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This journal is published by the Insurance and Indemnity Law Section, State Bar of Michigan
Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.
Greetings! We have had a great start to the 2014-2015 section year. We had a wonderful evening with Supreme Court Justice David F. Viviano at the Birmingham Athletic Club on December 1, 2014. It was terrific to see many new members (and of course, returning members). Many thanks to Adam Kutinsky for organizing the event.

At the business meeting preceding this event we discussed ways to create more participation in our committees. We currently have the following committees: membership, programs, and publications. I want to encourage every member to take an active part in the Section. If you are interested in being on one of these committees, please contact any of the Section Council officers.

The publication committee is a great place to start. Consider participating in the form of an article or other contribution to the quarterly Journal. If you are interested, please contact the Journal’s editor, Hal Carroll, at HOC@HalOCarrollEsq.com.

We have also launched the new section web page at http://connect.michbar.org/insurance/home. Please take a few minutes to visit the site and look around. We are looking for ideas for the discussion section. Please contact me if you have an idea or topic for starting a discussion thread.

I am pleased to report that we are now enjoying membership of over 860 attorneys. We are also financially flush with over $31,000 to plan some spectacular events and programs. We have the resources—we just need your time and commitment.

Our next council meeting will be on March 10, 2015. Please mark your calendars. More details re: time and location will be announced in advance of the meeting.

Finally, a hearty welcome is extended to the following new members:

Rachel Bissett
Devin William Bone
Jessica A. Buc
Benjamin Robert Bukari
Michael Butterfield
Adam Casey Decker
Katelyn Marie DePrekel
Arminia Duenas
Victoria Read Edgar
LaTrina Marie Edwards
Keith Richard Ellis
Todd W. Grant
Kevin S. Green
Jeffrey Albert Hoard
James E. Hoehner
Nicole Ashley Hughes
Jason A. Kanter
Lesley T. Keith
Elizabeth Anne King
Jamie Lynn McCutcheon
Hon. Thomas W. McDonell
Daniel Bryan McGrath
Kari L. Melkonian
James T. Mellon

Thank you for joining!

—Kathleen A. Lopilato

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.
You are fortunate. Despite the economic hardship and unemployment that many have experienced in the state of Michigan over the past several years, you have been busily toiling in the service of your employer. You have performed all assigned tasks to the best of your ability. Your supervisors have directed and approved your work and praised you for outstanding results. You are promoted and made an officer of the company. Nevertheless, a disgruntled client has brought false charges arising out of your efforts on his behalf. He files suit against you and your employer. Like any reasonable person, you look to your employer for protection and ask your employer to defend you.

Naturally, there is the question of insurance. It goes without saying that every reputable employer in Michigan obtains liability insurance that defines or describes its officers and employees as insureds or additional insureds. Those policies do not usually list the actual names of individual employees in a schedule or otherwise. Governmental agencies purchase insurance to cover police officers and fire fighters. Hospitals provide coverage for nurses and hospital personnel. School districts obtain coverage for teachers and administrators. The state and counties obtain insurance that covers judges and court personnel. They all become insureds by description in the policy.

Some of these policies may contain deductibles or self-insured retainages. Some may include the right to designate counsel in the event of a claim. Some may be “indemnity-only” policies that require the employer, the named insured, to provide the defense. In such cases, the company or employer is the named insured. Its officers and employees are usually defined or described as insureds or additional insureds for claims arising out of their work on behalf of the employer.

This sounds simple enough. There must be coverage for you. You determine that your employer has such liability insurance. The insurance agreement clearly defines current and former officers and employees as “insureds.” You conclude that someone, either the insurer or the employer, will provide a defense.

You tender the suit papers to your employer and its insurer and ask them to defend you. They refuse. Not only that, the employer files a cross-claim against you. What happens now? What rights do you have in connection with the insurance contract?

Insurance Contracts Generally

We start with the usual boiler plate. Insurance contracts are construed according to the sense and meaning of the terms used if those terms are clear and unambiguous. Courts will not re-write the terms of insurance agreements as long as the terms do not conflict with relevant statutes or public policy. An insurer has a duty to defend insureds and to pay covered claims.

An insurer cannot sue its own insured for amounts that it is obligated to pay or exercise a right of subrogation against its own insured or an additional insured. The rationale for this rule is that the insurer “accepts not only the risk that some third party may cause the casualty but also that its own insured may negligently cause the loss. The insurer, however, has consented to this latter risk in exchange for the premiums received for his compensation obligation.”

Third Party Beneficiaries

MCL 600.1405; MSA 27A.1405 describes rights of third party beneficiaries:

Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.

(1) A promise shall be construed to have been made for the benefit of a person whenever the promisor of said promise has undertaken to give or to do or refrain from doing something directly to or for said person.

A number of Michigan cases have addressed third party beneficiaries in the context of an employer/employee relationship. “The contracting parties’ motives and subjective intent are immaterial in determining the existence of a third-party beneficiary.”

So long as the contract necessarily and directly benefits the third person, it is immaterial that this protection was afforded him, not as an end in itself,
but for the sole purpose of securing to the promisee some consequent benefit or immunity. In short, the motive, purpose, or desire of the parties is a quite different thing from their intention. The former is immaterial; the intention as disclosed by the terms of the contract, governs. It is to be borne in mind that the parties are presumed to intend the consequences of a performance of the contract. That which is contemplated by the terms of the contract is “intended” by the parties.\footnote{7}

A third-party beneficiary can be a class of persons whose actual identity is not known at the time of the promise. With respect to the identity of a third-party beneficiary, MCL 600.1405(2)(b); MSA 27A.1405(2)(b) states:

If such person is not in being or ascertainable at the time the promise becomes legally binding on the promisor then his rights shall become vested the moment he comes into being or becomes ascertainable if the promise has not been discharged by agreement between the promisor and the promise in the meantime.

In addition, a third party beneficiary to a contract does not have to be specifically named in the agreement that is the subject of the claim even as a class as long as that person is a direct beneficiary.\footnote{8} Blanket additional insured endorsements that do not list others by name at the inception of the coverage are common in the construction industry.\footnote{9} The identity of the additional insured is revealed only when the named insured enters into a contract that requires it to obtain coverage naming the other contracting party as an additional insured.

In *Talucci v Archambault*,\footnote{10} the Court of Appeals held that an employee can be a third-party beneficiary of a contract entered into by his employer, even if employees are not specifically named in the agreement as a class.

If, as alleged, plaintiff’s employer intended by the contracts to benefit its employees, plaintiff, as a member of that class, is entitled to recover *ex contractu*.\footnote{11}

So, are you a third-party beneficiary of your employer’s contract with the insurance company and entitled to enforce the insurance contract so that you can obtain indemnity and a defense? The answer should be “yes.”

It is basic insurance law that “… additional insureds are necessarily third-party beneficiaries. As a third-party beneficiary, an additional insured has the right to enforce the insurance policy in his favor.\footnote{12} Additional insureds who are identified by a simple description have direct contract rights against an insurer.\footnote{13}

**Michigan’s Position**

In *Schmalfeldt v North Pointe Ins Co*,\footnote{14} the Supreme Court held that an injured bar patron did not have third-party beneficiary status under an insurance contract executed by the bar owner and its commercial insurance carrier. The injured patron sought benefits under the medical payments portion of the insured’s coverage. The insurance company agreed to pay the injured party’s dental expenses but only if the bar owner requested it. The bar owner refused to do so. Thereafter, the injured party sued the insurance company directly as a third-party beneficiary of the bar owner’s policy.\footnote{15}

The *Schmalfeldt* court relied on the fact that nothing “in the insurance policy specifically designates Schmalfeldt, or the class of business patrons of the insured of which he was one, as an intended third-party beneficiary of the medical benefits provision. At best, the policy recognizes the possibility of some incidental benefit to members of the public at large, but such a class is too broad to qualify for third-party status under the statute.”\footnote{16} Therefore, an injured person not named in an insurance contract is not a third-party party beneficiary to the contract. He or she is merely an incidental beneficiary without a right to enforce the contract.\footnote{17}

OK, an injured third-party who is not named, defined or otherwise described in a policy between an insurer and a named insured is not a third-party beneficiary and is not entitled to bring an action against the insurer for policy proceeds. But what about someone else who meets the definition of an insured or who is described as an additional insured?

