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From the Chair

As we start a new calendar year – our Section’s seventh year - our Section is looking forward to serving you with useful programs and resources, including of course our flagship publication, The Journal. You will find many informative pieces in this issue. If you have ideas for future issues or if you would like to make a contribution, please contact our editor, Hal Carroll. As you know, our Section is neutral as between insureds and insurers, and we welcome all perspectives in The Journal.

Joint Program with the Negligence Section

We held a very successful joint program with the Negligence Law Section on November 19, consisting of a holiday kickoff reception as well as a substantive presentation by attorney Doug Toering of the Toering Law Firm relating to the new Michigan Business Courts. It was an informative program followed by great fellowship, and it was a pleasure to see many of you there. We plan to explore having more joint sessions and joint programs with other sections in the future, so if you know of a section or other group that would be interested in a joint program, or if you have an idea for a joint program, please contact me or any Council member.

Coming Soon – Listserv and Searchable Directory

At our most recent meeting, the Council voted to approve the use of a new listserv so that we may more efficiently communicate with you via email. Stay tuned as we finalize the details. Also, the searchable directory of our members is now operational, so you can sign up and make your expertise known to your colleagues in this Section and among other members of the State Bar. In this issue there is a formal notice with a link that you can use to sign up. In a few weeks, we will send an e-blast to all members.

Council Meeting Calendar

We have set the following schedule of Council meetings for 2014:
• February 4, 2014
• June 3, 2014
• September 17-19, 2014 (in conjunction with State Bar annual meeting)
• November 18, 2014

Members are welcome to attend.
As always, if you have any suggestions or are interested in becoming more involved in the Section, please feel free to contact me or any other Council member.

Editor’s Notes


The Journal – now in its seventh year – 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. We welcome all articles of analysis, opinion, or advocacy. The Section itself takes no position on issues.

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

The Journal is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at HOC@HalOCarrollEsq.com.
A challenge that frequently arises in large exposure litigation is the order in which the parties’ insurers will respond to the settlement or verdict. The issue can be particularly thorny when one party is an “insured” – either named or additional – on more than one policy responding to the loss.

The question comes in his form: Do all policies providing primary coverage for the insured pay before any higher layers of coverage respond, or does a particular excess or umbrella policy follow after the exhaustion of the related underlying coverage? This article will address some of the approaches taken by various courts on the question of “horizontal” and “vertical” exhaustion of policies in a non-continuous tort situation, with a final and particular focus on how Michigan courts might rule on this issue under the current Commercial Liability Umbrella Coverage Form issued by the Insurance Services Office (“ISO”) in 2007.

“Horizontal exhaustion” of policies requires the insured to exhaust all primary policy limits before the next layer of coverage is triggered. “Vertical exhaustion” allows an insured to seek coverage from an excess insurer as long as the insurance policies immediately beneath that excess policy, as identified in the excess policy’s declaration page, have been exhausted, regardless of whether other primary insurance may apply.

Defining important terms is in order. An entity can be a “named” insured on its own policy, and it can also contract with another party to be an “additional insured” on that other party’s policy. This method of “risk transfer” is frequently seen in commercial contracts, such as those between a general contractor and a subcontractor. The policy or policies perched above an insured’s primary coverage can either be an “excess” or an “umbrella” policy. An “excess” policy provides additional limits above the limits of the underlying coverage, but offers no broader protection than that provided by the underlying coverage. An “umbrella” policy similarly provides additional limits of liability, but it also fills gaps by insuring some losses that are not covered under the primary policy.

Whether a particular states imposes “horizontal” or “vertical” exhaustion of policies significantly impacts insurers, and disputes over who pays next can impede the resolution of the underlying liability case. For example, a general contractor contractually requires its subcontractor to name it as an additional insured on the subcontractor’s policy, demanding $1 million in primary limits with a $3 million excess. The general contractor’s own insurance program consists of a $1 million primary and a $5 million excess. Plaintiff is severely injured in a construction site accident involving both the general contractor and the subcontractor, and the case can be settled for $5 million.

In our example, under “horizontal” exhaustion, the two $1 million primary policies respond before either excess policy is triggered. Under “vertical” exhaustion, the subcontractor’s $1 million primary policy and its $3 million excess policy respond...
before either of the general contractor’s policies is tapped. If the insurers of the general contractor and its subcontractor do not spot and address this issue early in the case, a potential settlement could be lost, or protracted coverage litigation could ensue.

“Horizontal exhaustion” of policies requires the insured to exhaust all primary policy limits before the next layer of coverage is triggered. “Vertical exhaustion” allows an insured to seek coverage from an excess insurer as long as the insurance policies immediately beneath that excess policy, as identified in the excess policy’s declaration page, have been exhausted, regardless of whether other primary insurance may apply.

“Horizontal” Cases

Illinois, California, and New York have adopted the “horizontal exhaustion” rule, under which all primary policies respond before any excess or umbrella policy’s coverage is reached. In adopting the horizontal exhaustion rule, the Illinois courts focused on the “different function” served by excess or umbrella policies, noting that the “premium is comparatively small” for the size of the risk, and concluding that they provide a “unique and special coverage” which public policy requires to respond before any excess or umbrella policies will be required to respond.9 Note that this result was based on the court’s view of sound public policy, rather than the specific policy language.

The New York court reiterated the principle that “umbrella coverages are regarded as true excess over and above any type of primary coverage,” but held that the extent of coverage is controlled by the relevant policy terms, rather than the terms of any underlying trade contract that required an insured to purchase coverages for itself and an additional insured.10

“Vertical” Cases

Opponents of the “horizontal exhaustion” rule contend that requiring all primary policies to pay first thwarts the contractual intent of the parties that the primary and excess insurers of the “downstream” party respond to a loss before the policy of any “upstream” party is triggered.

In Chemical Leaman Tank Lines, Inc v Aetna Casualty and Surety Co,11 the federal district court in New Jersey, relying on its analysis of a New Jersey Supreme Court case, stated that it “rejects the . . . argument that horizontal exhaustion of liable policies is required.”

Because of the relative rarity of cases that would present questions of “horizontal” versus “vertical” exhaustion in a non-continuous tort setting at the published opinion level, many states have yet to address the issue at all.

A Sixth Circuit decision, Federal-Mogul U.S. Asbestos Personal Injury Trust v Continental Cas Co,12 provides insight into the approach a Michigan court might take in resolving a horizontal versus vertical exhaustion of policies question. The case involved the issue of the duty to defend in a continuous tort case. The Sixth Circuit applied Michigan policy interpretation principles to resolve the question of whether an umbrella carrier was required to defend the insured when the scheduled underlying insurance had been exhausted, but two other primary carriers were continuing to defend.13 The court focused on particular policy language requiring the umbrella carrier to defend “when an occurrence is not covered by the underlying insurance listed in the underlying insurance schedule or any other underlying insurance collectible by the insured.”14 Significantly, the court noted that the policy did not define the term “underlying insurance”; therefore, it concluded that the term included all primary policies.15 Thus, the court held that the conditions for triggering Continental’s duty to defend had not yet been satisfied.16

The Federal-Mogul court’s focus on precise policy language could be a guide for Michigan practitioners confronted with a horizontal versus vertical issue. The current version of ISO’s CU 00 01 12 07 clearly defines “underlying insurance” as meaning “any policies of insurance listed in the Declarations under the Schedule of Insurance.” This definition, lacking in the Federal-Mogul case, could point to the adoption of a vertical exhaustion rule in Michigan, given the right set of facts.

Potential Complications

This area presents many possibilities for complications. For example, suppose Policy A and A-prime (the excess) say they are governed by Illinois law, so that horizontal exhaustion applies under public policy. Policies B and B-prime say they are governed by New Jersey law, so that vertical exhaustion must be applied. How would a court resolve that conflict?

To add another source of complication, Suppose policies C and C-prime are governed by the law of a state that treat the whole issue as one that is governed by the policy language, specifically the policies’ “other insurance” clauses. The court would then be faced with three distinct methodologies. This area of law has the potential for much confusion.

Conclusion

When presented with a situation, therefore, in which one party may be a named insured or an additional insured under multiple policies, counsel is well-advised to obtain and analyze complete copies of all applicable policies as early as possible.
Counsel should also determine the law of the state which will control the interpretation and application of the policies, as that state may be different from the state where the litigation is pending. Any disputes concerning the application and ordering of coverage should be identified early and a plan for resolution of the issues put into place well before undertaking resolution or trial of the underlying case.17

About the Author

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Endnotes

1 Application of primary and excess policies in a continuous tort action is beyond the scope of this article.


3 Id.

4 Cook, Mary Ann, Commercial Liability Risk Management and Insurance, 11.5 (1st ed. 2011)


6 Kajima, supra.

7 Padilla Constr Co v Transportation Ins Co., 150 Cal. App. 4th 984, 58 Cal. Rptr.3d 807 (4th Dist. 2007).


10 Bovis Lend Lease at 464.


12 666 F.3d 384 (6th Cir. 2011)

13 Id. at 387.

14 Id. at 388 (emphasis added).

15 Id. at 389.

16 Id. at 390.


Announcement

The Insurance and Indemnity Law Section's Searchable Directory of Members

Is Now Operational!

