From the Chair

“Participation”

We held our informal social and networking session November 29 at the office of Jaffe Raitt Heuer & Weiss” and it was well attended. Networking is an important part of any organization of lawyers, so we may treat this as our “first annual” networking meeting. If you have any ideas for other ways that the Section can provide or enhance networking opportunities, just contact any officer or council member.

Michigan Lawyers Weekly plans to publish an issue with an insurance focus on February 20, and has invited Section members to participate. The due date for copy is February 6. The word limit (not counting author information) is 1000 words. If you would like to be included, you can obtain a copy of the guidelines from Douglas Levy at Lawyers Weekly (Douglas.Levy@mi.lawyersweekly.com).

Liaison with other Sections. Most of our Section Members are also members of other State Bar Sections, and insurance and indemnity law questions arise in most of those practice areas. In fact, questions about indemnity and insurance coverage never arise in isolation. That means that each of you can be a source of ideas for ways that the Insurance and Indemnity Law Section can collaborate with other sections.

Programs. For example, the Insurance and Indemnity Law Section and another section may be able to jointly sponsor a program to address issues of interest to the other section. The program could be in the standard lecture format, or something more interactive, like a series of roundtable discussion. Joint sponsorship of a program makes a lot of sense for both sections. I urge each of you to give some thought to what we can provide by way of programs. When you come up with ideas, or if you have any questions about how to proceed, please contact our two program committee chairs, Elaine Murphy Pohl and Kimberly Ruppel at their email addresses, epohl@plunkettcooney.com and kruppel@dickinsonwright.com.

Articles. Another possibility is that we can provide articles in this Journal on topics of general interest that are submitted by members of other sections. Again, I urge you to discuss this with the members of the other sections and see if there is some topic that we can address. You can contact Hal Carroll the editor of the Journal or Larry Bennett of the Publication Committee at their email addresses: hecarroll@VGpcLAW.com and lbennett@gmblaw.com.

By now you can see the themes of this message. They are all related.

- One of the goals and purposes of the Insurance and Indemnity Law Section is to be a resource for other sections. We do not advocate for one side or the other when it comes to coverage and indemnity issues; instead, we see ourselves as a mechanism...
from the exchange of information, both among our members and with practitioners in other areas.

- Another purpose of our Section is to provide networking opportunities for our members. Members who are new to this area of practice can benefit from contacts with the more experienced members. If you a Section member who is new to this area, you will find no shortage of “mentors-in-waiting” who are willing to answer questions.

- Participation is the key to both of these themes. By enhancing the performance of the Section, you will also improve your own skill and expand your network of contacts.

The ideas I have outlined above are just a few of the ways the Section can expand and improve its operations. We have a large membership base now (559 at last count), which means we have 559 sources of ideas for what the section can do. If you have any ideas, even tentative one, please give me (or any council member) a call or contact me at my email address, mcooper@jaffelaw.com.

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Editor's Note

By Hal O. Carroll, Vandeveer Garzia, PC

The Journal is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. All opinions expressed in contributions to the Journal are those of the author. The Section itself takes no position on issues.

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 hcarroll@VGpcLAW.com.
Supreme Court Action

Since our last article, the Michigan Supreme Court has not issued any formal opinions that impact on Michigan No-Fault jurisprudence. However, the court did issue an order peremptorily reversing, in part, a published decision by the Michigan Court of Appeals regarding payment of a plaintiff’s attorney’s fee out of a medical expense recovery. In addition, the court issued orders on five cases, which will most assuredly have an impact on No-Fault law in the future. These cases are discussed below.

*Miller v Citizens Ins. Co.*
Docket No. 141747, Order Rel’d 11/4/2011

In *Miller v Citizens*, 288 Mich App 424, 794 NW 2d 622 (2010), the Michigan Court of Appeals determined that plaintiff’s counsel was entitled to payment of a one-third contingency attorney fee from $150,000.00 medical expense recovery. The medical provider, the Detroit Medical Center, objected to paying this fee, arguing that plaintiff’s counsel was not specifically retained by the Detroit Medical Center to represent its interests in pursuit of the unpaid medical expenses. The Court of Appeals upheld plaintiff’s counsel’s ability to take his one-third attorney fee out of the medical expense payment, based upon the “Common Fund” exception to the American Rule, which generally provides that each party is responsible for payment of his or her own attorney fees.

The Supreme Court granted leave to appeal earlier this year. Following briefing and oral argument, the Michigan Supreme Court issued a peremptory order on November 4, 2011, reversing in part and affirming in part the judgment of the Michigan Court of Appeals. The court specifically ruled that the lower court’s reliance on the “Common Fund” exception to the American Rule regarding payment of attorney fees was misplaced “because no common fund was created.” The Supreme Court further noted that the settlement was only between the Plaintiff, her attorney and the no-fault insurer. The Supreme Court noted:

“The circuit court’s order of dismissal pursuant to the settlement agreement did not have the effect of extinguishing the DMC’s right to collect the remainder of its bill from Plaintiff. Such a result could not have been achieved without an explicit waiver, or at least unequivocal acquiescence, by the DMC, which was not obtained.”

Simply put, Plaintiff’s counsel will need to confirm that he or she actually represents the interests of plaintiff’s medical providers, in addition to actually representing the plaintiff, before plaintiff’s counsel will be permitted to take his or her attorney fee out of a medical expense recovery.

**Progressive Marathon Ins. Co. v DeYoung**
Supreme Court Docket No. 143330

In this case, the claimant, Brian DeYoung, was injured while operating a vehicle owned by his wife and insured with Plaintiff Progressive Marathon Insurance Company. Mr. DeYoung was a “named excluded driver” on the Progressive policy. After learning of the accident, Progressive Marathon Insurance Company instituted a declaratory judgment action, asking the court to declare that Brian DeYoung was ineligible to recover no-fault benefits pursuant to MCL 500.3113(a), based on his alleged “unlawful taking” of his wife’s automobile. Two of his medical providers, Spectrum Health and Mary Free Bed Hospital, intervened in the action. On cross-motions for summary disposition, the trial court granted summary disposition in favor of Progressive, finding that MCL 500.3113(a), precluding payment of no-fault benefits to a person who has “unlawfully taken” a motor vehicle, barred Mr. DeYoung’s claim for no-fault benefits.

On appeal, the Court of Appeals reversed the decision of the trial court, relying on the “family member joyriding exception” to MCL 500.3113(a), first enunciated by the Michigan Supreme Court’s in its plurality opinion in *Priesman v Meridian Mut’l Ins. Co.*, 441 Mich 60, 490 NW 2d 314 (1992). The court recognized that it was bound by its earlier decisions in *Butterworth Hospital v Farm Bureau Ins. Co.*, 225 Mich App 244, 570 NW 2d 304 (1997) and *Roberts v Titan Ins. Co. (On Reconsideration)*, 282 Mich App 339, 764 NW 2d 304 (2009). The Court of Appeals also recognized that three justices (Justice Young, Justice Markman and former Justice Corrigan) would have granted leave to appeal in *Roberts v Titan Ins. Co.* to consider the validity of the “family member joyriding exception” to MCL 500.3113(a). See *Roberts v Titan Ins. Co.*, 485 Mich 935, 773 NW 2d 9045 (2009). However, because...
Butterworth was still binding precedent, the Court of Appeals was obligated to reverse the decision of the trial court and reinstate Mr. DeYoung’s claim for no-fault benefits. However, the Court of Appeals closed its opinion by noting:

“Consequently, whether this exception should have any continuing validity in our jurisprudence is squarely a matter left to our Supreme Court.”

