

The Journal of Insurance & Indemnity Law

A quarterly publication of the State Bar of Michigan's Insurance and Indemnity Law Section

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

From the Chair



Larry Bennett
Siekaly, Stewart &
Bennett PC

Our Section continues to increase its presence and participation within the legal community. We are also making efforts to coordinate with other organizations in our ongoing effort to broaden the resources available to all of our members and to provide you with value for your membership in the Section. The following are some of the activities the Council is engaging in over the next few months.

An Evening with the Hon. David M. Lawson

The Council's next meeting is on Monday, May 21st. There will be a special guest at the meeting: the Hon. David M. Lawson, United States District Court Judge for the Eastern District of Michigan. Judge Lawson will make a presentation on several areas where insurance intersects with the federal courts, including (1) No Fault and declaratory judgment actions; (2) ERISA cases, including the impact of Michigan legislation prohibiting the "arbitrary and capricious" standard; (3) interpleader cases involving insurance. Following his presentation, there will be an open question and answer period. This is a great opportunity to listen to and interact with one of the most respected jurists in our state. More details are in the announcement elsewhere in this issue.

Law Student Scholarship

The Section previously established a scholarship program to be operated collectively with each of Michigan's law schools on a rotating basis. The scholarship will be awarded to the student who submits the best article on a predetermined insurance related topic. This year, we are working with Cooley Law School at Western State University. The topic is *Bad Conduct and Disparate Remedies: Is it Time to Revisit Michigan Law Limiting Insurer Liability for Bad Faith?*

Students who seek to be awarded the scholarship will be submitting their articles in May. The articles will then be reviewed and ranked by the law school's professors. They will then be sent to members of the Council for review and final decision as to who the winner is. The results will be announced at the Section's annual meeting this fall during the State Bar of Michigan NEXT Conference, September 26-28, 2018, at DeVos Place, Grand Rapids.

ADR Summit

The section was asked to participate in an Alternate Dispute Resolution summit convened by the State Court Administrative Office and to be held on May 11, 2018. As expressed by the SCAO, there are two primary purposes for the Sum-

mit. First, it is seeking to identify changes in ADR practices and attitudes in the seven years since the SCAO conducted its first comprehensive study of mediation and case evaluation in 2011. Consultants have returned to three of the earlier studied courts to assess current ADR practices and their impact on the courts' dockets, and have again surveyed judges and lawyers about their experiences with and attitudes toward case evaluation and mediation. The consultants' report will be provided to attendees in advance of the meeting, and their key findings will be presented at the meeting.

Second, the SCAO we will be inviting attendees to provide recommendations to the State Court Administrator and Michigan Supreme Court for guiding the further development of ADR processes in the trial courts. I am sure many of you have thoughts on ADR that you would like to share. This is a great opportunity to provide input, so I encourage you to contact me, so I can pass them along as part of our position.

Bar Leadership Forum

The Section will be sending participants to the State Bar of Michigan Bar Leadership Forum, conducted on Mackinac Island in June. The Forum is attended by incoming presidents of local & special purpose bar associations, chairs of sections, and members of the Board of Commissioners. The Forum has skilled presenters on topics that are intended to help Bar leaders enhance what their Sections offer their members. It is also an opportunity to interact and network with the leaders of other Sections.

WLAM Centennial Gala

The Women Lawyers Association of Michigan will mark its 100th anniversary this year. The Section was asked to act as a sponsor for the Centennial Gala that is planned for April 27th. We were happy to participate in this historic event. This led to discussions with longtime friend and incoming WLAM President Elect Donna MacKenzie about a joint event between our Section and WLAM. Our current treasurer and WLAM member, Nicole Wilinski, is working on the details.

Shared Resources

The Section is in the seminal stages of seeding our Facebook and SBM Connect pages. If any of you have articles or other resources you would like to add, your contributions are truly welcomed. Sharing your product with other Section members not only enhances the development of insurance law and practice within the state but it is also a great way to promote your expertise.

I welcome your thoughts on how our Section is serving you. I also hope to see as many of you as possible at our meeting on May 21st. ■

Editor's Notes



By Hal O. Carroll
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The *Journal* – now in its eleventh 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. ■

2018 Spring Meeting Insurance and Indemnity Law Section

Monday, May 21, 2018

From 4:30 p.m. To 7:00 p.m.

Business meeting at 4:30 p.m., program starting at 5:30 p.m.

Mario's Restaurant, 4222 2nd Ave., Detroit

Hors d'oeuvres will be served with beer/wine

- Free to all members of the Insurance & Indemnity Law Section! Members please RSVP to inlaw2017@comcast.net
- Non-members of the Insurance Law Section (Includes Membership) \$15.00
Non-Members Download registration/membership application form (<http://files.constantcontact.com/b95e6ed6be/fa22ea12-cf2f-4a29-88c8-b8d71e55fbdf.pdf>)



Speaker: Hon. David Lawson U.S. District Court

- No Fault and declaratory judgment actions.
- ERISA cases, including the impact of Michigan legislation prohibiting the “arbitrary and capricious” standard.
- Interpleader cases involving insurance.



The Current Status of Bad-Faith Claims Involving Insurance

By Lynn Sholander, *Hewson & Van Hellemont, PC*

Introduction – Three Theories

The availability of causes of action under Michigan law premised on an insurer's bad faith has generated significant confusion for several decades. This confusion is likely due, in part, to differences in the law between state jurisdictions. In order to fully understand the types of claims that are viable under Michigan law, it is necessary to demarcate the most common types of potential claims and track Michigan cases considering their application. This piece will focus on the three most common categories of "bad-faith claims" and summarize whether each type of claim is viable in Michigan.

Breach of contract. First, this article will explore, and dedicate the greatest length to, the viability of claims based on an insurer's "bad-faith breach of contract." Concisely stated, Michigan does not recognize a cause of action for bad-faith breach of contract. Rather, in order to recover tort damages, such as mental distress damages, related to an insurer's conduct in conjunction with the execution of its duties under an insurance policy, the insurer must breach a tortious duty that is wholly separate and independent from the breach of contract.

Failure to pay a claim. The second, and often related, category of bad-claims consists of claims based on an insurer's bad-faith failure to pay an insurance claim submitted by its insured. In Michigan, an insured may not bring an independent cause of action based on his or her insurer's bad-faith failure to timely pay his or her claim. However, an insured may be entitled to recover penalty interest in the amount prescribed by MCL 500.2006 (in cases implicating the Michigan Uniform Trade Practices Act ("UTPA")) or MCL 500.3142 (in cases involving no-fault personal protection insurance benefits).

Michigan courts and federal courts applying Michigan law have repeatedly recognized that a plaintiff may not maintain an action in tort arising from the breach of a contractual duty.

Failure to settle a liability claim. The third category of claims discussed in this article includes bad-faith claims in the context of liability insurance. In short, Michigan law recognizes an insured's cause of action against his liability insurer for bad-faith refusal to settle a claim against the insured. It also

recognizes a cause of action brought by an excess liability insurer against the primary liability insurer based on the primary insurer's bad-faith handling of a suit or settlement that results in a judgment in excess of the primary insurance policy limit.

Michigan Rejects a Cause of Action for Bad-Faith Breach of an Insurance Contract

Confusion often surrounds whether a claimant may assert a cause of action for bad-faith breach of an insurance contract in Michigan. Much of this uncertainty arises from the fact that an insurer has a general obligation to act in good faith or use ordinary care in performing its duties under an insurance contract. This obligation arises out of – and is not independent of – the contract.¹ In short, Michigan courts and federal courts applying Michigan law have repeatedly recognized that a plaintiff may not maintain an action in tort arising from the breach of a contractual duty.² Correspondingly, the Michigan Supreme Court and the Michigan Court of Appeals have refused to recognize an actionable, independent tort based on an insurer's bad-faith breach of an insurance contract.³

The underlying rationale of this rule is that a plaintiff may not claim tort damages for the mere nonperformance of contractual duties. Additionally, Michigan courts have reasoned that bad-faith claims are inappropriate in the context of Michigan no-fault insurance given the comprehensive scheme in place under the no-fault act that includes penalties for an insurer's failure to timely pay an insurance claim, which are discussed are discussed later in this article.⁴

Consistent with these principles, the Michigan Supreme Court expressly recognized in *Kewin v Massachusetts Mutual Life Insurance Company* that when a party breaches an insurance contract, damages are limited "to the monetary value of the contract had the breaching party fully performed under it."⁵ Exemplary damages that do not arise naturally from the breach of the insurance policy are generally not recoverable.⁶ The reasoning supporting this rule is that insurance contracts are commercial in nature, in that they constitute "agreements to pay a sum of money upon the occurrence of a specified event."⁷ The court explained:

In the commercial contract situation, *unlike the tort and marriage contract actions, the injury which arises upon a breach is a financial one, susceptible of accurate pecuniary estimation.* The wrong suffered by the plaintiff is the same, whether the breaching

party acts with a completely innocent motive or in bad faith.^[8] (emphasis added)

However, *Kewin* and subsequent cases have recognized a caveat to this rule, which applies in cases where a party violates a duty separate from its contractual duties:

Cases recognizing a right to maintain an action in tort arising out of a breach of contract by the defendant[] generally involve a separate and distinct duty imposed by law for the benefit of the plaintiff that provides a right to maintain an action *without regard to whether there was a contractual relationship between the plaintiff and the defendant.*^[9]

On several occasions, the Michigan Supreme Court has delineated the proper means of determining whether a plaintiff may raise a tort claim in a situation where a contractual agreement exists between the parties. For example, in *Loweke v Ann Arbor Ceiling & Partition Co, LLC*,¹⁰ the court explained:

[I]n determining whether an action in tort will lie, *Fultz* [*v Union-Commerce Assoc*, 470 Mich 460, 462; 683 NW2d 587 (2004),] recast the test to focus on whether any legal duty independent of the contract existed. Notably, in requiring courts to focus on whether a defendant owed a legal duty to the plaintiff, *Fultz* directed courts to utilize the “ ‘separate and distinct’ definition of misfeasance.” . . . [The focus is] on whether a *legal duty* independent of a contract existed, rather than whether defendant’s conduct was separate and distinct from the tasks required by the contract or whether the hazard was contemplated by the contract.

