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From the Chair

Lauretta Pominville, *McNish Group*

Greetings and Happy New Year!

Who would have thought a year ago that we would find ourselves still in the midst of the pandemic? I hope that over the holiday all of you were able to take a much needed break and recharge. The last year has brought so many challenges, both professionally and personally, but we keep marching forward.

I would like to take this opportunity to thank our Immediate Past Chair, Nicole Wilinski, for her guidance through the last year, and welcome our new Council Members, Allison Eicher and Elizabeth King. A special shout-out is owed to longtime Section member, Deborah Hebert, who has for years provided Selected Insurance Decisions in our quarterly publication, the *Journal,* and we welcome her successor, Margaret Cernak. We hope that you find the *Journal* to be required reading. Founding member Hal O. Carroll has been the Editor of the *Journal* since day one, and is owed our thanks and recognition.

Our membership continues to grow. We are currently at 1,126 members and have a very active Council. Our Section has three Committees (Program, Membership and Publication) that are open to all Section members to be involved in. Our next Council Meeting with be by Zoom on Thursday, January 13, 2022, at 4:30 pm. Please check our Facebook page for additional information.

Please plan to join us on Thursday, April 14, 2022, at 4:00 pm the Detroit Athletic Club for our first in-person meeting since January, 2020, to discuss renewal of our 5-Year Strategic Plan. We are hopeful to have all of our prior Chairs in attendance to discuss the future course of our Section. Please watch our Facebook and SBM Connect pages for further details. Space will be limited.

Our 2022 Scholarship topic has been announced. Details can be found on our Facebook page or at *https://connect.michbar.org/insurance/home*. The topic is ransomware, and whether it should be paid as a matter of public policy. Any student currently enrolled in one of Michigan's five law schools is eligible to apply. Submissions are due by February 28, 2002.

Your input is invaluable! Please let us know what you would like to see from your membership in the Insurance and Indemnity Law Section. Please share your ideas for topics to be discussed. ■

Editor's Notes: Beginning Our 15th Year!

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

The *Journal* is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. All opinions expressed in contributions to the *Journal* are those of the author. The *Journal* – like the Section itself – takes no position on any dispute between insurers and insureds. 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. ■

Prosecuting and Defending Rescission Actions in Michigan

By Andy Portinga, *Miller Johnson, PLC*

In applying for any insurance, a potential policyholder will have to answer questions that the insurer will use both to determine whether it wants to insure the risk and what the appropriate premium will be. Unfortunately, answers in an insurance application sometimes turn out to be false. This may be the result of fraud by the applicant, who may be tempted to fudge the facts to obtain coverage or get a reduced premium. But it sometimes may be the result of an innocent mistake, where the applicant answers truthfully but in ignorance of the true facts. On more than one occasion, an insurance agent has filled out an application on behalf of the applicant, and the applicant failed to review or catch an error in the application. If an insurer later discovers that a statement in an application was false, the insurer may attempt to rescind the policy in order to avoid paying a claim.

Basis for Rescission

An insurance contract may be rescinded *ab initio* if it was procured by fraud.[1] While many rescission claims are based on allegations of an intentional misrepresentation, an innocent misrepresentation will support a claim for rescission if the insurer relied on the misstatement.[2] An action for rescission is equitable in nature.[3] To rescind the policy, insurer must prove the misrepresentation with clear and convincing evidence.[4]

MCL 500.2218 is relevant to rescission actions. This section of the Insurance Code states that no misrepresentation shall avoid coverage unless the misrepresentation was material. A misrepresentation is only material if knowledge of the true facts by the insurer would have lead the insurer to refuse to make the insurance contract.[5] If knowledge of the true facts would have either lead the insurer to reject the risk or to charge an increased premium, the misrepresentation is material.[6] In determining if a misrepresentation is material, the insurer's practices regarding insuring similar risks is admissible.[7]

Materiality does not require a showing of a causal link between the misrepresentation and the ultimate loss. If an insured falsely represents that he is a non-smoker when in fact he does smoke, and the insured is later killed in a car accident, the misrepresentation may be material even those the misrepresentation had nothing to do with the ultimate loss.[8] This is because the insurer may have increased the premium if it had known the true facts.[9]

The scope of MCL 500.2218 is uncertain. This uncertainty arises because the catch line and the first sentence of the statute refer to disability insurance, but section 1 of the statute refers to "any contract of insurance." Despite the catch line's reference to disability insurance, the Court of Appeals has applied the statute to policies for life insurance.[10] In the Eastern District of Michigan, Judge Denise Page Hood applied the statute to a professional malpractice policy.[11] But in an unpublished decision, the Sixth Circuit reversed, noting that Michigan courts have not applied the policy outside of the context of life, accident, and health insurance.[12]

Materiality does not require a showing of a causal link between the misrepresentation and the ultimate loss.

Post-Procurement Fraud

What if an insured is truthful and accurate in an application for insurance but makes a misrepresentation in connection with a claim made under the policy? At common law, such a post-procurement misrepresentation would not support a claim of rescission, because it did not induce the issuance of the policy.[13] But if the policy contains a provision that rescinds the policy in the event of post-procurement fraud, the policy may be rescinded if the post-procurement fraud relates to the failure to perform a substantial part of the contract or one of its essential terms.[14] In *Meemic Ins. Co v Fortson*,[15] the Michigan Supreme Court held that such a post-procurement fraud provision was not enforceable as to mandatory no-fault benefits, because neither the No-Fault Act nor the common law allowed for rescission actions based on post-procurement fraud.

Return of Premium

If an insurer wishes to rescind a policy, the insurer must refund any premiums paid. The insurer may not "collect a premium and provide coverage as long as there are no losses

and yet remain entitled to choose rescission and deny coverage if a loss occurs."[16]

But does an insurer have to tender back any premiums *before* bringing an action for rescission? The answer is unclear, and it dredges up the distinctions between law and equity in the days of the divided bench. In an action at law, tendering back the consideration for the contract was a precondition to suit.[17] But courts of equity were not so strict. At equity, the insurer must just "make a proffer of return as to what has been received."[18] In either situation, if the insurer prevails on a rescission claim, the insurer must return the premium paid. The insurer cannot have its premium and rescind coverage too.[19]

Rescission vs Cancellation

Rescission is distinct from cancellation. Cancellation is prospective in nature, while rescission is retroactive. "When a policy is cancelled, it is terminated as of the cancellation date and is effective up to such date; however, when a policy is rescinded, it is considered void *ab initio* and is considered never to have existed."[20] While an insurer must return premiums on any rescinded policy, an insurer does not have to return earned premiums on a cancelled policy.

An insurer's decision to cancel a policy, as opposed to rescind a policy, will operate as an election of remedies. Once the insurer has sent out a notice of cancellation, it may be estopped from attempting to rescind the policy.[21]

> While many rescission claims are based on allegations of an intentional misrepresentation, an innocent misrepresentation will support a claim for rescission if the insurer relied on the misstatement.

Innocent Third-Parties

What if rescission will lead to a lack of coverage for a third-party, who was innocent of and had no role in making any misrepresentation? In *Bazzi v.Sentinel Ins Co*,[22] the Michigan Supreme Court noted that the common law "innocent third party" rule—which held that the right to rescind ceases to exist once there is a claim involving an innocent third party—had been abrogated in its decision in *Titan Ins Co v Hyten*.[23] But the court also noted that an action for rescission was equitable in nature and was not a matter of right for an insurer, at least when innocent third parties are impacted.[24] A court must balance the equities in order to determine if rescission is warranted.

In his concurrence, Justice Markman outlined factors that a court should consider in balancing the equities in a rescission action, as follows: (1) the extent to which the insurer could have uncovered the subject matter of the fraud before the innocent third party was injured; (2) the relationship between the fraudulent insured and the innocent third party to determine if the third party had some knowledge of the fraud; (3) the nature of the innocent third party's conduct, whether reckless or negligent, in the injury-causing event; (4) the availability of an alternate avenue for recovery if the insurance policy is not enforced; and (5) a determination of whether policy enforcement only serves to relieve the fraudulent insured of what would otherwise be the fraudulent insured's personal liability to the innocent third party.[25]

While Justice Markman's concurrence is not binding, the Court of Appeals has endorsed these factors.[26] *Titan* and *Bazzi* were decided in the context of a claims for mandatory no-fault benefits. However, in an unpublished decision, the Court of Appeals applied *Bazzi* outside of the no-fault context and remanded a case for a determination of whether rescission would be equitable, given the potential impact on an innocent third party.[27]

Time Limits

There is no statute of limitations that directly governs an equitable claim for rescission, although the Court of Appeals has applied the six-year statute of limitations for contracts to such actions.[28] In *Maurer*, the Court of Appeals held that the statute ran from the date of the alleged misrepresentation. Under the reasoning of *Maurer*, if a policy contains a shortened, contractual limitations period, that period may apply to any rescission action.

Conclusion

Whether innocent or intentional, misrepresentations in an application for insurance are problematic for the policyholder, the insurer, and potentially third parties. An insurer that seeks to rescind a policy should act diligently and be prepared to refund the policy premium. An insured whose policy an insurer seeks to rescind should determine if, in fact, any misrepresentation was made and whether the misrepresentation was material. A third party that is impacted by a rescission action should consider *Bazzi* and whether rescission would be inequitable in the context of the claim. ■

About the Author

Andy Portinga *is a member of Miller Johnson, PLC, in Grand Rapids, Michigan. His practice focuses on insurance coverage, ERISA, and general commercial litigation.*

Endnotes

1 *Bazzi v. Sentinel Ins. Co.*, 502 Mich. 390, 408, 919 N.W.2d 20, 29 (2018).

2 *Lash v. Allstate Ins. Co.*, 210 Mich.App. 98, 532 N.W.2d 869, 872 (1995).

3 *Bazzi*, 502 Mich. at 411-412.

4 *Howard v. Golden State Mut. Life Ins. Co.*, 60 Mich.App. 469, 231 N.W.2d 655 (1975).

5 MCL 500.2218(1).

6 *Oade v. Jackson Nat. Life Ins. Co. of Michigan*, 465 Mich. 244, 632 N.W.2d 126 (2001).

7 MCL 500.2218(3).

8 *Montgomery v. Fid. & Guar. Life Ins. Co.*, 269 Mich. App. 126, 127, 713 N.W.2d 801, 803 (2005).

9 *Id.*

10 *Housour v. Prudential Life Ins. Co. of America*, 1 Mich.App. 455, 136 N.W.2d 689 (1965).

11 *Am. Guarantee & Liability Ins. Co. v. Jaques*, *Admiralty L. Firm* 2003 WL 22077774 (E. D. Mich. Aug. 7, 2003).

12 *Am. Guarantee & Liab. Ins. Co. v. Jaques Admiralty L. Firm*, 121 F. App'x 573, 575 (6th Cir. 2005).

13 *Meemic Ins. Co. v. Fortson,* 506 Mich. 287, 308, 954 N.W.2d 115, 125 (2020).

14 *Id.*

15 *Meemic, supra*

16 *Burton v. Wolverine Mut. Ins. Co.*, 213 Mich. App. 514, 519–20, 540 N.W.2d 480, 482–83 (1995).