Recently, the Court of Appeals decided the case of *Jordan (and Clark) v National City Bank & PNC Bank*.\footnote{18} In that case, Clark and Jordan were two African-American professional men, one a banker and one a stock broker. The Bank hired them, promoted them to Vice Presidents and directed them to recruit affluent black athletes as customers. The Bank wanted to benefit from large deposits by the athletes, commissions from handling their investments, and interest generated from lines of credit. A developer urged former Detroit Lion Charlie Batch to sue the Bank and Clark and Jordan, claiming that one of his investments had been mishandled. The Bank was the named insured under an indemnity only policy with a large retainage and deductible. The policy language said that:

"**Insured** means the Named Insured and any of its past, present and future:

***

c.) Employees …**"

Pursuant to the policy, the Bank agreed that it had the “sole duty” to defend all claims.\footnote{19}

Instead of defending and indemnifying Clark and Jordan, the Bank settled with the plaintiff, took an assignment from the plaintiff, and pursued its own former employees for reimbursement. In response, Clark and Jordan sued the Bank for failing to defend and indemnify them under its insurance
agreement as third party beneficiaries of that agreement. After all, as employees, they were defined as insureds. The trial court granted summary disposition to the Bank. Clark and Jordan appealed. The Court of Appeals panel of Jansen, Owens, and Shapiro affirmed, citing Schmalfeldt:

The contract was exclusively between the Bank and Advent Guaranty Corporation. Plaintiffs, as former officers of the Bank, were only incidental beneficiaries without a right to sue for benefits.20

This is unquestionably wrong since the policy clearly described and defined Clark and Jordan as insureds. The Supreme Court denied leave to appeal in a cursory comment.21 This raises the question. If the appellate courts ignored plain language in the insurance contract at issue in this case, why did they do so? Is this further evidence of the bias in favor of insurance and business interests by Michigan appellate courts? We will never know unless the Court of Appeals panel comes clean. It won’t. If you want to arrive at a certain outcome, just ignore uncontroverted evidence that compels the opposite conclusion.

Conclusion

It seems that in Michigan at this time, only the named insured can bring a legal action to enforce the terms of a liability policy even if the objective intent of an employer was to cover its employees. The logical extension of that thinking is that if a teacher, nurse, police officer, or judge is wrongfully sued, and the insurer or self-insured employer refuses to defend and indemnify, there is no remedy for that refusal.

Any argument that unpublished decisions like the decision in Clark and Jordan have no precedential value is fallacious. It has been the experience of the author that attorneys regularly cite unpublished opinions if they are on point and that trial courts often rely on them.22

Endnotes

1 Kingley v American Central Life Ins, 259 Mich 53; 242 NW 836 (1932); Raska v Farm Bureau, 412 Mich 355; 314 NW2d 440 (1982).
5 Hallmark Insurance Co, 72 Wisc 2d at 476; See, also, New Amsterdam Casualty Co v Homans-Kohler, Inc, 305 F Supp 1017 (D C R I 1969).
6 Emphasis added.
9 See 10 Elliott Square Corp v Mt Valley Indemnity Co, 634 F 3d 112, 121 (2d Cir 2010).
11 Talucci, 20 Mich App at 159.
13 Grant v United States, 271 F 2d 651, 656 (2d Cir 1959).
14 469 Mich 422; 670 NW2d 651 (2003).
15 Schmalfeldt, 469 Mich at 424.
16 Schmalfeldt, 469 Mich at 429.
17 Schmalfeldt, 469 Mich at 429.
19 In its written opinion, the Court of Appeals panel intentionally omitted this and other crucial policy language, probably to obfuscate and to evade any criticism.
22 For example, see Federal Insurance Company v Detroit Medical Center, 2009 U S Dist Lexis 3654 *25 (ED Mich) where the trial court relied on Amerisure Ins Co v MBM Fabricators Co, 2002 Mich App LEXIS 1714 (Mich Ct App Nov 19, 2002).
No Duty to Defend or Indemnify for Sexual Assault

**Court:** Muskegon County, Hon. Neil G. Mullally  
**Case:** *Auto-Owners v Nyhof*, No. 13-48858-CK  
**Date:** January 2, 2014  

**Issue:** Does the insurer of employers owe a duty to defend and indemnify the employers of a person who sexually assaulted the plaintiff at the resort operated by plaintiffs?  

**Ruling:** The court found two separate reasons for holding that Auto Owners was not required to defend or indemnify the insureds for the assault against Nyhof.  

First, an “occurrence” was defined as an “accident, including continuous or repeated exposure to the same general harmful conditions.” The court found that the assault against Nyhof was not an accident so there was no occurrence.  

Second, the policies provided an exclusion for “bodily injury...expected or intended from the standpoint of the insured.” The court, looking at the gravamen of Nyhof’s complaint, determined that Nyhof’s allegations were that defendants knew that the defendant Jones had a past criminal record and foreseeably should have expected the intentional assault by Jones upon Chandra Nyhof.  

The court held, “Based upon the insurance policies’ clear and unambiguous terms, the conclusion is inescapable that the [insurer] is not contractually obligated to defend or indemnify the [insureds] in the underlying tort case because the cause of the personal injuries to Chandra Nyhof was the intentional criminal rape committed by the defendant Jones.”  

**Note:** Many insurance coverage issues boil down to the language of the relevant policy compared to the allegations in the complaint.

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**Issue:** Does a breach of contract case brought by a nonprofit religious organization against its insurer belong on the business court docket or the general civil docket?  

**Ruling:** Business court jurisdiction is limited by statute to actions involving a “business or commercial dispute.” MCL 600.8035(3). The statute defines a business or commercial dispute as, *inter alia*, “An action in which 1 of the parties is a nonprofit organization, and the claims arise out of that party’s organizational structure, governance, or finances.” MCL 600.8035(3)(iii).  

The court held, “Although Plaintiff alleges that it is a nonprofit organization, its claim arises from an insurance contract between the parties, not from Plaintiff’s structure, governance, or finance. Further, Plaintiff is not a business enterprise because it is a religious organization. MCL 600.8031(1)(b).” Finding that the complaint does not allege a business dispute, the Court ordered the case reassigned to the general civil docket.  

**Note:** Practitioners are well-advised to determine prior to filing whether a case belongs in the business court. By statute, the business court has exclusive jurisdiction over business or commercial disputes. Thus, practitioners who cause or allow a case to be litigated to conclusion on the general civil docket rather than in the business court run the risk of obtaining a judgment that lacks finality.

**Homeowner’s Policy: Proper Recipient of Insurance Proceeds is Defined within the Policy**

**Court:** Muskegon County, Hon. Neil G. Mullally  
**Case:** *Craig M Hanson v Fremont Insurance*, No. 12-485576-CK  
**Date:** January 23, 2014  

**Issue:** Whether the Plaintiff is entitled to insurance proceeds from an insurance policy issued to cover residential premises that he had owned with his wife prior to their divorce on May 9, 2011.  

**Ruling:** The plaintiff’s home was damaged by fire on September 18, 2010. The plaintiff had moved out of the house on or
about March 2, 2010, and he never resided there again. The relevant homeowners’ insurance policy in this case was issued with an effective date of August 20, 2010, more than five months after the plaintiff moved out of the residence. The policy defined “residence premises” as “that part of any other building where you reside and which is shown as ‘residence premises’ in the Declarations.”

Because the plaintiff was not a resident of the insured premises at the time of the fire loss, his damages were not covered by the fire insurance policy.

**Note:** The clear and unambiguous language of an insurance policy will be enforced as written.

**About the Author**

**Kassem Dakhlallah** is a senior partner and supervising attorney with AT Law Group PLLC in Dearborn. Kassem is a Wayne County Circuit Court Business Court case evaluator and mediator. Kassem is also a board member of the Detroit Metropolitan Bar Association Barristers. Kassem’s practice focuses on business and commercial litigation, including commercial insurance litigation. His email address is kd@atlawgroup.com.

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**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](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](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”
Typically an owner or general contractor owes duties to the contractor or subcontractor to provide accurate plans and specifications for the work, to provide directions to the contractor, and to make payments during the course of the work in accordance with the terms of the contract. The general proposition is well settled that an owner by implication warrants the accuracy of plans and specifications provided to a contractor for the performance of the work. The owner’s warranty of the adequacy of the plans and specifications is referred to as the Spearin doctrine.

This doctrine is derived from the seminal U.S. Supreme Court decision in United States v Spearin. In this case the contractor was required to build a dry dock according to plans prepared and furnished by the owner, an agency of the United States. The contractor discovered undisclosed site conditions making it impossible to continue with the work. The contractor sued to recover its cost and lost profits on the contract. The court, finding in favor of the contractor, noted that the plans were very specific and held that the U.S. Government implicitly warranted the accuracy of the plans and specifications. Moreover, the court refused to find that the general language disclaiming the accuracy of the plans effectively disclaimed the owner’s implied warranty.

