribute to the amputation, and (3) Unum did not have an independent medical examination of the plaintiff. As to the first point, it was “insufficient [that the plaintiff] has” pointed to “nothing more than the general observation that [Unum] had a financial incentive to deny the claim.”

As to the second point, the court noted that the reviewing physicians did review the plaintiff’s doctor’s opinion, but disagreed with it and “reasonably discredited [his] conclusory assertion – indicated only by a circle around the word ‘no’ – that an illness did not contribute to” the plaintiff’s loss.

Thirdly, the Sixth Circuit held that an independent medical examination could not have enlightened whether the amputation was caused by or contributed to by diabetes.

Lastly, the Court held that the district court did not improperly deny the plaintiff discovery regarding Unum’s alleged conflict of interest because the plaintiff failed to “put forth a factual foundation to establish that he has done more than merely allege bias.”

United States District Court Update

Evidence of Functional Activity Contradicted Claims of Total Disability

Black v Metropolitan Life Ins. Co.

(W.D. Mich., 2017), Case no. 1:15-CV-1147 (unpub)

The plaintiff sustained a number of injuries in an automobile accident. Due to ongoing treatment for pain and exacerbation of preexisting problems with her right shoulder,

left knee and neck, she was unable to return to work and was awarded long-term disability benefits. As permitted by the terms of the insurance policy, MetLife periodically requested updated medical information.

Approximately six years after the accident, plaintiff’s medical records and information demonstrated her condition had improved in terms of reduced overall pain, increased shoulder mobility and improved walking. A social media investigation revealed that plaintiff had traveled to attend an out-of-state wedding, she was enrolled in an out-of-state doctoral studies program which required in-person attendance one weekend per month, and she had traveled to Dubai to present a paper at a conference. Nonetheless, plaintiff’s treating providers continued to support her claim of total disability, except for her physical therapist who opined that plaintiff was capable of sedentary work, with certain restrictions and limitations.

Despite express plan language conferring discretionary authority on the claim fiduciary, plaintiff argued for application of Michigan’s anti-discretionary clause regulation which precludes discretionary review language in insurance policy documents. MetLife argued the ERISA Plan at issue was not subject to Michigan’s insurance regulation which only applied to insurance policy forms or similar documents subject to review by the Commissioner.

The court declined to rule on the issue of whether Michigan’s anti-discretionary regulation applied, finding instead that even under a *de novo* standard of review, MetLife’s decision was supported by the evidence.

While plaintiff’s medical records demonstrated that she suffered some amount of pain resulting in restrictions and limitations, the court noted evidence of improvement of her functional activity which contradicted her claim that she was disabled from even sedentary activity. In particular, her ability to travel long distances undermined plaintiff’s claim that she was in constant pain and could not be up for more than a few hours; and her achievement of a 4.0 grade point in her doctoral program was inconsistent with plaintiff’s claim of extreme fatigue and brain dysfunction. Accordingly, the Court granted MetLife’s dispositive motion. ■

About the Authors

K. Scott Hamilton is a Member and commercial litigator in Dickinson Wright’s Detroit office. He specializes in ERISA, insurance, business and appellate litigation.

Kimberly J. Ruppel is a Member and commercial litigator in Dickinson Wright’s Troy office. She specializes in ERISA, insurance, healthcare and probate litigation.

Insurance
Case
Summary

Selected Insurance Decisions

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

Michigan Court of Appeals – Published Decisions

When Coverage Defenses Are Waived

*Bartlett Investments, Inc v Certain Underwriters at Lloyd's
London*

— Mich App — (2017)

Docket No. 328922

Released March 2, 2017

Plaintiff's vacant commercial property, insured with Lloyd's of London, sustained extensive damage from vandalism. Lloyd's denied plaintiff's claim by way of a letter citing wear and tear and lack of maintenance, and further attributing some of the damage to a prior vandalism incident covered by the policy. Plaintiff sued and in the course of the litigation, Lloyd's asserted two additional coverage defenses: (1) late notice and (2) failure to secure and regularly inspect the building as required by the policy.

The issue on appeal was whether Lloyd's had waived the added coverage defenses. Based on decades of Michigan case law, including a 1926 Supreme Court opinion directing that insurers "shall fully apprise the insured of all of the defenses it intends to rely upon" when declining coverage, the court concluded that insurers waive coverage defenses when they fail to state them at the outset. A general reservation of all rights under the contract does not suffice. The only exception to this rule is where waiver will create coverage for a risk never assumed by the insurer.

The court held that Lloyd's waived the 10-day notice defense because notice does not alter the risk assumed. But if proven, the insured's failure to secure and regularly inspect the vacant insured building would affect the risk assumed by Lloyd's and so that defense was not waived. The case was remanded for further proceedings.

Michigan Court of Appeals - Unpublished

Subcontractor's CGL Coverage for Indemnity Liability

Sanksa-Schweitzer v Farm Bureau Gen'l Ins Co of Michigan

Docket No. 328031

Released December 13, 2016

Supreme Court application pending

In this opinion, the Court of Appeals found that the named insured, a subcontractor, had coverage for its indemnity liability to the named additional insured, the construc-

tion manager. Farm Bureau's CGL policy provided indemnity coverage for claims of bodily injury occurring in the course of the named insured's ongoing operations for the additional insured. The liability complaint alleged that the injury occurred while the subcontractor was performing landscaping work for the construction manager. Farm Bureau thus had a duty to defend and also a duty to indemnify in the event the jury found the subcontractor was performing work for the construction manager, as opposed to the property owner.

Use of Property as a Private Residence –
Temporarily Unoccupied

Durham v Auto Club Group Ins Co

Docket No. 329667

Released December 13, 2016

Plaintiffs' homeowners policy required the insured property to be used "principally as a private residence." When the home was damaged by fire, the insurer denied coverage because it believed plaintiffs were living and working elsewhere and the home was unoccupied. The policy, however, expressly allowed the insured property to be unoccupied for unstated periods of time. "Defendant admits that 'the policy contemplates that a named insured may be away from the property for some period of time (i.e., wintering in Florida or taking an extended vacation)' and still maintain coverage."

