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In this Issue

Section News

Feature Articles

Columns

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Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.

From the Chair—Welcome 2021!

Nicole E. Wilinski
Collins Einhorn Farrell

The past year was certainly challenging for many of us, both as legal professionals and personally. But while this holiday season has been different for many of us, I hope that all of you still had very happy holidays.

Although the COVID-19 pandemic isn't completely behind us, yet**,** hope is on the horizon. And, while we will continue to host Zoom events and meetings until it is safe to once again gather in person, it is my hope that we will again be able to be together in person for the 2021 annual meeting.

I want to thank **Jason Liss**, our past Chairperson for his great leadership and enthusiasm during the past year and congratulate **Lauretta Pominville** on becoming Chairperson Elect, **Rabih Hamawi** on becoming Secretary and **Patrick Crandall** on becoming Treasurer. We also have a great group of hardworking council members this year.

2020 Annual Meeting and Program

On October 27, 2020, we held our annual business meeting and program via ZOOM. A huge thanks to our presenters **Edward Bouchard** (Kotz Sangster) and **Patrick Crandall** (Collins Einhorn Farrell) who braved the ZOOM webinar platform and walked us through the impact of the recent Michigan Supreme Court's recent decision in *Skanska USA Building Inc v M.A.P. Mechanical Contractors, Inc.,* which held that unintentionally faulty subcontractor work that damages and insured's work product constitutes an "occurrence" under a commercial general liability policy. For those who missed the program and are interested, we do have a video of the presentation. If you'd like view it, please send me an email: *Nicole.Wilinski@ceflawyers.com*.

Scholarship

Our section was pleased to award its third annual $5,000 scholarship to a law student interested in insurance law in 2020.

The scholarship award was presented during our business meeting to Cassandra Lee. Ms. Lee is a law student at Wayne State University School of Law.

Any student currently enrolled at a Michigan law school is eligible to apply for the scholarship. This year's topic and deadline will be posted on the State Bar of Michigan's website in the coming weeks. But, interested applicants can also reach out to me for additional information as well.

Next Meeting, Suggestions and Section Involvement

Our next meeting is on January 14, 2021 at 4:00 p.m. It will be held be ZOOM. If you are interested in attending, please email me so I can provide you with the ZOOM ID and password.

Additionally, we look forward to hosting two or more additional educational and social events during the year. Whether we do so via ZOOM or in person will be determined as the year proceeds. If you have suggestions for topics or speakers for programs, please share!

Finally, this section is made up of a diverse group of policyholder and insurer sided attorneys. If you have any interest in getting more involved with the council, a great way to start is by attending a meeting or writing an article for Journal.

Happy New Year to everyone. I hope to see many of you this year at our events and meetings whether that ends up being virtually or in person. ■

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Editor's Notes

By Hal O. Carroll, *www.HalOCarrollEsq.com*

The *Journal* is now beginning its fourteenth year and, with the efforts of many, is surviving the Covid-19 virus.

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.

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

The *Journal* is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at *HOC@HalOCarrollEsq.com*. ■

Insurers are Denying COVID-19-Related Business Income Loss Claims Based on Arguments of Convenience[1]

By Adam Kutinsky

Whether there is insurance coverage for COVID-19 related business income loss depends on the specific language of each insurance policy and the unique facts of each claim. However, this truth has not prevented the insurance industry and defense lawyers from publishing opinion commentary which make broad arguments against coverage for the claims. And, while there is limited use in making an argument in the absence of specificity, the positions taken by insurers demands a response on behalf of their policyholders.

What is good for the insurance company goose is good for the policyholder gander, so let us begin with this broad statement: Insurers marketed and sold business income loss insurance with a promise to cover claims arising from unanticipated events. But now that an unanticipated event is caused the deepest recession since the Great Depression, they are refusing to honor that promise. And in an almost comical twist, the industry is making arguments that it routinely rejects when made by policyholders.

Insurance companies generally do not consider the financial impact of their decisions on policyholders and the law does not require them to. Insurance companies pay or deny claims based on policy language and an appeal to sympathy will fall on deaf ears. Resultantly, if a home or business burns to the ground and the insurer denies coverage, a possible bankruptcy for the policyholder will not affect its decision. Yet, when the COVID-19 pandemic led to thousands of business income loss claims, the insurance industry published commentary insisting the sheer number of claims would bankrupt the industry.

As insurers began denying COVID-19 related business income loss claims, state legislatures introduced bills to prohibit the companies from denying coverage. The insurance industry understandably expressed outrage over government infringement on their freedom to contract. Insurers promised constitutional challenges based upon the Contracts Clause and were largely successful in their lobbying efforts to prevent the bills from becoming law. Yet, those same insurers who championed freedom to contract were very supportive of efforts to grant them immunity from COVID-19 related lawsuits. *See, Michigan House Bills 6030, 6031, 6032 and 6101.*

In litigation, insurers often argue that imposing coverage for risks not included in their premium calculation would be inequitable and inconsistent with their intent. COVID-19

is a virus and insurers contend that business income loss coverage was not meant to cover virus-related claims. But the industry was informed of the virus risk 14 years ago and provided an ISO form virus exclusion to attach to policies. Specifically, in 2006, ISO circulated an endorsement to exclude virus coverage, yet insurers continued to issue policies without the endorsement. Using the insurers' own reasoning, policyholders must have paid a premium for virus coverage under those policies that do not exclude it.

Even in the absence of a virus exclusion, insurers continue to deny COVID-19 related business income loss claims. The most common argument made is that policy language requires "direct physical loss or damage" to insured property. Since virus does not cause physical destruction, insurers argue that any resulting loss is not covered. But that is not a proper reading of "direct physical loss or damage." Rather, the "or" between "loss" and "damage" means either loss *or* damage is covered. When COVID-19 led to the shutdown of businesses, their owners suffered direct physical loss to property, commonly referred to as "loss of use," which does not require physical destruction to be covered under the policy language. And, although the language appears very clear, any ambiguity is interpreted in favor of coverage.

Since each claim is different and policies take different forms, broad arguments have limited utility. However, insurer commentary on COVID-19 related business income loss claims demands a response from policyholders. As explained above, the commentary from the industry relies on arguments of convenience, which insurers will continue to reject when made by policyholders. ■

About the Author

Adam Kutinsky *represents insurance policyholders and is a former chairperson of the Insurance and Indemnity Section. He can be reached at (248) 762-8644 or adam@kutinsky.com.*

Endnote

1 A version of this article appeared in *The Detroit News* on October 1, 2020.

Sweeping the Cobwebs off the Exclusions for Faulty Workmanship in the Standard Commercial General Liability Policy

By Margaret A. Cernak, *Collins Einhorn Farrell, PC*

For the past thirty years, faulty workmanship, standing alone, hasn't constituted an "occurrence" under Michigan law. Perhaps fittingly, the Michigan Supreme Court chose 2020 as the year to change what we thought we knew.[1] In *Skanska*, the court endorsed the rationale that "an insured's own defective workmanship is excluded from coverage via the explicit exclusions, not in the initial grant of coverage."[2] However, the court left "any determination regarding the extent to which the damages to the [insured's] work product are covered under the policy to the lower courts."[3] But, because the lower courts typically found that coverage was not triggered due to lack of an "occurrence," they previously said that "there [was] no need to address whether any of the exclusions apply."[4]

Now there is a need to address the exclusions.

