The Journal of Insurance & Indemnity Law

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If you have an article idea for the Journal, please contact the editor, Christine Caswell at christine@caswellpllc.com

Greetings and Happy New Year!

Ann-Marie E. Earls
Michigan Senate

I hope all our members had a relaxing and joyous holiday season! As we reflect on our Section's accomplishments in 2024 and aspirations for 2025, I want to thank Patrick Crandell, our past Chairperson, for his incredible work. He has worked tirelessly over the last year to seamlessly transition the *Insurance & Indemnity Section Journal* to its electronic form, increase engagement at our educational programs and networking events, and to make our committees more effective and efficient. I am excited to continue his work in the year ahead of us.

I also want to take a moment and introduce this year's Council and Executive Team:

Chair-Elect: Doug McCray;

Secretary: Jennifer Serwach;

Treasurer: Mike Spinazzola;

Council: Elizabeth King, Melissa Hirn, Stephanie Brochert, Charlotte McCray, Christopher Petrick, John Sier, Amy Diviney, Justin Gonzales, Alison Koppin, and Anthony Snyder.

As the newly elected Chairperson, I am honored to take on this role and would like to extend my heartfelt thanks to our section members for entrusting me, our Executive Team, and our Council to lead the section over the next year. Together, we aim to build on a foundation of excellence and foster innovation, collaboration, and growth within our section.

In addition to increasing engagement at our educational programs and other events, I plan to focus on continued participation from our committee members, expanding the reach of our scholarship program and cross-section collaboration on future events.

2024 Annual Meeting and Program

Our Annual Business Meeting and Program, held on October 28, 2024 at the Saint John's Resort in Plymouth, was a great success. The topic of this year's program was "AI, Ethics, and Efficiency in the Legal Practice and its Potential Influence on the Insurance Industry." I would especially like to thank our presenters, Senior Attorney John Allen of Varnum LLP; attorney and Chief Executive Officer Kellie Howard of Collins Einhorn; and Attorney and Risk Control Consulting Director Tracy Kepler, for CNA Insurance Company's Lawyers' Professional Liability Program.

This program highlighted the intersection of AI, legal ethics, and its implications for the insurance industry, providing valuable insights into the future of AI-driven practices in the legal and insurance fields. Among other things, we learned the integration of AI into the legal profession is reshaping traditional workflows and offers significant benefits in terms of efficiency, accuracy, and accessibility. However, it also presents challenges that must be carefully managed to ensure ethical and equitable use. As AI continues to evolve, legal professionals must adapt and find a balance between leveraging technology and preserving the human elements of legal practice. Ultimately, AI is not a replacement for lawyers but a powerful tool to augment their capabilities and deliver better outcomes for clients. The program was well-attended, and its attendees were engaged with the topic presented and asked many questions. Thank you to our attendees for making the program such a great success!

Next Business Meeting and Mixer

Our next business meeting is on Thursday, January 30, 2025 at 4:00 p.m. at DraftKings Sports & Social in Troy, Michigan. It will be followed by heavy appetizers, drinks, and trivia from 4:30-6:30 p.m. There is no charge for this event. Please register today by emailing Joan O'Sullivan at josullivan3399@gmail.com. While the Business Meeting may be attended via Zoom, I encourage everyone to come out and join us in person. I expect it will be a lot of fun!

We also look forward to hosting two or more additional educational programs and social events during the year. If you have any suggestions for topics or speakers for our programs, please email me.

Concluding Thoughts

I would like to welcome our new members and sincerely thank our existing members for their continued involvement in our Section. I encourage everyone to actively engage by attending events, contributing articles to the *Journal*, or assisting in planning educational programs.

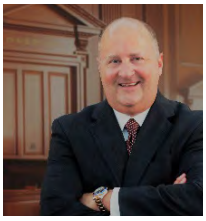
I am truly excited about the future of our Section. Having been a member for over a decade and serving on the Council, Executive Team, and now as Chairperson, I've had the privilege of meeting many remarkable members who have enriched both my personal and professional life. I hope your experiences in this Section have been equally rewarding.

If you have any feedback to help us enhance the Section, I encourage you to share your thoughts by emailing me at anniee-arls@mlmepc.com. Wishing you a happy New Year, and I look forward to seeing you at one of our programs or meetings!

Save the Date

Council Meeting and Social Outing

IIS's next business meeting is on Thursday, January 30, 2025, at 4 pm at DraftKings Sports & Social in Troy, Michigan. It will be followed by heavy appetizers, drinks, and trivia from 4:30-6:30 pm. There is no charge for this event. Please register today by emailing Joan O'Sullivan at josullivan3399@gmail.com.



Balancing the Equities: The Application of Insurance as a Sword and Shield.

By Michael S. Hale, Clairmont Advisors, LLC and Hale & Hirn, PLC

Insurance applications can serve as swords and shields by insurers and can be timebombs waiting to go off in many cases. They deserve the critical attention of those signing them.