17 *Meemic*, *supra* at n. 19 (citing *Chaffee v. Raymond*, 241 Mich. 392, 394-395; 217 N.W. 22 (1922)).

18 *Id.*

19 *Burton, supra.*

20 *United Sec. Ins. Co. v. Comm'r of Ins.*, 133 Mich. App. 38, 42, 348 N.W.2d 34, 35 (1984).

21 *Burton*, 213 Mich. App. At 518-20.

22 *Bazzi, supra.*

23 *Titan Ins. Co. v. Hyten*, 491 Mich. 547, 817 N.W.2d 562 (2012).

24 *Bazzi*, 502 Mich. at 408.

25 *Id.* at 414-415.

26 *Pioneer State Mutual Ins. Co. v. Wright*, 331 Mich. App. 396, 405, 411, 952. N.W.2d 586 (2020).

27 *Doa Doa, Inc. v. PrimeOne Ins. Co.*, Case No. 339215, 2019 WL 5680994 (Mich, Ct. App. Oct. 31, 2019).

28 *Maurer v. Fremont Ins. Co.*, 325 Mich. App. 685, 696, 926 N.W.2d 848, 854 (2018).

Smartphone Phishing Attacks Escalate, Bedeviling Law Firms

By Sharon D. Nelson, Esq. and John W. Simek

Just When You Thought You Had Perfected Your Cybersecurity Training for Law Firm Employees . . .

Time to think again. It's no secret that cybercriminals have increased all kinds of phishing activity since the pandemic. More people utilizing consumer grade equipment in a less secure work-at-home environment creates a fertile ground for phishing attack victims.

According to a ZDNet report, phishing attacks are shifting to mobile devices. That's not surprising since mobile devices are the primary computing technology for more than 50% of users. The goal of the attackers is to obtain usernames and passwords that could be used for accessing cloud services or other sections of the enterprise network. The goal of the cybercriminal is to gain network access. Attacking a smartphone means a greater success rate for getting that access.

So Why Are Phishing Attacks on Smartphones so Successful?

Spotting a phishing attack on a smartphone is much harder than on a computer. Think about it. When you get an email on a computer, determining the originating email address is pretty easy even if the display name is familiar. On a smartphone, typically you just see the display name and not the actual email address. It takes a lot more work and jumping through hoops to expose the actual originating email address.

As ZDNet states, "Tailoring phishing emails towards mobile devices can make them more difficult to spot because the smaller screen provides fewer opportunities to double check that links in messages are legitimate, while smartphones and tablets might not be secured as comprehensively as laptops and desktop PCs, providing attackers with a useful means of attempting to compromise networks."

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Multiple Attack Vectors Multiply the Problem

Multiple attack vectors make mobile devices particularly vulnerable to phishing attacks. There are a lot of vectors for cybercriminals to exploit on a smartphone. Some of the attack channels include the various social media platforms, messaging apps and plain old SMS text messages. In fact, according to a report from security provider Proofpoint, SMS text phishing (also called smishing) increased by almost 700% in the first half of 2021 as compared to the last six months of 2020.

Some of the more recent "smishing" campaigns revolve around impersonating delivery companies. This is particularly effective this time of year as we are all anxious about our holiday deliveries in light of the global supply chain issue. Imagine a text message impersonating UPS advising that there is a change in a scheduled delivery with a link prompting for your confirmation of some personal information. The webform that you are sent to is controlled by the cybercriminal and looks exactly like one you are familiar with. Mimicking PayPal and Amazon login pages are perennial favorite gambits.

Besides impersonating delivery services, expect to see smishing campaigns thanking you for a recent payment to your AT&T or Verizon account or something similar. The messages contain a link for you to "redeem" your special thank you gift by just completing a form. Again, the webform is identical to one you are used to seeing, but it is hosted on a malicious website. Sorry, but no thanks.

We would also suggest avoiding shortened URLs and QR codes. You really don't have any idea where they are going to send you unless you do a little bit of advanced research and investigation. Employees cheerfully simply click away.

Defending Those Vulnerable Smartphones

Cybercriminals will continue to target mobile devices as firms continue to embrace a work-from-home environment. To make matters worse, the security of mobile devices is typically left in the hands of the remote user and not the enterprise. That's another reason to seriously reconsider a BYOD (Bring Your Own Device) strategy and instead issue firm smartphones to end-users.

Train your employees to be particularly vigilant, especially if they use a mobile device to access corporate resources. Don't reply to suspicious text messages and by no means click on any of the links.

Proofpoint operates the 7726 text message system on behalf of the mobile carriers. To report a suspicious or fraudulent text message, forward it to the short code **7726** (SPAM) so that it can be investigated by your cellular carrier. Just like computers, make sure that your smartphone is up to date and fully patched with the latest software versions. Security firm Lookout reported that "56% of Android users were exposed to nearly three hundred exploitable vulnerabilities by running out-of-date versions of Android OS." Yikes.

In addition, you should be running some sort of security software on your smartphone (including iPhones) just like you do on your computer. After all, smartphones are really nothing more than small, hand-held computers that happen to be able to make phone calls. ■

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For Whom is the SOL Tolled?

By Joseph Milanowski, Melamed, Levitt, *Milanowski & Earls, PC*

For obvious reasons, practitioners need to have a good handle on the statute of limitations ("SOL") that applies to potential litigation they may consider getting involved in on behalf of a client. In the arena of residential and commercial property insurance, it has long been understood that the basic SOL applicable to litigation on a policy of property insurance in Michigan is roughly one or two years (depending on the usual policy language types) from the date a carrier formally denies liability. This basic assumption is drawn from the more specific statutory language applicable to property insurance policies.

Pursuant to MCL 500.2833(1)(q), litigation on a policy of property insurance must be commenced within one year after the loss, or within the time period specified within the policy, whichever is longer. However, the statute further provides for a tolling of the limitations period from the time the policyholder advises the carrier of the loss until the insurer formally denies liability, which provision was a legislative adoption of previous caselaw. *In re Certified Question*, 413 Mich 22, 319 NW2d 320 (1982). Most carriers have taken advantage of the permission to use a limitations period substantially shorter than is provided for breach of contract generally, and one- or two-year contractual limitation periods are typical. *Michigan Insurance Law and Practice*, Fabian, Slank, and Willmarth, Editors, ICLE, p. 381-382. Courts have held that the one-year (plus tolling) provisions of the statute are mandatory and engrafted upon a policy that does not specifically state that language. *Randolph v. State Farm Fire & Casualty*, 229 Mich App 102; 580 NW2d 903 (1998).

Statutory Tolling of the SOL May Not Apply to Surplus Lines Carriers

With apologies to the famous author and former owner of Michigan property, Ernest Hemingway, there are courts which have recently been muffling the bell which practitioners have become accustomed to hearing toll on the SOL. The question has been raised as to whether so-called "Surplus Lines Carriers" (often not licensed by the State of Michigan) are not subject to the statutory tolling provision and, thus, must be sued within the shorter one- or two-year period after the property loss date.

Surplus lines carriers are arguing they are exempt from the mandatory policy requirements of the Insurance Code, including the tolling clause for property insurance contracts, pursuant to MCL 500.1901, et. seq., which provides for certain exceptions to requirements applicable to domestic insurers.

Judges in both the Eastern District of Michigan and Wayne County Circuit Court have recently ruled that the tolling requirements of the Michigan Insurance Code do not apply to a surplus lines carrier. In *Klas Mgt., LLC v. Chubb Custom Ins. Co.*, No. 17-CV-12663, 2018 WL 3159676 (E.D. Mich., 2018), citing *Palmer Park Square, LLC v. Scottsdale Ins. Co*, 16-cv-11536, 2017 WL 227958 (E.D. Mich. January 19, 2017) rev'd on other grounds 878 F3d 530 (6th Cir, 2017), the court concluded that the surplus lines carrier was not bound by the mandatory tolling requirement of MCL 500.2833(1)(q). The *Klas* policy gave the insured two years from the date it sustained damage to file suit. However, Klas's legal action was filed two years and 1 month after the damage. The Eastern District concluded that Klas was not protected by the tolling provision of MCL 500.2833(1)(q) because Chubb Custom was a surplus lines carrier:

> Given that Chubb Custom is a surplus-lines carrier… it is not plausible that Klas is entitled to statutory tolling. Its breach-of-contract claim is thus barred by the policy's two-year limitations period. (*Klas* at p. 6).

The Wayne County Circuit's Business Court also concluded that the tolling provision in MCL 500.2833 did not apply to a policy issued by a surplus lines carrier. ~~in~~ *The Burlington Ins. Co. v. the Intern. Free & Accepted Modern Masons*, Wayne Circuit No. 18-006832-CB (August 28, 2019). The issue before that court was similar to the one in *Klas*: did the tolling provision of the Michigan Insurance Code apply to the insured's suit against the insurer where it was otherwise time barred? Like the policy in *Klas*, *Burlington's* insured was required to bring any action under the policy two years after the direct physical loss or damage occurred. Like the insurer in *Klas*, Burlington was a surplus lines carrier. In a written opinion, the circuit court concluded that the Burlington policy was not subject to MCL 500.2833's tolling provision because the insurer was a surplus lines carrier. Therefore, the contractual limitations period applied, making the insured's suit untimely.

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The argument that the tolling provision does not apply to surplus lines carriers seems to be this: surplus carriers are allowed to draft forms independent from and not subject to the Insurance Code. MCL 500.1904(2):

> (2) Forms used by unauthorized insurers [surplus lines carriers] pursuant to this chapter shall not be subject to this code, except that a policy shall not contain language which misrepresents the true nature of the policy or class of policies. [MCL 500.1904(2)].

The exemption provided by MCL 500.1904(2), the argument goes, grants surplus carriers the freedom to draft policies without provisions that standard admitted carriers must include in their policies. *Allen v. Michigan Property & Cas. Guaranty Assn*, 129 Mich App 271, 277; 341 NW2d 500 (1983). The express exemption of surplus line carriers from the provisions that govern authorized, admitted insurers recognizes the nature of surplus lines coverage. *Royal Prop Group, LLC v. Prime Ins. Syndicate, Inc*., 267 Mich App 708, 724-725; 706 NW2d 426 (2005). Surplus insurers provide a valuable service by offering coverage for risks that an authorized carrier will not cover. *Allen, supra* at 277; *Palmer*, *supra* at 4.

Those representing the insureds in these situations would argue that reliance on *Palmer,* and any subsequent case law relying on *Palmer*, as authority for the insurer's proposition that Michigan's statutory tolling provision does not apply in this kind of case is misplaced and should be disregarded by courts. On appeal, the 6th Circuit, in reversing the *Palmer* matter, declined to address the issue of whether the two-year contractual limitations period in the policy was tolled pursuant to MCL 500.2833(1)(q). The 6th Circuit Court of Appeals held, in pertinent part:

> Palmer argues in the alternative that, even if the two-year contractual limitations period applies to its claim for penalty interest, its claim is timely because the period was tolled under 500.2833(1)(q) of the Michigan Compiled Laws. The district court disagreed, concluding that surplus-lines insurers like Scottsdale are 'not subject to the general provisions of Michigan's Insurance Code," including 500.2833(1)(q). […] We need not reach this alternative argument because our conclusion that Palmer's claim is a personal action governed by the six-year limitations period found in MCL 600.5813 is dispositive of the appeal […].
>
> *Id.* at 541.