No coverage for Damaged Structure Not on the Insured's
Residence Premises

Melms v Auto-Owners Ins Co

Docket No. 329421

Released December 15, 2016

Auto-Owners' homeowner's policy does not cover damage to a barn destroyed by fire because coverage for "other structures" is limited to structures located at the insured's "residence premises", which is where the named insured actually resides. The named insured used the barns and garages on the insured property, which he owned, but he did not reside there. The home was occupied by tenants.

Marine Policy Exclusion Not Applicable

Overbeek v Fremont Ins Co

Docket No. 329339

Released January 17, 2017

Marine insurance policy for the insured fishing charter business covered liability for bodily injury to a customer because the injury arose out of “the ownership, maintenance or use of” a boat as it was being launched on a river. The endorsement cited by the insurer to deny coverage did not apply because the boat was not being transported at the time of the accident; it had already reached the river and slid off the truck because it was not properly secured.

UM Coverage Requires Physical Contact with a Vehicle

Lang v Auto-Owners Ins Co

Docket No. 329577

Released January 17, 2017

Plaintiff motorcyclist was not entitled to UM coverage where he took action to avoid hitting an unidentified vehicle and was injured, but was never struck by that vehicle. The definition of an “uninsured motor vehicle” in his policy included a “hit-and-run motor vehicle” defined as an automobile “that causes bodily injury by actual physical contact with the injured person or the automobile the injured person is occupying.”

UM Coverage Does *Not* Require Physical Contact with a Vehicle*Herrera v State Farm Mut Auto Ins Co*

Docket No. 329507

Released January 19, 2017

Plaintiff motorcyclist could be entitled to UM coverage where he was struck by a metal object that caused him to lose control of his bike. No one knew where the object came from or how long it had been in the road but there was evidence that it was a brace from a truck. The court held that plaintiff was not entitled to PIP benefits, which apply only where the accident is directly caused by the ownership, use, or maintenance of a motor vehicle (motorcycles are not motor vehicles). But if plaintiff could prove that the metal object came from a motor vehicle, he would be entitled to UM coverage because the UM insuring agreement only requires the *involvement* of a motor vehicle, not a direct causal connection. And although a UM vehicle was defined in the policy as a vehicle or motorcycle which strikes the insured or strikes the vehicle the insured is occupying, the court relied on Michigan case law to hold that coverage would be triggered if plaintiff established a “substantial physical nexus” between the object that struck him and the unknown vehicle.

General Affirmative Defenses of Fraud and Concealment Were Sufficient

Jordan v State Farm Fire and Cas

Docket No. 329305

Released February 9, 2017

In this fire loss case, a jury concluded that plaintiff did not cause the fire that damaged his property, but he did engage in false swearing and misrepresented his losses. Plaintiff argued that the issues of fraud and misrepresentation never should have gone to the jury because these defenses were only generally pled by State Farm and did not meet the specificity requirements of MCR 2.112(B)(1). The court affirmed, noting that plaintiff failed to cite any authority for applying the court rule to affirmative defenses and in any event, failed to raise that objection in the trial court. The court also found that plaintiff failed to establish any unfair prejudice in having to respond to State Farm’s general allegations of fraud and concealment.

Untimely ROR Results in a Waiver of Policy Exclusions

Home-Owners Ins Co v Fourment

Docket Nos. 327751, 330269

Released February 21, 2017

Home-Owners waived its coverage defenses to this dog bite claim because it defended its insureds for nearly a year without reserving the policy exclusions subsequently asserted. There was no dispute that Home-Owners possessed all of the information needed to assert those exclusions just days after the incident. The court held that a one-year delay was so untimely as to support a presumption of prejudice, but even without that presumption, the delay actually prejudiced these insureds because they proceeded through case evaluation and responded to the award in the belief that they had insurance coverage.

Mobile Equipment/Off-Road Vehicle Exclusion

Michigan Ins Co v Posen Chamber of Commerce

Docket No. 330176

Released February 23, 2017

Defendant had no coverage under its general liability policy of insurance for injuries sustained by a participant in the defendant’s “Bump-n-Run” race held at a local festival. The policy excluded coverage for injuries arising out of the use of mobile equipment in a racing activity. Mobile equipment was defined in the policy as any “vehicle designed for use principally off public roads.” The vehicle involved in this accident was modified for the race by the removal of lights, windows, and mirrors. It could not be used on a public road.

Covered/Owned Auto Exclusion Bars UIM Claim

Perry v Perry

Docket No. 330966

Released February 28, 2016

Plaintiff wife was injured when defendant husband, while operating their covered auto, rear-ended another vehicle. She sued her husband as well as their auto insurer for UIM benefits. But the policy excluded coverage if either the UM or the UIM vehicle was a “covered auto.”

UM Coverage Available where Uninsured Vehicle Struck Van that Struck Insured

Tucker v Metropolitan Group Property and Cas Ins Co

Docket No. 330199

Released March 14, 2017

Plaintiff was injured when a hit-and-run vehicle struck a van which then struck the plaintiff's parked vehicle while he was still inside. The definition of “uninsured motor vehicle” in his policy included “a hit and run motor vehicle” causing injury by “striking that person or a motor vehicle which that person is occupying at the time of the accident.” Because his policy did not require “direct” physical contact with the hit-and-run vehicle, the court considered the “physical nexus” between the hit-and-run vehicle and the object that struck him. The nexus was sufficient to support coverage.

UIM Exclusion for Other Owned Vehicle Applies

Grove v Woodfin

Docket No. 330706

Released March 16, 2017

Plaintiff motorcyclist was injured in a motor vehicle accident. He owned two cars, which he insured with Home-Owners. That policy provided UIM coverage, but not for “any person” occupying an owned automobile, if that automobile did not have UIM coverage. Per the policy, plaintiff's motorcycle was an automobile. It was insured with another company but not for UIM coverage. Plaintiff argued that the limitation of coverage for persons occupying an owned vehicle with no UM coverage did not apply to him. The court found that position “untenable.”