In the recent unpublished case of *USA Underwriters v DeJonnae Audrey Isaac,*[1] decided December 17, 2024, the Michigan Court of Appeals held that the "balancing of the equities" defense in an insurance recission action must be raised at the trial court or it is waived and, as a result, did not preclude rescission of a personal automobile insurance policy.

In that case, an application for personal automobile insurance stated that the insured had a valid driver's license. A policy of no-fault automobile insurance was then issued. Following an accident, the insurer, USA Underwriters, rescinded the policy based upon the revelation that the insured did not have a driver's license, a misrepresentation in the application. The injured party filed a lawsuit against the driver and a declaratory judgment action resulted. Progressive, which had issued an automobile policy to the injured party with uninsured/underinsured motorists' benefits, was added as a defendant. Progressive argued that per MCL 500.3009, USA Underwriters was required to provided residual liability benefits regardless of any misrepresentation, limiting Progressive's exposure. Citing a footnote in the Michigan Supreme Court case of *Titan Ins Co v Hyten,*[2] Progressive argued that fraud in the application precluded rescission for residual liability claims of innocent third parties.

The court held that the footnote in *Titan* was not of precedential value per *Bazzi v Sentinel Ins Co*[3] and that MCL 500.3009 did not include limiting language which would preclude rescission. Furthermore, the court cited *Bazzi* for the proposition that the appropriate inquiry at the trial court was a balancing of the equities, yet this was not argued at the trial court and thus, was waived.

This recent case, *albeit* unpublished, demonstrates that misrepresentation and rescission remain viable defenses being pursued by insurers in Michigan. According to one statistic, there were 17,654 insurance cases filed in federal court alone in 2024. We venture an educated guess that a good number of these cases involve misrepresentation and rescission.

Perhaps one of the worst representations (pun intended) of the insurance industry relates to insurance applications. They are traps for the unwary, often asking for a representation of information in questions that no one could ever possibly accurately answer.

In life insurance, the insurer generally only has two years to determine the existence of any misrepresentation, material or not. This is not so with business or personal lines insurance where insurers have the right to make this assertion at virtually any time.

Most property and casualty insurance policies contain some sort of provision governing concealment, misrepresentation, or fraud. These provisions allow the insurance company to void the policy if any insured conceals or misrepresents a material fact relating to coverage, the covered property, their interest in the covered property, or a claim presented under that coverage part. The pertinent inquiry is often whether the insurer would not have issued the policy or would have charged a higher premium had it known the correct answer.

Garaging locations of vehicles are often questioned by insurers at the time of an automobile insurance claim. At least one insurer requires notification by the insured within 30 days of any change in garaging locations. This is a scary proposition given the insured's obligation to read the policy and raise any questions within a reasonable time, something many insureds never do.[4]

In one case this author was involved with, an insurer denied coverage to its insured after a major fire, stating that the application which was completed by the agent represented that the building was 26 years old when it was really more than 50 years old.

Some examples of the quagmires of insurance applications:

Commercial insurance applications asked on the standard Acord Forms:

- *Any exposure to chemicals of flammables?* Every business has paper and cleaning supplies – flammables.
- *Any catastrophe exposure?* Every risk has some catastrophe exposure.
- *Any uncorrected fire code violations?* How in the world would an insured know if there are any uncorrected fire code violations? We would guess that almost all insureds have some sort of uncorrected fire code violations. Furthermore, you could be in violation of whatever a "fire code" is but not required to comply unless the building has a major loss.
- Under "Loss History" on this same application, there is a statement: *"Enter all claims or losses (regardless of fault and*

whether or not insured) or occurrences that may give rise to claims for the prior 5 years." Claims and losses are two different things. This question doesn't even limit the question to premises liability but would apply to losses that have occurred (or could occur in the future) for workers' compensation and every other area of claims. How do we know what losses could give rise to a future claim? It could be a slip and fall in the parking lot that is not reported and is unknown to the insured. Note that the question does not relate to "known" claims or losses.

- *Any medical facilities provided or medical professionals employed or contracted?* Most manufacturing facilities, as an example, will have First Aid rooms, which means that a medical "facility" is being provided even though there are no medical professionals employed or contracted.
- *Any operations sold, acquired, or discontinued in last 5 years?* Notice that this does not ask about businesses that are sold, acquired, or discontinued. It asks about "operations." The manufacturing plant or other businesses could have many operations that have been discontinued, so a "No" answer would be inaccurate.
- *Any parking facilities owned/rented?* Certainly, every business has parking facilities, so a "No" answer would be inaccurate.
- *Recreation facilities provided?* Many businesses have workout rooms or basketball hoops.
- *Any structural alterations contemplated?* This doesn't say within what period of time. "Contemplated" is sort of a mental process. It also doesn't say whose contemplation counts.
- *Have any crimes occurred or been attempted on your premises within the last three years?* How in the world would an applicant know whether a potential burglar has attempted to commit a crime on its premises? This crime could be attempted break-in of automobiles or attempted break-in in a building itself. The person signing the application really wouldn't know about it if it was an attempt, in most cases.
- *The Acord Umbrella application asks the applicant to* "list underlying insurance coverage information including all restrictions or extensions of coverage." We suppose that the only way to properly comply with this is to attach a copy of all underlying policies.
- *Are any drivers not covered by workers' compensation?* How would the insured know?
- *Any vehicles used by family members?* Any commercial vehicle could be used by a family member of someone.
- *Workers' compensation application. Any employees with physical handicaps?* Aside from the discriminatory aspects of this question, everyone has some sort of physical handicap. If you lost a fingertip, does this constitute a handicap? If you have an impaired field of vision, yet your eyesight is 20-20, is this a physical handicap?

