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BUSINESS COURTS-SPECIAL ISSUE

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Opinions expressed herein are those
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section council or the membership.



Elaine M. Pohl

From the Chair

I hope that the New Year finds all of you well.

This issue of the *Journal* is a special “theme issue” focused on the new Business Courts that are beginning to take shape in Michigan. Insurance coverage and indemnity are almost always at the forefront or immediately behind business disputes, and the breadth of the articles in this issue is a reflection of the depth of experience and expertise that our Section members have on pertinent issues of insurance coverage and indemnity.

In addition to the regular features, this issue has a series of articles related to Business Courts and the cases they will handle. The articles include:

- “Business Courts in Michigan – A History,” by Douglas L. Toering, explains the origins, structure and purposes of the business courts.
- “Business Courts and ADR,” by Douglas Van Epps, explains the role of the Supreme Court Administrative Office’s Office of Dispute Resolution in assisting in the work of the Business Courts.
- “Business Courts, Insurance Coverage and Indemnity Disputes, and Early Expert Evaluation,” by Mark Cooper and Hal Carroll, describes a method of early intervention ADR designed for insurance and indemnity disputes.
- “Business Court and Indemnity Cases,” by Noreen Slank, explores the details of handling indemnity issues in Business Courts.

These articles provide a comprehensive explanation of the theory and practice of the Business Courts, and they demonstrate the extensive range of talent and expertise that this Section can provide to the Business Courts and the litigants who are using them.

November Program – Successful Mediation

I wanted to take this opportunity to thank Brian Pappas and Edward Pappas, the presenters at our November 14, 2012 program, “Successful Mediation: Is It All About the Money?” Brian and Ed presented a lively discussion about mediation and ways to increase the likelihood that it is successful for your client. You’ll find some highlights of the program inside.

The program was followed by a networking reception and we were glad to see many of you there. Thank you also to Kim Ruppell on our Programs Committee, who took the lead in planning the event.

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From the Chair Continued from page 1

Our Committees

As I mentioned in our previous issue, the Insurance and Indemnity Law Section relies on strong and active committees to accomplish much of its work. Because of changes in positions after the September 2012 elections, I am happy to announce the chairpersons of our committees:

Membership Committee—Dan Steele and Barry Feldman. Our Section has about 580 members after five years of growth. The focus of our continued growth is to continue getting the word out. To do that, we need an active Membership Committee. To ensure a balance between insureds and insurers, we like to have two chairpersons, one from each side of the issues. Dan and Barry fill that need and we appreciate their willingness to serve.

Program Committee—Kathleen Lopilato. As Chair Elect, Kathleen now serves as the chairperson of the

Program Committee. Providing our members with useful and informative programs is a key part of our Section's strategic plan as we move forward.

Strategic Planning Committee—Adam Kutinsky. This committee is developing a 5-year plan in addition to our existing 2-year plan. We believe this planning will serve to ensure our Section's consistent growth and development.

Publications Committee—Hal Carroll. As editor of the *Journal*, Hal puts together a terrific product each quarter. Larry Bennett also serves on the committee, and the committee is an important part of that work.

Serving on a committee is an excellent way to network with your colleagues. If you are interested in serving on any of our committees, please contact me or any of the committee chairpersons. ■

Editor's Note



By Hal O. Carroll, www.HalOCarrollEsq.com

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.

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Business Courts in Michigan: 2001-2013

By Douglas L. Toering, Toering Law Firm PLLC ©2012

Introduction

On October 16, 2012, Governor Rick Snyder signed Michigan Public Act 333 (2012), which will establish business courts in every Michigan county with at least three circuit judges.¹ In those circuits, every “business or commercial dispute” (including suits between insurers and business insureds) will be assigned to a special docket.² The law is effective January 1, 2013. In this article, we will examine the 12-year effort to establish business courts in Michigan, discuss the business dockets in three circuit courts, provide a brief overview of the law as it pertains to insurance litigation, and look forward to the future.

History of Business Courts in Michigan The “Cyber Court”: No Cash, No Court

To understand the new business court act, it is helpful to hark back nearly 12 years. In 2001, then Governor John Engler signed a bill for a “cyber court.”³

Among the eight purposes of the cyber court were: (1) to “[e]stablish judicial structures that will help to strengthen and revitalize the economy of this state”; (2) to allow “business or commercial disputes to be resolved with the expertise, technology, and efficiency required by the information age economy;” and (3) to supplement “other state programs designed to make the state attractive to technology-driven companies.”⁴

Like the new business courts, the cyber court was limited to “business or commercial disputes” over \$25,000.⁵ This included disputes “arising out of business or commercial insurance policies.”⁶ In a dramatic departure from traditional courts, the cyber court’s proceedings would be conducted by audio, video, or Internet conferencing.⁷ In fact, the cyber court judge had the discretion to broadcast proceedings on the Internet.⁸ One of the most controversial parts of the cyber court, however, was the waiver of jury trials.⁹

But the main problem was this: Money. (Or more precisely, lack of it.) The cyber court was to be funded by the Michigan Supreme Court.¹⁰ With a tight state budget, it is no surprise that the Supreme Court had no extra money for the cyber court. The cyber court was never funded.

Anyway, the new business court act has formally repealed the cyber court statute and given it a proper burial.¹¹ Nonetheless, much of the business court statute was patterned after the cyber court.

Early History of Business Court Legislation

2001-2003: State Bar Business Law Council Proposes Business Courts

In December 2001, the State Bar of Michigan’s Business Law Council set up an ad hoc committee to study whether Michigan should establish some form of a business court. The ad hoc committee knew about the cyber court legislation, of course. Over 200 Michigan attorneys either joined or expressed interest in working with that committee. In April 2002, the committee identified three purposes of business courts: (1) enhancing the consistency, predictability, and accuracy of decisions in business cases; (2) enhancing efficiency through proactive case management, technology, and early alternate dispute resolution; and (3) attracting and retaining businesses in Michigan. Due to the size of the group, an Executive Committee was formed, chaired by Diane L. Akers.

The Executive Committee analyzed business courts in other states. In addition, they arranged for a presentation on business courts from Robert L. Haig of New York City, a national expert on business courts, and met with lawyers, judges, and representatives of chambers of commerce and industry associations. The comprehensive study by Mitchell L. Bach and Lee Applebaum, both of Philadelphia, was also helpful.¹²

The result? In 2003, the Executive Committee drafted a pilot proposal for a business court and presented this to circuit judges in Kent, Oakland, and Wayne Counties.

Over the next couple years, the Executive Committee continued its work. In 2005, the then majority whip of the Michigan House of Representatives, Brian Palmer of Macomb County, introduced a bill to establish a business court. That bill never made its way out of the House Judiciary Committee.

2009: Judicial Crossroads Task Force Recommends a Pilot Program

Fast forward to 2009. The State Bar of Michigan established a “Judicial Crossroads Task Force”, born largely from a concern about how the legal system had been “struggling to deliver justice in the face of diminishing resources and rising needs.” (Sound familiar?) As part of its work, the Task Force created a Business Impact Committee. That committee’s task was to “review the ways in which

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Business Courts in Michigan

Continued from page 3

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Michigan's court system serves the business community and to determine whether there are procedural or structural changes that would improve the system." Diane Akers and Andrew S. Doctoroff were members of the Task Force and co-chaired the Business Impact Committee.

In October 2010, the Judicial Crossroads Task Force adopted the Business Impact Committee's recommendations. Specifically, the Task Force recommended to the state that our Supreme Court should create "pilot business dockets" in at least two circuits and "designate no more than three judges per circuit to handle the business docket..." Ever cost conscious, the Task Force concluded that a business docket should require little or no cost and could result in "savings in time and expense to businesses and other court users."¹³

The seeds for the business court were planted.

2011: Business Court Legislation Is Again Introduced

A year later, the seeds started to germinate. On October 26, 2011, Representatives John F. Walsh and Kurt Heise introduced house bill 5128 in the Michigan House of Representatives. Generally, this proposed statewide business courts. Specifically, the state would be divided into four regions (consistent with the regions for the Michigan Court of Appeals). Jurisdiction would be the same as circuit courts (\$25,000).

Overall, the bill was well received. Judges liked its opt-out provisions. The main concern was the four regions. Within a year, the bill would be revised and become law.

2011-2012: Three Circuits Adopt "Specialized Business Dockets"

Shortly after HB 5128 was introduced, Macomb County began its "Specialized Business Docket", the first of its kind in Michigan. It opened November 1, 2011. Now over a year later, Judge John C. Foster remains the designated business docket judge.¹⁴

On March 1, 2012, Kent County started its Specialized Business Docket (SBD).¹⁵ Both the Macomb and the Kent SBDs are modeled after the Business Impact Committee's recommendations.

Indeed, both dockets emphasize active case management, such as initial pretrial disclosures (with a follow up pretrial re-

port) along with an early court conference and a detailed case management plan. In addition, the courts' opinions are available online. Judge Christopher Yates is the business docket judge for Kent County. In fact, he has written on Kent's Specialized Business Docket.¹⁶

Launched July 1, 2012, Oakland County's Specialized Business Docket is much different from Kent's or Macomb's.¹⁷ In Oakland, every judge is an eligible business judge. So depending on the blind draw, any judge on any given day can receive an SBD case. Moreover, Oakland has set a threshold of \$500,000, far higher than the \$25,000 amount in Macomb or Kent.

As of November 1, 2012, both Macomb's and Kent's Specialized Business Dockets have enough experience to report meaningful statistics.

Macomb County: 12 months of operation: 24 cases assigned to the SBD; 11 cases closed, all without going to trial. The closed cases were open for an average of 150 days.

Kent County: 8 months of operation: 112 cases assigned to the SBD; 28 cases closed, all without going to trial. The closed cases were open for an average of 104 days.

2013: The New Business Court Legislation Takes Effect

Although a detailed analysis of the new business court statute is beyond the scope of this article, it is helpful to note how the new law will affect insurance litigation. Because insurance companies are "business enterprises", any dispute between insurers (including those that are non-profits) will generally go to the business court.¹⁸ This would include, for example, declaratory judgment actions between insurers (or between an insurer and a business insured) as well as subrogation litigation.