Conflicting Other Insurance Clauses

*Travelers Property Cas Co of America v XL Ins America, Inc**XL Ins America, Inc v Allianz Risks Ins Co*

Docket No. 329277

Released March 16, 2017

This is a priority dispute among three excess liability insurers in connection with a serious auto claim. After the primary insurers tendered their policy limits, the three excess insurers agreed to a settlement with the claimants, but reserved their

rights to litigate priority of coverage among themselves. The Ace and Allianz policies contained very similar “other insurance” clauses. Both stated that if other valid and collectible insurance is available, their coverage would be excess, unless the other coverage is specifically written to be excess of “this policy.” The third policy, issued by Ironshore Specialty Insurance, contained an “other insurance clause” providing that its coverage was primary for autos owned by the named insured, unless there is other valid and collectible insurance, in which case its policy is excess. Both the trial court and the Court of Appeals held that the Ace and Allianz policies were equal in priority, with coverage prorated. Ironshore's policy was not triggered because it was written to be excess of *all* other collectible insurance, necessarily including the Ace and Allianz policies.

6th Circuit Court of Appeals Decisions

Priority of Auto Liability Coverage

Home-Owners Ins Co v Allied Property and Casualty Ins Co

Docket No. 16-1268

___ Fed Appx ___ (6th Cir 2016)

Released December 16, 2016

This is a priority dispute between two auto liability insurers. Allied issued a policy to the named insured corporation, providing liability coverage for “any auto.” One of its corporate officers was involved in an accident while driving his personal vehicle insured by Home-Owners. He failed to observe a stop sign on his way to interview a prospective employee. When suit was filed against both the corporation and the corporate officer, Home-Owners looked to Allied for primary coverage for the corporation. Allied, in turn, looked to Home-Owners for primary coverage for the corporation because the “other insurance” clause in Allied's policy stated that coverage was excess for non-owned vehicles. But that same clause went on to say that coverage was “primary for any liability assumed under an insured contract.” The corporation, through its by-laws, had contracted to indemnify its directors and officers acting in the interests of the company. Allied's policy was therefore primary for the company, which then had to indemnify the corporate officer. The same priority of coverage applied to the corporation's “follow form” commercial umbrella policy.

Professional Services Exclusion Bars Coverage

Orchard, Hiltz & McCliment, Inc v Phoenix Ins Co

Docket Nos. 16-1176, 16-1231

___ Fed Appx ___ (2017)

Released January 20, 2017

Plaintiff engineering firm (OHM) designed and supervised a major upgrade to a wastewater treatment plant. OHM was sued after an explosion killed one of the employees on site and severely injured another. It looked for coverage as an ad-

ditional insured under the CGL policies issued to the general contractor and to the subcontractor performing the work. But both policies contained professional services exclusions, applicable to liability “arising out of” the performance or failure to perform any professional engineering service, including the approval of plans, drawings, supervision, etc. OHM “designed the plans for every facet of the project, monitored their implementation, served as an on-site consultant, and supervised the work to ensure compliance with those plans.” The complaint alleged that OHM negligently performed those activities and caused this accident. The court applied the professional services exclusion because “the *substance* of the underlying claims is that OHM is liable for failing to properly plan for, and take preventative measures to ensure” the safe performance of that particular task. Neither insurer owed a duty to defend or indemnify OHM.

Federal District Court Opinions – Unpublished

Missing Property Exclusion Applies

First Class Tire Shredders, Inc v Employers Mut Cas Co

E.D. Case No. 16-cv-10930

Released December 15, 2016

Plaintiff insured made a claim under its property insurance policy for the loss of equipment as a result of theft. But the policy contained a “missing property” exclusion applicable

“where the only proof of loss is unexplained or mysterious disappearance of covered property, or shortage of property discovered on taking inventory, or any other instance where there is no physical evidence to show what happened to the covered property.” Plaintiff could not produce sufficient proof of loss and so coverage was properly denied.

Policy Limitations Period Enforced

Palmer Park Square, LLC v Scottsdale Ins Co

E.D. Case No. 16-cv-11536

Released January 19, 2017

Appeal filed February 9, 2017

Plaintiff building owner sued for penalty interest citing the defendant insurer’s delay in paying policy limits on a claim for property damage to the insured apartment complex. The policy required the insured to file any suit against the company within 2 years of the date of the physical loss; plaintiff’s lawsuit was filed later. The court held that because plaintiff was suing “on the policy,” it was subject to the policy’s 2-year limitations period. And the period was not tolled between the date of loss and the date of formal denial of the claim under MCL 500.2833(1)(q) because surplus line insurance contracts are not subject to the general provisions of Michigan’s insurance code. ■

No-Fault Corner



Fraud Exclusions In No-Fault Policies: The Rise and Fall of *Bahri v IDS Property Casualty Ins Co.*

Ronald M. Sangster, Jr.

Law Office of Ronald M. Sangster, rsangster@sangster-law.com

With its decision in *TBCI Inc v State Farm*,¹ the Court of Appeals took its first significant step toward applying a fraud exclusion in a nofault insurance contract to bar an entire claim for nofault benefits. In that case, the underlying claimant had submitted a claim for attendant care service benefits, and in the context of the claimant’s own suit for PIP benefits, the jury affirmatively determined that the claim was fraudulent. After the claimant’s trial, one of his medical providers, TBCI Inc., filed its own separate cause of action to recover payment of the medical expenses incurred by the underlying claimant. In defense, State Farm relied upon the fraud exclusion contained in the claimant’s insurance policy and argued that, pursuant to that exclusion, the claimant was no longer entitled to recover

any benefits under the insurance contract. State Farm further argued that because the medical provider was “in privity” with the underlying claimant, the medical provider’s claim for payment of medical expenses was likewise barred. Applying the principles of *res judicata*, the Court of Appeals affirmed the dismissal of the provider’s cause of action, based on State Farm’s fraud exclusion. Unfortunately, the effect of the Court of Appeals’ decision in *TBCI* was limited because *TBCI* involved two separate proceedings – an affirmative finding of fraud by the trier of fact in the first proceeding, and a subsequent claim by a medical provider, in a second proceeding, to recover said expenses.

