

# The Journal of Insurance & Indemnity Law

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## From the Chair

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Hal O. Carroll

When you read this, the “odometer” will have turned over to 2009. There will be changes in Washington, and changes in Lansing, the effects of which are unknown but likely to be significant.

The new year is always a good time to take stock of where we are and where we are headed.

First, let’s take another look at our membership. Our new section continues to grow. Last September, before dues notices went out we had 257 members. As of December, when the dues period ended, our membership has increased to 342. We continue to be geographically diverse. We have members in Illinois, Tennessee, Florida, Kansas, Ohio, Connecticut, and Missouri. We have members who are in private practice, members in government service, members employed by insurance companies, and members employed by other corporations. Some of our members have joined because they are knowledgeable in this area, and others have joined because they are new to it and want to become knowledgeable.

The growth in membership is one measure of success and shows that there is a need for our section. The question that we need to ask ourselves is how well we are meeting that need and what else we can do.

Increasing membership participation is always a primary goal for any organization. There are several avenues for interested members who want to participate.

**The Journal.** One is this publication itself. We have been fortunate to have many people submit articles for publication on a range of topics. If you have an idea for an article and want to share your knowledge with your colleagues, send it along to the editor. Remember, our *Journal* also reaches judges and selected members of the legislative and executive branches.

**Committees.** We have several committees that you can join. In addition to Programs, Insurance, and Indemnity, we have recently created a “Construction Risks Committee” and a “Legislative and Regulatory Affairs Committee.” If any of these appeal to you, please join. Or if you have an idea for a different committee for a different subspecialty, we’ll be happy to help you set it up.

**Programs.** So far, we have only had a program at our annual meeting. But if there is enough interest, we can put together other programs.

In general, please let us know what you would like your section to do more of (or less of) or differently. We have gotten off to a good start and we want to build on our successes. If you have any comments or suggestions, please contact any of the council members or officers. We are all listed on the last page of this issue. ■

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Opinions expressed herein are those  
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section council or the membership.

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**Casey on  
Coverage**

## The Number of Occurrences

By Timothy F. Casey, Kelley, Casey & Moyer PC, [tcasey@kcmlaw.com](mailto:tcasey@kcmlaw.com)

The last column dealt with determining when an “occurrence” takes place in the context of a typical general liability insurance policy. Assuming there has been an “occurrence,” a subsequent issue that can arise is determining the number of occurrences. Determining whether there was a single occurrence or multiple occurrences can affect which insurance policies may be involved and raise related questions as to policy deductibles, retentions, and limits. The potential exists for multiple occurrences within a single year or policy period, as well as a finding of occurrences taking place over multiple years.

Keep in mind that the first step is to examine the applicable policy language. Regarding this issue, that analysis can include the insuring agreement, the definition of “occurrence,” and “limits of liability” provisions.

In general, two tests have been applied by courts to determine the number of occurrences: the **effect** test and the **cause** test.

The effect test, a minority view no longer followed by Michigan courts, focuses on the resulting loss or the resulting injurious condition. This test was used by the court in *Elston-Richards Storage Company of North America v Indemnity Insurance Co of North America*.<sup>1</sup>

In *Elston-Richards*, the court determined whether damage that occurred to numerous Whirlpool appliances over a period of several months was one occurrence or multiple occurrences. The appliances were each damaged by a lift truck while being stored at the warehouse. The applicable policy language stated, under “Liability for Property,” that the insurer was obligated “[t]o pay on behalf of the insured all sums which the insured shall become obligated to pay by reason of the liability imposed by law upon him as a bailee, or loss or destruction of or damage to property of others contained in the premises . . . .”<sup>2</sup> The court concluded that the term “arising from one event or occurrence,” as found in the terms of the insurance policy, “was certainly not intended to apply collectively to events or occurrences happening many months apart.”<sup>3</sup>

The court went on to hold that, “[a]lthough the damage to each appliance may have resulted from a single cause, that is, the manner in which the clamp assembly on the lift truck was operated, the damage to each appliance was a separate accident and therefore ‘one event or occurrence’ within the meaning of those words as used in the limits-of-liability provision of the defendant’s policy.”<sup>4</sup> The court held that injury to each of the 4,000 appliances arose from a separate event or occurrence, so

that the \$2,500 deductible applied to each damaged appliance, and since the damage to each appliance was less than \$2,500, there was no coverage.

The Sixth Circuit subsequently noted that *Elston-Richards* was contrary to the vast majority of courts which apply the cause test, determining the number of occurrences by referring to the cause or causes of the damage and not to the number of injuries or claims. See *Michigan Chemical Corp v American Home Assurance Co*<sup>5</sup> (decided under Illinois law). In that case, the court held that each shipment of contaminated livestock feed, rather than each resulting injury, constituted an occurrence.

In the more recent case of *Dow Chemical Company v Associated Indemnity Corp*,<sup>6</sup> where Dow faced product liability claims, the court also rejected the effect test relied on in *Elston-Richards*, adopting the causation test instead, focusing on the causal connection between the injurious event and the resulting harm. The *Dow* court distinguished the policy language in *Elston-Richards*, concluding that the language, “tends to gloss over the distinction between the factual cause of damage and the legal cause of liability.”<sup>7</sup>

The court also concluded that “[i]n *Michigan Chemical*, the Sixth Circuit cited substantial authority for the proposition that an ‘occurrence,’ for the purpose of applying coverage limitations, is determined by reference to the cause or causes of the damage and not to the number of injuries or claims.”<sup>8</sup> The court discussed two approaches to the causation test. The first approach of the causation test treats an event as the common cause of multiple injuries only when it is the “proximate, uninterrupted, and continuous cause of the injuries.”<sup>9</sup> The second approach focuses more on “the underlying circumstances that result in the claims for damages.”<sup>10</sup> The court ultimately held that each separate damaged building constituted a separate occurrence within the meaning of the applicable policies. See also *Associated Indemnity Corp v Dow Chemical Co*,<sup>11</sup> finding that multiple damages resulting from an inherently defective product resulted from a single cause.

The causation test also has been applied by Michigan state courts. In *Walker v Allstate Insurance Company*,<sup>12</sup> the court applied the test where an insured sought to recover damages after being struck by two separate vehicles when crossing the street. The applicable policy language stated, “‘each accident’ is the maximum that we will pay for damages arising out of bodily injury to two or more persons in any one motor vehicle accident.”<sup>13</sup> The court found that in order to be more than one

accident, the causes of damage must be distinguishable and that in this instance, “[t]he second impact flowed naturally from the first and occurred well before plaintiff reached safety. Therefore, there was one indivisible event and a single ‘accident’ for contract purposes.”<sup>14</sup>

In summary, it seems clear that Michigan courts will apply the “cause” test for determining the number of occurrences, but application of that test still is dependent upon the underlying facts; for example, whether an inherently defective product is the sole cause of product liability claims or whether other causes also exist. A finding of single or multiple occurrences can have significant consequences, particularly regarding deductibles, self-insured retentions, and “per occurrence” and “aggregate” policy limits. Determining the number of occurrences thus potentially can affect multiple carriers and policies, as well as the policyholder. ■

*The views expressed in this article are those of the author and do not necessarily represent the views of the author’s law firm or its clients and do not constitute legal advice as to any particular matter.*

## Endnotes

- 1 194 F Supp 673 (WD Mich 1960), aff’d per curiam, 291 F2d 627 (6<sup>th</sup> Cir 1961).
- 2 *Id.* at 673.
- 3 *Id.* at 682.
- 4 *Id.*
- 5 728 F2d 374 (6<sup>th</sup> Cir 1984).
- 6 727 F Supp 1524 (ED Mich 1989).
- 7 *Id.* at 1528.
- 8 *Id.* at 1529.
- 9 *Id.*
- 10 *Id.*
- 11 814 F. Supp. 613 (1993).
- 12 2006 WL 1044239 (Mich App).
- 13 *Id.* at 1.
- 14 *Id.* at 2.