Similarly, the Michigan Supreme Court explained the distinction as follows in *Hart v Ludwig*¹¹:

We have simply the violation of a promise to perform the agreement. The only duty, other than that voluntarily assumed in the contract to which the defendant was subject, was his duty to perform his promise in a careful and skillful manner without risk of harm to others, the violation of which is not alleged. What we are left with is defendant’s failure to complete his contracted-for performance. This is not a duty imposed by the law upon all, the violation of which gives rise to a tort action, but a duty arising out of the intentions of the parties themselves and owed only to those specific individuals to whom the promise runs. A tort action will not lie.^[12]

Likewise, in *Kewin*, the court recognized this distinction as a basis for its refusal to recognize a tort consisting of the bad-faith breach of an insurance contract, holding that “ab-

sent allegation and proof of tortious conduct existing independent of the breach, exemplary damages may not be awarded in common-law actions brought for breach of a commercial contract.”¹³

numerous other Michigan cases have recognized that a plaintiff generally may not recover damages for emotional distress or anguish, or any other exemplary damages, for the breach of an insurance contract or for the negligent or bad-faith handling of an insurance claim.

In accordance with this case law, numerous other Michigan cases have recognized that a plaintiff generally may not recover damages for emotional distress or anguish, or any other exemplary damages, for the breach of an insurance contract or for the negligent or bad-faith handling of an insurance claim.¹⁴ Rather, in general, “the damages recoverable for breach of contract are those arising naturally from the breach or those in contemplation of the parties at the time the contract was made.”¹⁵ As discussed *infra*, an additional “remedy” may be available by statute. For example, in the context of a no-fault insurance policy, “a plaintiff’s remedy for a bad-faith refusal to perform the no-fault insurance contract is limited to recovery of actual attorney fees and the 12% interest provided for in MCL 500.3148; 500.3142,” along with the amount owing under the contract.¹⁶ But, again, exemplary damages are not available for an insurer’s bad-faith performance or violation of a contractual duty.

Before turning to the next category of bad-faith claims, there are two additional matters that merit discussion. First, Michigan courts have recognized an exception to the rule that exemplary damages are not recoverable for breach of contract in cases where a party breaches an agreement involving “ ‘rights we cherish, dignities we respect, [or] emotions recognized by all as both sacred and personal,’ ” as opposed to “a commercial contract in which pecuniary interests are most important.”¹⁷ In such cases, mental distress or other exemplary damages may be recoverable because “injuries to the emotions are foreseeable and must be compensated despite the difficulty of monetary estimation.”¹⁸ However, the *Kewin* Court explicitly held that this exception does not apply to the breach of insurance contracts, which are inherently commercial:

[Insurance] contracts are commercial in nature; they are agreements to pay a sum of money upon the occurrence of a specified event. The damage suffered upon the breach of the agreement is capable of adequate compensation by reference to the terms of the contract. We recognize that breach of the insur-

ance contract, as with almost any agreement, results in some annoyance and vexation. But recovery for those consequences is generally not allowed, absent evidence that they were within the contemplation of the parties at the time the contract was made.^[19]

Additionally, within this discussion, it is also important to briefly mention whether Michigan recognizes a claim for the breach of the implied covenant of good faith and fair dealing under a contract. The Court of Appeals recently summarized the applicable law in this regard and unequivocally stated that a separate cause of action is not available for a breach of the implied covenant of good faith and fair dealing apart from an ordinary breach of contract claim:

It is important to note that the penalty interest is available under MCL 500.2006 to claimants—meaning the insured or a person directly entitled to benefits under the contract—regardless of whether the insurer’s failure to timely pay the benefits was in good or bad faith.

Moreover, an implied covenant of good faith and fair dealing generally exists in all contracts, except employment contracts, which is an implied promise that neither party will do anything “which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract.” *Hammond v United of Oakland, Inc.*, 193 Mich App 146, 151–152; 483 NW2d 652 (1992). This implied covenant applies to the performance and enforcement of contracts even where a contractual term leaves the manner of its performance to one party’s discretion. *Ferrell v Vic Tanny Int’l, Inc.*, 137 Mich App 238, 243; 357 NW2d 669 (1984). Where a party to a contract makes the manner of performance a matter of its own discretion, it must exercise that discretion honestly and in good faith. *Id.* at 243. *Michigan does not recognize a separate cause of action for breach of an implied covenant of good faith and fair dealing apart from a claim for breach of the contract itself.* *Belle Isle Grill Group v. City of Detroit*, 256 Mich App 463; 666 NW2d 271 (2003). However, because the focus of the obligation of good faith is on the manner in which the agreement or other duty is performed or enforced, a breach of contract may be found where bad faith or unfair dealing exists in the performance of a contractual term when the manner of performance was discretionary. See *Ferrell*, 137 Mich App at 243–244; *Gorman v Am Honda Motor Co, Inc.*, 302 Mich App 113, 132–136; 839 NW2d 223 (2013).^[20] Thus, even though “the law does not hesitate to imply the proviso that such discretion be exercised honestly and in good faith” “where a party to a contract makes the manner of its performance a matter of its own discretion,”^[21] only an *ordi-*

nary breach of contract may be found based on a violation of the implied covenant.²² In addition, an implied duty “cannot override an express provision in a contract,”²³ meaning that “there is no implied duty of good faith where the parties have unmistakably expressed their respective rights, because the implied duty cannot override express contract terms.”²⁴

Therefore, in sum, Michigan does not recognize an independent cause of action for bad-faith breach of an insurance contract. Likewise, Michigan does not recognize a separate cause of action for a breach of the implied covenant of good faith and fair dealing, where applicable, apart from an ordinary breach of contract claim.

Statutory Penalty Interest Available for an Insurer’s Bad-Faith Failure to Timely Pay a Claim

The second category of potential bad-faith claims consists of those alleging entitlement to penalty interest and/or attorney fees for an insurer’s failure to timely pay an insurance claim. Under the Michigan Uniform Trade Practices Act (“UTPA”),²⁵ an insured may seek penalty interest for an insurer’s failure to timely pay an insurance claim where the payment is not reasonably in dispute. MCL 500.2006 recognizes an insurer’s general duty to timely pay insurance benefits to insureds and third-party tort claimants entitled to receive such benefits, and establishes the circumstances under which such insureds and claimants may recover 12% interest on their claims in accordance with the statute. Specifically, MCL 500.2006(4) provides:

(4) If 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. If the claimant is a third party tort claimant, the benefits paid bear 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 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. The interest must be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest is payable based on the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid as provided in this section must be offset by any award of interest that is payable by the insurer as provided in the award.

It is important to note that the penalty interest is available under MCL 500.2006 to claimants—meaning the insured or a person *directly* entitled to benefits under the contract—regardless of whether the insurer’s failure to timely pay the benefits was in good or bad faith.²⁶ However, a different standard applies to a third-party tort claimant. In cases involving such a claimant, penalty interest accrues if, *inter alia*, “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.”²⁷ The Michigan Court of Appeals has held, “[T]he ‘reasonably in dispute’ language of MCL 500.2006(4) applies only to third-party tort claimants; 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.”²⁸

This provision supplements other statutory provisions providing for the timely payment of insurance claims.²⁹ However, it is important to note that this statute does not apply to (1) claims for no-fault personal protection insurance benefits, (2) claimants regulated by the workers’ compensation act, (3) the processing and payment of Medicaid claims, and (4) the processing and payment of claims by health plans under some circumstances.³⁰ Additionally, it is important to underscore that an award of penalty interest under MCL 500.2006 must “be offset by any other award of interest that is payable by an insurer pursuant to the award.”³¹

The Michigan Court of Appeals has expressly recognized that MCL 500.2006 does not establish an independent tort cause of action to recover penalty interest,³² even though “a private party may directly recover the interest penalty in an action against the insurer.”³³ Additionally, Michigan Courts have repeatedly recognized that there is no private cause of action for a violation of the UTPA.³⁴ However, a recent opinion issued by the Sixth Circuit has taken a different approach, holding that a claimant may assert an independent cause of action under MCL 500.2006.³⁵ It is not clear whether Michigan’s appellate courts would agree with the Sixth Circuit’s analysis considering the courts’ prior decisions.

In the context of no-fault personal protection insurance claims, a claimant may recover penalty interest under MCL 500.3142(3) if benefits are “not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained.” A claimant also may recover reasonable attorney fees under MCL 500.3148(1) if an insurer “unreasonably refused to pay the claim or unreasonably delayed in making proper payment.” The penalty interest under MCL 500.3142(3) is available and must be awarded to an eligible claimant regardless of whether the insurer’s refusal or delay was in good or bad faith.³⁶

Likewise, with regard to the interest available under MCL 500.3142(3), an insurer’s rationale for delaying or denying a

claim is only relevant to the extent that it is related to whether the claimant provided “reasonable proof of the fact and of the amount of loss sustained.”³⁷ Although an insurer’s good faith may be relevant in determining whether its delay or refusal was reasonable for purposes of determining whether attorney fees are warranted under MCL 500.3142(3),³⁸ there is not, once again, any additional or separate remedy for an insurer’s bad-faith conduct.³⁹

Notably, as recognized by the Michigan Supreme Court, “[t]he adequacy of [these] existing legislative remedies has been a primary factor in refusing to recognize the bad faith tort.”⁴⁰ And, again, a claimant may not maintain an independent cause of action based on an insurer’s “breach” of MCL 500.3142 or MCL 500.3148.⁴¹ Rather, MCL 500.314 and MCL 500.3148 are remedies that may be imposed based on an insurer’s breach of a no-fault insurance policy or violation of a statutory entitlement to no-fault benefits.

Bad-Faith Claims in the Context of Liability Insurance

The third category of cases in which bad faith can be an issue involves the failure to pay a third-party liability claim asserted against the insured. Michigan law recognizes that, in the context of liability insurance, an insured may bring a claim against his or her insurer for bad faith in refusing to settle a claim against the insured within the policy limits.⁴² Although a direct duty of good faith does not exist between a primary liability insurer and an excess insurer, an excess liability insurer may bring a direct suit against the primary liability insurer, pursuant to equitable subrogation principles, based on the primary insurer’s bad-faith handling of a suit or settlement that results in a judgment in excess of the primary insurance policy limit.⁴³

The Michigan Supreme Court clarified the scope of bad faith in this context in *Commercial Union Ins Co v Liberty Mut Ins Co*.⁴⁴ The court first “define[d] ‘bad faith’ for instructional use in trial court as arbitrary, reckless, indifferent, or intentional disregard of the interests of the person owed a duty.”⁴⁵ It then provided a more detailed explanation of the applicable standard and identified several nonexclusive factors for a jury to consider in determining whether an insurer acted in bad faith:

Good-faith denials, offers of compromise, or other honest errors of judgment are not sufficient to establish bad faith. Further, claims of bad faith cannot be based upon negligence or bad judgment, so long as the actions were made honestly and without concealment. However, because bad faith is a state of mind, there can be bad faith without actual dishonesty or fraud. 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.