Bahri: Claimant's Fraud Bars Provider Claims

The Court of Appeals finally put some teeth into the insurer's fraud exclusion when it released its seminal decision in *Bahri v IDS Property Casualty Ins Co.*² *Bahri* marked the first time the Court of Appeals applied an insurer's fraud exclusion in a *pending action* to dismiss an entire claim for nofault benefits. In *Bahri*, the plaintiff was involved in a motor vehicle accident on October 20, 2011. As part of her claim, she submitted a claim for household replacement service expenses dating back to October 1, 2011 – three weeks prior to her involvement in the subject accident! Furthermore, surveillance revealed that the plaintiff was fully capable of performing many of the activities for which she was seeking compensation under her household replacement service claim. Give these facts, the Court of Appeals had no problem concluding that such claims were fraudulent on their face:

We agree with the Trial Court that the fraud exclusion applied in the instant case. In order to substantiate her claims for replacement services, Plaintiff presented a statement indicating that services were performed by "Rita Radwin" from October 1, 2011, through February 29, 2012. Because the accident occurred on October 20, 2011, on its face, the document Plaintiff presented to Defendant in support of her PIP claim is false, as it sought recoupment for services that were performed over the 19 days preceding the accident.³

Furthermore, to the extent that the surveillance videos contradicted the information contained on the household replacement service forms, the Court of Appeals likewise had no problem concluding that the entire claim was barred by virtue of the fraud exclusion in defendant's insurance policy:

This evidence belies plaintiff's assertion that she required replacement services, and it directly and specifically contradicts representations made in the replacement services statements. Reasonable minds could not differ in light of this clear evidence that plaintiff made fraudulent representations for purposes of recovering PIP benefits. Stated differently, we find no genuine issue of material fact regarding plaintiff's fraud. [Citation omitted] Because plaintiff's claim for PIP benefits is precluded, intervening plaintiffs' claim for PIP benefits is similarly barred, as they stand in the shoes of plaintiff.⁴

Significantly, it was the *plaintiff's* fraudulent household replacement service claim forms that *barred her medical provider's claims* for payment of the medical expenses incurred by plaintiff, as a result of the injuries suffered in the subject accident. Interestingly, it was the intervening

Plaintiff/medical providers who were the actual appellants in that litigation – not the injured plaintiff herself!

Unpublished Opinions Apply *Bahri* to Bar Entire Cause of Action for Claimant's Fraud

After *Bahri*, the Court of Appeals has subsequently issued other unpublished opinions which have affirmed the dismissal of Plaintiff's *entire cause of action* because of a fraudulent claims submission. For example, in *Ward v State Farm*,⁵ Plaintiff submitted a claim for nofault benefits with her insurer, State Farm, arising out of a motor vehicle accident that occurred on September 29, 2013. Specifically, she submitted a claim for household replacement service expenses under MCL 500.3107(1)(c), and in support, she submitted forms that were allegedly filled out by the service provider, Ashley Wutzke. She also submitted a claim for work loss benefits, on the basis that she was unable to continue her employment at a day-care center due to the injuries suffered in the subject accident. However, the service provider, Ashley Wutzke, testified that she never performed household chore services during the period of time referenced in the claim forms, and the documentary evidence obtained from Plaintiff's employer showed that she had been discharged due to employee misconduct. The lower court granted Defendant's Motion for Summary Disposition pursuant to *Bahri, supra*, and the Plaintiff appealed.

In affirming the decision of the lower court to dismiss Plaintiff's entire cause of action, the Court of Appeals stated:

"Plaintiff also contends that the trial court improperly made a credibility determination when it allegedly credited the deposition testimony of the purported service provider and discredited plaintiff's testimony. Plaintiff testified that her friend, Ashley Wutzke, came to her home literally every single day from September 30, 2013, until February 2, 2014, to perform services, such as cleaning, washing, and driving plaintiff. But when deposed, Wutzke testified that she *never* cleaned plaintiff's home and only took plaintiff shopping and drove her to appointments. While '[t]he court is not permitted to assess credibility, or to determine facts on a motion for summary judgment,' [Citation omitted], it is clear that reasonable minds would find this blatant inconsistency fatal to plaintiff's claim, see *Bahri*, 308 Mich App at 425-426 (holding that 'reasonable minds could not differ in light' of evidence that clearly contradicted the plaintiff's assertions that she required replacement services).

Moreover, assuming *arguendo* that the above, clear dichotomy between plaintiff's testimony and Wutzke's testimony is insufficient under a motion for

summary disposition to show that plaintiff made a false statement in an attempt to conceal a material fact from defendant, plaintiff also made other statements that warrant judgment in favor of defendant. Plaintiff asserted that she was entitled to wage-loss benefits because, although she did not want to, she ‘had to’ leave work ‘because of the accident.’ But the documentary evidence contradicts plaintiff’s assertion. Defendant produced plaintiff’s records from her daycare employer, which described a series of warnings for the failure to adhere to company policy that ultimately led to her termination. Due to this clear documentary evidence, reasonable minds could not differ on the conclusion that plaintiff made a false statement with the intent to conceal a material fact from defendant in relation to her wage-loss claim. See *id.* Therefore, pursuant to the contract’s plain terms, ‘[t]here is no coverage under th[e] policy,’ and defendant was entitled to summary disposition. Notably, *all* coverage is forfeited under the policy if a false statement was made ‘in connection with *any* claim under this policy.’ (Emphasis added.) Therefore, plaintiff’s false statement in connection with her wage-loss claim voids all coverage under the policy, including her claim for medical benefits. Accordingly, were we to hold that the trial court impermissibly engaged in making credibility determinations when it ruled that plaintiff’s statement that Wutzke provided replacement services was false, we affirm on the alternate ground that plaintiff made a demonstrably false statement—based on documentary evidence instead of mere conflicting testimony—related to why she was terminated from her job.”⁶

Importantly, the Court of Appeals emphasized that the insurer’s evidence of fraud must “directly and specifically contradict” the claims that were presented by the Plaintiff, before the fraud exclusion would be triggered.