## Alternative Markets for Risk Financing—An Introduction

By Zachary Fryer, Krolkowski, Capelli & Fryer, PLLC, zach@thegoodfirm.com



Zachary Fryer

The “alternative risk financing” market has become a large portion of the overall total market for various insuring mechanisms. As discussed in the preceding issue of the *Journal of Insurance and Indemnity Law*, Michigan passed special legislation in 2008 to allow the formation of a range of specialized insurers commonly referred to as “captive insurers.” Such captive insurance companies are a relatively common and important component of the alternative risk financing market.

This introductory article will define certain basic concepts in the realm of alternative risk financing, provide a general introduction to the area, and serve as a background for the discussion of future topics.

### Alternative risk financing defined

In general, alternative risk financing is any mechanism other than conventional, commercial insurance for funding a liability that otherwise could be insured. It is also called

alternative risk transfer and sometimes referred to by the acronym “ART.” Alternative risk financing includes a variety of self-insurance mechanisms, some of them involving trusts; all forms of captive insurance; rent-a-captive arrangements; catastrophe bonds; and other uncommon arrangements for guarding against these types of liabilities.

### Captive Insurance

Generally speaking, captive insurance is an arrangement where the insurance is provided by an insurance company that is incorporated (or otherwise formed as a discrete legal entity) and holds an insurance license in its domicile, but which is controlled by one or more of its major insureds, and is not offering insurance to the general public. Captive insurers are commonly formed under separate chapters of their domicile’s insurance laws that are intended specifically for captives, and are concentrated in a small number of domiciles that have sought to make their laws and regulatory environment attractive to the formation and operation of captives. However, there also

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exist some companies that would generally be considered captives but which are formed as ordinary insurers in domiciles without captive-specific laws.

**Benefits of captive insurance**

The major benefits that captive insurance may provide, in comparison to commercial insurance, are availability, greater control, greater stability, and lower cost. The last of these—

cost—is often viewed as the most important benefit by those outside the industry or those looking at captive insurance for the first time, but in many cases it is neither the most significant nor most important difference between a captive insurance arrangement and a commercial alternative.

The first benefit of a captive—availability—is a common driver of captive formation in “hard markets,” meaning insurance market conditions in which carriers are tightening their underwriting standards, raising premiums, and limiting the total amount of coverage that they will write. In “hard” markets, many major insureds, such as hospitals, may find it difficult to obtain insurance at any price, or may only be offered insurance from carriers with less than ideal financial stability. As a result, substantial numbers of captive formations are common when hard market conditions exist, as shown by the surge in formations in the early part of this decade, following the September 11, 2001 terrorist attacks and other factors that caused commercial carriers to reduce their offerings.

Control is a second major benefit of captive programs. When a major insured purchases insurance from a commercial carrier, it is often subject to the carrier’s own determinations of how to defend claims, including the selection of specific defense counsel and decisions of which cases to settle, which may be based on pragmatic financial considerations rather than on actual defensibility of a claim. Many large insureds are extremely sophisticated in their risk management practices, typically with one or more full-time, in-house risk managers, and believe that they can make better decisions in their claims handling and other insurance-related affairs. In particular, some insureds may want to defend claims where they believe they fully met the standard of care, even though a cash settlement might cost significantly less than fully defending the claim. This approach is often taken in order to prevent the company from becoming a known “soft target” for plaintiffs, which is presumed to invite additional claims of dubious merit.

Greater stability is a benefit that goes along with availability. Larger insureds and those with better risk profiles may be able to continue buying commercial insurance even through hard market conditions, but find that premiums increase

dramatically, in some cases literally doubling from one year to the next, as a result of such conditions. By retaining their risk in a captive, the premiums will be driven largely by actuarial analysis, based on both their own risks and the broader market, and by their own operating costs. While this typically does not make the captive completely immune to market conditions, it can greatly reduce the effects and therefore greatly reduce the swings in premium cost.

Finally, lower total cost is another potential benefit of a captive insurer. It is important to note that the captive must have the funds available to pay all legitimate claims, and accordingly its premiums will, over time, equal the total payments on losses plus the captive’s operating expenses. Since the captive is created to benefit its insureds rather than to generate profits for unrelated investors, it is not necessary for the captive to generate profits or shareholder dividends. It is, however, necessary for the captive to have sufficient capital and surplus that it can pay all claims, so its premiums will be set at a level that allows a cushion in excess of the actuarially predicted expected value<sup>1</sup> of the claims for an underwriting year. On a long-term basis, a captive should provide coverage for lower cost than a commercial carrier if its insureds have a risk profile that is the same or better (lower risk) than the overall market for that type of coverage, and the captive controls its costs to the same or lower, as a proportion of premium, as the commercial carriers writing that line of coverage. A captive will not necessarily provide coverage at lower cost than commercial during its first years of operation when it is building a surplus and may have greater operating costs as a result of being a start-up company.

**Typical users of captive insurance**

Since captive insurance, by definition, requires the formation of a dedicated insurance company to cover a discrete set of risks, it is clearly not suitable for every person or entity seeking insurance. In general, captives are not used to cover risks of individuals, but only risks of significant businesses. To be successful and financially practical, a captive insurer must have risks that are sufficiently predictable that the required insurance premiums can be established with a high degree of certainty. The law of large numbers governs insurance premium calculations, and provides that the expected payouts for covering a certain risk become more predictable, in total, as the number of risk exposures increase. Because of this, captives work best when the number of risk exposures is substantial—whether those exposures are constituted by the number of insureds, or by the frequency of an activity conducted by an insured that

creates a discrete risk for each time it is conducted.

Put simply, captives work best when either the insureds have numerous discrete risks, such as in a manufacturing or hospital setting (where each product or patient, respectively, represents an insurable risk), or when the number of participants in the captive is substantial. In the latter case, almost any area of commerce that requires insurance could potentially use a group captive, although the frictional costs of using a captive may exceed the benefits if the annual premiums are not well into the five-figure range.

### Regulatory issues

As its name implies, captive insurance is a form of insurance. However, this tautology disguises the fact that there are several differing ways to define insurance, depending on the context, and in some cases an arrangement may be captive insurance in the sense used in the commercial insurance industry, but not be deemed insurance for specific regulatory purposes, or for tax purposes.