The standard CGL policy form, CG0001, contains a series of exclusions that potentially apply to construction defect claims and suits:

- (j)(5) & (6) Damage To Property
- (k) Damage To Your Product
- (l) Damage To Your Work
- (m) Damage To Impaired Property

While it is the insured's burden to establish that its claim falls within coverage—i.e., a claim for "property damage" caused by an "occurrence"—the insurer bears the burden of proving that an exclusion negates coverage.[5]

Here's an overview of these exclusions.

Exclusions j(5) and j(6): Damage to Property - The "Work in Progress" Exclusions.

> **j. Damage To Property**
>
> "Property damage" to:
>
> * * * *
>
> **(5)** That particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the "property damage" arises out of those operations; or
>
> **(6)** That particular part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed on it.
>
> * * * *
>
> Paragraph **(6)** of this exclusion does not apply to "property damage" included in the "products-completed operations hazard".

The "work in progress" exclusions apply only to claims involving ongoing, not completed, operations.[6]

Temporally, courts interpret the language of (j)(5)—"that particular part of real property on which you . . . *are performing operations*"—to mean that "the only damage which is excludable is damage which occurred at the time defendant worked upon the property."[7] The (j)(5) exclusion is limited in both time and space: it bars coverage for property damage to "any real property on which the defendant [is] physically performing operations but not to surrounding or adjacent property."[8]

As to (j)(6), the policy itself says the exclusion does not apply to "property damage" included in the "products-completed operations hazard." The standard CGL policy defines "products-completed operations hazard" as including "all 'bodily injury' and 'property damage' occurring away from premises you own or rent and arising out of 'your product or 'your work,' except . . . work that has not yet been completed or abandoned."

Courts apply exclusions (j)(5) and (j)(6) only if the damage happened while the insured was in the course of its work, and only to damage directly connected to the defective work. However, the Michigan Court of Appeals declined to read the exclusions as literally requiring that "actual, physical operations had to be underway at the exact moment of damage."[9] In unpublished opinions, the court of appeals has held that:

- Exclusion (j)(5) barred coverage only for repairs to the defectively installed roof and not to interior damage caused by water leaking through the roof;[10]
- "That particular part of" property exclusions barred coverage for structural collapse where the subcontractor improperly installed bracing during the course of construction;[11]
- Exclusions (j)(5) and (6) barred coverage for costs to repair damaged grass where the insured improperly applied herbicide to the lawn;[12] and
- Exclusions (j)(5) and (6) barred coverage for costs incurred to repair and remediate a retaining wall built by the insured, which shifted while work was ongoing.[13]

Courts analyzing whether an insured was performing operations on a "particular part" of real property under (j)(5) or a "particular part" of any property under (j)(6) often look to the scope of the work called for by the insured's contract, as well as the actual operations performed by the insured.[14] Likewise, on the issue of whether the insured was still "performing operations" at the time of the loss or whether its work was completed, courts require factual evidence as to the status of the insured's work.[15]

Courts apply exclusions (j)(5) and (j)(6) only if the damage happened while the insured was in the course of its work, and only to damage directly connected to the defective work.

Exclusions (k) and (l): The "Business Risk" Exclusions.

> **k. Damage To Your Product**
>
> "Property damage" to "your product" arising out of it or any part of it.
>
> **l. Damage To Your Work**
>
> "Property damage" to "your work" arising out of it or any part of it and included in the "products-completed operations hazard."
>
> This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

The "(k) Damage To Your Product" exclusion is tied to the policy's definition of "your product." The standard CGL policy defines "your product" as follows:

> 21. "Your product":
>
> a. Means:

(1) Any goods or products, other than real property, manufactured, sold, handled, distributed or disposed of by:

(a) You;

(b) Others trading under your name; or

(c) A person or organization whose business or assets you have acquired; and

(2) Containers (other than vehicles), materials, parts or equipment furnished in connection with such goods or products.

b. Includes:

(1) Warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of "your product"; and

(2) The providing of or failure to provide warnings or instructions.

c. Does not include vending machines or other property rented to or located for the use of others but not sold.

Implied warranties are within the definition of "your product."[16]

Exclusion (m) applies where the insured's defective work or product has rendered other property less useful or unable to be used, but has not physically damaged the other property.

"Damage To Your Product"

To exclude coverage under the "damage to your product" exclusion, the insurer must show that (1) the damage was done to the insured's product, and (2) the damage arose out of the insured's product.[17]

A question often arises whether a building itself constitutes a general contractor's "product." The Michigan Court of Appeals has found entire buildings to be the insured's product.[18] But a federal district court judge applying Michigan law ruled that a grocery store the insured built was not "your product." The court based that conclusion on the "other than real property" carve-out in the "your product" definition: "Real property includes both the land and fixtures. The grocery store [the insured] erected is thus excluded from the definition of 'your product' as real property."[19]

"Damage To Your Work"

The "(l) Damage To Your Work" exclusion precludes coverage for "property damage" to the insured's work arising after a construction project is finished and in the owner's possession. That is, unlike exclusions (j)(5) and (j)(6), it applies to completed operations.

The standard CGL policy defines "your work" broadly:

"Your work"

a. Means:

(1) Work or operations performed by you or on your behalf; and

(2) Materials, parts or equipment furnished in connection with such work or operations.

b. Includes:

(1) Warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of "your work", and

(2) The providing of or failure to provide warnings or instructions.

However, the "(l) Damage To Your Work" exclusion, by its express terms, doesn't apply to work performed on the insured's behalf by a subcontractor. "The purpose of the subcontractor exception to the 'Your Work' exclusion is to provide coverage for the insured where the insured hires a separate entity to perform part of a larger project. Implicit in this general contractor / subcontractor relationship is the notion that the general contractor will provide all relevant information to the subcontractor so that the subcontractor can independently assess the situation and determine the best approach for construction."[20] Where there was a question of fact whether the insured general contractor supplied soil reports to the flooring subcontractor, the court ruled that the general contractor was not entitled to summary judgment in its favor as to the applicability of the subcontractor exception for a claim when the floor began to sink.[21]

Applying North Carolina law, a court found that the insured had the burden to produce evidence that the damage was caused by a subcontractor's faulty workmanship, because the burden of producing such evidence rests with the party

seeking application of the exception to the exclusion.[22]

Exclusion (m): Damage To Impaired Property or Property Not Physically Injured

Exclusion (m) applies where the insured's defective work or product has rendered other property less useful or unable to be used, but has not physically damaged the other property.

> **m. Damage To Impaired Property Or Property Not Physically Injured**
>
> "Property damage" to "impaired property" or property that has not been physically injured, arising out of:
>
> (1) A defect, deficiency, inadequacy or dangerous condition in "your product" or "your work"; or
>
> (2) A delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.
>
> This exclusion does not apply to the loss of use of other property arising out of sudden and accidental physical injury to "your product" or "your work" after it has been put to its intended use.