Fraud Disclosed in Surveillance Video “Directly and Specifically” Contradicted Plaintiff’s Claim

In *Thomas v Frankenmuth Mut’l Ins Co.*,⁷ the Court of Appeals likewise dismissed the plaintiff’s entire cause of action, based upon a fraudulent claim for transportation service expenses. In that case, the plaintiff was injured in a motor vehicle accident on July 6, 2013. Plaintiff’s treating physician, Dr. James Beale, M.D. instructed the plaintiff not to drive for six months. In his deposition, plaintiff denied that he ever drove an automobile at any time during this six-month period. However, surveillance conducted by Frankenmuth showed

that plaintiff was driving a vehicle on two separate occasions while, at the same time, using non-emergency medical transportation on those very same days. After suit was filed, Frankenmuth moved for summary disposition pursuant to the language of its fraud exclusion, set forth in the policy. The lower court granted the insurer’s motion for summary disposition based on *Bahri*, *supra*, and plaintiff appealed.

On appeal, the Court of Appeals likewise affirmed the decision of the court below to dismiss plaintiff’s cause of action in its entirety, based on the fraud exclusion in Defendant’s policy. The fact that plaintiff was observed driving a car when Dr. Beale supposedly disabled him from doing so was sufficient to trigger this exclusion. Once again, the insurer prevailed because its surveillance “directly and specifically” contradicted a claim actually presented by Plaintiff; namely, a claim for transportation services.

Claim Is Barred Where Plaintiff Claimed Household Services While She Was in Europe

Finally, in *Diallo v Nationwide Mut’l Fire Ins Co.*,⁸ Plaintiff was injured in a motor vehicle accident that occurred on July 2, 2013. Plaintiff subsequently presented a claim for household replacement service expenses through August of 2014. However, from April 2014 through August 2014, Plaintiff was in Europe while her husband/service provider remained at home. Upon discovering the fraud, Defendant moved for summary disposition under *Bahri*, which was granted by the circuit court.

On appeal, the Court of Appeals again affirmed the dismissal of Plaintiff’s cause of action, relying on *Bahri*. In this case, the Court of Appeals commented on how similar the facts in this case were to *Bahri*, when it noted:

“The facts of the present case reveal that Plaintiff submitted claims for household replacement services for every day from April 1, 2014, through the end of August of 2014. Those forms list the address as Plaintiff and Sarr’s [Plaintiff’s husband] home address. The forms in question were all signed by Sarr. The forms indicate that there were ‘multiple providers’ but only listed the names of Sarr and Khallo Diallo, Plaintiff’s mother.

It is further undisputed that during the months of April, May, June, July and part of August, Plaintiff was in Europe. It is also undisputed that Sarr and Khallo were not in Europe during those times . . .”⁹

Given the fact that the person receiving the services was an entire ocean away, the Court of Appeals had no difficulty concluding that Plaintiff’s entire cause of action should be dismissed.

“Accordingly, on this record, we are presented with a strikingly similar case to *Bahri*. Here, as in *Bahri*, it was physically impossible for the household replacement services to be performed in the manner outlined in the submitted claims. In *Bahri*, there were claims made for replacement services that were impossible to exist because the claimed days occurred before the accident that allegedly caused the injuries occurred. In the present case, household services claims were submitted by Sarr when he was undisputedly in Michigan and Plaintiff was undisputedly in Europe. Further, both Plaintiff and Sarr provided sworn testimony that the submitted replacement service forms reflected that Sarr actually performed the services that were claimed. Quite frankly and simply, that was impossible because Sarr and Plaintiff were on different continents, an ocean away from one another.”¹⁰

Again, the Court of Appeals was able to reach this result because the evidence obtained by the defendant “directly and specifically contradicted” a claim that had been presented by the underlying plaintiff.

“Direct and Specific Contradiction” Is Required

By contrast, where the insurer fails to show a “direct and specific contradiction” to a claim that has been presented by Plaintiff, Plaintiff may be able to survive a *Bahri* motion. Such was the case in *Sampson v Jefferson*,¹¹ In *Sampson*, the plaintiff was injured in a motor vehicle accident on December 20, 2012. He was diagnosed with a fracture of the cervical spine. He also sustained cervical and lumbar spine disc herniations as well as an injury to his left shoulder. As a result of these injuries, plaintiff submitted a claim for household replacement service expenses during the month of March 2013. The household service claim form for March 2013 was described as a “blank grid seven squares across, labeled Sunday through Saturday, and five squares down, presumably for the weeks of the month.” Significantly, there were no dates in any of the squares, even though all 35 squares had been filled out with handwritten letter, which designated which services were performed.

Notably, the service provider indicated that he did not drive plaintiff around, or run errands for plaintiff, every day of the month. The insurer obtained videotaped surveillance of plaintiff on March 6, 2013, and March 9, 2013, which showed him driving a car to a gas station and back home, taking a child’s bicycle out of the car, removing a duffle bag from the car and going to a store and getting some pizza. The lower court denied the insurer’s motion for summary disposition, and the Court of Appeals accepted the insurer’s interlocutory appeal. The same panel that issued the decision in *Thomas v*

Frankenmuth concluded that the evidence presented by the insurer did not “directly and specifically contradict” the claim submitted by plaintiff. Therefore, at the very least, there existed an issue of fact as to whether or not plaintiff’s claim was barred by virtue of the fraud exclusion in defendant’s policy, because there was no evidence proffered by the insurer which directly and specifically contradicted a claim submitted by plaintiff. Again, this case emphasizes the importance of securing evidence that “directly and specifically” contradicts a claim that was actually submitted by Plaintiff, either during the claim stage or during the course of litigation.