The implied warranty principle has also been extended to an owner’s specification that a product is suitable for its intended use. In Trustees of Indiana University v Aetna Casualty & Surety Co, the contractor installed bricks on the exterior walls of six buildings and the bricks began to spall after installation. The university sued Aetna, the contractor’s surety, asserting that the spalling condition was attributable to defectively manufactured bricks. In defense, Aetna asserted that the bricks specified by the university were not suitable for use on the building’s exterior walls. The court instructed the jury, in pertinent, part as follows:

“If an owner specifies in a construction contract that a particular brick is to be used, then the contractor is released from any promise or warranty as to the suitability of such brick for use as intended in the contract.”

Contractual Allocation of Risks

As noted above, if the owner controls the design decisions, the courts tend to impose a duty on the owner to provide accurate plans and specifications. Risks can also be expressly allocated between the contractor and the owner by contractual provisions. These provisions can allow the parties to establish a procedure for addressing unforeseen risks. One type of clause used to allocate these risks is a “different site conditions” clause. The purpose of a different site clause is to shift the risk of differing site conditions from the contractor to the owner when a contractor encounters conditions that differ from the plans. For example:

Differing Site Conditions

During the progress of the work, if subsurface or latent physical conditions are encountered at the site differing materially from those indicated in the contract, the party discovering such conditions must promptly notify the other party in writing, and an adjustment will be made and the contract modified in writing accordingly.

Another type of clause that can address unforeseen circumstances is the “inspection clause.” This type of clause may require the contractor to inspect the work and become familiar with it, not to rely upon the owner-provided information without further investigation.

The different site conditions clause and the inspection clause in a contract between the owner and the contractor provide a way to resolve disputes that allows for more flexibility than the simple application of implied warranty principles.

The general proposition is well settled that an owner by implication warrants the accuracy of plans and specifications provided to a contractor for the performance of the work. The owner’s warranty of the adequacy of the plans and specifications is referred to as the Spearin doctrine.

Change Orders

One way that unforeseen circumstances can be addressed is though change orders as the work progresses. Construction contracts typically require the owner to make progress payments and to process change orders. The owner’s failure to process change orders or to make payments, may constitute a material breach of the contract. A material breach may
entitle the contractor to abandon performance. If the owner attempts to invoke a surety bond, the owner's material breach may also serve as the basis for the surety's defense.

The obligation of the surety under a contract is coextensive with the obligation of the principal (i.e., the contractor-obligor). Any defenses of the principal to a claim, except personal defenses of the principal, can be asserted by the surety.

The Surety’s Obligations and Defenses

When a surety is involved, there are three parties to any potential dispute. With respect to the surety, the contractor is the “obligor” or “principal” and the owner is the “obligee.”

The obligation of the surety under a contract is coextensive with the obligation of the principal (i.e., the contractor-obligor). Any defenses of the principal to a claim, except personal defenses of the principal, can be asserted by the surety. Materiality of a breach turns on the unique facts of each case. Where the surety asserts justification for nonpayment, the principal’s (obligor's) information and performance is critical to the surety’s defense. For example In re: Fordson Engineering Corp5 the court stated that delay in making payment alone where the amount of the work done is disputed or negotiated is not, on that basis alone, a breach of contract. Rather, a breach occurs where a contractor unilaterally, as here, leaves a job site without completing its contractual duties.

In America Casualty Co v City of Detroit,6 the surety filed a declaratory judgment action claiming that the owner’s failure to shut off steam rendered performance impossible. The court rejected the surety’s and contractor’s claims. The court stated that neither the owner’s failure to shut off steam or the alleged nonpayments were material breaches justifying the contractor’s abandonment of the project. The court went on to say that the disputes clause of the contract was the proper means for the contractor to seek adjustment of the contract price. Thus, a surety’s recovery is limited by the terms of the principal’s (obligor’s) contract and by the ability to prove the owner’s (obligee’s) breach.

A design deficiency or changed condition can be resolved between the owner-obligee and the contractor-obligor by their agreeing to additional compensation. However, where change orders and modifications are so numerous or significantly alter the nature of the work this amounts to a cardinal change of the contract. In such cases, the surety may be discharged from liability under its bond. The duty of an owner to disclose to a surety is greater than the duties of parties to the contract. If the surety can show concealment it can void the bond.

Conclusion

Typically the owner or general contractor has an affirmative duty to the contractor or subcontractor to provide accurate plans for the work and make payments in accordance with the terms of the contract. A breach by an owner or general contractor of its duty to provide accurate plans and specifications to a contractor is a defense to the surety called upon to perform the contract work after the performance of the principal’s contract.

The Spearin doctrine is alive and well and is a decision with which the practitioner should become very familiar. It maintains that a contractor will not be liable to the owner for loss or damage which results solely from the insufficiencies or defects in such information, plans and specifications. Both state and federal courts have refined the Spearin doctrine to encompass two specific implied warranties. The first implied warranty is that the plans and specifications are accurate and the second is that they are suitable for their intended use. The doctrine applies to private as well as public construction contracts and may not apply in every state, but does apply in the majority of jurisdictions. The prudent contractor will insist upon written contract clauses warranting the plans and specifications and other requirements.

About the Author

James A. Johnson, of James A. Johnson, Esq. in Southfield is a trial lawyer. Mr. Johnson concentrates on insurance coverage cases under the Commercial General Liability Policy. He is an active member of the Michigan, Massachusetts, Texas and Federal Court Bars. Mr. Johnson can be reached at www.JamesAJohnson-Esq.com or 248-351-4808

Endnotes

1 248 U.S. 132 (1918); See L W Kinnear, Inc v Lincoln Park, 260 Mich 250; 244 NW 463(1932); Holloway Construction Co v Michigan, 44 Mich. App 508; 205 NW 2d 575 (1973); Battle Ridge Companies v. North Carolina Dept. of Transportation, 161 N.C. App. 156, 160; 587 S.E. 2d 426 (2003) – “It is simply unfair to bar recovery to contractors who are misled by inaccurate plans & submit bids lower than they might otherwise have submitted.”

2 920 F. 2d 429 (7th Cir. 1990), rev’d on other grounds, 29 F. 3d 274, 278 (7th Cir. 1994).

3 Id. at 435-36 n.9.


6 851 F. 2d 794 (6th Cir. 1988).
When push comes to shove in a dispute over coverage, the policy language is at the center of the dispute, and there are principles of interpretation that come into play. Many are pretty ordinary, since policies are contracts, but some require a little more attention.

The general principles that apply to contracts generally get cited as boilerplate.

The rules of contract interpretation apply to the interpretation of insurance contracts. The language of insurance contracts should be read as a whole and must be construed to give effect to every word, clause, and phrase.1

Principles more closely related to insurance policies include:

“An insurance policy must be enforced in accordance with its terms. . . . We will not hold an insurance company liable for a risk it did not assume. . . . In interpreting ambiguous terms of an insurance policy, this Court will construe the policy in favor of the insured. . . . However, we will not create an ambiguity where the terms of the contract are clear. . . . Where there is no ambiguity, we will enforce the terms of the contract as written.” . . . “Furthermore, this Court will interpret the terms of an insurance contract in accordance with their ‘commonly used meaning.’”2

Every practitioner in this area should have this language ready to drop into a brief. But what is really interesting in this area is how Michigan rejects the rules that the other states apply.

The reasonable expectations rule

The first rule that it is good to know – because it does not apply in Michigan – is the “reasonable expectations” rule. The reasonable expectations rule carries considerable weight in most other jurisdictions, but Michigan rejects it. The Supreme Court has held that the principle that the policy would be interpreted consistently with the reasonable expectation of the insured was “invalid as an approach to contract interpretation.”3

The problem with the reasonable expectation approach, as the Supreme Court saw it, was that it was either unnecessary or wrong. To the extent “reasonable expectation” was another way of saying that the “intent” of the parties is what the contract language says, the phrase “reasonable expectation” adds nothing and is unnecessary. But to the extent the phrase is used to import into the analysis a subjective impression of what the parties were thinking, it is wrong because the language always controls. Finally, when the language is ambiguous, reference to “reasonable expectations” does nothing that the principle of construction against the drafter would not do, so it is again unnecessary.

The reasonable expectations rule carries considerable weight in most other jurisdictions, but Michigan rejects it. The Supreme Court has held that the principle that the policy would be interpreted consistently with the reasonable expectation of the insured was “invalid as an approach to contract interpretation.

Contracts of adhesion

There is another rule that Michigan rejects. This is the rule that treats insurance contracts as “contracts of adhesion,” that is, contracts in which the buyer has little or no bargaining power. That’s a pretty fair description of the real world; not many people who buy insurance even read the policy, let alone demand that the definition of “occurrence” or “claim” be modified.