In fact, the statute specifically provides that disputes "arising out of business or commercial insurance policies" belong in the business court.¹⁹ But "insurance coverage disputes" involving an "individual consumer" are specifically excluded. Likewise, claims involving "[m]otor vehicle insurance coverage" (such as no fault, of course) are excluded, "except where 2 or more parties...are insurers..."²⁰

The Future

The legislation is effective January 1, 2013. The State Court Administrative Office expects to submit minimum business court standards, a model local administrative order, and proposed court rules to the circuits by January 1, 2013; the circuits, in turn, will nominate their judges by March 1, 2013 and submit their individual plans for approval by May 1, 2013. The

Supreme Court will then approve those plans and judges. Cases will be placed on the business dockets by July 1, 2013.²¹

What about training for the newly-minted business court judges? That's the responsibility of the Michigan Judicial Institute.²² What that will consist of, when, and where are yet to be decided. Who will conduct the training sessions? Will the training include any discussion of insurance disputes? How many judges will Wayne and Oakland designate for their business courts? That, too, is yet to be determined. Presumably, the existing SBD judges will be involved in training new business court judges.

And what about the pilot Specialized Business Dockets in the three counties? Existing cases will remain on those dockets, of course. For Kent and Macomb, the only major change involves the definition of the cases that will go to their business dockets. Other than that, their SBDs will look a lot like they do now. Oakland's business docket will change, however. In fact, Oakland is already making plans to lower its jurisdictional minimum from \$500,000 to the required \$25,000; Oakland will also designate specific judges for its business court.

Conclusion

Done right, business courts will meet the statute's goals. Business courts will help improve efficiency of the courts, will allow business disputes to be resolved by judges with expertise in those kinds of disputes, and will enhance the accuracy and predictability of decisions in business and insurance litigation.²³

But what exactly does "done right" mean, in the context of business courts here in Michigan? That remains to be seen. Undoubtedly, though, it includes early and active judicial intervention. That can include, for example, an early initial conference with the judge, customized scheduling orders, limited or expedited discovery, and follow up conferences (electronically or in-person) with the court as needed. The statute does not require any of this, although Kent's and Macomb's business dockets emphasize these strategies. Other circuits will probably adopt similar protocol as well. Online opinions, which are required under the new law, will also help. All of this should help make litigation involving insurance companies or their commercial insureds quicker and more efficient.

Yes, it did take nearly 12 years to get to this point. Will it be worth it? Stay tuned. ■

About the Author

Before becoming a principal at Toering Law Firm PLLC, Douglas Toering practiced as in-house counsel for General Motors Corporation and later as a partner in Bowman and Brooke

and as a principal at Grassi & Toering, PLC. His practice emphasizes commercial and insurance litigation along with business startups. In addition, Mr. Toering is a member of the State Bar of Michigan's Business Law Council, where he chairs the Commercial Litigation Committee, Small Business Forum, and the Law Schools Committee. He also serves as a volunteer director of the Christian Legal Aid of Southeast Michigan and as a TechTown Mentor.

Endnotes

- 1 MCL 600.8031 *et seq.*
- 2 § 8031(1)(a), (b), (c), (e).
- 3 MCL 600.8001 *et seq.*
- 4 § 8001(2)(a), (b), (f).
- 5 § 8005(1).
- 6 § 8005(4)(e).
- 7 § 8001(3).
- 8 § 8001(4).
- 9 §§ 8013, 8019. See, e.g., Toering, *Discovery in Cyber Space: The New Michigan Cyber Court*, ABA Pretrial Practice & Discovery Committee 12, Vol. X, No. 2 (Spring 2002).
- 10 § 8001(6).
- 11 MCL 600.8031, .8047.
- 12 See *A Brief History of the Creation and Jurisdiction of Business Courts in the Last Decade* (2003). This also provides an excellent history of the cyber court and the early effort to establish a business court in Michigan. That work was later published in 60 Bus. Law. 147 (2004).
- 13 <http://www.michbar.org/judicialcrossroads/JudicialCrossroadsReport.pdf> (pp. 14-15). See also ABA Annual Review of Developments in Business and Corporate Litigation 281-282 (2012).
- 14 <http://www.macombcountymi.gov/circuitcourt/sbd.htm>.
- 15 <http://www.accesskent.com/CourtsAndLawEnforcement/17thCircuitCourt/eFiling.htm>.
- 16 Yates, *Specialized Business Dockets: An Experiment in Efficiency* in Nelson P. Miller *et al.*, *Lawyers as Economic Drivers—The Business Case for Legal Services* 207 (2012).
- 17 <http://www.oakgov.com/courts/circuit/Documents/ao/12-03.pdf>.
- 18 MCL 600.8031(1)(a), (b).
- 19 § 8031(2)(e).
- 20 § 8031(3)(l), (m). Neither of these exclusions was mentioned in the cyber court act. MCL 600.8005.
- 21 <http://www.courts.michigan.gov/Administration/SCAO/Documents/General-Administrative/BusinessCourts.pdf>.
- 22 § 8043.
- 23 § 8033(3).



Business Courts and ADR: SCAO Research Supports Early ADR Interventions

By Doug Van Epps, *Director, Office of Dispute Resolution, State Court Administrative Office, Michigan Supreme Court*

The past two years have witnessed unprecedented change in Michigan's judiciary that can be summarized into just a few key phrases: concurrent jurisdiction, court consolidation, judicial resources recommendations, performance measures, and the subject of this issue of the *Journal*, business courts.

The State Court Administrative Office (SCAO) has approved business court Local Administrative Orders (LAOs) for three circuit courts and in early 2013 will be publishing model LAOs and guidelines for the operation of business courts for additional jurisdictions that will be creating business courts under 2012 PA 333.

The origin of the "early ADR" and "proactive case management" themes commonly associated with business court case management practice is discussed in another article in this issue. This article outlines several studies conducted by the SCAO and local court practices that support the integration of early ADR practices into business court case management.

Further, with the new focus on performance measurement, early ADR in any case type may also help courts meet case disposition, user satisfaction, trial date certainty, juror utilization, and other performance goals.

ADR is Not New; Determining Which Process, and When to Conduct it Is

Michigan's oldest form of ADR—case evaluation—has traditionally taken place in the near final moments of litigation, just before the final settlement conference. Currently, most courts report case evaluation disposition rates below or near 20 percent, meaning that considerable staff resources are invested in scheduling, conducting, and reporting back to parties on an event that by a significant margin does not immediately dispose of cases.

In contrast, far higher disposition rates—typically between 50 and 70 percent—are being achieved through mediation, and this is causing a sizeable shift in thinking among judges and court administrators about: (1) when ADR should first be discussed; (2) which ADR process should be conducted first; and (3) when the ADR process(es) should be held.

For example, the 13th Circuit Court, Grand Traverse County, several years ago discontinued the practice of automatically scheduling case evaluation in every case, determining that the resources expended in managing the process exceeded any benefit from the small number of settlements that resulted from the process. Having achieved far higher disposition rates

with the new focus on performance measurement, early ADR in any case type may also help courts meet case disposition, user satisfaction, trial date certainty, juror utilization, and other performance goals.

through mediation, the court adopted mediation as its default ADR process and includes it, rather than case evaluation, in its scheduling order.

Addressing the question of "when should ADR be discussed," the Sixth Circuit Court, Oakland County, for some years hosted Early Intervention Conferences (EIC) for "C" captioned cases (chiefly CH, CK, and CZ case types) approximately 100 days after the response. The purposes of the volunteer attorney-conducted conferences, were to discuss, with parties present: (1) the extent of settlement discussions to date; (2) whether any issues could be narrowed; (3) whether any contested motions were likely; and (4) when ADR might best be conducted. In short, the typically 30-45 minute conference was intended to bring parties together to take a realistic look at the trajectory of the case and to identify when it might be most advantageous to conduct an ADR process, which was most typically mediation.

For 2009, the court reported a 32 percent disposition rate from settlements either before at the conference date. Many of the volunteer attorneys anecdotally reported that they were later selected to serve as mediators, chiefly for their having already been involved in early case management discussions.

Of 116 attorneys responding to a survey, 71 percent responded that they were satisfied with the program, and 68 percent encouraged the use of the EIC for other case types.

The Court as Emergency Room

Over 30 years ago Harvard Professor Frank Sander encouraged judges to "fit the forum to the fuss." In a medical analogy, persons with medical issues approach an ER desk, briefly explain the reason for their being there, and then have outcomes as varied as a brief checkup and a release to go home, admission for testing with resulting prescriptions for medications and treatments, and most drastically, immediate surgery.

The traditional court response to someone with a legal issue, however, has been to send everyone down the hall toward

surgery, e.g., trial. An early opportunity to gauge the extent of the problem typically does not exist. In short, everyone gets sent toward surgery, even though 98 percent of the parties headed there won't in fact go under the knife.

The analogy is not perfect, and to be certain, court managers have had differentiated case management systems at their disposal for decades. But in Michigan, despite strong evidence that when parties talk, cases dispose, ADR has largely remained confined to the near final event before trial, even though at that moment its efficacy of saving time and money is largely lost, since 98 percent of the cases would most likely be disposed without anything but the final settlement conference and a firm trial date.

Triaging a Court Case

The creation of the business court, with its attendant goals of early and active intervention, provides the framework for an early triaging opportunity to pose to the parties the types of questions asked in the Early Intervention Conferences. Not surprisingly, these are the same questions identified as key to the early disposition of insurance and indemnification cases, addressed in another article in this issue of the *Journal* that proposes early evaluation early evaluation of those cases by a neutral expert:

1. what are the areas of agreement and disagreement;
2. what is the current posture of settlement negotiations;
3. whether any matters can be resolve collaboratively without contested hearings, e.g., contested discovery matters;

4. issues to be narrowed;
5. probable liability of the parties; and
6. possible areas of settlement.

Perhaps the most noteworthy aspect of the authors' Early Expert Evaluation proposal is that it already has a solid basis of performance in Michigan's ADR history: first as being a close cousin of case evaluation, except that it is conducted very early in the litigation; and second, in that it can result in a confidential written recommendation of settlement terms, which for over 12 years has been a core component of domestic relations mediation under MCR 3.216.

