From the Chair

We are pleased to report that your Section continues to grow both in membership and in relevance.

At the last Annual Meeting, the Council was expanded to 20 members. The Section now has 429 attorney members and three law student members. Our Section account balance is approximately $16,000.

We continue to reach out to other Sections and will be participating in the Real Property Law Section summer conference to address property and casualty insurance issues of interest to their Section. We also continue to explore the possibility of a seminar, co-sponsored with ICLE or another Section.

Our Section addresses various public policy items sent to us by the State Bar for review on a periodic basis. Our Section will be represented at an upcoming Michigan Supreme Court Case Evaluation and Mediation Study Meeting.

The Journal continues to impress, presenting substantive articles, updates on case law, legislative and regulatory reports, and other valuable information. Please continue to submit material for publication in the Journal. We also solicit your active involvement in our various Section committees.

Please plan to attend our Section’s annual meeting, which will be held in conjunction with the State Bar of Michigan Annual Meeting, on September 30, 2010 at 10:00 a.m. at the DeVos Place & Amway Grand Hotel in Grand Rapids. Chair-elect Mark Cooper is organizing our program, which will include a substantive presentation on trends and hot topics in legal malpractice insurance, including issues to examine and watch for when renewing or applying for professional liability insurance. William Healey and other representatives of Axis Capital will present the program.

We also will have our Section elections during our annual meeting. The elections will include the Officers for next year, as well as several Council positions which are expiring. Please plan to attend.

This will be my last “From the Chair column” and I wish to thank the Council, our membership, and the State Bar for assisting me and for the continued joint efforts to develop and improve our Insurance and Indemnity Law Section.
When Tender of Defense is Complex – “Additional Insured” and Indemnity Clauses

By Noreen L. Slank, Collins, Einhorn, Farrell & Ulanoff, PC

The named insured is getting sued. And what's worse, a bunch of those in its vicinity on the job site, or the premises, or wherever – are getting sued too. Almost everybody seems interested in having everyone else's insurer defending them. The insurer's tendency is to defend its named insured and leave the rest to fend for themselves. “The rest” bought their own CGL policies, so they should be content to use the defense they purchased. Sometimes, that's exactly the right answer. Sometimes, however, it's short-sighted.

Some basics. Most companies insured under Comprehensive General Liability (CGL) policies will have intact “insured contract” coverage. This means that if the named insured signed a hold-harmless agreement that said it would hold somebody harmless for whatever happened, when it gets sued under that contract, the insurer will owe the named insured a defense. If the named insured loses the indemnity lawsuit, then the insurer is going to have to pay the indemnity judgment even though it represents a contract measure of damages rather than a traditional property-damage or bodily injury award.

Of Belts and Suspenders

A named insured will also often agree to both hold another party harmless and place that party on its CGL policy as an additional insured. This belt-and-suspenders approach is the prevalent approach. There are a variety of Insurance Services Organization (ISO) coverage forms that handle additional-insured coverage in assorted ways. And insurance companies often create their own additional-insured coverage forms that

When the insurer is in the thick of the additional-insured maze, it can be helpful to study the named insured’s hold-harmless obligation.

confound prediction. When one insurer writes a policy for a named insured and the other writes additional-insured coverage under certain circumstances, the question of which insurer has the primary obligation can’t be answered without an exchange and comparison of policies. And even then, the proper resolution often does not emerge clearly or quickly. Tender by an additional insured rarely convinces an insurer to step up to the plate. Refusing such a tender from an additional insured is often the exactly correct decision for an insurer, especially early in the litigation of the injury case.

But study of the named insured’s indemnity obligation can bring its insurer’s prudent course into focus. Sometimes, by studying the indemnity agreement, the insurer can confidently predict that it is going to end up paying any judgment that lands on a wannabe additional insured, and all of that wannabe's defense costs as well. Refusing tender under such circumstances is completely defendable in any coverage case. But practically speaking, it is short-sighted. When the insurer is in the thick of the additional-insured maze, it can be helpful to study the named insured’s hold-harmless obligation. There are certainly many times when that study will create more heat than light. Yet other times, the clearly proper course emerges and directs that tender be accepted under the named insured’s indemnity contract.
Assume an indemnity contract as clear (and ridiculous) as: Named Insured Hapless agrees to hold Shopping Center harmless from any and all claims, and all associated expenses, including attorney fees, from people who fall in the parking lot between November 1st and April 1st. (And whatever Hapless contracted to do for the Center, it had nothing to do with constructing, repairing or maintaining a building, so MCL 691.991 is inapplicable.) Colonel Mustard fell in the parking lot on December 1st. Colonel Mustard sued both Hapless and the Shopping Center. Assume the contract between that Shopping Center and Hapless also requires Hapless to place the Shopping Center on its policy as an “additional insured,” and Hapless did that. But the additional-insured endorsement in Hapless’s policy limits the additional insured’s coverage to claims arising out of the performance of the named insured’s work for the additional insured. The Shopping Center tenders the complaint and seeks a defense. It might specifically tender under both the hold-harmless agreement and as an additional insured, but it will more likely just turn the complaint over to Hapless’s insurer and demand a defense.