The 6th Circuit's refusal to address the statutory tolling provision issue, as a result of its dispositive ruling on an alternative argument, seemingly makes the trial court's decision on the statutory tolling provision a nullity. "The general common-law rule governing the effect of reversal on a judgment is that, after reversal, '[the] decree [is] no longer of any force or effect. The parties [are] in precisely the same situation as though no decree had been entered.'"[1]

Surplus Line Carriers' Arguments Against Tolling May Violate Public Policy

44 years ago, in *Tom Thomas Org., Inc. v. Reliance Ins. Co.,*[2] the Michigan Supreme Court construed an inland marine insurance policy that contained a 12-month statute of limitations period. The court noted that, although a 12-month period might "represent a reasonable balance between the insurer's interest in prompt commencement of action and the insured's need for adequate time to bring an action, the insured usually does not have the full twelve months within which to commence an action."[3] In fact, because of delays built into standard insurance policies, an insured will always have at least minimally less time to decide whether to commence an action against an insurer than the stated limitations. These delays frequently include the time dedicated to filing a proof of loss, claim investigation and the period allowed for payment or settlement of the claim.[4]

To reconcile the proof of loss, investigation and payment-of-claims provisions with the limitations provision, and to avoid the prejudice created by a potentially substantial delay of time by the carrier before making its claim decision, the *Thomas* court adopted the judicial tolling approach of the New Jersey Supreme Court. It allowed the contractual period for limitations in which to bring a lawsuit against an insurance company to run until the insured gives notice of a claim to the insurer. Then, the limitations period was tolled until the insurer formally denied liability.[5] The New Jersey court found this was the best way to give effect to "the literal language of the limitation provision…"[6]

Michigan and New Jersey were not alone in having adopted the tolling doctrine. As the leading treatise on insurance law, *Couch on Insurance,* notes, those courts' adoption of the tolling doctrine:

> …stems from the pragmatic knowledge that there simply is no reason to bring suit until the insurer has either formally denied the claim or delayed so long that the delay itself becomes the basis for a suit. This rule also avoids the possibility that the insurer may drag out negotiations while the period passes, leading either to insureds losing their rights in a questionable manner or to costly evidentiary battles over whether the insurers' actions should be deemed to be a waiver of the defense, or to estop the insurer from raising it.[7]

In the *McDonald* dissent[8], to the Michigan Supreme Court's decision to abolish most of the judicial tolling doctrine, Justice Kelly noted the untenable position insureds are in without the tolling of the statute of limitations:

> If they bring a claim too soon, the court may dismiss it as unripe. If they wait for the insurer to decide their claim, they risk a technical forfeiture under a limitation-of-suit provision. An insured should not be forced to choose between filing a premature lawsuit and trusting that the insurance company will consider the claim after the contractual limitations period has expired. Choosing the first option may unnecessarily poison the relationship between the parties. It may create unnecessary litigation that serves only to burden our overtaxed judicial system. Such a result has been accurately called both "anomalous and inefficient." *Guam Housing*, 2001 WL1555206, 2001 Guam 24 at 11. Yet choosing the second option gives insurance companies the opportunity to avoid coverage on timeliness grounds.[9]

Under the majority's decision in *McDonald*, insureds going forward were then required to not only file a timely claim, they may also have had to make the hard decision to sue rather than await a reply. Absent judicial tolling, the burden on the insured was greatly increased. On the contrary, use of the judicial tolling doctrine guaranteed that the insurer shared the burden – the insurer had to pay or deny the claim while leaving the insured sufficient time to decide whether to litigate or not.

The *McDonald* majority's attempt to return the parties to the certainty of the contractual language may have actually left them in a state of greater uncertainty. As stated fifty years ago by the New Jersey Supreme Court in *Peloso*, judicial tolling "is more satisfactory, and more easily applied, than the pursuit of the concepts of waiver and estoppel in each of the many factual patterns which may arise."[10]

In light of these types of issues, the Michigan Legislature enacted MCL 500.2833(1)(q), essentially codifying the judicial tolling doctrine and mandating that the time for commencing an action under a property insurance policy "is tolled from the time the insured notifies the insurer of the loss until the insurer formally denies liability."

Does MCL 500.1904 Exempt Surplus Lines Carriers from the Provisions of the Michigan Insurance Code – Or Are Only the "Rates" Charged and "Forms" Used Exempted?

Surplus lines carriers assert that MCL 500.1904(2) immunizes them from compliance with the entire Insurance Code, including MCL 500.2833(1)(q). Michigan's Insurance Code specifically identified certain requirements that would not apply to surplus lines and other unauthorized carriers. Those inapplicable requirements are "rates used by unauthorized insurers"[11] and "forms used by unauthorized insurers."[12] No language within the Code seemingly extends these exemptions and exceptions to its tolling provisions. In fact, when read as a whole, the Code may be interpreted as applying all its other provisions to unauthorized insurers, as it requires all such carriers to be tested regarding their "understanding of this chapter, the surplus lines insurance business, and other chapters of this act…"[13]

The word "form" in MCL 500.1904(2) is a precise term of art. Under Michigan law, a "form" "means a form identified in [MCL 500.2236] or in any other section of the act that is subject to section 2236 procedures for approval or disapproval of forms."[14] MCL 500.1904(2) exempts "eligible unauthorized insurers" from this arduous "form" approval procedure. It does not otherwise exempt surplus lines carriers and their policies from the Insurance Code.

As the Michigan Court of Appeals held in *Allen,* "the existence of surplus lines insurers provides an escape from the rigid rate and form regulations imposed by states on admitted insurers."[15] Beyond "rate and form" requirements, however, surplus lines carriers are likely not exempt from the substantive requirements of the Insurance Code – no statute appears to provide otherwise. In fact, the Insurance Code, when construed as a whole, arguably confirms that surplus lines carriers are not exempt from its substantive requirements.

> ... allowed the contractual period for limitations in which to bring a lawsuit against an insurance company to run until the insured gives notice of a claim to the insurer. Then, the limitations period was tolled until the insurer formally denied liability.

Potentially Significant Deleterious Consequences of Surplus Lines Carriers Arguments

Surplus lines carriers knowingly and voluntarily insure Michigan insureds' property. Insureds pay a large premium for this higher-risk commercial property coverage. Surplus lines carriers charge an increased premium to take on a high risk – a calculated gamble undertaken to make a profit. Paying substantial claims are a part of surplus lines carriers' business, and paying them timely is required by law. Surplus lines carriers are at no greater legal risk than any other business that has to pay its legal obligations when due.

Further, surplus lines carriers seemingly ignore the severe impact their position will have on adjustment of Michigan property insurance claims and judicial economy. The rulings urged by surplus lines carriers could encourage insurers to de-

lay paying contractual damages until close to or after the policy's limitation period lapses, and then argue that the insured's claim is time-barred.

A conclusion that MCL 500.1904(2) exempts surplus lines carriers from the Insurance Code may leave surplus lines carriers free to impose almost any restriction they desire – such as to cancel a fire insurance policy without statutorily-mandated notice, impose patently unreasonable contractual limitation periods, preclude appraisal or indefinitely delay paying a claim – without any recourse for the policyholder and others having an interest in the insured property (such as mortgage lenders). This position will also undermine judicial economy by forcing insureds to file premature lawsuits before claims are either denied or paid in order to protect inchoate actions. Not to mention that it puts unsuspecting practitioners at risk of mistakenly blowing a SOL.

The Michigan Legislature likely did not intend such disruptive results. To assume otherwise would likely violate the express purpose of the Insurance Code – that is, "[p]rotecting persons seeking insurance in this state."[16] ■

About the Author

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Endnotes

1 *Disher v. Citigroup Global Markets, Inc.,* 486 FSupp2d 790, 798 (SD Ill 2007) (quoting *Kaplan v. Joseph,* 125 F2d 602, 606 (7th Cir. 1942)). See also *Keller v. Hall,* 111 F2d 129, 131 (9th Cir. 1940) (quoting *Butler v. Eaton,* 141 US 240, 244; 11 SCt 985; 35 Led 713 (1891)) (a judgment, "after it was reversed, was 'without any validity, force, or effect.'").

2 *Thomas Thomas Org., Inc. v. Reliance Ins. Co.,* 396 Mich 588; 242 NW2d 396 (1976), rev'd by *McDonald v. Farm Bureau Ins. Co.,* 480 Mich 191 (2008).

3 *Id.*

4 *Id.*

5 *Id.* at 593-597, citing *Peloso v. Hartford Ins. Co.,* 56 NJ 514; 267 A2d 498 (1970).

6 *Peloso, supra* at 521.

7 *17 Couch on Insurance, 3d* § 237:39, pp. 237-45.

8 *McDonald, supra* at 211-212.

9 *Id.* at 212.

10 *Peloso, supra* at 521.

11 MCL 500.1904(1).

12 MCL 500.1904(2).

13 MCL 500.1905(3)(b).

14 Mich. Adm. Code R. 500.2231 (Appendix B). MCL 500.2236 sets forth the extensive procedures for filing with and obtaining approval of a policy "form" by the Commission of Insurance.

15 *Allen, supra* at 277.

16 MCL 500.1902(a).

The No-Fault Amendments: How Do the Priority Provisions Work with Dissimilar PIP Limits?

(Part II)

By Christian C. Huffman, *Garan Lucow Miller, PC*

Introduction

Part I of this article concluded by positing that whether a person who is required by the no-fault act's "priority rules" to claim PIP benefits under a no-fault policy having a lower allowable expense PIP benefit limit than their own policy (or a household member's policy) may claim "excess" allowable expense PIP benefits under the higher-limit policy likely cannot be resolved solely by reference to the language of by Mich. Comp. Laws §§ 500.3114(2), (3), or (5).

Instead, resolution of that issue necessitates interpreting those sections in context with the modifying clause contained in Mich. Comp. Laws § 500.3114(1), which states that "*[e]xcept as provided in subsections (2), (3), and (5)*, a [PIP] policy . . . applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of

either domiciled in the same household . . . ." As stated at the conclusion of Part I, this modifying clause can be interpreted in two different ways. It is those divergent interpretations that will be explored herein.

A. One possible interpretation of the modifying clause

On the one hand, section 3114(1)'s modifying clause could be interpreted as meaning that "a [PIP] policy . . . ***applies*** to accidental bodily injury to the person named in the policy" and members of the named insured's household ***unless*** the named insured or a member of the named insured's household is injured while occupying "a motor vehicle operated in the business of transporting passengers" as described in section 3114(2), while occupying a motor vehicle owned or registered by an employer as described in section 3113(3), or while occupying a motorcycle as described in section 3114(5).

If that is what the Legislature intended, then a PIP policy that was issued to the named insured does not "appl[y]" to the named insured or a member of the named insured's household. That is, the "[e]xcept as otherwise provided in subsections (2), (3), and (5)" modifying clause not only entitles a person to claim PIP benefits from another insurer and places that other insurer higher in priority to pay PIP benefits than the insurer that issued the policy to the named insured, but also wholly *disentitles* the named insured and members of the named insured's household from claiming PIP benefits under the policy purchased by the named insured.