In many cases, the insurance agent or broker completes the application (whether online or in hard copy format) and asks the insured to sign it. This can be disastrous as under Michigan law, the insurance agent is the agent of the insured as an ordinary rule.[5]

In *Montgomery v Fidelity and Guaranty Life Ins Co*[6], the court held that a plaintiff cannot argue that it failed to read the policy or they simply signed an application that the agent prepared on their behalf. Failure to read the policy is not a defense to a material misrepresentation in an insurance application.

Practitioners should caution their personal and business insureds about the importance of properly completed applications.

About the Author

Michael Hale *is a licensed attorney and licensed insurance producer in Michigan. He has represented numerous insurance agencies in matters before DIFS and also has served as an expert witness in many insurance-related cases.*

Endnotes

1 *USA Underwriters v DeJonnae Audrey Issac et al*, No. 367384 (December 17, 2024)

2 491 Mich 547 (2012).

3 502 Mich at 406-407 (2018).

4 *Casey v Auto-Owners Ins Co*, 273 Mich App 388, 394-395 (2006).

5 *Genesee Foods Services, Inc v Meadowbrook*, Inc, 279 Mich App 649, 654; 760 NW2d 259 (2008).

6 269 Mich App 126 (2005).


Seeking Recovery under Hit and Run Provision with an Uninsured Motorist Policy

Christopher Best and Stephanie Strycharz

Most Uninsured Motorists policies have a provision to account for when there has been an alleged hit and run automobile accident. Policies differ on what they require, but most policies contain several conditions precedent that must be followed before an insured will even be evaluated as to whether they are legally entitled to recover under the additional provisions of the uninsured motorist policy (i.e., whether the insured was less than 50 percent at fault in causing the accident and whether the insured sustained a threshold qualifying injury). The condition precedent provisions are in place to prevent overarching fraud in pursuit of recovery. There are three conditions that have been explored in case law that are usually contained in a hit and run provision of an Uninsured Motorist policy. They include

1. that there be physical contact and that the accident be reported to the police within 24 hours,
2. that a claim under the hit and run provision of the Uninsured Motorists Provision of the policy of Insurance be made within 30 days, and
3. that the claim specifically making reference to the insured has a cause of action for damages against an unidentified person (i.e., the hit and run driver).

Most hit and run provisions also require that the vehicle be made available for inspection at the request of the insurance company. This article will explore some of the case law surrounding the conditions precedent and why strict adherence to these provisions is required.

Rory v Continental Insurance Company, 473 Mich 457, 465-466 (2005) has long held that Uninsured Motorist benefits ("UM") are not compulsory under the No-Fault Act. Because UM benefits are optional, they are purely contractual. This means that Uninsured Motorist Benefits are governed by contract and, whatever the terms of the contract are, dictate whether an insured could potentially recover under the contract. For the physical contact requirement, Michigan Courts have held that there must be some sort of physical contact between the hit-and-run vehicle or an integral part of the vehicle. For example, in *Said v Auto Club Ins Ass'n*, 152 Mich App 240, 393 NW2d 598 (1986), it was held that swerving to avoid hitting a vehicle would not qualify for recovery under a hit and run provision of an uninsured motorist policy. In *Adams v Zajac*, 110 Mich App 522; 313 NW2d 347 (1981), the Court of Appeals held that the requirement of physical contact is satisfied "when a vehicle or an integral part of it comes into physical contact with another vehicle." *Id*. Some policies contain language stating that there must be direct physical contact as opposed to just physical contact. If the policy only states that there is a physical contact requirement, courts have interpreted this to be very broad and includes things like items falling off a vehicle through "indirect physical contact." Conversely, if the policy states that there must be direct physical contact, courts have interpreted this to mean that the hit and run vehicle must make direct contact with the claimant's person or occupied vehicle. *McJimpson v Auto Club Ins Group*, 315 Mich App 353 (2016) explored this issue. In *McJimpson*, the plaintiff was injured when a piece of metal from a semi-truck struck her car. Plaintiff argued that the piece of metal satisfied Auto Club's hit-and-run policy provision, entitling her to uninsured motorist benefits. The Court of Appeals disagreed, holding that the plaintiff was not entitled to uninsured motorist benefits as a matter of law because the policy provided uninsured motorist coverage only where an unidentified hit and run vehicle made "direct physical contact" with the insured or her vehicle. The phrase "direct physical contact" was not ambiguous, and the undisputed facts demonstrated that the unidentified semi-truck never made "direct physical contact" with plaintiff's vehicle but, instead, "indirect physical contact" with the plaintiff's vehicle which did not satisfy the condition precedent to uninsured motorist benefits as written in the Auto Club policy provision relating to hit-and-run accidents. Contrast this with *Hill v Citizens*, 157 Mich App 383, 394 (1987) which did not contain the direct physical contact language. In *Hill*, the court held that it is necessary to at least establish that a substantial nexus between the hit-and-run vehicle and an object cast off or struck by that vehicle that comes into contact with the insured's vehicle or the insured causing bodily injury. In *Hill*, the Michigan Court of Appeals held that the UM policy at issue in that case was satisfied by showing that a rock cast off a hit and run vehicle caused bodily harm. In other words, in some circumstances where there is only physical contact language, this condition precedent can be satisfied by showing that there was contact with another vehicle or a part or debris off another vehicle simultaneously. In cases where there is no direct physical contact language in the hit and run provision, courts have been divided over the years as to whether debris from a vehicle must have been cast off and hit the other vehicle or whether the debris can be stationary in the road. However, it is clear, at the very least, that in order