The author certainly acknowledges the pressures facing defense counsel from clients who may have unrealistic expectations about what is or is not a “fraudulent” claim. However, we as defense counsel need to be cognizant of the fact that overly aggressive use of *Bahri* motions could lead to a backlash in the appellate courts, which could effectively “kill the goose that laid the golden egg.” In other words, we as defense counsel need to advise our clients that on occasion, “hard cases make bad law.”¹²

Fraud Exclusion Applies Only Where Plaintiff is Policyholder, Spouse or Domiciled Relative

Unfortunately, in February of this year, the Court of Appeals recently issued its published opinion in *Shelton v Auto-Owners Ins Co*,¹³ which exemplifies this old adage. *Shelton* effectively wipes out the ability of an insurer to utilize its fraud exclusion in cases where the plaintiff is not the actual policyholder, his or her spouse, or a relative domiciled in the same household. As shown below, it did not have to be this way. The Court of Appeals could have easily based its decision on the fact that the evidence presented by the insurer (which may not have been admissible, anyway) simply did not “directly and specifically contradict” an actual claim that had been presented by Plaintiff. The panel could have even limited its decision to the wording of the actual fraud exclusion, which made no reference to a fraudulent claim submission, but only to a fraud in the procurement of the policy, or fraud with regard to the actual occurrence. Unfortunately, the Court of Appeals’ holding is very broad and, because it is a published opinion, it remains the controlling legal authority on this issue until such time as it is modified or overruled by the Michigan Supreme Court.

In *Shelton*, Plaintiff was a passenger in an automobile owned and operated by one Timothy Williams and insured with Auto-Owners Insurance Company. Shelton did not own a motor vehicle. She was not married and did not reside with a relative who owned an automobile. Therefore, AutoOwners Insurance Company occupied the highest order of priority for payment of her nofault benefits pursuant to MCL 500.3114(4)(a), as the insurer of the owner or registrant of the motor vehicle she was occupying at the time of the accident.

The accident itself occurred on January 22, 2013. Plaintiff submitted a claim for household replacement service expenses, which was denied by the insurer. The reasons behind the denial of the household replacement service expense claim were not at all clear. Defendant claimed that it was because the claims were fraudulent. Plaintiff claimed that the claims were dismissed “based on a lack of proofs for the replacement services claim.” Unfortunately, the trial court made no specific finding as to whether or not those claims were fraudulent, and no appeal was taken from the dismissal of the household service claim.

Defendant then moved for a dismissal of the medical expense claims, based upon the purportedly false household replacement service claim. According to the Court of Appeals’ opinion, the insurer offered the following “evidence” as proof of a fraudulent claim:

- Investigative reports and “some photographs” that were taken by the investigator on June 1, 2013, where “many of the photographs are so blurred and distant that it is impossible to determine who is being photographed and what they were doing.”
- Investigator’s report of June 1, 2013, references the “claimant” as being “Timothy Williams” and not Plaintiff (a female); pronouns used in the report reference “he,” not “she.”
- The investigator noted that Plaintiff “appears to be wringing it out,” referring to a shirt; however, “there is no reference to any photographs or videotape to confirm even this self-serving statement.”
- Plaintiff was observed walking without a visible brace and was observed to bend on two occasions, even though Plaintiff acknowledged, at deposition, that she was able to walk, and that even though she always wore a back brace, she sometimes wore it under her clothing and sometimes over.

Again, the circuit court ruled that this evidence was insufficient to support a motion for summary disposition under *Bahri*, presumably because it did not “directly and specifically contradict” a claim that had been presented by Plaintiff. Defendant filed an Application for Leave to Appeal with the Court of Appeals, which was granted by the Court.

The Court of Appeals affirmed the lower court’s decision to deny the insurer’s Motion for Summary Disposition under *Bahri*. The lead opinion was authored by Judge Douglas Shapiro, and he was joined by Judge Elizabeth Gleicher. (Judge

Kirsten Frank Kelly concurred in the result, only.) In his opinion, Judge Shapiro compared the facts involved in *Shelton* with the facts involved in *Bahri* (which involved surveillance conducted periodically over the course of seven weeks) and noted:

“While such repeated activities are sufficient to establish the elements of fraud beyond a question of fact, a single episode of wringing out a shirt does not; nor do isolated examples of an injured person participating in simple physical actions such as bending, modest lifting, or other basic physical movements that they testify are painful or difficult. These type of inconsistencies with a claimant’s statements are not sufficient to establish any of the elements of fraud beyond a question of fact.”¹⁴

The Court of Appeals even noted some of the evidentiary problems with the proofs offered by the insurer:

“While not raised in the briefing, based on the record before us, it appears that many of the documents on which Defendant relies, including the three surveillance reports and the photographs do not meet the evidentiary requirements of MCR 2.116(G)(6) and should not have been considered. That rule provides that ‘affidavits, depositions, admissions and documentary evidence offered in support of or in opposition to a motion based on subrule (C)(1)-(7) or (10) *shall only be considered to the extent that the content or substance would be admissible as evidence.*’ (Emphasis added). The relied upon reports appear to be hearsay. Their ostensible author did not testify and has not provided an affidavit that the statements in his reports are true and that he will so testify at trial. The same is true of the photographs on which Defendant relies.”¹⁵

In the opinion of the author, if the Court of Appeals had simply stopped its analysis at this point, the Court of Appeals would have simply sent a message to insurers and the circuit courts of this state that in order to prevail on a *Bahri* motion, the insurer must present evidence which “directly and specifically contradicts” a claim that was made by the Plaintiff, and in this case, just as in *Sampson, supra*, the insurer simply failed to do so.