All Section members are invited and encouraged to register in the directory and indicate their areas of expertise and the services they can provide.

The directory will be a resource for attorneys and court personnel in Michigan to assist them in finding Section members to assist in the handling and/or resolution of litigation.

When you register you can include the following information, in addition to information on how to contact you.

Areas of Practice:

- Indemnity Issues, Contract Drafting, Insurance In-House, Insurance Policy Drafting,
- Insurance Coverage (Liability, First Party Auto, Third Party Auto, Life, Health, Disability)
- ERISA
- Regulatory Matters
- Corporate/Transactional

Services:

- Consultation
- Litigation and Appeals
- Contract Review
- ADR (Neutral Evaluation, Facilitation, Mediation)

Client Base (Percentage of work for insurers and insureds)

To JOIN the Searchable Directory, go to http://mistatebar.com/add-me check the appropriate boxes, enter your personal data, and click on “enter.”

To SEARCH in the Directory, go to http://mistatebar.com, click on “find a lawyer,” check as many of the boxes as apply. You can select by one or more of these:

Areas of Practice, Client Base (percentage of clients who are insurers, and insureds), Services Provided (e.g., ADR, Contract Analysis, Litigation), Location (by county).

Then Click on “Apply”
Significant Insurance Decisions

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

Sixth Circuit Cases
Expansion of Brokers’ Common Law Duties

_Cleveland Indians Baseball Co v New Hampshire Ins Co_
727 F3d 633 (6th Cir 2013)

In a case garnering national attention, a panel of the 6th Circuit (Clay, J. dissenting) held that Michigan courts would recognize a common law duty of care owed by commercial insurance brokers to additional insureds in procuring insurance coverage.

The Cleveland Indians hired event coordinator National Pastimes to host “Kids Fun Day” at several baseball games during the baseball season. At one of these events, a large inflatable slide collapsed and fatally injured a bystander. National Pastimes had asked its insurance broker for a liability policy covering these events, including coverage for claims arising out of “bounce houses and inflatables,” with the Cleveland Indians named as an additional insured.

The broker issued a certificate of insurance naming the Indians as an additional insured but failed to procure a policy with the endorsement for inflatables, which meant that coverage was excluded for this claim. The Indians sued the broker directly.

On appeal from the district court order of summary judgment due to the lack of any legal duty owed, the majority determined that because the broker knew of the relationship between its named insured and the Cleveland Indians and knew of the request for additional insured coverage, a special relationship existed between the broker and the additional insured, giving rise to a common law duty of care to procure the required insurance. The 6th Circuit remanded the case for further proceedings on the Indians’ claims of negligence and negligent misrepresentation against the broker. The dissenting judge did not agree that brokers owe separate and independent common law duties to those with whom their named insureds contract for additional insured coverage.

Michigan Supreme Court Cases

Exclusion in boat owners’ policy barred coverage for bodily injury claim by adult son who was using the boat and was thus “an insured”

_Farm Bureau Mutual Ins Co of Michigan v Bowers_
Order 11/6/13 granting leave and reversing
Sup Ct Docket No. 147611

The Supreme Court summarily reversed the Court of Appeals as to whether the adult son of the insured boat owners was also an insured under the policy. An “insured” was defined in the policy as any person legally responsible for the watercraft if that person had custody or use of the watercraft with the named insured’s permission. Liability coverage was
expressly excluded for any bodily injury claim by an insured. In finding that the son’s claims against his parents were subject to the exclusion of his status as an insured, the Supreme Court reasoned: “[a] bailment existed as a matter of law between the boat’s owners and the . . . [son], who “also had, as a matter of law, custody or use of the watercraft at the time of the incident. Therefore, he was an insured under the terms of the insurance policy because he was ‘legally responsible’ for and had ‘custody of use’ of the watercraft at the time of the incident.” There were no questions of fact to determine. Defendant son has filed a motion for reconsideration.

Law of the case on “occurrence” does not bar consideration of policy exclusion for mold

Hastings Mutual Ins Co v Mosher, Dolan, Cataldo & Kelly, Inc.
Order 11/6/13 remanding in lieu of granting leave
Supreme Court Docket No. 146900

Following a long history of appellate proceedings in this construction defect/CGL coverage case, the Supreme Court, in lieu of granting leave, vacated a February 2013 judgment of the Court of Appeals in which it declined to consider the effect of a mold exclusion on whether Hastings Mutual owed its insured full reimbursement for the costs of defending what was primarily a non-covered construction defect claim. The order of remand directs consideration of two issues: (1) which insurance policy or policies govern coverage in this case; and (2) whether any exclusions in the governing policy or policies apply. “The Court of Appeals erred in concluding that it was bound by the law of the case to accept a prior panel’s implicit determination that the policy exclusions do not apply. The prior panel did not make any implicit or explicit determination regarding the application of the policy exclusions.”

Michigan Court of Appeals—Published

Employee defined for workers compensation insurance

Auto-Owners Ins Co v All Star Lawn Specialists Plus, Inc.
__ Mich App ___ (2013)
Docket No. 307711, released 12/2/13

This case resolves a disagreement between panels of the Court of Appeals concerning the distinction between “employees” and “independent contractors” for purposes of workers comp insurance. The Workers’ Disability Compensation Act (WDCA) defines an employee as “[e]very person in the service of another, under any contract of hire, express or implied. . . .” MCL 418.161(9). To the extent a person is performing service in the course of some trade business, profession or occupation of another at the time of an injury, that person is deemed an employee for worker’s compensation coverage as long as “the person in relation to the service does not maintain a separate business, does not hold himself or herself out to render service to the public, and is not an employer subject to this act.” MCL 418.161(n).

The court held that all three statutory conditions – (1) not maintaining a separate business, (2) not holding himself or herself out to the public, and (3) not an employer under the WDCA – had had to be met before a person could be properly viewed as an independent contractor. Plaintiff in this case was working on the lawn crew of a landscaping company insured by Auto-Owners under a (1) CGL policy, (2) a workers’ comp policy, and (3) a commercial auto policy. Auto-Owners sought a determination as to which policy applied and the court determined that because the claimant was an employee as defined by the WDCA (he did not satisfy all three requirements for independent contractor status), this claim was covered under the workers’ comp policy, and no other.

The burden of proof for applying exclusions

Stein v Home-Owners Ins Co
__ Mich App ___ (2013)
Docket No. 310257, released 12/10/13

“Preponderance of the evidence” is the appropriate burden of proof for an insurer seeking to avoid coverage for a fire loss based on an exclusion. The policy expressly excludes coverage if the insured “intentionally concealed or misrepresented any material fact or circumstance; . . . engaged in fraudulent conduct; or. . . made false statements” relating to the policy or coverage. Because the parties contest the proper interpretation and application of that contract term, the applicable burden of proof is preponderance of the evidence. The trial court erred in instructing the jury on the clear and convincing burden, which is applicable to claims of fraud in the inducement of an insurance contract but not to the effect of exclusions. The Court of Appeals reversed the jury’s verdict for the homeowner and remanded for a new trial.

Michigan Court of Appeals—Unpublished

UM insurer may set-off social security and disability benefits

Taylor v Frankenmuth Mutual Ins Co
Unpublished Court of Appeals opinion of September 19, 2013
(Docket No. 308213)

Following an auto accident, the injured plaintiff settled with the tortfeasor for policy limits of $20,000 and agreed to arbitrate her UM claim with her insurer. The dispute was whether UM benefits may be offset by social security and long-term disability benefits received as a result of the same accident. Here, the difference was a recovery of $280,000 or $67,000. The arbitrators applied the set-off, after which plaintiff moved to set the award aside. Relying on Park v
American Casualty Ins Co, 219 Mich App 62 (1996), the Michigan Court of Appeals affirmed the arbitration award as a matter of law. This UM policy specifically stated that any amounts payable in UM benefits would be reduced by sums paid or payable “under any workers’ compensation, disability benefits law or any similar law.”