As mentioned previously, before the amendments to the no-fault act that enabled insureds to select varying levels of allowable expense PIP benefits, any insurer that section 3114(1) rendered "first in priority" to pay PIP benefits to a person who was injured while occupying "a motor vehicle operated in the business of transporting passengers" as described in section 3114(2), while a specified occupant of a motor vehicle owned or registered by an employer as described in section 3113(3), or while occupying a motorcycle as described in section 3114(5), was always liable to pay unlimited allowable expense PIP benefits under section 3107(1)(a). Thus, there was never any need for Michigan's appellate courts to consider whether the "[e]xcept as otherwise provided in subsections (2), (3), and (5)" modifying clause of § 3114(1) operated to deprive a named insured or a member of his or her household from claiming PIP benefits under the named insured's own policy – since there was never any need for the named insured or a member of the named insured's household to do so. Rather, the practical effect of the "[e]xcept as otherwise provided in subsections (2), (3), and (5)" modifying clause, by entitling the named insured and members of the named insured's household to claim unlimited allowable expense PIP benefits under another policy and simultaneously placing that other policy "first in priority" was to render any policy that had been purchased by the named insured unnecessary to provide reasonably necessary products, services, and accommodations for the injured person's care, recovery, or rehabilitation.

Because the no-fault act operated that way for more than 45 years,[1] many practitioners have been left with a preconceived notion that if sections 3114(2), (3), or (5) are implicated, then a PIP policy that was issued to a named insured simply *does not apply* to the named insured or members of the named insured's household. Perhaps because of this preconceived notion, many practitioners postulate that the appellate courts will ultimately hold that the "[e]xcept as provided in subsections (2), (3), and (5)" modifying clause does, in fact, operate to not only place another insurer "first in priority", but to simultaneously disentitle the named insured, or a member of his or her household, from claiming allowable expense PIP benefits under the named insured's policy if the named insured's policy contains a higher allowable expense PIP benefit limit.

Indeed, some very experienced and esteemed no-fault practitioners are operating under this assumption, at least with regard to motorcyclists pursuant to section 3114(5), as evidenced by articles they have published discussing the potential impact of the recent amendments.[2] Moreover, at least one member of the Legislature himself seems to be operating under this impression, as the Legislator introduced a bill shortly after the amendments took effect seeking to again amend section 3114 to alter the priority and entitlement provisions as they pertain to persons who sustain injury while occupying a motorcycle.[3]

And, of course, it may well have been that the Legislature intended for the "[e]xcept as otherwise provided in subsections (2), (3), and (5)" modifying clause to disentitle a named insured, or a member of his or her household, from claiming "excess" allowable expense PIP benefits under the named insured's policy. To be sure, ordinarily "[a]n exception exempts absolutely from the operation of" and "takes out of an . . . enactment something which would otherwise be part of the subject-matter of it."[4]

Because the no-fault act operated that way for more than 45 years, many practitioners have been left with a preconceived notion that if sections 3114(2), (3), or (5) are implicated, then a PIP policy that was issued to a named insured simply does not apply to the named insured or members of the named insured's household.

Such a conclusion arguably finds support from the fact that the Legislature also amended Mich. Comp. Laws § 500.3135(3). This provision of the no-fault act states that

"tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by [Mich. Comp. Laws § 500.]3101(1) was in effect is *abolished*" - save for certain exceptions.[5] This general abolition of an injured person's ability to sue an at-fault motorist or motor vehicle owner in tort was a trade-off for the Legislature's vesting the injured person with the right to recover no-fault PIP benefits.[6]

The Michigan Supreme Court previously held that the Legislature did not exceed the bounds of the Due Process or Equal Protection Clauses by wholly precluding a person injured in an automobile accident from maintaining a tort suit seeking recovery of allowable expenses from an at-fault motor vehicle owner or operator, and instead limiting the injured person to recovery of allowable expense PIP benefits

Before the recent amendments, section 3135(3)(c) listed among the exceptions to the Legislature's general abolition of tort liability "[d]amages for allowable expenses, work loss, and survivor's loss as defined in [Mich. Comp. Laws 500.3107 to Mich. Comp. Laws 500.3110] in excess of the daily, monthly, and 3–year limitations contained in those sections."[7] However, prior to the recent amendments, the allowable expense PIP benefits that had to be provided under *any* applicable no-fault policy were not subject to any "daily, monthly, and 3–year limitations." Rather, as discussed previously, they were effectively unlimited because the insurer had to continue paying reasonable charges incurred by the injured person for products, services, or accommodations so long as they were reasonably necessary for the injured person's care, recovery, or rehabilitation from an injury suffered in a motor vehicle accident. Thus, section 3135(3)(c)'s reference to "[d]amages for allowable expenses" was "essentially an empty vessel" because, in practical effect, it never operated to permit a person injured in a motor vehicle accident to maintain a tort action for "[d]amages for allowable expenses."[8]

The Legislature's recent amendments to the no-fault act creating the varying optional levels of allowable expense PIP benefits now gives section 3135(3)(c)'s reference to "[d]amages for allowable expenses" some meaning with respect to instances where an injured person is limited to receiving allowable expense PIP benefits under a policy providing for less than unlimited allowable expense coverage, as the injured person can now maintain a tort action seeking damages for any "excess" allowable expenses. Thus, under an interpretation of the modifying clause of section 3114(1) that prohibits an injured person from claiming "excess" allowable expense PIP benefits under a higher allowable expense PIP benefit coverage policy that they or a member of their household maintains, section 3135(3)(c)'s reference to "[d]amages for allowable expenses" is no longer "essentially an empty vessel."[9]

Moreover, the Legislature's recent amendment of section 3135(3)(c) added the language "[d]amages for allowable expenses . . . *including all future allowable expenses . . . in excess of any applicable limit under section 3107c* . . . ."[10] Thus, one could certainly argue that the Legislature intended for its amendments to limit an injured person falling within the ambit of sections 3114(2), (3), or (5) to seeking recovery for any "excess" allowable expenses in a tort action against any at-fault operator and/or owner involved in the accident, and did not intend for such a person to be able to seek recovery of "excess" allowable expense PIP benefits from any "second in priority" no-fault insurer.

Conceivably, an argument could be made that this interpretation of the "[e]xcept as provided in subsections (2), (3), and (5)" modifying clause – which would preclude a named insured or a member of his or her household from claiming "excess" allowable expenses under a policy maintained by the named insured or a member of his or her household containing a higher allowable expense PIP benefit limit – cannot be afforded to section 3114(1) because it does not pass constitutional muster.

It is, of course, a fundamental rule of statutory interpretation that courts will avoid an interpretation of a statute that would render it unconstitutional.[11] But, the no-fault act has on several occasions withstood various challenges premised upon the Equal Protection[12] and Due Process[13] Clauses of the Michigan and United States Constitutions.[14] This is because the Legislature's objectives are cloaked with a presumption of constitutionality, and are subject to judicial review under the lenient rational basis standard.[15]

The Michigan Supreme Court previously held that the Legislature did not exceed the bounds of the Due Process or Equal Protection Clauses by wholly precluding a person injured in an automobile accident from maintaining a tort suit seeking recovery of allowable expenses from an at-fault motor vehicle owner or operator, and instead limiting the injured person to recovery of allowable expense PIP benefits.[16] Thus, one would think it would similarly pass muster under the Due Process and Equal Protection Clauses for the Legislature to now limit an injured persons' recovery of allowable expense PIP benefits from his or her own no-fault insurer, or the no-fault insurer of a member of his or her household, in exchange for reinstating the potential of maintaining a tort action seeking damages for allowable expenses.

Similarly, it is doubtful that an interpretation of the "[e]xcept as provided in subsections (2), (3), and (5)" modifying clause that would preclude a named insured

or a member of his or her household from claiming "excess" allowable expense PIP benefits under a higher-limit policy maintained by the named insured, or a member of his or her household, would be held to violate the Contracts Clauses; i.e., the provisions of the Michigan and United States Constitutions providing that "[n]o . . . law impairing the obligation of contract shall be enacted" by the Legislature.[17]

A policy of insurance is a contract.[18] Thus, on first blush, the Legislature's amending the no-fault act to preclude a person from obtaining recovery under an insurance policy that they or a member of their household purchased and paid premiums for would seem to run afoul of the constitutional prohibitions against legislation that impairs contractual obligations. However, these constitutional provisions only prohibit the enactment of legislation impairing rights that have become vested under an *existing* contract, not a contract that has yet to be entered into.[19]

Here, the Legislature's amendments to the no-fault act via 2019 Mich. Pub. Acts 21 and 2019 Mich. Pub. Acts 22 became effective on June 11, 2019. But, the new allowable expense PIP benefit limits, by which someone could choose a higher coverage limit than what might be available to them under another policy pursuant to sections 3114(2), (3), or (5), apply only to "an insurance policy that . . . is issued or renewed after July 1, 2020."[20]

Furthermore, an insurer would have no "obligation" pursuant to such contract that could be "impaired" by the amendments until *after* such a policy was issued, a subsequent motor vehicle accident occurred, and the named insured or a member of his or her household had thereafter incurred charges for reasonably necessary products, services, or accommodations for their care, recovery, or rehabilitation. This is because no "vested"[21] contractual right invoking the constitutional prohibition against the impairment of contractual obligations would exist until such time.[22]

Thus, it is entirely possible that Michigan's appellate courts may ultimately conclude that section 3114 not only places an insurer implicated by sections 3114(2), (3), or (5) "first in priority" to pay any allowable expense PIP benefits to which an injured person is entitled, but simultaneously precludes the injured person from seeking recovery of any "excess" allowable expense PIP benefits under a policy containing a higher allowable expense PIP benefit limit that the injured person either maintains themselves or which is maintained by a member of the injured person's household – i.e, that the policy does not "appl[y] to accidental bodily injury" to such persons.

B. The other possible interpretation of the modifying clause

While it is entirely possible that Michigan's appellate courts will ultimately reach the conclusion that the Legislature intended for the "[e]xcept as provided in subsections (2), (3), and (5)" modifying clause to preclude a named insured or a member of his or her household from receiving PIP benefits under a named insured's own policy, such is not a foregone conclusion. Rather, it is plausible that the Legislature intended for the modifying clause "[e]xcept as otherwise provided in subsections (2), (3), and (5)" to have a different effect after the enactment of 2019 Mich. Pub. Acts 21 and 2019 Mich. Pub. Acts 22.

That is, it is entirely plausible that the Legislature <u>did not</u> intend for the "except as otherwise provided in subsections (2), (3), and (5)" clause to mean that the named insured's policy does not "appl[y]" to the named insured or members of the named insured's household if they are injured while occupying "a motor vehicle operated in the business of transporting passengers" as described in section 3114(2), while occupying a motor vehicle owned or registered by an employer as described in section 3113(3), or while occupying a motorcycle as described in section 3114(5). Rather, the Legislature could well have intended that, even in such situations, a PIP policy purchased by a named insured or his or her household members *continues to be applicable* to that named insured and resident relatives of his or her household, and that the "[e]xcept as otherwise provided in subsections (2), (3), and (5)" modifying clause instead serves the alternate purposes of *expanding the class of persons who are entitled to claim PIP benefits under a particular policy* and placing that policy "first in priority" to pay PIP benefits to that person.