Evaluation Findings

The SCAO's 2011 study, "The Effectiveness of Case Evaluation and Mediation in Michigan Circuit Courts," encourages continued expansion of primarily mediation services. The evaluators found that mediation resulted in faster case disposition times than if no ADR was used; mediation was more effective than case evaluation in achieving settlements; and mediation was viewed by judges and court administrators as reducing costs (case evaluation was not viewed as reducing costs to courts). Judges and attorneys both expressed more favorable views of the effectiveness of mediation compared to case evaluation.

On this latter "user satisfaction" element, 77 percent of the over 3,000 attorney respondents to a survey agreed that mediation is an effective method for resolving civil disputes. Eighty percent of judges agreed with the same proposition.

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Business Courts and ADR

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The study contains a wealth of information about both processes, and can be found at the Supreme Court's website.¹

. . . in Michigan, despite strong evidence that when parties talk, cases dispose, ADR has largely remained confined to the near final event before trial, even though at that moment its efficacy of saving time and money is largely lost . . .

Orders to Mediate Prompt Pre-Mediation Settlements

In separate 2011 study of cases that were ordered to mediation that had already been case-evaluated under \$25,000, the SCAO found that 40 percent of the cases settled prior to mediation taking place, and an additional 32 percent settled "at the table." Because an additional 7 percent of cases settled without any further court activity, fully 77 percent of the cases ordered to mediation could be attributed to this single event. Although these were very late-stage mediations, and essentially falling within the jurisdiction of the district court, the data supports a finding that simply ordering parties to the process will result in (in this case) significant dispositions. The full study is available at the Supreme Court's website.²

The Performance Measure Perk

While beyond the scope of this article, ADR has significant potential to help courts meeting performance measure goals they will be establishing in the years ahead. The evidence presented above reflects that courts experimenting with earlier ADR interventions could realize a reduction in the number of activities related to the scheduling and conducting of the down-line events, including hearings on contested discovery motions, case evaluation, settlement conferences, and trial.

Whether in meeting or improving upon a court's case disposition times, in enhancing user satisfaction, or improving juror utilization rates, early ADR interventions should be considered for helping parties most efficiently use limited judicial resources to reach the earliest possible, and just resolutions. These and related issues will be discussed in forthcoming editions of the SCAO's publication, "Connections."

The Opportunity for Litigants

While focused on early ADR's benefits to courts, the goal of the business court in the first place was to improve the dispute resolution process for litigants. To that end, ADR may help business litigants identify areas of agreement and disagreement that narrows the litigation; explore early settlement opportunities; reduce the number of contested motions; receive early input from experts; yield greater lawyer/client satisfaction rates, and ultimately reach quicker disposition times at less cost than under traditional case management practices.

The advent of the business docket provides an excellent opportunity for courts to experiment with early ADR interventions. Whether this involves meeting with a judge, volunteer attorney/mediators, "expert evaluators," or others, the special focus of the business docket provides judges with an opportunity to creatively promote early ADR and case management discussions as an alternative to simply sending all cases down the traditional trajectory toward trial.

SCAO's Office of Dispute Resolution (ODR)

In conjunction with SCAO's Regional Administrators and Trial Court Services, ODR staff is available to discuss and help design ADR systems in the trial courts, develop pilot projects, and assess how ADR interventions could be evaluated. ODR staff also administers the Community Dispute Resolution Program (CDRP), and can help courts explore how to most effectively and efficiently utilize the CDRP center serving their jurisdiction. ■

About the Author

Doug Van Epps is the Director of the Office of Dispute Resolution at the Michigan Supreme Court. In addition to overseeing the Community Dispute Resolution Program, this office oversees the development of ADR practices throughout Michigan's trial courts. Mr. Van Epps is an active facilitator and presenter on the integration of ADR into court management practices.

Endnotes

- 1 <http://courts.michigan.gov/Administration/SCAO/Resources/Documents/Publications/Reports/The%20Effectiveness%20of%20Case%20Evaluation%20and%20Mediation%20in%20MI%20Circuit%20Courts.pdf>
- 2 <http://courts.michigan.gov/Administration/SCAO/Resources/Documents/Publications/Reports/Mediation%20After%20Case%20Evaluation.pdf>



Business Courts, Insurance Coverage and Indemnity Disputes, and Early Expert Evaluation

By Mark Cooper, *Jaffe, Raitt Heuer & Weiss*, and Hal Carroll

The bill creating “Business Courts” has now become law (MCL 600.8031 et seq.) and the process of implementing it has begun. At least three counties – Kent,¹ Oakland² and Macomb³ – have adopted rules to put the statute into practice, and others will follow suit. Every circuit with three or more judges is required to establish a Business Court.”⁴

Disputes over insurance coverage and indemnity – usually contractual indemnity – are one category of disputes between businesses or between businesses and their insurers, that can benefit from the early intervention of a neutral expert to resolve the disagreement. The scope of authority of Business Courts specifically includes “Those [disputes] arising out of business or commercial insurance policies.”⁵ Disputes involving individual insureds are specifically excluded from Business Courts.⁶

Disputes over insurance coverage and contractual indemnity are notoriously bad candidates for conventional mediation or case evaluation. Case evaluation was designed for the resolution of cases that rest on disputed facts and relies on the practical knowledge of three case evaluators, each of whom will bring a different orientation to the dispute. After a brief presentation by the parties, the evaluators confer in private and announce a number. Whatever the merits of that model for tort cases, it never works well with insurance coverage and indemnity disputes, where factual disputes are minimal or nonexistent and written documents define the issues.

In addition, many disputes over insurance coverage and indemnity involve multiple parties. Consider a construction site injury, where the injured worker sues the general contractor and two subcontractors. Each of the three has a contract, a primary insurer and an excess insurer, so now there are nine parties to the dispute, as each insurer and indemnitor tries to push the loss onto one or more of the others. And, although the injured worker did not sue his or her employer, the other defendants will, because the employer’s contract with the general almost certainly has an indemnity clause and a duty to add the general, and maybe the other subcontractors, as additional insureds. Now there are 12 parties, and the number of possible links between them is not 12, but a multiple of 12.

Then there are the little arcanities that pervade insurance coverage and indemnity. When the effect of an indemnity clause is at issue, the difference between indemnity for a loss “arising out of your performance” and indemnity for a loss “caused by your act or omission” is the difference between

night and day. And every insurance law practitioner knows that a clause containing “the insured” and one containing “an insured” can lead to vastly different results.

The result, especially in multiple party disputes, is that the tort defendants are often unable to make a settlement with the tort plaintiff because they and their insurers cannot agree on who will bear what share of the payment. Litigation thus drags on – both the tort litigation and the coverage and indemnity dispute – and becomes more expensive.

Facilitation can work better, because the facilitator can spend more time drawing the parties out so that each can explain its positions to the other parties. But if the facilitator follows the shuttle diplomacy model, without engaging the parties on the issues, it can still fall short of a resolution, especially in a multiple party case.

The longer the coverage or indemnity dispute drags on, the more each party and each attorney becomes wedded to its position, and settlement becomes increasingly more difficult.

Early Neutral (Expert) Evaluation

But insurance coverage and indemnity disputes also have characteristics that make them good candidates for a specialized version of Alternate Dispute Resolution, based on early intervention and evaluation by a neutral expert. First, these are contract disputes, so the result depends on the language of the contracts. There is seldom any need to resort to testimony at all, and never a need to evaluate the credibility of a witness’s story. Even the convention that contracts are interpreted so as to give effect to the “intent of the parties” actually means the intent as expressed by the words of the contract.

Another characteristic of insurance coverage and indemnity cases is that there are no underlying factual disputes that need to be resolved. Even when the coverage and indemnity claims relate to an underlying tort claim, and that tort claim is unresolved at the time the coverage and indemnity dispute arises, the parties will know the range of possible outcomes on the tort claim. The Early Neutral Evaluation can proceed based on the possible outcomes.

When there are multiple parties, the tort claim will eventually result in some form of resolution that will take the form of percentages of fault. The resolution of the coverage or indemnity dispute will also take the form of percentages. The Early

continued on the next page

Business Courts and Insurance Coverage

Continued from page 9

Neutral Evaluation can easily factor different tort outcomes into the process.

Because insurance coverage and indemnity disputes are based on contracts, there is little or no need for discovery. The parties already know the relevant documents and can exchange them quickly. The Early Expert Evaluation process can start soon after the case is filed.

The Process

The critical differences between Early Expert Evaluation and other forms of ADR are the expertise and the active participation of the evaluator, and the process is designed to bring both to bear.

The Business Courts are designed to identify the candidate cases immediately upon filing. From those cases, the Court Administrator or designated ADR administrator can identify the cases that involve insurance coverage or indemnity issues. These cases can be selected for ADR and set for an early scheduling conference, ideally within a month of filing.

At the conference, the Business Court judge or the ADR administrator would have a list of evaluators who are experts in insurance coverage and indemnity disputes, and the parties would select a neutral evaluator from that list. They would also agree on which documents to exchange and to provide to the evaluator.

The normal scheduling deadlines would then be suspended while the Early Expert Evaluation takes place. Depending on the complexity of the issues, this would be two or three months. If the process succeeds, the case can be disposed of by stipulation of consent judgment. If not, then the case can return to the regular Business Court docket.

Within this broad outline, several variations are available for the parties to choose from, with the consent of the court.

The parties might prefer the evaluator to avoid offering an opinion, and instead merely ask pointed questions about each party's argument, so as to attempt to draw them out and see the weaknesses and strengths in each argument. This would be much like conventional facilitation, but with the added effect of bringing the evaluator's expertise to bear.

A more hands-on approach would begin as above, but the parties would also agree that if no resolution is reached, the evaluator will provide a written recommendation, with or without a statement of the reasons and analysis in support of it. Depending on the case, the recommendation would take

The result, especially in multiple party disputes, is that the tort defendants are often unable to make a settlement with the tort plaintiff because they and their insurers cannot agree on who will bear what share of the payment. Litigation thus drags on – both the tort litigation and the coverage and indemnity dispute – and becomes more expensive.

the form of a dollar amount or percentages of responsibility. The issue of sanctions for rejection would also be agreed at the start of the process.

If the parties prefer greater involvement, the evaluator would offer observations and comments about the strengths and weaknesses of each party's argument, drawing on the evaluator's expertise.

The parties might also agree to ask the evaluator to provide a written evaluation, much as a court would write an opinion.

In some cases, the parties might ask for a written evaluation and agree to be bound by it.

The range of options runs from a process that mirrors facilitation to one that is essentially arbitration.