Question of fact regarding the results of the insured’s misrepresentation about his suspended license

Meyers v Transportation Services, Inc
Unpublished Court of Appeals opinion of September 24, 2013
(Docket No. 300043)

When plaintiff applied for his auto insurance policy with Titan Insurance, he responded to a series of standard questions and reported that his license was not suspended. Plaintiff was subsequently injured as a pedestrian, and submitted a claim for PIP benefits, which Titan denied after learning that plaintiff’s license was indeed suspended when he applied for the policy. The claim was assigned to Transportation Services, who sought coverage from Titan. Plaintiff denied knowing that his license was suspended and contended that Titan would have issued the policy in any event.

The Court of Appeals determined that plaintiff was entitled to a trial on factual disputes regarding (1) the materiality of the misrepresentation, (2) whether plaintiff knew his representation was false when he made it or made it recklessly without knowledge of its truth, (3) whether plaintiff intended the misstatement to be relied upon by Titan, (4) whether Titan in fact relied on the misrepresentation, and (5) whether Titan suffered injury. There was also an issue as to whether plaintiff intended his injuries, in which case neither insurer would be liable for the PIP benefits.

Endorsement exclusion for government-seized property upheld

Torres Hilldale Country Cheese, LLC v Auto-Owners Ins Co
Unpublished Court of Appeals opinion of October 1, 2013
(Docket No. 308824)

This insured, in the business of producing and selling cheese products, was insured under a commercial property policy with Auto-Owners. Random government testing revealed the presence of Listeria in certain of the insured’s products and the insured was required to recall all products shipped during a certain span of time. The insured looked to Auto-Owners to cover the loss of products that were not contaminated but could not be shipped because they exceeded their expiration dates after being released by the government.

The trial court held for Auto-Owners regarding the lack of coverage. Although the non-contaminated products met the definition of covered property, coverage was expressly excluded by an endorsement concerning causes of loss. No coverage was afforded for any loss caused by “[s]eizure or destruction of property by order of governmental authority,” for any loss caused by “[d]elay, loss of use or loss of market,” or for any loss caused by “[a]cts or decisions, including the failure to act or decide, of any person, group, organization or governmental body.” The court declined to apply a more general provision from another endorsement stating that the insurance would not be affected by the “acts or negligence nor neglect or another.”

No-fault governs property damage claim against trucking company hauling contaminated soil from a remediation site

Silva v CH2M Hill, Inc.
Unpublished Court of Appeals opinion of October 15, 2013
(Docket No. 307699, leave app pending)

Plaintiff property owners filed a lawsuit against a trucking company hauling contaminated soil from the site of a chemical plant undergoing remediation. To the extent the trucking companies accidentally damaged neighboring property by dropping contaminated soil along the trucking routes, those property owners were governed by the no-fault act in seeking recovery; the damage had occurred in the course of the trucking company’s transportational use of its trucks as motor vehicles and was thus subject to no-fault rules of recovery (and no exceptions had been asserted). The property owners had to look to their own no-fault insurers for coverage.

Lack of notice to UIM insurer results in loss of benefits

Craig v Frankenmuth Ins Co
Unpublished Court of Appeals opinion of October 17, 2013
(Docket No. 311467)

Plaintiff failed to notify her UIM insurer of her settlement with the tortfeasors. She had initially sued both the tortfeasors and her UIM insurer but the trial court dismissed the insurer, stating that the claim was premature. Plaintiff proceeded to resolve her claims against the tortfeasors by accepting the case evaluation award but failed to provide notice of that award to her insurer. Because her policy required notice of settlements with tortfeasors as a condition of UIM coverage (to allow the insurer to decide whether to preserve subrogation rights), plaintiff lost the right to proceed with her UIM claim.
Homeowners policy does not cover a fire loss where the named insured is not a resident of the insured home

**Null v Auto-Owners Ins Co**
Unpublished Court of Appeals opinion of October 22, 2013
(Docket No. 308473, app for leave pending)

Plaintiff named insured in a homeowners policy with Auto-Owners did not live in the insured home for several years prior to a fire. His sister and her husband lived there instead, keeping the mortgage and the insurance premiums current. Defendant denied coverage for losses sustained by the sister and her husband after a fire because they were not “insureds” under the policy and because the named insured did not reside in the home. The trial court granted summary disposition for Auto-Owners, and that decision was affirmed by split decision in the Court of Appeals.

The policy, by its terms, defined the insured premises as “residence premises”, defined in turn as a dwelling or part of a building where “you” reside, with “you” referring to the named insured. Michigan law supports the denial of coverage based on failure to comply with residence requirements. “[T]he policy limits coverage to the dwelling in which the insured resides and which is used as the insured’s primary residence. The record confirms that [named insured] did not reside in the home at the time of the fire.” The dissenting opinion would remand for a hearing on the insured’s claim of equitable estoppel.

AI coverage for general contractor on bodily injury claim by sub’s employee

**Hobbs v Shingobee Builders, Inc.**
Unpublished Court of Appeals opinion of November 7, 2013
(Docket No. 307359)

Subcontractor’s insurer, State Auto, was obligated to defend two general contractors for injuries sustained by the subcontractor’s employee on two separate projects. The CGL policy contained an automatic additional insured endorsement providing liability coverage for any person with whom the insured entered into a written contract requiring such coverage. The additional insured coverage applied to claims that arose out of “acts or omissions” by the insured or on its behalf if the injury occurred during the insured’s ongoing operations. Although there were never any formal claims of wrongdoing by the insured subcontractor, there were allegations (and evidence) of comparative negligence on the part of that entity’s injured employee. The duty to defend arises if there are claims asserted that are arguably covered.

Subrogation allowed against uninsured motorists

**Titan Ins Co v Thomas**
Unpublished Court of Appeals opinion of November 12, 2013
(Docket No. 312747, leave app pending)

Assigned claims insurer is allowed to pursue subrogation against defendant uninsured motorist for PIP benefits on behalf of the passenger injured in the uninsured vehicle. There was no dispute that the defendant owned the vehicle at the time of the accident and that it was uninsured. Whether the defendant was also at fault or intoxicated was irrelevant.

UIM coverage not illusory

**Showman v Buser & State Farm Mutual Automobile Ins Co**
Unpublished Court of Appeals opinion of November 14, 2013
(Docket No. 311141)

State Farm’s underinsured motorist limits of $20,000/$40,000 was not illusory. It is possible that coverage would be triggered if Michigan tortfeasor’s policy limits were allocated to different claims. It is also possible that coverage would be triggered where the tortfeasor was covered under a policy issued under another state’s law allowing for lower limits. The Court of Appeals reversed the trial court’s contrary ruling, citing *ILE v Foremost Ins Co.*, 293 Mich App 309 (2011), rev'd 493 Mich 915 (2012).

Property insurance lost due to lack of timely proof of loss

**Slamo v MemberSelect Ins Co**
Unpublished Court of Appeals opinion of December 12, 2013
(Docket No. 310738)

Plaintiff homeowner’s failure to provide his insurance company with a written, signed and sworn proof of loss statement within 60 days of the loss, as required by the contract, resulted in a loss of coverage. The insurer did not waive the proof of loss requirement by offering to assist with the inventory of property or with estimating damage to the structure of the home; that offer clearly stated that the company was continuing to investigate the claim and reserved all rights under the policy. Nor did the insurer waive the proof of loss requirement by paying for temporary housing or accepting the insured’s valuation of damaged property.
Happy New Year to my fellow no-fault practitioners!

As readers of this column are well aware, the first three quarters of 2013 were quite busy in the no-fault world. By contrast, the last quarter of 2013 went out with a whimper. Governor Snyder did sign one important piece of legislation regarding access to police reports for purposes of soliciting victims of motor vehicle accidents. There have been no reported Supreme Court decisions in the interim and we have only a handful of significant Court of Appeals' decisions. This writer is fairly certain that all of this will change as we enter 2014.

Public acts 218 and 219

Anti-Solicitation Statutes

On December 21, 2013, Governor Snyder signed House Bills 4770 and 4771, which became Public Acts Numbers 218 and 219. Act 218 adds §503 to the Michigan Motor Vehicle Code, MCL 257.1 et seq and provides that:

“For 30 days after the date a motor vehicle accident report is filed with a law enforcement agency, a person may only access the report if the person or organization files a statement indicating that from the time the person or organization is granted access to the report until 30 days after the date the report is filed, the person or organization acknowledges that the person or organization is prohibited from doing either of the following:

(a) Using the report for any direct solicitation of an individual, vehicle owner, or property owner listed in the report.

(b) Disclosing any personal information contained in the report to a third party for commercial solicitation of an individual, vehicle owner, or property owner listed in the report”

Act 219 adds §410b to the Michigan Penal Code and provides:

“A person shall not intentionally contact any individual that the person knows has sustained a personal injury as a direct result of a motor vehicle accident, or an immediate family member of that individual, with a direct solicitation to provide a service until the expiration of 30 days after the date of that motor vehicle accident. This subsection does not apply if either of the following circumstances exists:

(a) The individual or his or her immediate family member has requested the contact from that person.