But Michigan rejects the contract of adhesion principle, too.

The contract construction approach of the lower courts is inconsistent with traditional contract principles. An “adhesion contract” is simply that: a contract. It must be enforced according to its plain terms unless one of the traditional contract defenses applies.4

The rejection of the reasonable expectations rule and the contracts of adhesion rule can at least claim the virtue of consistency, because each of them focuses intently on specific words, and not the world in which policies are written, sold and relied on.
Ambiguities

If the insured is not allowed his or her “reasonable expectations,” and cannot rely on the contract of adhesion principle to level out the playing field, maybe another principle – construction against the drafter – will help, at least when there is an ambiguity. Guess again. Other states expect the judge to apply the rule (known as \textit{contra proferentem}) when there is an ambiguity. But not in Michigan.

Michigan's rules concerning ambiguity start out well enough, until the time comes to apply them. First, the definition. “An insurance contract is ambiguous when its provisions are capable of conflicting interpretations.”

If two provisions of the same contract irreconcilably conflict with each other, the language of the contract is ambiguous. Further, courts cannot simply ignore portions of a contract in order to avoid a finding of ambiguity or in order to declare an ambiguity. Instead, contracts must be “constructed so as to give effect to every word or phrase as far as practicable.”

Second, an ambiguity must appear within the language itself; it cannot be created from the outside. “[W]here the terms of a contract are unambiguous, their construction is for the court to determine as a matter of law . . . and the plain meaning of the terms may not be impeached with extrinsic evidence.”

Third – and here is where Michigan parts company from most, if not all, of the rest of the country – an ambiguity is to be resolved as an issue of fact by the trier of fact, not the judge. Only the trier of fact can resolve the issue of ambiguity. To do that the trier of fact must hear evidence. It is only if the trier of fact cannot resolve the ambiguity by means of extrinsic evidence, that the presumption against the insurer can be used. If the trier of fact is not able to make a decision based on the evidence, then it must apply the rule “contra proferentem” and interpret the provision against the drafter.

In theory this requires testimony, although it is hard to see how either side would offer any. It is hard to imagine a property owner being asked to testify about the discussions he or she had with the insurer about exclusion III.(A)(1)(j). Similarly, it's not clear what witnesses the insurer would offer. The claim representative cannot claim any special right to explain what the policy language at issue “really” means, and the same is true of the insured. In the real world, there really is no testimony to be offered. More than that, in the real world, the underlying facts are almost never in dispute, and when they are the parties can stipulate for purposes of analyzing the policy.

So the Michigan version of \textit{contra proferentem} is pretty much useless. But it’s the rule.

The rejection of the reasonable expectations rule and the contract of adhesion rule can at least claim the virtue of consistency, because each of them focuses intently on specific words, and not the world in which policies are written, sold and relied on.

Conclusion

Michigan's rejection of the reasonable expectations rule and the contract of adhesion rule, and its transmutation of the \textit{contra proferentem} rule, all seem to be expressions of the underlying philosophy that describes itself as “textualism.” The distinction between textualism and literalism is probably in the eye of the beholder. But the fact is that insurance policies are written to address issues that arise in the real – not the textual – world, and there is something to be said for using principles that recognize reality and even perhaps give it more weight than philosophical purity.

About the Author

\textbf{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 2014. He also consults with businesses and insurers on the drafting of contracts, represents insureds and insurers in declaratory actions, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His website is www.HalOCarrollEsq.com and his email address is HOC@HalOCarrollEsq.com.

Endnotes

Selected Insurance Decisions

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

6th Circuit Court of Appeals

Federal court properly exercised jurisdiction over declaratory judgment action to decide status of claimant as an employee of the insured

**Western World Ins Co v Hoey**
___ F3d ___ (6th Cir 2014)
Case No. 13-2388

As to the procedural issue presented, the 6th Court affirms the district court’s exercise of jurisdiction in this declaratory judgment action despite a pending liability case in state court because the coverage facts will not be decided in that pending case. As a matter of substantive law, the 6th Circuit applies Michigan’s economic reality test to determine claimant’s status as an employee of the named insured for purposes of the employee exclusion, but also holds that the term “employee” is commonly understood to mean any person hired by another. Under the CGL insurance contract, employees include all who are hired by the insured, unless, as provided by the contract, they are volunteers, temporary workers, independent contractors, or working for another contractor.

Michigan Supreme Court

Duty to defend triggered by allegation of damage to other property in construction defect case

**Hastings Mutual Ins Co v Mosher Dolan Cataldo & Kelly, Inc.**
___ Mich ___; 856 NW2d 550 (2014)

In this most recent appellate ruling on the coverage afforded contractor Mosher Dolan for claims of construction defect, the Supreme Court finds that Hastings Mutual had a duty to defend its contractor insured in the underlying arbitration proceeding because the duty to defend is broader than the duty to indemnify and, although claims of defective construction were not covered under the insuring agreement, and claims of mold damage were excluded, claimants also alleged water damage to personal property, a covered claim that triggered the duty to defend.

First-party property insurance - proof of actual repair or replacement required for “replacement cost” coverage

**Dupree v Auto-Owners Ins Co**
497 Mich 1 (2014)

Plaintiff homeowners are only entitled to recover the “actual cash value” of their property loss as the result of a fire because their policy expressly conditions “replacement cost” on proof of actual repair or replacement. The insured failed to prove that the fire-damaged property was either repaired or replaced and thus are not entitled to the replacement cost otherwise afforded under their policy.

Definition of employee for workers compensation coverage

**Auto-Owners Ins Co v All Star Lawn Specialists Plus, Inc.**
497 Mich 13 (2014)

This opinion addresses the statutory distinction between “employees” and “independent contractors” for purposes of workers’ compensation insurance and resolves a dispute among panels of the Court of Appeals over the proper application of MCL 418.161(n). An “employee” means every person in the service of a trade, business, profession or occupation of another, as long as “the person in relation to this service does not maintain a separate business, [and] does not hold himself or herself out to render service to the public, and is not an employer subject to this act.” If any of the three exceptions listed in MCL 418.161(n) applies, the person is not an employee under the Workers Disability Compensation Act.

Michigan Court of Appeals—Published

Three-year statute of limitations for claims against insurance agencies

**Stephens v Worden Ins Agency, LLC**
___ Mich App ___ (2014), lv app pending
(Docket No. 314700)

MCL 600.5805(10) is the statute of limitations applicable to claims against an insurance agency for failure to secure the coverage requested by the insured. Negligent procurement and advice sounds in ordinary negligence, not malpractice. In a first impression ruling, the Court of Appeals held that the three-year period begins to run on the date “the insurer denies the insured’s claim” because the “wrong” required for
accrual of such a claim is the date plaintiff is harmed by the agency's actions.

No UM “hit and run” coverage absent physical contact

_Babri v IDS Property Casualty Ins Co_

--- Mich App --- (2014), lv app pending

(Docket No. 316869)

Plaintiff is not entitled to UM coverage under his auto policy because the definition of a “hit-and-run” vehicle requires physical contact. Plaintiff either had to have physical contact with the unidentified vehicle or with an object attributable to the unidentified vehicle. Plaintiff’s claim is that an unidentified speeding vehicle caused her to redirect her car in a way that resulted in the accident.

Michigan Court of Appeals – Unpublished

Untimely notice and loss of coverage

_Hankins v Fremont Ins Co_

Unpublished Court of Appeals opinion of December 4, 2014

(Docket No. 317358)

This homeowners policy requires “prompt notice” of claims. Plaintiff failed to report damage caused by a burst water pipe in his basement until five months after it occurred, and after he had made extensive repairs and remodeled. Because the insurer was unable to properly assess the damage caused by the burst pipe, plaintiff’s late notice resulted in a loss of coverage.

UIM coverage limited to accidents involving “your covered auto”

_Hempel v Farm Bureau Gen’s Ins Co of Mich_

Unpublished Court of Appeals opinion of November 25, 2014

(Docket No. 316483)

The Court of Appeals enforced the plain language of plaintiff’s personal auto policy, which provided UIM coverage “for your covered auto.” Because the insured was injured while operating a vehicle other than his covered auto, he was not entitled to UIM benefits under his policy.

Remand for factual determinations on policy exclusions

_Farm Bureau Gen’l Ins Co of Mich v Walsh_

Unpublished Court of Appeals opinion of November 25, 2014

(Docket No. 317505)

The insured homeowners owned a pole barn in which they allegedly conducted a vehicle repair business on the first level and rented out an apartment on the second level. A fire started on the lower level and caused the death of the tenant above. When the estate filed suit, the homeowners looked to their homeowners insurer for liability coverage. The trial court declined to apply any of the three exclusions asserted by the insurer (business use, rental property, and criminal acts) but the Court of Appeals reversed in part, remanding for factual findings on whether the insureds conducted a business in the lower level of the pole barn and if so, whether the fire arose out of the conduct of that business. Neither of the other exclusions applied.