Some claims professionals and attorneys will be distracted by the intricate and avoid the simple. Of course understanding an indemnity contract is often complicated and nuanced—anything but simple. But not so for our two contracting parties. When the state of the tendering party’s additional insured coverage is evaluated it is rare that the answer will be easily resolvable, or even discernable, even with concentrated study. It is almost always controversial. Here, the additional-insured decision requires an analysis of whether Colonel Mustard’s fall arose out of Hapless’s work for the Shopping Center and which policy is primary. The second issue requires studying the parties’ contracts and their insurance policies.

But the hold-harmless agreement teaches Hapless’s insurer that at the end of the day it will be paying Hapless’s share of the fault as well as the Shopping Center’s. This will happen as the Shopping Center’s share (and its defense costs) shifts to Hapless under the hold-harmless agreement because Colonel Mustard fell in the parking lot on December 1st. Hapless’s insurer should consider accepting the tender, conditioning acceptance on Hapless and the Shopping Center “playing nice” with each other and agreeing that both can be represented by one attorney. That’s an offer that is rarely refused. It often keeps peace between Hapless and the Shopping Center, which is a business consideration that can mean a lot to a named insured.

Attorneys are well positioned to help claims professionals understand the indemnity law dynamic in such complex tender situations. If the indemnity agreement liability is not clear, tender under the agreement should be resisted. But when a named insured’s indemnity liability is clear, the allure of miserly interpretations of additional insured endorsements as a route to a non-coverage result is what should be resisted.

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The Waiver of Subrogation Clause and Public Policy

By Hal O. Carroll, Vandeveer Garzia, PC

The “waiver of subrogation” clause is a part of the standard AIA form construction contract. It establishes, by contract, a sort of “no fault” system. The purpose is to ensure that if damage to the project itself occurs during construction, the owner and the general contractor will each look to its own insurance, and neither will sue the other.

The clause is usually in this format:

Waivers of subrogation. The Owner and Contractor waive all rights against each other and any of their subcontractors, sub-subcontractors, agents and employees, each of the other . . . for damages caused by fire or other perils to the extent covered by property insurance . . .

The clause is in the contract between the owner and the general contractor, but the waiver as to all subcontractors is clearly enforceable by subcontractors as third party beneficiaries under the third party beneficiary contract statute.

This is all pretty straightforward, and when the damage is some relatively minor mishap, no one fusses much about it. But if a subcontractor leaves some linseed oil-soaked rags in a corner, and they ignite and burn down an entire structure, the insurer that is stuck with paying the bill has a pretty strong incentive to attack the clause.

Most insurers include in their policies a clause that expressly acknowledges the right of the insured to waive subrogation. A typical clause, usually in the “other conditions” portion of the policy, reads:

Subrogation. If “we” pay for a loss, “we” may require “you” to assign to “us” “your” right of recovery against others. “You” must do all that is necessary to secure “our” rights. “We” will not pay for a loss if “you” impair this right to recover.

“You” may waive “your” right to recover from others in writing before a loss occurs.

Actually, the waiver of subrogation clause is effective even if the insurer does not include this language in its policy, because of the basic rule that a subrogor can assign only what it has, and once it has waived a claim it has nothing to assign. “It is well-established that the subrogee acquires no greater rights than those possessed by the subrogor.”

The Attack – Gross Negligence as a Possible Exception

The principal line of attack on the clause by an insurer seeking to circumvent the effect of the waiver is the “gross negligence” issue. The argument is that the waiver of subrogation clause is an exculpatory clause, and therefore subject to the rule that a person cannot exculpate himself or herself from liability for “gross negligence.”

The definition of “gross negligence” has changed in Michigan in recent years, and been brought more in line with conventional understandings of the term. For many years, “gross negligence” was defined broadly to include what was essentially a “last clear chance” doctrine, intended to ameliorate the harshness of the former contributory negligence rule. This definition was spawned in Gibbard v Cursan, which defined “gross negligence” this way:

In a case where the defendant, who knows, or ought, by the exercise of ordinary care to know, of the preceding negligence of the plaintiff, by his subsequent negligence does plaintiff an injury. Strictly, this is the basis of recovery in all cases of gross negligence. Such gross negligence is also sometimes called discovered negligence, subsequent negligence, wanton or willful or reckless negligence, discovered peril, last clear chance doctrine, and the humanitarian rule.

In Jennings v Southwood, the Supreme Court abolished this definition as out of date and unnecessary. Jennings says forthrightly that although “gross negligence” as defined in Gibbard “is a seventy-year-old doctrine, we must nevertheless discard it because it has outlived its usefulness.” The Supreme Court in Jennings adopted a definition of gross negligence based on a concept of intent:

[Wil]lful and wanton misconduct is made out only if the conduct alleged shows an intent to harm or, if not that, such indifference to whether harm will
result as to be the equivalent of a willingness that it does. Willful and wanton misconduct is not, as the Gibbard Court observed, a high degree of carelessness.7

Jennings was formulating a definition for use in applying a statutory exception to governmental immunity under the Emergency Medical Services Act,8 so it could be argued that Jennings did not adopt a new common law rule. However, in Xu v Gay,9 the Court of Appeals adopted the Jennings formulation for application in the common law context of a personal injury wrongful death case where the defendant relied on a contractual waiver of liability. Xu summarized the reasoning of the Jennings case and concluded “we adopt the statutory definition of gross negligence as defined in the GTLA and engrafted into the EMSA by the Jennings Court.”10

Thus, the definition of gross negligence as applied in statutes defining governmental immunity now applies in common law contexts as well.