Facilitation is sometimes used in insurance coverage and indemnity cases as an alternative to mediation. Early neutral evaluation is different in these ways: First, by design it occurs as early as possible in the litigation, before discovery is commenced. The point is to engage the parties early before the litigation has already become expensive and the positions have hardened. Second, early expert evaluation relies on the specialized expertise of the evaluator to be brought directly to bear on the issues. A facilitator might focus on specific points and ask the parties to elaborate on them for the opposition, but the neutral expert evaluator would speak directly to the parties regarding the case law and the language of the policy or contract.

The degree of the court's involvement also would be established at the outset. At one end of the spectrum, the parties might prefer that the parties simply advise the court that the evaluation worked or did not. At the other, the evaluator could provide a written report for the use of the parties and the court.

Under any of these variations in the procedure, an intended consequence is that each party becomes more aware of the

weaknesses in its case and the strengths in the other parties' cases. The purpose is to make each party see its case and its prospects of success, more clearly. At a minimum, this would enhance the quality of the presentations if the case still goes to the court for resolution.

Summary

The characteristics that distinguish insurance coverage and indemnity disputes from other disputes make it a poor candidate for conventional case evaluation and conventional facilitation, but they also make it an excellent candidate for early intervention by a neutral person who is an expert in insurance coverage and indemnity law.

The new Business Courts provide a framework in which Early Expert Evaluation of disputes over insurance coverage and/or indemnity can be brought to swift resolution, thereby reducing the expense of litigation to the parties and the courts. ■

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Endnotes

- 1 Kent County Circuit Court Administrative Order 2011-05.
- 2 Oakland County Circuit Court Administrative Order 2012-03 established a "Specialized Business Docket (Business Court)."
- 3 Macomb County Circuit Court Administrative Order 2011-05.
- 4 MCL 600.8033. (1) "Every circuit with no fewer than 3 circuit judges shall have a business court and shall submit a plan for the operation of the business court to the state court administrative office and the supreme court for approval."
- 5 Section 8031(2)(E).
- 6 The statute specifically excludes "Insurance coverage disputes in which an insured or an alleged insured is an individual consumer." MCL 600.8031(3)(M).

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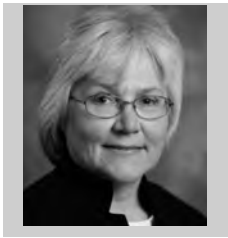
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Business Court and Indemnity Cases

By Noreen L. Slank, Collins, Einhorn, Farrell & Ulanoff, PC

Some indemnification practitioners bemoan the quality of judging in our cases. Doubtless that's mostly about taming our savage beast—the one that makes us lose an indemnity argument on account of *Smith v Jones* one day, but when we're on the opposite side of *Smith v Jones* the next day we still lose. The beast is likely lack of clarity in our case law. But we're quick to argue that judging should be better and then we would stop looking so foolish because we'd be able to more accurately predict results for our clients.

Check out the Business Court Act, MCL 600.8031 et seq. The statute says that one of its purposes is to “enhance the accuracy, consistency, and predictability of decisions in business and commercial cases.” 600.8033(3)(c).

Any county with three or more circuit judges must set up a business court. The statute's effective date is January 1, 2013, but operational plans need to be submitted to SCAO and the Supreme Court for approval, so don't hold your breath on implementation. Perhaps the circuits that have been part of the business court pilot program, Oakland, Macomb and Kent, will be able to move quickly.

There are opportunities to move indemnification cases to the business courts.

First off, the broad outline. What's “in” the business court is any “business or commercial dispute” as defined at 600.8031(1)(c) and (2), subject to the exceptions set out at (3)(a) through (q). Yes (a) through (q). If all of the parties are “business enterprises,” which is what is almost always going to be true in a contractual-indemnity case if we could extract the principally injured party, then you've got a “business or commercial dispute” under §8031(c)(i). There are other routes to being a “business or commercial dispute,” but § 8031(c)(i) will scoop in contractual-indemnity cases **unless** some exception applies and **provided** we don't have to litigate the indemnity case with any non-business-enterprise parties in tow. However, individuals who are a party's “present or former owners, managers, shareholders, members, directors, officers, agents, employees, suppliers or competitors” won't destroy the “business or commercial” nature of the dispute provided “the claims arise out of those relationships.” 600.8031(c)(ii).

Just to add a bit of a twist, §8031(2) next teaches us that “business or commercial disputes” “include but are not limited to” certain types of cases. Included in (2)(c) are those cases “arising out of contractual agreements or other business dealings, including” a list of yet more embedded descriptors. Those descriptors don't include indemnity agreements. But no

need for the business-court-bound to be queasy about anything in (2) because (2) gets you “in” to business court and doesn't get you kicked “out” of business court.

“Notwithstanding (1) and (2),” which is everything you've read so far, a case *isn't* a “business or commercial dispute” if it's one of the seventeen kinds of cases listed in §8031(3). For a wannabe contractual-indemnity business-court inhabitant, two exceptions will routinely matter. But there may be a viable workaround.

“Personal injury actions, including but not limited to, wrongful death and malpractice actions” and “product liability actions in which any claimant is an individual” are not “business or commercial disputes.” Sections 600.8031(3)(a) and (b). They are even listed right up there at the top of the alphabet soup, so keeping personal injury cases out of business court was probably the first thing the drafters thought of. It makes sense.

Often a contractual-indemnity case is a cross claim or third-party complaint in a personal-injury action. If you have an individual injured plaintiff (a person), that individual's presence in the lawsuit almost assuredly destroys business-court potential because everybody won't be a “business enterprise” and §8031(c)(i) won't be satisfied. You are probably already thinking about that list of individuals who don't destroy business-court potential including “employees” provided “the claims arise out of those relationships.” 600.8031(c)(ii). You are thinking about all the contractual-indemnity cases where the injured plaintiff is an employee of one of the indemnity parties, with his claims also probably arising out of “those relationships.” Interesting, but my bet is this is no ticket to business court. The “no personal injury” lawsuit ban under §8031(3)(a) is a high priority matter if business courts are to stay, well, business courts.

To get a share of that “accuracy, consistency, and predictability” the Business Court Act promises, consider filing indemnity cases as separate cases. Forget the cross complaints and third-party complaints. A separate case would keep the personal injury, wrongful death and individual product-liability exceptions at bay. After shedding the injured plaintiff, what is left will almost always be only business-enterprise defendants and your indemnity case should be a “business or commercial dispute.” Be mindful of necessary joinder and nonjoinder of parties rules, see MCR 2.205 and MCR 2.207. But if codefendants in the injury action can be as committed to filing no cross claims or third-party complaints as you are

then those rules should not be an impediment to litigation in business courts.

What to do about discovery is something to consider as well. A case assigned to business court can be reassigned by blind draw to the regular docket “if the action ceases to include a business or commercial dispute.” 600.8035(5). If the injury case and the indemnity case were consolidated only for discovery purposes, you might be concerned that the power of the personal-injury exception could erase the business nature of your case. In any event, the two cases can’t actually be consolidated for discovery purposes, because there will be two different judges. If there is a discovery motion, would we be expecting the judges to “draw straws” to decide who will rule?

If the parties to the two cases can find common enough ground to allow discovery to proceed together without consolidation, that could work. A wary personal-injury plaintiff might be impressed that resolution of an indemnity case can facilitate a settlement for the injured party. But then allowing

“extra” defendants to participate in discovery could also feel like ganging up. If the indemnity parties are also parties to the injury action, they already have a voice in whatever is happening discovery-wise. But some indemnity parties, for example an injured plaintiff’s employer, will have no voice in the injury case.

There are practical hurdles to litigating an indemnity case separate from the injury case, including management of discovery. And the business-court route may not always be desirable. But, with the new act there are new possibilities for creative lawyering. ■

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ERISA Case Summary



ERISA Decisions of Interest

Michael R. Shpiece, *Kitch Drutchas Wagner Valitutti & Sherbrook*, michael.shpiece@kitch.com
Kimberley J. Ruppel, *Dickinson Wright*, kruppel@dickinsonwright.com

Sixth Circuit

Plan Administrator’s Interpretation of Plan Language Based on Social Security Administration Definitions is Reasonable.

Lipker v AK Steel Corp, 698 F3d 923
(6th Cir, Oct. 31, 2012)

This case presents the not-uncommon dispute over calculation of ERISA governed surviving spouse pension benefits. After the plaintiff’s husband died, she applied for surviving spouse benefits under the pension plan administered by his former employer. Her application was granted, but her monthly amount was considerably less than what she expected. As a result, she filed suit to recover the greater amount to which she believed she was entitled.

The Plan provided that the amount of the surviving spouse benefit payable was calculated by reducing the deceased employee’s monthly pension benefit by half and then further reducing by half of the widow’s benefit payable under the Social Security Act (the “Act”) “without regard to any offset or suspension imposed by such law.” Using numbers may help to explain the formula. The plaintiff’s husband’s pension benefit was \$1,386. Both parties agreed that the starting point for calculating the plaintiff’s benefit was half of that figure, or \$693.

When the Social Security Administration (“SSA”) notified the plaintiff of the amount of her widow’s benefit payable un-

der the Act, that figure represented the primary insurance benefit of the plaintiff’s husband offset by the plaintiff’s own old-age benefit. Thus, the dispute here centered around whether or not the Plan language is properly interpreted to exclude the offset applied by the SSA, as the defendant argued; or whether the net amount of the SSA widow’s benefit is properly used in calculating the pension benefit, as argued by the plaintiff.

According to the SSA, the plaintiff’s widow’s benefit without any offset was \$1,469. The defendant reduced the starting pension benefit by half of that figure, or \$734, which resulted in a negative amount, thereby triggering the Plan’s minimum payment provision of \$140 per month.

The plaintiff argued that the pension benefit should instead be reduced by half of her widow’s benefit under the Act – inclusive of the offset, for a net figure of \$485. Reducing \$693 by half of \$485 (\$242) resulted in a potential monthly benefit amount of \$450.

The plaintiff also argued that the Plan administrator’s interpretation conflicted with the terms of the summary plan description (“SPD”), which did not contain the offset language. After a discussion of the Supreme Court opinion *Cigna v Amara*,¹ the Sixth Circuit found that the SPD’s omission of the offset did not result in an inconsistency, and that the Plan language was controlling.