(b) The person is an employee or agent of an insurance company and the person is contacting the individual or his or her family member on behalf of that insurance company to adjust a claim. This subdivision does not apply to a referral of the individual or his or her immediate family member to an attorney or to any other person for representation by an attorney.”

The term “direct solicitation to provide a service” is defined as:

“A verbal or written solicitation or offer, including by electronic means, made to the injured individual or a family member seeking to provide a service for a fee or other remuneration that is based upon the knowledge or belief that the individual has sustained a personal injury as a direct result of a motor vehicle accident and that is directed toward that individual or a family member.”

The penalties are identical – $30,000.00 fine for the first violation and for a second or subsequent violation, imprisonment for not more than one year and/or a fine of not more than $60,000.00. It will be interesting to see what effect this legislation on subsequent no-fault litigation and how vigorously it will be enforced by law enforcement officials.

Court of Appeals Action

Mother’s Insurer May Be Responsible for Payment of Minor’s No-Fault Benefits, Even Though Minor Was Not...
Living with the Mother at the Time of the Accident.

In Chaney v Titan Indemnity Co, docket no. 311513, unpublished decision rel’d 1/7/2014, the minor plaintiff lived with his half-sister in a home owned by his mother in Detroit. His mother, though, lived in a separate home in Grand Blanc, but there was evidence that the mother would spend two or three weekends per month at the Detroit home. Plaintiff sought first party no-fault insurance benefits under his mother’s insurance policy with Titan Indemnity Company as “a relative . . . domiciled in the same household” under MCL 500.3114(1). The lower court granted the insurer’s motion for summary disposition on the basis that plaintiff was, in fact, not domiciled with his mother, and plaintiff appealed.

During the pendency of the appeal, the Michigan Supreme Court released its decision in Grange Ins Co of Michigan v Lawrence, 494 Mich 475, 493; 835 NW 2d 363 (2013). This case was discussed, at some length, in our prior issue. In Grange, the Supreme Court held that a minor child’s domicile is established by operation of law and that the custody order conclusively determines the child’s domicile for all purposes, including the No-Fault Act. In this case, the Plaintiff presented the Court of Appeals with a default judgment of divorce, from 1993, which provided that plaintiff’s mother “is awarded the care, custody, maintenance and education of” Plaintiff. In light of Grange, the Court of Appeals ruled that, absent any subsequent changes to the custody order, the minor was, in fact, domiciled with his mother as a matter of law. The court remanded the matter back to the trial court to allow the insurer to challenge the authenticity of the Judgment and to introduce any subsequent orders that may modify that Judgment.

Court of Appeals Clarifies Employee versus Independent Contractor Status Under Workers’ Compensation Act, and Upholds Workers’ Compensation Exclusion Contained in Commercial Auto Policy

In Auto Owners Ins. Co. v All Star Lawn Specialists Plus Inc., ___ Mich App __, ___ NW 2d ___ (docket no. 307711, rel’d 12/3/2013), an en banc panel of the Court of Appeals resolved the conflict between the prior opinion in this case and Amerisure Ins Co v Time Auto Transport Inc, 196 Mich App 567, 493 NW 2d 482 (1992). These cases dealt with the definition of the term “employee” as found in the Workers’ Disability Compensation Act, MCL 418.161(1). If the injured party was deemed to be an “employee,” he would be limited to recovering workers’ compensation benefits and would be barred from pursuing a negligence claim against his fellow employee who caused his injuries. If, on the other hand, he was an independent contractor, he would be able to pursue his tort claim against the individual who caused his injuries and would be able to pursue a claim for no-fault benefits under the commercial auto policy.

MCL 418.161(1) defines the term “employee” as

(l) Every person in the service of another, under any contract of hire, express or implied . . .

* * *

(n) Every person performing service in the course of the trade, business, profession, or occupation of an employer at the time of the injury, if the person in relation to the service does not maintain a separate business, does not hold himself or herself out to and render service to the public, and is not an employer subject to this act.”

In Amerisure, the Court of Appeals had previously concluded that only one of the three criteria set forth in MCL 418.161(n) needed to be satisfied. In other words, under Amerisure, a full-time secretary employed by a law firm, who advertised to the public and performed some typing services outside of that full-time employment, would be considered an “independent contractor.”

The en banc panel overruled Amerisure in this case and held that, in order for a person to be considered an “independent contractor,” all three conditions must be satisfied due to the legislature’s use of the word “and” in MCL 418.161(1) (n). Under the earlier Amerisure decision, the injured claimant would have qualified as an “independent contractor” because he held himself out to the public as someone who performed lawn maintenance and snow removal services. Once again, the Court of Appeals overruled Amerisure and determined that, because the injured claimant did not satisfy all three criteria for being deemed an “independent contractor,” he was an employee. As a result, his “exclusive remedy” was under the Workers’ Compensation Act. As a result, the Court determined that the commercial general liability policy, as well as the commercial auto policy included Workers’ Compensation exclusions and, as a result, Auto Owners had no obligation to provide coverage under those policies.

This decision certainly clarifies the criteria for establishing whether an individual is an employee or an independent contractor under the Workers’ Compensation Act and will, in all likelihood, result in a determination that most individuals will be deemed to be “employees.” As a result, no-fault insurers will likely be able to take advantage of the mandatory set-off provisions for workers’ compensation benefits under MCL 500.3109(1) far more frequently. The legislature may also wish to consider amending the Michigan No-Fault Insurance Act to incorporate the Workers’ Compensation Act’s definition of the term “employee” to avoid the specter of a person being deemed an “employee” under the No-Fault Insurance Act, but an “independent contractor” under the

continued on the next page
Workers’ Compensation Act, for purposes of applying the employer-furnished vehicle priority provision found at MCL 500.3114(3).

Court of Appeals Reverses Order Granting Motion for Directed Verdict, and Allows Issue of Causation and Serious Impairment to go to Jury

In Kallman v Whitaker, docket no. 312457, unpublished decision rel’d 11/26/2013, Plaintiff was involved in a 2001 motor vehicle accident. She was only 10 years old. After receiving routine emergency room treatment, Plaintiff was asymptomatic until April 2006, when she began experiencing back pain and leg problems. She also suffered a slip and fall the day after she began experiencing her back pain. She was eventually diagnosed with three herniated discs, which her treating physician related to the 2001 motor vehicle accident. Defendant’s medical expert testified that, although Plaintiff had one herniated disc and multiple bulging discs, he could not relate any of these conditions to the 2001 motor vehicle accident.

The lower court granted Defendant’s motion for directed verdict. However, the Court of Appeals reversed in light of the Supreme Court’s decision in McCormick v Carrier, 487 Mich 180, 795 NW 2d 517 (2010) and remanded the matter back to the trial court for trial.

Court Limits Scope of Non-Party Expert Discovery

In Kincaid v Groskey, docket no. 310148, unpublished decision rel’d 11/21/2013, a non-party, Exam Works, appealed from an order of the Wayne County Circuit Court, which granted discovery of financial and ownership documentation pertaining to Exam Works and two physicians who performed the IMEs on plaintiff at the request of the defendants. The trial court permitted the disclosure of income and financial information regarding the physicians at Exam Works, which included the gross income of the physicians that they received from performing “defense medical examination” through Exam Works.

The Court of Appeals reversed the lower court’s order compelling production of this financial information. In doing so, the Court of Appeals specifically noted that, under MCR 2.303(B)(4)(i), the discovery of documents from a non-party is by deposition or a written request for documents under MCR 2.310(B)(2). Simply issuing a subpoena to Exam Works for this financial information was simply not warranted by the Michigan Court Rules.

The court then discussed how discovery of the expert witnesses’ financial information might be obtained and cautioned the trial courts about allowing such information at trial:

The implication that arises from the order and content of the subrules suggests that a litigant must first take the deposition of the expert and then, if unsatisfactory, may proceed to seek alternative means of discovery from the court. In this instance, plaintiff has not scheduled or sought to take the deposition of either IME physician.

Plaintiff’s discovery request is subject to limitation, with regard to both method and scope, consistent with caselaw and the rules of evidence. The interest, bias or prejudice of a witness, including an expert witness, is recognized as a proper subject of cross-examination. MRE 611(c). It is proper to cross-examine an expert about the number of times he or she has testified in court or was involved in a particular type of case. Wilson v Stilwell, 411 Mich 587, 599-600; 309 NW2d 898 (1981). It is also appropriate to cross-examine an expert to demonstrate a pattern of testimony for a specific attorney or a particular category of plaintiffs or defendants. Id. at 600-601. However, ‘such testimony is only minimally probative of bias and should be carefully scrutinized by the trial court.’ Id. at 601. Evidence of an expert’s credibility is generally admissible unless its probative value is substantially outweighed by the danger of unfair prejudice.”