Given this definition of gross negligence as based on the presence of intent or an equivalent, the question then becomes whether gross negligence should operate as a public policy exception to the effect of the waiver of subrogation clause. There are no published cases on point in Michigan’s courts that are directly on point, but an unpublished case adopts a broad reading of the clause and argues strongly against applying a “gross negligence” exception.

An initial response is that the clause itself does not say so, which means that applying it as written the clause should apply irrespective of the nature of the claim. The waiver of subrogation clause identifies physical causes as triggers – “fire or other perils” – but it makes no exceptions for the degree of culpability. Thus, the clause is unambiguous and should be enforced as written.11

But the “gross negligence” argument draws on public policy as an override, on the basis that a party cannot by contract protect itself from liability for gross negligence or willful and wanton misconduct.12 Whether this principle limits the effect of a waiver of subrogation clause depends on how the clause is classified – as an exculpatory clause or as something else.

Waiver of Subrogation vs. Exculpation

An unpublished Michigan Court of Appeals case, Zurich Insurance Company v Midwest Management, Inc,13 discussed the nature of the clause. It distinguished the clause from a simple exculpatory clause. The Court of Appeals explained the difference between a waiver and an exculpatory clause in terms of the differing purposes of the clauses. “The purpose of the waiver clause was to insure that insurance covered losses to the work so that the construction project could continue unimpeded, without the parties to the contract being involved in litigation.”14

Given this definition of gross negligence as based on the presence of intent or an equivalent, the question then becomes whether gross negligence should operate as a public policy exception to the effect of the waiver of subrogation clause.

The waiver clause at issue is not a straight exculpatory clause . . . . Instead, the clause mutually absolves both parties from liability where insurance covers the loss. The clause here was not formulated to protect one party from its own negligence . . . . Rather, it was designed for the benefit of both parties.15

Zurich went on to quote with approval from a New Hampshire case:16

[Waiver of subrogation clauses] exist in the contract as part of a larger comprehensive approach to indemnifying the parties involved in the construction project, allocating the risks involved, and spreading the costs of different types of insurance. These paragraphs do not present the same concerns as naked exculpatory provisions. . . . The insurance provisions of the standard AIA contract are not designed to unilaterally relieve one party from the effects of its future negligence, thereby foreclosing another party’s avenue of recovery. Instead, they work to ensure that injuries or damage incurred during the construction project are covered by the appropriate types of insurance, and that costs of that coverage are appropriately allocated among the parties. . . . Not only have we acknowledged that this contractual approach to allocating insurance burdens is not contrary to public policy, we have acknowledged that it is of particular value to those involved in the construction industry.17

A waiver of subrogation clause is fundamentally different from a true exculpatory clause, such as a release, in three ways.

First, a waiver of subrogation is reciprocal, not unilateral. A typical release protects only one person, the potential defendant. The waiver of subrogation clause protects all parties within its scope equally.

Second, the waiver of subrogation clause is, by design, limited in its scope. It applies only to physical damage to the project itself. If there is damage to adjacent property, resulting in a loss to a person not involved in the project, the clause does not apply. Perhaps more important, if there is personal injury, in the project or outside of it, the clause does not apply. The public policy against exculpation for personal injury therefore has no application here.
Some Degree of Success Sufficient for Award of Attorney Fees.

Hardt v Reliance Standard Life Ins Co, ___SCT ___, Case no. 09-448 (May 24, 2010)

ERISA 502(g)(1) permits a “court in its discretion [to] allow a reasonable attorney’s fee and costs of action to either party.” The high court handed down a decision on the degree of success required in order to recover attorney’s fees from an adverse party. After a long term disability claim was remanded to the carrier which ultimately reversed its decision and awarded benefits, the plaintiff sought to recover her attorney’s fees. The Supreme Court determined that a claimant need not obtain an enforceable judgment to be eligible for a statutory attorney’s fee award, finding that the “prevailing party” standard was inapplicable in an ERISA denial of benefits case. Rather, a claimant must demonstrate “some degree of success on the merits” to be awarded attorney’s fees in the court’s discretion. The Court did not provide clear guidance as to what would constitute “some degree of success” except to indicate that a party must achieve more than “trivial success” or a “purely procedural victory.”

The Court did not rule out the consideration of particular factors to guide a court in exercising its discretion. With respect to cases in the Sixth Circuit, it appears that the five fac-

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Endnotes

1 MCL 600.1405.
3 Gibbard v Cursan, 225 Mich 311; 196 NW 398 (1923).
4 Gibbard at 319-320.
5 Jennings v Southwood, 446 Mich 125; 521 NW2d 230 (1994).
6 Jennings at 132.
8 MCL 333.20901.
10 Xu at 269.
14 Zurich, slip op. p 3.
15 Zurich, slip op. p 4.
17 Chadwick, quoted at Zurich, slip op. p 4.
The possibility of other remedies if a decision-maker was incompetent, dishonest or unfair.