Among the factors which the factfinder may take into account, together with all other evidence in deciding whether or not the defendant acted in bad faith are:

- 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 the 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.

In applying any factors, it is inappropriate in reviewing the conduct of the insurer to utilize “20–20 hindsight vision.” The conduct under scrutiny must be considered in light of the circumstances existing

at the time. A microscopic examination, years after the fact, made with the luxury of actually knowing the outcome of the original proceeding is not appropriate. It must be remembered that if bad faith exists in a given situation, it arose upon the occurrence of the acts in question; bad faith does not arise at some later date as a result of an unsuccessful day in court.^[46]

Subsequent cases have applied this standard as well.⁴⁷ However, it bears repeating that this type of bad-faith claim does not provide a basis for an insured to bring a bad-faith claim in the context of a no-fault insurance policy; rather, Michigan courts have repeatedly considered it in cases involving liability insurance coverage.

Lastly, Michigan law does not recognize a claim for bad faith breach of an insurer’s duty to defend under an insurance policy. As the Michigan Supreme Court explained in *Stockdale v Jamison*:⁴⁸

The duty to defend . . . arises solely from the language of the insurance contract. A breach of that duty can be determined objectively, without reference to the good or bad faith of the insurer. If the insurer had an obligation to defend and failed to fulfill that obligation, then, like any other party who fails to perform its contractual obligations, it becomes liable for all foreseeable damages flowing from the breach.

Conclusion

As demonstrated by the foregoing summary, bad-faith claims are only available in isolated contexts under Michigan insurance law. Parties are often divided on the issue of whether Michigan has taken the best approach compared to that adopted by other jurisdictions. Regardless, the law is now well established, and this writer hopes that this piece has clarified the existing principles. ■

About the Author

Lynn Sholander is an associate attorney at *Hewson & Van Hellemont, P.C.*, who focuses her practice on general litigation, appellate advocacy, and legal research and writing. Before joining the firm in September 2017, Ms. Sholander served as a research attorney and a judicial law clerk for the Michigan Court of Appeals, working under the Honorable Michael J. Riordan and the Honorable Kurtis T. Wilder.

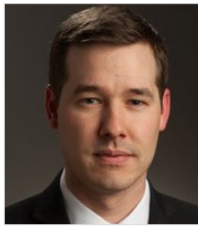
Endnotes

- 1 See, e.g., *Burnside v State Farm Fire & Cas Co*, 208 Mich App 422, 432-433; 528 NW2d 749 (1995) (TALBOT, J., concurring) (“Every contract is accompanied by a common-law duty to use ordinary care in the performance of that contract. *Nelson v Northwestern Savings & Loan Ass’n*, 146 Mich App 505; 381 NW2d 757 (1985). That duty, however, is not independent of the contract. It is not a duty imposed by law upon all that gives rise to a tort action. It is a duty arising out of that contract only and owed only to the contracting parties. Therefore, a tort action with exemplary or consequential damages cannot lie. *Kewin*, *supra* 409 Mich at 422.”)
- 2 See, e.g., *Kewin v Massachusetts Mutual Life Insurance Company*, 409 Mich 401, 420-421; 295 NW2d 50 (1980).
- 3 See, e.g., *Roberts v Auto-Owners Ins Co*, 422 Mich 594, 604-605, 607-608; 374 NW2d 905 (1985); *Kewin*, 409 Mich at 420-421; *Casey v Auto Owners Ins Co*, 273 Mich App 388, 401-402; 729 NW2d 277 (2006) (“A plaintiff cannot maintain an action in tort for nonperformance of a contract. There must be a separate and distinct duty imposed by law. An alleged bad-faith breach of an insurance contract does not state an independent tort claim.”) (footnotes omitted); *Runions v Auto-Owners Ins Co*, 197 Mich App 105, 110; 495 NW2d 166 (1992) (referring to “the non-existent tort of bad-faith handling of an insurance claim”); *Taylor v Blue Cross/Blue Shield of Michigan*, 205 Mich App 644, 657-658; 517 NW2d 864 (1994) (“Failure to pay a contractual obligation does not amount to outrageous conduct, even if it is wilful or in bad faith. At best, plaintiffs’ claim lies in the tort of bad-faith refusal to pay an insurance claim, an action that is not recognized by the courts of this state.”) (citations omitted); *Burnside*, 208 Mich App at 426, 430-431.
- 4 See, e.g., *Roberts*, 422 Mich at 604, 607-608.
- 5 *Kewin*, 409 Mich at 414-416 (applying *Hadley v Baxendale*, 9 Exch 341; 156 Eng Rep 145 (1854)); see also *id.* at 419 (“The damages recoverable [for the breach of an insurance policy] 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.”).
- 6 *Id.* at 419-421.
- 7 *Id.* at 414-416.
- 8 *Id.* at 420 (emphasis added).
- 9 *Ferrett v Gen Motors Corp*, 438 Mich 235, 245; 475 NW2d 243 (1991) (emphasis added). See also, e.g., *Hart v Ludwig*, 347 Mich 559, 562; 79 NW2d 895 (1957); *Brewster v Martin Marietta Aluminum Sales, Inc*, 145 Mich App 641; 378 NW2d 558 (1985); *Brock v Consol Biomedical Labs.*, 817 F2d 24, 25 (CA 6, 1987); *Sudden Serv, Inc v Brockman Forklifts, Inc*, 647 F Supp 2d 811, 815 (ED Mich, 2008).
- 10 489 Mich 157, 169; 809 NW2d 553 (2011).
- 11 347 Mich 559, 565-566; 79 NW2d 895 (1957)
- 12 See also *id.* at 565 (“[I]f a relation exists which would give rise to a legal duty without enforcing the contract promise itself, the tort action will lie, otherwise not.”) (quotation marks and citation omitted).
- 13 *Kewin*, 409 Mich at 421, 423 (citation omitted).
- 14 See, e.g., *Tennent v State Farm Mutual Automobile Insurance Company*, 143 Mich App 419, 425-426; 372 NW2d 582 (1985); *Hajciar v Crawford and Company*, 142 Mich App 632, 636-637; 396 NW2d 860 (1984); *Shikany v Blue Cross and Blue Shield of Michigan*, 134 Mich App 603, 606-610; 350 NW2d 910 (1984); *Butt v Detroit Automobile Inter Insurance Exchange*, 129 Mich App 211, 216-218; 341 NW2d 471 (1983); *Butler v Detroit Auto Inter-Ins Exch*, 121 Mich App 727, 733; 329 NW2d 781 (1982).
- 15 *Butler v Detroit Auto Inter-Ins Exch*, 121 Mich App 727, 733; 329 NW2d 781 (1982).
- 16 *Id.* at 735.
- 17 *Kewin*, 409 Mich at 416, quoting *Stewart v Rudner*, 349 Mich 459; 84 NW2d 816 (1957); see also, e.g., *Hajciar v Crawford & Co*, 142 Mich App 632, 637; 369 NW2d 860 (1985); *Butler*, 121 Mich App at 733-734.
- 18 *Kewin*, 409 Mich at 416.
- 19 *Id.* at 416-417 (citations omitted; emphasis added).
- 20 *PTN-NRS, LLC v Co of Wayne*, unpublished per curiam opinion of the Court of Appeals, issued October 5, 2017 (Docket No. 332135) (emphasis added).
- 21 *Burkhardt v City Nat Bank of Detroit*, 57 Mich App 649, 652; 226 NW2d 678 (1975). See also *Lancia Jeep Hellas SA v Chrysler Group Int’l*, unpublished per curiam opinion of the Court of Appeals, issued March 24, 2016 (Docket No. 329481) (“This Court has recognized that a covenant of good faith and fair dealing may attend contracts that make the manner of one party’s performance ‘a matter of its own discretion.’ Applying Michigan law, the Fifth Circuit Court of Appeals has explained that ‘[t]he implied covenant of good faith and fair dealing essentially serves to supply limits on the parties’ conduct when their contract defers decision on a particular term, omits terms or provides ambiguous terms.’”) (citations omitted).
- 22 *Fodale v Waste Mgmt of Michigan, Inc*, 271 Mich App 11, 35; 718 NW2d 827 (2006); *Belle Isle Grill Corp v City of Detroit*, 256 Mich App 463, 476; 666 NW2d 217 (2003).
- 23 *Eastman & Blevins Agency*, 206 Mich App 299, 302-303; 520 NW2d 640 (1994).
- 24 *Lancia Jeep Hellas SA*, unpub op at 10, quoting *Stephenson v Allstate Ins Co*, 328 F3d 822, 827 (CA 6, 2003).
- 25 MCL 500.2001 *et seq.*
- 26 MCL 500.2006(4).
- 27 *Id.*
- 28 *Griswold Properties, LLC v Lexington Ins Co*, 276 Mich App 551, 566; 741 NW2d 549 (2007) (quotation marks and citation omitted).
- 29 See, e.g., MCL 500.2836(2) (fire insurance claims); MCL 500.3416 (disability insurance payments); MCL 500.4030 (life insurance claims).
- 30 See MCL 500.2006(6), (7).