Accepting the Court of Appeals’ invitation, the Michigan Supreme Court granted the insurer’s application for leave to appeal on September 21, 2011. In its order, the Supreme Court indicated:

“The parties shall address:

(1) whether an immediate family member who knows that he or she has been forbidden to drive a vehicle, and has been named in the no-fault insurance policy applicable to the vehicle as an excluded driver, but who nevertheless operates the vehicle and sustains personal injury in an accident while doing so, comes within the so-called ‘family joyriding exception’ to MCL 500.3113(a); and

(2) If so, whether the ‘family joyriding exception’ should be limited or overruled.”

It appears that the current philosophical majority of the Michigan Supreme Court will (finally) overrule the “family joyriding exception” enunciated in Priesman v Meridian Mut’l Ins. Co., supra.

**Spectrum Health v Farm Bureau Ins Co., Docket No. 142874**

In yet another “unlawful taking” case, the Supreme Court granted leave to appeal to consider whether or not an “unlawful taking” has occurred where there has been a chain of permissive use, even though the owner of the vehicle has expressly forbidden the final operator of the vehicle from driving it. In Spectrum Health, Craig Smith Jr. was injured while operating a motor vehicle owned by his father, Craig Smith Sr. Craig Sr. had previously prohibited his son, Craig Jr. from driving the car. Craig Sr. had given permission to Craig Jr.’s girlfriend, Kathleen Chirco, to drive the vehicle. Chirco subsequently gave permission to Craig Jr. to drive the vehicle. Craig Jr. was legally intoxicated at the time of the occurrence and had no valid driver’s license.

Because of the chain of permissive use, Craig Jr.’s medical provider, Spectrum Health, argued that there was no “unlawful taking” of the vehicle, relying upon the Supreme Court’s decision in Cowan v Strecker, 394 Mich 110, 229 NW 2d 302 (1975). Both the trial court and Court of Appeals agreed with Spectrum Health’s argument, and ruled that there was no “unlawful taking” of Craig Sr.’s motor vehicle, which would have precluded no-fault benefits to Craig Jr. under MCL 500.3113(a).

On September 1, 2011, the Supreme Court granted Farm Bureau’s application for leave to appeal. In its order, the Supreme Court indicated:

“The parties shall address whether an immediate family member who knows that he or she has been forbidden to drive a vehicle may nevertheless be a permissive user of the vehicle eligible for personal protection insurance (PIP) benefits under MCL 500.3113(a), when, contrary to the owner’s prohibition, an intermediate permissive user grants the PIP claimant permission to operate the accident vehicle.”

Given the order granting leave to appeal in this case, and in DeYoung, the Supreme Court’s rulings on these cases will certainly clarify the criteria that courts need to apply to determine whether or not there has been an “unlawful taking” of a motor vehicle, particularly among family members.

**Titan Ins. Co. v Hyten, Docket No. 142774**

In this case, the Supreme Court will address the issue of whether a no-fault insurer has a legal duty to verify the representations set forth in an application for insurance, particularly where there are “innocent third parties” involved. In Hyten, Titan Insurance Company’s insured, McKinley Hyten, misrepresented the status of her driver’s license on an insurance application. After a policy had been in effect for a period of months, Hyten was involved in a motor vehicle accident that resulted in injuries to an “innocent third party.” Titan Insurance Company instituted a declaratory judgment action to reduce the applicable policy limits to the statutorily required minimum policy limits of $20,000/$40,000, arguing that pursuant to Hammond v Metropolitan Property & Casualty Ins. Co., 222 Mich App 485, 563 NW 2d 716 (1997), United Security v Insurance Commissioner, 133 Mich App 38, 348 NW 2d 34 (1984) and Keys v Pace, 358 Mich 74, 99 NW 2d 547 (1959), there was no obligation, on the part of an insurer, to verify the information set forth in an application for insurance. The injured party’s underinsured motorist carrier, Farm Bureau, argued that pursuant to Farmers Ins. Exchange v Anderson, 206 Mich App 214, 520 NW 2d...
686 (1994), Ohio Farmers v Michigan Mutual, 179 Mich App 355, 445 NW 2d 228 (1989) and State Farm v Kurylowicz, 67 Mich App 568, 242 NW 2d 530 (1976), the insurer had a duty to verify that information that was “easily ascertainable”; otherwise, the insurer was precluded from reforming an insurance policy to eliminate optional coverages. Both the trial court and the Michigan Court of Appeals ruled in favor of the UIM carrier, Farm Bureau, and determined that, because the status of Hyten’s driver’s license was “easily ascertainable,” Titan Insurance Company was precluded from reducing the applicable insurance policy limits down from $100,000.00/ $300,000.00 to the statutorily required minimum policy limits of $20,000.00/ $40,000.00.

In its order granting leave, issued on September 23, 2011, the Michigan Supreme Court stated:

“The parties shall include among the issues to be briefed whether an insurance carrier may reform an insurance policy on the ground of misrepresentation in the Application for Insurance where the misrepresentation is ‘easily ascertainable’ and the claimant is an injured third party.”

As matters now stand, whenever an insurer receives an insurance application, it must gaze into its “crystal ball” and determine who will be making a claim against the policy in the future. If it is the applicant who will be filing a claim under the policy, there is no obligation to verify the representations contained in the application. If, however, it is an “innocent third party,” the insurer has a duty to verify those representations that are “easily ascertainable.” Otherwise, it will be precluded from reforming the policy to eliminate optional coverages. (The reader should note that the insurer did not dispute the proposition that under the Financial Responsibility Act, MCL 257.520(f), it was obligated to afford liability coverage in the statutorily required minimum policy limits of $20,000.00/ $40,000.00.)

Admire v Auto Owners Ins. Co.
Docket No. 142842

In Admire, Plaintiff was catastrophically injured as the result of a motor vehicle accident occurring in 1987. His no-fault insurer, Auto Owners Insurance Company, purchased a van and modified it to meet his transportation needs in 2000. The van agreement provided that at the expiration of the seven-year period, the van would be traded in for a replacement vehicle. Seven years later, plaintiff gave Auto Owners notice of his intent to replace the van. At that time, Auto Owners disputed its obligation to pay for the base cost of the van, relying on the Supreme Court’s decision in Griffith v State Farm, 472 Mich 521, 697 NW 2d 895 (2005). Although Griffith dealt with the narrow issue of whether the cost of food, which was just as necessary for an injured as it was for an uninjured person, was nonetheless compensable under the No-Fault Act, many no-fault insurers had been using Griffith to support the argument that the no-fault insurer was only obligated to pay the cost of modifying a van, as opposed to the base cost of the van itself.

