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Hal O. Carroll, Journal Editor ■ www.HalOCarrollEsq.com ■ (734) 645-1404

From the Chair

Jason J. Liss
Fabian, Sklar, King & Liss

Happy New Year! Happy New Decade!

I am hopeful that all of our members had a very happy holiday and will have a very rewarding and fulfilling year, this first year of the new decade!

Past Meeting and Program

Our Annual Business Meeting and Program, held on October 17, 2019 at the State Bar of Michigan Building, was a great success! A big thank you to the State Bar of Michigan staff for their assistance. I would especially like to thank our presenters, Ethan Gross, CEO of Globe Midwest/Adjusters International and Bill Butler, president of Butler & Associates Adjusting Company, for their excellent presentation *Properly Preparing, Presenting & Handling Homeowners and Commercial Property Insurance Claims Prior to Litigation—Duties, Obligations, and Best Practices*. The program was well-attended, and the attendees engaged with the topic and asked many questions of the presenters.

An article written by one of the presenters, Ethan Gross, is reprinted in this issue of the *Journal*.

Program presenter Bill Butler

Program presenter Ethan Gross

Next Meeting and Program

As of this writing, I look forward to our next program on January 16, 2020 at the Birmingham Athletic Club. John M. Sier, senior partner with Kitch Drutchas Wagner Valitutti & Sherbrook, P.C. and head of the firm's commercial litigation practice, will be presenting on the topic of indemnification and will be addressing the extent of indemnity available to a party (such as the limitations of MCL 691.991), whether indemnity applies only to third party claims, and the characteristics of common law/implied indemnification compared with contractual indemnity.

Chair Gus Igwe presents scholarship check to Kaitlin Gant, winner of the 2019 scholarship essay contest

Scholarship

Our section is very pleased to continue its annual sponsorship of a $5,000 scholarship to an eligible law student interested in the area of insurance law.

The winner of the 2019 competition was Kaitlin Gant, a senior at Michigan State University College of Law. She received her scholarship check at the October meeting and her article is printed in this issue.

Any student currently enrolled in one of Michigan's five law schools is eligible to apply for the scholarship. The winner will be selected based on the submission of an article of original work on a topic chosen by the section's council. The topic and the details of the required submission can be viewed and downloaded at *https://tinyurl.com/insur-indem-scholarship*. Submissions are due no later than February 29, 2020 and the council's scholarship committee has been actively reaching out to each of the law schools to promote awareness of the scholarship, including a meet and greet at the University of Detroit's law school in mid-January.

Membership

Our section continues to grow, and I am very happy to report that 104 new members joined our section this year, bringing our total current membership to 908. I would like to welcome all our new members and encourage them to actively participate in the section by submitting an article for the section's quarterly *Journal* or by helping to plan and organize an educational program for our membership.

Again, I wish a happy new year to all of our members and I look forward to seeing many of you at our coming program at the Birmingham Athletic Club in Bloomfield Hills, MI. ■

Editor's Notes

By Hal O. Carroll
www.HalOCarrollEsq.com

The *Journal* is now entering its thirteenth year. The *Journal* is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The *Journal* – like the Section itself – takes no position on any dispute between insurers and insureds. All opinions expressed in contributions to the *Journal* are those of the author. We welcome all articles of analysis, opinion, or advocacy for any position.

Watch for our next Eblast, in which we suggest possible article topics.

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.

Index coming soon. Because we now have completed 48 issues, it's time to set up an index of past articles for those who want to be able to refer to analyses of the many topics the *Journal* has covered over the past twelve years. Our plan is to have it up and running by Spring.

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. ■

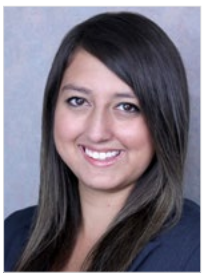
Photos from the Annual Meeting and Program

The new officers: Chairperson Jason J. Liss, Chairperson Elect Nicole Wilinski, Secretary Lauretta Pominville, and Treasurer Rabih Hamawi

Jason Liss presents plaque to outgoing chairperson Gus Igwe

Gus Igwe presents gavel to incoming chairperson Jason Liss

2019 scholarship essay contest winner Kaitlin Gant and her parents, Keith and Norma, with the scholarship check



Disqualify the Qualified: Independent Medical Examinations in Michigan's No-Fault System

By Kaitlin Gant, Michigan State University College of Law*

Introduction

Michigan's No-Fault Act, was amended by Public Act 22 of 2019, signed by the governor on June 11, 2019. The act imposed new and increased restrictions on physicians performing independent medical examinations. These examinations are regularly conducted for the purpose of evaluating claims of injury in first-party personal injury protection (PIP) actions, as well as other types of claims involving personal injuries. This article will further highlight the unintended consequences of the new restrictions.

Statutory Overview

Michigan's No-Fault Act was enacted in 1973 and requires drivers in the State of Michigan, involved in a motor vehicle accident, to file a claim with their own insurance company for benefits, regardless of who was at fault in the accident.[1] Michigan drivers are required to purchase personal injury protection benefits through their automobile insurance policies, which are designed to cover policyholders and their families for the cost of minor injuries.[2] Under Michigan's No-Fault Act, drivers may have two separate claims for recovery: 1) a first-party PIP claim; and, 2) a tort liability claim.[3]

"Under Michigan No-Fault law, an auto-accident victim has the right to recover certain 'no-fault benefits' (usually from the victim's own insurance company), no matter who caused the accident."[4] An insurer is liable to pay personal protection insurance benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, and such benefits are due without regard to fault.[5] First party claims for personal injury protection benefits arise when an insured seeks payment of all or some of the following: medical bills, replacement services, attendant care, and lost earnings.

When these PIP actions arise, it is standard practice for the defendant insurer to hire physicians to conduct independent medical examinations in order to evaluate the plaintiff's claimed injuries for which they are seeking monetary relief. Independent medical examinations, often referred to as "defense medical examinations," are done for the purpose of responding to the plaintiff's physicians offering opinions about medical conditions, need for medical treatment, necessity of attendant care and replacement services, and their ability, or in ability, to return to work.

Plaintiffs also have their own treating physicians and are often also sent to other doctors for evaluation, treatment, and medical opinions regarding the extent of their injuries and injury causation for PIP claims. Specifically, "[w]hen the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, the person shall submit to mental or physical examination by physicians."[6] As such, a "personal protection insurer may include reasonable provisions in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits."[7]

"Independent medical examinations" are medical examinations conducted for litigation purposes to evaluate physical or mental injuries sustained by the party in question. Insurance companies and plaintiff's and defense attorneys usually solicit testimony from physicians employed by agencies in the business of providing independent medical examinations from credentialed medical professionals. Due to the frequency of these actions and the near constant need for medical examinations, the parties often use the same physicians repeatedly.

Newly Amended Legislation

Because the insurance market is affected by the pubic interest, the state is permitted to regulate insurance companies for the protection of the public when necessary.[8] Public Act 22 of 2019 included more stringent regulations on independent medical examinations.[9] MCL 500.3151(1) allows for independent medical examinations, and states, "[i]f the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, at the request of an insurer the person shall submit to mental or physical examination by physicians."[10] "In the particularized setting of an [independent medical examination], the physician's goal is to gather information for the examinee or a third party to use." It is not to provide a diagnosis or treatment of medical conditions."[11]

* *This article was written by third-year law student Katlin Gant, a student at Michigan State University College of Law, and was the winning entry in the Insurance and Indemnity Law Section's 2019 scholarship competition.*

While this requirement was already a part of Michigan's No-Fault Insurance law, the requirements for these physicians have become significantly more strict, with the intention of preventing biased opinions garnered from physicians whose sole practice and source of income is from conducting independent medical examinations, rather than being in active clinical practice. Active clinical practice is defined as, "the practice of medicine in which physicians assess patients (in person or virtually) or populations in order to diagnose, treat, and prevent disease using their expert judgment."[12] Specifically, the two new rules are:

> "1) a physician who conducts a mental or physical examination . . . must be licensed as a physician in this state or another state and meet the following criteria, if applicable: (a) If care is being provided to the person to be examined by a specialist, the examining physician providing the care, and if the physician providing the care is board certified in the specialty, the examining physician must be board certified in that specialty[;]"

> "2) During the year immediately preceding the examination, the examining physician must have devoted a majority of his or her professional time to either or both of the following: (i) [t]he active clinical practice of medicine and, if subdivision (a) applies, the active clinical practice relevant to the specialty; (ii) [t]he instruction of students in an accredited medical school or in an accredited residency or clinical research program for physicians and, if subdivision (a) applies, the instruction of students in the specialty."[13]

Limiting the pool of qualified physicians

While these new regulations appear to promote the use of well-qualified and experienced physicians actively dedicated to healthcare, the regulations also limit the pool of potential physicians by eliminating the use of experienced, yet retired, physicians. These new amendments became effective on June 11, 2019.[14]

Further, the limitations on the pool of physicians to conduct independent medical examinations may be logistically stifling. For example, many physicians who are in active clinical practice are either 1) too busy with their practice to make the time to conduct independent medical examinations, especially specialists; or 2) may not be interested in making these exams part of their practice. The constant need for independent medical examinations and physicians to conduct them is a major part of Michigan's No-Fault system, and requires many physicians to fulfill this need.

Anticipated Effects on the Legal System

Independent Medical Examiners

Independent medical examinations are used to evaluate a plaintiff's eligibility for benefits in many PIP claims. Before an independent medical examination can be performed, parties must agree upon the manner, conditions, and scope of the examination.[15] "If the parties are unable to agree upon the manner, conditions, and scope of the examination, then the party requesting the [independent medical examination] must file a motion to seek relief from the court."[16] For the motion to be successful, the requesting party must establish good cause for conducting the examination, and the subsequent court order must specify the manner, conditions, and scope of the examination, in addition to who will be examined before the exam could take place.[17] The party requesting the independent medical examination must demonstrate good cause and compelling need for every aspect of the examination.[18] However, "the court may preclude an examination or procedure that would be unduly dangerous or painful to the person being examined, and order other safeguards and restrictions on the examination that may be appropriate under the circumstances."[19]

In *Muci v State Farm Mutual Automobile Insurance Co*, [20] the Michigan Supreme Court held that MCL 500.3159 controls over MCR 2.311.[21] MCL 500.3159 states, "[i]n a dispute regarding an insurer's right to discovery of facts about an injured person's earnings or about his history, condition, treatment, and dates and costs of treatment, a court may enter an order for discovery.[22] "[A]s justice requires, [a court] may enter an order refusing discovery or specifying conditions of discovery[;]"[23] however, "[w]hen the mental or physical condition of a party is in controversy, . . . the court in which the action is pending may order the party to submit to a physical or mental or blood examination by a physician (or other appropriate professional)[.]"[24]

Under MCL 500.3159, conditions on independent medical examinations may be imposed only if the party seeking to impose the conditions can establish that the examination will cause annoyance, embarrassment, or oppression.[25] However, "when an insured fails to demonstrate good cause that submission to a particular examination will cause annoyance, embarrassment, or oppression, the trial court may not impose conditions on the examination.[26] Courts will also consider if there are reasonable alternative means to collect the requested information without conducting the additional examination.[27]

Shrinking the pool of qualified physicians

On their face, these new restrictions appear to ensure that doctors performing independent medical examinations are actively practicing medicine rather than simply being paid for an opinion because they are licensed. However, these new regulations will have unintended, far-reaching effects on retired

physicians whose primary occupation is conducting medical examinations for the purpose of providing expert reports and testimony in conjunction with PIP claims. For example, these physicians who have not been in active clinical practice or teaching for longer than one year just prior to the examination, because they are retired, would not meet the requirements to qualify as an expert under the new amendment. This is a negative and detrimental consequence because competent and very experienced physicians are suddenly, as of the effective date of the amendments, considered under-qualified, for independent medical examination purposes, which is contrary to the motivation behind the amendment.