More specifically, the Legislature could very well have intended that "a [PIP] policy . . . *<u>applies</u>* to accidental bodily injury to the person named in the policy [and members of his or her] household" *unless §§ 3114(2), (3), or (5) are implicated, in which case the policy <u>also applies</u> to the occupant of the motor vehicle operated in the business of transporting passengers, the specified occupants of the employer-provided vehicle, or the occupant of the motorcycle*,[23] and simultaneously places that policy "first in priority" to pay PIP benefits to those occupants rather than any policy which may be maintained by the occupant or by a member of the occupant's household.

Interpreted in this manner, a policy that a person purchases *remains applicable* to that person and members of that person's household pursuant to section 3114(1) even though the injury occurred during the occupancy of a motor vehicle operated in the business of transporting passengers as stated in section 3114(2), during the occupancy of an employer-provided vehicle as stated in section 3114(3), or during the occupancy of a motorcycle as stated in section 3114(5). In such cases, it is just that the [e]xcept as otherwise provided" modifying clause renders the insurer specified in sections 3114(2), (3), or (5) *also liable* to pay PIP benefits to or for the benefit of the injured person, while simultaneously rendering the insurer specified in sections 3114(2), (3), or (5) "first in priority" to pay those PIP benefits and rendering secondarily liable the

insurance company that issued any policy under which the injured person or a resident relative is the named insured.

As such, under this interpretation, the insurer specified in sections 3114(2), (3), or (5) bears sole responsibility to pay any work loss, replacement service, or survivor's loss PIP benefits that the injured person may be entitled to recover, and also bears sole responsibility to pay allowable expense PIP benefits *up to* the allowable expense PIP benefit limit chosen by the named insured of the insurer specified in sections 3114(2), (3), or (5).[24] But, once any allowable expense PIP benefit limits of the policy issued by the insurer specified in sections 3114(2), (3), or (5) are exhausted, because any policy maintained by the injured person or a member of his or her household continues to "appl[y] to accidental bodily injury to the person named in the policy [or a member of his or her] household", such persons can then claim allowable expense PIP benefits from the other insurer if that policy provides for a higher allowable expense PIP benefit limit.

This alternative interpretation is arguably consistent with the fact that the legislative purpose of section 3114, as our Supreme Court has noted,[25] and as its title expressly states,[26] was merely to establish the "*order of priority* for claim[ing PIP benefits by a] motor vehicle occupant or motorcycle operator or passenger."[27] "[T]he word 'priority' is relevantly defined as 'in law, a precedence or preference in claims, etc.; as, certain debts are paid in *priority* to others.'"[28] It is similarly defined as "*[t]he status of being earlier in time or higher in* degree or *rank*; *precedence*" and "*[a]n established right to such precedence; esp., a creditor's right to have a claim paid before other creditors of the same debtor receive payment*."[29]

Thus, as commonly understood, the word "priority" indicates a legislative preference that insurers implicated by sections 3114(2), (3), and (5) take precedence over and pay PIP benefits before the insurer of the named insured, or the insurer of a member of the named insured's household, pays any PIP benefits which may be owed. However, it *does not* necessarily indicate that the Legislature intended that a named insured, or a member of his or her household, would not be able to claim additional allowable expense PIP benefits under a policy maintained by the named insured if and when the allowable expense PIP benefit limits of the other policy are exhausted.

This alternative interpretation of the effect of the "[e]xcept as provided in subsections (2), (3), and (5)" modifying clause of § 3114(1) is also, at least arguably, "most consistent with the purposes of the no-fault statute," the "overall goal" of which was "to provide victims with assured, adequate, and prompt reparations at the lowest cost to both the individuals and the no-fault system"[30] while simultaneously reducing the need for motor vehicle accident victims to resort to litigation to procure such reparation.[31]

It arguably serves the Legislature's goal of "provid[ing] victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses"[32] by ensuring that persons who may properly claim under a no-fault policy containing a higher allowable expense PIP benefit limit than a policy from which they are entitled to claim PIP benefits under sections 3114(2), (3), or (5) be able to promptly receive reparation for allowable expenses in the form of PIP benefits from a no-fault insurer, rather than have to suffer the long payment delays and potential under-compensation inherent in the tort system that the no-fault act was, in part, intended to replace.[33]

Moreover, the contrary interpretation of the "[e]xcept as provided in subsections (2), (3), and (5)" modifying clause of section 3114(1), whereby the implication of sections 3114(2), (3), or (5), precludes the named insured and members of his or her household from claiming any "excess" allowable expense PIP benefits under the named insured's own policy, would only partly serve the Legislature's intended goals in enacting the no-fault act. This is because such disentitled persons would receive "assured, adequate, and prompt reparation for certain economic losses"[34] from a no-fault insurer for *only some* of their allowable expenses. For any additional allowable expenses, they would be forced to pursue tort litigation - if possible - and to suffer the long payment delays and potential under-compensation inherent in doing so. And, if pursuing tort litigation were not possible, such as if there were no other at-fault motor vehicle involved in the accident or if the at-fault driver were uncollectable, they would have no avenue for seeking any additional reparation.

Similarly, this alternative interpretation of the "[e]xcept as provided in subsections (2), (3), and (5)" modifying clause of section 3114(1), at least arguably, best comports with the obvious legislative intention permeating through both the

original no-fault act and its recent amendments to ensure that persons who purchase no-fault policies receive the "benefit of the bargain" that is struck when a policy is purchased, while at the same time "assur[ing] that compulsory no-fault insurance in Michigan would be available to motorists at fair and equitable rates;"[35] i.e., that reparations for allowable expense PIP benefits come "at the lowest cost to both the individuals and the no-fault system."[36]

More specifically, under this alternative interpretation the person or entity that purchased the policy containing the lower allowable expense PIP benefit coverage limit made applicable by sections 3114(2), (3), or (5) receives the benefit of the reduced premium promised by the Legislature when it enacted section 3107c.[37] The insurer rendered "first in priority" by sections 3114(2), (3), or (5), in exchange for receiving the lower premium, receives the benefit of having its potential liability to pay allowable expense PIP benefits capped at that lower limit with respect to not only its named insured, but also with respect to members of the named insured's household and "an any other person with a right to claim [PIP] benefits under the policy."[38]

The injured person, on the other hand, receives the benefit of being entitled, and having members of their household similarly be entitled, to recover the higher allowable expense PIP benefit limit of their own policy in exchange for their having paid the increased premium therefore, while at the same time receiving the premium reductions applicable to any policy "issued or renewed after July 1, 2020"[39] that was promised by the Legislature via the recent no-fault act amendments contained in 2019 Mich. Pub. Acts 21 and 2019 Mich. Pub. Acts 22. Moreover, having received premiums from its named insured concomitant with its named insured having opted for a higher allowable expense PIP benefit coverage, the other insurer receives the benefit of its exposure being reduced by the lower allowable expense PIP benefit limit of the policy made applicable and placed "first in priority" by sections 3114(2), (3), or (5).[40]

And, finally, this alternative interpretation is, again at least arguably, entirely consistent with the Legislature's amendment to section 3135(3)(c). The reason is that it of course must be noted that the maintenance of a tort suit seeking recovery of allowable expense PIP benefits in excess of the limits of any policy made applicable by sections 3114(2), (3), or (5) would only be possible if there were, in fact, someone other than the injured person who was at fault for the motor vehicle accident. As such, the perceived Legislative intent of providing "assured, adequate, and prompt reparation for certain economic losses," including reparation for allowable expenses, "without regard to 'fault'"[41] would be contravened by the amendments under the first possible interpretation.

Similarly, since it was supposedly the Legislature's intent to create a system under which "victims of motor vehicle accidents would receive insurance benefits for their injuries as a substitute for their common-law remedy in tort,"[42] it seems unlikely that the Legislature intended for their amendments to create a dichotomy in which PIP benefit coverage for which a named insured, or a member of his or her household, had paid increased premiums is replaced with "the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or 'fault') liability system."[43] Instead, it seems more likely that section 3135(3)(c) was amended to permit the maintenance of a tort suit seeking recovery of "future allowable expenses" in instances where there is only one policy potentially available and its limits have been exhausted, or where there is more than one policy potentially available and the limits of each of them have been exhausted.

Conclusion

There is no clear answer as to whether the Legislature intended for its recent amendments to the no-fault act to preclude persons from claiming allowable expense PIP benefits under their own policy, or under a policy maintained by a member of their household, when sections 3114(2), (3), or (5) places another insurance policy having a lower allowable expense PIP benefit coverage limit "first in priority." Textual arguments, and preconceived notions founded upon the pre-amendment interpretation of the pertinent provisions of the no-fault act, may very well cause Michigan's appellate courts to conclude that a person is so precluded. However, both the text and the recognized legislative purposes behind the no-fault act and its amendments could ultimately result in Michigan's appellate courts ruling the other way.

It will be interesting to see how Michigan's appellate courts ultimately resolve this issue. ■

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Endnotes

1 The no-fault act became effective on October 1, 1973. Mich. Comp. Laws § 500.3179. And, as noted above, the varying coverage levels for allowable expense PIP benefits only apply to policies that are issued or renewed after July 1, 2020. Mich. Comp. Laws § 500.3017c(1).

2 *See, e.g.*, Ronald M. Sangster, *No-Fault Reform – The End Of An Era – Part II*, 12 J. Ins. & Indem. L., at 19 (Jul. 2019) ("[F] or [an] accident occurring after July 1, 2020, [a motorcyclist's] entitlement to no-fault benefits will be capped at whatever PIP coverage level was chosen by the owner of the motor vehicle involved in the accident."); *See also*, George T. Sinas et al., *Navigating The Chaos: The New No-Fault Legislation*, 16 (June 14, 2019) https://sinasdramis.com/wp-content/uploads/michigan-no-fault-reform-summary.pdf (stating that "[i]f a motorcyclist is in [an] accident involving another motor vehicle that has a limited no-fault policy, the motorcyclist will receive no-fault benefits under that limited no-fault policy, even if the motorcyclist purchased a no-fault policy on their own motor vehicle with higher limits or lifetime coverage.").

3 S.B. 528, 100th Leg., Reg. Sess. (Mich. 2019)(This bill was introduced by Senator Peter J. Lucido on September 19, 2019 – just three months after the recent amendments made by the Legislature via 2019 Mich. Pub. Acts 21 and 2019 Mich Pub. Acts 22 took effect on June 11, 2019. The bill was referred to the Senate's Committee on Insurance & Banking on the same date that Senator Lucido introduced it, September 19, 2019. Interestingly, we can find no record of this bill in the list of bills that are presently before the Committee on Insurance & Banking, and thus it appears that the bill likely died in committee).

4 *N. & M. Friedman Co. v. Atlas Assur. Co.,* 133 Mich. 212, 221; 94 N.W. 757 (1903) (quoting Bouvier's Law Dictionary).