for the physical contact condition precedent to be satisfied that there must be physical contact. So, for example if an insured files a hit and run claim under the policy of insurance and it was due to them swerving to avoid a vehicle, they have not satisfied the physical contact requirement under the contract.

The requirement that the accident be reported to the police within 24 hours is another condition precedent that has resulted in dismissal of uninsured motorist claims under an Uninsured motorist policy. For example, in *Butler v Lane,* Unpublished No 363695 (February 1, 2024), *Adams v Allstate Fire & Cas Ins Co*, Unpublished No 362830 (December 14, 2023), and *Hensley v Auto Club Grp Ins Co*, Unpublished No. 353205 (October 14, 2021), those courts all held that the failure to report a hit and run motor vehicle accident to the police within 24 hours was grounds for dismissal. If an insured is unable to show that they reported the accident within 24 hours they are not entitled to any recovery. So, if the insured does not have some form of proof of this, whether it be a UD-10 police report or otherwise, that the hit and run accident was reported within 24 hours, they cannot maintain a cause of action for UM benefits under their policy of insurance.

Similarly, provisions within a UM policy requiring that a UM claim be made within 30 days and identify that the insured has a claim against an unidentified driver has also resulted in dismissal of uninsured motorist benefit claims. For example, in *DeFrain v State Farm*, 491 Mich 359 (2012), the Michigan Supreme Court held that the 30-day notice provision required strict adherence and that the failure to abide by same was grounds for dismissal of the uninsured motorist benefits claim. Strict adherence is mandated under the 30-day notice requirement. It is simply not enough that an individual state that they have a claim for an automobile accident. The insured must state that they have a claim against an unidentified hit and run driver and that they are seeking UM benefits under their policy.

Strict adherence is required pursuant to case law and if an insured does not satisfy all conditions precedent in the policy of insurance regarding uninsured motorist benefits under the hit-and-run provisions, then a denial of the claim or dismissal by the court where a lawsuit has been filed is warranted.

About the Authors

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INSURANCE AND INDEMNITY 101

The Often-Misunderstood Certificate of Insurance

By Rabih Hamawi, CPCU®, CIC, CRM, LIC, MSF

www.hamawilaw.com

It would be hard to find anything in the area of liability insurance that is more misunderstood than the certificate of insurance. It's frequently called the "ACORD" form because these words appear at the top. Over my last 20 years in the business, both as an attorney, and previously as an insurance agent, I have talked to many insureds that referred to ACORD as the insurer, but that's obviously not true.[1]

At the root of this misunderstanding are two misconceptions: first, the insurer issues the certificate; and second, the certificate amends the policy. Neither is true. Yet attorneys who counsel commercial insureds may have a hard time convincing their clients that the certificate does not protect them and may not even be worth the paper it is printed on.

Here's an example. There's a construction project with a general contractor (GC) and one or more subcontractors. The GC is worried about being sued if someone is injured and may be seen as the target defendant with the deep pockets. How does the GC protect itself? First, of course, it buys a commercial general liability policy, with perhaps a large excess policy. But that's not enough.

The GC wants to be sure that the subcontractors have insurance, so their pockets are also deep. To confirm, the GC insists on getting proof of insurance from each sub, listing its policies, and the amounts of coverage provided by each, hopefully with limits equaling or exceeding the GC's policy limits. The subcontractor contacts its insurance agent, and obtains a certificate, which confirms that the subcontractor is insured. It is like the certificate of insurance we all carry in our cars. That certificate confirms to the Secretary of State that the car is insured, but it does not make the Secretary of State an insured.

It's the same with the ACORD certificate of insurance form. It shows that the subcontractor is insured, but that's all it does. It yells in all caps and bold letters that it is issued for information only and that it isn't a policy or a policy endorsement.