In all prominent jurisdictions, a captive insurer must hold an insurance license in its domicile in order to operate. As noted above, many jurisdictions offer separate statutes for captive insurers that provide more flexible regulation. Common features of captive-specific statutes include lower capital requirements than apply to commercial insurers; fewer detailed mandates in the statutes, in place of which is the requirement for each captive to file a detailed business plan and operate only in accordance with that document; and fewer investment restrictions than apply to commercial insurers. In addition, most prominent captive domiciles have a separate office or dedicated personnel who work only with captives within the agency that regulates insurance.

In the United States, insurance is regulated on a state-by-state basis, subject to limited federal intrusions. Accordingly, an insurer that is licensed in one state cannot necessarily operate within another state without meeting that state's own regulatory requirements. For commercial insurers, a framework established by the National Association of Insurance Commissioners and adopted by each state allows a commercial insurer to operate in other states by making certain filings and payments, and complying with NAIC standards. No comparable framework exists for most captive insurers, so that in many cases a captive (other than an RRG, described below), is limited to operating within its domicile state. As a result, many captives operate as reinsurers of commercial companies that have the direct relationship with the ultimate insureds. This arrangement is often referred to as "fronting."

### The Liability Risk Retention Act

A federal law, the Liability Risk Retention Act of 1986<sup>2</sup> (the "LRRRA"), allows for the creation and operation of two specialized insurance-related entities. These entities are risk

retention groups, a form of insurer, and risk purchasing groups, a group purchasing mechanism. For each of those, the entity will actually be formed as a corporation or other legal entity under the laws of a selected U.S. state, but if structured to meet certain definitions under the LRRRA, it will be entitled to the benefit of federal preemption of a wide range of state laws that might otherwise prohibit its operation or reduce its potential benefits.

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Risk purchasing groups are useful for arranging group insurance programs to cover unrelated entities with similar insurance risks; for instance, a purchasing group might be created . . .

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### Risk retention groups

A risk retention group, or RRG, is a special type of insurer that is formed under state law, but is provided a number of special benefits, including an exemption from most insurance laws of states other than its domicile, by virtue of the LRRRA. The RRG must hold an insurance license in its domicile, but on the basis of that license it may offer coverage in all other states after making a simple registration filing with each state in which it intends to operate.

Many RRGs look and function like captive insurers, while other RRGs more closely resemble commercial insurers. RRGs may only write liability insurance, excluding personal lines and workers' compensation. There have been some proposals in recent years to allow RRGs to insure commercial property risks, but to date no such changes have been enacted.

RRGs also may insure only their members, all of whom must be insureds of the RRG, and their membership must have some relationship in the type of liability risk to which they are exposed, by virtue of "any related, similar, or common business, trade, product, services, premises, or operations."<sup>3</sup> As a result, most RRGs are oriented towards a particular type of industry, such as manufacturing or health care, while some RRGs may instead be focused on a single large insurable risk, such as a hospital, and incidentally insure related risks such as joint ventures with that hospital and physicians on that hospital's medical staff. The intent of these requirements is to ensure that RRGs function like mutual insurers, to provide a benefit for the members and to use all profits either in furthering the RRG's operations or by returning them to the members. RRGs are not intended to be formed and operated as commercial insurers with pure investors seeking a return on capital.

An insurer that meets the criteria to qualify as an RRG obtains the benefit, through federal preemption under the terms of the LRRRA, of being able to operate in all states with only a simple notice filing to the relevant insurance

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commissioner, with only its state of domicile having the power to comprehensively regulate it.<sup>4</sup> This is an enormous benefit in comparison to other captives which, as noted above, are generally unable to operate outside of their domicile.

**Comparison of captives and RRGs**

Captive insurers and RRGs are not inherently the same entities, but there are many insurance entities that fit within both categories. A captive is an insurer that serves a specific purpose for one or more of its insureds, and generally has a limited number of owners (often only one). In contrast, an RRG is any insurance entity that qualifies as an RRG under the definitions of the Liability Risk Retention Act. The requirements of that Act prohibit an RRG from excluding members solely for competitive reasons, so to some extent an RRG would be available to insure parties other than those it had originally been formed to insure. (However, in practice, the extension of coverage to members other than those originally intended is often very limited due to underwriting considerations.)

An RRG can be formed and operated much like a captive insurer, and in fact, many RRGs are formed under the captive-specific laws of states like Vermont and Hawaii that have enacted such laws. However, RRGs can in most states also be formed under the general insurance company laws, and a significant number of RRGs more closely resemble commercial insurers in having hundreds of insureds and members, rather than being operated only for a small, selected group.

A captive that is not an RRG has much greater flexibility in its operations. For instance, it can insure entities that are not members or owners of the captive; it can exclude insureds for competitive business reasons; subject to the requirements of its insurance license, it can insure property risks, workers' compensation,<sup>5</sup> and potentially even employee benefits.<sup>6</sup>

**Risk Purchasing Groups**

A risk purchasing group or purchasing group (occasionally, though not generally, referred to as an RPG) is another type of entity that is formed under state law but obtains certain benefits under the LRRRA. As the name implies, a risk purchasing group is formed for the purpose of group purchasing of insurance. The group members must have some relationship in the type of liability risk to which they are exposed, and the group must purchase group liability insurance only for its members. It is important to note that a purchasing group is not a risk-bearing entity, but rather simply a pass-through purchasing organization for the purpose of purchasing insurance.

Risk purchasing groups also receive the benefit of federal

preemption under the LRRRA, although this preemption is much narrower in scope compared to that afforded RRGs. A purchasing group is exempt from any state laws that would prohibit its establishment or operation, the offering of a discount to the group by insurers, or certain other specified prohibitions and roadblocks that might exist in state law.<sup>7</sup> This is a significant benefit, but it does not broadly preempt state laws that might be inconvenient, such as laws limiting the types of insurers that may be used.<sup>8</sup>

Risk purchasing groups are useful for arranging group insurance programs to cover unrelated entities with similar insurance risks; for instance, a purchasing group might be created to provide a comprehensive liability insurance program to auto repair shops, or equestrian facilities, and one major commercial insurer might be selected to underwrite its program on terms more favorable than that insurer would offer to each individual entity.

**Common domiciles for captive insurers (or, "Why do I always hear about sunny tropical islands when captive insurance is discussed?")**

Two of the largest and oldest captive insurance domiciles are Bermuda and the Cayman Islands, both of which are island nations in warm regions.<sup>9</sup> Bermuda and Cayman have enviable positions in the captive insurance market as the first and second leading domiciles worldwide, with over 1,000 and 700 captives respectively. Notably, other prominent domiciles include the not-so-tropical locales of Vermont (with over 500 captives) and Guernsey. Hawaii is also notable as the second-largest U.S. captive domicile, after Vermont.

All of these major captive domiciles have established their positions through enacting pro-captive-insurance legislation, creating a positive and stable regulatory environment, and being relatively early entrants to the field of captive insurance domiciles.

The most successful captive domiciles, such as Bermuda, the Cayman Islands, and Vermont, have several key features in common: a specific statute pertaining to captives and regulating them differently, and more flexibly, than other insurers; a stable and pro-business regulatory environment, which typically implements and interprets the captive insurance statute in a flexible manner; and a base of service providers in the necessary fields, particularly accounting (for auditing) and banking.