In fact, this new amendment provides, in the extreme, that a licensed physician, who has only been in active clinical practice for one year, is qualified to perform an independent medical examination to be used in PIP actions, whereas a physician with 35 years of experience, but who has been retired for two years from active clinical practice, would no longer be considered qualified. It is doubtful that the amendment drafters had this consequence in mind when proposing the amended legislation. It is detrimental to all parties for experienced doctors to be prevented from offering their expert medical opinion in PIP claims and will surely result in much less qualified physicians giving expert opinions and having an impact on the outcomes of PIP claims. Additionally, these new restrictions fail to account for physicians whose medical practice is dedicated to conducting independent medical examinations and are indeed qualified, especially given the need for such physicians under Michigan's No-Fault system.

Enforcement mechanisms

Another major issue with the new restrictions on medical examiners is that the amended legislation does not propose a specific penalty for failure to adhere to the requirements. The courts will have to determine the remedy if the physician performing the independent medical examination fails to meet the requirements. Potential penalties include excluding the physician's testimony and their reports. As a result, parties may be forced to find new physicians and have new, additional independent medical examinations conducted if their experts are suddenly determined to be unqualified, costing courts and parties more time and money unnecessarily. Currently, there is no grace period or opportunity for suddenly unqualified physicians to meet these qualifications before the amendments took effect, which impacts the livelihood of physicians whose practice is almost exclusively dedicated to performing independent medical examinations.

Timeliness of challenges

A related issue is whether attorneys can challenge the qualifications of medical examiners under these new restrictions after the deadline for discovery has passed. If so, prior reports and testimony may have to be stricken from the record, and the affected party will have to petition the court to reopen the discovery period to allow for hiring a new expert and re-examination. These motions would cause a snowball of responses from the opposing party concerning potential prejudice because of the delay that would be associated with reopening discovery.

Retroactivity

The third major issue is that attorneys are attempting to retroactively impose the new restrictions on cases currently pending in Michigan courts. Because of this, courts will have to determine, on a case-by-case basis, whether experts currently involved in PIP actions filed before the amendments took effect, when the new amendments took effect, would be affected by the amendment. While the language of the new amendment does not explicitly state that the amendments apply retroactively to already decided or pending cases, there has yet to be a resolution of that issue.

Conclusion

In conclusion, the Michigan Legislature, in enacting these new amendments to Michigan's No-Fault Insurance Act, may have had good intentions but ultimately fell short. Indeed, if the concern was that those offering medical opinions in PIP cases on either side are not qualified or not offering valid medical opinions and recommendations, they did not remedy this with this new legislation; rather, the amendments will disqualify many who are in fact well qualified. ■

About the Author

Kaitlin Gant *is a third-year law student at Michigan State University College of Law. Ms. Gant plans to sit for the Michigan Bar Exam in July 2020. She intends to practice civil litigation. Ms. Gant graduated from the University of Michigan-Ann Arbor in 2017. Her undergraduate majors were in Spanish, History, and Secondary Education. Her email address is gantkait@msu.edu.*

Endnotes

1 *Background on: No-fault auto insurance*, Insurance Information Institute (Nov. 6, 2018), *https://www.iii.org/article/background-on-no-fault-auto-insurance*.

2 *Id.*

3 Sinas Dramis, *Michigan No-Fault Law Overview*, What is Auto No-Fault Law? Blog (accessed Aug. 1, 2019), *https://autonofault-law.com/michigan-no-fault/overview/*.

4 *Id.*

5 1 M.L.P.2d Insurance § 219 (2nd 2019).

6 MCL 3151.

7 *Id.*

8 19 M.L.P. 2d INSURANCE § 1 (2nd 2019).

9 *Id.*

10 MCL 500.3151(1).

11 *Dyer v. Trachtman*, 470 Mich. 45, 51 (Mich. 2004).

12 *Policy Issue Brief-Physician Licensing*, American College of Preventative Medicine (accessed on Aug. 2, 2019), www.acpm.org/page/IssueBrief_Licensure.

13 2019 HB 4397.

14 *Id.*

15 Steven R. Gabel, Column: Of Counsel: IME's: Are Invasive Techniques and Sedation Permissible?, 75 MI Bar Jnl. 836 (1996).

16 *Id.*

17 MCL 2.311.

18 *Schlagenhauf v. Holder*, 379 US 104, 119 (1964).

19 2 Webster, Michigan Court Rules Practice (3d), p 340.

20 478 Mich 178; 732 NW2d 88 (2007)

21 *Muci, supra,* 478 Mich at 180-81.

22 MCL 500.3159.

23 *Id.*

24 MCR 2.311.

25 MCL 500.3159.

26 *Muci, supra*.

27 Column: *Of Counsel:* "IME's: Are Invasive Techniques and Sedation" (quoting *Schlagenhauf, supra*, 379 U.S. at 118; see also, *2 Martin Dean Webster,* Michigan Court Rules Practice (3d) at 338).

On What Authority? DIFS Exercises its Regulatory Power to Impact No-Fault Reform

By Matthew S. LaBeau, *Collins Einhorn Farrell, PC*

Executive Summary

Since the passage of the No-Fault reform legislation, interested parties have been diligently working to interpret the new statutory language, and determine how it will impact the landscape going forward. The State of Michigan Department of Insurance and Financial Services (DIFS) has issued several orders and bulletins instructing insurance carriers on how to proceed under the new legislation.

The orders issued by DIFS impact the ability of carriers to utilize new statutory language that limits the scope of coverage, and the ability of the Michigan Automobile Insurance Placement Facility (MAIPF) to impose caps on benefits. The bulletins issued attempt to clarify certain provisions under the amended legislation.

A dispute has arisen as to whether DIFS has authority to issue these promulgations, and whether these clarifications modify the language of the statute. Regardless of the outcome of that dispute, observers on both sides of no-fault claims are watching intently.

Introduction

Since the passage of Reform, DIFS issued two orders, and several bulletins, addressing the applicability of the amended provisions of the No-Fault Act. While there are disputes pending as to DIFS authority to issue these pronouncements, they provide clarity as to some of the ambiguities created by the new legislation. This article summarizes the statutory authority of DIFS and impact of its recent orders and bulletins.

DIFS Regulatory Authority

The State of Michigan Department of Insurance and Financial Services (DIFS) is an administrative agency with the purpose of regulating the insurance and financial services industries in the state of Michigan[1]. Under MCL 500.200, DIFS has the obligation to execute the laws of Michigan in relation to insurance. DIFS also has the authority to issue rules and regulations to effectuate the purposes and to execute and enforce the provisions of the insurance laws of Michigan[2]. That being said, DIFS authority comes solely from the legislature, and has no inherent regulatory authority beyond that[3].

DIFS has the authority to investigate insurers for unfair claim practices and initiate civil actions against insurers[4]. Those actions can result in cease and desist orders and monetary penalties.[5]As part of the reform legislation, DIFS was tasked with updating its website to make claims of fraud by claimants and providers, and unfair claims practices by insurers, easier to submit.[6]

The recent legislation limited what factors insurers can consider in establishing or maintaining rates. Insurers are prohibited from considering sex, marital status, home ownership, educational level attained, occupation, postal zone, or credit score.[7] The new legislation also provided for different coverage levels for allowable (i.e., medical related) expenses, and insurers were required to reduce premiums by certain percentages of the average premium in effect as of May 1, 2019 for each coverage level.[8] Insurers are required to create forms that inform policyholders of the potential coverage options for personal injury protection and bodily injury coverages, and the forms must be signed by insureds and submitted to insurers.[9] DIFS is responsible for enforcing these provisions, and approving proposed rates and forms.

MCL 500.6301 establishes an anti-fraud unit within DIFS that is a criminal justice agency dedicated to prevention and investigation of criminal and fraudulent activities. The agency may investigate all persons, including insurers and agents subject to DIFS authority, who have allegedly engaged in criminal or fraudulent activity. The agency may also conduct criminal background checks on individuals seeking licensure, maintain records of fraudulent and criminal activity, and share information with other criminal agencies.

Pursuant to MCL 500.3157a, medical providers are required to submit to utilization reviews performed by an insurer. An insurer may require a provider to explain the necessity or indication for treatment in writing. If an insurer deems treatment to be overutilized or inappropriate, or the cost of a treatment to be inappropriate, the provider may appeal the decision to DIFS and will be bound by the decision. A provider who knowingly submits false or misleading documents or other information to an insurer, the MCCA, or DIFS, commits a fraudulent insurance act and is subject to criminal penalty.

Orders Regarding Scope of Coverage

Before delving into the specifics of these orders, it is important to keep in mind how the order of priority framework was changed by the new legislation. Under the prior law, a pedestrian or occupant who did not have their own coverage, or coverage through a spouse or resident relative, would seek coverage from the vehicles involved in the accident. Those individuals would be entitled to lifetime allowable expenses, or medical related benefits.

Under the new law, individuals who do not have coverage would automatically seek coverage through the Michigan Automobile Insurance Placement Facility (MAIPF)[10], and would be limited to no more than $250,000 for allowable expenses. The only exception is that, in the case where a person is allowed to opt out of coverage, and that coverage lapses, the coverage limit is $2,000,000. Since the amended statutory language did not have a specific effective date, there was an assumption by many that it was entitled to immediate effect[11].

On September 20, 2019, DIFS issued its first order relative to reform.[12] This order was meant to address the "limited number of automobile insurers [that] have attempted to apply the amended provisions to claims made under existing, in-force policies without first submitting revised forms and rates for the Director's review and approval." The order prohibited automobile insurers from utilizing the amendments to the No-Fault Act that affect the scope of coverage without first submitting revised forms and rates to DIFS. In doing so, DIFS relied upon statutory authority requiring such submission before policies can be delivered or issued for delivery[13].