Life insurance benefits denied to former wife

_Hites v AAA Insurance Company_

Unpublished Court of Appeals opinion of November 13, 2014

(Docket No. 317829)

Plaintiff is not entitled to a share of the proceeds of her former husband’s life insurance policy because the divorce decree made her an irrevocable beneficiary under a policy in effect at the time of the divorce, but did not require that policy to remain in effect. Once the policy lapsed, plaintiff’s rights to life insurance benefits were extinguished and she had no claim under a subsequent policy purchased after the divorce.

Arbitration award affirmed – water damage

_Theater Group 3, LLC v Secura Ins Co_

Unpublished Court of Appeals opinion of November 13, 2014

(Docket No. 317393)

Arbitration award under a first-party property claim for water damage is affirmed because there was a genuine issue of fact as to whether the damage was caused by water coming from “under the ground surface” or seeping through the foundation and the arbitrator did not exceed her authority in making findings of fact applying them to this insurance contract language.

No property coverage where loss occurred on the day the premium check was mailed

_Joy Management v Michigan Basic Property Ins Ass’n_

Unpublished Court of Appeals opinion of October 28, 2014

(Docket No. 317414)

Plaintiff-insured applied for a fire insurance policy for his rental property but failed to submit the required premium with the application. Payment was mailed two weeks later, the same date the property was damaged by fire. The insurer denied coverage because no policy ever existed (the insured’s check was returned). Even assuming the premium was received on the date it was sent, i.e., the day of the fire, the policy would not have taken effect until the following day. The Court of Appeals affirmed the trial court’s order of summary disposition for the insurer and rejected claims that the insurer’s application procedures violated provisions of the Michigan Insurance Code.
Breach of coverage conditions results in loss of coverage

**Home-Owners Ins Co v Griffith**

Unpublished Court of Appeals opinion of October 28, 2014
(Docket No. 312707)

This fire loss claim was properly denied due to the insured’s refusal to cooperate with the investigation of the claim and failure to timely submit a sworn proof of loss. Both were required as conditions of coverage under the contract. At her examination under oath, the insured refused to provide her date of birth, social security number, or former names. She also failed to submit a sworn proof of loss until a week after it was due, at which time she submitted an unsworn statement. The Court of Appeals discussed the importance of providing the information requested at an EUO and the reasons for sworn statements and affirmed the trial court’s ruling of no coverage. The insurer, however, was not entitled to recover advances it made under the policy or recover the cost of its investigation.

Homeowners business exclusion applied

**Farm Bureau General Ins Co of Michigan v Holstein**

Unpublished Court of Appeals opinion of September 2, 2014, lv app pending
(Docket No. 314652)

In addition to his full-time job as a truck driver, the insured homeowner operated a meat processing business in his detached garage, where he skinned deer for customers and for himself. The garage was filled with commercial equipment and used solely for meat processing. A friend of the insured’s son was injured while helping to clean a meat mixer, and the insured looked to his homeowners policy for liability coverage because he had no commercial liability policy for the business. The Court of Appeals enforced the business exclusion in the homeowners policy, which excluded coverage for liability arising out of a business engaged in by the insured. The exclusion applied even though the injured claimant was a minor and was not injured while performing the business activity.

CGL Coverage denied for defective construction

**Michigan Ins Co v Channel Road Construction, Inc.**

Unpublished Court of Appeals opinion of October 21, 2014, lv app pending
(Docket No. 315837)

This opinion continues the string of cases denying CGL coverage for construction defect claims. Five years after the insured assembled claimant’s log home, they discovered water damage caused by the insured’s failure to install metal flashings above the windows and failure to properly angle the window sills. The Court of Appeals affirmed the lower court’s denial of coverage due the lack of an occurrence; the damage was limited to the insured’s own work.

“ Innocent third party rule”

**Frost v Citizens Ins Co of America**

Unpublished Court of Appeals opinion of September 23, 2014, lv app pending
(Docket No. 316157)

Under **Titan Ins Co v Hyten**, 491 Mich 547 (2012), the Court of Appeals reversed the trial court’s application of the “innocent third party rule” to find coverage and remanded the case for further proceedings on whether Progressive could rescind this auto policy.

Nephew is not a resident of insureds’ household

**Patterson v Auto Club Ins Ass’n**

Unpublished Court of Appeals opinion of August 21, 2014
(Docket No. 316100)

A jury decided that the decedent, who was killed in an auto accident, did not reside with this aunt and uncle at the time of the accident and thus was not an insured under their auto policy. The trial court subsequently granted the estate’s motion for JNOV but the Court of Appeals reversed and reinstated the jury verdict. “Residence” is legally synonymous with “domicile,” requiring the assessment of a number of different factors, and the evidence supported the jury’s application of those factors to this claim.

Insured cannot reform policy’s effective date

**Estate of Morse v Titan Ins Co**

Unpublished Court of Appeals opinion of August 14, 2014, lv app pending
(Docket No. 309837)

Titan’s auto policy did not take effect until a day after the insured’s accident and thus did not afford coverage. A jury decided to reform the policy and make it effective on the date the insured paid the premium to her insurance agent but the Court of Appeals reversed because there was no mutual mistake between the actual parties to the contract. Titan commenced coverage on the date requested in the insurance application submitted by the insurance agency (agent for the insured) and Titan expected coverage to take effect that day.
As we begin another year of litigating Michigan no-fault insurance claims, those of us who have been practicing in this area for over 25 years can recall that one of the purposes behind the enactment of the Michigan No-Fault Insurance Act in 1973 was to reduce the amount of litigation stemming from motor vehicle accidents. Forty-one years later, issues involving first-party coverage under the No-Fault Insurance Act continue to be one of the most heavily litigated areas of law in this state.

The Michigan Supreme Court has not issued any decisions impacting on the No-Fault Insurance Act in some time. However, we do have a U.S. Sixth Circuit Court of Appeals decision which clarifies, once and for all, whether diversity of jurisdiction exists when a Michigan resident files suit against an insurer domiciled in another state. We also have two published Michigan Court of Appeals decisions which impact on the No-Fault Insurance Act in some time.

In Ljuljdjuraj v State Farm, the Sixth Circuit noted that a liability action is not the same as a claim against one's own no-fault insurer for payment of no-fault benefits. Essentially, the court distinguished between a first party lawsuit (which is not a liability claim) and a third party lawsuit (which generally involves a liability claim). The Sixth Circuit also distinguished its earlier decision in Ford Motor Co v Ins Co of North America, 669 F. 2d 421 (6th Cir 1982), which did not involve a claim for first-party, no-fault PIP benefits but rather, Property Protection Insurance (PPI) benefits under MCL 500.3121 et seq. In doing so, the court noted that a claim for Property Protection Insurance benefits is a substitute for a claim for property damage, caused by an automobile, which would otherwise have been filed under the common law. As noted by the Court of Appeals:

“In any direct action against the insurer of a policy or contract of liability insurance . . . to which action the insured is not joined as a party-defendant, such insurer shall be deemed a citizen of the State of which the insured is a citizen . . .”

Observing that the “direct action” statute was “designed to prevent local tort suits from overwhelming the federal courts,” the Sixth Circuit noted that a liability action is not the same as a claim against one's own no-fault insurer for payment of no-fault benefits. Essentially, the court distinguished between a first party lawsuit (which is not a liability claim) and a third party lawsuit (which generally involves a liability claim). The Sixth Circuit also distinguished its earlier decision in Ford Motor Co v Ins Co of North America, 669 F. 2d 421 (6th Cir 1982), which did not involve a claim for first-party, no-fault PIP benefits but rather, Property Protection Insurance (PPI) benefits under MCL 500.3121 et seq. In doing so, the court noted that a claim for Property Protection Insurance benefits is a substitute for a claim for property damage, caused by an automobile, which would otherwise have been filed under the common law. As noted by the Court of Appeals:

“Stated differently, suits against insurance companies by owners of damaged property are far more similar to direct action suits based on liability insurance than suits by car occupants who are listed in the insurance policy pursuant to the statute as ‘insured’ prior to the occurrence of the accident. It follows that, while we are bound by our published holding in Ford, that holding binds most with respect to the Property Protection benefits that were at issue in that case. Thus, the direct action proviso of the federal diversity statute does not apply in this case, notwithstanding our holding in Ford.”