Exclusion (m) relies on the defined term "impaired property." The CGL policy defines "impaired property" as:

> [T]angible property, other than "your product" or "your work", that cannot be used or is less useful because:
>
> a. It incorporates "your product" or "your work" that is known or thought to be defective, deficient, inadequate or dangerous; or
>
> b. You have failed to fulfill the terms of a contract or agreement;
>
> if such property can be restored to use by the repair, replacement, adjustment or removal of "your product" or "your work" or your fulfilling the terms of the contract or agreement.

Like exclusion (l) ["Damage To Your Work'], exclusion (m) has a built-in exception that often becomes the focus of litigation. The exception is in the last paragraph:

> This exclusion does not apply to the loss of use of other property arising out of sudden and accidental physical injury to "your product" or "your work" after it has been put to its intended use.

Michigan courts generally haven't addressed the "sudden and accidental injury" exception. Elsewhere, courts have found that the "sudden and accidental" exception includes both a temporal aspect (i.e., the physical injury to the insured's product must appear suddenly) and an element of surprise (i.e., the physical injury must be 'unexpected or unintended' from the standpoint of the insured)."[23] The insured should be prepared to present evidence as to both requirements to get the benefit of the exception.

But there are other reasons the exclusion might not apply. The exclusion applies only if the claimant's property hasn't sustained physical damage and there is evidence that the impaired property could be restored by the repair or replacement of the insured's defective work or product.[24] The exclusion applies only if the impaired property isn't the insured's property or work. The insurer has the burden to show a loss of use of property that was not physically injured, other than the insured's work.[25]

However, the exclusion can preclude coverage for the costs of replacing the insured's defective product.[26] In the *Kent* case, the insured was a subcontractor on a construction project at a hotel. The insured installed a concrete slab above some snow-melt tubing that was installed by another contractor. A different contractor then installed brick pavers above the concrete slab. The general contractor then notified the insured it failed to properly create weep holes in the concrete slab, thereby causing damage to the snow-melt tubing. As a result, the snow-melt tubing had to be replaced, and the insured assumed responsibility for the cost of removing and replacing the original concrete slab and the brick pavers. The insured's claim did not involve the cost of the damage to the snow-melt tubing. The court found that exclusion (m) applied to the expenses associated with removing and replacing the brick pavers.

The Takeaways

These exclusions can be hard to digest. In Michigan, it's harder because until now, courts generally haven't needed to address them. Often, it's helpful to first determine whether the factual record forecloses any of the exclusions or exceptions.

- If the loss occurred after the property owners took possession of the completed property, then exclusions (j)(5) and (j) (6) shouldn't apply.
- If the claim only is for physical damage to property, then exclusion (m) shouldn't apply.
- If the physical injury was gradual, the sudden and accidental exception to exclusion (m) shouldn't apply.

Also, many policies use the standard ISO language. Courts elsewhere may have applied the same policy language to similar facts. Decisions that apply "the most reasonable reading of the policy language" are compatible with *Skanska*.[27] And that's not new. Michigan law has long held that "[t]erms in an insurance policy must be given their plain meaning."[28] At least that didn't change in 2020. ■

About the Author

Meg Cernak *is part of the insurance coverage team at Collins Einhorn Farrell PC. She counsels and represents insurers on litigated and non-litigated matters. Prior to joining CEF, Meg spent many years teaching legal research, writing, counseling, and advocacy at the University of Michigan Law School.*

Endnotes

1 *Skanska USA Bldg. Inc. v. M.A.P. Mech. Contractors, Inc*., 2020 WL 3527909 (Mich. June 29, 2020).

2 *Id*. at *8.

3 *Id*. at *8 n.15.

4 *Skanska USA Bldg Inc v MAP Mech Contractors, Inc*, unpublished opinion of the Court of Appeals, issued March, 19, 2019 (Docket No. 340871), 2019 WL 1265078, p *8.

5 *Hunt v Drielick*, 496 Mich 366, 373 (2014).

6 See *Afcon, Inc v Ellis-Don Michigan, Inc*, unpublished opinion of the Court of Appeals, issued February, 22, 2005 (Docket No. 250100), 2005 WL 415671.

7 *Action Auto Stores v United Capitol Ins Co*, 845 F Supp 428, 435 (WD Mich 1993).

8 *Id*. at 434.

9 *Envision Builders, Inc v Citizens Ins Co of Am*, unpublished opinion of the Court of Appeals, issued July, 24, 2012 (Docket No. 303652), 2012 WL 3020738, p *4.

10 *Oak Creek Apartments, LLC v Garcia*, unpublished opinion of the Court of Appeals, issued March, 21, 2013 (Docket No. 308256), 2013 WL 1165217.

11 *Envision Builders*, 2012 WL 3020738.

12 *Looking Good Lawns, LLC v Secura Ins Co*, unpublished opinion of the Court of Appeals, issued January, 10, 2012 (Docket No. 301805), 2012 WL 75357.

13 *Afcon,* 2005 WL 415671.

14 See *Acuity v Socy Ins*, 339 Wis 2d 217, 237 (2012) ("We are persuaded that the phrase 'that particular part' in the k.(5) and k.(6) exclusions applies only to those parts of a building on which the defective work was performed, which is determined based on the scope of the construction agreement."); *Am Equity Ins Co v Van Ginhoven*, 788 So 2d 388 (Fla Dist Ct App, 2001) (although the insured initially was hired to perform spot repairs on a pool, it was in fact working on the entire pool when the loss occurred, such that all damage to the pool was excluded).

15 See, *e.g., Scottsdale Ins Co v TL Spreader*, LLC, 2017 WL 4779575 (WD La, October 20, 2017) (relying on evidence in the record that the property damage did not occur until all of the work called for in the insured's contract had been completed, the court found that insurer failed to carry its burden to show that (j)(6) applied).

16 *Auto-Owners Ins Co v Keizer Morris, Inc*, unpublished opinion of the Court of Appeals, issued June, 28, 2011 (Docket No. 297657), 2011 WL 2557617.

17 See *GB Dupont Co, Inc v Michigan Mut Ins Co*, unpublished opinion of the Court of Appeals, issued May, 7, 1996 (Docket No. 167847), 1996 WL 33364419 (exclusion applied to costs associated with replacing the insured's products—threaded parts called "pins," "bolts," or "studs" used to attach seat belts to car doors—where the damages arose because the pins broke or cracked).

18 *Groom v Home-Owners Ins Co*, unpublished opinion of the Court of Appeals, issued April, 19, 2007 (Docket No. 272840), 2007 WL 1166050 (entire condominium was insured's product); *Mark A Reenders Const, Inc v Cincinnati Ins Co*, unpublished opinion of the Court of Appeals, issued January, 24, 2006 (Docket No. 256592), 2006 WL 167700 (two buildings were general contractor's products); *Heaton v Pristine Home Builders, LLC*, unpublished opinion of the Court of Appeals, issued October, 25, 2012 (Docket No. 305305), 2012 WL 5290305 (entire house was the work product of the general contractor).

19 *Houseman Const Co v Cincinnati Cas Co*, No. 1:08-CV-719, 2009 WL 2095994, at *4 (WD Mich, July 14, 2009).