- 31 *McCahill v Commercial Union Ins Co*, 179 Mich App 761, 779-780; 446 NW2d 579 (1989).
- 32 See, e.g., MCL 500.230; *Young v Michigan Mut Ins Co*, 139 Mich App 600, 604; 362 NW2d 844 (1984), citing MCL 500.230 and *Barker v Underwriters at Lloyd's, London*, 564 F Supp 352, 355 (ED Mich 1983).
- 33 *Young*, 139 Mich App at 605.
- 34 *Isagholian v Transamerica Ins Corp*, 208 Mich App 9, 17; 527 NW2d 13 (1994) (“[I]n general, a violation of the Uniform Trade Practices Act . . . does not give rise to a private cause of action.”); *Crossley v Allstate Ins Co*, 155 Mich App 694, 697; 400 NW2d 625 (1986) (“An allegation, such as plaintiff’s allegation that defendant’s conduct violated §§ 2006 and 2026 of the UTPA, that a defendant has breached an obligation imposed upon the defendant by law is an allegation of tort. Plaintiff’s allegation with regard to violation of the UTPA fails as a matter of law because the act provides a comprehensive, exclusive scheme of enforcement of the rights and duties it creates; no private cause of action exists in tort for a violation of the UTPA.”) (citations omitted; emphasis added). See also *Safie Enterprises Inc v Nationwide Mutual Fire Ins Co*, 146 Mich App 483, 494; 381 NW2d 747 (1985); *Young*, 139 Mich App at 605-606 (1984); *Society of St Vincent de Paul v Mt Hawley Ins Co*, 49 F Supp 2d 1011, 1020 (ED Mich, 1999); *Kovelle v Hartford Ins Co*, unpublished per curiam opinion of the Court of Appeals, issued December 11, 2013 (Docket No. 242749).
- 35 *Palmer Park Square, LLC v Scottsdale Ins Co*, 878 F3d 530, 535-536 (CA 6, 2017).
- 36 *Morales v State Farm Mut Auto Ins Co*, 279 Mich App 720, 730; 761 NW2d 454 (2008) (“Penalty interest must be assessed against a no-fault insurer 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.”) (quotation marks and citations omitted); *Davis v Citizens Ins Co of Am*, 195 Mich App 323, 328; 489 NW2d 214 (1992).
- 37 *Morales*, 279 Mich App at 730-731.
- 38 *Davis*, 195 Mich App at 329.
- 39 *Van Marter v Am Fid Fire Ins Co*, 114 Mich App 171, 183-84; 318 NW2d 679, 684 (1982) (“Plaintiff’s remedy for defendant’s alleged bad faith refusal to perform the no-fault contract is limited to recovery of actual attorney fees, as provided in MCL. § 500.3148; MSA. § 24.13148, and the 12% penalty interest, as in MCL. § 500.3142; MSA. § 24.13142.”).
- 40 *Roberts*, 422 Mich at 635 n 8.
- 41 See *Butler*, 121 Mich App at 735.
- 42 *J & J Farmer Leasing, Inc v Citizens Ins Co of Am*, 472 Mich 353, 357 n 3; 696 NW2d 681 (2005); *Frankenmuth Ins Co v Keeley*, 436 Mich 372, 375; 461 NW2d 666 (1990) (adopting Justice Levin’s dissent in *Frankenmuth Mutual Ins Co v Keeley*, 433 Mich 525, 546; 447 NW2d 691 (1989)); *Commercial Union Ins Co v Liberty Mut. Ins Co*, 426 Mich 127; 393 NW2d 161 (1986); *Wakefield v Globe Indemnity Co*, 246 Mich 645; 225 NW 643 (1929).
- 43 See 14 Mich Civ Jur Insurance § 471; *Commercial Union Ins Co v Liberty Mut Ins Co*, 137 Mich App 381; 357 NW2d 861 (1984), aff’d 426 Mich (1986); *Commercial Union Ins Co v Med Protective Co*, 426 Mich 109, 119; 393 NW2d 479 (1986) (“For all these reasons, we would hold that an excess insurer may maintain a cause of action against a primary insurer for the latter’s bad-faith failure to defend or settle within policy limits. The excess insurer is equitably subrogated to the position of the insured and acquires no lesser or greater rights than those held by the insured.”).
- 44 *Commercial Union*, 426 Mich 127.
- 45 *Commercial Union*, 426 Mich at 136.
- 46 *Commercial Union*, 426 Mich at 136-139 (footnotes omitted).
- 47 See, e.g., *Tibble v American Physicians Capital, Inc*, unpublished per curiam opinion of the Court of Appeals, issued October 28, 2014 (Docket No. 306964) (suit against medical malpractice insurer).
- 48 416 Mich 217, 224; 330 NW2d 389 (1982) (emphasis added), holding limited by *Frankenmuth Ins Co*, 436 Mich 372 (adopting Justice Levin’s dissent in 433 Mich 525 (1989)).

Mission Statement of the Insurance and Indemnity Law Section

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.



Underinsured Motor Vehicles and Setoffs for Tortfeasor Coverage

By Jeffrey D. DenBraber and Daniel J. James, *Wheeler Upham, PC*

Underinsured motor vehicle (“UIM”) coverage in general applies where an automobile tortfeasor’s liability limits are less than the UIM limits of the insured’s policy. Also, most UIM policies allow the UIM carrier to setoff, i.e. reduce its limits by, among other things, payments made by and on behalf of the tortfeasor. If the policy so provides, worker’s compensation and Social Security disability benefits may also be set off.¹ Sounds simple enough, right? But numerous issues can arise when the language of a UIM policy is applied to factual scenarios involving multiple claimants, multiple tortfeasors, and single limits coverage.

It is critical to note that UIM coverage, like uninsured motorist (“UM”) coverage, is not required by law.² Therefore, the scope of coverage and limitations thereto are governed by each contract for insurance, as well as contract law.³ Accordingly, in UIM cases, different outcomes can be reached, despite similar factual circumstances, because of differing policy language.

What Is an Underinsured Motor Vehicle?

In Michigan, there is no statutory definition of an underinsured motor vehicle. However, most policies include language similar to the following:

A motor vehicle which has bodily injury liability protection the limits of which are less than the limits of liability for underinsured motorist coverage listed in the policy.

Some policies may also require that the tortfeasor’s liability coverage be equal to or greater than Michigan’s statutory minimum liability limits of 20/40. Other policies may define an underinsured motor vehicle in reference to the insured’s damages, i.e. as a motor vehicle with liability limits that are less than the insured’s damages.

In *Pyles v MIC Gen Ins Corp*,⁴ where the definition of an underinsured motor vehicle simply involved a UIM limits-to-liability limits comparison, the tortfeasor was involved in a motor vehicle accident with another vehicle with three occupants, who had 50/100 UIM coverage. The court held that the tortfeasor, who had 50/100 liability limits, was not underinsured, despite the fact that two of the occupants did not receive a full \$50,000 per person limit, because the limits of the two policies were the same.

However, compare that to the situation in *Long v Pioneer State Mut Ins Co*, an unpublished opinion of the Court of Appeals.⁵ In *Long*, the UIM policy at issue contained a definition of underinsured motor vehicle similar to the definition in *Pyles* above.⁶ The tortfeasor had single limits liability coverage of 100/100, and the two UIM claimants had UIM coverage of 100/300. The UIM insurer argued that the tortfeasor did not meet the definition of an underinsured motor vehicle because the per person limits were the same. On the other hand, the insureds argued that the tortfeasor met the definition because the per accident limits of the UIM coverage were greater than the tortfeasor’s per accident liability limits. The court agreed with the insured and found that the tortfeasor was underinsured as defined by the policy. The UIM coverage “plainly exceeded” the tortfeasor’s liability coverage because there was a total of \$200,000 in UIM coverage available to the two insureds but only \$100,000 available under the tortfeasor’s liability coverage.⁷

See also *Farm Bureau Gen Ins Co v Hare*⁸ for an example of a case where a tortfeasor with 250/500 liability limits was determined to be underinsured, even though the UIM policy had 100/300 limits, because the amount of damages sustained by the multiple claimants was more than the tortfeasor’s liability coverage.

Setoff for Payments Made by Tortfeasors

After it has been determined that the tortfeasor is underinsured, the issue becomes what UIM benefits are available to the claimant. Most, if not all, policies allow the UIM insurer to set off the amount paid, and in some policies also the amount payable, by the tortfeasor from the UIM coverage. These setoffs generally apply to the UIM limits, as opposed to the amount of the insured’s damages.⁹ In situations where there is one tortfeasor and one claimant, the math is straightforward. For example, an insured with 100/300 UIM limits, would under typical policy language be entitled to, at most, \$80,000 in UIM benefits, after collecting a tortfeasor’s \$20,000 per person liability limit.

Moreover, a UIM insurer may be permitted to set off more than the just the amount of the automobile tortfeasor’s liability coverage. Some policies contain language reducing UIM limits by amounts payable by *all* legally responsible persons,

which can include not only amounts payable by the automobile tortfeasor but also amounts received from a dram shop tortfeasor.¹⁰

However, a provision allowing a setoff for payments by “legally responsible” persons does not allow a UIM carrier to set off its limits by UM benefits an insured receives from another insurer. In *Erickson v Citizens Ins Co*,¹¹ the court held that a UIM carrier with \$100,000 limits could not take a setoff for the \$100,000 the insured received from another UM carrier because that UM carrier was not “legally responsible” for the accident. However, “other insurance” provisions should also be consulted in this type of factual scenario.

Setoffs in Multiple Claimant Cases

Setoff issues can arise when the insured does not recover a full per person limit from the tortfeasor because the number of injured people is greater than the “liability limits ratio,” which is, for purposes of this article, the ratio of the per accident liability limits to the per person liability limits. Whether the insurer can reduce the UIM limit by the limit of the tortfeasor’s liability coverage, or by only the amount the insured receives from the tortfeasor, depends on the policy language.

*Wilkie v Auto-Owners Ins Co*¹² is a well-known Michigan Supreme Court case because not only did it reject the reasonable expectations doctrine; it also addressed the complicated issue of UIM setoffs. In *Wilkie*, the Michigan Supreme Court allowed the UIM carrier to reduce its per person limit of coverage by the complete limit of the tortfeasor’s coverage, even though each insured did not receive a full limit. In *Wilkie*, the two plaintiffs were injured in a motor vehicle accident caused by a tortfeasor with \$50,000 single limit liability coverage. The liability limits ratio was, therefore, two. The plaintiffs split the \$50,000 equally. They were both insured for UIM benefits under a policy that had 100/300 limits. The plaintiffs argued that they were each entitled to \$75,000 in UIM benefits, which represented the \$100,000 per person UIM limit less the \$25,000 they each received from the tortfeasor. The insurer, however, argued that they were each entitled to only \$50,000, which represented the \$100,000 per person UIM limit less the tortfeasor’s total \$50,000 liability limits.

The UIM provision at issue in *Wilkie* allowed the insurer to reduce its UIM limits by “the total limits of all bodily injury liability bonds and policies available to the owner or operator of the underinsured automobile.” The *Wilkie* court explained that this policy language unambiguously allowed the insurer to reduce each per person UIM limit by the tortfeasor’s entire \$50,000 coverage because, as the court emphasized, that was the total limit of coverage *available* to the tortfeasor. It did not matter that the plaintiffs had only received \$25,000 each. The Court noted that its interpretation of the provision was supported by other provisions that provided that the limit of

coverage was not increased because of the number of claims made, suits brought, or persons injured.

In *Farm Bureau Gen Ins Co v Hare*,¹³ which was discussed above in reference to the definition of an underinsured motor vehicle, the court held that the 100/300 UIM limits were completely set off by the tortfeasor’s 250/500 limits. Even though the four UIM claimants had received no payment from the tortfeasor – because it had been exhausted by payments to two other injured people – the tortfeasor’s coverage had been “payable” to the four claimants, and therefore, the UIM carrier could take the setoff.