More and more U.S. states have taken an interest in captive insurance in recent years, with South Carolina, Nevada, Arizona, and the District of Columbia having become significant captive domiciles since 2000.

### Rent-a-captives

One subset of the field of captive insurance is the intriguingly named “rent-a-captive.” While these exist in varying forms, they typically comprise an insurance vehicle domiciled in one of the prominent captive domiciles, onshore or offshore, and created by investors for the purpose of selling the ability to use its corporate structure and insurance license to insureds that are interested in some aspects of a captive insurance structure but which have not formed their own stand-alone captive, typically due to cost or time and management commitment considerations. Many rent-a-captives are structured as segregated cell companies, in which one corporate structure exists over a number of separate “cells” which are legally insulated from each other’s cell’s liabilities.

### Self-Insurance arrangements

The field of alternative risk transfer also includes a range of self-insurance mechanisms. Self-insurance can, in one sense, be as simple as failing to purchase insurance and therefore having to pay any legal liabilities or losses out of general assets. However, this approach is generally not viewed as being self-insurance in the Alternative Risk Transfer sense. Instead, self-insurance as used by sophisticated organizations generally involves regular, careful analysis of the loss exposure and the loss cost likely to be incurred annually, and setting aside funds for such losses. In some simple cases, the set-aside funds may be in just another bank account of the organization, but in many cases, particularly for workers’ compensation self-insurance (in states where it is permitted) and for professional liability self-insurance for hospitals, the funds will be set aside in a self-insurance trust, which is established by a written trust agreement, with an independent trustee.

For some organizations, this sort of formalized self-insurance can be a valuable yet simple tool for financing their risks, with minimal overhead cost. In many cases, the self-insurance arrangement is established to pay losses up to a certain limit, and commercial excess insurance is purchased to cover losses above that limit. This approach works particularly well when there are a large number of relatively small losses, such that commercial coverage would result in “trading dollars” —i.e., paying premiums for limits that were virtually certain to be paid out during the policy year.

### Conclusion

This article attempts to provide the reader with an overview of some of the more common financial arrangements that may be used in place of conventional, commercially purchased insurance, and therefore are considered to be alternative risk financing. Because of the size of the field, this introduction can only provide a high-level view of the more common mechanisms and the basic features of such mechanisms. However, the reader should come away with a clear description

of the inner boundaries of alternative risk transfer, as a field, and a basic understanding of the major benefits and limitations of the most common arrangements. ■

*Zachary Fryer, a founding member of Krolikowski, Capelli & Fryer, PLLC, is a graduate of the Northwestern University School of Law and of Michigan State University. His experience includes representing captive insurance companies and their owners in a variety of insurance and self-insurance arrangements. He has worked with captives domiciled in South Carolina, Hawaii, Kentucky, Nevada, and Arizona, as well as offshore captives, segregated cell companies, and rent-a-captives domiciled in the Cayman Islands, Bermuda, and Barbados. His e-mail address is zach@thegoodfirm.com.*

### Endnotes

- 1 The amount that is statistically most likely to be paid out. On a long-term basis, the total payments from the captive should equal the actuarial expected values that were forecast. For any specific underwriting year, the payments may vary substantially either higher or lower from that value.
- 2 15 USC § 3901 et seq
- 3 See 15 U.S.C. s. 3901(a)(4)(F).
- 4 See 15 U.S.C. s. 3902(a).
- 5 Many states limit the types of insurers that can provide acceptable worker’s compensation insurance, so the utility of a captive for this coverage varies.
- 6 Most employee benefits are subject to ERISA, and significant additional requirements apply in order to use a captive insurer for such benefits.
- 7 See 15 U.S.C. s. 3903(a).
- 8 See 15 U.S.C. s. 3903(f) and 15 U.S.C. s. 3903(g).
- 9 Bermuda, contrary to many people’s perceptions, is not in the Caribbean, but rather in the Atlantic Ocean east of North Carolina. Bermuda has a cool winter.

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## Reinsurance 101 and 102

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### Introduction

Reinsurance is a contract of indemnity between insurance companies. One company, the reinsurer, agrees with another, the “cedent,” to indemnify it against a loss, which the cedent has assumed under a separate and distinct contract of insurance. Historically, there are two basic types of reinsurance, “facultative” and “treaty.”

Facultative reinsurance involves ceding part or all of the risk an individual policy to a reinsurer, while treaty reinsurance covers all, or specified classes of a reinsured’s policies, at a specified percentage. A facultative reinsurance policy transfers risks under an individual policy to the reinsurer, which has the right (faculty) to accept or reject it. A treaty reinsurance policy is automatic and binds the reinsurer to accept all risks ceded to it of a certain type or category.

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“Follow the fortunes” or “loss settlements” means that within the terms and conditions set forth in the reinsurance agreement, the reinsurer assumes the original risk in the same way as the cedent.

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A fundamental purpose of reinsurance is to permit an insurer to reduce its reserve requirement. By utilizing reinsurance, an insurer can spread the risk it undertakes over a larger number of policies, thereby reducing the amount of reserves required to maintain its business and increase its profitability. The reinsurance relationship is characterized by the mutual duty of “**utmost good faith**” and “**follow the fortunes**,” which obligate the reinsurer to indemnify the ceding insurer for all losses paid by the ceding insurer on the reinsured policy. In short, it is a commercial transaction between sophisticated companies governed by equity and utmost good faith.

### Follow the Fortunes

“Follow the fortunes” or “loss settlements” means that within the terms and conditions set forth in the reinsurance agreement, the reinsurer assumes the original risk in the same way as the cedent. Pursuant to this doctrine a reinsurer is obligated to accept the cedent’s good faith decisions on all things concerning the underlying insurance terms and claims against the underlying insured. The decisions may include coverage, compromise, tactics or capitulation. Thus, reinsurers

are responsible for the payment of a loss insured under the original policy. A reinsurer cannot second guess the good faith reinsured’s (cedent’s) decision to waive defenses to which it may be entitled.<sup>1</sup> Reinsurance contracts are considered **gentlemen’s agreements** or **honorable engagements** built on trust and confidence. Notwithstanding that the cases unequivocally hold that the doctrine extends to pre-settlement and post-settlement loss allocations, it applies only if the allocation meets the “follow the fortunes” requirements of good faith, reasonableness and within the applicable policies. Moreover, “follow the fortunes” or “follow the settlements” do not obligate the reinsurer to follow settlements that are categorically outside the scope of the original policy between the cedent and its insured.<sup>2</sup>

Because of the unique relationship between the parties and the paucity of decisional law, traditional contract interpretation and analysis is not always followed to resolve disputes. Evidence of custom and practice in the reinsurance industry is used by the courts to determine rights and obligations of the parties and to impose follow the settlements, as a matter of law. *North River Ins Co v CIGNA Re* involved a dispute for reimbursement of defense costs paid in excess of policy limits. The court held that “follow the fortunes” is an implicit agreement in every reinsurance contract, as a matter of law.<sup>3</sup> However, in *Bellefonte Reinsurance Co v Aetna Casualty & Surety Co*, the court held that the reinsurer’s obligation to follow the fortunes of the cedent did not extend beyond the stated amount in the facultative certificates.<sup>4</sup> This decision was premised on the uncontroverted evidence of the parties’ past conduct and course of dealings. Indemnity, cost and expenses were subject to the express cap in each certificate.