Simply put, Interrogatories that seek information regarding the expert witness’ financial information should be objected to on the basis that the court rules simply do not allow a person to obtain this information through interrogatories. Rather, the litigants must simply depose the witness first and then resort to the court for additional relief, if warranted.

Court of Appeals Confirms that Oral Notice of a Loss, With No Written Notification Whatsoever, Fails to Satisfy the Notice Requirement Set Forth in MCL 500.3145(1)

In Schildgen v Allstate Ins. Co., docket no. 311339, unpublished decision rel’d 11/19/2013, Plaintiff was injured while occupying a motor vehicle owned by her friend and insured with Allstate. Plaintiff verbally reported the loss to Allstate the following day. She subsequently received a letter from Allstate Insurance Company acknowledging the claim, but no forms, such as an Application for Benefits, were ever completed and submitted to Allstate. Approximately four months after the accident, Plaintiff indicated that her son owned a motor vehicle that was insured with Progressive and that she would file a claim with Progressive as the household insurer under MCL 500.3145(1). One and one-half years after the loss, Plaintiff’s counsel contacted Allstate, at which time counsel was informed of the purported household insurer, Progressive. Shortly thereafter, it was discovered that plaintiff’s son was actually insured with Allstate at the time of the accident, and that the Progressive policy had expired prior thereto. Allstate
denied the claim because Plaintiff had failed to comply with the written notice provision set forth in MCL 500.3145(1). This section of the No-Fault Act provides:

“The notice shall give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place and nature of his injury.”

Relying on early case law, including Keller v Losinski, 92 Mich App 468, 285 NW 2d 334 (1979), the Court of Appeals affirmed the lower court’s decision granting Allstate’s motion for summary disposition noting that there was simply no dispute but that plaintiff had failed to provide written notice of the accident to the Defendant and that mere oral notice was insufficient under the statute. The court further distinguished Walden v Auto Owners Ins. Co., 105 Mich App 528, 307 NW 2d 367 (1981) and Dozier v State Farm, 95 Mich App 121, 290 NW 2d 408 (1980) and noted that in those cases, there was some form of writing, based upon the claimant’s oral communications. In this case, though, there was a complete lack of any writing that would satisfy the written notice provision of MCL 500.3145(1).

In Livingston v. Sullivan and Progressive Michigan Ins. Co., Court of Appeals docket no. 308434, unpublished decision rel’d 10/10/2013, Plaintiff was involved in a motor vehicle accident in 2008. As a result, she filed a first party action against her insurance carrier, Progressive, as well as a tort action against the motorist who rear ended her. The tort claim proceeded to trial in May 2011, at which time plaintiff’s pre-existing medical history including her multiple prior motor vehicle accidents, was introduced as evidence. The jury concluded that plaintiff suffered no injuries as a result of that occurrence – a ruling that was affirmed by the Court of Appeals on the basis that “there was ample evidence before the jury to give rise to a reasonable question of fact regarding whether Livingston was injured in the accident.”

Turning to the first-party claim, the Court of Appeals relied on the Supreme Court’s decision in Monat v State Farm, 469 Mich 679, 677 NW 2d 843 (2004), which involved a similar fact pattern, to affirm the lower court’s decision to grant summary disposition in favor of Progressive. Simply put, a finding that the Plaintiff was not injured in a motor vehicle accident precludes any claim for no-fault benefits.

What is a CPCU®?

By Adam Kutinsky, JD, CPCU®, The Kitch Firm

The odds are that if you have been in communication with an insurance company or insurance agent you have seen the acronym CPCU® following a person’s name. However, if you are not regularly engaged in the business of insurance, you reasonably neither knew nor were interested in knowing what this acronym meant.

However, since attorneys understand the importance of higher education (at least enough to spend 3 years in post-graduate studies and subject themselves to the torment of the bar exam), the CPCU® designation should generate some level of respect from them. This article discusses what the CPCU® designation is and what is required to attain it.

In the risk management and insurance industry, the professional designation of CPCU® is synonymous with insurance professional. The acronym is short for “Chartered Property Casualty Underwriter” and is usually earned by persons who have worked in the insurance industry for several years if not decades before seeking the designation. It is also common for CPCU®s to maintain leadership positions in their organizations both before and after the conferment of the designation.

The curriculum for earning the designation is arduous and requires any person seeking the designation to pass 8 separate exams, each focusing on some aspect of insurance and risk management (lawyers get a pass on the legal exam).
are required to work a minimum of 17 1/2 hours a week in acceptable insurance activities for any 24 months during the five-year period immediately preceding the conferment of the designation. Finally, all CPCU®s must pass an ethics exam and are bound by a unique code of ethics for the duration of their designation.

A recent survey of CPCU® candidates conducted by the Greater Detroit Chapter of CPCU® determined that the most significant factor to those pursuing the designation is career advancement. This same survey found that candidates are most interested in furthering their insurance and risk management knowledge through continuing education. There is also a considerable amount of marketing opportunities through the national and local chapters of CPCU®, both of which are made up of local and national insurance industry leaders.

For more information concerning the CPCU® designation, please visit http://greaterdetroit.cpcusociety.org/ or contact Adam Kutinsky at adam.kutinsky@kitch.com.

The Manuscript Policy

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

Your correspondent does some work for insureds and some for insurers. For one insurer (a “risk retention group,” actually) he assists in drafting their policies. That’s what a manuscript policy is: a policy drafted by the insurer itself. This distinguishes it from the primary source of policies, the Insurance Services Office. The acronym is ISO, and you will see their tagline on the bottom of their forms. Insurance companies license the right to use their forms.

From the Insurer’s Side

Back to the manuscript form. From the point of view of the lawyer who drafts them it can be nerve-wracking. Edgar Allen Poe said that in a short story, unlike a novel, every word must play a part or be discarded. That goes times two for drafting a policy.

You might be surprised how much time it takes to choose between “prior incident” and “antecedent incident.” Or choosing between “but for” and “in the absence of.” The list goes on. It’s not enough that the language is almost perfect.

Apologies are owed to Poe, because if there is one thing a policy is not, it’s compelling literature. More important, though, Poe had a friendly audience. The policy drafter, not so much. The policy drafter writes for “hostile eyes.” He or she must always be aware that the “audience” for the policy will eagerly seek out any mistake in punctuation, any sloppy choice of words, and any poorly structured subordinate clause. Any lack of clarity is fodder for the opposition.

A peculiarity of the manuscript policy is that people who are bad at drafting don’t know how bad they are. A simple example from a company for which your correspondent does not draft polices: One policy, in a single paragraph, rendered the word insured as “insured,” “Insured” and “INSURED.” Since it is common to have different classes of insureds under a single policy, it’s a fair hypothesis that the three usages refer to different classes. Unfortunately there was no indication of that anywhere else. Was it just sloppy drafting, with no effect on coverage? Maybe, but the point of drafting is to avoid raising interesting questions like that. The insurer’s reply, when its attorney asked why the trifurcated usage, was an impatient shrug of the shoulders.

One of the more creative flights of language in that policy was the definition of a claim. The policy was “claims-made,” so the making of the claim (not the underlying occurrence) is what triggers coverage and also triggers the duty to report the claim. The usual definition is something like, “a claim is a demand for money.” That’s pretty simple. A letter saying “you owe us money” is enough, and letters have dates and postmarks. But this policy said: “a claim exists when the insurer learns that a lawsuit may result.” How do we link a date to that accretion of knowledge? How much knowledge must the insured have before coverage is triggered? Is “may result” different from “will result?” Using a subjective test is dangerous for the insurer.

Drafting is perfect work for the word nerd. To refer to one of the examples above, “prior” refers only to time, but “antecedent” suggests both time and causation. The word “antecedent” alone is not enough to express the idea of causation, but
if causation is what you are going for, “antecedent” is better than “prior.”

The choice between “but for” and “in the absence of” is based on different considerations. They mean the same thing logically, but if a dispute arises, and causation is the key, “but for” is better. Why? The audience then becomes a judge, and “but for” is a well understood component of the definition of causation.

Drafters spend a surprising amount of time staring at a wall or, if they’re lucky, out a window, pondering word choices like the above, as well as restrictive versus non-restrictive clauses.

**From the Insured’s Side**

Which leads us to the other side of the divide. When the attorney for the insured or the tort plaintiff is trying to confirm coverage, the heart beats a little faster when he or she comes across a manuscript form. A manuscript form is often like Forrest Gump’s box of chocolates. There may be some good things inside.