In Admire, both the trial court and the Court of Appeals ruled that the no-fault insurer was responsible for the entire cost of the van— not just the modifications. In so ruling, the Court of Appeals relied upon its earlier decisions in Begin v Michigan Bell Telephone Co., 284 Mich App 581, 773 NW 2d 271 (2009) and Davis v Citizens Ins. Co., 195 Mich App 323, 489 NW 2d 214 (1992).

On September 23, 2011, the Supreme Court ordered oral argument on whether to grant the application for leave to appeal. In its order, the Supreme Court stated:

“At oral argument, the parties shall address whether, or to what extent, the Defendant is obligated to pay the Plaintiff personal protection insurance benefits under the no-fault fact, MCL 500.3101 et seq, for handicapped-accessible transportation.”

No-fault practitioners expect that the Supreme Court will clarify whether or not an “incrementalist” approach will be applied in cases involving significant expenditures, including claims for housing and transportation needs.

DeFrain v State Farm,
Docket No. 142956

In DeFrain, Plaintiff filed a claim for uninsured motorist benefits under his policy with State Farm. State Farm denied the claim, based upon plaintiff’s failure to notify State Farm of an accident involving a hit-and-run motor vehicle within thirty days. Relying upon the Supreme Court’s decision in Koski v Allstate Ins. Co., 456 Mich 439, 572 NW 2d 636 (1998), the Court of Appeals, in a published opinion, ruled that unless State Farm could show prejudice, brought about as a result of the Plaintiff’s failure to notify State Farm of the hit-and-run motor vehicle accident within thirty days after its occurrence, State Farm was obligated to provide UM coverage under the policy. In doing so, the Court of Appeals distinguished the Supreme Court’s earlier order in Jackson v State Farm, 472 Mich 942 (2005), which found that State Farm could properly rely upon the 30-day notice provision in its policy, without regard to whether or not it was prejudiced by the failure to comply with the notice provision.
On September 21, 2011, the Supreme Court ordered oral argument on State Farm's application for leave to appeal. In its order, the Supreme Court stated:

“At oral argument, the parties shall address whether this case is controlled by Jackson v State Farm Mut'l Automobile Ins. Co., 472 Mich 942 (2005), and whether the 30-day notice requirement regarding hit-and-run accidents in the Defendant's policy is enforceable without a showing of prejudice to the Defendant due to the Claimant's failure to comply with the provision.”

The Supreme Court's ruling in this case will undoubtedly affect an insurance company's ability to rely upon other exclusions, contained in the uninsured/underinsured portions of the policy.

### Court of Appeals Action

*Hardrick v ACIA*

__ Mich App __, __ NW2d __ (no. 29487, rel’d 12/01/2011)

On December 1, 2011, the Michigan Court of Appeals issued a published opinion that directly impacts on the issue of whether or not a no-fault insurer is obligated to pay an “agency rate” or a “pay rate” for attendant care services rendered to a catastrophically injured Claimant by family members. In its published opinion in *Hardrick*, the Court of Appeals ruled that evidence of an agency rate (i.e., what an agency charges to a no-fault insurer to provide attendant care services) “bears relevance to establishing a rate for family-provided services.” In this 2-1 decision, authored by Judge Gleicher, the Court of Appeals declined to follow the non-binding dicta found in Judge (now Justice) Zahra’s opinion in *Bonkowski v Allstate Ins. Co.*, 281 Mich App 154, NW 2d 784 (2008).

Judge Gleicher recognized that the language in *Bonkowski* was non-binding dicta, because the insurer in *Bonkowski* never argued that the Court of Appeals' decision in *Manley v DAIIE*, 127 Mich App 444, 339, NW 2d 205 (1983) (which ruled that “comparison to rates charged by institutions provides a valid method of determining whether the amount of that expense was reasonable and for placing a value on comparable services performed [by family members]”) was not properly decided. In *Hardrick*, AAA did argue that Manley was wrongly decided and, therefore, this issue was presented squarely to the Court of Appeals. The Court of Appeals' majority simply noted that while the “pay rate” was one piece of evidence that could be introduced to determine what a “reasonable” hourly rate was for the attendant care services provided, evidence of the “agency rate” “bears relevance to establishing a rate for family-provided services.”

The Court of Appeals majority approved the use of AAA's proposed jury instruction, which would have allowed the jury to consider both the “pay rate” and the “agency rate” when determining what a reasonable hourly rate would have been for the attendant care services. The proposed jury instruction reads:

“Plaintiff can recover benefits for care provided by member[s] of Plaintiff's family at its reasonable market value. In determining the reasonable market value of such care, you are to consider:

1. The type and amount of care Plaintiff reasonably needed;
2. The various types of in-home care available from outside care providers;
3. The duties performed by outside care providers;
4. The customary billing and payment practices of outside care providers; and
5. The type and amount of services being performed by the member[s] of Plaintiff's family.”

There is evidence that rates charged by home care agencies are higher than the amounts paid to the employees who actually render care. The difference between the rates charged by agencies and the amounts paid to its employees include agency overhead, such as social security contributions, malpractice insurance, health insurance, disability insurance, office clerical staff, rent, legal fees, accounting costs and office supplies, in addition to profit for the agency. In determining the amount owed for care rendered by member[s] of Plaintiff's family, you are to consider whether any additional amounts charged by home care agencies are also necessary for the family member to provide care to Plaintiff.”

The Court of Appeals ruled that this proposed jury instruction “accurately reflects that many factors are relevant to the
reasonable rate issue." The Court of Appeals also observed that this proposed jury instruction was consistent with the Supreme Court’s decision in Sokolek v General Motors, 450 Mich 133, 538 NW 2d 369 (1995), a worker’s compensation case which held that the issue of whether a “pay rate” or an “agency rate” was appropriate for payment of attendant care services, is a question of fact, not an issue of law. It was also consistent with the Court of Appeals’ earlier decision in Sharp v Preferred Risk, 142 Mich App 499, 370 NW 2d 619 (1985), which indicated that the cost of “overhead” was properly considered in calculating a reasonable rate for the caregiver’s services. Therefore, the matter was remanded back to the Oakland County Circuit Court for a new trial.

Judge Markey dissented from the majority’s ruling on the hourly rate issue. She would adopt the Bonkowsi rationale and hold that as a matter of law, the rate charged by an agency is irrelevant when determining an hourly rate for family-provided attendant care services. Rather, the only relevant piece of evidence would be the amount actually paid by the agency to the employee who provides such services.

As this article is being drafted, AAA is currently considering whether to file an application for leave to appeal with the Michigan Supreme Court on the hourly rate issue.

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**CIGNA Corp v Amara:**
**Making ERISA Claims Even More Complicated**

By Robert B. June, Esq., Law Offices of Robert June, P.C.

*Editor’s Note: This article first appeared in the Fall 2011 issue of the MAJ Journal, and is reprinted with permission.*

On May 16, 2011, the Supreme Court of the United States decided an important ERISA case, **CIGNA Corp v Amara**, 563 US ___; 131 S Ct 1866; 179 L Ed 2d 843 (2011). The full impact of the decision will not be known for years, but it already seems that the case may become something of a landmark, and there is no doubt that it will add complexity to the already complicated area of ERISA litigation.