5 *Grange Ins. Co. of Mich. v. Lawrence,* 494 Mich. 475, 490; 835 N.W.2d 363 (2013) ("Michigan's no-fault act generally abolishes tort liability arising from the ownership, maintenance, or use of a motor vehicle."); *Johnson v. Recca,* 492 Mich. 169, 175; 821 N.W.2d 520 (2012) ("Although the no-fault act generally abolishes tort liability arising from the ownership, maintenance, or use of a motor vehicle, [Mich. Comp. Laws §] 500.3135 provides several exceptions to the general rule.").

6 *Shavers v. Kelley,* 402 Mich. 554, 579; 267 N.W.2d (1978).

7 *Johnson*, 492 Mich. at 175 (quoting the version of § 3135(3)(c) before June 11, 2019).

8 *Johnson*, 492 Mich. at 189-90.

9 *Id.*

10 Mich. Comp. Laws § 500.3135(3)(c)(amended June 11, 2019) (emphasis added).

11 People v. Nyx, 479 Mich. 112, 124; 734 N.W.2d 548 (2007) (quoting U.S. v. Jin Fuey Moy, 241 U.S. 394, 401; 36 S. Ct. 658, 60 L. Ed. 1061 (1916)) (stating the fundamental rule that "'[a] statute must be construed, if fairly possible, so as to avoid not only the conclusion that it is unconstitutional but also grave doubts upon that score.'").

12 Mich. Const. art. I, § 2 ("No person shall be denied the equal protection of the laws."); U.S. Const. amend. XIV ("[N]or deny to any person within its jurisdiction the equal protection of the laws.").

13 Mich. Const. art. I, § 17 ("No person shall be . . . deprived of life, liberty or property, without due process of law."); U.S. Const. amend. XIV ("[N]or shall any State deprive any person of life, liberty, or property, without due process of law.").

14 *See, e.g.*, *Shavers v. Kelley,* 402 Mich. 554, 579; 267 N.W.2d (1978):

> The No-Fault Act, insofar as it provides benefits to victims of motor vehicle accidents without regard to "fault" (as a substitution for tort remedies which are, in part, abolished), constitutionally accomplishes its goal. After intense scrutiny of this litigation's extensive record, this Court holds that the No-Fault Act does not exceed the traditional scope of the Legislature's police power. The partial abolition of tort remedies under the act is consistent with constitutional principles articulated by this Court. The act's personal injury protection insurance scheme, with its comprehensive and expeditious benefit system, reasonably relates to the evidence advanced at trial that under the tort liability system the doctrine of contributory negligence denied benefits to a high percentage of motor vehicle accident victims, minor injuries were overcompensated, serious injuries were under-compensated, long payment delays were commonplace, the court system was overburdened, and those with low income and little education suffered discrimination.
>
> *See also*, *Davey v. Detroit Auto. Inter-Ins. Exch.*, 414 Mich. 1, 3-4; 322 N.W.2d 541 (1982); *O'Donnell v. State Farm Mut. Auto. Ins. Co.,* 404 Mich. 524, 537-38; 273 N.W.2d 829 (1979); *McKendrick v. Petrucci,* 71 Mich. App. 200, 203-07; 247 N.W.2d 349 (1976).

15 *Shavers*, 402 Mich. at 612-14.

16 *Id.* at 620-25.

17 Mich. Const. art. I, § 10; *see also* U.S. Const. art. I, § 10 ("No State shall . . . pass any . . . Law impairing the Obligation of Contracts".).

18 *Titan Ins Co v Hyten,* 491 Mich. 547, 554; 817 N.W.2d 562 (2012).

19 *Campbell v. Michigan Judges Ret. Bd.,* 378 Mich. 169, 180; 143 N.W.2d 755 (1966) ("Vested rights acquired under contract may not be destroyed by subsequent State legislation or even by an amendment of the State Constitution."); *Taylor Sch. Dist. v. Rhatigan,* 318 Mich. App. 617, 629-30; 900 N.W.2d 699 (2016) ("[T]he Legislature therefore did not in any way act to impair the [contract], because the [contract] simply did not exist at the time of the statutory enactment."); *Aguirre v. State of Michigan,* 315 Mich. App. 706, 715; 891 N.W.2d 516 (2016)

(quoting *Seitz v. Prob. Judges Ret. Sys.,* 189 Mich. App. 445, 455; 474 N.W.2d 125 (1991)) ("'These clauses provide that vested rights acquired under a contract may not be destroyed by subsequent state legislation.'").

20 Mich. Comp. Laws § 500.3107c(1); *Perkins v. Century Ins. Co., Ltd., of Edinburgh, Scotland,* 303 Mich. 679, 683; 7 N.W.2d 106 (1942) ("[E]ach renewal of a policy of insurance has been held to be a new contract."); *Brady v. NW. Ins. Co.,* 11 Mich. 425, 444 (1863) ("We have no doubt that each renewal of the policy was a new contract. Each was upon a new consideration, and was optional with both parties."); *See also Maurer v. Fremont Ins. Co.,* 325 Mich. App. 685, 696 n 6; 926 N.W.2d 848 (2018) (citing *Russell v. State Farm Mut. Auto. Ins. Co.,* 47 Mich. App. 677, 680; 209 N.W.2d 815 (1973)) ("A renewal policy is considered to be a new contract.").

21 *In re Certified Questions from U.S. Ct. of Appeals for the Sixth Cir*., 416 Mich. 558, 573; 331 N.W.2d 456 (1982) ("[O]nce a cause of action accrues, - i.e., all the facts become operative and are known—it becomes a 'vested right'.").

22 Mich. Comp. Laws § 500.3110(4)("Personal protection insurance benefits payable for accidental bodily injury accrue not when the injury occurs but as the allowable expense … is incurred."); *See also* Mich. Comp. Laws § 500. 3142(1)("Personal protection insurance benefits are payable as loss accrues.").

23 *See, e.g.*, *Michigan Mut. Ins. Co. v. Farm Bureau Ins. Grp.,* 183 Mich. App. 626, 633-34; 455 N.W.2d 352 (1990) (stating that the Legislative purpose behind § 3114(2) and (3) was to "create[] what amounts to a business household"):

[T]he Legislature generally "intended that an injured person's personal insurer stand primarily liable for . . . benefits whether or not its policy covers the motor vehicle involved and even if the involved vehicle is covered by a policy issued by another no-fault insurer." *Lee v DAIIE*, 412 Mich 505, 515; 315 NW2d 413 (1982). The "injured person's personal insurer" is, of course, the insurance company providing no-fault insurance in his household which was purchased by an "owner or registrant of a motor vehicle." MCL §§ 500.3101(1) and 500.3114(1). While a business can be an owner or registrant of a motor vehicle, and thus required to purchase no-fault insurance, a business obviously cannot be a "household," or have a "spouse" or "relative," in the primary and generally understood meaning of those words. Accordingly, insurers of business vehicles usually would not be first in order of priority under the general priority scheme. The Legislature recognized this and created what amounts to a business household in § 3114(2) and (3), so that responsibility for providing benefits would be spread equitably among all insurers of motor vehicles.

The business household in § 3114(3) consists generally of occupants of the motor vehicle who are related to the employee of the business. The household in § 3114(2) consists of the operator of the motor vehicle, and passengers under certain circumstances. [*Id*.]

24 Mich. Comp. Laws § 500.3107c(5).

25 *Belcher v. Aetna Cas. & Sur. Co.*, 409 Mich. 231, 251-52; 293 N.W.2d 594 (1980).

26 *People v. Bruce,* 504 Mich. 555, 576 n 15; 939 N.W.2d 188 (2019) ("If the body of a statute is ambiguous, a court may look to the title to resolve the ambiguity."); *Kalee v. Dewey Prod. Co.,* 296 Mich. 540, 545; 296 N.W. 826 (1941) ("Whenever the body of an act contains a provision which is considered ambiguous there is much justification, when a construction is called for, in giving consideration to the title which the act bears.").

27 (Emphasis added).

28 *In re* MGR, 504 Mich. 852, n 8; 928 N.W.2d 184 (2019) (Viviano, J., dissenting) (quoting Webster's New Twentieth Century Dictionary Unabridged, at 1431 (2d ed.)).

29 Black's Law Dictionary (11th ed.) (emphasis added); *See also Priority*, Black's Law Dictionary (6th ed.) (defining "priority", in relevant part, as "[p]recedence, *going before*. A legal preference or precedence. The relative ranking of legal claims to the same property.") (emphasis added).

30 *Celina Mut. Ins. Co. v. Lake States Ins. Co.,* 452 Mich. 84, 89; 549 N.W.2d 834 (1996) (In *Celina*, the Michigan Supreme Court applied this rule in determining the Legislature's intention regarding the scope of the provision at issue here, Mich. Comp. Laws § 500.3114(3). More specifically, the Court considered "whether § 3114(3) of the no-fault act applies when the injured person is operating an insured vehicle in the course of self-employment." *Id.* at 85. In determining that it does, the Court stated "[w]e believe that it is most consistent with the purposes of the no-fault statute to apply § 3114(3) in the case of injuries to a self-employed person" because doing so would "allocate the cost of injuries resulting from use of business vehicles to the business involved through the premiums it pays for insurance." *Id.*).

31 *Shavers v. Kelley,* 402 Mich. 554, 578-80; 267 N.W.2d (1978); *See also U.S. Fid. & Guar. Co. v. Michigan Catastrophic Claims Ass'n,* 484 Mich. 1, 25; 795 N.W.2d 101 (2009) (quoting *Miller v. State Farm Mut. Auto. Ins. Co.,* 410 Mich. 538, 568; 302 N.W.2d 537 (1981)).

32 *Shavers v. Kelley,* 402 Mich. 554, 578-79; 267 N.W.2d (1978); Celina Mut. Ins. Co. v. Lake States Ins. Co., 452 Mich. 84, 89; 549 N.W.2d 834 (1996).

33 *Shavers v. Kelley,* 402 Mich. 554, 579; 267 N.W.2d (1978).

34 *Id*. at 578-79; *Celina Mut. Ins. Co. v. Lake States Ins. Co.,* 452 Mich. 84, 89; 549 N.W.2d 834 (1996).

35 *Shavers*, 402 Mich. at 580.

36 *Celina Mut. Ins. Co. v. Lake States Ins. Co.,* 452 Mich. 84, 89; 549 N.W.2d 834 (1996).

37 Mich. Comp. Laws § 500.2111f.

38 Mich. Comp. Laws § 500.3107c(5).

39 Mich. Comp. Laws § 500.2111f(2); Mich. Comp. Laws § 3107c(1).

40 *Celina*, 452 Mich. at 89 (Incidentally, § 3114(3) renders an insurer higher in priority to pay PIP benefits than an injured person's personal insurer, or the insurer of their spouse or a resident relative, because the injured person was occupying an employer-provided vehicle. Like § 3114(2) with regard to "a motor vehicle

operated in the business of transporting passengers", § 3114(3) was "designed to allocate the cost of injuries resulting from use of business vehicles to the business involved through the premiums it pays for insurance."); *State Farm Mut. Auto. Ins. Co. v. Sentry Ins.*, 91 Mich. App. 109, 114; 283 N.W.2d 661 (1979) (In other words, as the Court of Appeals has explained, "[t]he exceptions in s[ection] 3114(2) and (3) relate to 'commercial' situations. It was apparently the intent of the Legislature to place the burden of providing no-fault benefits on the insurers of these motor vehicles, rather than on the insurers of the injured individual."); *See also Besic v. Citizens Ins. Co. of the Midwest,* 290 Mich. App. 19, 31-32; 800 N.W.2d 93 (2010); *Farmers Ins. Exch. V. AAA of Michigan,* 256 Mich. App. 691, 697-99; 671 N.W.2d 89 (2003); *Michigan Mut. Ins. Co. v. Farm Bureau Ins. Grp.,* 183 Mich. App. 626, 633-34; 455 N.W.2d 352 (1990).