“Single Honest Mistake” Does Not Deprive Fiduciary of Discretion

Conkright v Frommert, 130 S.Ct 1036, 2010 U.S. LEXIS 3479 (April 21, 2010).

The Supreme Court also issued an important decision that renewed its endorsement of the deferential treatment of plan fiduciaries’ interpretations of ERISA governed pension plans. Under ERISA, if the plan delegates discretionary authority to the claims decision-maker, a reviewing court is supposed to uphold the claim denial unless the court determines that the denial was “arbitrary or capricious.” The question in this case was whether that level of deference still applied to a new decision when the decision-maker’s original decision had been rejected. After the 2008 decision in Metropolitan Life v Glenn, concerning the effect of a financial conflict of interest on the standard of review to be applied to a fiduciary’s decisions, there has been uncertainty as to the level of discretion that a fiduciary was entitled to exercise, even where the plan documents expressly allow such discretionary authority. However, the Court in Conkright reaffirmed the core principles of ERISA – efficiency, predictability and uniformity – and found that deference to a plan fiduciary’s decision is vital to the implementation of those principles.

The issue before the court was whether the lower court owed deference to the plan administrator’s interpretation of the plan terms on remand, concerning the method of accounting for the distribution of past pension benefits in the calculation of current benefits. The court traced its consideration of the deference issue beginning with its seminal 1989 decision, Firestone Tire & Rubber Co v Bruch, and focused on principles of trust law, the terms of the plan at issue, and the governing principles of ERISA. Because the court held in Glenn that a financial conflict of interest does not necessarily eliminate deference to a fiduciary’s decision, the court reasoned here that “a single honest mistake” in plan interpretation does not warrant eliminating discretion for subsequent interpretations.

It remains to be seen whether such a hearty endorsement of deference would also apply in a case concerning a factual determination of a benefit claim decision, as opposed to interpretation of plan terms. Further, the court’s focus on a “single, honest mistake” here raises the question of whether the outcome might be different in another case involving compelling evidence of bad faith. The court seemed to acknowledge the possibility of other remedies if a decision-maker was incompetent, dishonest or unfair.

Sixth Circuit Court of Appeals

Termination of Benefits upheld, Based on Opinions of Board Certified Specialists

Hall v Liberty Life Assur Co of Boston, 595 F.3d 270 (6th Cir. 2010)

As part of a routine re-evaluation of a long term disability claim, two board certified medical specialists both concluded that the plaintiff was impaired, but could return to work based upon evidence that she frequently drove, walked and read, and was otherwise able to perform her job duties. Based in part on a vocational assessment that the plaintiff was capable of performing various occupations, and contradictory opinions from her treating physician, the court upheld the defendant’s decision to terminate payment of benefits.

The defendant additionally filed a counterclaim to recover an overpayment in benefits resulting from a retroactive Social Security disability payment. The court held that an equitable lien on future Social Security disability benefits was expressly prohibited by statute. However, the court found that equitable relief appropriately included restitution by imposition of a constructive trust or an equitable lien on the amount of the overpaid benefits.

Insurer Reasonably Relied on IME Opinion


The plaintiff challenged the termination of long term disability benefits after the two year “own occupation” period had elapsed without any change in her condition. The court found that found that ERISA does not impose a heightened burden of explanation on insurers when they reject a treating physician’s opinion, particularly where, as here, that opinion was ambiguous and contradictory. Instead, the court held that the defendant reasonably relied on the opinion of the IME physician.

Of additional interest is that the court amended its original decision and found that a claimant does not necessarily have a right to receive an IME report generated during an administrative appeal. Yet, even if such a right exists, the claimant is required to request a copy, which she failed to do in the instant case. The court held that this failure did not render the administrative appeal procedurally defective.

Voluntary Intoxication Not a Bar to Disability Benefits

Kovach v Zurich American Ins. Co., 587 F3d 323 (6th Cir. 2009)

Thomas Kovach was severely injured in motorcycle accident. He was driving the motorcycle; his blood alcohol level

Continued on next page
was 0.148% and he had opiates and benzodiazepines in his system. As a result of the accident, his leg was amputated and he sought AD&D benefits.

This case is notable for three reasons.

First, before Zurich denied the claim, it requested a legal opinion from outside counsel. While Kovach tried to argue that this was an impermissible delegation of authority, the Court rejected the argument. Rather, the Court commented that this “fact seem[ed] to demonstrate that [Zurich] took the process seriously and attempted to ensure that its decision had a strong legal basis.”