Emphasizing the trust-like structure of the obligations ERISA imposes on employee benefit plans and their fiduciaries, the court reinforced the concept that ERISA’s remedies are equitable in nature. The court clarified the range of equitable remedies available to aggrieved benefit plan participants and beneficiaries, likening ERISA remedies to those available in the days of the divided bench. As a result, there may be more ways for ERISA plaintiffs to proceed in court than many lawyers previously thought, but the process is far from simple.

The *Amara* case involved a pension plan offered by CIGNA Corporation to its employees. CIGNA changed its pension plan from a defined benefit plan to a “cash balance” defined contribution plan in 1998. In the process, CIGNA converted the previously accumulated old-plan benefits to an opening amount in each employee’s cash balance account. The method for making and calculating this opening amount became a source of dispute, and it is one of the reasons that a class of approximately 25,000 beneficiaries sued to challenge CIGNA’s adoption of the new plan.

... there may be more ways for ERISA plaintiffs to proceed in court than many lawyers previously thought, but the process is far from simple.

The federal district court found that CIGNA had violated several of its obligations under ERISA, causing the class members “likely harm,” and the court reformed the new plan under the auspices of §502(a)(1)(B) of ERISA, which permits a plan participant or beneficiary to file suit to “recover benefits due to him under the terms of his plan.” The Supreme Court rejected this maneuver, concluding that plan reformation is not among the remedies available under this section of the ERISA statute. However, the court also found that plan reformation is among the remedies permitted under a different section of the statute, §502(a)(3), which authorizes “appropriate equitable relief” for violations of ERISA. Noting that “the relevant standard of harm will depend upon the equitable theory by which the District Court provides relief,” the Supreme Court then remanded the case for further proceedings. In the process, however, the Supreme Court made several observations that will impact multiple facets of ERISA litigation.

First and foremost, of course, is the fact that a variety of equitable remedies are available under §502(a)(3) of ERISA when relief may not be available under the basic recovery-of-benefits-due provision contained in §502(a)(1)(B). The relief
available under §502(a)(3) includes all of the remedies that were typically available in equity before the merger of law and equity. The Supreme Court now has made it clear that this includes remedies such as injunction, lien, constructive trust, mandamus, and restitution. Exclaiming that “[e]quity suffers not a right to be without a remedy,” the court also noted that traditional equity chancellors had developed a host of other distinctive equitable remedies “fitted to the nature of the primary right” they were intended to protect. These more situational remedies include reformation of contract, enforcement of promise under an estoppel theory, and a surcharge remedy compensating beneficiaries for losses suffered as a result of a plan fiduciary’s breach of trust. Thus, while the traditional remedy for lost benefits under §502(a)(1)(B) was narrowed, the equitable relief available under §502(a)(3) was broadened substantially.

However, as can be seen from the outcome of the case, which was remanded for litigation under the proper theory of relief, it is essential to proceed under the correct theory of liability. Because this involves equitable theories as they were litigated “in the days of the divided bench,” this may become a pleading and procedural nightmare for the uninstructed practitioner. It is unclear even to the court what the appropriate standard of harm is for these equitable remedies, but it must be some type of actual harm. Detrimental reliance is an essential element of an estoppel claim, but it may not be necessary to prove detrimental reliance to obtain other forms of equitable relief under ERISA. While money damages are not traditionally considered an equitable remedy, it may be possible to obtain money damages as make-whole relief under a theory of surcharge interposed against a benefit plan fiduciary. Clearly, to proceed with such a claim, it will be essential to address traditional equitable remedies in the modern context of the trust-like obligations imposed on plans and their fiduciaries by ERISA.

In the course of rendering this decision, the Supreme Court also emphasized the different responsibilities of the ERISA plan sponsor and the ERISA plan administrator, likening them respectively to the settlor and the fiduciary of a trust. On the one hand: “The plan’s sponsor (e.g., the employer), like a trust’s settlor, creates the basic terms and conditions of the plan, executes the written instrument containing those terms and conditions, and provides in that instrument ‘a procedure for making amendments.’” Conversely: “The plan administrator, a trustee-like fiduciary, manages the plan, follows its terms in doing so, and provides participants with the summary documents that describe the plan (and modifications) in a readily understandable form.” These roles are not interchangeable, and it is not permissible for the plan administrator to indirectly set or modify plan terms under the guise of plan interpretation. This portion of the Supreme Court analysis is likely to spawn further litigation regarding the scope of discretion a plan administrator when making a denial of benefits.

Importantly, the Supreme Court made it clear in Amara that a summary plan description created by the plan administrator is not legally binding like the actual plan document created by the plan sponsor. In short, after Amara, the provisions of a summary plan description appear to be completely unenforceable unless they would provide the basis of an estoppel claim made by a plan beneficiary against a plan fiduciary. This is somewhat stunning as a practical matter because many plan administrators and insurers have casually relied on the terms of the summary plan description as though it constituted the terms of the plan itself, and they no longer may do so. The potential consequences are unclear. For example, where a plan administrator previously relied on the terms of a summary plan description to claim a lien against a tort recovery, does this mean the lien is effectively nullified in the absence of a separate plan document establishing a right of reimbursement? It may. Can a summary plan description establish the terms regarding how a plan participant must name a life insurance beneficiary? Apparently not.

Another area of confusion is likely to involve insured ERISA plans. For example, some insurers issue summary plan descriptions for the employers purchasing their group policies, but it is not clear after Amara that an insurer may do this without essentially undertaking the role of plan administrator together with all of the fiduciary obligations imposed on that role by ERISA. Similarly, there is likely to be some controversy regarding the procedures for amending insurance policies that fund ERISA plans, as well as whether an insurer may be sued in “surcharge” for breaching trust in its role as a plan fiduciary.

Obviously, all of these issues will take time to litigate, creating a great deal of uncertainty until they are resolved. There always has been something uncomfortable about squeezing
modern ERISA benefit plans into the framework of trusts from centuries past. Unfortunately, the Amara decision ensures us that this anxiety will continue for some time to come.

About the Author

Bob June is a sole practitioner who handles ERISA benefit claims throughout Michigan. His office is in Ypsilanti and his email address is bobjune@junelaw.com.

Endnotes

2. 29 USC 1132(a)(1)(B).
3. 29 USC 1132(a)(3).
5. Id., p 18.
7. Id.

The Commercial General Liability (“CGL”) policy forms the basis for insurance coverage across the United States. The CGL basic form (the CG 001) has undergone numerous revisions over the years, the latest occurring in 2007.¹ The CGL policy is split into multiple coverage sections, including Coverage A (insuring for “bodily injury” and “property damage” arising out of an “occurrence”), Coverage B (insuring for damages because of “personal and advertising injury”), and Coverage C (medical expenses for “bodily injury”).

Of the three, Coverages A and C have been referred to as the “snap, crackle and pop” coverages – a reference to the bodily injury and property damage claims which they cover. On the other hand, while Coverage B extends to some “consequential” flesh and bone damages, it is primarily designed to cover economic injury arising out of losses that do not or may not manifest in physical injury to persons or property.