ACORD® **CERTIFICATE OF LIABILITY INSURANCE** DATE (MM/DD/YYYY) 02/21/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

Then it certifies that the policies of insurance listed below have been issued to the insured named on it for the policy period indicated.

COVERAGES	CERTIFICATE NUMBER:	REVISION NUMBER:
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED.NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.		

If the ACORD is so clear, what is the confusion then?

At the bottom left, there is a box entitled "certificate holder." That is where the GC's name goes in our example. But often, instead of just saying "XYZ General Contractor Company," the box gets filled in with something more specific: "XYZ General Contractor Company is an additional insured on project 123."

Seeing this, the GC thinks it is protected as an additional insured, but Michigan cases don't agree for a few reasons. The certificate is not a part of the policy, and it is not issued by the insurer. The Michigan Supreme Court has held that "The certificate is no[t] part of the insurance contract."[2]

The Michigan Court of Appeals made the same point stating:

> [T]he insurance certificate at issue did not purport to represent the terms, benefits, or privileges promised under the policy. Instead, the stated purpose was merely to certify that the listed insurance policies had been issued.[3]

The certificate is not a part of the policy because it isn't issued by the insurer. At the top, in the space marked "Producer," the insurance agent issuing the certificate inserts his or her name. In other sections, the insurance agent lists the name of the insurer, with the policy number and effective dates, but this may not be enough to guarantee that coverage has been issued or to bind the insurer because, generally, an independent agent is the agent of the insured and not the agent of the insurer. "[T]he independent insurance agent or broker is considered an agent of the insured rather than an agent of the insurer."[4] Usually, the insurance agents that contractors deal with are independent agents. The contractor comes to the agent with a list of coverages it needs (typically auto, worker compensation, liability, and excess) and the independent agent solicits bids from various insurers. Generally, the independent agent can't usually speak on behalf of the insurers, and it can't change the policies those insurers have issued.

So, is the ACORD worthless? Not at all, though it is worth less than what the GC and the subcontractor often think. Often the subcontractor's policy will have a provision that identifies who else besides the sub is insured under the sub's policy. Commonly this is found in an endorsement called a "blanket additional insured (BAI) endorsement," or some variation on that title. The provision will say that an additional insured includes anyone the sub is "required to add as an additional insured under this policy under . . . an oral agreement or contract where a certificate of insurance showing that person or organization as an additional insured has been issued."

So, the certificate can have an effect, but note that it is the endorsement that really does the heavy lifting. Also, if the GC, or its attorney, is paying attention, somewhere in the contract between the GC and the subcontractor, there will be a requirement that the sub makes its insurer add the GC as an additional insured on the sub's policy. If this clause is in the sub's contract with the GC, then that alone is generally enough to make the GC an additional insured, with or without a certificate. The BAI endorsement may also automatically include as an additional insured anyone the sub is "required to add as an additional insured on this policy under a written contractor agreement."

It's still important for the GC to get the ACORD certificate to confirm that the required policies are actually issued and in place, and to periodically audit the subcontractor to confirm that no changes have been made. But it's equally important for the GC's attorney to let the GC know that the certificate is only part of the puzzle and that much more is needed. Frankly, this is often a hard sell; contractors tend to place great reliance on the certificate alone.

It's also important for the GC's attorney to read the contract forms themselves, which should specify the types of coverage, the minimum amounts of coverage, and whether the additional coverage is primary or secondary to the GC's policy. The GC's attorney also needs to look closely at the indemnification language and determine whether a waiver of subrogation endorsement is needed. Stay tuned for more on this topic in future articles.

About the Author

Rabih Hamawi *is a past chairperson of the Insurance and Indemnity Law Section. He is a principal at the Law Office of Rabih Hamawi, P.C. and focuses on representing policyholders in fire, property damage, and insurance-coverage disputes with insurers and in errors-and-omissions cases against insurance agents.*

Endnotes

1 The Association for Cooperative Operations Research and Development (ACORD) is a non-profit organization in the insurance industry. ACORD publishes and maintains an archive of standardized forms. ACORD has also developed a comprehensive library of electronic data standards with more than 1200 standardized transaction types to support exchange of insurance data between trading partners. ACORD itself, though, is not an insurance company and does not process claims or provide insurance coverage of any kind. https://en.wikipedia.org/wiki/ACORD

2 *Chrysler Corp v Hardwick*, 299 Mich 696, 700; 1 NW2d 43 (1941).

3 *West American Ins Co v Meridian Mutual Ins Co*, 230 Mich App 305, 311; 583 NW2d 548 (1998).

4 *West American,* 230 Mich App at 310.

LEGISLATIVE UPDATE

The Democrats' Bicameral Majority Comes to a Close; Bipartisan Efforts on the Horizon!