Ljuljdjuraj, slip opinion at page 8.
Given that the Sixth Circuit Court of Appeals has now clarified this area of the law, it remains to be seen whether there will be an increase in the number of first party PIP lawsuits being filed in the federal court system, or transferred from the state court to the federal court system by insurers domiciled outside the State of Michigan.

Michigan Court of Appeals

Court of Appeals affirms right of medical providers to file their own lawsuits against no-fault insurers

**Wyoming Chiropractic Health Clinic v Auto-Owners Ins Co.**

Docket no. 317876, published decision rel’d 12/9/2014

In *Wyoming Chiropractic*, the no-fault insurer challenged a medical provider’s right to file its own cause of action a no-fault insurer, where the injured individuals failed to do so. Essentially, Auto-Owners attempted to argue that the medical providers lacked standing because the provider was not the “real party in interest.” The lower court had denied Auto-Owners’ motion for summary disposition, based primarily on the Court of Appeals’ decisions in *Munson Medical Ctr v ACLA*, 218 Mich App 375, 544 NW2d 49 (1996); *Lakeland Neurocare Ctrs v State Farm*, 250 Mich App 35, 645 NW2d 59 (2002) and *Regents of Univ of Mich v State Farm*, 250 Mich App 719, 650 NW2d 129 (2002).

On appeal, the Court of Appeals reaffirmed each of these earlier decisions and rejected Auto-Owners’ argument that the issue of standing was not squarely before the Court in those cases. Auto-Owners also raised a number of “public policy” arguments, which were likewise rejected by the Court of Appeals:

“In addition, the public policy goals of the No-Fault Act support allowing a healthcare provider to have standing to sue an insurer for PIP benefits. Auto-Owners argues that this rule will force insurers to defend multiple lawsuits at different times and in different courts. Auto-Owners also points out that insurers face an increased risk of having to pay penalty interest if healthcare providers have standing to sue because insurers will not be able to concentrate their efforts on paying insured individuals on time and at ‘fair and equitable rates.’ However, as discussed above, this Court interpreted the plain language of MCL 500.3112 as allowing healthcare providers to maintain direct causes of action against insurers to recover PIP benefits under the No-Fault Act. Thus, the Michigan legislature addressed the public policy issues related to healthcare provider standing when it drafted MCL 500.3112.

Furthermore, public policy favors provider suits. The goal of the No-Fault Act is ‘to provide victims of motor vehicle accidents with assured, adequate, and prompt reparation for certain economic losses.’ The No-Fault Act was designed to remedy ‘long delays, inequitable payment structure, and high legal costs’ in the tort system. Allowing a healthcare provider to bring a cause of action expedites the payment process to the healthcare provider when payment is in dispute. Thus, provider standing meets the goal of prompt reparation for economic losses. Healthcare provider standing also offers healthcare provider a remedy when an insured individual does not sue an insurer for unpaid PIP benefits, thus preventing inequitable payment structures and promoting prompt reparation. Therefore, public policy supports this Court’s prior opinions.”

Given the fact that this is published decision, it is now binding precedent, unless the Supreme Court decides to take up this matter. As of the date this article is being prepared, an Application for Leave to Appeal has not yet been filed with the Michigan Supreme Court.

Court of Appeals affirms dismissal of plaintiff’s entire cause of action, including claims for medical expenses filed by intervening medical providers, where claimant submits fraudulent household replacement service claims

**Bahri v IDS Property Casualty Ins Co.**

Docket No. 316869, rel’d for publication 12/9/2014

In *Bahri*, Plaintiff was involved in a motor vehicle accident on October 20, 2011. As a result, he filed a claim for no-fault benefits with his insurer, IDS Property Casualty Insurance Company, including claims for household replacement service expenses. These claims turned out to be fraudulent in the following respects:

“In order to substantiate her claims for replacement services, Plaintiff presented a statement indicating that services were provided ‘Rita Radwan’ from October 1, 2011, to February 29, 2012. Because the accident occurred on October 20, 2011, on its face, the document Plaintiff presented to Defendant in support of her PIP claim is false, as it sought recoupment for services that were performed over the 19 days preceding the accident.

Moreover, defendant produced surveillance evidence depicting Plaintiff performing activities inconsistent with her claimed limitations. Plaintiff was observed bending, lifting, carrying objects, running errands, and driving—on the dates when she specifically claimed she needed help with such tasks. Of particular note, on November 11, 2011, Plaintiff represented that she required assistance vacuuming, cooking, dishwashing, making beds, grocery shopping, taking out the garbage, driv-
ing, and running errands. Yet, surveillance videos captured her performing various activities, such as lifting, carrying, and dumping a large bucket of liquid in her yard. On December 19, 2011, Plaintiff indicated that on that day, she was observed running several errands from 11:05 a.m. until 7:00 p.m. Plaintiff’s individual claims for all no fault benefits, nor can intervening plaintiffs.

Defendant insurer moved for summary disposition, based upon its general fraud exclusion, which provided:

“We do not provide coverage for any insured who has made fraudulent statements or engaged in fraudulent conduct in connection with any accident or loss for which coverage is sought under this policy.”

The trial court agreed with the insurer’s argument, to the effect that no reasonable minds could differ as to whether or not Plaintiff Bahri submitted fraudulent household replacement service claim forms, and granted summary disposition in favor of the insurer.

Plaintiff and her medical providers (who had intervened in the lawsuit) appealed to the Court of Appeals. In a landmark decision, the Court of Appeals affirmed the decision of the trial court to grant summary disposition in favor of the insurer based on the fraudulent claims. In addition to excluding Plaintiff’s individual claims for all no-fault benefits, the Court also dismissed the claims presented by the medical providers because their claims were derivative.

“Because intervening plaintiffs stood in the shoes of the named insured, if plaintiff cannot recover benefits, nor can intervening plaintiffs.”

This statement stems from the Court of Appeals’ earlier decision in TBCI P.C.v State Farm, 289 Mich App 39, 795 NW2d 229 (2010).

Finally, the Court of Appeals affirmed the dismissal of Plaintiff’s claim for uninsured motorist benefits, based not only on the fraud exclusion, but also on the fact that she failed to prove direct physical contact between her automobile and the “hit-and-run” vehicle that purportedly caused the subject accident.

Those of us on the defense side have seen, all too often, claims for household services for cutting grass in January, and shoveling snow in July. Unfortunately, some, but certainly not all, of my colleagues on the Plaintiff side have been less than diligent when it came to submitting claims for household services. Given the fact that Bahri is now a published decision, Plaintiff attorneys are well advised to advise their clients to put together legitimate household replacement service claim forms that accurately reflect precisely what was done on any given day. Failure to be more diligent in the submission of household replacement service claims can result in a dismissal of one’s entire claim for no fault benefits under this case.

As of the date this article is being prepared, an Application for Leave to Appeal to the Michigan Supreme Court, filed by the Intervening Plaintiffs/medical providers, remains pending.

Court of Appeals reaffirms earlier decision in Moody v Home-Owners Ins Co, 304 Mich App 415, 849 NW2d 21 (2014) and voids district court judgments for the individual claimant and the transportation company, even though only the individual’s verdict exceeded the district court jurisdictional threshold.

Redmond v State Farm

Docket no. 313413, unpublished decision rel’d 12/2/2014

In Redmond, Plaintiff filed suit in the 36th District Court for the City of Detroit to recover no-fault benefits from her no-fault insurer, State Farm. A transportation company, Destinee’s Transportation, filed a separate action to recover payment of the transportation expenses incurred by Redmond as a result of her injuries. Both actions were later consolidated for trial. At trial, the jury rendered a verdict in favor of Plaintiff Redmond in the amount of $63,793.00, and in favor of Destinee’s Transportation in the amount of $8,750.68. No-fault penalty interest was likewise awarded to both plaintiffs. The Court also awarded no-fault penalty attorney fees, at the rate of $400.00 per hour, to Redmond’s attorneys, and at the rate of $200.00 per hour to Destinee’s Transportation’s attorneys.

On appeal, the circuit court voided the judgment entered in Redmond’s case, because Redmond had been requesting damages far in excess of the $25,000.00 jurisdictional limit of the district court. However, the circuit court affirmed the district court’s judgment in favor of Destinee’s Transportation because that particular judgment was less than the $25,000.00 jurisdictional limit of the district court. State Farm subsequently filed an Application for Leave to Appeal to the Court of Appeals, which was granted.