Coverage A, which insures against third party liability for losses to persons and property, provides the liability coverage that, historically, businesses have sought when purchasing insurance. Coverage B, on the other hand, can be analogized to a younger sibling of the more well known Coverage A. Indeed, prior to 1986, “personal” or “advertising” injury coverage was not part of the standard CGL policy, and had to be added by way of an optional endorsement. Now, however, organizations that do not need or desire coverage for “personal and advertising injury” claims must obtain an endorsement to exclude it.

Like a younger sibling, Coverage B has grown in significance to CGL policyholders since it was first added to the standard coverage in 1986. And as the United States economy moves from a manufacturing base to service and web-based industries, Coverage B will become increasingly important. The proliferation of “personal and advertising injury” claims is noticeably significant because of the broader coverage for resulting injuries when triggered. The expansive coverage for “personal and advertising injuries” may not be appreciated by a manufacturer with limited exposure to the internet or other forms of mass media, but “personal and advertising injury” coverage becomes substantially more important to companies that rely heavily upon web-based media and advertising whose end-users of the information may be unknown, and in some cases virtually unidentifiable. Even more noteworthy is the simplicity of publishing information to hundreds – or thousands – or millions – of people without much effort.

For example, consider the many social media websites whose membership consists mainly of professional service providers. “Posting” a message on such a website is easy and free. Once the message is sent into cyberspace, it can be viewed by every person who visits the page. Occasionally, those websites will also send an email to its members, announcing the posting and providing a link with an opportunity to respond.

It would be nearly impossible for the “poster” to know every single person who becomes an end-user of the published information, especially because membership is “organic” – meaning it can grow and shrink without the control of its individual members. In this respect, any person who posts on a professional website is likely
engaging in a personal and advertising injury risk that is potentially covered by Coverage B of the CGL. For these reasons, the social media boom portends a growing risk assumed by insurers that provide CGL coverage.

So, what protection does Coverage B provide to a 21st century, information-based business? The analysis of whether a claim triggers either the duty to defend and/or the duty to indemnify the insured involves a four part analysis: the language of the insurance agreement, the predicate offenses that give rise to a “personal and advertising injury” claim, the set of specific exclusions and – somewhat collaterally – whether the insurer’s duty to defend the policyholder is triggered.

“[P]ersonal and advertising injury” coverage becomes substantially more important to companies that rely heavily upon web-based media and advertising whose end-users of the information may be unknown, and in some cases virtually unidentifiable.

In examining the standard ISO form, Coverage B’s “insuring agreement” – the basic grant of coverage – states that the insurer will pay those sums the insured is legally obligated to pay because of “personal and advertising injury” to which the insurance applies. Significantly, the insurer also has the right and duty to defend the insured in any suit seeking “personal and advertising injury” damages. The insurer’s assumption of the duty to defend the policyholder – even under a reservation of rights – is of significant economic value to the insured.

The “Definitions” section of the CGL policy defines “personal and advertising injury” as one or a combination of seven specific acts or “predicate offenses”:

1. False arrest, detention or imprisonment;
2. Malicious prosecution;
3. Wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord, or lessor;
4. Oral or written publication of material that slanders or libels a person or organization’s goods, products, or services;
5. Oral or written publication of materials that violate a person’s right of privacy;
6. The use of another’s advertising idea in your “advertisement”; or
7. Infringing upon another’s copyright, trade dress or slogan in your “advertisement.”

One reason why the proliferation of “personal and advertising injury” claims must be treated seriously is Coverage B’s use of two significant, but undefined terms in the coverage grant: “injury” and “advertising.” As discussed in one authoritative text:

It is noteworthy that the definition is phrased in terms of injury, not bodily injury. The CGL coverage form does not define injury. However, injury has a much broader meaning than bodily injury. Black’s Law Dictionary (8th ed. 2004) defines injury as “[t]he violation of another’s legal right, for which the law provides a remedy; a wrong or injustice,” or simply as “[a]ny harm or damage”. So, for example, injury includes mental anguish or injury, fright, shock, humiliation, and loss of reputation, but it is not limited to these things.2

“Injury,” as used in Coverage B, also includes “consequential” bodily injury. “Consequential” bodily injury may accompany the commission of a “personal and advertising injury,” such as where a tenant is evicted from a house, or when a customer scuffles with a security guard in an false arrest situation.3

Although the CGL policy defines “advertising”, it does not define “advertising.” Michigan has adopted a broad definition of “advertising,” holding that it means “to advise, to announce, to apprise, to command, to give notice of, to inform”.4 If the alleged wrongful act or acts is one of the “seven deadly sins” listed above, the second step in the analysis is determining whether coverage under B is precluded under one or more of the 15 specific exclusions. Some of the exclusions are identical to those found in Coverage A (breach of contract, war, contractual liability, criminal acts, etc.). Although not all of the exclusions specific to Coverage B will be listed here, the practitioner will frequently encounter “knowing violation of the rights of another” (exclusion [a]), “material published with knowledge of falsity” (exclusion [b]), and “infringement of copyright, patent, trademark, or trade secret” (exclusion [i]).

A cursory reading of the triggering offenses, followed by the exclusions, could lead an insured or its counsel to believe that the coverage provided under B is illusory – the predicate offenses seem to naturally trigger the exclusions. How can slander be anything other than a “knowing violation” of another’s rights? How can “libel” not be “knowingly false”? How can infringement on a copyright or trade dress not implicate the “infringement” exclusion?

The key to understanding the triggers for the duty to de-
fend and indemnify in a Coverage B situation depends in significant part on the elements of the particular cause of action alleged. Michigan law has long been clear that the duty to defend is broader than the duty to indemnify, and that the insurer has the duty to look behind the allegations in the complaint to analyze whether coverage is possible.\(^5\) If there is any doubt whether a complaint alleges liability covered under the policy, the doubt must be resolved in the insured’s favor.\(^6\) If any theory falls within the policy, the insurer owes a duty to defend the suit.\(^7\) For example, the elements of a defamation claim are a false and defamatory statement, of and concerning the plaintiff, an unprivileged communication to a third party, and fault amounting to “at least negligence” on the part of the publisher.\(^8\) An insured sued for “defamation,” therefore, would be entitled to a defense under Coverage B, since the tort of defamation does not require “knowledge” of the allegedly false statement or writing. Similarly, if the complaint leaves open the possibility that the insured acted without “knowledge” of the alleged falsity, the exclusion cannot be applied to the complaint in its entirety.\(^9\) Finally, if the terms used – such as “wrongful invasion” or “false arrest” – are undefined, the court must give the words their plain and ordinary meaning, apply the definitions set forth in the contract\(^10\) with any ambiguities being construed against the insurer in favor of the insured.\(^11\)

As noted earlier, as America transitions to a knowledge and information-based economy, the protection provided under Coverage B of the CGL policy will play an important role in risk management for insureds, and in defense and indemnity exposures for insurers. An understanding of the predicate offenses, applicable exclusions, definitions, and existing case law will continue to be a necessary and valuable skill for both insureds and carriers. *

About the Authors

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Endnotes

3 The 1998 ISO revisions to the CGL policy provided coverage for “consequential” bodily injury under Coverage B, and precluded it in exclusion (o) to Coverage A. Malecki, Donald S. & Flitner, Arthur L., Commercial General Liability, 50 (8th ed. 2005).
6 Radenbaugh at 138, 610 NW2d 272.
10 GAF Sales at 261, 568 NW2d at 167.