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Evidence of custom and practice in the reinsurance industry is used by the courts to determine rights and obligations of the parties and to impose follow the settlements, as a matter of law.

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Ignoring custom and practice, the Michigan Court of Appeals reversed the trial court and opined that “follow the fortunes” doctrine may not be read into a reinsurance contract. Absent an express provision to “follow the fortunes,” liability of the reinsurer can only be imposed by the terms of the reinsurance contract.<sup>5</sup> Relying on *Michigan Millers Mutual Ins Co v North Am Reinsurance Corp*,<sup>6</sup> the court stated

that liability for reimbursement or indemnity depends on the language in the reinsurance contract and it is not sufficient that the underlying insurer may have made payment to an insured. In Michigan, indemnity in a reinsurance contract, without a “follow the fortunes” clause, is not what the reinsured paid, but what it was legally bound under its policy to pay, by reason of the loss.

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### Declaratory Judgment Expenses

In a dispute over a reinsurance contract, are declaratory judgment expenses recoverable by the cedent? The cedent will assert that the doctrine of “follow the fortunes” requires the reinsurer to indemnify for this expense. The reinsurer will maintain that liability for declaratory judgment expense is not part of the cedent’s insurance liability and therefore is not ceded to the reinsurance contract. Also, it is not incurred as part of the claims handling process, but arises from an adversarial proceeding and it is extracontractual. In the context in which the question is raised, the answer is a resounding “No.” Declaratory judgment expense is not a risk inherently or customarily the subject of reinsurance and is incurred by a cedent as part of the administration of its own business.

However, if an ambiguity exists in the express terms of a reinsurance contract, extrinsic evidence of the parties’ intent, course of performance and custom and practice will be considered.<sup>7</sup> *Affiliated FM Ins Co v Constitution Reinsurance Corp* was remanded from the Massachusetts Supreme Judicial Court (No. 89-24111) to the trial court. The trial court jury found on special questions that *Affiliated* was entitled to recover declaratory judgment expenses. A facultative reinsurance certificate was issued by Constitution Re in 1976, based on which the jury answered “yes” to a question if the parties had a common understanding that declaratory judgment expenses would be covered under the agreement.

The decision in *Affiliated* is not instructive outside of Massachusetts because of today’s legal climate and significant changes in the reinsurance industry. Absent a specific grant of coverage for declaratory judgment expenses, the concept of “follow the fortunes” cannot create coverage where none exists.<sup>8</sup> The traditional reinsurance relationship is changing and many disputes previously arbitrated are being litigated. The venerable concepts of “utmost good faith” and “follow the fortunes” between the parties have deteriorated. One big reason is the astronomical losses engendered by toxic tort, environmental, asbestos, breast implant and terrorism claims. Also, escalating risks arising from climate change and weather-

related disasters have significantly impacted underwriting decisions.

These so-called gentlemen’s agreements secured by a handshake are a thing of the past. For example, a dispute over whether a reinsurer is liable to a cedent for approximately one million dollars in expenses over the \$150,000 limits of the facultative certificate was the subject of forum shopping under the guise of a motion to transfer from U.S. District Court in New York to California. The New York district judge denied the transfer motion based on judicial economy and based on the fact the dispute will be resolved by interpretation of the underlying contract.<sup>9</sup>

### Arbitration

On the question whether a reinsurer can compel a liquidator to arbitrate, rather than litigate, in the insolvent insurer context, *US v Fabe* provides some guidance.<sup>10</sup> The primary issue was whether a state law enacted for the purpose of regulating the business of insurance is preempted by federal law. The McCarran-Ferguson Act provides, in relevant part, “No act of Congress shall be construed to invalidate, impair or supersede any law enacted by any state for the purpose of regulating, the business of insurance, unless such act specifically relates to the business of insurance.”<sup>11</sup>

The answer under McCarran turns on whether the state statute was enacted for the purpose of regulating the business of insurance and if so, whether enforcing arbitration would invalidate, impair or supersede a state insurance law. The Sixth Circuit in *Fabe* held that insolvency provisions of a state insurance code regulate the business of insurance and prevail over the inconsistent federal statute. The U.S. Supreme Court affirmed in part and reversed in part, opining that the McCarran-Ferguson Act partially precludes application of the federal priority statute, but only to the extent that the state priority statute affects the rights and interests of policyholders.

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The venerable concepts of “utmost good faith” and “follow the fortunes” between the parties have deteriorated. One big reason is the astronomical losses engendered by toxic tort, environmental, asbestos, breast implant and terrorism claims.

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Finally, the question of the enforcement of an arbitration provision depends on the particular state statute at issue. Moreover, if there is no federal-state conflict, McCarran issues do not arise and arbitration will generally be required under the Federal Arbitration Act.<sup>12</sup> Neither Michigan<sup>13</sup> nor Massachusetts<sup>14</sup> precludes arbitration in its liquidation statutes.

Continued on next page

## Reinsurance

Continued from page 9

## Conclusion

Although reinsurance practice may be unfamiliar to most lawyers, it is premised on insurance contract law and the historical relationship discussed above. Reinsurance policies are legal instruments, the result of an arm's length commercial transaction between negotiating equals. Contract wording is the key. Leave ambiguity in the conference room and draft your indemnity provisions with clarity. It is imperative that you set out attachment points, expenses, caps, "follow the fortunes," arbitration and forum selection clauses with specificity.

Keep in mind that typical or common language in the underlying commercial general liability policy, provides, in pertinent part, "legally obligated to pay as damages because of bodily injury or property damage..." and "this insurance applies to bodily injury and property damage only if: the bodily injury and property damage is caused by an occurrence that takes place in the coverage territory." Any property casualty insurance lawyer not familiar with these words in a liability coverage dispute – Stop! Do not reread this article. This is not for you – read another article. However, for those of you who are reasonably experienced trial lawyers together with good negotiation and mediation skills, open a new page in your trial notebook. ■