Second, the Court held the injuries were the result of an “accident” – even though the Zurich argued that an injury was the “reasonably foreseeable consequence of driving while highly intoxicated.” Although the court did condemn drunk driving, it could not distinguish this from other activities that a “typical policyholder would consider accidental.” Of particular interest, it distinguished a 2007 case that held that drunk driving injuries were not accidental. But the driver in the earlier case had a BAC at 0.321. Which raises the question, if 0.321 is high enough and 0.148 is not, where is the dividing line? The court also rejected the argument that it was excluded as a “self-inflicted wound.” Finally, the court noted that had Zurich wanted to be clear, it could have added a specific exclusion for injuries arising out of drunk driving. (The 2007 case was Lennon v Metropolitan Life Ins. Co., 504 F.3d 617 (6th Cir. 2007).)

Third, having determined the denial was improper, the court could either remand to Zurich for reconsideration or make a final decision itself. Because there were no factual issues, Court decided to award benefits.

USDC, Eastern District of Michigan

Change of Beneficiary Effective When Signed

This case involved the interpleader of ERISA governed life insurance benefits and competing claims of the decedent’s ex-wife and his two sons. The ex-wife had been designated as the decedent’s beneficiary until their divorce, after which the decedent completed a change of beneficiary form, naming his sons as co-equal beneficiaries. However, the decedent’s employer’s record keeper rejected the change of beneficiary form, claiming it was illegible. The form was also delivered to the insurer, evidently in a timely manner. The court enforced the established ERISA “plan documents rule” and found that because the plan provided that a change of beneficiary designation became effective when signed (and not when a legible form is received by the employer’s record keeper), the sons were properly entitled to the proceeds.

No-Fault Carrier Obligated to Reimburse Health Insurer

In this declaratory judgment action, the parties disputed whether the ERISA governed health benefit plan’s right of reimbursement was from the plaintiff’s tort action settlement amount, which was compensation for non-economic damages. The plaintiff’s medical expenses were covered by her employer-provided, self-funded plan, which expressly provided for reimbursement and a right of first recovery. The court held that reimbursement of medical expenses from the settlement proceeds was “appropriate equitable relief” under ERISA, and that the no-fault carrier was obligated to reimburse the plaintiff for the funds required to be paid to the plan.

Wife Convicted of Voluntary Manslaughter, Disqualified from Husband’s Pension Benefits

Although the plaintiff was designated as her deceased husband’s pension beneficiary, the court found that a voluntary manslaughter conviction disqualified the plaintiff from collecting survivorship benefits. The plaintiff argued that because she was not convicted of “intentionally” causing her husband’s death (who she stabbed repeatedly during a domestic dispute), she should still be allowed to recover his retirement benefits. Despite the defendant’s procedural failings, the court found that under either the federal equitable “slayer’s rule” or Michigan’s “slayer’s statute”, voluntary manslaughter is an intentional killing such that the plaintiff was not entitled to recover survivorship benefits.

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Significant Insurance Decisions

By Deborah A. Hebert, Collins, Einhorn, Farrell & Ulanoiff, deborah.hebert@ceflawyers.com and Adam Kutinsky, Kitch, Drutchas, Wagner, Valitutti & Sherbrook, adam.kutinsky@kitch.com

Sixth Circuit

ERISA – Permanent Disability Claim Denied

*Balmert v Reliance Standard Life Ins Co (Amended)___ F3d ___ (6th Cir 2010)*

Plaintiff applied for permanent disability benefits but was awarded short term benefits instead. The Sixth Circuit affirmed the limited award in a decision that addresses the elements of full and fair review by an administrative agency. As to the merits of the award, the Court held that ERISA does not require a plan administrator to accord special deference to the opinion of the treating physician, nor does ERISA impose a heightened burden on the plan administrator to explain why a treating physician’s opinion is rejected. Plan administrators may defer to the opinions of other physicians as long as the treating physician’s assessment is not ignored.

Michigan Supreme Court

Commercial UM/UIM Coverage

*Berkeypile v Westfield Insurance Company Order of Supreme Court dated March 12, 2010*

This order reverses a published decision of the Court of Appeals interpreting a commercial UM/UIM auto policy. Because the commercial policy did not include the “anti-duplication” clause typically contained in the personal auto policy, the Court of Appeals decided that claimant could seek UM benefits even after settling with the tortfeasors for more than the UM policy limits. The Supreme Court reversed. A provision in the commercial policy states: “[i]f there is other applicable insurance available under one or more policies or provisions of coverage . . . [t]he maximum recovery under all coverage forms or policies combined may equal but not exceed the highest applicable limit for any one vehicle under any coverage form or policy providing coverage on either a primary or excess basis.” The Court held that because “[t]his provision limits the insured’s maximum recovery to the highest policy limit of any single policy available,” and because plaintiff had recovered more than the limits available under the highest policy, she was not entitled to UM/UIM benefits. The Court also corrected an error in the Court of Appeals’ analysis of the basic insuring agreement.

Michigan Court of Appeals—Published

Undiscounted Charges by Health Care Provider are Usual and Customary


Plaintiff, an uninsured patient, was admitted to the defendant hospital for treatment of a kidney stone. Plaintiff executed an agreement promising to pay the hospital’s “usual and customary charges.” Afterward, plaintiff was billed for services based on a “Charge Master” which uses an index of charges not incorporating the discounts typically provided to third party payors. Plaintiff refused to pay the full amount billed, claiming that “usual and customary charges” meant the discounted payments for third party payors. The Court of Appeals held that the hospital properly relied on the Charge Master to uniformly charge all patients and the fact that it discounted payments from some payors did not alter plaintiff’s contractual obligation. “[W]e conclude that the trial court properly found that the phrase “usual and customary charges” unambiguously refers to the Charge Master.”