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The defendant argued that the Plan provision must be interpreted in light of the definitions set forth in the Act, under which the “widow’s benefit” included an offset that the Plan expressly excluded. The Sixth Circuit agreed, and reversed and remanded for entry of judgment consistent with the plan’s interpretation.

Judge Goldsmith (sitting by designation from the Eastern District of Michigan) dissented in part with respect to the majority’s application of *Cigna v Amara*, which was decided after the plaintiff filed suit and after this appeal had been fully briefed. Judge Goldsmith took the position that the Court should have remanded the case to the District Court to consider whether the plaintiff could proceed on an equitable theory under ERISA section 502(a)(3) in light of the Supreme Court’s ruling. However, the majority rejected that position, in part because the plaintiff did not expressly seek equitable relief.

Retirees Can Sue for Lifetime Retiree Benefits Even After Union Lost Same Argument

Amos v PPG Industries, Inc., 699 F3d 448
(6th Cir Nov. 1, 2012)

Retiree health benefit cases continue to arise in both union and non-union cases.² Generally, the cases arise where there has been a long-standing collective bargaining agreement (CBA) or policy under which retirees (and sometimes their spouses) are entitled to health coverage upon retirement. As health costs have increased, employers try to reduce, change or eliminate the retiree coverage. While employers may be able to do that prospectively for existing employees, it is unclear whether employers may do that for existing retirees. The answer seems to hinge on what was intended by the parties adopting the CBA or policy – an intention that was rarely expressed at the time of the original adoption.

Amos presents a different twist. The employer, PPG, unilaterally decided to require retirees to pay a portion of the health care costs. The involved unions sued PPG alleging that the retiree benefits were vested and thus PPG could not impose this payment requirement. While the unions’ case was pending, several PPG retirees sued PPG making similar

allegations. The retiree case was held in abeyance pending the resolution of the unions’ case. Ultimately, the unions lost their case, and PPG moved to dismiss the retirees’ case based on collateral estoppel. The district court agreed, but the Sixth Circuit reversed.

The basis of the Sixth Circuit’s reversal was that under applicable labor law, a union does not have a duty to represent retirees – and it cannot do so unless it obtains the assent of the retirees. “Without that assent, a union may not represent retirees in litigation that could bind them.”³

The court acknowledged that its decision had the possibility of exposing PPG to repetitive litigation with potentially different outcomes, but responded by saying that “the Supreme Court is a stickler about the due-process rights of nonparties to litigation.” In addition, it said that “PPG has largely itself to blame for its predicament” because it could have sought to join the retirees in the unions’ case, citing Fed. R. Civ. P. 19 (joinder).⁴

ERISA Claim Accrues When Plan Clearly Repudiates Benefits; Anti-Cutback Rule Applied Where Retiree Had Met Service But Not Age Requirement.

Fallin v Commonwealth Industries, Inc Cash Balance Plan,
695 F3d 512 (6th Cir. Aug. 23, 2012).

This case involved a convergence of technical pension issues that only an actuary could love: conversion to a cash balance plan, early retirement subsidies, and the anti-cutback rule.

Commonwealth Industries sponsored a traditional defined benefit pension plan that permitted participants to receive a heavily subsidized early retirement benefit at age 55 if they had completed at least five years of service. In 1998, Commonwealth converted the plan to a “cash balance” plan where each participant received a “hypothetical individual account” with an initial benefit equal to the value of that participant’s accrued benefit under the traditional plan. These are quintessential actuarial calculations.

Nine participants retired after the 1998 conversion and took their pension in a lump-sum. Later, they sued claiming that the conversion calculations did not fully reflect the value of the early retirement benefit. The district court rejected all nine’s claims.

The Sixth Circuit divided the plaintiffs into two groups. It held that eight of the plaintiffs’ claims were barred by the statute of limitations. ERISA does not explicitly state a statute of limitations for benefit claims. Therefore, a court applies the most analogous state statute of limitations, in this case Kentucky’s five-year statute. The Court held that the claim

The court acknowledged that its decision had the possibility of exposing PPG to repetitive litigation with potentially different outcomes, but responded by saying that “the Supreme Court is a stickler about the due-process rights of nonparties to litigation.”

accrued when the claimant is “give[n] clear and unequivocal repudiation of benefits,” i.e., when the lump-sum was paid. This “represented the Plan’s determination of all the benefits that each plaintiff was entitled to receive, and thus unequivocally repudiated any claim to additional benefits.” Since the eight had filed the lawsuit more than 5 years after the payment, their claims were time-barred.

But a ninth plaintiff, Corley, was different. Although he filed suit five years and one month after the payment, he was pursuing administrative remedies for two months of that time. The district court had concluded that Kentucky would have permitted equitable tolling during this time, “so long as he beg[an] the administrative process within the statute of limitations.” The Sixth Circuit endorsed that approach. “Common sense suggests that we should encourage plaintiffs to pursue their administrative remedies before coming to court with the dispute – and indeed we sometimes require them to do so.” (The general rule in ERISA benefit cases requires exhaustion before bringing suit.) So, Corley’s claim was not time-barred.

Corley claimed that the 1998 conversion had the effect of reducing his accrued early retirement benefit and that this violated ERISA’s “anti-cutback” rule, which generally prohibits the decrease of “accrued benefits.” ERISA 204(g). As of 1998, Corley had completed five years of service but had not reached age 55. Thus, he had not met *all* of the plan’s criteria for a benefit, and the general rule is that a benefit does not accrue until all of the requirements are met.

However, the anti-cutback rule has a special rule for subsidized early retirement benefits: if the benefit is attributable to service before an amendment, it cannot be reduced even if other requirements are satisfied after the amendment. This was Corley’s situation: he satisfied the service condition before the amendment and the age condition afterward. Thus, the plan could not reduce his benefit.⁵

United States District Court

ERISA’s Anti-Retaliation Section Doesn’t Protect Employee’s Unsolicited, Internal Complaint.

Sexton v Panel Processing, Inc., ___ FSupp ___,

2012 WL 5353605, No. 12-10946 (ED Mich. Oct. 30, 2012).

ERISA 510 generally protects from retaliations plan participants who exercise their rights under ERISA or a plan. It also prohibits retaliation against any person “because he has given information or has testified . . . in any inquiry or proceeding relating to” ERISA. The question in this case was whether that protection applied to an employee who made an unsolicited, internal complaint to his employer and was thereafter fired.

Brian Sexton was a long-time Panel Processing employee, and a member of its Board of Directors. Several years after Panel Processing created an ESOP, Sexton was appointed as an ESOP trustee. In the course of the 2011 election of the board of directors, Sexton was perceived as supporting two challengers to incumbent directors running for reelection; the board then removed Sexton and another person as ESOP trustees (on a 4-3 vote). The following Monday, Sexton sent an e-mail to Panel Processing’s CEO and Board Chair threatening to report this action to state and federal authorities “unless they are immediately remedied.” Six months later, Sexton was fired.

Sexton sued in state court alleging state law claims under the Michigan Whistleblowers’ Protection Act, and for wrongful discharge. The defendants removed the case to federal court based on ERISA preemption of the state whistleblower claim. While generally, federal preemption of a state law action is not a basis for removal, the Supreme Court has held that ERISA’s preemptive force is so strong that if ERISA 502 provides a similar action, ERISA converts that state-law claim into federal claim that can be removed.⁶

In the federal district court, Panel Processing moved for summary judgment on the Michigan whistleblowers’ claim claiming it was preempted by ERISA because it referred to and involved (and thus “related to”) the ESOP, an ERISA-governed plan. The court agreed.

The court then considered whether ERISA 510 protected the plaintiff, that is, whether 510 applied to an “unsolicited, internal complaint.” The court noted that the circuits were evenly split, with the Fifth, Seventh, and Ninth holding it did, and the Second, Third, and Fourth holding it did not. The court turned to the language of ERISA 510, and the dictionary definitions of “proceedings” and “inquiry.” It determined that there were no proceedings or inquiries, so the language of 510 did not apply. “The ordinary meaning of an ‘inquiry’ is thus asking for information – not offering it. . . . While the section does not require a dialog, it does not cover an isolated accusation unconnected to any request for information.” The court’s review of the decisions of the Circuits did not change its mind; it either distinguished or criticized the Circuits holding in favor of protecting the employee.

Having held that the whistleblower count was preempted, the court declined to exercise supplemental jurisdiction over the remaining state-law wrongful discharge claim.

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ERISA

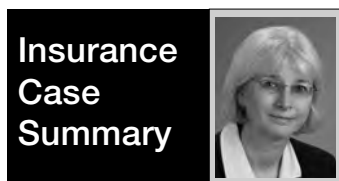
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Endnotes

- 1 This case was covered in our July 2011 issue.
- 2 We also discussed retiree health cases in the October 2010 issue.
- 3 This explains some of the machinations involved in implementing the changes to the UAW-Big 3 retiree health benefits. See, e.g., *International Union v. General Motors Corp.*, 497 F.3d 615 (2007).
- 4 The court also has a good discussion of the federal common law doctrine of collateral estoppel.
- 5 The court remanded because it was not clear to the court as a factual matter whether Corley's accrued benefit had been reduced. "Neither party has explained to us the calculations the Plan was supposed to perform or those that it did perform." It also warned the district court to be "mindful of the risk of double counting [Corley's] early-retirement benefits." So the district court can look forward to a future actuarial exposition of the issues in the case.
- 6 *Metropolitan Life Ins. Co. v. Taylor*, 481 US 58 (1987). Interestingly, the Sixth Circuit had seemingly limited this rule to claims for benefits under ERISA 502(a)(1)(B). *Warner v. Ford Motor Co.*, 46 F.3d 531 (6th Cir. 1995); but cf. *Harris v. Michigan Consolidated Gas Co.*, 117 F.Supp. 2d 642 (E.D. Mich. 2000) (allowing removal of an age-discrimination case, based on the applicability of ERISA 510; claiming *Warner* did not address 510 claims). The *Sexton* court did not address this issue. ■



Significant Insurance Decisions

By Deborah A. Hebert

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Michigan Supreme Court

A Plain and Ordinary Definition of "Premises"

Fremont Ins Co v Izenbaard
 ___ Mich ___, 820 NW2d 902
 (Docket No. 144728)

In an order summarily reversing the judgment of the Court of Appeals, the Michigan Supreme Court rejected a legal definition of "premises" as land on which buildings are located, and opted for an ordinary definition of broader scope. Citing several dictionary definitions, and quoting Black's Law Dictionary (6th ed), the Court observed that "[p]remises is an elastic and inclusive term, and it does not have one definite and fixed meaning; its meaning is to be determined by its context, and is dependent on the circumstances in which used, and may mean a room, shop, building, or any definite area."