20 *Houseman Const Co v Cincinnati Ins Co*, No. 1:08-CV-719, 2010 WL 1658959, at *5 (WD Mich, April 23, 2010).

21 *Id*.

22 *Breezewood Of Wilmington Condominiums Homeowners' Ass'n, Inc v Amerisure Mut Ins Co*, 335 Fed Appx 268, 278 (CA 4, 2009).

23 *Hartzell Indus, Inc v Fed Ins Co*, 168 F Supp 2d 789, 801 (SD Ohio, 2001).

24 *Cardinal Fabricating, Inc v Cincinnati Ins Co*, unpublished opinion of the Court of Appeals, issued June, 18, 2020 (Docket No. 348339), 2020 WL 3399576 (exclusion not applicable).

25 *Houseman*, 2009 WL 2095994 (exclusion not applicable).

26 *Kent Companies, Inc v Wausau Ins Companies*, unpublished opinion of the Court of Appeals, issued May, 3, 2011 (Docket No. 295237) (exclusion applicable).

27 2020 WL 3527909, at *9.

28 *Heniser v Frankenmuth Mut Ins Co*, 449 Mich 155, 161 (1995).

Settling Liability Cases When Insurance Coverage is Contested

By Yosef C. Klein, *Rich, Campbell & Roeder PC*

Whether there is, or might be, insurance touches litigation from the very beginning – from the plaintiff's decision whether to pursue the case, to the settlement negotiations, to satisfaction of a settlement or judgment.

As we will discuss, winning on the issues of liability and damages is not everything in a lawsuit. In fact, winning can be nothing, or worse. Winning can be hundreds of hours and thousands of dollars spent to obtain a judgment not worth the paper that it is written on. A truly successful lawsuit must include collectability on the resulting judgment. And that frequently hinges on insurance.

Liability Limits, Collectability and the Value of a Lawsuit

Consider the following scenario based on actual experience. Defense counsel is retained by an insurance company to defend the at-fault driver in a lawsuit arising out of a car versus motorcycle accident. Liability is clear. The victim, a young man in his 20s, was killed in the accident and his estate was represented by a law firm with a reputation for high-dollar verdicts. In this case, a jury easily could have returned a seven-figure award. But the lawsuit settled for just $20,000. Why? Because that was all the insurance money that was available, and the at-fault driver had no other collectible assets. The plaintiff's attorney understood that a huge verdict against the driver would not have resulted in the plaintiff estate receiving any more than the $20,000 that was available from the insurance company. But it would have cost a lot more to get that huge verdict. The best result was to take the $20,000 offered and stop incurring costs. This is not uncommon.

Consider another liability scenario that directly turned on the issue of coverage. A woman's ex-husband had, unprovoked, shot her boyfriend. Now her boyfriend was in the hospital and her ex-husband was in jail. Based on the facts presented, there appeared to be significant damages and clear liability. But the assailant had no assets and, even if he had liability insurance, it would not cover a non-defensive, intentional shooting. Getting a judgment against the assailant might not be hard, but in the financial sense the case was unlikely to be a winner.

Even when a defendant, or potential defendant, has collectible assets, insurance money may carry the day. Going after personal assets can be a lengthy and complicated process. A crafty defendant can employ many mechanisms to make collection frustrating and unpleasant. Moreover, the average person may have assets, without having significant *collectible* assets. Conversely, an agreement with an insurance company means getting a check now that the plaintiff will be able to cash. Knowing this, a claimant may opt to accept a pretrial settlement limited to available insurance money over going to trial to possibly obtain a verdict that exceeds the policy limits.

On the other side, even people who are confident in their legal positions fear getting sued because of the costly attorney fees. But, if an insurance company will pay for the defense, that is no longer a problem. In this way, the availability of insurance coverage can be the difference between a defendant offering to settle to avoid being litigated into bankruptcy as opposed to confidently litigating without concern for the defense cost.

Michigan's Court Rules recognize the important role of insurance. Even though such information is inadmissible at trial, MCR 2.302(B)(2) gives plaintiffs a right to information about insurance available to the defendant.[1] And under the recently revised rules, MCR 2.302(A)(1) requires the parties to disclose insurance information at the outset of a case without even receiving a request. The idea is so that parties can determine early on how much insurance money is available and adjust their litigation strategies and practices to the reality of the extent of what may well be the only significant means of payment.

In sum, the amount of insurance frequently plays a role in the resolution of a case. Knowing that there is a finite amount of insurance money can influence a plaintiff to settle for far less than an expected jury award. But knowing how much insurance there is is not always straightforward.

How Much Insurance is Available is Not Always Clear

Typically, a policy's declaration page contains the policy's limits. But many policies include different limits for different types of losses. Some losses are capped at sub-limits that might be found on the declarations page of a specific endorsement. Some policies have "wasting," or "eroding," limits, where the indemnity coverage is decreased by defense costs incurred. Liability policies also typically include aggregate limits which may be depleted, in whole or in part, by other claims. Similarly,

there could be other claims pending that are competing for what remains of a particular limit.

There can be disputes about whether all of the damages alleged in the lawsuit will be covered under the policy or if certain categories of damages may be subject to a different limit, a sub-limit, or an exclusion. And then there are cases where coverage on the whole is contested. Is the alleged injury within the policy's coverage grant(s)? Does an exclusion bar coverage and, if so, is there a relevant exception? Did the insured comply with the policy conditions? Was there is a misrepresentation in the procurement? Any of these issues could lead to there being no coverage at all.

> Even when a defendant, or potential defendant, has collectible assets, insurance money may carry the day. Going after personal assets can be a lengthy and complicated process.

Furthermore, it is important to clarify the policies that are available. Did the incident occur during the policy period? If so, were the limits different during that period? Is another, or an additional, insurer on the risk? We recently saw a case where it looked like a party faced liability significantly above its policy limits. But, after some digging, it turned out that that party also had coverage under another party's insurance policy, providing additional coverage. Then, additional digging turned up yet another applicable policy, several times the size of the first two combined. All of the sudden a party facing bankruptcy was well covered.

Such questions, whether about the overall application of the policy or how much coverage is available, can throw a wrench in the resolution of a claimant's case against the insured. Which brings us to the question: How do we resolve cases when there is a coverage issue?

Posture of a Coverage Dispute
Reservations of Rights and Declaratory Actions

Coverage issues manifest in different ways.

Insurers typically reserve the right to deny coverage on any potentially relevant basis, even when they expect or intend to then defend and resolve a case on behalf of the insured. In such a case, the insurer should send a letter to the insured that sets forth the bases for a potential denial of coverage, in whole or in part.

When there is a major coverage issue, there is more likely to be a declaratory judgment lawsuit, filed by either the insurer or an insured, to resolve the coverage issue. Under Michigan law, a claimant cannot directly file suit against the allegedly at-fault party's liability insurer in the liability action itself. Michigan is not a "direct-action" state. But claimants (the "underlying plaintiffs") have a right to participate in declaratory actions and are frequently included as defendants because they are parties in interest to the potential insurance proceeds.