By Christopher J. Petrick and Katharine Buehner Smith
Collins Einhorn Farrell PC

The results of the election are in and the Democrats bicameral majority in the Legislature has come to an end. Democrats hoped to capitalize on their majority as the session came to a close, but several members from both sides of the aisle opted to skip the last days, leaving several bills to die on the vine. A new session starts in January with Democrats holding a majority in the Senate and Republicans holding a majority in the House. This shift will mean that it will take true bipartisan action to move bills through the Legislature in the new year. Several bills remained in the pipeline at the end of the session; only time will tell whether the new Legislature takes up any of the bills that were not enacted during the last session.

Prior to the end of the session, a couple of bills were enrolled; however, at the time of drafting, the bills have not been signed.

- **HB 5950 –** amends the Insurance Code to provide a definition for peer-to-peer car sharing programs and allows an insurer to exclude coverage for a loss or injury occurring during a car sharing period. ***Passed the House (101-1) on 11/14/2024; Passed the Senate (33-5) on 12/19/2024; Bill enrolled on 12/23/2024; Presented to the Governor on 1/08/2025.***
- **HB 5956 –** amends the Insurance Code to prohibit an insurer from discrimination against a health professional acting within the scope of their license; however, it does not require the insurer to contract with any health professional willing to abide by its terms and conditions. ***Passed the House (57-55) on 12/10/2024; Passed the Senate (20-18) on 12/20/2024; Bill enrolled on 12/23/2024; Presented to the Governor on 1/08/2025.***

One bill advanced since our last update, but wasn't passed before the end of the session:

- **SB 1106** – amends the Insurance Code to require a health plan or nonprofit dental care organization that provided dental benefits to have at least one method of payment or reimbursement that provided the dentist or dental therapist with 100% of the amount payable and did not include a fee for the payment or reimbursement. ***Passed the Senate (36-0) on 12/12/2024; Read before the House on 12/12/2024; Motion to discharge committee approved on 12/13/2024.***

And several bills advanced from Committee but were not signed prior to the end of the session:

- **HB 6099 – 6104, 6106 –**amend the Insurance Code to make various changes to the regulation and requirements relating to captive insurance companies and special purpose financial captives in Michigan. ***Passed the House on 12/12/2024; Referred to the Senate Committee on Government Operations.***

Several bills were first introduced and referred to committees since our last update, but they were not advanced prior to the close of the session:

- **SB 1030 –** amends the Insurance Code to require health insurance policies to include coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome.
- **SB 1087 –** amends the Insurance Code to provide for increased penalties for violations of the Insurance Code.
- **SB 1088 –** amends the Insurance Code to provide for increased penalties for late payments on claims.
- **SB 1089 –** amends the Insurance Code to prohibit post-claim underwriting.
- **SB 1090 –** amends the Insurance Code to require compliance with any appeal decision reached during the utilization review process.
- **SB 1126 –** amends the Insurance Code to require health insurance policies to include coverage for mental health and substance use disorders that are medically necessary.
- **SB 1143 –** amends the Insurance Code to prohibit denying or conditioning coverage of a Medicare supplement policy on particular factors.
- **HB 6126 –** amends the Insurance Code to remove limits for required coverage for autism spectrum disorders.
- **HB 6251 –** amends the Insurance Code to provide parameters for coverage and benefits for caregiver reimbursement where a health care provider listed in section 3157 that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance.

- **HB 6252 –** amends the Insurance Code as it relates to reimbursement or coverage for expenses within personal protection insurance coverage to include reimbursement for physical therapy; include therapy under supervision of advance practice registered nurse.
- **HB 6253 –** amends the Insurance Code to correct cross-references in section 3114.
- **HB 6265 –** amends the Insurance Code to define a process for market conduct examinations and requires insurers to pay for the same.
- **HB 6266 –** amends the Insurance Code to provide for specific underwriting transparency for automobile or homeowners policies.
- **HB 6267 –** amends the Insurance Code to provide particular requirements for manuals of rules filed by automobile insurers.
- **HB 6268 –** amends the Insurance Code to modify rules relating to data security enforcement.

RECENT OPINIONS

By Eric Cohn

Unpublished Michigan Court of Appeals Decisions

The Intersection of Equity and the No-Fault Act Continues to Cause Appealable Issues

USA Underwriters v Progressive Michigan Insurance Co, et al
Docket No. 367384

DeJonnae Isaac applied for auto insurance with USA Underwriters in March 2021. In her application, she represented that she had a valid driver's license and elected residual liability coverage limits of $50,000/$100,000 under MCL 500.3009(5). After Isaac was involved in an accident with Lorrayne Defer in April 2021, USA Underwriters discovered that Isaac did not have a valid driver's license when she applied for the policy. USA Underwriters rescinded the policy based on this material misrepresentation.

Defer filed a claim against Isaac seeking damages for bodily injuries sustained in the crash. USA Underwriters filed a declaratory action seeking a determination that it had no duty to defend or indemnify Isaac. Progressive, which had issued an auto policy to Defer that included uninsured/underinsured benefits, was added as a defendant. Progressive argued that it did not have to pay uninsured benefits until after all applicable policies were exhausted, and that USA Underwriters remained responsible for paying residual liability insurance despite rescinding Isaac's policy.