However, the outcome was different in *Long v Pioneer State Mut Ins Co*,¹⁴ which was also discussed above in regard to the definition of an underinsured motor vehicle. As noted above, in *Long*, the two plaintiffs were rear-ended by a tortfeasor with a \$100,000 single limit liability policy. The liability limits ratio was, therefore, two. The plaintiffs were insured for UIM coverage with the insurer with 100/300 limits. After splitting the tortfeasor’s \$100,000 coverage equally, the plaintiffs then sought UIM coverage in the amount of \$50,000 each, which represented the \$100,000 per person limit of the UIM coverage less the \$50,000 paid to each of them by the tortfeasor. However, the UIM insurer asserted that the plaintiffs were not entitled to any UIM benefits because the \$100,000 UIM limit was completely setoff by the \$100,000 paid by the tortfeasor, in total, to both of them.

Similar to *Wilkie*, the issue to be decided was what amount was to be subtracted from the stated \$100,000 per person UIM limits to reach the applicable limit of coverage. The policy provided that “[t]he limit of liability shall be reduced by all sums paid” by the tortfeasor. While it was true that the tortfeasor had paid \$100,000 in total to both plaintiffs, the court held that the setoff had to be applied on a per person basis rather than a per accident basis. The court noted that the policy prefaced its description of the per accident limit by stating that it was “[s]ubject to this limit for each person.” The court interpreted this “subject to” language as “establish[ing] the frame of reference for calculating UM benefits” and identifying the each-person limit as the “relevant guidepost for further calculations.”¹⁵ Accordingly, the insurer could only reduce the per person UIM limits by the amount each person recovered from the tortfeasor.

The *Long* court acknowledged that *Wilkie* shared factual similarities but observed that the policy language differed

Some policies contain language reducing UIM limits by amounts payable by all legally responsible persons, which can include not only amounts payable by the automobile tortfeasor but also amounts received from a dram shop tortfeasor.

significantly. The policy in *Wilkie* contained no specific reference to per person limits and instead reduced the UIM limits by the total limit of coverage “available” to the tortfeasor, whereas the policy in *Long* reduced the limits by all sums “paid.” The court further explained that to the extent *Wilkie* applied, it supported the circuit court’s denial of the UIM insurer’s motion for summary disposition, because *Wilkie* performed a per person to per person analysis.

In addition to setoff language in the “limits of liability” section, the definition of “underinsured motorist” should also be consulted and may shed light on the issue of the amount of any setoff.

As alluded to by the *Long* court, an issue that can arise when there are multiple injured persons is whether the amount of UIM coverage is calculated on a per person or per accident basis. This issue arises where the number of injured people is greater than the UIM limits ratio, i.e. the ratio of the per-accident UIM limits to the per-person UIM limits. For example, suppose three people occupying one motor vehicle are injured in an accident by a tortfeasor with a 100/300 liability policy, and each person receives \$100,000 from the tortfeasor. If these three people then present a claim for UIM coverage under a policy with 250/500 limits, i.e. a UIM policy with a UIM limits ratio of two, are the limits of coverage \$200,000, i.e. the \$500,000 *per accident* UIM limits less the \$300,000 *per accident* liability limits, or are they \$450,000, i.e. the \$250,000 *per person* UIM limits less the \$100,000 *per person* liability limits, and then multiplied by three claimants? Does the outcome change if two of the injured people are in the tortfeasor’s auto and are not making a claim for UIM coverage under the policy at issue? Of course, because UIM coverage is not mandatory, the outcome should depend on the language of the policy.

These authors have found no Michigan opinion, published or unpublished, that has addressed this exact issue. In *Wilkie* and *Long*, because the number of UIM claimants was less than the UIM limits ratio in both cases, there was no dispute that calculating the limit of coverage started with the per person UIM limit; the question in those cases was the amount to set-off from the UIM per person limit, the total amount available to the tortfeasor or the total amount paid by the tortfeasor. In *Hare*, the Court did not have to address the issue because the outcome, i.e. a complete setoff of UIM coverage, was the same under either calculation.

The purpose of UIM coverage can be viewed as putting the insureds in the same position they would have been in had the tortfeasor had liability coverage with limits equal to the insureds’ UIM coverage. If the language of a UIM policy successfully adopts this view, then in the example above the insurer should owe at most \$200,000.

However, *Long* suggests that where a policy provides that its per accident limit is “subject to” the per person limit, UIM coverage should be calculated on a per person basis, with the total amount paid capped at the per accident limit. Thus, in the example above, *Long* suggests that limit of UIM coverage would be \$150,000 per person and \$450,000 per accident, which would allow the three injured people to recover, in total, \$750,000, which is \$250,000 more than the \$500,000 per accident UIM coverage.

An argument can be made that *Long*’s interpretation of the “subject to” language, as setting an order by which UIM benefits are calculated, is incorrect and that the language simply means that where the per accident limit comes into play – because the number of claimants is greater than the limits ratio – any one person can still not recover more than a per person limit. *Long* is unpublished and, therefore, not precedentially binding under the rules of stare decisis.¹⁶

In addition to setoff language in the “limits of liability” section, the definition of “underinsured motorist” should also be consulted and may shed light on the issue of the amount of any setoff. A definition that an underinsured motor vehicle is one with liability limits less than the UIM limits may support an argument that the purpose of the UIM coverage is simply to put the insured in the same position as if the tortfeasor had liability coverage in the same amount as the insured’s UIM coverage. In contrast, a definition that an underinsured motor vehicle is one where the insured’s damages are greater than the tortfeasor’s liability limits may support an argument that the focus is on the insured’s damages and that the UIM coverage should, therefore, be construed to maximize the insured’s recovery, i.e. calculated on per person basis.

Conclusion

Determining the applicable limit of UIM coverage can be very straightforward or rather complicated depending on the number of claimants, number of tortfeasors, and the existence of a single limit policy. Additionally, because the language of the UIM policy controls, the policy in any given case should be carefully reviewed. As demonstrated by *Long* and *Wilkie*, two factually similar cases can have different outcomes because of differing policy language. ■

About the Authors

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Endnotes

- 1 See *Park v American Cas Ins Co*, 219 Mich App 62; 555 NW2d 720 (1996).
- 2 *Nickola v Mic Gen Ins Co*, ___Mich___ ; 894 NW2d 552, 555-556 (2017).
- 3 *Rory v Continental Ins Co*, 473 Mich 457, 465-466; 703 NW2d 23 (2005).
- 4 Unpublished per curiam opinion of the Court of Appeals, issued Feb 21, 2003 (Docket No 237712).
- 5 Unpublished per curiam opinion of the Court of Appeals, issued Nov 30, 2010 (Docket Nos 293556, 293569).
- 6 The Pioneer policy defined an underinsured vehicle as a vehicle “to which a bodily injury liability ... policy applies at the time of the accident but its limit for bodily injury liability is less than the limit of liability for this coverage.”
- 7 *Long*, unpub op at 5.
- 8 Unpublished per curiam opinion of the Court of Appeals, issued Aug 20, 2015 (Docket No. 1620).
- 9 See *Nankervis v Auto-Owners Ins Co*, 198 Mich App 262; 497 NW2d 573 (1993) (the \$20,000 received by the insured from the tortfeasor was to be setoff from her \$25,000 UIM limits, and the insured was entitled to \$5,000.00 in UIM benefits.)
- 10 See *Parker v Nationwide Mut Ins Co*, 188 Mich App 354; 470 NW2d 416 (1991); *Mead v Aetna Cas & Surety Co*, 202 Mich App 553; 509 NW2d 789 (1993).
- 11 217 Mich App 52; 550 NW2d 606 (1996).
- 12 469 Mich 41; 664 NW2d 776 (2003)
- 13 *Supra*. See footnote 8.
- 14 *Supra*. See footnote 5.
- 15 *Long*, unpub op at 10.
- 16 MCR 7.215(C)(1).



Insurance and Indemnity 101

Reinsurance

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

If you practice long enough in this area, especially liability policies, and especially if you consult with insurers on the drafting of their policies, then you run a significant risk of encountering reinsurance.

Viewed from the outside, and from the perspective of someone familiar with insurance policies, reinsurance is a little odd.

At first glance, reinsurance looks a little like an excess insurance policy, because it definitely is not a primary policy. But the big difference here is over who is the insured. Reinsurance is neither primary nor excess insurance because it is not bought by a person or business. Instead the insurer with a policy of \$ million may decide that having \$4 million of its assets at risk is too great a financial risk. That's especially so if the insurer issues multiple policies to multiple insureds. So, the insurer buys reinsurance from a reinsurer. For example, the insurer might reinsure \$3 million of its \$4 million. The excess insurer pays a premium and the reinsurer issues its reinsurance agreement. By the way, the reinsurer can even buy reinsurance from another reinsurer.

The insured person or business plays no part in this and probably does not know or care whether its primary and excess insurers have reinsured their risk or not.

Within the world of reinsurance there are some terms to learn. The “reinsured” insurer in our hypothetical is the “reinsured” or the “ceding insurer,” because it cedes some of its risk to the reinsurer.

In addition, there are two broad categories of reinsurance agreements: “facultative” and “treaty.”¹ In treaty reinsurance, the reinsurer agrees to reinsure all of the policies issued by the initial insurer, where the policies are of a type agreed in the reinsurance treaty. In facultative reinsurance, the agreement is a one-off. The reinsurer agrees to reinsure some of the risk of a particular policy issued to a particular insured.

In either case, though, the reinsurer will want to know the exact terms of the ceding insurer's policy, so that it knows just what risks it is taking on. That is the reason why attorneys who consult with insurers on their policies can come into contact with reinsurance agreements. The changes you suggest to your client's insurance policy may well be screened by the reinsurer.

Viewed from the inside, reinsurance is a new world.

Partly it's the jargon, but that's a minor difference. The reinsurer does not issue a policy; reinsurance is created by an

“agreement,” not a policy. In the agreement, the reinsurer is called, logically enough, the “Reinsurer,” but the “reinsured” insurer may be called “ceding insurer” or just “the company,” but not the “insured.”

But the main difference is the text itself. The land of reinsurance has never met the “plain English” movement. This is a world where the text is as dense as a neutron star, and the building blocks are actual blocks of text: single paragraphs that consume the better part of a page.

The insurance policies that we all work with on a daily basis are not easy reads, to be sure, but they are structured. The policies have distinct parts – the insuring agreement, the exclusions, the definitions and the conditions.

But, what’s more important is that, with real insurance policies, the parts themselves have structure. Provisions are broken down into parts and subparts and subsubparts and assembled mostly in outline form. This makes it easier to see how the subparts relate to each other. Not so with a reinsurance agreement. Here it’s all about searching through the block of text looking for conjunctions and disjunctions to figure out what a clause actually means.

Many of the provisions themselves are familiar, at least in concept. There is a part that describes the kind of business that the reinsurer will cover. There’s a coverage limit provision, a set of exclusions, a list of defined terms, and so on.