41 *Shavers v. Kelley,* 402 Mich. 554, 578-79; 267 N.W.2d (1978).

42 *Shavers*, 402 Mich. at 579.

43 *Id.* at 578.

Legislative Update: Into the New Year and New Legislative Districts

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

We're now into the final year of the legislative cycle – with all state offices (Governor, Senate and House) up for election in November. And Michigan's newly minted Independent Redistricting Commission recently voted on new Congressional and state legislative district maps. The maps look much different and are likely to be challenged in the courts.

But, in the meantime, incumbents and candidates have started declaring for their current or new districts. Take a minute a find your house on the new maps – it's a good bet that you'll live in entirely new districts in 2023.

As for the legislative committees, they met a few times before the holiday break and sent four bills to the Governor:

- **WDCA – Forest fire fighters and cancers –** HB 4171 amends the Workers Disability Compensation Act to extend a presumption to forest fire officers and fire/crash rescue officers that certain cancers were caused by job hazards *Passed the House (106-3) on 3/17/21; Passed the Senate (35-0) on 11/2/21; House Concurred in Substitute S-2 (103-2) on 11/10/21; Signed by the Governor (PA 117'21) with Immediate Effect on 11/30/21*
- **WDCA – Firefighters and cancers -** HB 4172 amends the Workers Disability Compensation Act to extend a presumption to firefighters that certain cancers were caused by job hazards, and creates a First Responder Presumed Coverage Fund *Passed the House (106-3) on 3/17/21; Passed the Senate (35-0) on 11/2/21; House Concurred in Substitute S-1 (96-3) on 12/2/21; Signed by the Governor (PA 129'21) with Immediate Effect on 12/15/21*
- **Group health claim disclosures –** SB 447 amends the Insurance Code to require disclosure of group health claim utilization in certain circumstances *Passed the Senate (35-0) on 11/10/21; Referred to the House Insurance Committee on 11/10/21*
- **Annuity interest rates –** SB 624 amends the Insurance Code to modify the interest rate used in determining the minimum nonforfeiture amount in annuities *Passed the Senate (34-1) on 11/10/21; Referred to the House Insurance Committee on 11/10/21*

And the Legislature as a whole remains busy – 1663 bills introduced in the House and 796 in the Senate – with some new referrals to the House and Senate Insurance Committees:

- **HB 5303 –** amends the No-Fault Act to modify the reimbursement fee schedules.
- **HB 5307 –** amends the No-Fault Act to modify the order of priority for motorcyclist PIP claims.
- **HB 5341 –** amends the No-Fault Act to permit an insured to select the $50,000 PIP limit if they are a participant in a health care sharing ministry.
- **HB 5498 –** amends the No-Fault Act to modify a PIP utilization review by incorporating a "medically accepted standards requirement" and defining that term.
- **HB 5499 –** amends the No-Fault Act to expand the hour limitations for attendant in-home care.
- **HB 5500 –** amends the No-Fault Act to insert the defined term "medical treatment" into the PIP reimbursement schedule.

- **HB 5626 –** amends the No-Fault Act to extend the requirement for an insurer to issue a policy (without fee or increased premium) to a previously uninsured vehicle owner.
- **HB 5648-5649 –** amends the Vehicle and Insurance Codes to eliminate the requirement that active duty military Michigan residents living out-of-state possess a no-fault policy when renewing vehicle registration.
- **HB 5651 –** amends the Insurance Code to limit the restrictions insurers can place on health policy coverage for telemedicine.
- **HB 5654 –** amends the Insurance Code to require prescription drug insurance policies to cover hormonal contraceptives.
- **SB 712 –** amends the Insurance Code to modify the liquidation and rehabilitation procedures for fraternal benefit societies. ■

Selected Insurance Decisions

By Deborah A. Hebert & Margaret Cernak, *Collins, Einhorn, Farrell PC*

Michigan Court of Appeals – Unpublished Decisions

UM coverage properly denied for failure to file a police report within 24-hours

Hensley v Auto Club Group Ins Co
Docket No. 353205
October 14, 2021

Plaintiff's UM policy with Auto Club applied to hit-and-run accidents only if the insured submitted a written report of the accident to a law enforcement agency "within 24 hours." Because plaintiff waited two days before reporting this accident to the Inkster Police Department, his claim for UM benefits was properly rejected. Plaintiff's handwritten "statement sheet," which was unsigned and unwitnessed, and not submitted to any law enforcement agency, did not suffice.

UIM insurer ordered to cover prejudgment interest, penalty interest, and case evaluation sanctions in excess of policy limits

Atkinson v Kreilter, American Alternative Ins Corp, et al
Docket Nos. 353079, 353080, 353364
October 21, 2021
Motion for Reconsideration den 12/2/21

This UIM claim arises out of an accident that occurred when a vehicle operated by defendant Kreilter collided with an ambulance insured by American Alternative. Two of the three occupants of the ambulance were fatally injured. Kreilter's vehicle was insured under a liability policy with a limit of $50,000 per accident, so the $1,000,000 UIM coverage for the ambulance was in play. And the jury ultimately awarded separate damage awards for the three occupants, which resulted in judgments totaling more than $1,200,000.

American Alternative never disputed the availability of UIM coverage and denied having breached any contractual obligation to pay (presumably because its UIM coverage required a determination of the tortfeasor's liability exposure and was conditioned on payment of the tortfeasor's policy limits). The Court of Appeals disagreed, and went on to hold that American Alternative was responsible for prejudgment interest, case evaluation sanctions, and penalty interest in excess of its policy limit.

The panel acknowledged that American Alternative's UIM contract did not include a "standard interest clause," which affords separate coverage for pre-judgment interest. Nor did the panel quote any contract provision affording coverage for an insured's other litigation costs, including case evaluation sanctions. But because the policy didn't expressly exclude separate coverage for prejudgment interest and litigation costs, the coverage was available, including for evaluation sanctions. And it was not subject to the $1,000,000 limit because that limit applied only to the insured's "compensatory damages." As to penalty interest, the panel acknowledged the Supreme Court's decision in *Nickola v Mic Gen Ins Co*, holding that "an insured making a claim under his or her own insurance policy for UIM benefits cannot be considered a 'third party tort claimant' under MCL 500.2006(4)." But the panel found coverage here because the Supreme Court in *Nickola* did not base its decision on proofs of loss. American Alternative was, however, allowed to offset the statutory interest owed on the judgment. Finally, the Court declined to reduce the $1,000,000 UIM limit by the $50,000 in liability insurance available for the tortfeasor because "it is not clear from the record whether this amount was actually paid" and so "we are not persuaded that the trial court erred by declining to rule on the issue."

Coordination of No-Fault Benefits with HMO plan

Estate of Reid v
Wardell Council and State Farm Mut Auto Ins Co
Docket No. 355062
November 9, 2021

State Farm issued a coordinated auto policy to its insured, who had health insurance through an HMO plan with Blue Care Network. That HMO plan restricted the insured's choice of providers other than for emergency purposes. Intervening provider-plaintiffs were not approved HMO providers. And there was no evidence that their services were emergency-based or otherwise approved by the HMO plan. Relying on MCL 500.3109a and the Supreme Court's opinion in *Tousignant v Allstate Ins Co*, 444 Mich 301 (1993), the court held that plaintiff "was required to establish that BCN 'would not or could not provide the medical care she needed'" before seeking primary coverage under her auto policy with State Farm. Because there was no such evidence, the trial court erred in failing to grant summary disposition for State Farm on these claims for payment.

Priority of coverage between UIM policy and the at-fault driver's personal umbrella policy

James River Ins Co v Citizens Ins Co of America
Docket No. 355140
November 18, 2021
Motion for Reconsideration pending

The injured party was operating his personal vehicle while logged onto the Uber platform when he was struck by a vehicle with liability insurance limits of $100,000 per person. The at-fault driver also had a personal umbrella policy with Citizens, which provided coverage for auto claims after the first $250,000 in liability exposure. And as an occupant of the vehicle logged onto the Uber platform, the injured party qualified for UIM coverage up to a limit of $1,000,000 under the commercial auto policy issued by James River.

All agreed that the at-fault driver's policy was responsible for the first $100,000 in liability exposure, and that James River was responsible for the next $150,000. The dispute was over the priority of coverage between the UIM coverage and the personal umbrella coverage after $250,000. Both coverage forms contained "other insurance" clauses making coverage excess to any other "available" or "applicable" insurance. The court concluded that "when the two policies are read in context, it is clear that the James River underinsured-motorist policy is intended to be a primary policy that provides excess coverage under limited circumstances" for auto-related liability, whereas the Citizens policy was a true excess policy. So James River was responsible for all damages in excess of the first $100,000.

Rescission allowed for pre-litigation, postprocurement fraud due to substantial misrepresentation

Meemic Ins Co v Estate of Pearce
Docket No 352724
November 23, 2021
Cavanagh, J. dissenting

The majority opinion appears to be the first attempt to coordinate the seemingly inconsistent, post-*Bahri*, published decisions on contract rescissions in *Haydaw*, *Fashho*, and *Meemic v Fortson*. As explained by the majority, "[t]he current state of insurance fraud litigation in Michigan separates fraud into two broad categories: (1) fraud that occurred before litigation; and (2) fraud that occurred after litigation began." Post-litigation fraud cannot void an insurance contract. And where fraud occurs prior to litigation, the test for rescission depends on whether the fraud occurred preprocurement or postprocurement. If preprocurement, common law contract principles apply. If postprocurement, rescission is limited to substantial breaches only. In this case, the fraud occurred prior to litigation, when the insured added a driver (her daughter) as a household member but failed to report that information to Meemic. And the breach was substantial because the daughter had a prior alcohol-related driving offense on her record and regularly drove one of the covered autos. Meemic would not have continued the coverage had it been provided this information.

The dissent relied on another published decision, *Williams v State Farm,* as the controlling authority, and concluded that rescission is limited to preprocurement fraud. This insured did not misrepresent household members when she applied for the policy. The dissent also concluded that antifraud provisions are not essential terms of insurance contracts, so an insured's failure to update information is not a substantial breach of the contract.

Man who simultaneously maintained two residences, one being the home he shared with his mother, was entitled to liability coverage as an "insured" under the mother's homeowner's policy.