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Named Insureds, Described Insureds, Additional INSUREDS, and Additional Named Insureds

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The topic for this issue is one that sounds simple, but like many insurance topics has a few wrinkles in it. The question is what the word “insured” means in a policy, particularly a liability policy, in the various forms it appears or is used.

**Named Insured.** First, of course, is the person or entity that owns the policy. This is the “named insured.” The neutral term is that insurers like to use is “policyholder,” especially if they are disputing coverage. That little quibble aside, the policy will usually speak in terms of “the Named Insured shown in the Declarations.” This is often in the introductory paragraphs, which usually precede the policy’s first section, the Coverages section. This paragraph informs the policyholder that the words “you” and “your” refer to the “named insured,” which is the person or entity shown in the declarations.

**Described Insured.** What is the “described insured”? Actually that’s the author’s term. You won’t find it in any treatises or cases. “Named Insured” is a term of art, with a definite meaning. “Described insured,” for our purposes, is merely...
a way of explaining that the category of Named Insured can include several persons who are not named in the declarations, but are described as also being insured. Somewhere in the policy there will be a section with a title like “Who Is An Insured.” In this section there will be a list of persons or entities who are considered insureds on a par with the Named Insured. This insureds are identified by being described, in terms of their relationship to the Named Insured.

The list is usually a long one, but for the most part it is a matter of common sense and that are no real surprises. If the Named Insured is a person, the spouse will also be considered an insured. If the Named Insured is a partnership, then each partner is also an insured, if the claim relates to the partnerships business. If the Named Insured is a limited liability company (LLC) the LLC’s members are insureds. If the Named Insured is a corporation, then the executive officers and directors are insureds. So are stockholders with respect to any liability they may have as stockholders. The list goes on to include employees for acts within the scope of their duties for the Named Insured.

You always need to check the details, of course, but it’s mostly a common sense descriptions of persons who should be covered. It would make little sense, for example to say that an employer is insured but the employee is not, since the respondent superior basis of liability links them so closely.

Additional Insured. This is a term of art, like Named Insured. It connotes someone who is made an insured by virtue of an endorsement. Some think it can happen by means of a certificate of insurance, but that is a topic for another day. For now, let’s accept that only an endorsement can make someone an Additional Insured. A common name for this endorsement is “Blanket Additional Insured Endorsement,” or something similar. The important point here is that the status of Additional Insured comes with limitations that don’t apply to Named Insureds.

Apart from the first question of how the Additional Insured gets to be an additional insured in the first place, which is a topic for a later day, once the additional insured does get that status, it comes with three main limitations. First the additional insured is typically insured only with respect to work that the Named Insured does for the additional insured or work done for the additional insured by someone acting on behalf of the Named Insured. The common formulation is

That person or organization is only an additional insured with respect to liability arising out of “your work” for that additional insured by or for you

Remember, “you” means the person or entity named in the declaration, i.e., the Named Insured. This is a significant limitation. For example, if the Named Insured is a subcontractor and the additional insured is the general contractor, then the general can be an additional insured if it incurs liability because of something the subcontractor did. Those last two words, “for you,” would embrace something the Named Insured-subcontractor might have contracted out to a subcontractor.

The second limitation is in the amount of coverage. If the additional insured is covered because a contract between the Named Insured and the Additional Insured requires it, then the coverage amount will usually be the lesser of what the policy provides or what the underlying contract required.

The third limitation falls into the category of “other insurance.” In our hypothetical the Additional Insured is the general contractor and you can bet that he or she or it has a policy of its own. If both policies apply, how do they apply? You can bet that each insurer would like the other to pay first. The endorsement that creates the additional insured will usually have a clause that addresses this. Of course, the contractor’s policy has its own “other insurance” clause, too, so then you have to figure out how to make these work together and how to decide who wins if they can’t get along. That’s also a topic for another day.

“Additional Named Insured.” Since the distinction between Named Insured and Additional Insured is so important, what should we make of the phrase “Additional Named Insured”? This phrase often crops up, usually in discussions with lawyers who don’t practice insurance law. The problem is, if you hear someone say that, you don’t know if they mean Named Insured or Additional Insured. There is no third category of “Additional Named Insured,” with some third degree of coverage, so they have to mean one thing or the other. Calling any person an “additional named insured” is not helpful. As soon as you hear someone use that phrase, you must ask, “which is it?”

Now, there are “named insured endorsements,” which say essentially “Jane Doe is added as a named insured under the policy.” In that case, Jane is a Named Insured. Yes, she has been added, so she could be described as “additional,” but the point is that she is a Named Insured. It doesn’t matter whether she got there by way of the declaration pages or an endorsement. Being a Named Insured is like being a citizen: whether you are natural born or naturalized doesn’t matter. Additional Insureds are the resident aliens of the liability insurance world.

Words matter in insurance coverage, and never more than when the question is what the claimant’s status is under the policy. There are only two groups, so don’t let sloppy usage confuse things. Don’t worry – there’s plenty of opportunities for confusion in other parts of the policy.
Michigan Supreme Court

Evidence supported trial court finding of an innocent co-insured

*Hicks v Auto Club Group Insurance Company*
490 Mich 888 (2011)(Case No. 143234)

In an order issued September 23, 2011, the Supreme Court reversed a decision previously reported in this journal, adopted the dissenting opinion of the Court of Appeals, and reinstated the trial judge’s bench verdict for the insured wife, which held that she was not a participant in her husband’s scheme to exaggerate the property loss after a fire in their home. The inquiry was not whether the claim was inaccurate but whether the wife “was intentionally responsible for any of the inaccuracies.” While there was evidence on both sides of that issue, the law required the appellate court to defer to the trial court’s fact-finding role under, subject to a clear error standard of review. The case was remanded for a decision on the other issues raised in the appeal but not addressed.

Michigan Court of Appeals Published

UIM coverage for a car pool member

*Pugh v Farmers Ins Exchange*

This case involves a UIM claim by an injured passenger. Plaintiff, who did not have a driver’s license, rode back and forth to work every day in a vehicle insured by Farmers. She paid $20 a week to help defray costs. Farmers’ policy included a UIM form, with an exclusion of coverage for injuries sustained to persons being carried for charge. That exclusion expressly did not apply to “shared-expense car pools.” The court held that, under the commonly understood meaning of the words used in this exclusion, plaintiff was the member of a car pool. This was not a “carry for charge situation,” which connotes more of a profit-making venture. None of the arguments offered by the insurer were persuasive. A car pool does not require shared responsibility for the driving, as long as there is a sharing of costs; there is no requirement that members of the car pool are friends or co-workers; and there is no requirement that the members of the car pool are all headed to the same destination.