The Parties

Lawsuits have plaintiffs and defendants, and that is typically good enough to let you know a given party's posture. But, using just those terms can be confusing when there is a coverage issue, especially when a declaratory judgment has been filed. As a result, more specific terminology should be used to identify the parties. For example, a party who files a liability suit might be referred to as a liability plaintiff (as opposed to a plaintiff in the declaratory judgment action), an underlying plaintiff (because the liability lawsuit underlies the declaratory judgment action), or a claimant. A party sued in a liability suit might be called a liability defendant, an underlying defendant, or an insured, additional insured, or putative insured (if that party's status as an insured is contested). This is not meant to be an exhaustive treatment of terms used across insurance coverage briefs and cases. But these are common terms used to clarify who we are discussing when dealing with liability coverage litigation.

This overlap of multiple layers of litigation naturally leads to many sets of attorneys with distinct functions, frequently including at least: (1) the claimant's liability counsel; (2) the claimant's coverage counsel; (3) the liability defendant's liability counsel; (4) the liability defendant's coverage counsel; (5) and the insurance company's coverage counsel.

Interests of the Parties

Insurance coverage disputes create aligned interests between otherwise adverse parties. When an insurance company contests coverage, it creates a shared interest between the liability claimant (the plaintiff) and the insured defendant because both want the insurance company to pay. Consider, even if the insured defendant denies liability, he still wants to be defended and for the claims against him to be put to rest. He may prefer to win outright, but if somebody has to pay, he would rather that the money come from his insurance company than out of his own pocket. On the other side, the plaintiff wants the defendant to be insured so that there is insurance money to pay a settlement or judgment. The plaintiff and defendant are directly at odds with each other on the merits of the case, but become allies against the insurance company in order to find coverage.

The Insurer's Chinese Wall

In the typical case involving insurance defense counsel, defense counsel reports to the defendant's insurance adjuster. Based on counsel's analysis and recommendations, the adjuster makes many key decisions for the defense, including settlement authority. Some policies include consent to settle

clauses that restrict or prohibit the insurer from settling the case without the insured's consent, but such provisions are rare. Most allow the insurer to settle regardless of the insured's preference.

A coverage issue can complicate the insurer's determination whether to settle. On the one hand, the insurer has a duty to defend its insured. On the other hand, the insurer does not want to pay for loss that is not covered. For this reason, insurers (should) assign separate adjusters to evaluate coverage issues. That does not mean that the insurer necessarily has separate adjusters for liability and for coverage. It may be the same group of people. But one specific adjuster will not oversee both the liability defense, in which the insured's interests are paramount, and the coverage dispute, in which the insurer's interests are considered. This scenario is referred to as "Chinese wall." The two adjusters may in fact be right next to each other, but they operate independently, as if there were a paper wall between them.

The Tripartite Privilege

The tripartite privilege refers to the attorney-client privilege that exists between an insured, his insurer-assigned defense attorney, and the defense adjuster. The insured is the client, and the attorney owes her uncompromised ethical duties to the client, notwithstanding that her payment is coming from the insurance company. But the attorney's communications with the adjuster will be privileged just like the attorney's communications with the client. In this way, the attorney can communicate candidly with the defense adjuster, who typically holds the purse strings, outside the eyes of the claimant. But the attorney's communications with the adjuster cannot be withheld from the client.

Tripartite issues do not generally come up when there is no coverage issue. The insurance company is essentially part of the defense team. But when there is coverage litigation, more care is required. Now the insured should have another attorney, frequently referred to as "personal" counsel (as opposed to insurance-appointed counsel) or "coverage" counsel. As between these attorneys, the insured's personal counsel is entitled to see defense counsel's entire file, including all communications with the insured or the insurance company. This is because coverage counsel stands in the shoes of the insured, who is defense counsel's client. Conversely, defense counsel is *not* entitled to coverage counsel's file or communications with the client. This is because defense counsel reports to the insurer, who, by virtue of there being a coverage dispute, has an adverse interest to the insured.

With the above in mind, astute personal coverage counsel for the insured will review the defense attorney's file, including all communications, and request to be copied on defense counsel's further communications with the carrier. In this way, personal counsel can confirm that the insurance company is providing a complete defense. For example, person counsel will check to see that the insurer is not denying defense counsel authorization to incur costs for experts, surveillance, medical examinations, motion practice, or other costs that may reasonably be sought by defense counsel in the furtherance of the defense of the case. This also provides a check just in case defense counsel is tempted to favor the hand that feeds (the insurer) over her actual client.

Tools for the Insurer

Liability coverage cases involve two disputes (the underlying liability case of Plaintiff v Defendant and the suit between the Insurer and the Insured). The insurer need win only one. If liability defense counsel defeats the claimant's claims, then that typically moots the issue of whether coverage was owed. If the insurer defeats the insured on coverage, then the insurer is not responsible for whatever results in the liability case.

(If the insurer did not retain defense counsel for the insured, then the insured may proceed with an action against the insurer for reimbursement of the defense cost. But at that point, there remains only a single action – the coverage action – and it is for a specific sum, the amount of defense costs incurred. Note that insurance coverage is a matter of contract. Accordingly, the insurer's refusal to defend and/or indemnify is a contractual breach. Like other breach of contract actions, in typical insurance cases, the insurer will not be ordered to pay the insured's costs pursuing the breach.)

The insurer can use this advantage to obtain a lower settlement with the claimant.. In doing so, the insurer might remind the claimant that if the claimant does not take offer, then the claimant risks getting nothing if the insurer succeeds in the coverage action. For example, if the underlying case has a reasonable settlement value of $100,000, but the insurer believes that it has a 50% chance of winning on coverage, the insurer might suggest a value of $50,000.

But one specific adjuster will not oversee both the liability defense, in which the insured's interests are paramount, and the coverage dispute, in which the insurer's interests are considered. This scenario is referred to as "Chinese wall."

The insurer can also leverage patience. The claimant has, presumably, incurred injury and the insured faces uncertainty with the claimant's lawsuit for which there may ultimately be no insurance money. But the insurer is a sophisticated litigant and the adjuster, while responsible for the claims on her desk, has not been injured and is not personally at risk of a judgment. The insurer can role the dice, knowing that it

can survive a loss, while the claimant may not be in a position to take such risk. Moreover, the insurer can afford to pay for an appeal if the coverage issues do not fall in the insurer's favor, and all the while it earns interest on the money in dispute.

The insured can explore a settlement that includes a consent judgment with an assignment of the insured's rights against the insurer and an agreement that the claimant will only perfect the judgment against insurance money. These tools are more nuanced and should be used with caution.

Tools for the Insured

Like the insurer, the insured need only win one battle. If the insured beats the claimant, then it owes no liability. If the insured beats the insurer, then the insurer covers the liability. It can be helpful to hire coverage counsel that is also familiar with the types of issues at play in the underlying case. This way coverage counsel can ensure that the insurer-appointed defense counsel is doing everything possible to defeat the claimant's claims.

An insured might have general counsel or a "go-to" personal attorney. Both the insured and the insured's general counsel should understand that insurance coverage is a complex and nuanced area of the law that should be taken seriously. If the general counsel is not an experienced insurance coverage attorney, a specialized attorney should be retained, or at least consulted. Failing to do so would be akin to using general counsel to defend a medical malpractice case. It is certainly not wise for the attorney or the client.