The DIFS order also prohibited insurers from relying upon "conformity to law clauses" as a method of modifying existing policy language, indicating that such reliance would constitute an unreasonable and deceptive policy provision in violation of MCL 500.2236(5). Lastly, the order relied upon the position that the Michigan Insurance Code prohibits automobile insurers from reducing coverage without first providing notice to policyholders.[14] The order also prohibited MAIPF from providing coverage to claims submitted to it based on the amended provisions that limited scope of coverage where there otherwise would have been a policy in place, unless there was prior approval by DIFS.

On September 24, 2019, DIFS issued its second order.[15] This order specifically targeted MAIPF. It prohibited MAIPF from imposing the $250,000 cap on allowable expenses, which is found in MCL 500.3172(7). DIFS asserted that, since that statute references opt-out provisions that do not go into effect until July 2, 2020, the entire statute must have an effective date of July 2, 2020[16]. The order also expressed concern that, if allowable expenses were capped at $250,000, at-fault drivers would be exposed to future allowable expenses without the benefit of the higher mandatory bodily injury policy limits that go into effect on July 2, 2020.[17]

The September 20, 2019 order issued by DIFS is primarily aimed to prevent insurers from denying claims on order of priority, and sending potential claimants to the MAIPF for coverage. Under the terms of the order, insurers must first submit rates and forms to DIFS and have them approved before using the new statutory provisions. The September 24, 2019 order, which is more direct, prohibits the MAIPF from enforcing the $250,000 cap on benefits. So taking these orders together, DIFS is, in effect, prohibiting insurers from sending claimants who are otherwise entitled to coverage, to the MAIPF for coverage, and prohibiting MAIPF from capping benefits.

Not surprisingly, MAIPF did not agree with DIFS interpretation of the law, and filed an action in the Michigan Court of Claims seeking to invalidate the orders. MAIPF argues that the orders are beyond the authority of DIFS. MAIPF also argues that the orders are unconstitutional based on the separation of powers doctrine and constitute an attempt to usurp the power of the Legislature. Lastly, MAIPF argues that DIFS

is ordering it to violate the law because it is being told to deny coverage when the statute indicates it must be provided.

If the Michigan Automobile Insurance Placement Facility prevails, it is important to point out that insurance carriers will have a basis to deny PIP claims on the basis that MAIPF is responsible for benefits. Moreover, at fault drivers and their insurance carriers will face immediate exposure for future allowable expenses, without the benefit of higher limits or fee schedules, when the plaintiff has PIP coverage through MAIPF.

DIFS Bulletins Clarify No-Fault Reform Provisions

DIFS has issued bulletins on a wide range of topics. Some of the bulletins clarify issues that seem self-explanatory. These are the more impactful interpretations issued by DIFS.

Reasonable Charges

A bulletin was issued on June 28, 2019 noting that the fee schedule for medical expenses does not go into effect until July 1, 2021. Therefore, automobile insurers and health care providers were reminded that, until that time, insurers were obligated to pay, and providers were obligated to charge, a reasonable charge. DIFS also confirmed that the changes to MCL 500.3112, permitting providers to file a direct cause of action against insurers, were effective as of June 11, 2019.

Inapplicability of PIP Choice to Self-Insurers

A bulletin was issued on September 27, 2019 related to self-insurers and municipal governmental insurance pools. DIFS noted that these entities did not provide coverage under a policy, but instead a certificate of self-insurance. The language for PIP coverage limits contained in MCL 500.3107c refers to an "applicant or named insured", neither of which applies to a self-insurer or self-insurance pool. It also makes reference to "insurance policies" which these groups do not issue. Therefore, PIP coverage limits (i.e., $50,000, $250,000, $500,000, or unlimited) do not apply to self-insurers or municipal governmental insurance pools.

Liens on Attorney Fees

One of the more noteworthy changes brought on by No-Fault reform was that, under MCL 500.3148(1), an attorney lien could only be claimed if the benefits were both authorized and overdue (i.e., not voluntarily paid benefits)[18]. Many interpreted this as a prohibition on attorneys claiming a fee when benefits were voluntarily paid. A bulletin was issued on October 14, 2019 providing that an injured person could contract with an attorney to assist in the recovery of no-fault benefits, and that an attorney may hold in trust any funds paid to a claimant via a two party check. This would suggest that, as long as there is a contract between the injured person and the attorney, an attorney fee can be charged for payment of voluntarily paid benefits, taking a narrow interpretation of the broad language of MCL 500.3148(1).

Out of State Residents

The reform legislation eliminated the requirement under MCL 500.3163 that authorized insurance carriers file certifications to provide coverage to non-resident policyholders, and eliminated eligibility for no-fault benefits to non-residents unless they owned a motor vehicle registered and insured in Michigan. DIFS clarified on October 18, 2019 that these certifications were valid for accidents occurring prior to June 11, 2019, but had no effect and could not be relied upon to claim coverage on or after that date.

Limits on Attendant Care

DIFS issued a bulletin on November 1, 2019 making it clear that automobile insurers are not be permitted to apply the 56-hour per week limitation on non-professional attendant care under MCL 500.3157(10) until on or after July 2, 2021[19]. DIFS also made note that, under MCL 500.3157(11), insurers were allowed to offer additional hours of attendant care to injured persons. The more significant portion of the bulletin was the assertion that "Insurers' decisions whether to contract for additional attendant care benefits will be subject to the Director's authority to perform utilization review under Section 3157a of the Code, MCL 500.3157a." Thus, it appears DIFS may be reserving unprecedented oversight over attendant care agreements between claimants and carriers.

Looking Ahead

Considering the regulatory authority DIFS possesses over insurance carriers, promulgations such as those referenced above carry great weight. To the extent that those promulgations may contradict statutory language, you can expect that insurers, claimants, or other state agencies or associations to challenge the scope of DIFS authority as it pertains to orders and bulletins, and the accuracy of its analysis. DIFS has signaled that it intends to issue several orders and bulletins going forward to provide guidance to the insurance industry. Only time will tell as to how that guidance is interpreted and received. ■

About the Author

Matthew S. LaBeau *is a partner at Collins Einhorn Farrell, PC. He focuses his practice on defense litigation in first party No-Fault claims, uninsured and underinsured motorist claims, automobile negligence, premises liability, general negligence, and contractual disputes. Matthew has extensive experience in defending catastrophic No-Fault claims, as well consulting insurers regarding catastrophic claims prior to litigation. His email address is* matthew.labeau@ceflawyers.com.

Endnotes

1 MCL 550.991

2 MCL 500.210.

3 *Blue Cross and Blue Shield of Mich v Demlow*, 403 Mich 399 (1978)

4 MCL 500.2026

5 MCL 500.2038; MCL 500.2040

6 MCL 500.261

7 MCL 500.2111

8 MCL 500.2111f ($50,000 - 45% or more; $250,000 - $35% or more; $500,000 - $25% or more; Unlimited – 10%; Opt-Out – no premium charged)

9 MCL 500.3009(6); MCL 500.3107c(2); MCL 500.3107d(3)

10 The MAIPF is an insurance pool that is the insurer of last resort. The MAIPF previously only provided benefits when no PIP coverage is applicable to the injury, no PIP coverage applicable to the injury can be identified, there is a dispute between two or more carriers concerning their obligation to provide benefits, or the identifiable coverage is inadequate due to financial inability to fulfill its obligations. A significant revision to the statute is that additional claimants are eligible to receive benefits through the MAIPF.

11 Const 1963, Art 4, Sec 27

12 DIFS, Order No. 2019-048-M

13 MCL 500.2106, 500.2108, 500.2236

14 MCL 500.2104(5); *Casey v. Auto Owners*, 273 Mich App 388 (2006)

15 DIFS, Order No. 2019-049-M

16 MCL 500.3107d(6)(c) and MCL 500.3109a(2)(d)(ii)

17 The mandatory minimum bodily injury limits prior to July 2, 2020 are $20,000 per person and $40,000 per accident. The limits on or after July 2, 2020 re $250,000 per person and $500,000 per accident, but a policyholder may choose limits as low as $50,000 per person and $100,000 per accident with the submission of certain documentation. MCL 500.3009.

18 MCL 500.3148(1)(a) and (b) –

> An attorney advising or representing an injured person concerning a claim for payment of personal protection insurance benefits from an insurer shall not claim, file, or serve a lien for payment of a fee or fees until both of the following apply:
>
> a. A payment for the claim is authorized under this chapter.
>
> b. A payment for the claim is overdue under this chapter.

19 Under MCL 500.3157(10), the limitation on attendant care only extends to care provided by an individual related to the injured person, domiciled in the injured person's household, an individual with whom the injured person had a business or social relationship before the injury.

What You Don't Know Might Hurt Your Client the Complex and Challenging World of Property Insurance Claims

By Ethan A. Gross and Stuart M. Dorf, *Globe Midwest Adjusters International*

One of the goals as a legal professional is to be "more" to our clients: more than a zealous litigator, a contracts wordsmith or a skilled negotiator. And somewhere during the course of representing your client, you do become more to your client, especially as he or she starts to view you as a trusted advisor – someone they can turn to in their times of need regardless of whether it is in your area of expertise!

While trusted advisors cannot be experts at everything, it is important they do have a working knowledge of certain events that are likely to present issues in the lives of their clients. The world of property insurance claims is one such field. Whether your clients own a home, commercial property or both, it is likely they have an insurance policy to cover their risk.

But having insurance and using insurance (when a claim is made) are two completely different things. Accordingly, the purpose of this article is to provide trusted advisors who do not specialize in first-party property insurance claims a basic understanding of the structure of a property insurance policy and what their clients will encounter when making a property damage insurance claim.

Understanding where to look

Sometimes clients do foolish things like unilaterally enter into contracts they do not read that can affect their largest assets, all the while never bothering to get advice or counsel from you, their trusted advisor! If this does not sound like

your client, think again – it is. Your client did exactly that when they bound coverage on their property insurance.

At its core, an insured's relationship with their insurance carrier is contractual in nature and is governed by a contract more popularly known as an insurance policy. Please remember, an insurance contract is not just any old contract – it is unique, as it is an adhesion contract, so either take it or leave it.

Since many clients do not have the option of leaving it – i.e., forgoing insurance –they enter into these contracts blindly. The fact is most insureds have never read their insurance policy, so they are completely unaware of their rights and responsibilities. Which is not to say that reading the policy is a tremendous help. The typical property insurance policy is very confusing, as it is riddled with provisions that provide cove rage in one section, take it away in another, give it back in yet another section, etc. Most insureds tend to assume they are fully covered so they do not bother with a thorough review of their policy.

But "fully covered" is a myth. No insurance policy exists that covers everything.