This issue arose in connection with liability coverage for

a homeowner arising out of his use of an all-terrain vehicle on land adjacent to his insured residence, land that was privately owned by Consumers Energy. The homeowner's policy excluded liability coverage for claims arising out of motor vehicle accidents, unless the accident was the result of the insured's ownership or use of a recreational vehicle on an "insured location." An insured location was defined in the policy as "any premises used by you in connection with" the insured residence premises. The Supreme Court remanded the case to the Court of Appeals for review under this broader definition of "premises."

On November 27, 2012, the Court of Appeals issued its unpublished opinion on remand, concluding that the broader definition of "premises" created a question of fact for the trial court about whether this accident occurred on premises used by the insured in connection with his insured residence. The case was further remanded to the trial court.

Michigan Court of Appeals - Published

Employee Dishonesty Coverage

*Amerisure Insurance Company v Debruyn Produce Company*___ Mich App ___, app lv pending,
Docket No. 307128, October 16, 2012)

This is a first impression case in Michigan interpreting an employee dishonesty policy. The claim arose when the insured discovered that a former controller had been issuing herself an extra paycheck every payroll, in the same net amount as her actual payroll check. Amerisure's policy covered incidents of "employee dishonesty" where the employee's actions resulted in an actual loss to the insured as well as a financial benefit to the employee. Coverage did not extend, however, to losses that were "employee benefits earned in the normal course of employment, including: salaries, commissions, fees, bonuses, promotions, awards, profit sharing or pensions."

At issue was whether the extra checks amounted to salary earned in the normal course of employment. After a survey of national case law, the court distinguished between payments intentionally made by the employer based on employee dishonesty, such as where an employee misrepresents hours or sales and is paid a salary or commission based on that misrepresentation (an excluded claim), and cases in which an employee takes money from an employer without that employer's knowledge or consent (a covered claim). The facts of this case fit the latter category of claims.

Bobtail "Business Use" Exclusion Applies

*Hunt v Drielick*___ Mich App ___, (2012)
(Docket No. 299405, November 20, 2012)

A "business use" exclusion in the insurer's "bobtail" policy barred coverage in this garnishment action. The insured's driver was dispatched to pick up a trailer of goods to be hauled to another location. He was involved in an accident while driving his semi-tractor to the yard where the trailer was located. The tractor was insured under a non-trucking use, "bobtail" policy, which excluded coverage for bodily injury sustained "while a covered auto is used to carry property in any business." At issue was whether the tractor had to be actually carrying property at the time of the accident or whether it was sufficient that the tractor was generally engaged in that business purpose.

The court interpreted the language of the exclusion to apply to tractors dispatched to transport property. Had the parties intended to exclude coverage only after the tractor was attached to a trailer, the exclusion would have stated so. Instead, the exclusion addressed covered autos being used in the business of carrying property and this tractor was engaged in that activity at the time of the accident. Coverage was excluded.

Fire Loss Appraisal in Resolution of a Claim is Not a "Verdict" for Purposes of Case Evaluation Sanctions
Acorn Investment Co v Michigan Basic Property Ins Assc.
___ Mich App ___,

(Docket No. 306361, November 27, 2012)

This insured sued after its property insurer denied a fire loss claim, stating as its reason a lapse of the policy prior to the fire. The trial court granted summary disposition to the insured on the coverage question, holding that the notice of cancellation was inadequate. Following that ruling, the parties agreed to decide the value of the property by an appraisal. The trial court later entered a judgment in the amount of the appraisal, and added judgment interest, but declined to award case evaluation sanctions or add the cost of "debris removal" to the judgment.

The Court of Appeals agreed that the appraisal process mandated by MCL 500.2833(1)(m) for the valuation of fire losses "is a substitute for the judicial determination of disputes over the amount of losses to be paid by insurers," quoting *Auto-Owners Ins Co v Allied Adjusters & Appraisers, Inc.*, 238 Mich App 394, 399 (1999). An appraisal is essentially the same as arbitration, and is not a "verdict" for purposes of case evaluation sanctions. As to the request for debris removal costs, the court found the issue waived because plaintiff never sought those expenses in the appraisal process.

Sixth Circuit Court of Appeals

*Tooling, Manufacturing & Technologies Assc v
Hartford Fire Ins Co*
693 F3d 665 (6th Cir, 2012)

The insured (TMTA) is Michigan trade association of entities in the manufacturing and tooling industry. One of its services is to sell insurance to its members, through a separate agency created for that purpose. TMTA hired and paid an employee, who was then assigned to manage the agency's business. TMTA eventually learned that the employee stole roughly \$715,000 in commissions that should have been paid to the agency, and would have been passed on to TMTA.

At the time of the discovery of the theft, TMTA – but not the agency – was insured under an employee fidelity policy with Hartford. That policy afforded coverage for an insured's direct loss of money or other property as the result of theft by an employee. Coverage was expressly excluded, however, for losses that were an indirect result of any act or occurrence otherwise covered by the policy. The 6th Circuit agreed with Hartford that there was no coverage for this theft. The agency's direct loss of commissions was not covered because the agency was not an insured under the policy. And the insured, TMTA, suffered no direct loss but only an indirect loss due to

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Insurance Case Summary

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employee theft: “there was an intermediate step between [the employee’s] . . . theft and TMTA’s loss.” Indirect losses were expressly excluded. The dissenting judge would have found a direct loss to TMTA.

Selected Unpublished Decisions of the Michigan Court of Appeals

Collapse Damage Under Homeowner’s Policy Does Not Require a “Cave-In”

Kokas v Citizens Insurance Company of America
Unpublished per curiam of September 13, 2012,
lv app pending (Docket No. 303592)

Plaintiffs’ homeowner’s policy covered structural damage to the “kitchen nook” in their home because it was triggered by a “collapse.” The area was sagging due to defective construction and hidden decay. Citizens argued that “collapse” meant a “cave-in” as opposed to this type of gradual structural damage and further contended that the damage was caused by earth movement, an excluded cause of loss under the policy. The case was submitted to a jury, which found damage caused by collapse. The Court of Appeals affirmed. Because the policy did not define “collapse” as a cave-in, it was up to the jury to apply the plain and ordinary meaning of the term to the facts established at trial. Furthermore, conflicting testimony created an issue of fact about whether there was also earth movement and that question was thus properly resolved by the jury. Because the claim was not timely paid, Citizens was subject to 12% penalty interest.

Inland Marine Coverage Not Available for Unscheduled Property

Merlo Construction Company, Inc v Citizens Insurance Company of America
Unpublished per curiam of September 25, 2012,
lv app pending (Docket No. 304184)

Plaintiff insured, a construction company, failed to amend the equipment schedule on its inland marine policy to reflect its purchase of a new caterpillar wheel loader to replace an older model scheduled on the policy. When the new model was stolen, the insurer declined coverage for the non-covered property. The Court of Appeals agreed that the non-scheduled equipment was not covered. The court also declined to reform the contract given that the error in failing to report the newly purchased property was unilateral, not mutual and it further declined to view the contract as illusory.

Jury Question on Whether Vehicle Was Damaged During a Drag race

Mascia v IDS Property Casualty Insurance Company
Unpublished per curiam of October 2, 2012
(Docket No. 304607)

This case involves a first party claim for property damage to the insured’s 1998 Dodge Viper. While driving this vehicle during the Woodward Dream Cruise, plaintiff jumped a curb and struck a utility pole. Because there was evidence that plaintiff was drag racing at the time, the insurer denied coverage under a policy exclusion for damage to insured vehicles “used in preparation for any prearranged or organized racing . . . or used in the event itself.” Plaintiff explained that the two cars next to him were drag racing and forced him off the road. This question of plaintiff’s involvement in a “prearranged race” was submitted to a jury, which resolved the issue for the plaintiff. The Court of Appeals affirmed this finding of fact.

Late Proof of Loss Bars Fire Loss Claim

Brittingham v Michigan Insurance Company
Unpublished per curiam opinion of October 4, 2012
(Docket No. 305173)

Plaintiffs submitted two claims to their homeowner’s insurer following a fire loss. The first claim was for water damage caused by efforts to put out the fire. A proof of loss for that claim was submitted to the insurer within one year, tolling the applicable statute of limitations. The second claim arose out of the use of an anti-microbial spray to clean the heating ducts after the fire. Plaintiffs claimed a bad reaction to the spray, forcing them to vacate the house and incur the expense of a hotel. Plaintiffs also claimed expenses for environmental clean-up. A proof of loss was not submitted for this second claim until after the one-year period had expired. Plaintiffs had coverage for the first claim but not the second, which was time-barred.

The agency’s direct loss of commissions was not covered because the agency was not an insured under the policy. And the insured, TMTA, suffered no direct loss but only an indirect loss due to employee theft: “there was an intermediate step between [the employee’s] . . . theft and TMTA’s loss.” Indirect losses were expressly excluded.

Refusal to Cooperate with Requests for EUO Bars Coverage

Preston v Pioneer State Mutual Insurance Company
Unpublished per curiam of October 9, 2012
Docket No. 305295

Plaintiff's home was destroyed by fire. Her homeowner's insurer requested an examination under oath (EUO) and plaintiff initially cooperated. After the first examination, the insurer sought a continuing EUO, which plaintiff had to reschedule due to an illness in the family. She subsequently refused to make herself available and refused to produce other persons. The insurer denied coverage because of plaintiff's refusal to cooperate with its investigation, which was a breach of a condition of coverage. Nine months later, plaintiff attempted to reopen the investigation but the insurer declined. The Court of Appeals held that under the terms of the insurance contract, plaintiff was required to submit to an EUO "as often as [the insurer] reasonably requires" as a condition of coverage. Her failure to comply resulted in a loss of that coverage.