On appeal, the Court of Appeals affirmed the circuit court’s decision to void the district court judgment that had been rendered in favor of Plaintiff Redmond and, in doing

With regard to the transportation company’s lawsuit, the Court of Appeals observed that, because the transportation company’s lawsuit was consolidated with Redmond’s lawsuit for purposes of trial, “there is virtual identity between Destinee’s Transportation’s claims and Redmond’s claims such that they all could have been brought in a single action involving a single judgment, and because these separately filed actions were consolidated in the district court, just as in *Moody*, we likewise conclude that these claims were merged for the purposes of determining the amount in controversy pursuant to MCL 600.8301(1).” As a result, the Court of Appeals reversed the decision of the circuit court and vacated the district court’s judgment on the transportation company’s claim.

Judge Shapiro issued a vigorous dissent, arguing that *Moody* was wrongly decided but acknowledging that, because it was a published decision, a special conflict panel should be convened to resolve the issue, pursuant to MCR 7.215(J)(2), but for the fact that the Supreme Court had granted plaintiff’s Application for Leave to Appeal in *Moody*. While it is true that the Supreme Court granted Plaintiff’s Application for Leave to Appeal on September 26, a motion to dismiss the appeal was filed by Plaintiff’s counsel on November 24, 2014.

Court of Appeals reverses lower court’s decision to strike defense medical expert’s testimony, based upon expert’s failure to produce financial information

*Hubbert v ACIA*

Docket no. 314670, unpublished decision rel’d 12/4/2014

Prior to trial, the Wayne County Circuit Court struck the testimony of AAA’s defense medical expert, Dr. Phillip Friedman, as a sanction for Dr. Friedman’s failure to comply with a subpoena, issued by Plaintiff’s counsel, requiring him to produce financial documents pertaining to the income he derived from performing independent medical evaluations. As a result, the jury returned a judgment in favor of Plaintiff and AAA appealed.

On appeal, the Court of Appeals reversed the decision of the lower court, on the basis that Dr. Friedman was not a party to the litigation, but rather was simply a defense medical expert. The Court of Appeals stated: “we disagree with the trial court’s unstated premise that it is appropriate to sanction a party for a non-party witness’s failure to comply with a subpoena duces tecum” requiring the production of the financial documents.

The court observed that under MCR 2.113(D)(2), sanctions may be imposed when a party or an officer, director or managing agent of a party fails to obey an order to provide or permit discovery. However, these sanctions were simply not applicable in a case involving a defense medical expert. Because it was Dr. Friedman, not the insurer who failed to produce the required documents, the appropriate sanction would have been to hold Dr. Friedman in contempt under MCR 2.506(E)(1) and the court’s earlier decision in *McGee v Macambo Lounge Inc*, 158 Mich App 282, 404 NW2d 242 (1987).

Furthermore, the Court of Appeals noted that, as a result of the lower court’s decision to strike Dr. Friedman as an expert witness, the “substantial right of a party [AAA] is affected,” and that the striking of Dr. Friedman’s testimony was “inconsistent with substantial justice.” As noted by the Court of Appeals:

“The trial court’s striking of Dr. Friedman’s testimony affected defendant’s substantial rights because it deprived defendant of its sole expert witness who could dispute plaintiff’s new causation theory introduced during Dr. Jawad Shah’s deposition testimony. In particular, Dr. Shah testified that the motor-vehicle accident played a causal role in plaintiff’s infection-induced paraplegia because he suffered cervical disc trauma in the accident, which made

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him more prone to an infection in that location. By contrast, Dr. Friedman opined that there was no medical basis to causally connect plaintiff’s infection to the accident, given the amount of time that had passed since the accident.”

HUBBERT, slip opinion at page 5-6.

Judge Michael Kelly vigorously dissented, arguing that AAA did, in fact, have control over its defense medical expert, Dr. Friedman, because it was AAA that “actually took action to protect Friedman from having to disclose his finances.”

Court of Appeals affirms bench trial determination that the need for 24-hour-per-day attendant care did not arise out of injuries suffered in a 2003 motor vehicle accident

FARM BUREAU v WARRINER
Docket no. 317674, unpublished decision rel’d 11/25/2014

In WARRINER, the Court of Appeals reviewed the findings of the Hillsdale County Circuit Court, which determined that the need for 24-hour-per-day attendant care did not arise out of a motor vehicle accident occurring on August 21, 2003, which resulted in the onset of a traumatic brain injury. This case is essentially a “battle of the expert witnesses,” and the Court of Appeals goes to great length to compare and contrast the expert medical testimony presented by Dr. Firoza Van-Horn Ph.D., Dr. Joseph Hornyak M.D., Dr. James Rowan Ph.D., and Dr. Walter Sobota Ph.D., who testified on behalf of Defendant Warriner. The court also summarized the results of the independent medical evaluations performed by Dr. Robert Fabiano Ph.D., Dr. Steven Putnam Ph.D., and Dr. Elliot Wolf M.D. In affirming the findings of the circuit court, sitting as the trier of fact, the Court of Appeals simply noted that the trial court was free to weigh the findings and opinions of the various medical experts as it saw fit. Reviewing the matter under a “clear error” standard, the Court of Appeals noted that the injured party had failed to leave the appellate court “with a definite and firm conviction that a mistake was made.”

Court of Appeals affirms jury verdict awarding plaintiff less than $10,000.00 in the face of a $630,000.00 demand

BLACKSHER v STATE FARM
Docket no. 312701, unpublished decision rel’d 12/4/2014

In BLACKSHER, Plaintiff filed an appeal from a jury verdict awarding less than $10,000.00 to Plaintiff and her medical provider, McLaren Regional Medical Center, in the face of a $630,000.00 requested verdict. In doing so, Blacksher and McLaren challenged the jury trial judgment, claiming that it was internally inconsistent and against the great weight of the evidence. State Farm appealed from the denial of its request for no-fault defense attorney fees under MCL 500.3148(2).

In affirming the decision of the lower court, the Court of Appeals summarized, in great detail, some of the medical testimony that was presented at trial. For example, the Court of Appeals noted that Plaintiff had withheld vital information from her treating physician, Dr. Sabbagh. Specifically, she informed Dr. Sabbagh that she had never suffered bouts of dizziness in the past. However, six years earlier, she sought treatment for dizziness, headaches and body aches, connected to a sinus infection.

The Court of Appeals also commented that, even though Blacksher’s MRI and CT scans of the head were negative, Dr. Atty, who conducted the initial evaluation for admission into the McLaren head injury program, diagnosed Blacksher with a mild traumatic brain injury. The Court also summarized the defense medical expert testimony presented by Dr. Leonard Sahn M.D., Dr. Lisa Metler Ph.D., Dr. Joseph Femminineo M.D. and Dr. Robin Hanks Ph.D. After analyzing the evidence presented to the jury, the Court of Appeals simply concluded that it was not prepared to disturb the jury’s verdict.

The Court of Appeals likewise affirmed the lower court’s decision not to award no-fault defense attorney fees to State Farm, noting that, “although the disparity between the amount demanded and the ultimate award may comprise evidence that the initial claims were excessive, that does not mean that the disparity conclusively established that the claims were excessive.” BLACKSHER, slip opinion at page 14.

Court of Appeals determines that one of the three statutory exceptions to the parked vehicle exclusion found in MCL 500.3106(1) must be satisfied before no-fault benefits are payable for injuries arising out of a parked motor vehicle

KALO v HOMEOWNERS INS CO.
Docket no. 316442, unpublished decision rel’d 9/9/2014

Plaintiff was helping her daughter move her belongings into a rented U-Haul truck, in preparation for her move to Chicago. She was standing on an aluminum ladder at the back of the U-Haul truck, attempting to fix the latch so the door would close. As Plaintiff was pulling on the fabric strip, attached to the door, she lost her balance and fell off of the ladder. Plaintiff filed a claim for no-fault benefits with her no-fault insurer, which was denied based upon the Parked Vehicle Exclusion set forth in MCL 500.3106(1). The lower court granted summary disposition in favor of the injured party, and Defendant insurer filed an appeal with the Court of Appeals.

The Court of Appeals reversed the decision of the lower court and remanded the matter back to the lower court for entry of summary disposition in favor of the insurer. In doing so, the Court of Appeals observed that, in MILLER v AUTO-OWNERS INS CO, 411 Mich 633, 309 NW2d 544 (1981), the Supreme Court held that in cases involving maintenance on a parked vehicle, compensation was required pursuant to MCL 500.3105, without regard to the Parked Vehicle
Exclusion and the statutory exceptions thereto found in MCL 500.3106(1). However, the court noted that the rationale in Miller was inconsistent with later decisions from the Michigan Supreme Court, including Frazier v Allstate Ins Co, 490 Mich 381, 808 NW2d 450 (2011) and LeFevers v State Farm, 493 Mich 960, 828 NW2d 678 (2013). In light of the more recent Supreme Court jurisprudence, the Court of Appeals held that in order for any injured claimant to recover benefits arising out of a parked motor vehicle, the claimant must demonstrate compliance with one of three statutory exceptions to the Parked Vehicle Exclusion set forth in MCL 500.3106(1):

“Here, plaintiff cannot recover pursuant to MCL 500.3105 alone. Any analysis of plaintiff’s claim involving her injury required a complementary analysis of MCL 500.3106(1), because plaintiff’s injury arose out of her contact with a parked vehicle. [Citations omitted]. Accordingly, we reject plaintiff’s argument on appeal that plaintiff can collect no-fault benefits for her vehicle pursuant to MCL 500.3105(1) without consideration of MCL 500.3106.