The insured should know its rights under the specific insurance policy at issue. The insurer's coverage determination letter is not dogma. The policy itself should be closely reviewed. Was the correct limit cited? Is there an exception to a cited exclusion? Does the cited language apply to the coverage part at issue? Is there an endorsement that broadens a coverage grant or definition, or removes or narrows an exclusion? All of this will be based on the policy and nothing should be taken for granted. In addition to the policy, the insured should review the underwriting documents to ensure that the policy reflects the coverage purchased, and the claim notes.

In terms of settlement negotiation and strategy, the insured should remember that it can participate and negotiate apart from the insurer. If the insured has assets, this may include negotiation of a reasonable settlement that the insured could then seek to recoup from the insurer. Alternatively, the insured can explore a settlement that includes a consent judgment with an assignment of the insured's rights against the insurer and an agreement that the claimant will only perfect the judgment against insurance money. These tools are more nuanced and should be used with caution. The insurer will argue that they run afoul of policy terms such as the "voluntary payments" provision, and they may well.

Tools for the Claimant

The biggest trap for the claimant is thinking that the insurance dispute involves only the insured defendant and the insurer. In many cases, the insured does not have the resources to retain coverage counsel. If the insured is uncollectable, it may not care what happens in the coverage litigation. In these cases, if the claimant fails to participate in the coverage litigation when the insurer files a declaratory action, the insurer will obtain a judgment in its favor, i.e., against its insured, and there will be no coverage and no money for the claimant to collect. In that situation, the claimant must take the initiative to litigate the coverage issue in the declaratory action.

Like the insured, the claimant should realize that it might need a second attorney who is familiar with coverage issues. The claimant's liability counsel may know the ins and outs of a personal injury action, but insurance coverage is a different animal. A wise personal injury attorney in this position will retain appropriate coverage counsel to either represent the claimants in the coverage case or at least to consult on the coverage issues.

Once a coverage issue comes to light, the claimant may note that the issue is only with some of the claims. For example, the claimant may have alleged alternative theories of negligence and intentional injury. The intentional injury will likely not be covered by insurance, making the negligence claim more likely to be collectible. No party or attorney should lie or misrepresent, but part of advocacy is highlighting facts and theories that advance your client's interests. A claimant should highlight its claims for which coverage is not contested. It should make sure to develop facts that may not move the needle on liability but will establish that the matter is covered.

Best Practice is to Have Experienced Coverage Counsel

Liability insurance disputes involve multiple gears moving at once. Whether the insurer, the insured, or the claimant, the wise litigant will retain experienced coverage counsel to ensure that its interests are protected. ■

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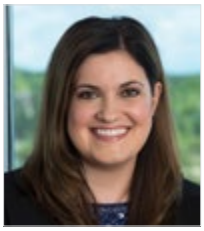
Endnote

1 *Davis v O'Brien*, 152 Mich App 495 (1986) ("Policies of insurance … are discoverable under MCR 2.302(B)(2)").

A Practical Approach to Preserving and Asserting No-Fault Fraud Defenses in the Wake of *Haydaw, Fortson* and *Glasker-Davis*

By Adam A. Fadly and Stefania Gismondi, *Foster Swift Collins & Smith, PC*

In the span of approximately six weeks, Michigan's higher courts handed down three significant decisions that, at first glance, might appear to dismantle the often asserted fraud defense in no-fault litigation. Although these binding precedents will have a major effect on whether and how fraud defenses are asserted, they are by no means an abolishment of the fraud defense, nor do they proclaim to be. Briefly, the three opinions are:

- On July 9, 2020, the Court of Appeals issued a published decision holding the "fraud provision in no-fault insurance policies do not provide grounds for rescission based upon false statements made by the insured during first-party litigation." *Haydaw v Farm Bureau Insurance Company,* __ Mich App __; __ NW2d __ (2020) (Docket No. 345516).
- On July 29, 2020, the Michigan Supreme Court held in a published decision that an anti-fraud provision of an insurance policy was "invalid and unenforceable because it is not based on statutory or unabrogated common-law defense." *Meemic Ins Co v Fortson,* __Mich __; ___ NW2d___ (2020) (Docket No. 158302).
- On August 13, 2020, the Michigan Court of Appeals issued a published decision holding that "a defense premised on an alleged violation of an anti-fraud provision in an insurance policy constitutes an affirmative fraud defense . . . [and] must be stated with particularity . . . [t]hus, it is insufficient simply to state that a plaintiff's conduct had been fraudulent." *Glasker-Davis v Meemic Ins Co,* __ Mich App __; __ NW2d __ (2020) (Docket No. 345238).

In light of these holdings, the question that must be addressed is: What can insurers do to timely and properly assert and preserve a fraud defense before litigation begins and increase the likelihood courts will uphold the denial once it is litigated?

Most no-fault insurance policies and the Michigan Assigned Claims Plan ("MACP") require an insured or other person claiming no-fault benefits to cooperate with the insurer's requests for information in the investigation of the claim. These investigations may begin before litigation commences, but are often implemented or completed after litigation has been initiated. The methods of investigating a claim include, but are not limited to:

- Obtaining affidavits regarding proofs for coverage;
- Completing signed applications for benefits;
- Signing authorizations for the release of school, employment, medical records, etc.;
- Attending a mental and/or physical examination;
- Submitting to unrecorded and/or recorded interviews conducted by the carrier or its agents; and
- Submitting to examinations under oath.
- While not an action that requires cooperation from the insured or claimant, insurers may also conduct surveillance to investigate the claim.

These tools have always been critical to filtering out fraudulent claims that should be denied and in obtaining necessary information to support the legitimacy of claims where proofs may be lacking. Moving forward, this should not change. However, now more than ever before, these fraud investigation tools should be used before litigation begins when possible.

The information derived pre-suit may very well serve as the foundation of fraud affirmative defenses required to be pleaded with specificity in the first responsive pleading after a complaint is filed and served, as well as invoking the anti-fraud provision of a no-fault policy. The Michigan Court Rules and the Court of Appeals in *Glasker-Davis* make it clear that a party may move to amend its affirmative defenses at any time and courts should freely allow a party to do so. But according to the holding in *Haydaw*, amending affirmative defenses during litigation with information obtained through the formal discovery process might amount to nothing more than the insurer creating a credibility question for a prospective jury to weigh, let alone be sufficient to invoke the anti-fraud provision of a no-fault policy and win a motion for summary disposition.

Accordingly, the information obtained through a pre-suit investigation should be viewed in anticipation of litigation, and its findings should be used to identify any fraudulent acts at the outset of the claim. Even though this may appear to

create a "race to the courthouse" scenario for plaintiffs to file a lawsuit before the pre-suit investigation can be conducted or completed, there should be little incentive for a plaintiff's attorney to do so in light of the amendments to the No-Fault Act that mandate benefits be "overdue" before an attorney can assert an attorney lien or fee, and a medical provider has standing to sue. To that end, in an effort to counteract the gamesmanship of some litigants rushing to the courthouse the moment they receive a request for information within the scope of an investigation, insurers should act fast in making a decision to suspend or deny a claim if there is suspicion of fraud or a failure to cooperate in the insurer's investigation.