Lapse of Policy Results in Loss of Coverage

Chu v Grange Insurance Company
Unpublished per curiam of October 18, 2012
Docket No. 304603

Plaintiffs' homeowner's policy was cancelled on December 29th for nonpayment of premium. The notice of cancellation allowed reinstatement of the policy upon payment of a specified amount but stated that coverage would be reinstated only as of the date indicated on a revised declarations page. Coverage was reinstated effective January 7th, when the plaintiffs made the required payment. But plaintiffs had sustained a fire loss on January 1st, when coverage was lapsed. Because the homeowner's policy was not in effect at the time of the fire loss, the insurer properly denied coverage.

No CGL Coverage for Defective Construction

Heaton v Pristine Home Builders
Unpublished per curiam of October 25, 2012
(Docket No. 305305)

Auto-Owners insured a general contractor hired by claimants for a home improvement project. One of the subcontractors installed pre-cast concrete foundation walls that shifted during construction and damaged the entire structure. A jury found the general contractor 40% at fault and the subcontractor 60% at fault. The subcontractor satisfied its share of the judgment but Auto-Owners denied indemnity coverage for the general contractor. Claimants attempted to garnish the CGL policy issued by Auto-Owners, but the Court of Appeals followed a long line of cases and concluded that there was no CGL coverage for the insured's faulty construction work.

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The Exclusion for Violation of the TCPA Bars Coverage

GM Sign, Inc. v Auto-Owners Ins Co
Unpublished per curiam of October 11, 2012
(Docket No. 301742)

This opinion interprets and applies the "TCPA" exclusion for liability coverage. It bars coverage for claims arising out of the insured's violation of the Telephone Consumer Protection Act (TCPA), the CAN-SPAM Act of 2003, or any similar statute prohibiting or limiting the transmission of information. In this case, an Illinois company sent a "blast fax" to a number of businesses, including plaintiff in Michigan. Plaintiff responded with a lawsuit against the offending company and then also commenced a declaratory judgment action to determine that company's liability coverage. The Court found that the "TCPA" exclusion applied on its plain terms and the Illinois company had no CGL coverage for the claim. Two judges on the panel also engaged in separate and extended discussions of the standing of a claimant to seek declaratory judgments on a defendant's insurance coverage prior to entry of any judgment. ■

About the Author

Deb Hebert serves on the Council for the Insurance and Indemnity Section of the State Bar. Her practice focuses heavily on insurance coverage, with a strong emphasis on declaratory judgment litigation and appeals. She is co-author of the chapter on commercial general liability insurance in *Michigan Insurance Law & Practice (ICLE)* and has been selected by her peers for inclusion in the *Top Lawyers of 2011 and 2012*, published in "dbusiness," *Detroit's Premier Business Journal*. Her email address is deborah.hebert@ceflawyers.com



No-Fault Corner



By Ronald M. Sangster, Jr.
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As noted in our previous article in the October *Journal*, the Michigan Supreme Court ended the 2011-2012 term with a number of significant decisions that will impact no-fault jurisprudence for the foreseeable future. Since then, the number of significant appellate court decisions has tapered off. This article will discuss two recent cases where the Michigan Supreme Court granted leave to appeal. It will also discuss a number of Court of Appeals' decisions that have recently been handed down.

Supreme Court Action

Supreme Court to Consider Whether a Tailgate on a Dump Truck Is "Equipment" under MCL 500.3106(1)(b).

On October 4, 2012, the Michigan Supreme Court granted oral argument on Defendant's Application for Leave to Appeal in *LeFevers v State Farm*, Supreme Court docket no. 144781. In *LeFevers*, Plaintiff was standing outside of his parked dump truck, attempting to unload some contaminated dirt into a toxic waste dump. While standing at the edge of the pit, Plaintiff attempted to open the tailgate of his dump truck. Unfortunately, the latch was stuck. After hitting the latch a few times, the tailgate finally opened, but Plaintiff lost his balance, falling backwards into the toxic waste pit. Plaintiff argued that he was entitled to no-fault benefits under the second exception to the Parked Vehicle Exclusion set forth in MCL 500.3106(1)(b), which provides that no-fault benefits are payable where an injury occurs as a direct result of physical contact with "equipment" permanently mounted on the vehicle, while the equipment is being used. Both the lower court and the Court of Appeals held that Plaintiff was entitled to recover benefits.

In its order granting oral argument on Defendant's Application for Leave to Appeal, the parties were instructed to "address whether the tailgate on the Plaintiff's dump truck was 'equipment permanently mounted on the vehicle' for purposes of MCL 500.3106(1)(b) and, if so, whether the plaintiff's injury was 'a direct result of physical contact with' the tailgate. A decision is expected some time in early 2013.

Supreme Court to Decide Dual Domicile Case

On September 19, 2012, the Michigan Supreme Court granted Plaintiff Grange Insurance Company's Application for Leave to Appeal from the Court of Appeals' published decision in *Grange Ins Co v Lawrence, et al*, 296 Mich App

319, 819 NW 2d 580 (2012). In *Grange*, the Court of Appeals held that a minor child of divorced parents could have two domiciles for purposes of determining priority under MCL 500.3114(1), notwithstanding the fact that the divorce decree granted sole legal and physical custody to only one parent. In its order, the Supreme Court ordered the parties to brief the following issues:

- Whether a person, particularly a minor child of divorced parents, can have two domiciles for purposes of determining coverage under MCL 500.3114(1);
- Whether a court order determining the minor's custody has any effect in determining "domicile" for purposes of MCL 500.3114(1);
- Whether an insurance policy provision, which gives conclusive effect to the custody arrangement set forth in a divorce decree, is enforceable, in a situation where the facts demonstrate that the minor actually shared time in both households.

A decision on this issue is expected some time in early 2013.

Court Of Appeals Action

Defendant Remains Responsible for All Damages Arising Out of a "Road Rage" Incident, Despite the Fact That Plaintiff's Motor Vehicle Was Uninsured.

In *Gray v Chrostowski*, __ Mich App __, __ NW 2d __ (Court of Appeals docket no. 303536, rel'd 12/6/2012), the Michigan Court of Appeals reversed the lower court's grant of summary disposition, in favor of defendant, and reinstated plaintiff's cause of action. Plaintiff was injured in a "road rage" incident that occurred on January 2, 2009. Plaintiff was driving her own motor vehicle, which was not insured as required under MCL 500.3101. Normally, she would have been precluded from recovering "pain and suffering" damages under MCL 500.3135(2)(c). However, plaintiff relied on the immunity provision set forth in MCL 500.3135(3), which provides:

Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101 was in effect is abolished except as to . . . Intentionally caused harm to persons or property."

In its order granting oral argument on Defendant's Application for Leave to Appeal, the parties were instructed to "address whether the tailgate on the Plaintiff's dump truck was 'equipment permanently mounted on the vehicle' for purposes of MCL 500.3106(1)(b) and, if so, whether the plaintiff's injury was 'a direct result of physical contact with' the tailgate."

In determining that Plaintiff was entitled to recover non-economic damages from defendant, notwithstanding the fact that she was driving her own uninsured motor vehicle at the time of the accident, the Court of Appeals determined that the phrase "notwithstanding any other provision of law" in MCL 500.3135(3) trumped the uninsured motorist preclusion language of MCL 500.3135(2)(c). In so ruling, the court noted that, "section 3135(3)(a) strips a defendant of tort immunity for intentionally-caused harm "notwithstanding any other provision of law."

Shareholder of a Law Firm Is Entitled to Recover Not Only W-2 Wages, But Also Flow-Through Earnings As the Sole Shareholder of a Subchapter S Corporation.

In *Brown v Home Owners Ins. Co.*, ___ Mich App ___, ___ NW 2d ___ (docket no. 307458, rel'd 12/4/2012), the Michigan Court of Appeals addressed whether or not Plaintiff, an attorney with a law firm of Brown & Brown, was entitled to recover work loss benefits based on both his W-2 wages plus the profit that the Subchapter S Corporation would have generated during the period of disability, which would have appeared on the attorney's K-1 form. Home Owners argued that Plaintiff was only entitled to recover his W-2 earning, and that the profit generated by Subchapter S Corporation was not recoverable under the work loss provision of the No-Fault Insurance Act, MCL 500.3107(1)(b). In affirming the lower court's grant of summary disposition in favor of Plaintiff, the Court of Appeals noted:

"Under the circumstances here where the Subchapter S Corporation was operating at a profit and where Plaintiff was receiving and paying tax on flow-through income from the corporation, to not treat all income as loss of income from work would have the result of placing Plaintiff in a worse position than he would have been in had the accident not occurred. This result is consistent with the overall purpose of the No-Fault Act, 'to place individuals in the same, but not better, position that they were in before their automobile accident.'"

However, the Court of Appeals reversed the lower court's award of attorney fees in favor of Plaintiff, finding that there

existed a legitimate question of statutory interpretation, particularly under the Michigan Supreme Court's decision in *Ross v ACIA*, 481 Mich 1, 748 NW 2d 552 (2008), which discussed payment of work loss benefits, to a sole employee and sole shareholder of a Subchapter S Corporation which did not report any taxable income.

Plaintiff Is No Longer Entitled to Benefits When Insurer Mistakenly Determines that It Owes No Coverage, and Subsequent Notice to Assigned Claims Facility Is Untimely

In *Visner v Harris*, Court of Appeals docket no. 307506, unpublished decision rel'd 12/6/2012, the Michigan Court of Appeals issued an opinion affirming the decision of the Tuscola County Circuit Court granting summary disposition in favor of Pioneer State Mutual Insurance Company and State Farm Mutual Automobile Insurance Company, as assignee of the Michigan Assigned Claims Facility. Although unpublished, this decision could potentially impact many claimants who receive no-fault benefits for over a year, only to have the insurer suddenly discover that it did not owe coverage for the loss. In *Visner*, Plaintiff was struck by an uninsured motor vehicle while standing in her driveway. Plaintiff was listed as a "named driver" on an insurance policy issued by Pioneer State. However, the Pioneer State policy only listed her then-fiancé as the "named insured." Pioneer State paid benefits for 1½ years before realizing that Plaintiff was not entitled to coverage under the policy as she was neither the named insured, spouse, or resident relative of its named insured. Plaintiff then filed a claim with the Michigan Assigned Claims Facility, which denied the claim, based upon the one-year notice provision set forth in MCL 500.3145(1). The Assigned Claims Facility subsequently assigned the matter to State Farm for defense.