It is undisputed that plaintiff’s vehicle was parked at the time of plaintiff’s injuries. Therefore, to determine whether plaintiff was entitled to no-fault personal protection benefits as a matter of law pursuant to MCL 500.3105(1) and MCL 500.3106(1), we first look to whether plaintiff’s injury meets one of the requirements of MCL 500.3106(1).”

Kalo, slip opinion at page 2.

The court held that because Plaintiff failed to demonstrate that her injury fell within one of the three statutory exceptions to the Parked Vehicle Exclusion, set forth in MCL 500.3106(1), she was ineligible to obtain no-fault insurance benefits.

The author respectfully submits that the Court of Appeals properly applied the actual statutory language utilized in MCL 500.3105(1) and MCL 500.3106(1). The Supreme Court’s holding in Miller, to the effect that at least with regard to maintenance injuries, such injuries are compensable under MCL 500.3105(1) without regard to MCL 500.3106(1) is contrary to the actual statutory text which, in fact, precludes compensation for “maintenance” injuries arising out of a parked motor vehicle unless one of the three statutory exceptions to the Parked Vehicle Exclusion are met. ■

In Memoriam
Michael Shpiece

Michael Shpiece, a Section member and frequent Journal author, passed away on December 25, 2014 at the age of 58. He left behind his wife, two sons, brother, sister, and many other family members. He practiced in the areas of employee benefits, health and hospital, insurance, regulatory and administrative law. He was chairperson of the Employee Benefits Committee of the Torts, Trial and Insurance Practice Section of the American Bar Association, a member of the ABA’s Joint Committee on Employee Benefits, a member of ICLE’s executive committee, and vice-chairperson of the Employee Benefits committee of the Oakland County Bar Association. Mike will be remembered for his humor and his intellect, in addition to many other positive qualities. ■

The Insurance & Indemnity Law Section has launched a new website and interactive online community for its members—SBM Connect (http://connect.michbar.org/). This private community will enhance the way we communicate and build relationships through the Section. Log in to SBM Connect today and see what the buzz is all about!

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SBM Connect will eventually replace the current section website. Both websites will run concurrently to allow you time to discover the new tools and features available to members.
ERISA Decisions of Interest
Kimberley J. Ruppel, Dickinson Wright, kruppel@dickinsonwright.com

I am saddened by the recent loss of my co-author, Michael Shpiece, who passed away on December 25, 2014.

United States Supreme Court
Statute of limitations for fiduciary breach
Tibble v Edison Int'l, Inc, 135 S Ct 43 (Oct. 2014)
The Supreme Court granted a petition for writ of certiorari in a case from the Ninth Circuit Court of Appeals to hear the question of whether a claim that ERISA plan fiduciaries breached their duty of prudence by offering higher-cost retail-class mutual funds to plan participants, even though identical lower-cost institution-class mutual funds were available, is barred by 29 U.S.C. 1113(1) when fiduciaries initially chose the higher-cost mutual funds as plan investments more than six years before the claim was filed.

The plaintiffs here argued that the ERISA investment plan fiduciaries, who convened on a quarterly basis to review plan investments, had an ongoing duty to review prior decisions. This case may decide whether a theory of “continuing violation” can be used to escape ERISA’s limitations period. A finding in favor for the plaintiffs could expose ERISA fiduciaries to increased risk for past actions. Expect oral argument to be scheduled this spring.

United States District Court
Failure to communicate requirements for increased coverage may result in breach of fiduciary duty
In this case, the employer sponsored plan allowed for supplemental life insurance benefits up to $300,000 without supplying evidence regarding an employee's health. However, to increase optional coverage over $300,000, an employee was required to prove “good health” and satisfactorily complete an “Evidence of Insurability Form” (“EIF”). Although the full plan document included this condition, that document was never provided to the employee. Instead, employees received only a summary plan description, which did not explain the requirements for coverage in excess of the $300,000 limit.

During periods of open enrollment, the insured employee here continued to elect increasing amounts of coverage in excess of $300,000, ultimately up to four times her salary, and premiums were charged and collected accordingly by the employer without any mention of the good health requirement or completion of an EIF.

As the plan administrator, the employer was responsible for ensuring that coverage elections (including any required proof of good health) were processed correctly, and that premium remittances were accurate and timely. Although processing EIFS was generally the employer's responsibility, on one occasion the employer asked the insurer to mail an EIF to the employee here, which was allegedly never received.

After the employee passed away, her parents submitted a claim for benefits. Upon reviewing the file, the plan's insurer denied the supplemental insurance claim in excess of $300,000 because proof of good health had never been provided. The parents sued both the employer and the insurer of the plan benefits. The complaint included claims for benefits under ERISA section 502(a)(1)(B), as well as claims for breach of fiduciary duties under 502(a)(3).

When considering the defendants' motion to dismiss on the benefits claim, the court held that, because the insurance company rendered the decision to deny benefits, and the employer did not control or influence that decision, the claim for benefits could survive against the insurer only, but not the employer.

Turning to the breach of fiduciary claims, based on the employer’s actions of accepting enrollment forms, confirming enrollment and accepting premiums, the court found that the employer exercised discretionary authority and therefore acted as a fiduciary. As a result, the court held that the plaintiffs’ claims of material misrepresentation and detrimental reliance were viable against the employer and could lead to an award of compensatory damages. Equitable estoppel and unjust enrichment claims were dismissed as to both defendants.

This case may decide whether a theory of “continuing violation” can be used to escape ERISA’s limitations period. A finding in favor for the plaintiffs could expose ERISA fiduciaries to increased risk for past actions. Expect oral argument to be scheduled this spring.

continued on the next page
Plaintiffs also asserted a claim against the employer, the insurer and the plan for failure to provide documents evidencing that Defendants either provided an EIF to the employee, or requested that she complete an EIF. The court held that plaintiffs failed to state a claim under ERISA section 502(c), which obligates a plan administrator to provide plan documents to participants, because the referenced documents were not “plan documents” requiring production by the employer, and because the insurer was not the plan administrator and thus not subject to liability for this claim. The court left the door open for the plaintiffs to assert a claim under ERISA section 503, requiring adequate notice and explanation of a claim denial and production of documents related to the claim decision.

The court found that the employer exercised discretionary authority and therefore acted as a fiduciary. As a result, the court held that the plaintiffs’ claims of material misrepresentation and detrimental reliance were viable against the employer and could lead to an award of compensatory damages.

Disclaimer in pension confirmation precluded claim for equitable estoppel


The plaintiff here was a truck driver for over thirty years. Multiple companies made pension contributions on his behalf to a multi-employer employee pension benefit plan. At various times over the decades, the plaintiff inquired about his benefits and each time he was told that he had earned 14.3 years of contributory service credit, as defined by the plan. Each confirming communication also contained the caveat that the figure was based on current information and that his eligibility could change if conflicting information was discovered.

Upon the plaintiff’s request for credit for additional years of service, the Fund began investigating his employment history. The earnings report obtained from the Social Security Administration and a questionnaire completed by the plaintiff raised questions regarding the plaintiff’s entitlement to years of service credits. Indeed, the plaintiff’s earnings report showed that he was self-employed for several of the years in question. Also, in his questionnaire response, he confirmed that he was paid based on a percentage of revenue as opposed to an hourly wage or salary, and he disclosed that he was not paid separately for wages and equipment according to the company’s standard protocol, a statement which he later recanted. Upon the plaintiff’s application for pension benefits, his claim was denied based on the determination that he was not an “employee” of the participating employer.

The court found that the Fund correctly applied the common law definition of an “employee,” which was not supported by the contradictory evidence provided by the plaintiff. The court also rejected the plaintiff’s equitable estoppel claim based on the Fund’s disclaimer that confirming his service credits was based on then-current information, which was later proven to be inaccurate.

About the Author

*Kimberly J. Ruppel* is a Member in Dickinson Wright’s Troy office. Ms. Ruppel is a commercial litigator who specializes in ERISA, insurance, healthcare and probate litigation.
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