A well-crafted insurance policy works – or should work – like an auto’s transmission. The pieces fit together and each works well with all of the others. But any clashing of gears is music to the ears of the insured’s attorney.

One policy form, for example, referred to “parole” evidence, rather than parol evidence. A lawyer wouldn’t make that mistake. No, we lawyers make different mistakes. Lawyers tend to favor what Mark Twain called transatlantic sentences - long circuitous excursions that try to put everything together, but end up winding an intricate path through clause after dependent subclause.

Another characteristic is the obsession to sound like a lawyer, by saying “in the event that” instead of “if,” and “hereinabove” instead of “above.” This, by the way, is often what the clients like. Consider an indemnity clause, for example. Your correspondent drafted one for a business and made it short and to the point. Months later, the client, having attended a meeting of his business colleagues, complained that their clauses were more “sophisticated.” “Sophisticated” means “complex.” The other guys’ clause was two or three times as long. It was also self-contradictory. Apparently size matters.

The length of a paragraph or clause is often a clue that the drafting is poorly done. A manuscript policy with an “other insurance” clause began by saying that the policy was “excess to” all other policies, but then went on to say that is would share with the other policy “in proportion to their policy limits.” For the attorney representing the other insurer, disappointment turned to joy.

Another example of a manuscript policy that contains hidden gems is from a claims-made policy. Like all claims made policies, coverage requires two conditions. The claim must be made within the policy year, and also reported in the policy year. Failure of either requirement voids coverage without the need to show prejudice. The insured was sued in 2002 and did not report the claim until 2004. Unfortunately for the insurer, the drafter of the policy decided to define when the claim is made this way: “a claim shall be deemed to be made when the insured reports it to the insurer.” So the claim reported in 2004 is “deemed to be made” in 2004 and is timely.

An example may help to demonstrate how inexpert drafting can put devils in the details. A definition of “property damage” reads:

**Property Damage** – The term “Property Damage,” wherever used herein, shall mean damage to or destruction or loss of use of property of others, excluding, however, damage to property in the care, custody or control of the Named Insured, including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed, the liability of the Company being limited to the payments outstanding.

There is a lot to be said for this clause, and most of it isn’t good.

1. “The term” adds nothing; it just takes up space.
2. Likewise “wherever used herein.” Where else would the definition be used?
3. “Shall mean” is a legalism, as if the policy must mandate the meaning. Plain old “means” is all it needs.
4. “Property Damage . . . shall mean damage.” Using the defined word to define the word you’re defining is a bad idea. Something like “Property Damage means physical injury including loss of use . . .” is better
5. This phrase is almost archaic: including property which is purchased by the Named Insured under a contract which provides that the title remains with the sellers until payments have been completed.” Since the UCC, the operative term is “security interest,” which embraces a wide variety of methods. A title-retaining contract is only one.
6. The concluding sentence has the wrong measure of coverage: “the liability of the Company being limited to the payments outstanding.” If a buyer owes periodic payments, those payments include interest. Therefore the sum of “the payment outstanding” is greater than the remaining principal owed.

The paragraph would read better like this:

**Property Damage** means physical damage to or destruction or loss of use of the tangible property of others, but not any property of others that is in the care, custody or control of the Named Insured. For property purchased by the Named Insured and
which is subject to a security interest, the coverage provided by this policy shall not exceed the principal amount of the debt.

The insurer elected to keep the clause unchanged. As is mentioned above, one peculiarity of drafting is that an insurer that has poorly written manuscript forms will almost certainly have no idea how poorly written they are.

Conclusion

There are few other areas of law where the words and the grammar play such a critical role as in drafting insurance policies (and indemnity clauses). The consequences of careless drafting can be a serious problem for one side and delightful opportunity for the other.

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. Mr. Carroll practices extensively in the area of insurance coverage and indemnity law, and was designated a “Super Lawyer®” again in 2013. He also consults with businesses and insurers on the drafting of contracts, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His website is www.HalOCarrollEsq.com and his email address is HOC@HalOCarrollEsq.com.

ERISA Decisions of Interest

Michael R. Shpiece, Kitch Drutchas Wagner Valittuti & Sherbrook
Kimberley J. Ruppel, Dickinson Wright

United States Supreme Court Update

Contractual limitations period that begins to run before a cause of action has accrued is enforceable


In this unanimous decision, the Supreme Court resolved a split among the Courts of Appeals regarding whether an ERISA welfare benefits plan’s contractual limitations period is enforceable even where the limitations period has begun to run before a claimant could file suit under ERISA section 502(a)(1)(B). Approving what has been established law in the Sixth Circuit, the Supreme Court found that a contractual limitations period must be given effect as written unless the period is unreasonably short, or if the provision conflicts with another statute. Because neither situation was present in this case, the court held that the limitations period was enforceable and thus, the participant’s claim was time-barred.

The plan at issue in this case precluded a participant from commencing legal action more than three years after proof of loss was due. The plaintiff here filed her claim for long term disability benefits in August 2005. After a lengthy review process, the plan administrator issued its final claim denial in November of 2007. The plaintiff filed suit in November 2010, less than three years after the final claim denial but more than three years after proof of loss was due.

As a general rule, ERISA plan participants are required to exhaust any internal administrative review process before challenging an adverse claim decision in court. Typically, the time period for a statute of limitations begins to run once a cause of action accrues. With respect to ERISA benefit decisions, a participant’s cause of action does not accrue until the plan administrator issues a final denial of a claim. The plaintiff in this case argued that because “proof of loss” is due before the internal review process was concluded, the contractual period of limitations was not enforceable.

The court found that the general rule that contractual terms must be enforced as written is particularly applicable with respect to ERISA plan documents which provide that claims for benefits provided under the plan are to be processed as provided by the plan terms. This is a central principle to the goal of ERISA for plans to be administered efficiently and expeditiously.

The court also found that ERISA regulations are structured to promote timely review and to prevent dilatory action by
plan administrators. The court noted that waiver, estoppel
and other equitable doctrines are available as remedies to plan
participants whose claims might otherwise be time-barred due
to a plan administrator’s bad faith or wrongful actions.
This decision emphasizes the need for a plan participant to
be mindful of the plan’s terms and not to rely on the date of
a final denial decision as the starting point for the limitations
period.

Sixth Circuit Update

Disgorgement of profits awarded as damages for a breach
of fiduciary claim

Rochow v Life Insurance Company of North America, __
F3d __, 2013 U.S. App LEXIS 24271 (6th Cir. 2013)

In this latest opinion in an ongoing litigation which had
been previously appealed and remanded, the Court of Appeals
seemed to stray from the well-established rule that when a
claim denial is found to be arbitrary and capricious, the
appropriate award of damages is the amount of benefits wrong-
fully withheld, perhaps combined with prejudgment interest
and/or attorney’s fees. Typically, where a claim based upon an
alleged breach of fiduciary duty is not distinguishable from
the benefit denial claim, no additional damages are recover-
able. Instead, after finding in an earlier decision that the plan
administrator arbitrarily and capriciously denied the benefit
claim for which damages were awarded in the amount of the
withheld benefits, the court here upheld an additional award
for disgorgement of profits in the amount of $3.8 million as
damages for the breach of fiduciary duty claim.

The majority opined that this case was an extension of
other cases in which courts had found exceptions to the rule
against overlapping recovery for claims for wrongful denial of
benefits and an associated claim for breach of fiduciary duty.
The majority found that disgorgement here was not equivalent
to double recovery because actual damages (withheld benefits)
plus disgorgement of profits that had accrued in relation to the
benefit amount were two separate categories of damages. Also,
the majority reasoned that disgorgement did not constitute a
punitive measure because the plan administrator would be no
worse off than if the plan had paid the benefits when due.

In terms of calculating the amount of the award, the Dis-
trict Court found that since the withheld benefit amount was
not a separate and distinct fund within the plan adminis-
trator’s coffers, that money was available for use as “bottom
line equity” for any business purpose. The Court of Appeals
agreed that where benefit funds are not traceable, damages are
properly calculated based on a proportionate share of profits.
Where the plan administrator’s profits are sizeable, reasoned
the court, so should be the disgorgement. It found support
for its decision in a Ninth Circuit case which phrased the fun-
damental tenet of accounting and disgorgement as, “if you
take my money and make money with it, your profit belongs
to me.” However, the court seemed to suggest that if the dis-
puted benefits were held separately, disgorgement would be
limited to the actual income earned by that fund.

In a scathing dissent, Justice McKeague characterized the
disgorgement award as an “astonishing windfall” which under-
mined ERISA’s remedial scheme of making a claimant whole
without being punitive. Justice McKeague also noted that the
potential for recovery of profits would cause litigants to engage
in more discovery, which was also contrary to ERISA’s goals and
policies of expeditious and inexpensive claim resolution. The
majority responded to that concern by stating that avoiding ex-
pensive discovery should serve as motivation for plan adminis-
trators to act in the interest of participants in the first instance.