Life insurance proceeds reimburse state for the beneficiary’s prison expenses

*State Treasurer v W Snyder*
___ Mich App ___ (2011) (Docket No. 298554)

The State Correctional Facility Reimbursement Act (SCFRA), MCL 800.401, *et seq.*, imposes a duty on prisoners to reimburse the state of Michigan for the cost of incarceration and allows the state to receive up to 90% of the value of the prisoner’s assets for that purpose. Defendant inmate relied on the Disclaimers of Property Interests Law (DPIL), MCL 700.2901 *et seq.*, in an attempt to “disclaim” the life insurance proceeds left to him by his mother. But the court held that the legislature intended to bar prisoners from using the DPIL to avoid their reimbursement obligations under SCFRA. A reading of SCFRA in its entirety reflects an intent on the part of the legislature “to recover, when possible, the cost of prisoner incarceration by seeking and securing prisoner assets through any legal means necessary . . . . The legislature’s vigor in this endeavor is only tempered by its recognition of a prisoner’s legal and moral obligations to support dependants” or retain a homestead. “[D]efendant had no right to disclaim his interest in the insurance proceeds.”

Unpublished Court of Appeals Decisions

Material misrepresentation in the application defeats coverage

*Sahabi Convenience Store, Inc v State National Ins Co*
Unpublished per curiam of September 15, 2011
(Docket No. 298849)

The policyholder lost coverage for theft and fire losses due to a material misrepresentation in the insurance application. Although the application was filled out by the insurance agency, the policyholder signed it and the statements were attributable to him. The Court rejected claims that the policyholder was unfamiliar with the English language. No factual support was offered to support that claim and in his statement under oath, the policyholder explained that he had resided in the United States for approximately 32 years, 17 of which were spent as sole shareholder of the insured business.

*continued on next page*
Auto – no evidence of an excess work loss claim

*Bassett v Chrysler, LLC*
Unpublished per curiam of September 22, 2011
(Docket No. 298616)

Plaintiff failed to produce sufficient evidence of an excess work loss claim under MCL 500.3135(3)(c), because plaintiff was unemployed at the time of the accident and although he did obtain a job soon afterward, he was terminated three months later for performance problems. Plaintiff’s loss of wages was not work-loss benefits because no income would have been earned following plaintiff’s termination even if the accident had not occurred.” Plaintiff’s claims for serious impairment of injury, however, were remanded because the trial court wrongly assessed that claim under *Kreiner* instead of *McCormick*.

UIM insurer may withhold coverage pending tender of tortfeasors’ policy limits

*Bencheck II v Paille*
Unpublished per curiam of October 6, 2011
(Docket No. 298334)

The insured’s tort action against the at-fault driver also named his own UIM insurer. Prior to the date set for trial, all parties were required to attend a settlement conference with “full authority to settle.” UIM insurer, Integon National, sent a representative with authority to settle after payment of the tortfeasor’s liability limits. The trial court decided this was not “full authority,” found Integon in contempt of court, and adjourned the conference so that Integon could send a representative with the requisite authority. Integon’s next representative also had full authority to settle as long as the tortfeasor’s policy limits were tendered first. The trial court sanctioned Integon after both conferences, but the Court of Appeals held that sanctions on these facts were an abuse of discretion. Integon did send a representative with full authority to settle consistent with the terms of its contract. Because the UIM contract required payment of the tortfeasor’s policy limits as a condition of UIM coverage, the trial court did not have the authority to force Integon to settle a liability it never assumed in its contract.

Criminal acts exclusion

*Municipal Risk Management Authority v Boos*
Unpublished per curiam of October 18, 2011
(Docket No. 299273)

A former deputy sheriff did not have coverage for sexual abuse claims filed by inmates of the Livingston County Jail, because the relevant liability policy contained an exclusion for criminal acts. Coverage was excluded if a criminal act was alleged, and then proven, admitted, or uncontested. The deputy sheriff pled guilty to second-degree criminal sexual misconduct with regard to some of the claimants; as to the remaining claimants, he never contested his misconduct.

The insured claimed that he shot at the customer only to scare him away, but the court observed: “even in the absence of intent to cause bodily injury, an injury cannot be deemed to be caused by an accident if the insured’s intentional acts created a direct risk of harm.” Because the insured fired intentionally and thereby created a direct risk of harm, the shooting was not an accident.

Commercial liability – shooting is no occurrence

*Home-Owners Insurance Company v Chammas*
Unpublished per curiam of October 18, 2011
(Docket No. 299412)

Storeowner’s shooting of a hostile customer was not an “occurrence” within the meaning of his commercial liability policy and the insurer thus had no duty to defend or indemnify against the resulting lawsuit. The insured claimed that he shot at the customer only to scare him away, but the court observed: “even in the absence of intent to cause bodily injury, an injury cannot be deemed to be caused by an accident if the insured’s intentional acts created a direct risk of harm.” Because the insured fired intentionally and thereby created a direct risk of harm, the shooting was not an accident.

Title insurance – chain of title exclusion

*Blase v First American Title Ins Co*
Unpublished per curiam of November 29, 2011
(Docket No. 297555)

An exclusion in a title insurance policy for claims relating to “restrictions upon the use of the [titled] premises not appearing in the chain of title” relieved title insurer of having to defend or indemnify its insureds against a lawsuit by neighboring property owners, who sought to impose a negative reciprocal easement on the insureds’ use of their land. The exclusion applied whether the restrictions related to the use of the building or the land.
Cases involving Homeowners’ Policies

Renewal requires payment of the premium

Starr v Farm Bureau Gen'l Ins Co of Michigan
Unpublished per curiam of September 20, 2011
(Docket No. 298136)

This homeowners policy had a continuous renewal provision. It conditioned renewal on payment of the premium: “[t]he premium must be paid to us prior to the expiration of the then current policy term and, if not so paid, the policy will end.” Because the homeowner did not pay the premium before the existing policy expired, the policy did not renew and was not in effect when a fire broke out one month later. The 10-day notice requirement for cancellation did not apply because the policy was not cancelled. It was never renewed.

Another premium case - no payment, no policy

Simpson v Memberselect Insurance Company
Unpublished per curiam of November 22, 2011
(Docket No. 299658)

When the policyholder’s check for the first premium payment was dishonored, no policy took effect and there was no coverage for the water damage claim submitted five days later. The application for insurance expressly stated that a “check . . . which is not honored for any reason will not constitute payment” and that any action taken on the application would be “null and void.” Because the insured never paid for her insurance, her policy was null and void and she had no coverage at the time of her loss. The 10-day notice requirement for cancellation did not apply.

Animal exclusion

Nolan v Auto-Owners Insurance Company
Unpublished per curiam of November 22, 2011
(Docket No. 300106)

This policy for rental property contained an exclusion for property damage “resulting directly or indirectly from . . . animals owned or kept by any insured or tenant.” The insurer thus properly denied coverage for the damage caused by 18 animals (mostly dogs) housed on the property by the tenants after they moved. The contract language was clear and unambiguous, and did not require the insured’s knowledge of the presence of the animals. Nor was the exclusion repugnant to public policy.

Loss of coverage due to misrepresentations regarding damage

Nelson v American Fellowship Mutual Insurance Company
Unpublished per curiam of November 22, 2011
(Docket No. 299528)

Plaintiff waited too long to sue her homeowners’ insurer for breach of contract following the denial of her fire loss claim based on misrepresentations in her notice of loss documents. Nor did she produce any evidence to support claims of race and/or gender discrimination.