From a trusted advisor's perspective, general principles found in common law and even case law regarding liability and damages (in regard to torts) as well as standard contractual issues, for the most part, do not apply. Rather, all the rules of the game of making an insurance claim – all the requirements, obligations, timeframes, even methods of dispute resolution – are for the most part contained within the provisions of the policy. Regardless of whether this is fair or equitable, it is critical to understand the rules of the game and how to comply with them for your client to properly submit their claim and receive the fair and just settlement they deserve.

It is important that trusted advisors have a very basic understanding of the documents they are looking at in the event a client contacts them about an insurance claim. Often when clients refer to their insurance policy, they are usually speaking about one of two documents: either the "dec sheet" or the "body of the policy." A quick overview of each follows.

The Declarations Sheet

Many clients initially think the declaration page, aka the dec sheet, is the entire insurance policy. It is not. The dec sheet identifies the type of property being insured, coverage limits and deductible amounts. Dec sheets also identify additional types of coverage that may not appear in the body of the policy but are offered through an endorsement. The dec sheet does not provide the details of coverage; those details are contained in the body of the policy and all related forms and endorsements.

The policy divides property coverages into three primary categories. There also are numerous other coverages throughout the policy, but the three primary coverages are building, contents and time element:

Building - This category covers the physical structure including items permanently affixed to the structure. In residential policies this coverage is often listed as "Coverage A-Dwelling." In commercial policies, it is typically referred to simply as "Building."

Contents - This covers all items that are not attached to the building/dwelling. As we like to say, "If you take the building, flip it over and shake it, everything that falls out is "contents." In residential policies this is referred to as "Coverage C-Personal Property"; in commercial policies it is referred to as "Business Personal Property."[1]

Time Element Losses - This category provides coverage for additional expenses and/or loss of income suffered by an insured. In residential policies this is referred to as "Coverage D-Loss of Use" or "Additional Living Expenses" and covers the additional cost incurred if a homeowner is forced to live in a temporary accommodation following a covered loss. In commercial policies the time-related coverages are referred to as "Loss of Income" and "Extra Expense." In general, these cover the lost profits as well as other expenses incurred to attempt to maintain operations or minimize lost profits after a covered loss has occurred.

The Body of the Policy

As the old adage goes, "The devil is in the details" and this is especially true when it comes to reading the body of your client's property insurance policy. There are numerous provisions in insurance policies; all are important. With all of the fine print it is extremely important to read the entire policy to understand how the various provisions impact your client's coverage. For purposes of this article we will only address a few key provisions that will always apply.

Definitions. Words and phrases in bold are terms that will be defined in the definitions section. It is critical to see how the policy defines these words and phrases, as the definition impacts the coverage.

Covered Property/Property Not Covered. As the headings indicate, this section identifies what physical property is covered by the policy and what is not. Please note, many policies have additional cover ages via endorsement that are not subject to the policy limit, but rather have their own sub-limit.

Covered Causes of Loss. As mentioned, there is no such thing as "fully covered." This section identifies the types of risks that are covered. Most policies are either "open perils" a/k/a "all risk," or "named perils." An open perils policy covers everything that causes physical damage to covered property – except the numerous perils that are excluded or limited elsewhere in the policy. A named perils policy only covers damage caused by the specific perils listed in the policy, such as fire, lightning, wind, etc.

Exclusions and Limitations. Where the insurance policy grants coverage in one section, it "taketh away" in another; the exclusions and limitations sections are where coverage is minimized/ limited. These must be looked at closely, as there are often exceptions built into the exclusion or limitation that may actually allow for coverage in certain circumstances.

Loss Conditions/Additional Conditions. This section contains miscellaneous conditions and requirements of the insured. These conditions address everything from the insured's duties to the rights of others.

Preparing and Presenting the Insurance Claim

There is a misconception held by most clients that all they have to do to get compensated for a property damage loss is pay their premium. Well, nothing could be further from the truth! Paying an insurance premium is the first step – not the only step – your client must take in order to receive a full and just settlement. Remember, your client already agreed to a number of affirmative obligations when they bought their insurance that only "spring to life" once a claim is made. These duties are usually found in the loss conditions subsection titled "Duties in the Event of Loss or Damage."

Failure to comply with any or all of these "Duties in the Event of Loss or Damage" may result in a denial of the claim. These duties include, among other things, providing prompt notice of the loss, protecting the subject property from further damage as well as the "duty to cooperate," and providing any and all financial, tax, utility or other documents requested by the insurance company in a timely fashion. The most cumbersome and difficult of the obligations placed on your client is their duty to prepare and present their claim to the insurance company.

Additionally, there is a requirement to submit a "Sworn Statement in Proof of Loss." This critical document must include certain information, including the amount of the claim. This must be properly completed, signed by the insured and notarized. By statute this must be submitted within 60 days of the date of loss, unless the time is extended in writing.[2] Many policies provide that the proof of loss is due upon request, which extends the time for filing until requested.

Practice Alert: Michigan courts have upheld claim denials for merely failing to file the proof of loss on time.[3] This is an extremely harsh result; as such, it is important to make your client aware of this deadline.

While the policy tells your client what they need to do, no one is telling your client how to comply with these obligations. For example, "damages" in the world of property insurance are documented using means and methods unique to the insurance industry that are very different from the real world or what our clients would consider common sense. Failing to be aware of how to work within these standard industry practices can be devastating to an insured's recovery.

For instance, in determining loss of income, the insurance policy sets forth a very specific formula for calculating a loss of income claim. A CPA unfamiliar with the formula and related rules may prepare a calculation that seems logical, but when reviewed based on the terms of the policy, may in fact be too high or too low and end by being rejected by the insurance carrier.

The same concepts hold true for building and contents claims. In identifying the amount of loss and damage to repair a building following a fire or o her event there are means and methods used in the industry that are customary. A repair estimate that does not follow these is less likely to be accepted. Similarly, contents claims that are not identified according to industry practices are also not accepted, creating more work and less recovery for insureds.

Leveling the Playing Field for Your Client

In large losses, the insurance carrier will often hire a team of experts to review and/or calculate the claim; remember the relationship the insurance carrier has with your client is and always has been about business, not personal. This team will include forensic accountants, building consultants, inventory specialists, and other consultants as needed. All of these consultants work directly for the insurance company and are typically looking out for the best interest of the insurance company. As most insured are not experts in any of these fields, this gives the insurer and their experts an unfair advantage in the insurance claim negotiations and creates an unlevel playing field.

Your Client has the Right to Hire Their Own Experts

When preparing the claim, it is important the insured take the time to read and understand the policy as well as thoroughly document their losses. Most large losses contain enough complexities that the insured should seriously consider retaining their own experts to assist hem with the process.

As a trusted advisor, it is important you understand the resources and experts available to your clients if they make an insurance claim. These experts may include forensic accountants, building estimators, content specialists and engineers. Additionally, they will also need an expert familiar with the policy and the process who knows how to prepare the claim in the format the insurance company will understand. And, in many cases, the insured will need counsel to deal with direct claim-related issues as well as ancillary issues resulting from the claim, such as landlord-tenant issues, vendor service contracts, customer issues (contractual fulfillment and otherwise), etc.

Your insured also has a right to hire their own insurance adjuster. Adjusters who work exclusively for policyholders, not insurance companies, are called public adjusters. Public adjusters are licensed by the State of Michigan to represent insureds in preparing, presenting and negotiating their firstparty property claims. Professional licensed public adjusting firms often have most of the needed experts on staff and are familiar with the many duties and obligations p l ac ed on your client by the terms of the insurance policy.

An experienced and knowledgeable public adjuster can help level the playing field by advocating or the insured. As the saying goes, "You don't know what you don't know." Many insureds settle claims for substantially less than they were entitled to recover without realizing they left money on the table. That is where the right experts can make all the difference. Of course, as with all professions, if a public adjuster is needed it is important to interview them to confirm they have the capabilities to handle your client's specific claim.

Methods of Dispute Resolution

Property insurance claim disputes, like most disputes, can often be resolved through good-faith negotiations. When an amicable settlement cannot be reached, then resolution of this otherwise typical contract dispute becomes anything but typical.

Dispute resolution in property insurance claims are governed by the insurance policy itself and the Michigan Insurance Code. The insurance code has numerous provisions that may impact the litigation and the resolution. We can only touch on a few of these provisions in the remainder of this article.

The most significant provision in the insurance code when it comes to property insurance claims is MCL 500.2833 – "Fire insurance policy; mandatory provisions; coverage." This statute, and the provisions contained therein, provide substantial governing law in regard to property insurance claims and dispute resolution. MCL 500.2833 provides that all fire insurance policies shall contain the provisions set forth in MCL 500.2833.[4] While the statute specifically references fire insurance policies, most property insurance policies cover a variety of risks in addition to fire; as such, all the provisions would apply. Property policies that do not cover fire – i.e., a flood-only policy – may not be subject to this statute.

In property damage claims there are two main categories of dispute: coverage, and valuation of loss and damage. Coverage disputes may involve drastic matters such as a carrier denying a claim due to alleged arson by the insured. Other coverage disputes may only involve portions of a claim; for example, an insurance company may agree that a claim is covered, but there is a dispute over how a particular coverage is applied. As with other contract disputes, irreconcilable coverage disputes must be resolved in litigation.

In regard to disputes over valuation, these typically revolve around the cost of repair or replacement, the depreciated value of repairs or replacement, and the value of the property prior to the damage, all of which may have implications in regard to possible amounts payable. Uniquely, when there is a dispute over valuation only, litigation is not an available method of dispute resolution. Rather, a process called appraisal, which will be addressed below, is the only method of resolution.

Litigation

When coverage issues cannot be resolved, then the proper recourse is litigation. There are several key factors to be aware of when approaching property insurance litigation, including the statute of limitations and bad faith. As it pertains to the statute of limitations, under a fire insurance policy the time limit is one year, unless extended in writing.[5] It is important to read the policy, as there is typically a provision in the loss conditions titled "Legal Action Against Us" that will set forth the time period for suit.

Notably, Michigan, unlike most states, has a statutory tolling provision for fire insurance policies. The statute provides that the "time for commencing an action is tolled from the time the insured notifies the insurer of the loss until the insurer formally denies liability."[6] Property insurance claims can take more than one year to resolve for a variety of reasons. Tolling Is a great provision that allows the insured and insurer to continue to work together to resolve the claim without forcing the insured into litigation for the sole reason of preserving their rights.

Bad Faith/Extra Contractual Damages/Penalty Interest

In the event a claim cannot be resolved and litigation is filed, the question of bad-faith damages always comes up. While many states have strong bad-faith laws to protect consumers of property insurance, Michigan is very limited in terms of any type of bad-faith protections. For the most part, an insurance carrier can deny a claim in Michigan for any reason and not be subiect to any bad faith penalty or punitive damages.