Muha v Allstate Property and Casualty Insurance Co
Docket No. 354476
December 16, 2021

Walid Odeh lived in a home owned by his children's mother, Krystine Muha. He also lived in a home owned by his mom, Connie Odeh. Muha's home was destroyed by fire. Allstate was her homeowner's insurer. Allstate denied coverage, accusing Walid of setting the fire. Muha sued Allstate; Allstate filed a third-party subrogation complaint against Walid. Walid tendered the suit to Connie's homeowner's carrier, Pioneer. Pioneer filed a declaratory judgment action against Walid, but did not name Allstate, Connie or Muha as party-defendants. Pioneer and Walid eventually settled. Muha and Allstate also settled. Allstate then got a judgment against Walid, and filed a garnishment action against Pioneer.

In the garnishment action, the trial court granted summary disposition in Allstate's favor. The court of appeals affirmed. First, the appellate court rejected Pioneer's arguments that the suit was barred by collateral estoppel, res judicata, or as a collateral attack on the settlement between Pioneer and Walid. The court then found that because Pioneer's policy defined "insured" to mean the named insured and "residents of your household" who are "your relatives," Walid qualified as an insured on Connie's policy. Under Michigan law, a person can be a resident of more than one household, and the facts in the record were that Walid routinely lived at both Connie's and Muha's homes. Because one of Walid's residences was Connie's home, the Pioneer policy provided liability coverage for Walid, and Pioneer was obligated as garnishee for the judgment against Walid.

Coverage for construction defect claims remanded to trial court

Skanska USA Building, Inc v Amerisure Ins Co (On Remand)
Docket Nos. 340871 and 341589
December 28, 2021

On remand, the opinion in this construction defect case first summarizes the Supreme Court's decision on why *Hawkeye-Security Ins Co v Vector Construction* does not apply to current CGL insuring agreements, and the conclusion that "an 'accident' may include unintentionally faulty subcontractor work that damages an insured's work product." It then reasons that because the Supreme Court did not overrule or reject *Hawkeye-Security Ins Co v Vector Construction* as competent authority, but instead concluded that it does not apply to present day contract language, there was no basis to consider the decision's prospective or retroactive effect. The panel opted to remand the case back to the lower court to address how this new law applies to this claim. It determined that additional information is needed to decide whether the named insured's "own faulty workmanship that damages only its own work product, requiring the product to be repaired or replaced" qualifies as an accident as discussed by the Supreme Court. It also determined that arguments regarding policy exclusions were premature.

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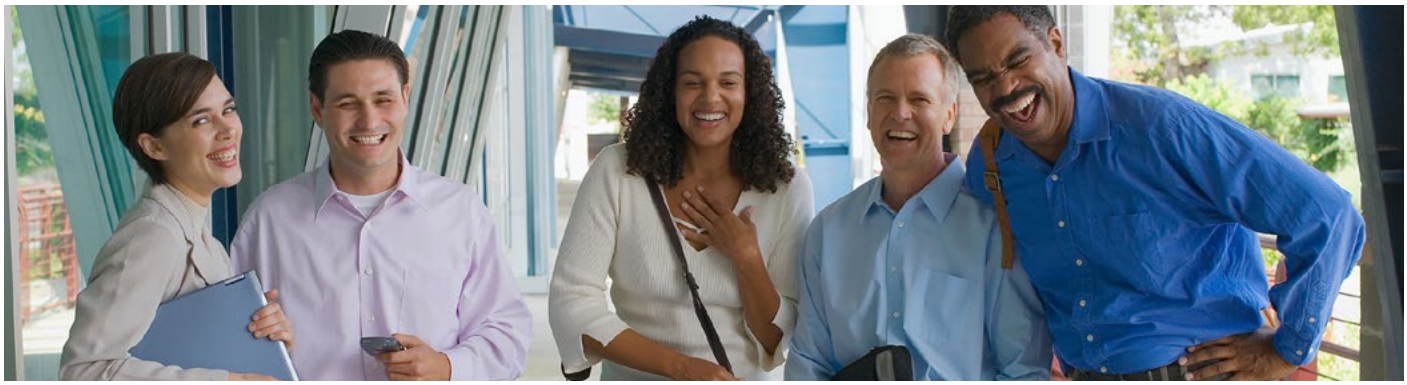

Sixth Circuit Court of Appeals

"Known or should have known" exclusion applies to claim for loss of contaminated vegetable products

Arbre Farms Corp v Great American E&S Ins Co
Case No. 21-1091
November 2, 2021

Plaintiff-insured grows vegetables and sells them to food manufacturers and distributors. In 2017, a batch of its green beans had to be quarantined after testing positive for pathogenic bacteria listeria monocytogenes (LM). The insured learned in 2019 that the beans were accidentally mixed with 8 million pounds of products, all of which had to destroyed. The insured looked to Great American for coverage, but its policy contained an exclusion for any "insured event" or set of circumstances giving rise to an "insured event" if discovered, known by, or should reasonably have been known by, the insured prior to the policy inception. The insured never claimed any ambiguity in the contract language below so the 6th Circuit found that appellate argument to be unpreserved. And because there was no dispute about the initial discovery of the contaminated product in 2017 and the 2018 inception date for Great American's policy, the exclusion applied.

Coverage afforded by the other two insurers named in the lawsuit were subject to the same terms as the Great American policy. In addition, coverage applied only after Great American's limits were exhausted.

Federal District Court – Eastern District of Michigan

No coverage for pandemic-related economic losses and business shutdown due to lack of direct physical loss and under the virus exclusion

Madison Square Cleaners v State Farm Fire and Casualty Co
Case No. 2:21-cv-11273
September 17, 2021

Executive orders forced the insured dry-cleaning business to suspend operations. The insured suffered economic losses and permanently closed its doors. In a short opinion, the court granted the insurer's motion to dismiss plaintiff's complaint for its pandemic-related economic losses because (1) the insured did not allege any direct physical harm to covered property and (2) the policy excluded harm resulting from a virus.

Rental policy covering property when "used principally as a private residence" did not require actual occupancy at the time of loss and allowed for an issue of fact as to what activities satisfy that condition.

Carver v State Farm Fire and Casualty Co
Case No. 19-cv-13634
October 19, 2021

Plaintiff's father conveyed a house to plaintiff, which the plaintiff then leased to tenants. State Farm issued a rental dwelling policy on the property. When the original tenants left the house, plaintiff leased it back to his parents on a month-to-month basis, and plaintiff's father used the garage as a wood workshop. During that time, the property sustained water damage. State Farm denied the plaintiff's claim on the ground that the loss resulted from plaintiff's failure to use reasonable care to maintain heat in the house. However, in the coverage action, State Farm moved for summary judgment on the ground that the property was not being "used principally as a private residence" as required for coverage under the policy. The court denied the motion. First, the court found that the policy language required only that the insured property be a family dwelling, and did not preclude coverage because the plaintiff was in-between tenants. Second, the court found that what constitutes "*principally*" using the premises as a private residence is a question of fact, which might be satisfied by the parents' regular use of the premises, even though they slept elsewhere.

Court again dismisses complaint for COVID-19 business income losses

Milan v The Cincinnati Insurance Co
Case No. 20-cv-12222
October 21, 2021

"Plaintiff's dental practice, like most businesses, was detrimentally affected when it was forced to suspend or reduce its operation pursuant to civil orders enacted to stem the spread

of COVID-19." In line with Sixth Circuit and other Michigan District Court decisions, the court found that there must be direct physical loss or direct physical damage to state claims for Business Income, Extra Expense, and Civil Authority coverages.

Insurer entitled to rescind homeowners policy

Taybron v Liberty Mutual Ins Co
Case No. 20-cv-10925
October 21, 2021

In the course of investigating the insured's claim for a fire loss to her insured home, Liberty Mutual learned that plaintiff operated a licensed in home day care business on the premises. The insured claimed that she reported that fact to the insurer's sales representative, a claim that the representative refuted. Most importantly, the application signed by the insured electronically asked whether any businesses were operated on the premises, and specifically, whether the insured provided home day care services. The insured answered both questions: "no." The court relied on *Bazzi v Sentinel Ins Co* and general elements of fraud to find that the insured knowingly made a material misrepresentation in signing the application with this false information. The contract could be rescinded.

Reinsurer not entitled to rescind its certificates; and reinsurer's payments for loss expenses did not to erode the certificates' liability limits.

Amerisure Mutual Insurance Co v Transatlantic Reinsurance Co
Case No. 18-cv-11966
November 23, 2021

The plaintiff issued general liability and umbrella policies to Armstong Machine Works. The defendant reinsurer covered a portion of the plaintiff's risk under umbrella policies. Over the years, Armstrong was sued in thousands of cases of asbestos-related injuries. When the claims reached the defendant's reinsurance layer, defendant refused to pay. Plaintiff sued, and the court issued a lengthy opinion, including a choice of law analysis, as to competing summary judgment claims by the parties.

The defendant argued that it was entitled to rescind the certificates of reinsurance because (1) the plaintiff knew of and failed to disclose the asbestos exposure and (2) the defendant would not have issued the reinsurance certificates had it known of such exposure. The court found issues of fact on both points. The court also found issues of fact as to the defendant's claim for rescission on the basis of untimely notice, there being evidence from which a factfinder could conclude that the plaintiff reasonably may have believed that the reinsurer wasn't earlier facing liability. Finally, the court found that under the terms and conditions of the reinsurance certificate, the defendant's payment for loss expenses did not count against the liability limits of the certificates; only loss settlements would exhaust the certificate's liability limits.

Insurer entitled to rescind homeowner's policy after fire loss due to insured's misrepresentation that property taxes were not delinquent

Peatross v Liberty Mutual Personal Insurance Co
Case No. 20-cv-10919
December 14, 2021

Plaintiff purchased a home by quitclaim deed, and didn't check to see whether property taxes had been paid. They had not been paid for three years. When plaintiff applied for homeowner's insurance, she stated that to her knowledge, property taxes were current. After investigation of a fire loss at the property, the insurer rescinded the policy because it would not have issued the policy had it known the property taxes were delinquent for three years. Even if the misrepresentation was innocent, the court found that it was material. Plaintiff argued that under the Essential Insurance Act, specifically MCL 500.2103, she was an "eligible person" who could not be denied home insurance because she wasn't the one who had failed to pay the taxes for two or more years. The court found that plaintiff was responsible for the delinquent property taxes, such that she was not an "eligible person" under the statute. Further, the Act provides only for administrative remedies and did not prevent enforcement of the policy language permitting the insurer to rescind for a material misrepresentation.

Federal District Court – Western District of Michigan

Agreeing to pay pro-rata time-on-the-risk for long-tail environmental claims doesn't satisfy duty to defend

Wolverine World Wide, Inc v American Insurance Co
Case No. 19-cv-10
October 18, 2021

The underlying complaints alleged claims for tannery-waste groundwater contamination from 1971-1986. The CGL insurers on the risk contended that the insured wanted to keep control of its defense and merely wanted the insurers to share defense costs, which the insurers agreed to do. The court rejected the insurers' argument that this satisfied their defense obligation. The court found that the insured's request for "participation," "costs sharing," and "steadfast control of its defense" did not excuse or modify the insurers' duty to defend. Rather, "[t]he onus is on the insurers to bargain for a writing relieving them of the duty to defend." The court also found that there were factual issues as to whether coverage was limited by pollution exclusions. ■

SBM

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