The Court of Appeals affirmed summary disposition in favor of USA Underwriters. The Court rejected Progressive's reliance on footnote 17 and the argument that USA Underwriters could not use recission to avoid liability. In doing so, the Court noted that the Supreme Court in *Bazzi* had clarified this footnote was non-binding dicta. Instead, following *Bazzi*, the Court held that common-law defenses like rescission are available unless prohibited by statute. Because MCL 500.3009 contains no language limiting or prohibiting rescission as a remedy, USA Underwriters could properly rescind the policy based on the material misrepresentation.

Importantly, the Court also noted *Bazzi* does preclude the use of recission to avoid liability. The process for doing so, referred to as a "balancing of the equities" may have allowed Progressive a different avenue to successfully defend the matter. However, the Court determined that argument was waived by Progressive in the trial court and on appeal.

Takeaway: The continued interplay of equity and the no-fault act creates confusion and issues for attorneys on both sides of the aisle. In this case, relying on *Bazzi*, the Court determined that the recission is not precluded by statute and therefore was an available defense. The Court did not stop there, however, and made clear that *Bazzi* does permit a balancing of the equities to cutoff the defense of recission in the appropriate case, making a clear point that this path must be preserved or waived.

Spoliation of evidence and record retention policies are no-fault issues just as much as priority and serious impairment are.

Vincent v AAA Insurance Company
Docket No. 368830

In 1977, WV was injured as a teenage passenger when the car he was riding in collided with a school bus. In December 2021, his wife Barbara Vincent, acting as his guardian due to his deteriorating mental condition which she alleged stems from the traumatic brain injury sustained in the accident, filed suit against AAA seeking PIP benefits. She claimed WV's parents had insurance through AAA at the time and that WV had received benefits, though she could not provide a claim or policy number.

AAA's records showed no evidence of a policy for WV's parents or any claims made on WV's behalf. While AAA located records showing the vehicle owner had a policy and made claims in 1977-1982, there was no way to determine if any payments

were made to WV. AAA's record retention policy prior to 1997 only required keeping records of PIP claims where payment was issued, and paper files were typically destroyed after four years. Digital storage did not begin until 1985.

Vincent argued AAA should be estopped from raising the one-year-back rule and sought sanctions for spoliation of evidence based on the presumed destruction of documents under AAA's record retention policy. The Court of Appeals affirmed summary disposition for AAA based on the one year back defense, finding Vincent failed to show that a timely claim was ever made for WV's injuries in the first instance. The Court reasoned that Vincent's failure to prove a claim had been made was fatal to the recovery of PIP benefits.

The Court also rejected the spoliation argument. The foreseeability factor that is considered when weighing whether spoliation has occurred was the most prescient for the Court. The Court determined "there is nothing here to suggest that [AAA] should have foreseen that plaintiff would seek PIP benefits 44 years after the accident occurred." The Court said AAA could not foresee that Vincent would require AAA to provide claims files and policy information to support her arguments, and further that if information would have been saved by one of the parties, it perhaps should have been saved by WV given Vincent's argument that the family destroyed its records when WV's mother entered a nursing facility in 2019.

Takeaway: This is an interesting case from multiple perspectives. First, spoliation issues come up routinely in first and third-party no-fault litigation. Therefore, this case serves as a prime case for the "foreseeability" of litigation when it comes to destruction of evidence claims. This case further highlights that standard practices, especially historical practices, are likely insufficient to constitute spoliation of evidence since it meets the standard of a "nonfraudulent explanation" for the decision to destroy evidence.

Finally, this case is interesting because a motion for reconsideration was recently denied by the Court of Appeals, perhaps signifying we may not have seen the last of this case.

For subrogation claims, it pays when an insurer remembers what "involved in the accident" truly means

Auto-Owners Insurance Co v Hastings Mutual Insurance Co
Docket No. 365910

In a multi-vehicle accident on April 24, 2019, a Peterbilt semitruck insured by Hastings blew a tire and lost control, crossing into oncoming traffic. The semitruck struck a Ford F-250 which then hit a stopped Honda Ridgeline insured by Auto Club. The semitruck ultimately crashed into a residence insured by Auto-Owners after traveling across a cemetery insured by Hastings. A Chevrolet Express van insured by Allstate, attempting to avoid the out-of-control semitruck, veered off the road and hit a mailbox.

Hastings and Auto-Owners sought subrogation from the insurers of other vehicles involved, arguing all vehicles were "involved in the accident" under MCL 500.3125. The trial court granted summary disposition to Hastings and Auto-Owners except for a Mercury Mariner that was struck by tire debris.

The Court of Appeals reversed, finding the trial court erred in concluding the Honda Ridgeline and Chevrolet Express were "involved in the accident." Following *Turner*, the Court held that being "involved in the accident" requires active, rather than passive, contribution. The Honda was merely struck while stopped, and the Chevrolet's collision with the mailbox while avoiding the semitruck was a separate accident that did not actively contribute to the property damage at issue.