There is some case law to support arguments for extra-contractual damages in the event the insurance company is found to have been in breach of contract. Even extra-contractual damages are difficult to recover.[7]

One remedy that consumers In Michigan do have is the right to recover 12 per cent penalty interest on delayed payments by an insurance carrier. Insurance claims must be paid within 30 days after the insurer receives proof of the amount of loss.[8] If the insurance carrier fails to make payment within 60 days of proof of the amount of loss, then pursuant to

the Unfair Trade Practices Act, the insurer must pay 12 percent interest starting on day 61.[9] While this interest is often referred to as penalty interest, there is no requirement that the insurer act in bad faith when not issuing payment. It is also irrelevant as to whether the amount owed reasonably In dispute. Any amount unpaid after 60 days from the submittal of the proof of the amount of loss is subject to the 12 percent interest.[10]

Statutory Appraisal

When there is a dispute regarding the actual cash value of the property or the amount of the loss under a property insurance policy, the only remedy is statutory appraisal While technically a form of alternate dispute resolution, statutory appraisal is not voluntary. The parties cannot unilaterally opt out of the appraisal process and resolve these non-coverage related disputes in litigation.[11]

Once either party demands to submit their differences to appraisal, it must go to appraisal. Statutory appraisal is very similar to arbitration. The details of the appraisal process are set forth in the statute,[12] but in a nutshell, the insured and insurer each select an appraiser. The two appraisers then choose a neutral umpire. This creates the appraisal panel. Once any two of the three members on the appraisal panel agree on the amounts, they sign an appraisal award, which becomes binding.

Appraisal is a substitute for judicial determination when it comes to determining value. It is an informal process so the rules of evidence do not apply and the format of each appraisal can vary substantially. Once entered, the appraisal award is binding on the parties. Appraisal awards may only be set aside by the court in cases of "bad faith, fraud, misconduct, or manifest mistake."[13]

When disputes arise and statutory appraisal is demanded, there may be some gray areas as to whether an issue is a coverage dispute or a valuation dispute. Some carriers have attempted to argue that the scope of damage – i.e., how much drywall must be replaced – is a coverage issue and that only the cost of the drywall, for example, is subject to appraisal. That is not the case. Both scope and costs are part of the valuation and are subject to appraisal.[14]

Conclusion

Property insurance claims are complicated. The insurance policy creates a minefield of issues that, if not properly navigated, can blow up and destroy the claim. In a large commercial claim, it will typically involve a bevy of experts on both sides to identify the damages and negotiate the complex terms of the policy. Add a coverage dispute, and the complexity increases exponentially.

For the trusted advisor unfamiliar with the field of property insurance who is approached by a client with a claim, it is important to follow a few simple rules:

1) read the entire policy,

2) learn about the process,[15]

3) encourage the insured to obtain the necessary experts to level the playing field, and

4) if the claim seems to be heading in a bad direction, consider consulting with attorneys who specialize in first-party property claims. ■

About the Authors

Ethan A. Gross, *JD, is the CEO of Globe Midwest Adjusters International, where he exclusively represents property and business owners during the insurance claim process. Mr. Gross frequently presents on insurance claims issues to professional groups throughout the country and has published several articles on a variety of property insurance claim topics. He also presents insurance courses certified by the State of Michigan for continuing education credits. Before joining Globe Midwest as a Fourth -generation public adjuster, he worked as an attorney specializing in first-party property insurance litigation. He is a member of the American and Michigan Bar Associations as well as the National Association of Public Insurance Adjusters, and is the current president of the Michigan Association of Public Insurance Adjusters.*

Stuart M. Dorf, *JD is an SVP at Globe Midwest Adjusters International, where he specializes in exclusively representing commercial property and business owners during the insurance claim settlements process. Stuart is a member of the American, Michigan and Oakland County Bar Associations and is a member of the OCBA Real Estate Committee as well as a member of the Michigan and National Association of Public Adjusters. Stuart is a licensed instructor and presents insurance courses certified by the State of Michigan for continuing education credits.*

Endnotes

1 It should be noted that in commercial policies there can be some overlap in coverage for building and business personal property. Both coverages will include fixtures as well as machinery and equipment that may be properly claimed under either building or business personal property. Where to cover it may depend on who owns it – landlords or tenants – and if it was physically connected to the building.

2 MCL 500 2333(2) This provides that, except as set forth in subsection (1). all fire insurance policies must include the provisions in the prior statute. MCL 500 2832, also known as "the 165 lines." Line 97 contained the proof of loss requirement.

3 *Reynolds v Allstate Insurance Co*, 123 Mich App 488; 332 NW2d 583 (1983). No prejudice need be shown. Failing to timely file is enough unless the policy itself requires prejudice to the carrier. See *Board v Allstate Indemnity Co*, 2011 US Dist, Lexis 85490 2011 WL 3330567.

4 Recently some non-admitted carriers that sell insurance in Michigan have argued they are not subject to any of the provisions of MCL 500.2833, arguing surplus risk carriers are not subject to the provisions of the Michigan Insurance Code. This has been used in attempts to get around the tolling provisions of the statute of limitations in *Palmer Park Square LLC v Scottsdale Ins Co,* ED case no. 16-cv-11536.

The court upheld the denial upheld the denial of an insurance claim for filing outside the two-year limitation period, as set forth in the policy, holding tht the time period was not tolled between the date of loss and the date of formal denial, as set forth in MCL 500.2833(1)(q) opining that the Michigan Insurance Code does not apply to non-admitted carriers. This case was reversed on appeal for other reasons. *Palmer Park Square LLC v Scottsdale Ins Co,* 6th Circuit no. 17-1158, December 22, 2017.

5 MCL 500.2833(1)(q).

6 MCL 500.2833(1)(q) See also footnote 4 regarding non-admitted carriers.

7 For a more detailed review of the limited bad-faith and extra-contractual damages available see "Michigan Recognizes Claims for Bad Faith But the Burden is High, and There Are Many Limitations," Kutinsky, Adam, *Michigan Bar Journal,* March 2019, page 28.

8 MCL 500.2833(1)(q).

9 MCL 500.2006(4)

10 *Griswold v Lexington Ins Co,* 275 Mich App 543; 740 NW2d 659 (2007).

11 *Frans v Harleysville Lake States Ins Co,* 270 Mich App 201**;** 714 NW2d 671 (2006)**.**

12 MCL 500.2833(1)(m).

13 *Auto Owners v Kwaiser,* 190 Mich App 482; 476 NW2d 467 (1991).

14 See *Kwaiser, supra*. *The D Boys, LLC v Mid-Century Ins Co,* 644 Fed Appx 574 (CA 2016) and *Smith v State Farm,* 737 F Supp 2d 702 (ED Mich 2010). See also State of Michigan Department of Insurance and Financial Service Memorandum from the Director of the DFIS dated December 20, 2017 subject "Rescission of Bulletin 2006-07-INS."

15 There are a number of resources available regarding property insurance claims. Perhaps the most beneficial for the practitioner is the ICLE *Michigan Insurance Law and Practice,* edited by Michael H. Fabian, Mark D. Wilmarth and Nicole E. Wilinski.

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33450 W 12 Mile Rd
Farmington Hills MI 48331-3350
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Fax: (248) 553-2020
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No-Fault Corner

Dye v Esurance Property & Casualty Ins Co: Death of the "Insurable interest" Argument in No-fault Claims?

Ronald M. Sangster, *Law Offices of Ronald M. Sangster PLLC*

Lost among the chaos created by the Legislature when it passed the recent nofault reform amendments, 2019 PA 21 and 22, was an important decision from the Michigan Supreme Court regarding precisely who is obligated to maintain insurance on an automobile. For years, nofault insurers were arguing that in cases where their named insureds had no insurable interest in a motor vehicle being insured under their policy, the insurance contract was void as being against public policy. Closely related to this line of reasoning was the Michigan Court of Appeals' decision *Barnes v Farmers Ins Exch*, 308 Mich App 1; 862 NW2d 681 (2014), which held that an owner or registrant of a motor vehicle was obligated to insure it, and their failure to insure their motor vehicle, in his or her own name, triggered the application of the "uninsured motor vehicle" exclusion found at MCL 500.3113(b).

In *Dye v Esurance Property & Casualty Ins Co*, 504 Mich 167, 934 NW2d 6745 (2019), the Michigan Supreme Court overruled *Barnes* and essentially held that even if the owner or registrant of the motor vehicle is not insuring the vehicle in his or her own name, they are not excluded from recovering nofault benefits under MCL 500.3113(b) so long as the vehicle itself is insured – even if a third party is insuring the vehicle in his or her own name.

However, as discussed below, the third party's insurer still may not be responsible for payment of the nofault benefits incurred by the owner or registrant of the subject motor vehicle, based upon application of the priority provisions set forth in MCL 500.3114 and MCL 500.3115. In certain cases, application of the statutory priority provisions will extricate the third party's nofault insurer from paying the owner or registrant's nofault claim, and in these situations, the claim will end up being handled by the Michigan Assigned Claims Plan.

Consider the following scenario, which occurs rather frequently in situations involving families with young drivers. Jack and Diane have a son, John, who graduates from high school when he is 18 years old. When John first obtained his driver's license, Jack and Diane purchased a clean, late model car for John to use. John likes the car so much that he continues to use it throughout his college years. John later has a girlfriend, and together they move into a home in Warren. John utilizes the Warren address for purposes of registering the automobile, but in an effort to help John save some money, Jack and Diane, who live in Shelby Township, agree to keep insuring the vehicle under their auto policy, covering their other automobiles. John and his girlfriend are both listed as drivers under the policy, but the insurance company is never made aware of the fact that ownership of the vehicle has been transferred to John – until, of course, a loss occurs.

Insurable Interest and PIP Claims

As noted below, denial of a claim for PIP benefits, utilizing an "insurable interest" argument, is questionable at best. More often than not, this type of argument fails because unlike the old case law that explicitly tied the validity of an insurance policy to the named insured's ownership of a specific vehicle, this rationale does not apply with regard to PIP claims, for the simple reason that PIP insurance is designed to insure *people*, not *vehicles*.

This issue was first addressed by the Michigan Court of Appeals in *Madar v League General Ins Co*, 152 Mich App 734, 394 NW 2d 90 (1986). In that case, the decedent, Albert Madar, had purchased a six-month auto policy from AAA, which was scheduled to run from November 2, 1982 through May 22, 1983. Midway through the policy term, though, the decedent sold the automobile named in the AAA policy to another individual. He neglected to cancel his auto insurance. Two weeks after he sold the vehicle, and while his AAA policy was still in effect, he was walking across the street when he was struck by a motor vehicle whose owner was insured by League General Insurance Company.