Although *Fortson's* ruling may appear to limit an insurance carrier's ability to void a policy due to fraud, it is arguably limited in application. For the most part, *Fortson* stands for the proposition that fraudulent acts committed by insureds should not serve to punish the injured person who did not take part in the fraudulent act, especially when benefits are statutorily mandated. The *Fortson* ruling did not address whether an insurer may void a policy for fraud committed by an insured during the claims process who happens to be the injured person directly claiming benefits. Further, *Fortson* does not appear to prevent an insurer from denying or rejecting fraudulent claims without rescinding the entire policy.

In sum, the important takeaway from all three cases is that it is critical to take a proactive approach and attempt to get a complete picture of the claim before a lawsuit is filed. The pre-suit investigation is a critical phase that may directly affect whether the no-fault policy's anti-fraud provision to void and/or rescind the policy can be invoked. Importantly, identifying fraud pre-suit will assist carriers in properly pleading fraud with particularity as an affirmative defense once a lawsuit is filed. ■

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Legislative Update: The Legislature Adjourns

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

Another legislative cycle ends and a new one begins. And, at least for insurance-related matters, it was a quiet lame duck session (only six bills made it to the Governor's desk since the last update). Any bills still pending on December 31 expired and must be reintroduced when the new legislative cycle begins in January. As House Insurance Committee Chair Rep. Daire Rendon won her re-election bid (this will be her third and final term), there may not be any change to Insurance Committee leadership. But I'll report on that in my next update.

In total, legislators introduced 3,808 bills (House – 2,548; Senate – 1,260), with about 140 referred to the Insurance Committees. Here are the final insurance-related bills that made it to the Governor:

- **Travel insurance –** HB 4508 amends the Insurance Code to change the definition of "travel insurance" and to add a new chapter to regulate the sale of that insurance ***Passed the House (105-2) on 2/25/20; Passed the Senate (38-0) 12/10/20; Ordered Enrolled on 12/16/20***
- **Medical providers fee cap –** HB 4459 amends the Public Health Code to require nonparticipating medical providers to accept 150% of the Medicare fee, or the regional median insurer negotiated amount, whichever is less; provides for review of median amount; creates certain emergency or complicating factor exceptions; permits providers to seek binding arbitration (part of a bill package to regulate nonparticipating providers – HB 4459, 4460, 4990, 4491) ***Passed the House (101-5) on 6/24/20; Passed the Senate (32-6) on 9/30/20; Signed by the Governor (PA 234'20 with immediate effect) on 10/28/20***
- **Medical providers' disclosures –** HB 4460 requires a nonparticipating medical provider who is providing nonemergency services to give the patient certain disclosures regarding the potential lack of health coverage for those services (part of a bill package to regulate nonparticipating providers – HB 4459, 4460, 4990, 4491) ***Passed the House (106-0) on 6/24/20; Passed the Senate (37-1) on 9/30/20; Signed by the Governor (PA 235'20 with immediate effect) on 10/28/20***
- **Enforcement of fee cap and providers' disclosures – disciplinary action. –** HB 4490 amends the Public Health Code to include violating HB 4459 and 4460 as grounds for disciplinary action, beginning 1/1/21 (part of a bill package to regulate nonparticipating providers – HB 4459, 4460, 4990, 4491) ***Passed the House (107-0) on 9/10/20; Passed the Senate (37-1) on 9/30/20; Signed by the Governor (PA 232'20 with immediate effect) on 10/28/20***
- **Fines for violating fee cap and providers' disclosures –** HB 4491 amends the Public Health Code to prescribe fines for violating HB 4459 and 4460 (part of a bill package to regulate nonparticipating providers – HB 4459, 4460, 4990, 4491) ***Passed the House (104-2) on 9/10/20; Passed the Senate (37-1) on 9/30/20; Signed by the Governor (PA 233'20 with immediate effect) on 10/28/20***
- **Regulation of reinsurers –** SB 1015 amends the insurance code regarding reinsurers, requires for reciprocal jurisdiction of assuming insurer and other technical amendments ***Passed the Senate (37-0) on 9/2/20; Passed the House (108-0) on 12/16/20; Presented to the Governor on 12/23/20**** ■

Mission Statement of the Insurance and Indemnity Law Section

Issues arising out of insurance contracts and indemnity agreements affect a broad range of practice areas. In addition, insurance is a regulated industry, and state and federal regulations present specialized questions. The membership of the Insurance and Indemnity Law Section of the State Bar of Michigan consists of those who have expertise in this area of practice, as well as those whose expertise lies in other practice areas that are affected by insurance and indemnity issues. The mission of the Section is to provide a forum for an exchange of information, views and expertise from all perspectives on both insurance coverage issues and indemnity issues, and to provide information and assistance to other persons or organizations on matters relating to insurance and indemnity. Membership is open to all members of the State Bar of Michigan.

Selected Insurance Decisions

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

Michigan Supreme Court

Leave Granted

Esurance Property & Cas Ins co v MACP
Docket No. 160592
September 23, 2020

The Supreme Court has granted leave to consider "whether a finding that an insurance policy was void *ab initio* because it was procured by fraud bars a subsequent claim for equitable subrogation for benefits that were paid pursuant to that policy before it was found to be void."

Michigan Court of Appeals – Unpublished Decisions

Lack of direct physical contact with UM vehicle bars coverage

Rozenberg v Auto Club Insurance Company
Docket No. 348773
December 29, 2020

Plaintiff's UM policy compensates for injuries caused by a hit-and-run vehicle, but only if that UM vehicle "makes direct physical contact" with an insured, or with a vehicle occupied by an insured. Plaintiff was injured when a piece of metal detached from the truck he was following and caused plaintiff's vehicle to spin out of control. There was never any contact with the truck. The court cited a number of published decisions as authority for rejecting plaintiff's claim that because the piece of metal was once part of the truck, it met the requirements of the insuring agreement. Quoting *Kersten v DAIIE*, 82 Mich App 459 (1978), the court observed that "[j]ust as a horseshoe is not a horse, so, too, a tire and rim is not a car."

For a different view, see the *Tankanow* decision (below).

Failure to report ongoing home improvements bars full replacement coverage

Fabatz v Auto-Owners Insurance Co
Docket No. 350209
December 17, 2020
Publication request pending

Plaintiffs' homeowners policy provided "Guaranteed Home Replacement Cost," as long as the insured "immediately [informed Auto-Owners] of any additions, alterations or improvements . . . which individually or cumulatively increases your dwelling replacement cost by $10,000 or more." The insured was also required to pay the increased premium. Plaintiffs were in the process of remodeling their home when a fire broke out. At that point, plaintiffs had paid roughly $150,000 of the estimated $229,000 cost of the project. But plaintiffs never read the renewal terms and so never reported the improvements.

When presented with plaintiffs' claim, Auto-Owners paid the maximum coverage of $175,000 under the existing policy and denied plaintiffs' claim for full replacement coverage. The court agreed with Auto-Owners' interpretation of the policy. The renewal terms were not ambiguous. The policy's terms explained the obligation to report improvements and pay additional premium based on the increased value of the property, not just at the completion date of any improvement. The court also denied plaintiffs' claim for coverage of a bathhouse as an additional structure because plaintiffs failed to comply with the contractual time requirements for filing proofs of loss.