There are also differences. The reporting requirements are more extensive. There is a provision that gives the reinsurer access to the insurer’s records. There’s a provision for setoffs,

because in a continuing relationship, activities for different years might accrue benefits to one side or the other. There may also be a provision dividing the reinsurers’s obligation differently, in percentage terms, at different levels of loss suffered by the insurer.

But it’s the drafting that makes reinsurance such a difficult area. Like the person who adopts a clothing style, and sticks with it through the following decades, reinsurance agreements stand proudly loyal to a style of writing that brings back memories of the film noir genre of decades past. ■

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 2017. 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.

Endnotes

- 1 *Michigan Millers Mutual Insurance Co v North American Reinsurance Association*, 182 Mich App 410, 413; 452 NW2d 841 (1990).

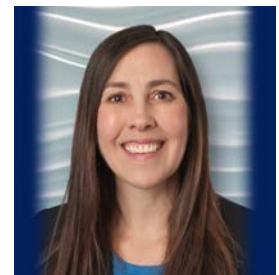


Practice Attorney Spotlight

Margaret A. Cernak

- Specializes in providing insurance coverage advice and analysis to insurers, on a national basis, and as to a complete array of insurance lines.
- Spent over 7 years working closely with claims professionals while on the staff of a captive law firm.
- Exceptional writing and analytical skills earned her an appointment to teach courses in legal research, writing, counseling, and advocacy at the University of Michigan Law School for over a dozen years.

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Legislative Update

By Patrick D. Crandell, Collins, Einhorn, Farrell PC

Heading Toward the Midterms

With the midterm elections less than six months away, during which the entire Legislature is up for election/re-election, expect to see less committee work, as the members focus on passing already introduced bills and taking time off over the summer to campaign. We already are starting to see this as the Senate Insurance Committee has not met since the last update. But the members still continue to introduce bills (1754 in the House and 740 in the Senate).

Since the last update, the following bills have advanced:

- **Insurers' disclosure of security breaches** – HB 5275 requires insurers to annually disclose all security breaches that require notice to residents under the Identify Theft Protection Act. *Reported out of the House Insurance Committee on 2/22/18*
- **Tort liability of insurance agents** – SB 638– clarifies the available tort liability for insurance agents *Reported out of the Senate Insurance Committee on 11/30/17; Passed unanimously in the Senate on 12/6/17; Reported out of the House Insurance Committee on 2/15/18; Passed by the House on 3/1/18 (108-1); Concurred in unanimously by the Senate on 3/6/18; Presented to the Governor for signature on 3/15/18.*
- **Vehicle registration expiration dates** – HB 5399 would change vehicle registration expiration dates to coincide with insurance expiration dates.
- **Factors used to determine premiums** – HB 5419 would modify and limit the factors that automobile insurers can rely upon when determining premiums.
- **Electronic delivery of insurance notices** – **HB 5430** – would allow and create requirements for electronic delivery of insurance notices and documents *Reported out of the House Insurance Committee on 3/1/18; Passed unanimously by the House on 3/14/18; Referred to the Senate Insurance Committee on 3/15/18.*
- **Elimination of no-fault** – HB 5517-HB 5523 would eliminate Michigan's No-Fault law
- **Revising text of insurance code** – HB 5544 would eliminate reference to “colored persons” in the insurance code
- **Permitting choice of PIP coverage levels** – HB 5552 would permit people to select the maximum limit of personal protection benefits payable under their automobile policies
- **Rates for attendant care by relatives** – HB 5553 would provide for attendant-care payments to relatives of an injured person, at the same rates as direct-care workers or minimum wage
- **Value of gifts from insurers to insureds** – HB 5609 would raise the value of gifts that insurers can give to customers from \$10 to \$50 per calendar year *Reported out of the House Insurance Committee on 3/1/18; Passed the House (107-2) on 3/13/18; Referred to the Senate Insurance Committee on 3/14/18*
- **Abolishing mandatory automobile insurance** – **HB 5627-HB 5633** would abolish mandatory automobile insurance
- **Cap on non-economic damages** – HB 5675 would enact a cap on non-economic damages recoverable due to a motor vehicle accident; tie-barred to HB 5517 (elimination of the no-fault law)
- **Prohibits rate increase for not-at-fault driver** – HB 5699 would prohibit an insurer from raising automobile insurance premiums due to an accident in which law enforcement determines that the insured was not substantially at fault
- **Prohibits charges after gap in coverage** – HB 5736 would prohibit an insurer from refusing coverage, increasing the premium or charging a re-instatement fee for a gap in insurance coverage during the preceding 90 days
- **90-day prescription refills** – HB 5737 would prohibit an insurer from denying a claim for a refill of a 90-day prescription under certain circumstances
- **Choice of PIP coverage for over-65** – SB 787 would allow people over 65 years old to select the maximum limit of personal protection benefits payable under their automobile policies

- **Real-time electronic insurance verification** – SB 819-SB 820 would enact the real-time electronic insurance verification act
- **Modify licensing criteria for insurance providers** – SB 830 would modify the licensing requirements for insurance producers, to add a rebuttable presumption in favor of producers under certain circumstances
- **Limit compensation of director of health endowment fund** – SB 846 would limit the compensation for an executive director of a health endowment fund corporation to that of the Michigan Senate Majority Leader or the Speaker of the Michigan House, whichever is less
- **Captives' reporting date** – SB 898 would modify the date when captive insurance companies must provide their annual reports ■



Selected Insurance Decisions

By Deborah A. Hebert
Collins, Einhorn, Farrell PC

Michigan Court Of Appeals – Published Decisions

UM coverage not applicable where covered auto struck debris in the road

Drouillard v American Alternative Ins. Corp.
___ Mich App ___ (2018) (Docket No. 334977)
Released February 27, 2018

Plaintiff's UM policy defined "uninsured motor vehicle" as a hit-and-run vehicle that hits *or causes an object to hit* the insured. Plaintiff was a passenger in a covered auto and was injured when that vehicle struck some objects lying in the road. Those objects had fallen off a pick-up truck moments before the accident. In a decision that includes one concurring and one dissenting opinion, the court concluded that the disappearing pick-up truck did not cause the building materials to strike the covered auto. Rather, the covered auto ran into stationary materials left in the middle of the roadway. Plaintiff was not entitled to UM benefits under the terms of this policy.

Recreational vehicle accident did not occur on "insured premises" as required for homeowners liability coverage

Meemic Ins Co v Bischer
___ Mich App ___ (2018) (Docket No. 335126)
Released February 13, 2018

This homeowners policy excluded coverage for bodily injury claims arising out of the ownership and use of a motorized vehicle designed for recreational use. An exception to the exclusion kept coverage in place if the recreational vehicle was being used on the "insured premises," defined in the policy as the residence and "any premises used by you in connection with" the residence. The court held that the non-residence

property had to be used "in connection with" the residence, and that "neighboring property is not used 'in connection with' the residence merely because it is regularly used by an insured with implied permission." The insured's son was operating the family-owned ATV on a series of trails that crossed over many properties in the surrounding neighborhood. The accident did not occur on the insured premises.

Michigan Court Of Appeals –Unpublished Decisions

UM coverage triggered where operator was unknown

Gonzalez v Farm Bureau General Ins Co of Michigan
Docket No. 331956
Released January 4, 2018 (S Ct app lv pending)

Plaintiff's UM policy defines an "uninsured motor vehicle," in part, as a hit-and-run vehicle "whose owner **or** operator is unknown." The person driving the vehicle that struck the insured's car fled the scene of the accident. The owner was located but claimed that the vehicle had been stolen a couple of months earlier and was uninsured. UM coverage applied.

Homeowners' insurer did not have a duty to direct or supervise repairs

Horrocks v Citizens Ins. Co. of America
Docket Nos. 335972, 336480
Released January 25, 2018

Plaintiff sued her homeowners insurer claiming that the insurer should have advised her on how to properly identify the source of a leak in her home and on how to repair it, and should have warned her about the need to remediate the resulting mold, which eventually made the house uninhabitable

and caused health problems. But the coverage provided by the policy was “the actual cash value of the damage until actual repair or replacement is complete.” After actual repairs, the policy would pay actual replacement cost. The policy did not require the insurer to direct or advise the insured as to how to proceed with remediation or repair and did not require the insurer to hire contractors or pay them up front. And there was no evidence that the insurer created a new hazard by actually providing the insured with bad advice.

**Mortgage life and disability insurance terms
do not violate MCPA**

Kolk v Household Finance Corp

Docket No. 337178

Released January 23, 2018

Plaintiff sued the defendant mortgage company challenging the terms of its mortgage-based disability and life insurance policy for that 15-year mortgage. The disability coverage, while providing up to 180 months of coverage over the life of the loan, was subject to a “Critical Period” rule, which limited coverage to 24 months for any one claim. Defendant did not breach the contract by cutting off disability payments at the conclusion of 24 months of the mortgage-holder’s first disability claim. The policy also stated that coverage would automatically terminate as of “the payment due date [on which] you are two months delinquent . . .” Neither policy provision violated Michigan’s Consumer Protection Act.

6th Circuit Court of Appeals Decisions

Exclusion for “illegal use of alcohol” not applicable

Heimer v Companion Life Insurance Co.

___ F3d ___ (6th Cir 2018)

Case No. 16-2274

Plaintiff was injured in a motorbike accident and sought coverage for medical expenses under his policy with the defendant. Coverage was disclaimed based on an exclusion in the policy for injuries resulting from the “illegal use of alcohol.” Plaintiff was of legal drinking age at the time of the accident. After consuming alcohol with his friends, the group decided to ride their motorbikes in a field where the accident occurred. Plaintiff’s blood alcohol content level at the time exceeded Michigan’s limit for the legal use of off-road vehicles. Both the Western District Court of Michigan and the 6th Circuit applied the plain language of the exclusion and found coverage: the exclusion for an insured’s “illegal use of alcohol” “most naturally refers to the act of consuming alcohol, and not post-consumption conduct.” Plaintiff did not illegally use alcohol. And his injuries occurred after he completed consumption. (J. McKeague, dissenting)

Claim for penalty interest is subject to 6-year statute of limitations

Palmer Park Square, LLC v Scottsdale Ins. Co.

878 F3d 530 (6th Cir 2017)

Plaintiff insured a vacant apartment complex with the defendant. After discovering that the building had been burglarized and vandalized, plaintiff submitted proofs of loss, which resulted in payments. But those payments were made well after the 30-day period required under Michigan’s insurance laws. MCL 500.2836(2). So plaintiff filed this lawsuit to recover the penalty interest provided for by MCL 500.2006(4). In a first-impression ruling, the 6th Circuit held that because the legal duty to pay penalty interest was created by statute, the policy’s two-year limitation for claims made “under the policy” did not apply. Plaintiff was not suing to recover amounts due under the policy, but to recoup statutory penalty interest. Michigan’s “catch-all” six-year statute of limitations applied.