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## Endnotes

- 1 *Christiana Gen Ins Corp v Great American Ins Co*, 979 F2d 268, 280 (2d Cir 1992); *International Surplus Lines Insurance v Certain Underwriters at Lloyd's*, 868 F Supp 917,920 (SD Ohio 1994); *British Intl Ins Co v Seguros La Republica*, 342 F 3d 78, 85 (2nd Cir 2003), *See also, Commercial Union Ins Co v Seven Provinces Ins Co*, 217 F 3d 33 (1<sup>st</sup> Cir 2000) – follow the fortunes doctrine also applies to a cedent's good faith decision on how to allocate a settlement involving multiple policies.
- 2 *North River Ins Co v Philadelphia Reinsurance Corp*, 831 F Supp 1132, 1142 (DNJ 1993); *Michigan Millers Mutual Ins Co v North American Reinsurance Corp*, 182 Mich App 410, 452 NW 2d 841 (1990), *American Employers Insurance Co v Swiss Reinsurance Corp*, 275 F Supp 2d 29 (D Mass 2003), *Affiliated FM Ins Co v Employers Rein Corp*, 369 F Supp 2d 217, 227 (DRI 2005), *Allstate Ins Co v American Home Assurance Co*, 837 NY S 2d 138 (2007).
- 3 *North River Ins Co v CIGNA Re*, 52 F3d 1194 (3d Cir 1995)
- 4 903 F2d 910 (2d Cir 1990); *Allendale Mut Ins Co v Excess Ins Co*, 970 F Supp 265 (SDNY 1997)
- 5 *Michigan Township Participating Plan v Federal Insurance Co*, 233 Mich App 422,592 NW 2d 760 (1999); *Rory v Continental Ins Co*, 473 Mich 457 (2005)- a fundamental tenet of our jurisprudence is that unambiguous contracts are not open to judicial construction and must be enforced as written; *Devillers v Auto Club Ins Ass'n*, 473 Mich 562 (2005)- contractual language must be enforced according to its plain meaning and cannot be judicially revised or amended to harmonize with the prevailing whims of the court. *See also, Travelers Casualty & Surety Co v Certain Underwriters at Lloyds of London*, 96 NY 2d 583 (2001), 760 NE 2d 319 (NY 2001) – New York's highest court rejected a reinsurance recovery theory of aggregating environmental contamination at 160 different sites The NY Ct of Appeals held as a matter of law that a "follow the fortunes" clause cannot override the terms of the policy
- 6 *Supra*, note 2
- 7 *Affiliated F M Ins Co v Constitution Reinsurance Co*, 416 Mass 839, 626 NE 2d 878 (1994)
- 8 See John S Butler & Robert M Merkin, *Reinsurance Law* (rev ed 1993); Otmar Schmidlin, "The Scope of Reinsurance Coverage: The Costs of Declaratory Judgments and the Problem of Punitive Damages in International Reinsurance," *Asbestos Claims* 90 (1988)
- 9 Mealey's Litigation Reports: Reinsurance, Vol 8, No 22, March 25, 1998
- 10 508 US 491 (1993), *See, e.g., Nichols v Vesta Fire Ins Corp*, 56 F Supp 2d 778 (EDKY 1999) reh'g denied; *Suter v Munich Reinsurance Co*, 223 F 3d 150 (3d Cir 2000)
- 11 15 USC §1012 (b)
- 12 9 USC §2; *See, American National Insurance Co v Everest Reinsurance Co*, 180 F Supp 2d 884 (SD Tex 2002) – demonstrating substantial deference to panel decisions in confirming the arbitral award; *Gulf Guar Life Ins Co v Connecticut Gen Life Ins Co*, 304 F 3d 476 (5<sup>th</sup> Cir 2002) – reversing a district court order removing one of the arbitrators before the arbitration hearing on the merits
- 13 MCL 5008101 et seq
- 14 MGL Ch 175 §180A et seq

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## Indemnity Law Case Note

# Comparative Fault Contractual Indemnity Agreement to be Scrutinized by Michigan Supreme Court

By Noreen L. Slank

*Collins, Einhorn, Farrell & Ulanaoff, noreen.slank@ceflawyers.com*

### The Case

*Zahn v Kroger Company of Michigan*, unpublished opinion per curiam of the Court of Appeals, Docket No. 274994 (released March 27, 2008), leave to appeal granted 755 NW2d 661 (2008)

### General outline of the case

Zahn is Appellant Cimarron's employee. He fell from scaffolding and was injured at a Kroger renovation construction site. F. H. Martin was the general contractor. Zahn sued Kroger and Martin. Kroger cross-claimed against Martin for indemnity. Martin filed a third party contractual indemnity claim against Cimarron. Martin and Kroger settled with Zahn. Only Martin's contractual indemnity case against Cimarron was tried. Only that claim is the subject of the appeal. The case was bench-tried.

### Key terms of the contract

The parties agreed that Zahn's injury arose out of Cimarron's performance of its subcontract work at the construction site. Consistent with MCL 691.991, the contract excluded indemnity if the damages arose "exclusively through the negligence of" Martin. Similar to the type of contract first discussed in *MSI Constr Managers v Corvo Iron Works*, 208 Mich App 340 (1995), the contract shifted liability only to the extent of Cimarron's comparative fault. The contract required Cimarron to indemnify Martin and Kroger:

*to the extent of the negligence attributed to such acts or omissions by the Subcontractor [Cimarron], or anyone employed by Subcontractor for whose acts any of them may be liable.*

### The Court of Appeals opinion

The trial court decided, and the Court of Appeals agreed, that Cimarron was 80 percent at fault and Martin was 20 percent at fault. The judgment ordered Cimarron to pay "80 percent of all sums" Martin paid to settle its and Kroger's liability to Zahn.

Martin failed to inspect the scaffolding and failed to take steps to make the site safe for Zahn. The Court of Appeals panel explained that Cimarron's negligence was "more active because it directed Zahn's labor and ordered him onto the

scaffolding after he protested that it was unsafe." The panel found "persuasive evidence" of Cimarron's and its employees' negligence and basically that was the end of the opinion.

There is only a footnoted hint of what has interested the Supreme Court. The Court of Appeals panel "noted" Cimarron's argument that "imposing indemnification liability against it is contrary to the statutory abolition of joint liability." But it decided that the liability the contract imposed was "several" rather than joint "in the sense that it did not exceed the percentage share of fault attributed to Cimarron by the fact finder." The panel also ruled that the abolition of joint liability doesn't apply "to contract actions like this." It found support for its holding in *Gerling Konzern v Regent of the University of Michigan*, 472 Mich 44, 51-52 (2005), writing that arguments "similar to" Cimarron's had been rejected there. Members of this section should emit a collective sigh because *Gerling Konzern* is a contribution, not an indemnity, case.

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It has not been often, in the last several decades, that our Supreme Court has tackled an indemnification case. Meanwhile, "comparative fault" indemnity agreements have become much more common, particularly in the construction industry.

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### The Supreme Court's leave grant order

The Supreme Court granted leave. It directed the parties to brief five questions:

- Whether the abolition of "joint and several liability has had any effect on the potential contractual indemnification liability of employers for injuries sustained by their employees"
- Whether *Gerling Konzern* affects the appropriate resolution of *Zahn*
- Whether a tortfeasor's settlement of an injured employee's claims "may legally be viewed as encompassing the damages attributable to the negligence of the employee's employer," where the workers compensation exclusive remedy eliminates the employer's tort liability, but the employer "has contractually assumed a duty of care owed by an indemnitee"

Continued on next page

**Indemnity Law Case Note**

Continued from page 11

- Whether, despite the workers compensation exclusive remedy provision, the third party defendant employer “voluntarily subjected itself to liability for the payment to its employee of damages attributable to its own negligence by entering into the indemnification agreement”
- “Whether a contractual indemnification clause limiting the indemnitor’s liability to the indemnitee’s duties, can support an award of indemnification arising out of the settlement of a negligence claim made against the contractual indemnitee”

The Supreme Court’s leave grant order directs that the case will be argued in January, 2009.