Justice McKeague also criticized the majority for claiming
to rely on certain precedential authority for the disgorgement
award, and distinguished each of those opinions in turn. The
dissent explained that, in Hill v BCBSM, 409 F3d 710 (6th Cir
2005), injunctive relief was awarded in addition to damages in
order to resolve a plan-wide claim handling error. In Gore v El
Paso Energy Corp Long Term Disability Plan, 477 F3d 833 (6th
Cir 2007), the court expressly denied recovery on both of the
claims for misrepresentation and wrongful denial of benefits,
holding that the plaintiff there could recover for one theory or
the other, but not both. Finally, in Parke v First Reliance Std
Life Ins Co, 368 F3d 999 (8th Cir 2003), the Eighth Circuit
awarded “disgorgement” in the amount of $700 in prejudg-
ment interest, but not a disgorgement of profits based on the
withheld benefit amount.

This is a decision which bears watching, as the authors
anticipate a request for en banc review.

GM Salaried retirees lose life insurance

Haviland v Metropolitan Life Insurance Co,
730 F3d 563 (6th Cir 2013)

This is another retiree benefits case, but this time involv-
ing life insurance and the GM bankruptcy. GM provided
its salaried retired employees with continuing life insurance,
which was insured by Metropolitan Life. As part of its re-
organization, GM reduced the amount of the life insurance
to $10,000. (Some retirees previously had insurance of more
than $100,000.) Instead of suing GM (which would prob-
ably be unsuccessful because of the bankruptcy court’s order
approving the reduction), the retirees sued MetLife, based on
letters it had written to the retirees saying things like, “this life
insurance remains in effect, without cost to you, for the rest
of your life.”

The court began by holding that the underlying GM plan
and summary plan description both adequately reserved to

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GM the right to amend, reduce, or end the retiree life insurance benefit. It then rejected each of the retirees’ claims.

First, the “promissory estoppel” claim was rejected because the “reservation of rights” language was unambiguous. The court had previously held that “principles of estoppel . . . cannot be applied to vary the terms of an unambiguous document; estoppel can only be invoked in the context of ambiguous plan provisions.” The court did not view the MetLife letters as inconsistent with the reservation of rights; rather it viewed the letters as merely being a description of the retirees’ current benefit and not any statement of their future benefit.

Second, the court rejected the breach of fiduciary duty claim. Even assuming that MetLife was a fiduciary and although an ERISA fiduciary is barred from lying and giving inaccurate or misleading information, the court held that MetLife did not breach any fiduciary duty because the information was a truthful statement of the retirees’ current benefit.

Finally, the Court quickly rejected the retirees’ claims that MetLife breached the GM plan’s terms and their claims of unjust enrichment and for equitable restitution.

United States District Court Update

Another Loss for GM Retirees


In 1999, Delphi Corporation separated from the General Motors Corporation (“Old GM”). In 2005, Delphi filed for bankruptcy. In 2006, Old GM, the UAW, and a class of Delphi retirees agreed that the Delphi retirees’ health coverage would be provided by a VEBA trust; and in 2007, Delphi, Old GM, and the UAW entered into a Memorandum of Understanding, which among other provisions, conditionally required Old GM to pay $450 million to the VEBA. (Because Delphi had previously been a division of Old GM, Old GM arguably had some obligation to fund the Delphi retirees’ health benefit.)

In 2009, Old GM filed bankruptcy and sold most of its assets to “New GM.” At about the same time, New GM and the UAW entered into an agreement that specified the retiree obligations that New GM was going to assume. This agreement did not mention the $450 million payment and had a provision that said that New GM’s obligations for Old GM retirees were fixed and capped by this 2009 agreement.

In 2010, the UAW filed suit against New GM seeking New GM to pay the $450 million. (The GM bankruptcy court lifted the automatic stay and let this action proceed.) The court, after reviewing this rather complicated history, held that the 2009 agreement extinguished any obligation that New GM had to pay the $450 million.

Court Grants Disability Claim on Review of Insurer’s Denial


Ashima James was injured in a car accident. At the time of her accident, she had disability coverage through her employer that was insured by Liberty Life. The coverage defined disability as the inability to perform her current occupation for the first 24 months of disability and the inability to perform any occupation thereafter. The policy also limited benefits for a disability due to mental illness to 24 months. Liberty Life denied her claim for benefits because it claimed that she failed to provide objective evidence that her condition precluded her from performing her job.

The court began by determining that it would review the claim de novo. Readers of this column will recall that the basic rule is that courts review benefit denials de novo unless the plan document grants the plan administrator or insurer the discretionary authority to determine plan benefits. If this discretionary authority is granted, the court’s review is raised to an “arbitrary and capricious” standard, i.e., the court can only reverse the benefit denial if it finds the denial was arbitrary and capricious. (Not surprisingly, most plans now include this grant of discretionary authority.) However, in 2007, the Michigan Office of Financial and Insurance Services adopted a regulation prohibiting the use of discretionary clauses in insurance policies. The court held that as a result of the 2007 regulation, it would review the claim de novo, meaning it would simply decide whether or not it agrees with the denial. It did apply precedent in determining that its review, although de novo, would be based exclusively on the record compiled by the insurer; that is, no additional evidence would be considered.

Based on its review, the court determined that Ms. James was disabled under the policy’s “regular occupation” definition of disability. It also rejected Liberty Life’s claim that James failed to provide evidence of her disability. First, the court held that the policy did not require objective evidence. It defined “proof” and included some objective medical evidence as examples of proof. But the policy said that proof “includes but is not limited to” the evidence given as examples. Further, the court held that Ms. James had, in fact, submitted sufficient objective evidence, including MRIs, physical examinations, and other test results.

Finally, the court recognized that after 24 months, the standard for disability would change and any benefits for a disability due to a mental illness would end. But it also recognized that Liberty Life had not yet reviewed James’ claim under these provisions and thus the Court could not determine whether Ms. James still qualified for benefits. It remanded this issue to Liberty Life for its further consideration.
Another Decision of Note

The following is another recent decision that your authors determined do not warrant a full write-up. Only certain aspects of the decision are mentioned.

Michigan Insurance Regulation Prohibiting Discretionary Clauses Does Not Apply to Policy Issued in Another State


As noted in the discussion of the *James* case, above, Michigan has an insurance regulation that prohibits the inclusion of “discretionary clauses” in insurance policies issued or delivered in Michigan. Although Mr. Burmania worked for the employer-policyholder (YRC Worldwide) in Michigan, the policy in this case was actually issued in Kansas. (YRC operates in many states.) Therefore, the Court held that the Michigan regulation did not apply and decided the case under the “arbitrary and capricious” standard. The Hartford also cited MCL 500.402b(d) which says that the lawful issuance of a master policy to an employer located in another state for the benefit of employees residing in Michigan does not constitute the transaction of insurance in Michigan.

The court also discussed the effect of a determination of disability under the Social Security Act on a disability claim. The court noted that in 2003 the US Supreme Court held that a Social Security disability determination did not automatically mean that the individual was disabled under a disability benefit plan. The court then discussed the substantive differences between a social security determination and a determination under an insurance policy.

About the Authors

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Analysis of Recent Legislation

By John M. Sier, Kitch, Drutchas, Wagner, Valitutti & Sherbrook

Several bills are now pending in the legislature that relate to insurance in various ways. The summary below is based upon the Legislative Analyses prepared for each bill.

Each of the bills changes language to note the recent creation of the Department of Insurance and Financial Services to replace the Office of Insurance Regulation within the Department of Licensing and Regulatory Affairs among other technical corrections and substantive changes.

Group Life Insurance – HB 5146

This bill adds several provisions that would make state law conform with the model act from the National Association of Insurance Commissioners (NAIC). For the model act from which these provisions are drawn, see: [http://www.naic.org/storefree/MDL-565.pdf](http://www.naic.org/storefree/MDL-565.pdf)

For employee life insurance, a policy could define “employees” to include one or more of the following: (1) the employees of one or more subsidiary corporations; (2) the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships, or partnerships, if the business of the employer and the affiliated corporations, proprietorships, or partnerships is under common control; the retired employees, former employees, and directors of a corporate employer; and, for a policy issued to insure the employees of a public body, elected or appointed officials.

For association life insurance, the bill would add that group life insurance could be issued to an association, or to a trust, or to the trustees of a fund established or maintained for the benefit of members of one or more associations. Group life insurance could not be issued to an association unless all of the following criteria were met:

1. The association at the outset had at least 100 members.
2. The association had been organized and maintained
for a purpose other than obtaining insurance.