Continued on next page

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UIM Insurance

Dancey v Travelers Property Cas Co of America ___ Mich App ___ (2010)(Docket No. 288615)

The Court of Appeals found a question of fact about whether claimant was occupying an auto “covered” under this commercial auto policy. The vehicle was personally leased to the son of the insured business owners, who testified that the business then leased the vehicle from the son, even though there was no written contract. Their testimony was enough to create a question of fact. The Court also found a question of fact about whether the claimant (the son’s wife) was injured by a “hit and run” vehicle, where she lost control of the vehicle after running over a ladder laying in the lane of travel on the expressway. The Court held that the location and circumstances of the accident would allow a jury to infer that another vehicle had dropped the ladder, and was therefore caused by an uninsured vehicle defined in the policy as a vehicle that causes an object to hit the insured.

UM/UIM Contractual Limitations Period

OFIS Order No. 05-060-M Not Applicable to Policy Renewals

(Application for Leave Pending)

In response to the Supreme Court’s opinion in Rory, which upheld the one year contractual period of limitations in UM/UIM insurance policies, the Office of Financial and Insurance Services (OFIS) issued a notice and order of prohibition, No. 05-060-M, barring no fault automobile insurance forms with contractual limitations periods of less than three years for UM claims. Farm Bureau had issued plaintiff a policy with a one-year limitation period prior to the OFIS order; that policy renewed every six months without modification. Order No. 05-060-M only prohibits the issuance, advertisement and delivery of policies with one-year limitations periods; “it does not prohibit their renewal or reissuance.” Because this policy was in effect prior to the date of the order, its one year limitations period was enforceable. The Court also considered whether the UM claim could be considered timely by relating it back to the original complaint against the tortfeasor. The answer is no, because the relation back doctrine does not apply to contractual limitation periods, only to statutory limitation periods.

Sexual Molestation Exclusion – Publication Granted


The Michigan Court of Appeals approved this previously unpublished opinion which interprets an exclusion for claims of sexual molestation. See the April 2010 issue of the Journal for a discussion of the issue.

Named Driver Exclusion


Michigan’s No-Fault Act requires a very specific warning whenever an insurance policy excludes a named driver. That warning must be on both the certificate of insurance and on any one of the following: the face of the policy or the dec page or the certificate of the policy. Progressive’s policy contained the statutorily required warning on the dec page. It also set forth warnings on the face of the policy and on the certificate of insurance, but they departed from the statutory language by one word. Michigan’s statute required a warning informing that owners would be liable for the use of the vehicle by the named excluded person; Progressive’s warning stated that the owners would be responsible for the use of the vehicle by the excluded insured. In a decision consisting of three separate opinions (one dissent), the Court of Appeals found that the exact statutory language was required. Because the policy did not comply, the named excluded driver provision was unenforceable.

Michigan Court of Appeals—Unpublished

Insured’s Polygraph Results Not Admissible to Contest Coverage Decision

Dillard v Farm Bureau Insurance Co, Unpublished per curiam opinion of the Court of Appeals, Issued March 11, 2010 (Docket No. 288134) (Application for Leave Pending)

Homeowner’s insurer denied a property damage claim resulting from vandalism and theft because it believed the homeowner may have been involved in the wrongdoing and also materially misrepresented the circumstances of the loss. The insured sued for coverage and at trial, was allowed to intro-
duce evidence that he had passed a polygraph test concerning the claim. On appeal, the Court held that the polygraph test was wrongly admitted under People v Barbara, 400 Mich 352 (1977), which established a per se exclusionary rule for polygraph evidence at trial. Because it was more probable than not that a different outcome would have occurred absent the polygraph evidence, a new trial was ordered.

**Dealer-Owned Vehicle Not Being Used for Purposes Incidental to Business, Precluding Coverage Under the Garage Liability Policy**

Empire Fire and Marine Insurance Co v Lynch, et al,
Unpublished per curiam opinion of the Court of Appeals
Issued March 9, 2010 (Docket No. 289695)

Empire Fire and Marine issued a garage liability policy to defendant car dealership. The son of the dealership was injured while operating a dealership-owned vehicle in the course of his job delivering pizzas. Empire denied coverage for the reason that the son was not operating the car in connection with garage operations. The Court of Appeals agreed. Quoting the policy definition of “Garage Operations,” which included “all operations necessary or incidental to a garage business,” the Court declared: “[t]he policy at issue was issued to cover vehicles mainly confined to the dealership grounds and the risks attendant to such limited use, not vehicles on the streets for normal sundry uses and thus exposed to the full range of risks attendant to such usage.” The Court expressly rejected the argument that the vehicle was being used to advertise the dealership through its dealer plates.