**Conclusion**

This could be a hugely influential decision. It has not been often, in the last several decades, that our Supreme

Court has tackled an indemnification case. Meanwhile, “comparative fault” indemnity agreements have become much more common, particularly in the construction industry. It is very typical that the indemnity liability rolls downhill to the injured plaintiff’s employer. If such contracts are to be tort reformed or if the workers compensation exclusive remedy provision impairs the ability to secure indemnity, “the times they are a-changin’.” And settlements have long confounded predictability in indemnity litigation. Consider *St Luke’s Hospital v Giertz*, 458 Mich 448 (1998) (common law indemnity), *Grand Trunk Western Railroad v Auto Warehousing*, 262 Mich App 345 (2004) (contractual indemnity) overruling in part *Ford v Clark*, 87 Mich App 270 (1978). Clarity on the settlement issue may finally prove more important to the industries that rely on indemnity contracts than how the court actually answers the question. ■

**Insurance  
Case  
Summary**

## Significant Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell & Ulanaoff*, [deborah.hebert@ceflawyers.com](mailto:deborah.hebert@ceflawyers.com) and Adam B. Kutinsky, *Kitch Drutchas Wagner Valitutti & Sherbrook*, [adam.kutinsky@kitch.com](mailto:adam.kutinsky@kitch.com)

### Michigan Supreme Court

60-day vacancy exclusion in property insurance policy

*Ellis v Farm Bureau Ins Co*

Supreme Court Case No. 136069; 1008 Mich LEXIS 2135

Farm Bureau insured residential rental property damaged in a fire. Its policy excluded coverage if the property was vacant or unoccupied for more than 60 consecutive days. Both the trial court and the Court of Appeals (Docket No. 275240) held that the exclusion did not apply because the property was undergoing renovations at the time, a fact known to the agent. On December 3, 2008, the Supreme Court heard arguments on whether to grant Farm Bureau’s application for leave to appeal. The parties were directed to address the proper interpretation of the exclusion and also whether there the exclusion violated the Consumer Protection Act.

### Michigan Court of Appeals Opinions—Published

Insurers need not show actual prejudice where the insured violates the “take no action” or “voluntary payment” provisions of a liability policy

*Tenneco, Inc v Amerisure Mut Ins Co*

\_\_\_ Mich App \_\_\_ (2008); 2008 Mich. App. LEXIS 2144 (Docket No. 262385)

Plaintiff insured was an auto parts company involved in various environmental cleanup proceedings across the country. While initially notifying its insurer in the 1980’s and 1990’s of “occurrences” involving these contaminated sites, it never provided notice of any of the EPA suits. The insured eventually entered into consent judgments for remediation and then sought coverage from defendant liability insurer. The Court of Appeals held that the insured failed to comply with the “notice of suit” requirement in its policies, which prejudiced the insurer, who “forever lost the opportunity to contest plaintiffs’ liability, engage in settlement negotiations, or seek a judicial determination of its liability to plaintiff under the policies.” More significant, however, is the Court’s discussion of the insured’s breach of the “voluntary payment” and “take no action” provisions of the policy, which also resulted in a loss of coverage. The insurer was not required to show actual prejudice as a result of these breaches. It was enough to prove that the insured “voluntarily entered into various consent decrees and incurred extensive costs to remediate environmental contamination” without the insurer’s consent.

“This Court has found the ‘voluntary payment’ and ‘no action’ clauses here at issue to be clear and unambiguous and has enforced them as written without a showing of prejudice.” To require a showing of prejudice for the insured’s breach of duties unrelated to notice would be contrary to settled principles of contract interpretation.

Reformation of optional coverages under no-fault policy

*Manier v MIC General Ins Corp*

\_\_\_ Mich \_\_\_ (2008); 2008 Mich. App. LEXIS 2253

Two minor children were injured in an auto accident while occupying a vehicle owned by their father and their grandmother, and driven by their father’s girlfriend. The father had falsely informed the no-fault insurer that he resided with the grandmother. He actually resided with his children and his girlfriend in another city. MIC paid the children’s PIP benefits but reformed the policy so that it reflected the father’s correct address. Because of the policy’s household exclusion, this reformation effectively reduced the girlfriend’s liability coverage to the \$20,000/\$40,000 mandatory minimums required by statute rather than the \$100,000/\$300,000 afforded by the policy. The father challenged the reformation, but the Court of Appeals held: (1) insurers do not have a duty to investigate or verify representations made by the insured on the insurance application; (2) the “innocent third party” doctrine does not prevent an insurer from reducing optional coverages to the mandatory minimums where the insured has obtained the policy through misrepresentation; and (3) the financial responsibility act, MCL 257.501, does not limit the insurer’s reformation of a policy to the minimum mandatory limits.

### Court of Appeals unpublished opinions

Coverage owed under homeowner’s policy for bar fight claim

*Sarkis v Cincinnati Ins Co*

November 13, 2008 (Docket No. 280860)

The insureds (a husband and wife) were involved in a physical altercation with another couple while dancing at a nightclub. They were later sued by way of a complaint that described intentional misconduct only. Their homeowner’s insurer denied coverage due to the lack of an “occurrence.” At deposition, however, the wife described the encounter as more accidental in nature. In the ensuing declaratory judgment action, the Court agreed that “on the face of the complaint, plaintiff’s injuries were not the result of an ‘accident,’ and defendant would have no duty to defend . . . . However, looking beyond the allegations, as we must, [the] deposition testimony raises—perhaps only barely—enough of a factual question whether coverage is arguable for summary disposition to be inappropriate.”

Arson not within scope of vandalism exclusion in fire policy

*Johnson v State Farm Fire & Casualty Co*

October 28, 2008 (Docket No. 278267)

The insured’s vacant rental home was damaged in a fire caused by arson. Although the insured was not linked to the fire, his property insurer denied coverage under an exclusion for losses caused by “vandalism and malicious mischief...if the dwelling had been vacant for more than 30 consecutive days before the loss.” Although the dwelling was vacant for the required 30+ days, both the trial and the appellate courts held that the exclusion did not extend to damage caused by arson. The Court of Appeals read the policy as a whole and applied the contract interpretation principle that “Courts must... give effect to every word, phrase, and clause in a contract and avoid an interpretation that would render any part of the contract surplusage or nugatory.” Because fire and vandalism were listed as separate perils and were treated differently in the policy, the Court determined that arson was a separate peril not contemplated by the exclusion for vandalism and malicious mischief and therefore, not an excluded peril.

Innocent co-insured doctrine not necessarily applicable in corporate context

*DKE, Inc v Secura Insurance Co.*

September 16, 2008 (Docket No. 278032)

Plaintiff corporation owned a commercial building insured by the defendant. The building was entrusted to the son of plaintiff’s only shareholder, and there was evidence that the son “had a very involved managerial role in plaintiff’s day-to-day operations with little or no oversight.” After determining that the son was involved in the arson, the insurer denied coverage based on the dishonest or criminal act exclusion in the policy. Plaintiff’s sole shareholder countered with the “innocent co-insured” defense, arguing that his son’s actions could not be attributed to the company or its shareholder. But the Court of Appeals held that the doctrine does not apply where the wrongdoer is an authorized company representative having dominion and control over the company’s affairs. The case was remanded for findings on the son’s role in the company.