Takeaway: While the result is not surprising, this case was highlighted because in this space we rarely take the time to focus on subrogation matters, choosing instead to focus on first and third-party litigation. The takeaways are thus two-fold. First, under the no-fault act, there is more to be litigated and evaluated than personal injury disputed. The breadth of the no-fault act therefore provides any litigator that has worked within the field for several years the opportunity to experience many issues that other litigators and practitioners rarely see.

The second, substantive takeaway, is that under MCL 500.3125, a vehicle must actively contribute to an accident, not merely be present or struck, to be considered "involved in the accident" for a property protection claim. A "but for" connection is simply insufficient without evidence the vehicle's presence would have changed the accident's outcome.

Sticking to the basics of statutory interpretation and the definition of terms is still an important tool in a litigator's toolbox

Johnson v Michigan Assigned Claims Plan
-- Mich App --; Docket No. 368048

While riding his mini-bike in a bike lane, Trevon Johnson was struck by a car making a left turn. Johnson suffered severe injuries requiring two surgeries and physical therapy. Because his mini-bike was uninsured, Johnson filed a claim for PIP benefits with the Michigan Assigned Claims Plan ("the MACP"). However, the MACP refused to assign his claim, forcing Johnson to file suit. The MACP moved for summary disposition, arguing Johnson's vehicle was a motorcycle under the No-Fault Act and thus required insurance for him to be eligible for PIP benefits. The trial court denied the motion, finding a genuine issue of material fact existed regarding whether the vehicle was a motorcycle. After the MACP's motion for reconsideration was denied, the parties entered a $200,000 consent judgment in Johnson's favor, with collection stayed pending appeal.

The Court of Appeals reversed. Analyzing the statutory definition of "motorcycle," the Court found Johnson's mini-bike had a saddle, two wheels, and a motor exceeding 50cc. The Court then determined the mini-bike was not a moped (as its engine exceeded 100cc) and not an ORV because it was modified for street use with brake lights, headlights, turn signals and street tires. Because the vehicle met the statutory definition of a motorcycle and required insurance which Johnson did not have, he was not entitled to PIP benefits under MCL 500.3113(b).

Takeaway: Sometimes an attorney merely needs to get down to the basics. And nothing within the auto negligence world is more basic than the definitions of a motor vehicle and motorcycle. And, while Plaintiff's counsel apparently did an admirable job in creating a theme that Johnson was riding a mini-bike, the Court saw past the thematic nuances and applied basic concepts to ascertain that the mini-bike was a motorcycle. A rose by any other name is just as sweet, and a two-wheeled mini-bike modified for highway travel is just a motorcycle.

Reality is more important than expectations when it comes to reformation

Memberselect Insurance Company v Estate of McDougall
-- Mich App --; Docket No. 368674

Marilyn McDougall was killed in an automobile accident along with her husband Larimore when he failed to yield at an intersection and collided with another vehicle. Both were named insureds on a Memberselect policy with stated bodily injury liability limits of $250,000 per person and $500,000 per accident. Marilyn's estate filed a wrongful death action against both the other driver and Larimore's estate.

Memberselect sought a declaratory judgment regarding coverage, arguing that its household exclusion provision limited coverage to $50,000 based on MCL 500.3009's minimum limits. The estate countered that because neither Marilyn nor Larimore had completed a form to elect lower limits, the minimum liability limit under MCL 500.3009 was $250,000 per person.

Following the Court's recent decision in *Espinoza-Solis*, the Court of Appeals affirmed the trial court's ruling in favor of the estate. The Court held that the statutorily required minimum residual liability insurance for policies issued after July 1, 2020, is $250,000 per person and $500,000 per accident under MCL 500.3009(1)(a) and (b), unless proper steps are followed to exercise the option of selecting lower coverage amounts under MCL 500.3009(5). Since there was no indication the McDougalls opted for lower coverage, the $250,000/$500,000 limits applied.

Takeaway: Pre-amendment, a Michigan motorist could only expect to recover $20,000 and therefore, when there was non-cooperation and a policy was reformed, that is all that a plaintiff could recover. With multiple ways to reduce limits of liability, expectation is less important than reality post *Espinoza-Solis*, and to reduce limits of liability to $50,000, an insured must actively and validly seek that reduction, making reformation a much less potent way for an insurer to reduce its risk.

Scenes from the Annual Meeting

October 28, 2024, Saint John's Resort

The passing of the gavel from 2023-24 Chair Pat Crandall to 2024-25 Chair Annie Earls

2024-25 Chair Annie Earls acknowledging 2023-24 Chair Pat Crandall's contributions to the section

Pat Crandall, John Yeager (right), and program presenter Kellie Howard

Stephanie Brochert, program presenter John Allen, Jennifer Serwach, Gail Storck, and Alison Koppin

2024 Scholarship winner Maryana Odisho with Pat Crandall and Elizabeth King

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