UIM coverage limited to judgment against tortfeasor

Estate of Parks v Sandy and Pioneer State Mut Ins Co
Docket No. 349546
December 17, 2020

The insuring agreement in this underinsured motorist policy promised to pay damages that the insured "is legally entitled to recover" from the owner or operator of the at-fault vehicle. In this case, the vehicle that struck and killed the decedent was insured under a policy with $100,000 in liability limits. The decedent's own policy with Pioneer included UIM coverage up to $250,000. Pioneer agreed to allow trial to go forward against the tortfeasor only. The result was a jury verdict of $200,000, reduced by 50% due to the decedent's comparative negligence.

The court held that the estate was collaterally estopped from demanding a second trial against Pioneer to determine a separate UIM recovery, even though Pioneer had reserved the right to demand a second trial itself when it consented to trial against the tortfeasor only. The court held that mutuality is not required to assert collateral estoppel defensively. So, even though Pioneer preserved its right to a separate trial depending on the outcome of the first trial against the tortfeasor, Pioneer could still assert collateral estoppel as a defense to any further litigation on damages for the UIM claim. And because plaintiff had a full and fair opportunity to litigate the amount he was legally entitled to recover against the tortfeasor, the jury's award in that case was dispositive.

Property damage caused by neglect not covered

Kirk v Allstate Property and Casualty Insurance Co
Docket No. 350529
September 10, 2020

Plaintiffs sought coverage under their homeowners policy when a large section of the stucco exterior of their home detached, exposing the steel framing underneath. The damaged area was located under a balcony and the insurer's investigation showed that the cause of the damage was long-term water intrusion and an inadequate draining system that resulted in corroded steel framing. Plaintiffs' policy excluded coverage for damage caused by aging, weathering, and lack of maintenance. But plaintiffs insisted that the damage was the result of a sudden and unexpected collapse, which they claimed was a covered loss under the policy. The collapse, however, had to be the result of any one of four factors, none of which applied. And several exclusions did apply, including property damage caused by water seeping or leaking through any part of the residence, damage caused by wear and tear and aging, and damage caused by failure to take reasonable steps to maintain the property. Plaintiffs had learned of the penetration of water from the balcony some years earlier as established by claim records with their prior insurer. They offered no evidence of any attempt to address the problem prior to this loss.

UM coverage based on "substantial physical nexus"

Tankanow v Citizens Insurance Co of America
Docket No. 348669
September 17, 2020
SCT application pending

In an opinion seemingly at odds with *Rozenberg,* reported above, and the cases discussed in that opinion, another panel of the Court of Appeals interpreted similar UM contract language to provide coverage when an item becomes detached from a vehicle. In this case, the item was a certain type of cart used in horse-racing, which broke free from the RV pulling it. Plaintiff's policy defined an uninsured motor vehicle as "a hit-and-run" vehicle whose operator or owner cannot be identified and which hits . . . your 'covered auto' . . . . Although it was undisputed that the RV never struck plaintiff's vehicle and that the cart was not a motor vehicle, the court found coverage by applying the "substantial physical nexus" test, which created a question of fact as to whether there was any such a nexus between the RV and the cart.

The policy's terms explained the obligation to report improvements and pay additional premium based on the increased value of the property, not just at the completion date of any improvement.

Fraud during the renewal process bars coverage

Lost Lake Distillery, LLC v Atain Insurance Company
Docket No 346552
September 17, 2020

Plaintiff failed to renew its commercial policy with Atain prior to a fire loss on October 27th, which occurred 11 days after the policy lapsed. Instead, plaintiff, through its insurance agency, contacted Atain the day after the fire and successfully renewed the policy backdated to October 16th, never informing Atain of the fire. When the agency later reported the loss, it provided a loss date of October 30th. Some months later, in February, Atain issued a notice of non-renewal based on the condition of the property. One month after that, in March, Atain formally rescinded the policy for fraud. The Court of Appeals approved the rescission. It declined to apply the notice of nonrenewal as a bar because there was no evidence that Atain knew of the fraud when it issued that notice. The court also declined to bar rescission on grounds of untimeliness. Atain rescinded within six weeks of learning that it had reason to rescind.

Federal District Court – Eastern District of Michigan

No coverage for losses caused by COVID-19 shut-down

Kirsch, DDS v Aspen American Ins Co
Case No. 20-11930
December 14, 2020

This insured dental practice was covered under a policy titled "Building, Blanket Dental Practice Personal Property and Income Coverage." Plaintiff submitted a claim under that policy for loss of income and extra expenses incurred as a result of the Governor's executive order suspending all non-emergency dental procedures for two months. When defendant denied coverage, plaintiff filed this lawsuit as a class action. The court determined there was no coverage for loss caused by the Covid-19 shutdown under the policy terms, which focused on losses caused by physical damage to the covered property.

The basic insuring agreement afforded coverage for loss of income caused by "direct physical damage to the building or blanket dental practice personal property at the described premises caused by or resulting from a covered cause of loss or power failure . . . ." And although the policy included a "civil authority" provision, it applied to the loss of income "you sustain caused by action of civil authority that prohibits access to the described premises due to the direct physical damage to property. . . ." The court held that "direct physical loss or damage" refers to tangible damage to property.

COVID-19 restrictions on the practice did not cause tangible physical damage to any property.

Lack of coverage for funeral home claims

Allstate Insurance Co v Cantrell Funeral Home
Case No 19-cv-11192
December 11, 2020

Allstate issued a commercial general liability policy to defendant, which included an endorsement for Funeral Director's Liability coverage, as well as a commercial umbrella policy. Defendant funeral home sought coverage for a series of claims filed by families and by the State of Michigan's Department of Licensing and Regulatory Affairs after human remains were found hidden throughout the funeral home in 2018. The court held there was no "occurrence," defined in each policy as an accident. The liability claims involved allegations of intentional mishandling and misrepresentations regarding the location of remains. In addition, the resulting personal and bodily injury to family members were not sustained until the after the policies had expired. This decision also addresses the circumstances under which declaratory judgment actions can be decided on the merits in the absence of any opposition from parties who fail to appear. ■

New A.O. Offers Professionalism Principles for Lawyers and Judges

December 18, 2020

The Michigan Supreme Court has authorized twelve principles of professionalism for attorneys and judges adopted by the State Bar of Michigan to use as guidance for appropriate standards of personal conduct in the practice of law. The principles, established in Administrative Order No. 2020-23, are meant to serve as a reminder that members of the legal profession, together and individually, must exhibit the highest levels of professional conduct in order to maintain and preserve, and to advance, the profession.

The principles are not intended to form the basis for discipline, professional negligence, or sanctions; alter the Michigan Rules of Professional Conduct, the Michigan Code of Judicial Conduct, or the Michigan Court Rules; or recast the Lawyer's Oath, although many of the Principles are derived from these sources.

Please watch for updates from SBM about on this important guidance in the near future.

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- *Name Change Request Form*—Supporting documentation is required

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Term Expires 2022

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