**Use of Reasonable Force Triggers Exception to Intentional Act Exclusion Under Liquor Liability Policy**

Kacho v KSK Hospitality Group, Inc, et al,
Unpublished per curiam opinion of the Court of Appeals
Issued March 2, 2010 (Docket No. 289012)
(Application for Leave Pending)

A bar patron was injured by the manager of the bar as he attempted to control a barroom brawl. When the patron sued, the liability insurer denied coverage under the intentional act exclusion. The Court of Appeals held that while the act was intentional within the meaning of the exclusion, the exception to the exclusion applied. The exception states: “we won’t apply this exclusion to intentional bodily injury or property damage that results from the use of reasonable force to protect people or property.” Because there was a question of fact about whether the manager used reasonable force to protect another person during the brawl, the Court reversed the trial court’s order of summary disposition for the insurer and remanded the case.

**No Homeowner’s Insurance Coverage for Rental Property**

Matheny v Homesite Ins Co of the Midwest
Unpublished per curiam opinion of the Court of Appeals
Issued April 15, 2010 (Docket No. 289599)

Plaintiff purchased a homeowner’s insurance policy to cover a house that he operated as rental property. When the house was damaged by a fire and vandalized, he submitted a claim to the insurer, who denied coverage. The policy covered only “residence premises” or other property not involved here. The Court held that the insured was clearly informed by the policy that he must reside in the home. This requirement was not altered by the fact that the insurance agent failed to ask the insured about how the property would be used nor by the fact that the insurer had sent a notice of cancellation with an effective date that occurred after the fire.

**Motor Vehicle Exclusion in Homeowner’s Policy Excludes Coverage**

State Farm Fire and Cas Co v Malec
Unpublished per curiam opinion of the Court of Appeals
Issued April 20, 2010 (Docket No. 289929)

The motor vehicle exclusion in a homeowner’s insurance policy precluded coverage for a claim arising out of the use of a crane mounted on a truck operated by the insured. The truck was a motor vehicle as defined in the policy. And even if the truck qualified as a vehicle “in dead storage” immediately prior to the accident, it was not located in a covered, “insured location.”

**Identity of Principal Driver a Question of Fact**

Arevelo v Auto Club Insurance Association
Unpublished per curiam opinion of the Court of Appeals
Issued May 18, 2010 (Docket No. 289863)

Auto Club denied coverage for an auto theft claim because of the insured’s misrepresentation concerning the principal driver of the vehicle. The Court distinguished between principal and regular drivers and, based on conflicting testimony, found a question of fact as to whether the identity of the principal driver had been misrepresented. The case was remanded to resolve the factual dispute.

**UM Benefits Triggered Where Tortfeasor’s Liability Coverage is Lost Due to Lack of Notice of the Complaint**

Integon National Insurance Company v Berry
Unpublished per curiam opinion of the Court of Appeals
Issued March 25, 2010 (Docket No. 289320)

In these consolidated appeals, the Court first held that the auto liability insurer who did not receive notice of a complaint against its insured was deprived of the opportunity to

Continued on next page
defend and thus had no duty to indemnify. MCL 257.520(f) (6) states: “The insurance carrier shall not be liable on any judgment if it has not had prompt notice of and reasonable opportunity to appear in and defend the action in which such judgment was rendered.” The Court then went on to hold in the second appeal that the lack of liability insurance for the tortfeasor qualified the claimant for UM benefits under her own policy.

One of the policy definitions of a UM vehicle is a vehicle “[n]ot insured by a bodily injury liability bond or policy that is applicable at the time of the accident.” The panel reasoned that in order for the policy to be “applicable,” the insured must be “entitled to the protection afforded under the policy.” Liability coverage was not available until the tortfeasor complied with the relevant policy terms. Because he failed to comply with the notice requirement, he was never entitled to coverage, i.e., the policy never became “applicable at the time of the accident.” Claimant was thus injured by an “uninsured vehicle” within the meaning of her own policy. The Court of Appeals also refused to hold that the claimant’s opposition to the tortfeasor’s motion to set aside the default entered against him violated the “take no action” clause of the UM policy or otherwise interfered with the insurer’s subrogation rights.

Personal Auto Coverage for an Accident Involving Employer’s Vehicle

*Progressive Michigan Insurance Company v Sneden*

Unpublished per curiam opinion of the Court of Appeals
Issued March 30, 2010 (Docket No. 285265)
(Application for Leave Pending)

While operating his employer’s milk truck in the course of employment, defendant Sneden rear-ended another vehicle fatally injuring one of the occupants and injuring two others. The employer’s auto insurer tendered its policy limits, after which claimants turned to the personal auto policy issued to Sneden by Progressive. That policy promised to “pay damages . . . for bodily injury . . . for which an insured person becomes legally responsible because of an accident . . . .” An “insured person” was defined as “you with respect to an accident arising out of the maintenance or use of any vehicle with the express or implied permission of the owner of the vehicle.” A “vehicle” had to have a gross weight of 12,000 pounds or less. The milk truck exceeded 12,000 pounds but the claimants’ vehicle weighed less.