The Court of Appeals then examined the actual fraud language that was at issue in *Shelton* and compared it to the fraud exclusion set forth in the *Bahri* policy. The exclusion at issue in *Bahri* provided:

“We do not provide coverage for any insured who has made fraudulent statements or engaged in fraudulent conduct in connection with any accident or loss for which coverage is sought under this policy.”

By contrast, the Auto-Owners exclusion at issue in *Shelton* provided:

“We will not cover any person seeking cover any person seeking coverage under this policy who has made fraudulent statements or engaged in fraudulent conduct *with respect to procurement of this policy or to any OCCURRENCE* for which coverage is sought. [Emphasis added].”

The Court of Appeals noted that there was nothing in the fraud exclusion that referenced claims that were presented as the result of an “occurrence” and specifically noted the following:

“Defendant has not provided us with the policy definition of ‘occurrence,’ but in all cases dealing with that term, it has been defined as the accident or event during which the injury occurs. See e.g., *Frankenmuth Mut’l Ins Co v Masters*, 460 Mich 105, 112-113; 595 NW2d 832 (1999) (stating that the applicable insurance policy defined the term ‘occurrence’ as ‘an accident, . . . which occurs during the policy period’), *Group Ins Co v Czopek*, 440 Mich 590, 597-598; 489 NW2d 444 (1992) (stating that the term ‘occurrence’ was defined in the policy as ‘an accident, . . . which results, during the policy term, in bodily injury or property damage.’), and *Michigan Basic Property Ins Ass’n v Wasarovich*, 214 Mich App 319, 327-328; 5421 NW2d 367 (1995) (finding that the definition of ‘occurrence’ in the policy included an accident that resulted in personal injury during the policy period). Defendant has not alleged any fraud ‘with respect to the procurement of the policy’ nor with respect to the ‘occurrence.’ The claimed fraud was in the reporting of services later provided, an event not referenced in the provision.”¹⁶

However, because the issue of the wording of the fraud exclusion was not raised in the lower court, the Court of Appeals declined to base its ruling on this ground. Again, if the Court of Appeals had simply stopped its analysis at this point, a message would have been sent to insurers and their counsel that before you can rely on a fraud exclusion, the insurer needs to have language in the fraud exclusion that actually references fraudulent claims – not just fraud in the procurement of a policy or fraud regarding the actual accident that gives rise to a claim for nofault benefits.

However, the Court of Appeals in *Shelton* went further and, as noted above, effectively limited the impact of fraud exclusions only to those claimants who are actually the named insured under the policy, their spouses, or relatives domiciled in the same household. In the court’s view, this is because MCL 500.3114(1), which is the “general rule” regarding priority, provides that an insurance policy “*applies* to the person

named in the policy, the person’s spouse and relatives of either domiciled in the same household.”¹⁷ In this case, Shelton was neither the named insured, the spouse of the named insured nor a relative of either the named insured or his spouse. Therefore, the Auto-Owners policy, issued to Timothy Williams, simply did not “apply” to Plaintiff.¹⁸ Instead, Shelton’s ability to recover benefits from Auto-Owners Insurance Company derives from operation of law; i.e., MCL 500.3114(4) (a), which references “the insurer of the owner or registrant of the vehicle occupied.” The court also noted that, in *Rohlman v Hawkeye Security Ins Co*, 442 Mich 520, 502 NW2d 310 (1993) and *Harris v ACIA*, 494 Mich 462, 835 NW2d 356 (2013), the ability of the plaintiffs in those cases to recover nofault benefits arose “solely by statute,” which is “the ‘rule book’ for deciding the issues involved in questions regarding” nofault insurance benefits. As noted by the Court of Appeals:

“Defendant’s argument is directly contrary to the grounds for the holdings in both *Rohlman* and *Harris*. Here as in those cases, Plaintiff’s nofault benefits are governed ‘solely by statute.’ Thus, the exclusionary provision in Defendant’s nofault policy does not apply to Plaintiff and cannot operate to bar Plaintiff’s claim.”¹⁹

In other words, fraud exclusions do not apply to those individuals who are “strangers to the insurance contract,” such as motorcyclists who are injured as the result of the involvement of a motor vehicle (see MCL 500.3114(5)), employees who are occupying employer-furnished vehicles (see MCL 500.3114(3)), pedestrians who are injured in motor vehicle accident and do not have policies of their own available in their household (see MCL 500.3115(1)) and those individuals, like the plaintiff in *Shelton*, who are occupying another person’s motor vehicle and who do not have policies of their own available in their household (see MCL 500.3114(4)). Obviously, this is a rather large group of individuals who are no longer bound by the fraud exclusion under the policy under which they are claiming benefits.

In response to the insurer’s “public policy” arguments, the Court of Appeals noted that the insurer can still deny a claim based on fraud – it just cannot rely on a policy exclusion to obtain a dismissal of the entire claim:

“Defendant argues that as a matter of public policy we should depart from the statute because if we do not, nofault insurers will lose the ability to deny fraudulent nofault claims. This argument is meritless. As always, if an insurer concludes that a claim is fraudulent, it may deny the claim. Should the Claimant then file suit, the burden is on the Claimant to prove that he is entitled to his claimed benefits, a burden that it highly unlikely to be met if the factfinder concludes that the claim is fraudulent.

And insurers can obtain attorney fees for having to litigate any claims that are determined to be fraudulent. MCL 500.3148.”²⁰

Obviously, it is far more expensive to litigate and try claims, even those that are potentially fraudulent, as opposed to securing an order granting a summary disposition motion under *Bahri*. Because the insurer has now lost the ability to summarily dismiss fraudulent claims where the claimant is not the named insured, his or her spouse or a relative domiciled in the same household, an insurer will now be forced to make an economic decision to possibly settle a fraudulent claim, as opposed to taking the claim through trial.