Federal District Court Decisions

Summary judgment denied on coverage and duty to defend

Peerless Ins Co v Conifer Holdings, Inc.

E.D. Mich Case No. 17-cv-10223

January 14, 2018

Peerless defended its insureds, under a reservation of rights, in a liability lawsuit alleging misappropriation of trade secrets, breach of fiduciary duties, breach of contract, and more. A verdict was ultimately entered against the insureds on some of the liability claims. Peerless filed this declaratory judgment action to obtain a ruling on the lack of coverage under the insureds’ CGL policy and to recoup defense costs. The trial court denied Peerless’s motion for summary judgment, concluding that as to indemnity coverage, Peerless did not provide enough information from the underlying case to allow the court to make a determination, and as to defense costs, Peerless failed to establish that no claim was even arguably covered.



No-Fault Corner

Is the “Innocent Third Party” Doctrine a Phoenix, Rising from the Ashes of Its Own Demise?

The Michigan Supreme Court Hears Oral Argument on *Bazzi v Sentinel Ins Co*

By Ronald M. Sangster Jr.

The ability of an insurance company to rescind coverage completely, even as to innocent third parties, has been a controversial issue ever since the Michigan Supreme Court released its decision in *Titan Ins Co v Hyten*, 491 Mich 547, 817 NW2d 562 (2012). Readers of this column will recall that *Hyten* addressed the ability of an insurance company to rescind or reform third party liability policy limits down to the statutorily required minimum policy limits of \$20,000.00/\$40,000.00 in cases where the insured made a material misrepresentation in the Application for Insurance. In its decision, the Michigan Supreme Court ruled that a nofault insurer could avail itself of common law defenses to a breach of contract action, including fraud. In doing so, however, the Supreme Court also noted that the insurer’s remedies may be limited by statute, and in footnote 17, the Michigan Supreme Court specifically noted that under MCL 500.3009, all automobile insurance policies sold in this state were required to carry the minimum policy limits of \$20,000.00/\$40,000.00.

Finally, in June 2016, the Michigan Court of Appeals released its long-awaited decision in *Bazzi v Sentinel Ins Co*, 315 Mich App 763, 891 NW2d 13 (2016). In *Bazzi*, the Court of Appeals extended the rationale in *Hyten* to claims involving first-party, no-fault PIP benefits, and determined that an insurer could rescind coverage completely based upon fraud on the part of the insured, even if the rescission affects the interest of so-called “innocent third parties”; i.e., those individuals who were not a party to the fraudulent misrepresentations made by the insured in the Application for Insurance. In its ruling, the Court of Appeals specifically noted that in *Hyten*, the Michigan Supreme Court had abrogated the “easily ascertainable” requirement, enunciated by the Court of Appeals in *Kurylowicz v State Farm*, 67 Mich App 568, 242 NW2d 530 (1976), in which insurers were under a duty to verify that information contained in an insurance application which was “easily ascertainable.” In *Bazzi*, the Court of Appeals ruled that the “easily ascertainable” rule and the “innocent third party” rule were essentially one and the same, as both rules had their roots in *Kurylowicz*, *supra*, and *Ohio Farmers Ins Co v Michigan Mut’l Ins Co*, 179 Mich App 355, 455, NW2d 228 (1989) – both of which were overruled by the Michigan Supreme Court in *Hyten*. Given this holding, the Court of

Appeals remanded the matter back to the Wayne County Circuit Court in order to allow Sentinel Insurance Company to establish proper grounds for rescission of its policy. Implicit in the Court’s ruling, of course, was that the injured Claimant, Ali Bazzi, would have an alternative source of recovery of his PIP benefits – Citizens Insurance Company, as assignee of the Michigan Assigned Claims Plan, the “insurer of last resort.”

Following the release of the *Bazzi* decision, the Court of Appeals issued a series of Opinions, both published and unpublished, applying *Bazzi* in a number of different factual circumstances. In some cases, members of the particular Court of Appeals’ panel deciding the case were critical of the Court of Appeals’ decision in *Bazzi*, but pursuant to MCR 7.215, the panel was obligated to follow that controlling legal authority. See e.g., *State Farm v Michigan Municipal Risk Mgmt Authority*, 317 Mich App 97, 892 NW2d 451 (2016) (Murphy, J. concurring), lv app pending 894 NW2d 595 (2017); *SE Michigan Surgical Hosp v Allstate Ins Co*, 316 Mich App 657, 892 NW2d 434 (2016), lv app pending 894 NW2d 591 (2017).

On May 17, 2017, the Michigan Supreme Court granted Plaintiff’s Application for Leave to Appeal in *Bazzi*. After extensive briefing by both the parties and numerous *amicae*, the Michigan Supreme Court entered oral argument on Thursday, January 11, 2018. The author was present during oral argument, and it was clear that the court was struggling with the ramifications of rescinding an insurance policy completely, and what recourse the “innocent third party” would have in the event of such rescission. There are many types of “innocent third parties” and, in *Bazzi*, the injured party was actually the son of the insured who perpetrated the fraud upon Sentinel Insurance Company. Therefore, because Mr. Bazzi certainly had the use of the insured vehicle for a period of time greater than 30 days, Justice Wilder questioned whether or not he would be an “owner” of that vehicle, and therefore not truly an “innocent third party.”

There are, of course, situations where there are true “innocent third parties”; i.e., motorcyclists who claim benefits from the insurer of the owner of the motor vehicle involved in the accident under MCL 500.3114(5), occupants of motor vehicles who do not have insurance of their own in their house-

hold, and therefore claim benefits under MCL 500.3114(4) and non-occupants of motor vehicles who likewise do not have insurance available to them in their households, and who therefore obtain their benefits pursuant to MCL 500.3115(1). It has been this author's experience that those "innocent third party" situations arise somewhat more frequently than cases involving family members, and hopefully the Supreme Court will not lose sight of the broader issue involved in the case; namely, how an insurer's decision to rescind a policy affects the interests of those "innocent third parties" who are actually "innocent third parties"!

More importantly, the Court seemed genuinely troubled regarding the timing of any rescission action. Justice Bernstein posited a situation in which he was a passenger in Justice McCormick's vehicle and, as a result of injuries suffered in a motor vehicle accident, Justice McCormick's nofault insurer paid his PIP benefits for a number of years pursuant to MCL 500.3114(4). Suddenly Justice McCormick's insurer discovers that Justice McCormick committed fraud in the insurance application, and attempts to rescind coverage even as to Justice Bernstein's claims. Justice Bernstein asked whether he would be without a remedy, as it was his understanding that he would have had one year from the date of loss to place the next highest priority insurer (the Michigan Assigned Claims Plan) on notice of his claim. In fact, the Court of Appeals addressed this very issue in *SE Michigan Surgical Hosp, supra*, where Allstate Insurance Company did not rescind coverage until more than one year after the loss occurred.

In response, counsel for Sentinel Insurance Company argued that where the MACP is the next highest order of priority, it does not have to be notified of a claim within one year of the date of loss, contrary to the Court of Appeals' holding in *Spencer v Citizens Ins Co*, 239 Mich App 291, 608 NW2d

113 (2000). Rather, counsel took the position that, pursuant to MCL 500.3174, the MACP only needs to be given notice of a claim "within the time that would have been allowed for filing an action for personal protection insurance benefits if identifiable coverage applicable to the claim had been in effect." Turning to MCL 500.3145(1), counsel for Sentinel Insurance Company argued that the time "for filing an action for personal protection insurance benefits" is "one year after the most recent allowable expense, work loss, or survivor's loss has been incurred" – commonly referred to as the "One-Year-Back Rule." In other words, the MACP need not be given notice of a claim within one year from the date of loss. Instead, so long as notice is given "within one year after the most recent allowable expense, work loss or survivor's loss has been incurred," that will suffice. Although the author is not familiar with the timing of Sentinel Insurance Company's rescission action, the author suspects that Sentinel opted to rescind coverage more than one year after the accident, thereby forcing Sentinel Insurance Company to adopt what is essentially a tolling argument, regarding notice to the MACP.

However, the MACP is not always the insurer occupying the next highest order of priority in rescission cases. Take the case of John, a motorcyclist who is involved in a motor vehicle accident with Sue as the owner, registrant and operator of the involved motor vehicle. John would normally obtain his nofault benefits through Sue's insurer, pursuant to MCL 500.3114(5). Imagine that Sue's insurer pays John's claims for over a year, but suddenly discovers fraud in Sue's insurance application. John owns a motor vehicle himself, but he does not put his own motor vehicle insurer on notice of his claim, because he reasonably relies on the fact that Sue's insurance company paid his nofault benefits for over a year. Is notice to one insurer notice to all potential insurers in the chain of priority? According to *Titan Ins Co v North Pointe Ins Co*, 270 Mich App 339, 715 NW2d 324 (2006), the answer is no. Therefore, if the Supreme Court is inclined to adopt Sentinel's reasoning, with regard to notice to the MACP, it should also consider how its ruling would affect cases where the MACP is not the insurer in the next order of priority.