As a result of the injuries he suffered in the accident, Mr. Madar died approximately one and half months later. His estate subsequently filed claims for no-fault benefits with AAA and League General Insurance Company. Plaintiff's position was that AAA occupied the highest order of priority under MCL 500.3114(1). However, if AAA succeeded in its argument that Mr. Madar no longer had an insurable interest in his automobile at the time of his accident, thereby voiding the policy, then League General Insurance Company would occupy the next order of priority pursuant to MCL 500.3115(1).

AAA argued that it was not obligated to afford coverage for this loss, even though its policy was still in effect, because Mr. Madar no longer had an insurable interest in the motor vehicle that was insured under the policy. The Court of Appeals summarized AAA's argument as follows:

> "Plaintiff first argues that once the Plaintiff's decedent transferred his ownership in the vehicle named in the policy, he no longer had an insurable interest and the Personal Protection Insurance coverage automatically terminated. An insurable interest in property is broadly defined as being present when the person has an interest in property, as to the existence of which the person will gain benefits, or as to the destruction of which the person will suffer loss. *Crossman v American Ins Co,* 198 Mich 304, 309, 164 NW 428 (1917). Plaintiff would apply this principal in the automobile context by relying upon *Payne v Dearborn National Casualty Co*, 328 Mich 173, 177, 43 NW 2d 316 (1950), for the proposition that automobile insurance is entirely dependent on ownership by the named insured of the automobile described in the policy, and that there is no insurance separate and distinct from ownership of the automobile. Consequently, Plaintiff argues that since Plaintiff's decedent did not have an automobile on the date of the accident, he could not have no-fault automobile insurance as a matter of law because he had no insurable interest in an automobile."
>
> *Madar*, 394 NW 2d at 92.

The Court of Appeals rejected this argument, though, relying upon the Michigan Supreme Court's decision in *Lee v DAIIE*, 412 Mich 505, 315 NW 2d 413 (1981), in which the Michigan Supreme Court made it clear that:

> "Our decision in this case rests, in the last analysis, upon our recognition that it is the policy of the No Fault Act that persons, not motor vehicles, are insured against loss."
>
> 412 Mich 509; 315 NW 2d 413.

After recognizing that PIP benefits are intended for the benefit of persons, not vehicles, the Court of Appeals had no difficulty rejecting the application of the "insurable interest" arguments in the context of a PIP claim:

> "Thus, there is no requirement that there be an insurable interest in a specific automobile since an insurer is liable for personal protection benefits to its insured regardless of whether or not the vehicle named in the policy is involved in the accident. A person obviously has an insurable interest in his own health and well-being. This is the insurable interest which entitles person to personal protection benefits regardless of whether a covered auto is involved."
>
> *Id*, 394 NW 2d at 92-93.

As a result, AAA, Mr. Madar's personal no-fault insurer, AAA, occupied the highest order of priority for payment of his no-fault benefits, even though he no longer had an insurable interest in the motor vehicle that was being insured under the policy.

The "insurable interest" argument may succeed in cases where the injured claimant has no relationship whatsoever to the named insured. However, for the reasons more fully discussed in the next section, it is usually not necessary to resort to an "insurable interest" argument if the claim can be denied based on a straight priority analysis. This was the situation in the recent unpublished Michigan Court of Appeals' decision in *Bracy v Farmers Insurance Exchange*, Court of Appeals docket No 341837, unpublished decision rel'd September 19, 2019. In *Bracy*, Plaintiff was a pedestrian when she was struck by a motor vehicle owned and operated by one Yolanda Nichols. Because the pedestrian, Bracy, did not have an automobile of her own, she filed a claim for no-fault benefits with the Michigan Assigned Claims Plan, which assigned the claim to Farmers Insurance Exchange. Further investigation showed that at the time of this occurrence, Ms. Nichols' motor vehicle had been listed on a policy of insurance issued by GEICO Indemnity Company to her son, Marcus. However, Marcus had no ownership interest in his mother's motor vehicle. Furthermore, his mother did not reside with her son, either. Therefore, the issue before the Court was whether or not GEICO Indemnity Company was the insurer of the "owner" of the motor vehicle (Yolanda) involved in the accident with Plaintiff. The lower court determined that GEICO did, in fact, occupy the highest order of priority, and GEICO appealed.

On appeal, the Court of Appeals reversed the decision of the lower court and remanded the case back to the lower court with instructions to grant summary disposition in favor of GEICO. In doing so, the Court of Appeals first determined that although GEICO undoubtedly insured the motor vehicle, it did not insure the owner, registrant or operator of the motor vehicle, under its policy terms. (This argument will be explored later in the next section). However, it then addressed the "insurable interest" raised by GEICO. After first observing that most of the cases where the "insurable interest" argument had been struck down involved owners or potential owners of the involved vehicle, the Court of Appeals distinguished those cases by noting that here, GEICO's named insured, Marcus, had no "insurable interest" in his own health or well-being with regard to insuring his mother's vehicle. As stated by the Court of Appeals:

> "Here, GEICO offered undisputed evidence showing that Yolanda was the sole titled owner and registrant of the Lumina when Marcus added it to his GEICO insurance policy in 2013. There is no evidence that Marcus had the use of the vehicle in a manner that might have afforded him the status of

> an owner under MCL 500.3101(2)(l). Nor did he undertake a contractual obligation to obtain insurance or have any intention of acquiring the vehicle as was the case in [*Universal Underwriters Group v Allstate Ins Co,* 246 Mich App 713, 635 NW 2d 52 (2001).] In addition, Marcus had his own insurance and was not a member of Yolanda's household, who could potentially turn to her insurance as a resident relative under MCL 500.3114(1), so his interest in protecting his own health and well-being could not form the basis of an insurable interest in the Lumina.
>
> There is simply no evidence that Marcus had a recognized insurable interest, and Farmers has offered no argument as to what type of alternative interest Marcus may have had that would support the issuance of an insurance policy covering the Lumina. Because Marcus had no insurable interest, the policy was void with respect to the Lumina… and the trial court erred by granting summary disposition in favor of Farmers because GEICO did not issue a valid policy from which Bracy could receive PIP benefits under MCL 500.3115(1)."

The scenario posited above probably falls somewhere in between *Madar, supra* and *Bracy, supra*. That is, we are dealing with whether or not Jack and Diane could potentially have an "insurable interest" in the "health and well-being" of their son, in the event that he was injured in a motor vehicle accident. As a result, I would exercise caution about using an "insurable interest" argument to void a policy in cases involving parental named insureds or their children, and reserve those arguments for cases involving complete "strangers to the insurance contract." As will be noted in the next section, it is simpler to deny the claim based upon a straightforward application of the priority provisions set forth in MCL 500.3114(1) and MCL 500.3114(4). In this regard, the recent nofault amendments do not alter this analysis.

Application of Priority Provision

The Court of Appeals' decision in *Stone v Auto-Owners Ins Co,* 307 Mich App 169, 858 NW 2d 765 (2014) is strikingly similar to the facts involved in our scenario. The *Stone* decision, released a few month earlier than *Barnes,* has been largely ignored because by utilizing the argument in *Barnes*, nofault insurers were able to escape responsibility from paying nofault benefits altogether in situations where the owner or registrant himself had failed to insure the vehicle in his or her own name. In *Stone*, Stephanie Stone was killed in an automobile accident while operating a motor vehicle that was owned and registered in her name.

Neither the decedent, Stephanie Stone nor her husband had an insurance policy on her vehicle. Rather, the widower's parents, John and Linda Stone, had added Stephanie's motor vehicle to their existing policy with Auto-Owners two months before the subject accident. Both the widower and the decedent had been listed as drivers under his parent's auto policy since 2008. However, the named insureds were listed as his parents, John and Linda Stone. There was an issue as to whether or not the agency knew that the vehicle was owned by Stephanie Stone. The lower court determined that Auto-Owners was obligated to afford coverage because it had accepted the premiums for the vehicle from John and Linda Stone, and that through the agency, it knew that Stephanie Stone did not live with them. Auto-Owners appealed.

On Appeal, the Court of Appeals reversed and, in doing so, applied a straightforward priority analysis. First, the Court of Appeals observed that neither the widower nor the decedent were domiciled relatives with Auto-Owners' named insured, John or Linda Stone. Despite the fact that they had both been listed as drivers, the Court of Appeals noted that pursuant to its earlier decisions in *Transamerica Ins Corp v Hastings Mutual Ins Co*, 185 Mich App 249, 460 NW 2d 271 (1990), and *Dairyland Ins Co v Auto-Owners Ins Co*, 123 Mich App 675, 333 NW 2d 322 (1983), simply being designated as a driver under a policy did not convert the drivers into a "named insured." Therefore, Plaintiff was simply not eligible for benefits under MCL 500.3114(1), the "general rule" of priority for payment of no-fault benefits.

Plaintiff then tried to argue that he was eligible for benefits under MCL 500.3114(4), because Auto-Owners Insurance Company was the insurer of the "owner" of the motor vehicle Stephanie Stone was occupying at the time of the accident – Stephanie herself. After reviewing the policy language at issue, the Court of Appeals rejected this argument, noting that there was nothing in the policy that would have extended coverage beyond the "named insured" — John and Linda Stone. Therefore, MCL 500.3114(4) had no application to this claim, either.

Finally, the Court of Appeals rejected the argument that the policy should be reformed, noting that because the agent was an independent agent, the insurance company was not bound by whatever the agent may have known about the true ownership of the vehicle being insured under the policy.

This rationale has been upheld in a couple of unpublished Court of Appeals decisions. For example, in *Culbert v Starr Ind and Liability Co,* Court of Appeals docket No 320784, unpublished decision rel'd 7/16/2015, one Tearra Mosby and her two companions were injured in an automobile accident while Ms. Mosby was driving her vehicle. Ms. Mosby did not have an auto policy of her own at the time of the accident. However, her ex-boyfriend, Traves Fudge, had added the vehicle to his policy with Starr Indemnity and Liability Company.

However, only Fudge was listed as the named insured on the policy, but both Mosby and Fudge were listed as drivers. In the application for insurance, Fudge represented that he owned all the vehicles listed in the application. However, there was no dispute but that the owner of the involved vehicle was Mosby, not Fudge. All three Plaintiffs sued Starr Indemnity Company for their no-fault benefits. The lower court determined that all three individuals were entitled to claim benefits through Starr Indemnity Company and Starr appealed.

On appeal, the Court of Appeals reversed the decision of the lower court and in doing so, engaged in a straightforward priority analysis. First, the court observed that none of the three Plaintiffs were entitled to benefits under MCL 500.3114(1), as they were not the named insureds under the policy, and were not relatives domiciled with the named insured. The Court of Appeals then recognized that even though Mosby had been listed as a driver under the policy, this fact did not convert Mosby into a "named insured" under the Starr Indemnity and Liability Company policy.