Court-ordered appraisal award cannot increase policy limits

*Frans v Harleysville Lake States Insurance Company*

September 23, 2008 (Docket No. 280173)

Plaintiff’s business property was damaged in a fire. The insurer was ordered by the courts to grant the insured’s request for an appraisal, which resulted in an appraisal of damages at roughly \$10,000 above policy limits. The insurer paid policy limits only. Plaintiff sought a judgment for the \$10,000 difference as well as pre-suit and statutory interest,

Continued on page 15

## The Drafting Table

# Curlicues and Gewgaws

By Hal O. Carroll, *Vandever Garzia, PC*, [hcarroll@VGpclAW.com](mailto:hcarroll@VGpclAW.com)

A curlicue is an embellishment, especially a “fancy twist or curl, such as a flourish made with a pen.” *American Heritage Dictionary*, 3<sup>rd</sup> Ed., p 458. A “gewgaw” is “a decorative trinket; a bauble.” *Id.*, p 763.

In one of his novels (*The Dean’s December*, if memory serves) Saul Bellow referred to “the high-flown illiteracy of lawyers arguing before the bench.” Bellow was not a lawyer-hater, but he did know his language, and was inclined to be harsh with those who abused it.

Your columnist once received a letter whose intent was to summarize what a judge had said at a conference in chambers the day before. The letter began: “Anent the matters adumbrated by Judge Jones in camera yesterday. . . .” It really did say that; you can’t make this stuff up. Now, nothing annoys a language nerd more than throwing a word at him that he doesn’t know. Here were two in a single sentence—“anent” and “adumbrated.” So, off to the dictionary. “Anent” means “regarding, concerning.” “Adumbrated” is a little subtler but means essentially “referred to in general terms.” So all the letter really said was “regarding what the judge talked about. . . .” Your columnist went to the thesaurus, found even more obscure words, and fired them back. Unfortunately, they are lost to memory.

Then there was a letter from the general counsel of a

company to outside counsel about an upcoming project. The letter contained this gem: “Should you require any assistance, my staff shall assist you.” What possesses someone to talk or write like that? This is a truly impressive mix of pomposity and illiteracy. Pomposity, because “should you” instead of “if” conjures images of someone looking down from a lofty height. Illiterate because “shall” is the wrong form of the verb. Simple futurity is called for, not command.

Yet, for many, this is “writing like a lawyer.”

Some of it comes from the historical nature of law. Someone once said that lawyers always walk backwards into the future steering by the past. Anyway, “lawyers’ triads” are one remnant. We say in a will “give, devise and bequeath.” In real property, the phrase “lands, tenements and hereditaments” is another example. In 12<sup>th</sup> century England, before the Norman conquerors and the native Anglo-Saxons had melded, three languages were in use: English, French, and Latin. So if one word from each language was used, then everyone could have a pretty good idea of what was going on. Doing something because we did it that way in the twelfth century may not be the best reason, but it’s not such a bad one, either.

The fault is not with the jargon. Jargon gets a bad rap, but it’s good. It’s quick and compact. The words “habeas corpus” contain pages of meaning. It’s what we do with “real” words

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that hurts. We think, why say “if,” when we have “in the event that” in our arsenal? And “before” and “after” are mere saccharine compared to “prior to” and “subsequent to.” “The payment” can’t compare to “said payment.”

Take this flourish that begins so many policy definitions: Instead of just “*Bodily injury* means . . .,” the definition intones “As used in this policy, *bodily injury* shall mean . . .” Where else than this policy? Is the author worried that the person who reads the contract might think that “bodily injury” means what the policy says it means everywhere in the world, in newspapers or the essay written by the neighbor’s daughter’s best friend? And why the imperative command “shall”? Why not just state a fact, instead of issuing a command?

Contracts—not just insurance policies—are filled with these and other curlicues and gewgaws. We warn that if someone doesn’t perform, we will “deem” it a breach. We say a certain word “shall mean” thus and so. When we define a term, we say “as used in this policy, xyz shall mean . . .,” perhaps to guard against the danger that the reader might think that this definition is not limited to the contract but binds the very world.

It all conjures up a sense of the nineteenth century, when men wore waistcoats and celluloid collars, had pocket watches, and worked at roll-top desks.

Does any of this really matter? Every trade has its distinct way of talking and writing, after all. The point is that if a drafter of a contract spends so much time using formulaic words that are either useless (“in the event that”) or unclear, how much actual thought is going into the real meaning of the words? And it is the lack of thought that is the worry. Attorneys who sue insurance companies often rely on the lack of thought showing up in the policy. One policy, for example, combined standard “claims made” language with a requirement that the claim be reported “as soon as practicable,” the classic occurrence policy language. What is the result

when the insured misses the policy year deadline but meets the “as soon as practicable” test?

It is not entirely clear why persons whose trade requires them to use words in the way that engineers use numbers commit these affronts. If there were as many engineers as unskilled in using numbers as there are lawyers unskilled in using words, suspension bridges would be like carnival rides.

But it’s not all our fault. Your columnist once wrote a contract for someone going into a business relationship. The contract carefully avoided all of those pompous, obscure words and long, convoluted, clause-dripping sentences. Proudly he showed it to the client, who read it, looked perplexed, and became visibly uncomfortable. Finally the client burst out “But, but, is it legal? I can understand it.”

Next: Less is more, and more is less (knowing when to stop). ■

**Significant Insurance . . .**

Continued from page 13

taxable costs, and penalty interest. The Court of Appeals found that the appraisal award could not alter the applicable policy limits, and therefore, a money judgment for the amount of the appraisal in excess of the policy limits was not warranted. However, the Court awarded penalty interest under MCL 500.2006(4) based upon the *Griswold Properties* precedent that “a first-party insured is entitled to 12 percent penalty interest if a claim is not timely paid, irrespective of whether the claim is reasonably in dispute.”

Jury verdict cannot be enforced to the extent it exceeds amounts recoverable under the policy

*Van Dyke Liquor Market, Inc v MBPIA*  
October 28, 2008 (Docket No. 278892)

In another fire claim, plaintiff’s building and its contents were destroyed by fire. The parties could not agree on the value of the loss of the building, and so the question was submitted to a jury. Despite evidence being presented at trial that the value of the loss of the building was \$939,948.64, the jury awarded \$1.2 million. The trial court denied the insurer’s motion for remittitur, and the insurer appealed. The Court of Appeals found that the trial court abused its discretion in denying the motion and remanded the case for entry of a judgment in the amount of the actual damages as evidenced by the proofs. ■

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The *Journal* is a medium for the exchange of views and expertise, both within the section and for interested persons outside the section.

If you have a topic in mind, send us an article or give us a call to discuss it.

Length: Flexible, but around 1,000-1,200 words. Include a photo and a short biographical statement.

E-mail the editor for detailed author’s guidelines: hcarroll@VGpclAW.com

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