Frankly, the author is not good at reading the proverbial "tea leaves," when it comes to predicting what the Supreme Court may do on any given case. However, it seems apparent that the Court could adopt one of the following positions. First, it could uphold the insurer's right to rescind coverage, even as to "innocent third parties," and determine that the next insurer in the order of priority (including the MACP) would then be obligated to pick up the benefits, regardless of the timing of the rescission action. As a general proposition, there are sound public policy considerations that weigh in favor of this approach. After all, why should an insurance company be forced to pay out potentially millions of dollars



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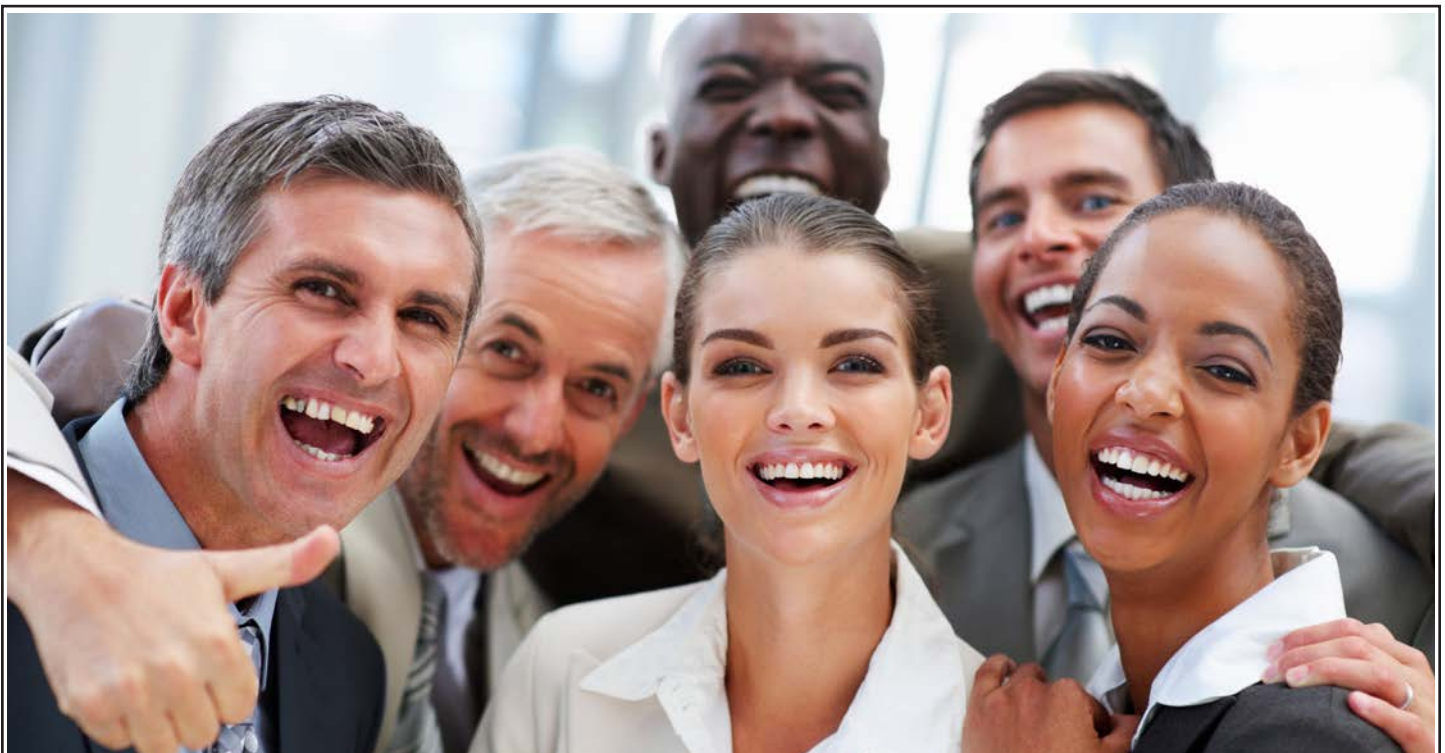
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on a claim for an “innocent third party” pursuant to an insurance contract that never would have been issued had the insured not perpetrated a fraud upon the insurance company? Furthermore, if proper notice has been given to the highest priority insurer, which subsequently rescinds coverage for the loss, the next highest priority insurer would simply obtain the rescinding insurer’s claim file materials, and pick up the claim where the rescinding insurer left off. Why should it matter whether the next highest priority insurer (or the MACP) received notice of the claim within one year from the date of loss, as it would essentially be “stepping into the shoes” of the rescinding insurer, and presumably would be paying the claim just as the rescinding insurer had been paying the claim.

Second, the Supreme Court could uphold the insurer’s right to rescind coverage, even as to an “innocent third party” but limit the rescinding insurer’s ability to rescind coverage to one year from the date of loss, in order for the rescinding insurer to notify the “innocent third party” of the next highest priority insurer or the MACP. Essentially, an insurer would be estopped from rescinding coverage as to an “innocent third party” if the rescission action occurs more than one year post accident. This “middle ground” approach has some appeal, as it still allows an insurer to rescind the policy but, at the same time, it protects the interests of the “innocent third

party” by still allowing them to pursue their claims for nofault benefits with other insurers in the chain of priority, and would not do violence to the one-year-notice provision set forth in MCL 500.3145(1).

Third, the Supreme Court could reverse the Court of Appeals’ decision in *Bazzi* and essentially return the state of the law to where it existed prior to 2012. By reaffirming the “Innocent Third Party” Doctrine, the Supreme Court would certainly be protecting the rights of the “innocent third parties” to recover benefits (a point which no one should seriously dispute), and would also provide a semblance of certainty regarding payment of those benefits. However, it would undoubtedly encourage fraud on the part of insurance applicants and policyholders, and would saddle insurance companies with the potential of paying millions of dollars in claims to “innocent third parties” under an insurance policy which, if the true state of affairs had been made known, would never have been issued. In this writer’s opinion, perhaps the “middle ground” approach, referenced above, would be the best way to resolve the conflicting interests of the defrauded insurer while, at the same time, ensuring that those individuals who are truly “innocent third parties” still have adequate resources to their PIP benefits. Either way, a decision is expected from the Supreme Court by the close of its term on July 31, 2018. ■



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ERISA Decisions of Interest

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Sixth Circuit Update

Plan Allowed Offset for “Other Income Benefits,”
 Permitting Insurer to Offset from Plan Benefits Earnings
 Claimant Made as a Consultant

Barber v Lincoln Nat'l Life Insurance Co.,
 (6th Cir, Jan. 23, 2018),
 Case No. 17-5588, 2018 WL 509318

The plaintiff was a trial attorney insured under a plan that provided monthly disability benefits for insureds who cannot “perform one or more of the Main Duties of his or her Specialty in the Practice of Law on a full-time basis.” He applied for, and was granted, benefits based on Parkinson’s disease. He thereafter began working as an independent contractor for a political campaign. The Plan deducted the earnings he made from that activity from his monthly benefits under a plan provision that allows deductions for “Other Income Benefits,” which includes “Earnings” that are defined as “pay the Insured Employee earns or receives from any occupation or form of employment, as reported for federal income tax purposes.” The plaintiff filed a class action challenging the insurer’s deduction. The district court dismissed the action for failure to state and claim, and for failing to exhaust administrative remedies.

The Sixth Circuit affirmed, rejecting the insured’s argument that the insurer’s “inherent conflict of interest” in deciding and paying claims meant its decision was not entitled to deference. The court explained that the insured “effectively asks this court to overlook language in the Other Income Benefits section” and, “[g]iven the policy’s clear language, we cannot.”

The Sixth Circuit also rejected the insured’s argument that statutory violations of ERISA do not require exhaustion of administrative remedies before suing, and his breach of fiduciary duty claim therefore did not require exhaustion. The court explained that “the statutory-claims exception to the exhaustion requirement shuns ‘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.’” Because the only duty the insured alleged was violated (using tax documents to calculate the Earnings offset, as opposed to other information) could only come from the policy itself, his claim was based on the policy, not any statutory provision, and he was required to either exhaust administrative remedies or plead futility. Because he did neither, his complaint was properly dismissed.

Denial of Benefits Was Affirmed Where Claimant Failed to
 Provide “Objective Evidence” of Disability

Castor v AT & T Umbrella Benefit Plan No 3,
 (6th Cir, March 26, 2018), Case No. 17-3400

The claimant was a customer sales representative under a disability plan that gave the administrator discretion to determine benefits. She filed a claim for benefits based upon an infectious condition, which benefits were initially approved. The insurer conducted an independent file review through a physician who concluded that the “available information does not establish a functional impairment or need for restrictions that would preclude sedentary work” The insurer terminated benefits on that basis.

The insured appealed, providing additional medical records concerning only mental-health issues, which the insured had reviewed by an internist and a psychiatrist “who concluded that mental-health issues did not prevent [the insured] from performing her job.” The insurer also had the need medical records reviewed by the physician who conducted the initial file review. The insurer upheld the administrative decision. The insured filed an action, and on cross-motions the district court held that the insurer’s decision was not arbitrary or capricious.

The Sixth Circuit affirmed in a 2-1 decision. The majority held that the insurer did not fail to conduct a “full and fair” review under ERISA, rejecting the insured’s argument that the insurer improperly referred her administrative appeal to one of the physicians who did the initial review. The court held that ERISA regulations “neither affirmatively preclude an administrator from seeking additional reviews, nor preclude an administrator from asking the original doctor whether his opinion has changed in light of new medical evidence.” The majority noted that it “would be odd to suggest that a plan administrator . . . could not circle back to the initial doctor to see whether, in light of any new information, his assessment had changed.”

The court also held that the insured failed to meet the plan’s requirement that a disability “must be supported by objective Medical Evidence.” Although she had self-reported symptoms of depression and anxiety, the plan says “[m]edical evidence must be ‘objective,’” and “self-reported symptoms -- i.e., the subjective evidence [the insured] attempts to rely on now—generally will not be considered sufficient, unless accompanied by some objective evidence—an observable condition.”

Plan Arbitrarily Denied Benefits by Failing to Have Claimant Physically Examined, and Requiring Proof of Disability Through Objective Evidence

Guest-Marcotte v. Life Insurance Co. of N. America,
(6th Cir., March 30, 2018),
Case No. 17-1233, 2018 WL 1578090

The plaintiff suffered from Ehlers-Danlos Syndrome, a hereditary disease that causes loose connective tissue and is characterized by severe pain. She filed a claim for benefits, alleging she was disabled from her occupation as a risk manager, a primarily sedentary job. She submitted medical documentation in support of her claim, which the insurer reviewed. The insurer was allowed under the plan to conduct a physical examination, but did not do so. After the insurer denied benefits, the insured sued. She moved for discovery on the question of bias, which the district court denied. On cross-motions, the district court affirmed the denial of benefits, holding that it was not unreasonable for the insurer to require proof of disability through objective evidence, and that it was not required to conduct a physical examination of the insured to make a reasoned decision.

The Sixth Circuit reversed, holding that the “decision to deny [benefits] was arbitrary and capricious because [the insurer] had the option to conduct a physical examination, yet declined to do so even though there was a clear medical

consensus that [the insured] suffered from [Ehlers-Danlos Syndrome]—a disease medically known to cause chronic and severe pain—and abundant evidence that she in fact experienced such pain.”

Moreover, the court held that it was arbitrary and capricious for the insurer to require objective proof of disability because “nowhere does the Plan specify that only proof of objectively observable limitations will suffice.” That fact distinguished this case from others in which the plans do require “objective proof.” Additionally, unlike some conditions, Ehlers-Danlos Syndrome can be verified and conclusively diagnosed, which distinguished the case from those involving, for example, fibromyalgia or chronic back pain.

Lastly, the Court affirmed the denial of discovery on the issue of bias. The plaintiff only made general accusations and allegations of bias, rather than showing a procedural irregularity that is necessary to “throw open the doors of discovery in an ERISA case.” ■

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