At this point, it is unclear if the insurer will file an application for leave to appeal with the Michigan Supreme Court. A legislative fix would also appear to be warranted. For example, expanding the scope of MCL 500.3173a(2) to all insurers, not just those insurers adjusting MACP claims, would go a long ways toward curbing the number of potentially fraudulent claims that a nofault insurer is forced to defend while, at the same time, preserving the requirement that, in order to prevail on a fraud defense, the insurer would still need to present admissible evidence that “directly and specifically contradicts” a specific claim presented by Plaintiff. As matters now stand, however, a nofault insurer’s ability to utilize a fraud exclusion, contained in its policy, has been severely curtailed by the Court of Appeals’ decision in *Shelton*. In the author’s opinion, *Shelton* is another clear example of where “hard cases make bad law.” ■

Endnotes

- 1 289 Mich App 39, 795 NW2d 229 (2010).
- 2 308 Mich App 420, 864 NW2d 609 (2014).
- 3 *Bahri*, 864 NW2d at 862.
- 4 *Bahri*, 864 NW2d at 613 (emphasis added).
- 5 docket no. 327018, rel’d 9/15/2016.
- 6 *Ward*, slip opinion at pp 4-5 (italics in original, emphasis added).
- 7 docket no. 326744, rel’d 7/12/2016.
- 8 Court of Appeals docket no. 328639, rel’d 11/15/2016.
- 9 *Diallo*, slip opinion at p. 4.
- 10 *Diallo*, slip opinion at p. 5.
- 11 Court of Appeals docket no. 326561, rel’d 7/14/2016.
- 12 See *Morales v Auto-Owners Ins Co*, 458 Mich 288, 305, 582 NW2d 776 (1998) (Taylor, J. dissenting.)
- 13 ___ Mich App ___, ___ NW2d ___ (Court of Appeals docket no. 328473, rel’d 2/14/2017),
- 14 *Shelton*, slip opinion at p. 7.
- 15 *Shelton*, slip opinion at p. 6, footnote 7.
- 16 *Shelton*, slip opinion at p. 5, footnote 6.
- 17 *Shelton*, slip opinion at p. 4 (italics in original).
- 18 *Id.*
- 19 *Shelton*, slip opinion at p. 3. (Emphasis added).
- 20 *Id.*, slip opinion at p. 4.

Legislative Update



A New Legislative Session Begins

Patrick D. Crandell, *Collins Einhorn Farrell PC*

The 99th Michigan Legislature has started its work, with House members having introduced a total of 358 bills and Senate members a total of 238 bills since the legislative session began in January.

While legislative committees are subject to restructuring after every election cycle, both the House and the Senate continue to maintain Insurance Committees. Representative Lana Theis (R-Brighton) chairs the 17-member House committee and Senator Joe Hune (R-Hamburg) chairs the 10-member Senate committee.

The following bills have been referred to either the House or Senate Insurance Committees since the start of the legislative session:

- **Confiscation of license plate if no proof of insurance.** HB 4010 requires a law enforcement officer to confiscate

a vehicle license plate and notify the Secretary of State, if the driver is unable to produce proof of insurance.

- **Electronic or photographic copy of registration.** HB 4013 amends the Michigan Vehicle Code to allow an electronic copy or photograph of a vehicle registration to satisfy the requirement that registration must be carried in the vehicle or by the driver. *Passed unanimously by the House on 3/14/17.*
- **Health insurance must include contraceptives.** HB 4019 requires a health insurance policy issued in Michigan (that covers prescription drugs) to also cover prescriptive contraceptives.
- **Insurers must notify Secretary of State when policy expires.** HB 4041 requires automobile insurers to notify

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the Secretary of State when policies expire, are terminated or are cancelled; increases the fines for operating a vehicle without insurance.

- **MCCA must disclose computations to set rates.** HB 4049 requires the Michigan Catastrophic Claims Association to disclose its actuarial computations used to set rates.
- **MCCA subject to Open Meetings Act and annual audit.** HB 4353-4354 makes the Michigan Catastrophic Claims Association subject to the Open Meetings Act and to FOIA; revises its membership; requires an annual audit.
- **Drug coverage must include an opioid.** HB 4074 requires a health insurance policy issued in Michigan (that covers prescription drugs) to also cover at least one opioid analgesic drug product per opioid analgesic ingredient.
- **Monthly insurance and registration permitted for installment sales.** HB 4097-4099 – creates a mechanism for automobile insurers to issue monthly insurance policies and for the Secretary of State to issue monthly vehicle registrations, for installment-sale vehicle transactions.
- **DFIS authority to suspend insurance producer's license for dishonesty or breach of trust.** HB 4117 permits the DIFS Director to place on probation, suspend, revoke and/or refuse to issue an insurance producer's license, if that producer was convicted of a felony involving dishonesty or a breach of trust.
- **Premium increase barred for damage caused by potholes.** HB 4279 prohibits automobile insurers from in-

creasing an insured's premium due to a prior claim involving pothole damage.

- **Insurance producer continuing education.** HB 4325 permits an insurance producer to carry over continuing education hours into the next reporting period; permits the DIFS Director to revoke or suspend approval of or place a continuing education provider on probation under certain circumstances.
- **Coverage for cranial hair prosthetics.** HB 4357-4358 requires a health insurance policy issued in Michigan (and Medicaid) to cover cranial hair prosthetics for someone less than 19 years old who has cranial hair loss due to a medical condition.
- **Alternate cash reserve for pooled public employee health plans.** SB 43 permits an alternative cash reserve option for pooled public employee and officers' health-benefit plans. *Scheduled for a hearing on 3/16/17*
- **Indian tribes exempt from health insurance assessment act.** SB 96 exempts Michigan's federally recognized Indian tribes from the health insurance claims assessment act.
- **Expansion of auto theft prevention authority.** SB 168 expands the auto theft prevention authority assessment to commercial vehicles. *Scheduled for a hearing on 3/16/17*

We will track these bills in future legislative updates and will advise on new bills that are introduced. ■