The court then engaged in a lengthy analysis of the Starr Indemnity and Liability Company policy language to determine whether or not the policy could be construed to insure the "owner" of the vehicle, Mosby, under its policy language. Significantly, the Court of Appeals noted that the vehicle occupied by the three individuals did not even qualify as "your covered auto" under the policy, because it was not "owned by you" — the named insured! Because the Plaintiffs were not occupying a vehicle that met the definition of "your covered auto," none of the individuals were entitled to benefits under the policy. Simply put, Starr Indemnity Company could not be construed as the insurer of the "owner" of the motor vehicle that the three individuals were occupying at the time of the accident.

Similarly, in *Spectrum Health Hosp v Auto-Owners Ins Co*, docket No 330914, unpublished decision rel'd February 23, 2017, Spectrum Health Hospital attempted to obtain payment of medical expenses incurred by one Angela Grant as a result of a motor vehicle accident. Ms. Grant was driving a motor vehicle owned by her husband, Arthur Grant, but insured under a motor vehicle policy obtained by Mr. Grant's mother, Vera Herington through Auto-Owners Insurance Company. At the time of the accident, neither Angela Grant nor Arthur Grant were living with his mother. However, the vehicle was added to Mr. Grant's mother's policy during a period of time when Arthur Grant was separated from Angela Grant and living with his mother. The lower court ruled in favor of the insurer, and Spectrum Health appealed.

On appeal, the Court of Appeals affirmed the decision of the lower court, and simply observed that:

> "Angela Grant is not entitled to no-fault benefits under Auto-Owners policy because she is not a named insured, and she is not a relative domiciled in the household of the named insured, Vera Herington. MCL 500.3114(1). Angela Grant is also not entitled to no-fault benefits under Herington's insurance policy because Auto-Owners is not the insurer of either Arthur Grant, the owner of the vehicle, or Angela Grant, its operator. MCL 500.3114(4)."

Again, a straightforward priority analysis was sufficient to deny the claims in all three cases.

Dye v. Esurance Property and Casualty Insurance Company

But isn't John, as the titled owner of his motor vehicle, disqualified because he didn't insure it – his parents did. Until July 11, 2019, the answer would have been, "yes," based upon the Michigan Court of Appeals' decision in *Barnes, supra*. In *Barnes*, the co-owner of a motor vehicle attempted to have the vehicle insured through a friend from church, under his policy with State Farm. The co-owner was subsequently involved in a motor vehicle accident while driving the vehicle. She turned to State Farm for payment of her benefits. State Farm denied the claim on the basis that (1) the Co-owner of the vehicle was not the "named insured" under the State Farm policy, and (2) because there was nothing in the State Farm policy language that would have rendered State Farm as the insurer of the "owner" of that vehicle. After all, State Farm's named insured had no ownership whatsoever in that vehicle. Plaintiff then turned to the Michigan Assigned Claims Plan, which had assigned the claim for Farmers Insurance Exchange. Farmers Insurance Exchange denied the claim on the basis that as an "owner" of the motor vehicle, Plaintiff was required to insure it in her own name. Because she failed to insure the vehicle in her own name, she was disqualified from recovering benefits. The Court of Appeals ruled in favor of Farmers Insurance Exchange. Thereafter, insurers routinely took the position that even though a vehicle may have been insured by a third party, coverage was denied because it was not the owner or registrant who insured it.

However, on July 11, 2019, the Michigan Supreme Court issued its decision in *Dye v Esurance Property and Casualty Ins Co*, 504 Mich 167, 934 NW 2d 674 (docket No 155784, rel'd 7/11/2019). In a 5-1 decision, authored by Justice Zahra, the Supreme Court observed that MCL 500.3101(1) only requires that the owner of a vehicle "maintain security" on that vehicle, but does not state *how* the owner must "maintain" insurance. All that is required is that the vehicle itself be insured and, in *Dye*, there was no doubt but that the vehicle was insured at the time of the accident. As to *where* the injured party would turn to for payment of the benefits, the matter was remanded back to the circuit court with instructions to apply an earlier settlement agreement that had been reached between the two disputing insurers, Esurance Property and Casualty Insurance Company and GEICO Indemnity Company.

In *Dye*, Plaintiff had been injured while occupying his own motor vehicle, which he had asked his father to register and insure for him. His father obtained the insurance through Esurance. Plaintiff's wife owned the motor vehicle that was insured by GEICO. In fact, GEICO and Esurance had reached a tentative agreement whereby the insurers agreed to pay the benefits on a 50/50 basis. Before the settlement agreement could be finalized, though, the Michigan Court of Appeals released its published decision in *Barnes, supra*, at which point Esurance took the position that because Plaintiff was operating a vehicle that he owned, but which was not insured in his name, but was insured under his father's name, Plaintiff was disqualified from recovering benefits. Although the Court of Appeals had affirmed Esurance's position, based upon its earlier, published decision in *Barnes, supra,* the Supreme Court reversed and, in overruling *Barnes, supra,* the court simply noted that the NoFault Act only requires that the owner or registrant "maintain" insurance on the vehicle. The Act does not say *how* that insurance is to be "maintained." Because Plaintiff had "maintained" insurance on his motor vehicle, through his father's insurance policy, the Supreme Court concluded that Plaintiff was not disqualified from recovering benefits under MCL 500.3113(b).

Justice Clement dissented and posited a situation where a vehicle may be "insured" but the insurance may not cover the "owner" of that vehicle:

> "To illustrate, let's say Plaintiff hit a pedestrian not covered by a personal or household policy. The priority scheme, MCL 500.3115(1) directs the hypothetical pedestrian to submit a claim to 'insurers of owners… of motor vehicles involved in the accident,' but since Plaintiff has no insurer, the pedestrian's claim would be outside the priority scheme, and he or she would be limited to recovery through the Assigned Claims Plan. The pedestrian's PIP benefits would then be funded through increased rates for all policy holders, as though the pedestrian were a hit and run victim."

In my opinion, Justice Clement's analysis, regarding the end result, is spot on. In the scenario referenced above, the vehicle's owner, John, properly "maintained" insurance on the vehicle, through Jack and Diane's policy. As a result, he is not disqualified from recovering benefits under MCL 500.3113(b). However, utilizing the straightforward priority analysis discussed above, he now turns to the Michigan Assigned Claims Plan for his benefits — just as predicted by Justice Clement in her dissent! This is because John is not domiciled with his parents, Jack and Diane and, as a result, there is no coverage available under MCL 500.3114(1). Jack and Diane are no longer "owners" of John's motor vehicle, either. Therefore, under the former version of MCL 500.3114(4)(a), there is no coverage through Jack and Diane's insurer, as the insurer is no longer the insurer of the *owner* of the motor vehicle occupied by John. Therefore, John turns to the Michigan Assigned Claims Plan for payment of his nofault benefits. Under the new reform amendments, John likewise goes directly to the Michigan Assigned Claims Plan, as he is no longer domiciled with his parents.

In the majority opinion, Supreme Court made reference to the potential for fraud, but apparently gave it short shrift:

> "GEICO also raises the specter of fraud to favor its interpretation by claiming that
>
> > 'For the system to work for all members of the pool, risk must be allocated and managed as accurately as possible. Through MCL 500.3101(1), the Michigan legislature recognized that what matters most for nofault insurance is the identity of the vehicle owner or registrant. Otherwise, vehicle with high risk factors would be able to avoid premiums applicable to the risk they present by adding their vehicles to the policies of others, including friends and even roommates. And the problem is not resolved owners of other vehicles to be listed as drivers because listed drivers do not fill out applications; they do not receive the same scrutiny as an applicant.'
>
> First, as Plaintiff rightly points out, there is no indication of fraud in this case. Second, 'this court has been clear that the policy behind a statute cannot prevail over what the text actually says. The text must prevail.' *Elezovic v Ford Motor Co*, 472 Mich 408, 421-422, 697 NW 2d 851 (2005). In other words, the specter of fraud does not distract us from our goal of interpreting the applicable statutory language to determine the rule of law. Third, the legislature clearly understands how to enact laws to mitigate fraud within the No Fault Act."
>
> *Dye*, slip opinion at page 23, fn 66.

In light of this footnote, the author cannot help but wonder if the Supreme Court is casting some doubt on an insurer's ability to rescind a policy for fraud, notwithstanding its holding in *Bazzi v Sentinel Ins Co*, 502 Mich 390, 919 NW 2d 20 (2018), decided one year earlier.

In any event, the court's holding in *Dye, supra* was recently applied by the Court of Appeals in *Howard v Progressive Michigan Ins Co,* docket No 343556, unpublished decision rel'd 10/15/2019, in which the court determined that Plaintiff was

eligible for no-fault benefits while driving a motor vehicle that he owned, but which was insured by his wife under her policy with Progressive.

Concluding Remarks

It will be interesting to see how subsequent appellate court decisions apply the Supreme Court's decision in *Dye*. The Supreme Court seems to be saying that so long as there is insurance on the vehicle itself – regardless of who is insuring it – the owner or registrant of a motor vehicle who is injured while occupying that vehicle will be entitled to benefits. In light of the recent order from the Insurance Director, 19-049, even if the owner, John, ends up filing the claim with the Michigan Assigned Claims Facility, he will at least be able to recover lifetime, unlimited benefits if the loss occurs prior to July 2, 2020. After that date, though, he will be capped at recovering "allowable expense" benefits at $250,000.00, regardless of whether or not Jack and Diane may have opted for higher coverage limits on their own policy, covering John's vehicle. It will also be interesting to see if the Legislature tweaks these amendments as the effective date draws nearer. ■

Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*

Michigan Supreme Court

CGL coverage and construction defect claims

Skanska USA Building Inc v
M.A.P. Mechanical Contractors, Inc
Order granting leave
___ Mich ___; 933 NW2d 703 (2019)

On October 18, 2019, the Supreme Court granted leave to address commercial general liability coverage for construction defect claims. The order requires the parties to brief two specific issues. The first is whether "the definition of 'occurrence' in *Hawkeye-Security Ins Co v Vector Construction Co*, 185 Mich App 369; 460 NW2d 329 (1990), remains valid under the terms of the commercial general-liability policy at issue here." The second is whether "the plaintiff has shown a genuine issue of material fact as to the existence of an 'occurrence' under those terms."