3. The association had been in active existence for at least two years.

4. The association’s bylaws provide that:
   a. members must meet at least annually;
   b. dues must be collected and contributions solicited from members, except for credit union associations; and
   c. members have voting rights and representation on the governing board.

The association life policy would be subject to all of the following:

1. The policy could insure members of the association, employees of the association, or both members and employees for the benefit of persons other than the employee’s employer.

2. The premium must be paid from money contributed by the association, employer members, or covered persons.

3. A policy on which no part of the premium comes from money contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.

4. However, an insurance company could exclude or limit coverage on an individual when evidence of insurability is not satisfactory.

Under the bill, discretionary group life policies could not be issued unless the director of the Department of Insurance and Financial Services (DIFS) finds that (1) the issuance of the group policy is not contrary to the best interest of the public; (2) the issuance of the policy would result in economies of acquisition and administration; and (3) the benefits of the policy are reasonable in relation to the premiums charged.

Further, the premium for such a policy must be paid from either or both of the policy holder’s funds or the funds contributed by the covered persons. An insurer could exclude or limit coverage on an individual when evidence of insurability is not satisfactory.

The certificate that is delivered by an employer to an employee whose life is insured under a group policy would constitute notice to the employee of the conversion rights under a group policy, and a separate notice would not be required at the employee’s termination.

The bill would specify that a group policy offered by an insurer issued in another state could not be issued in Michigan unless the director of DIFS determines that certain Michigan statutory requirements have been met.

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Entries due April 4, 2014

DEMOCRACY: Why Every Vote Matters


The Michigan Legal Milestones program highlights the state’s important cases, laws, and individuals. The Milestones can be found on the State Bar of Michigan website www.michbar.org/programs/milestones.cfm

One Person, One Vote | Sojourner Truth | Eva Belles’ Vote | Freedom Road

To participate in the Law Day contest, one or more milestones may be used to illustrate the 2014 theme in a creative project. Examples of creative projects include essays, debates, mock trials, podcasts, dramatic or musical plays, re-enactments, short documentaries, board games, video games, and more. Electronic submissions are highly encouraged.

Enter online—www.michbar.org/programs/lawday/
Variable life and annuity products – HB 5147

This bill specifies that a variable life product or variable annuity product approved by the US Securities and Exchange Commission (SEC) for sale in the state would be considered compliant with the section. The bill also repeals Section 2206, an outdated section that deals with a minor’s capacity to receive insurance benefits. That section refers to “a minor who has attained the age of 18”; however, 18 is now the legal age of majority.

Insurers’ Minimum Asset Requirements – HB 5148

House Bill 5148 deals with the definition of qualified assets for the purpose of determining minimum asset requirements of insurance companies. Under the bill, qualified assets would include preferred stock of companies organized under the laws of Canada or a province or territory of Canada. (The act currently refers to companies organized under the laws of the United States, any US state, or the District of Columbia.)

Accelerated Benefits – HB 5149

Generally speaking, the term “accelerated benefits” refers to instances when a portion of a death benefit from life insurance can be paid to the insured before death for certain medical conditions. The bill would specify that “accelerated benefits” do not include benefits payable to an insured under a long-term care policy. It also would add “chronic illness” as a “qualifying event” that allows the payment of accelerated benefits. “Chronic illness” would be defined as a permanent medical condition that results in an individual being unable to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating. The term would also include a permanent severe cognitive impairment or similar form of dementia.

Annuity Contracts – Application and Cancellation – HB 5150

House Bill 5150 would amend a section dealing with life insurance and annuity contracts. It does two things. First, the bill specifies that an application obtained through electronic means counts as an application, and that the information contained in the application must be endorsed upon or attached to the policy.

Second, the bill would add language regarding refunds of premiums paid for annuity contracts when the contract is canceled during the first 10 days after the date that the customer receives the policy. For a variable annuity, the refund would have to equal the sum of: (1) the difference between the premiums paid, including any policy or contract fees or other charges, and the amounts allocated to any separate accounts under the policy or contract and (2) the value of the amounts allocated to separate accounts under the policy or contract on the date the returned policy is received by the insurance company or its insurance producer (i.e., the agent).

Penalty Interest – HB 5151

House Bill 5151 would preclude penalty interest from accruing on benefits payments made greater than 60 days after proof of loss “due to circumstances not in the control of the insurer.” MCL 500.2006 requires benefits to be paid on a timely basis and requires interest to be paid on benefits not paid within 60 days of the date that satisfactory proof of loss was received by the insurance company. The bill would preclude interest from accruing if the nonpayment was “due to circumstances not in the control of the insurer.”

The phrase is not defined in the statute or the bill. The last clarification of the penalty interest provision was Griswold Props., LLC v Lexington Ins Co, 276 Mich App 551; 741 NW2d 549 (2007)(conflict panel) addressing the application of the phrase “reasonably in dispute” on the timing of the 60 day period. The conflict panel held that the “reasonably in dispute” language of MCL 500.2006(4) applies only to third-party tort claimants; if the claimant is the insured or an individual or entity directly entitled to benefits under the insured’s contract of insurance, and benefits are not paid on a timely basis, the claimant is entitled to 12 percent interest, irrespective of whether the claim is reasonably in dispute.” The language of HB 5151 does not clarify whether it applies only to third party claims or first party claims – or both. Without the definition or clarification, it is difficult to assess how the bill’s language would be applied.

About the Author

John M. Sier is a principal in the Detroit office of Kitch, Drutchas, Wagner, Valitutti & Sherbrook. His email address is john.sier@kitch.com
The **Roberts P. Hudson Award** goes to a person whose career has exemplified the highest ideals of the profession. This award is presented periodically to commend one or more lawyers for their unselfish rendering of outstanding and unique service to and on behalf of the State Bar, given generously, ungrudgingly, and in a spirit of self-sacrifice. It is awarded to that member of the State Bar of Michigan who best exemplifies that which brings honor, esteem and respect to the legal profession. The Hudson Award is the highest award conferred by the Bar.

The **Frank J. Kelley Distinguished Public Service Award** recognizes extraordinary governmental service by a Michigan attorney holding elected or appointed office. Created by the Board of Commissioners in 1998, it was first awarded to Frank J. Kelley for his record-setting tenure as Michigan’s chief lawyer.

The **Champion of Justice Award** is given for extraordinary individual accomplishments or for devotion to a cause. No more than five awards are given each year to practicing lawyers and judges who have made a significant contribution to their community, state, and/or the nation.

The **Kimberly M. Cahill Bar Leadership Award** was established in memory of the 2006-07 SBM president, who passed away in January 2008. This award will be presented to a recognized local or affinity bar association, program or leader for excellence in promoting the ideal of professionalism or equal justice for all, or in responding to a compelling legal need within the community during the past year or on an ongoing basis.

The **John W. Cummiskey Pro Bono Award**, named after a Grand Rapids attorney who was dedicated to making legal services available to all, recognizes a member of the State Bar who excels in commitment to pro bono issues. This award carries with it a cash stipend to be donated to the charity of the recipient’s choice.

The **John W. Reed Michigan Lawyer Legacy Award** was introduced in 2011 and is named for a longtime and beloved University of Michigan Law School professor and Wayne State University dean. This award will be presented periodically to a professor from a Michigan law school whose influence on Michigan lawyers has elevated the quality of legal practice in the state.

All SBM award nominations are due by 5 p.m. Friday, April 18, 2014.

The **Liberty Bell Award** recipient is selected from nominations made by local and special-purpose bar associations. The award is presented to a non-lawyer who has made a significant contribution to the justice system. The deadline for this award is Monday, May 12, 2014.

An awards committee co-chaired by Francine Cullari and SBM President-Elect Thomas Rombach reviews nominations for the Roberts P. Hudson, John W. Reed, Champion of Justice, Frank J. Kelley, Kimberly M. Cahill, and Liberty Bell awards. The SBM Pro Bono Initiative Committee reviews nominations for the Cummiskey Pro Bono award. These recommendations are then voted on by the full Board of Commissioners at its June meeting.

Last year’s non-winning nominations will automatically carry over for consideration this year. Nominations should include sufficient details about the accomplishments of the nominee to allow the committees to make a judgment.

Any SBM member can nominate candidates for awards. Submit a nomination online (http://www.michbar.org/programs/eventsawards.cfm). Cummiskey Award nominations can also be directed to Robert Mathis at rmathis@mail.michbar.org; all other nominations can be submitted to Joyce Nordeen, State Bar of Michigan, 306 Townsend St., Lansing, MI 48933 or jnordeen@mail.michbar.org. For more information call (517) 346-6373 or (800) 968-1442 ext 6373.
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