Son’s theft of his father’s property not covered

McGuinness v IDS Property Casualty Insurance Company
Unpublished per curiam of November 29, 2011
(Docket No. 299902)

This policy excluded coverage for stolen property if the theft was committed by “an insured person.” The named insured shared joint custody of his minor son with the mother. The son spent at least half of his time with his father. Because the son was a relative living in the named insured’s household, he was an “insured person” as defined in the policy. There was no coverage for the son’s theft of his father’s comic book collection.

Definition of “premises” in a homeowner’s policy

Freemont Insurance Company v Izenbaard
Unpublished per curiam of November 29, 2011
(Docket No. 300825)

The insured sought liability coverage for a lawsuit filed by a friend who was injured while driving an ATV on a strip of land near the insured’s property. The property on which the accident occurred was owned by Consumer’s Energy. Liability coverage extended to any claims arising out of the insured premises or any other “premises” used “in connection with” the insured property. The court held that “premises” means more than just land, it means land with buildings. Because there was no building on the Consumer Energy property, it was not “premises used in connection with” the insured property.
Contractual Liability and the Insured Contract

By James A. Johnson, johnsonjajmf@hotmail.com ©2011

Introduction

Contractual liability in a Commercial General Liability (CGL) policy is an exclusion that bars coverage for breach of contract and breach of warranty claims. The purpose of this exclusion is to eliminate coverage for claims arising under all contracts except claims arising under an incidental or “insured contract.” To fully understand contractual liability and its application you should reread my articles in the July 2009, January and July 2011 issue of The Journal of Insurance and Indemnity Law entitled “Additional Insured Endorsement, Construction Defect Claims as Occurrences Part I and Part II.” *

The contractual liability exclusion in the standard Insurance Services Office (ISO) CGL policy form bars coverage for breach of contract claims except for “insured contracts” for bodily injury or property damage arising after the execution of the agreement. The CGL policy defines “insured contract,” in relevant part as:

That part of any other contract or agreement pertaining to your business under which you assume the tort liability of another party to pay for “bodily injury” or “property damage” to a third party or organization. Tort liability means a liability that would be imposed by law in the absence of a contract or agreement.

An “insured contract” does not include that part of any contract or agreement:

That indemnifies an architect, engineer or surveyor for injury or damage arising out of:

1. Preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports [etc.]
2. Giving directions or instructions, or failing to give them . . .

[Emphasis added]

Contractual Liability Exclusion

The contractual liability exclusion bars coverage for breach of contract claims, except for “insured contracts” for bodily injury or property damage arising subsequent to the execution of the agreement. Avoiding coverage for breach of contract claims is the primary reason the CGL policy excludes all contractual coverage and then provides limited contractual liability coverage by an exception to the exclusion. The two exceptions are:

Liability of the insured that would be imposed without the contract or agreement
or
Liability assumed in a contract or agreement that is an “insured contract.”

Liability of the insured that would be imposed without the contract or agreement applies when the insured becomes legally obligated to pay damages imposed by law for torts such as negligence, and not to damages for breach of contract. Liability assumed by the insured under contract refers to liability incurred when one promises to indemnify or hold harmless another, and does not refer to liability that results from breach of contract.

The operative phrase in this exclusion is “assumption of liability by contract,” which refers to liability incurred when the insured promises to indemnify or hold harmless another. It does not refer to liability that results from breach of contract. It is the assumption of another’s liability that constitutes performance of the contract.

Hold Harmless

The purpose of the hold harmless or indemnity agreement is to transfer the risk of financial loss from one party (indemnitee) to another party (indemnitor). Properly written hold harmless and indemnity agreements should set out clearly the duty to defend, indemnification for any loss, costs or expenses, including attorney fees, obligating the indemnitor to the indemnitee. For example:

Indemnification

Subcontractor agrees to hold harmless, defend and indemnify the general contractor for any loss, costs or expenses, including attorney fees and costs, attributable to bodily injury or damage to property, arising out of subcontractor’s work or

* Editor’s Note: See also “Insured Contract Coverage 101” by Noreen Slank, Vol. 3 No. 1 (January 2010) of the Journal.
Subcontractor further agrees to procure insurance coverage naming the general contractor as an additional insured to satisfy the above hold harmless and indemnification obligation.

In sum, the CGL policy contains a detailed definition of “insured contract” and covers liability for bodily injury or property damage that the insured has assumed under any contract that meets the definition of an “insured contract.” Contractual liability insurance coverage applies only to hold harmless or indemnity agreements found in an “insured contract.” However, an agreement to indemnify another is not insurance and has nothing to do with insurance. Notwithstanding that insurance may pay for obligations assumed in an indemnity agreement, insurance is completely independent of the obligation to indemnify. And, the indemnity agreement found in a contract is extrinsic to an insured’s CGL policy.

“Insured contract” is defined and the definition begins by listing five types of contracts that are common to many businesses and organizations:

• A contract for a lease of premises (but not for a promise to pay for fire damage to a premise you rent or occupy).
• A Sidetrack agreement.
• Any easement or license agreement (not for construction or demolition on or within 50 feet of a railroad).
• An obligation, as required by ordinance, to indemnify a municipality (except for work for the municipality).
• An elevator maintenance agreement.

The contractual liability coverage provided for “insured contracts” is blanket in that the insured does not need to list or designate the covered contracts. Nor is a separate premium charge made for contractual liability coverage.

Also the definition of an “insured contract” includes not only the list above but also includes “that part of any other contract or agreement pertaining to your business . . . under which you assume the tort liability of another party to pay for ‘bodily injury’ or ‘property damage.’” . . . Thus the blanket contractual clause extends coverage to any contract pertaining to the named insured’s business under which he or she assumes the tort liability of another. “Tort liability” here means liability imposed other than by contract. Coverage applies only to a particular type of assumed liability that arises from a breach of duty and that exists independent of any contractual relationship the indemnitee may have with an injured party.

Conclusion

In sum, the CGL policy contains a detailed definition of “insured contract” and covers liability for bodily injury or property damage that the insured has assumed under any contract that meets the definition of an “insured contract.” The contractual liability exclusion therefore does cover the named insured’s hold harmless or indemnification agreements in a construction contract. It does not cover the named insured for its own liability arising out of faulty workmanship, breach of contract or breach of warranty claims. Contractual liability in a CGL policy is an exclusion unless the liability assumed in a underlying contract or agreement is an insured contract. This is a reference to an indemnity clause often found in a subcontractor’s contract but may also be in an equipment lease or a contract for services.

Contractual liability coverage applies the existing scope and amount of coverage to the indemnification requirement and does not expand the policy to cover different types of damages beyond that comprehended by the CGL Policy. This comports with the purpose of liability insurance which enables insurers to enforce the tortuity concept by excluding from coverage any policyholder’s agreements to become liable after the insurance is in force and liability is a certainty.

About the Author

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Endnotes

2 The Insurance Services Office is an insurance industry organization that prepares and disseminates standard form policies.
Happy New Year

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