Michigan Court of Appeals – Unpublished Decisions

Lack of homeowners coverage in fatal stabbing case

State Farm Fire & Cas Ins Co v Ravenscroft
Docket No. 345377
Released September 17, 2019

Defendants filed a wrongful death action against their son-in-law after he fatally stabbed his wife (defendants' daughter) multiple times. He had a history of auditory hallucinations and paranoia, and was found not guilty by reason of insanity at his criminal trial. State Farm was the couple's homeowners insurer. It defended the husband in the wrongful death action under a reservation of rights and pursued this declaratory judgment action to determine whether the injury was the result of an occurrence, and if so, whether the injury was expected or intended. The trial court relied on the insanity verdict to find an occurrence and lack of intent to injure, but the Court of Appeals reversed. Regardless of the husband's mental illness, "the death of Kristy Jo was not the result of an accident." No reasonable person could find "that Noah accidentally stabbed his wife twenty-four times . . . ." Nor was it possible to conclude, based on the multiple stabbings, "that the harm inflicted was not intended." Given the lack of an occurrence and the expected or intended injury, State Farm owed no defense or indemnity under the homeowners policy.

Bazzi applied to a commercial property loss

DOA DOA Inc and Garden City Real Estate, LLC v
Primeone Ins Co
Docket No. 339215
Released October 31, 2019
Supreme Court lv app pending

Primeone Insurance rescinded a commercial policy after a fire destroyed a building in which the named insured, Doa Doa, operated a bar. Another entity, Garden City Real Estate, owned the building. The Court of Appeals allowed Primeone to rescind coverage for the named insured's loss of business because the owner falsely answered questions on the insurance application about the frequency of police calls to the premises. The insured reported one call during the preceding year. Police records documented nine calls, all involving fights or other acts of violence. The information withheld was material because Primeone's underwriting guidelines barred coverage for

locations involving two or more assault or battery incidents over a period of three years.

The Court of Appeals remanded for further proceedings on coverage for the property owner. Garden City Real Estate was supposed to be named as an additional insured for all coverages, but was only named as an additional insured for liability coverage. One issue on remand was whether the policy issued should be reformed to include full coverage based on a mutual mistake. If so, the second question to be addressed is whether Garden City Real Estate is an innocent party and whether the balancing of equities discussed in *Bazzi v Sentinel Ins Co,* 502 Mich 390 (2018) warranted coverage for that insured.

Accrual of a cause of action for life insurance benefits

Payne v Ohio Nat'l Life Assurance Corp
Docket No. 344060
Released November 19, 2019

Plaintiff submitted a claim for life insurance benefits in 2017, following the death of her husband. She learned for the first time that the policy had been cancelled in 1999 for lack of premium payments. Plaintiff filed suit on the ground that Ohio National never sent the notice of cancellation as provided for in the policy. That notice would have triggered a grace period of 31 days from the date on the notice. Ohio National moved for summary disposition based on the six-year statute of limitations for contract actions. The trial court granted the motion but the Court of Appeals reversed. The Court of Appeals held that plaintiff's cause of action under the life insurance policy did not accrue "until the claim could actually be brought," that is, until "the date on which the defendant's breach harmed the plaintiff," which was the death of her husband. The Court of Appeals remanded the case for further proceedings, which would include a determination of whether the policy was properly cancelled.

When is a vehicle "involved in the accident" for no-fault property damage

Dept of Transportation v National Interstate Ins Co
Docket No. 343009
Released November 26, 2019
Request for publication pending

National Interstate insured a trucking company hired to transport an oversized load across Michigan roads. MDOT required two escort vehicles, one in front and one behind. The lead escort vehicle, insured by Frankenmuth, was equipped with a measuring rod to test clearances before the truck negotiated an underpass. At one location, the driver of the lead vehicle failed to issue a timely warning of insufficient clearance and the truck caused significant damage to a bridge on US 23 in Monroe County. The state sued both insurers for the property damage under Michigan's no-fault act. National Interstate asked the court to rule that the insurers shared responsibility, but Frankenmuth opposed the request.

The Court of Appeals found coverage under both policies because the lead escort vehicle was "involved in the accident" within the meaning of MCL 500.3125. MDOT expressly required a lead vehicle with height measuring equipment to prevent the truck with an oversized load from proceeding through underpasses without adequate clearance. Evidence established that the lead escort was in fact performing this function, regularly communicating with the driver about clearances, but failed to timely warn of this particular one, which tested too low. Because the lead vehicle insured by Frankenmuth "perpetuated the motion of another vehicle [the truck] that caused property damage" to the bridge, it was actively involved in the accident. Frankenmuth shared in the coverage.

General liability policy exclusion for injuries to workers on construction site

Estate of Messenger v Atain Ins Co
Docket No. 344690
Released December 26, 2019

An endorsement in Atain Insurance Company's commercial liability policy for this insured general contractor excludes coverage for bodily injury to employees, to subcontractors and their employees, to temporary and leased workers, and to volunteer workers. Atain relied on that endorsement to decline coverage for a claim filed against its insured by a subcontractor injured on the job site. After the declination of coverage, the insured entered into a consent judgment with the injured subcontractor for policy limits and assigned its rights under the insurance contract. Both the trial court and the Court of Appeals enforced the plain language of the contract, which clearly excluded coverage for the subcontractor employee's bodily injury claim.

Sixth Circuit Court Of Appeals

Asbestos litigation and insurer recoupment of defense costs

Continental Cas Co v Indian Head Industries
Case No. 18-cv-2152
Decided October 23, 2019

After fourteen years of litigation, which ended with a 6th Circuit decision in 2016 affirming the trial court's pro rata allocation of indemnity and defense costs between insurer and insured, Continental filed this new suit against its insured to recoup defense costs paid above its share. The district court dismissed the action as untimely and further found that relief was barred by the prior action. The 6th Circuit disagreed and remanded the case for further proceedings. The current request for relief does not ask the courts to amend or other-

wise alter the declaratory judgment in the prior proceeding. The new suit is authorized by 28 USC § 2202, which allows a party to seek "further necessary or proper relief based on a declaratory judgment."

Federal District Court – Eastern District Of Michigan

No covered "cause of loss" for water damage

Christ Church of the Gospel Ministries v Guideone Mut Ins Co
Case No. 19-cv-11208
Decided November 19, 2019

Guideone Mutual Insurance denied this insured's claim for water damage to the insured property. The water intrusion occurred while a roofing contractor was installing a new roof and failed to properly tarp the exposed areas after removing the old shingles. The policy excluded "coverage for interior water damage, unless the building first sustains damage from a 'covered cause of loss.'" Covered causes of loss were events such as a windstorm or hail. The court agreed there was no covered cause of loss involved in this claim, only a contractor's failure to secure the exposed roof. The court granted Guideone's motion for summary judgment on lack of coverage.

Auto policy business use exclusion not applicable

Allstate Ins Co v Stack
Case No. 18-cv-12999
Decided December 18, 2019

Insured who was driving from his home to his place of work in order to deliver business documents in his possession was merely commuting from home to work when he caused this fatal accident. He was a corporate official carrying documents to work in his car; he was not performing courier work. The business exclusion in his personal umbrella liability policy did not apply as a bar to liability coverage. ■

Legislative Update: Halfway Through the Legislative Cycle

By Patrick D. Crandell,
Collins, Einhorn, Farrell PC

The Legislature rested in December and resumed its work in January. We are now halfway through the two-year legislative cycle and, after modifying No-Fault, the focus has been on a supplemental budget and road funding. So activity in the House and Senate Insurance Committees remains slow. But there has been movement on a few bills since the last update:

- **Felony and Licensing –** HB 4044 limits the effect of a felony on an insurance producer's licensing (only felonies involving dishonesty or breach of trust would impact a producer's license) ***Passed the House (109-0) on 6/20/19; Passed the Senate (35-1) on 11/7/19; Signed by the Governor on 11/21/19 (PA 124'19 with immediate effect)***
- **Reimbursable Chiropractic Expenses –** HB 4449 removes certain chiropractic services from the list of non-reimbursable personal injury protection benefits ***House Insurance Committee adopted H-1 Substitute on 4/18/19; Referred to House Committee on Ways and Means on 6/20/19; Passed by the House (102-5) on 12/10/19; Referred to the Senate Insurance and Banking Committee on 12/11/19***
- **Privacy policies –** SB 172 modifies the requirements for insurers to provide privacy policies to customers ***Passed the Senate (35-2) on 11/5/18; Referred to the House Insurance Committee on 11/5/19***

New Bills

And, as always, members continue to introduce new bills (1310 in the House and 695 in the Senate), with several new referrals to the House and Senate Insurance Committees:

- **Restriction on territorial grouping –** HB 5096 would amend the Insurance Code to prohibit automobile insurers from establishing rates based on the insured's postal code and from grouping risks by territory
- **Cap on physician visit co-pay –** HB 5111 would amend the insurance code to prohibit a health insurer from issuing a policy that requires more than a $5.00 co-pay for primary care physician visits
- **Change to agent and broker fees –** HB 5174 would amend the insurance code to modify the fees that personal and surplus lines agents or brokers can charge in addition to commission ***Referred to the House Insurance Committee on 10/29/12; Referred to the House Committee***

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Legislative Update Continued from page 23

on Ways and Means on 12/3/19; Passed by the House (108-0) on 12/11/19

- **Health and life insurance reserves –** HB 5241 would remove a provision that currently exempts certain health and life insurers from establishing reserves using a principle-based valuation (per the NAIC *Valuation Manual*) ***Referred to the House Insurance Committee on 11/13/19; Referred to the House Committee on Ways and Means on 12/3/19; Passed by the House (103-2) on 12/4/19; Referred to the Senate Insurance and Banking Committee on 12/5/19***
- **Supervisor of internationally active group –** HB 5242 would amend the Insurance Code to authorize the Director of the Department of Insurance and Financial Services to act as or appoint a group-wide supervisor for an internationally active insurance group (required for NAIC accreditation) ***Referred to the House Insurance Committee on 11/13/19; Referred to the House Committee on Ways and Means on 12/3/19; Passed by the House (103-2) on 12/4/19; Referred to the Senate Insurance and Banking Committee on 12/5/19***
- **Internal audits -** HB 5243 would amend the Insurance Code to require an internal audit function (IAF) for certain insurers and defines the organization of and duties for an IAF ***Referred to the House Insurance Committee on 11/13/19; Referred to the House Committee on Ways and Means on 12/3/19; Passed by the House (103-2) on 12/4/19; Referred to the Senate Insurance and Banking Committee on 12/5/19***
- **Surprise billing protection –** SB 570 would amend the Public Health Code to add Article 18 (Surprise Billing Protections), requiring nonparticipating providers to accepts as payment for certain health care services either the average amount negotiated with a health benefit plan or 150% what Medicare covers (whichever is greater)
- **Grounds for discipline –** SB 571 would amend the Public Health Code to include violations of SB 570 and 572 as grounds for discipline
- **Direct billing for emergency services –** SB 572 would amend the Public Health Code to permit nonparticipating providers to bill patients for nonemergency services not covered by the patient's health insurance, only if the patient consents in writing and certain conditions are met
- **Fine for surprise billing –** SB 573 would amend the Public Health Code to prescribe a fine for violating SB 571 ■