The lower court granted summary disposition in favor of both Pioneer State and State Farm. The Court of Appeals affirmed. First, the Court of Appeals determined that State Farm, as assignee of the Michigan Assigned Claims Facility, was entitled to summary disposition pursuant to the one-year notice provision set forth in MCL 500.3145(1). The court determined that State Farm, as assignee of the Michigan Assigned Claims Facility, is to be treated no differently than a private insurer. The one-year notice provision means what it says, and rejected Plaintiff's argument that the one-year notice provision should be tolled pursuant to the Court of Appeals' decision in *Richards v American Fellowship*, 84 Mich App 629, 270 NW 2d 670 (1978) and a 1981 Attorney General Opinion, OAG1981 No. 6016 (December 1, 1981). The court specifically noted that *Richards* had been overruled by the Michigan Supreme Court in *Devillers v ACIA*, 473 Mich 562, 702 NW 2d 539 (2005).

The Court of Appeals then affirmed the grant of summary disposition in favor of Pioneer State. The court noted its prior

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No-Fault Corner

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decision in *Harwood v Auto Owners*, 211 Mich App 249, 535 NW 2d 207 (1995), which held that “merely listing a person as a designated driver on a no-fault policy does not make the person a “named insured.” Since plaintiff herself was not the “named insured” under the policy, and was not a spouse or resident relative of the “named insured,” Pioneer State was not obligated to afford coverage for this loss.

Finally, the Court of Appeals rejected Plaintiff’s equitable estoppel arguments, noting that if the claimant had access to the same set of facts as the insurer, equitable estoppel would not apply, relying on its earlier decision in *Sisk-Rathburn v Farm Bureau*, 279 Mich App 425, 760 NW 2d 878 (2008). Because Plaintiff did not claim that she did not have access to the insurance policy issued by Pioneer State, which would have provided the means for her to determine that she was not a “named insured,” the Court of Appeals rejected plaintiff’s estoppel arguments.

Court Applies Traditional Domicile Factors to Conclude that Injured Claimant Was a Relative of her Mother’s Household Notwithstanding the Fact that She Had Actually Moved Out of Her Mother’s Home Seven Years Earlier.

In *ACIA v Frankenmuth*, docket no. 305592, unpublished decision rel’d 11/29/2012, the injured Claimant, Elizabeth Ulinksi, was injured after being struck by a motor vehicle insured with Plaintiff Auto Club Insurance Association (ACIA). After commencing payment of no-fault benefits to Ms. Ulinksi, AAA subsequently determined that Frankenmuth insured a vehicle owned by Plaintiff’s mother. AAA then filed suit against Frankenmuth, seeking to recover payment of the no-fault benefits paid by AAA to or on behalf of Elizabeth. After considering all of the evidence, the lower court determined that Elizabeth was, in fact, domiciled with her mother at the time of the accident. Therefore, Frankenmuth occupied a higher order of priority for payment of Elizabeth’s no-fault benefits.

In affirming the lower court’s decision, the Court of Appeals acknowledged that the case “presents a very close call.” The Court noted that at the time of the accident, Elizabeth was 25 years old and acknowledged that she had moved out of her mother’s house approximately seven years earlier. Thereafter, she supported herself through prostitution, living in various cheap motels and with friends, and never staying long in any one location. She periodically returned to her mother’s house for one to three nights at a time.

However, she also used her mother’s home as her mailing address and listed her mother’s address on her Michigan

identification card, voter registration card, cellular telephone contract, and her application for SSI benefits. She maintained some possessions at her mother’s house and both Elizabeth and her mother testified that she always had a room in which to stay when Elizabeth came to visit, even though her former bedroom had been converted into a computer room. Elizabeth had testified that her mother’s house was the only place that she ever considered to be her home and that she viewed her lodging in motels and with friends as merely temporary places of abode. Noting that her mother’s home “remained the one constant in Elizabeth’s young, troubled life and the place to which she repeatedly returned,” the Court of Appeals affirmed the lower court’s grant of summary disposition in favor of AAA.

Analysis of Compensability of Chiropractic Expenses Following the January 2010 Amendments.

In *Warren Chiropractic v Homeowners Ins Co*, docket no. 303919, unpublished decision rel’d 11/8/2012, Warren Chiropractic sought to recover payment of chiropractic expenses for services that were allowable under the statutory amendments to the scope of Chiropractic Act, MCL 333.16401 *et seq*, which took effect on January 5, 2010. However, those expenses would not have been recoverable under the old version of MCL 333.16401, which was in effect on January 1, 2009. In holding that Warren Chiropractic was not entitled to recover medical expenses for services that were previously unauthorized under MCL 333.16401, the Court of Appeals noted the clear and unambiguous statutory language set forth in MCL 500.3107(b), which provides:

“Reimbursement or coverage for expenses within personal protection insurance coverage under section 3107 is not required for either of the following:

* * *

- (b) A practice of chiropractic service, unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.”

Because the services performed by Warren Chiropractic were not authorized as of January 1, 2009, the Court of Appeals had no difficulty determining that said expenses were not compensable under the No-Fault Insurance Act. ■

Section News

Council Meeting, Program, Informal Members Meeting

On November 14, 2012, the Section Council met, after which there was a program on mediation, and then an informal member's meeting.

Council Meeting

At the Council meeting, the new Chairperson, Elaine Murphy Pohl presided.

She reported that the membership has reached 578 members at the most recent count.

The new Treasurer, Larry Bennett, reported a balance of \$25,553 as of September 30.

The *Journal* Editor, Hal Carroll, presented an Editor's Report. The *Journal* has now completed five years of publication. The January 2013 issue will be a theme issue devoted to the new Business Courts.

There was also discussion of the Section's committees. The Membership Committee usually has two chairpersons, one who practices primarily for insureds and one who practices for insurers. At present both positions are vacant because of changes resulting from the election in September.

The Chair reported to the Council that the State Bar recommended that all sections adopt a diversity pledge. After a reading of the pledge, a discussion followed, and the Council voted unanimously to adopt the pledge. The pledge is reproduced below.

The meeting then adjourned, and the program began.



Edward H. Pappas



Brian A. Pappas

Program: Successful Mediation: Is It All About The Money?

"Top Ten Tips to Increase Your Chances of Successful Mediation"

The program was presented by Edward H. Pappas and Brian A. Pappas.

The program was well attended, with about 35 attendees. The attendees included former Supreme Court Justice Alton Davis, as well as several well known mediators, including Marty Reisig, Richard Hurford, and Bob Wright, who is also the incoming Chair of the ADR Section.

At the program Ed and Brian Pappas provided and spoke from an outline of ten points:

1. Select the right mediator for your case.
2. Prepare, Prepare, Prepare.

3. Write a good mediation summary.
4. Make a reasonable opening offer.
5. If you don't have a reason not to share information, share it.
6. Encourage client to participate.
7. Recognize that there is no such thing as a dollar-only dispute.
8. Do not provide your bottom line too early.
9. Be a good, careful listener.
10. Be professional.

Diversity Pledge

Adopted by the Section Council on November 14, 2012

"We believe that diversity and inclusion are core values of the legal profession, and that these values require a sustained commitment to strategies of inclusion.

"Diversity is inclusive. It encompasses, among other things, race, ethnicity, gender, sexual orientation, gender identity and expression, religion, nationality, language, age, disability, marital and parental status, geographic origin, and socioeconomic background.

"Diversity creates greater trust and confidence in the administration of justice and the rule of law, and enables us to better serve our clients and society. It makes us more effective and creative by bringing different perspectives, experiences, backgrounds, talents, and interests to the practice of law.

"We believe that law schools, law firms, corporate counsel, solo and small firm lawyers, judges, government agencies, and bar associations must cooperatively work together to achieve diversity and inclusion, and that strategies designed to achieve diversity and inclusion will benefit from appropriate assessment and recognition.

"Therefore, we pledge to continue working with others to achieve diversity and inclusion in the education, hiring, retention, and promotion of Michigan's attorneys and in the elevation of attorneys to leadership positions within our organization, the judiciary, and the profession." ■

**Office of
Financial &
Insurance
Regulation**



Organizational Structure and Division Responsibilities

Sarah G. Wohlford, Office of Financial and Insurance Regulation

In June 2012, the United States Supreme Court upheld the individual mandate provision of the Patient Protection and Affordable Care Act (ACA), resolving some uncertainty about the future of health care reform. One of the major next steps states were required to take was to identify an essential health benefits (EHB) benchmark plan to be used as a model for all non-grandfathered individual and small group plans starting January 1, 2014.

While most large-group and self-funded health plans offer a wide array of services, some small group and individual plans offer fewer services and less robust coverage. The EHB requirement of the Affordable Care Act was intended to make coverage in small group and individual market plans more commensurate with coverage typically found in large group plans.

The ten EHB categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Importantly, starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for services in the ten EHB categories. In addition, all plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

The ten EHB categories are statutory and may not be altered. However, individual states are required to select an EHB “bench-

mark plan”: a plan that will serve as a reference plan, reflecting both the scope of services and any limits offered by a “typical employer plan” in the state as required by section 1302(b)(2)(A) of the ACA. Under the approach set forth by the United States Department of Health and Human Services, beginning on January 1, 2014, any small group or individual market plan offered in the State must be “substantially equivalent” to the benchmark plan in both the scope of benefits offered and any limitations on those benefits, such as visit or duration limits.

The benchmark plan is a “floor,” and does not prohibit carriers from adding benefits or altering certain benefit limitations. Plans may cover additional benefits beyond the EHB package as long as two rules are followed: if a plan covers abortion services, the issuer must collect separate premium checks for that coverage and cannot use any premium tax credits or other federal funding for those services. In addition, if a plan is required under state law to cover services beyond the EHBs, the state must pay any additional tax credits or cost-sharing reductions related to those benefits.

Michigan selected Priority Health’s HMO plan for its benchmark plan; addition. See www.michigan.gov/ofir and click “Essential Health Benefits” to read the Executive Report and the Governor’s recommendation. Selected benchmark plans will remain effective for coverage years 2014 and 2015. For coverage years 2016 and beyond, states may select a different plan or elect to keep the same benchmark. ■

This article reflects the views of its author and should not be construed as an official agency statement, position, interpretation or guidance.