The Court of Appeals held that because Progressive’s insured was involved in an accident arising out of the use of a vehicle less than 12,000 pounds (the other car), the personal auto policy was triggered. It did not require, as Progressive urged, that the vehicle operated by the named insured weigh less than 12,000 pounds. Also at issue was whether the claimants had standing to appeal the trial court’s adverse coverage decision where the named insured did not also appeal. The Court found that injured parties have standing because they have a legally protected interest in jeopardy of being adversely affected, “an even greater interest in pursuing coverage . . . than [the insured] may have.” Progressive’s naming of the claimants in its declaratory judgment acknowledged that an actual controversy existed between itself and its insured and the injured family.

**Claims Made Policies – Annual Policy Period Controls**

**Even Where Policy is a Renewing Policy**

*Westport Insurance Corporation v Al Bourdeau Insurance Services*

Unpublished per curiam opinion of the Court of Appeals
Issued April 15, 2010 (Docket No. 287920)
(Motion for Publication Denied)

A claims made policy protects against claims made during the life of the policy. They “deal with situations in which the error, omission, or negligent act is difficult to pinpoint and may have occurred over an extended period of time.” Coverage was denied in this case because the insured knew about the claim prior to the policy under which it was submitted and waited until after judgment was entered to submit the claim. The Court refused to view the policy as a “continuing policy” where it was renewed on an annual basis over a period of years. Each policy contained specific forms and endorsements that varied its terms of coverage from year to year. This opinion also states the proposition that an insurance company’s failure to set forth its defenses or waive them “will ordinarily not be applied to broaden coverage.”

**Renewal Exception**

*Ruzek v USSA Ins Agency, Inc*

Unpublished per curiam opinion of the Court of Appeals
Issued April 27, 2010 (Docket No. 288053)
(Motion for Reconsideration Pending)

The Court of Appeals affirmed the trial court’s finding of coverage but two judges on the panel would have reached a different result if not for a prior panel’s decision. The prior panel remanded this case to the trial court specifically to apply the “renewal exception” to coverage. This exception requires an insurer to give notice to an insured if there is any change in coverage when a policy is renewed. Failure to do so affords the insured the greater coverage. Two judges on this panel...
disagreed that the renewal rule applied to this policy, which started out as a Wisconsin auto policy and was later reissued as a Michigan auto policy when the insureds moved from Wisconsin to Michigan. This panel would have held that the Michigan policy was a new policy, not a renewal.

Criminal Acts Exclusion Not Applicable
Auto Club Group Insurance Company v Wooten
Unpublished per curiam opinion of the Court of Appeals
Issued April 27, 2010 (Docket No. 289159)
(Motion for Reconsideration Pending)

Criminal acts exclusion in a homeowner's policy did not bar coverage for the homeowner insured who accidentally discharged a gun and injured a guest while trying to release the ammunition clip. The exclusion “clearly requires that the injury must result from the criminal act.” No one claimed that the homeowner aimed or pointed the gun at the injured person. “Thus, there is no evidence that [the insured] discharged the gun,” as opposed to carelessly handled it. “We find no cases where the conduct was criminal without any pointing of the gun at a person, waving it around, firing it indiscriminately, or carrying it in a fight.”

Agency Relationship – No Duty to Advise About Coverage
General Agency Company v Huron Oil Company
Unpublished per curiam opinion of the Court of Appeals
Issued April 27, 2010 (Docket No. 288663)

Insurance agency is entitled to recoup the balance owed in premiums. The insured believed it was charged too much for the coverage afforded and argued that the agency had a duty to procure the best possible coverage. There was no evidence of a special relationship obligating the agency to advise the insured about coverage.

Additional Insured Coverage for a Bodily Injury Claim
FH Martin Construction Co v Secura Ins Holdings, Inc.
Unpublished per curiam opinion of the Court of Appeals
Issued May 11, 2010 (Docket No. 289747)

An additional insured endorsement in a subcontractor's CGL policy obligated the insurer to defend and indemnify the general contractor against a bodily injury claim. The subcontract contained a provision by which the subcontractor promised to make the general contractor an additional insured. The subcontractor's insurance policy contained an additional insured endorsement that covered any person with whom the named insured contracted to provide insurance but “only with respect to liability arising out of your ongoing operations performed for that insured.” Another subcontractor's employee was injured while attempting to use the insured subcontractor's ladder and sued the general contractor. The claim triggered the additional insured endorsement because the injury arose as a result of ongoing operations. The insured subcontractor had been working outside and had moved to the inside of this building but had not completed its operations. The Court also rejected the insurer's claim that its policy was excess to the general contractor's CGL policy because the insurer had failed to produce a copy of the other policy or add the other insurer as a necessary party.

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If you are a member of the section and would like to be on our list of speakers, please contact:

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Supreme Court Action

As this report is being prepared, the Michigan Supreme Court has yet to rule upon the two cases that could potentially change the no-fault landscape and overrule two significant decisions issued by the former Michigan Supreme Court majority during the Taylor era, which ran from 1999 to 2008. These decisions are expected to be handed down by the Michigan Supreme Court no later than July 31, 2010, when its current term ends.

Kreiner

In McCormick v Carrier, lv. granted 485 Mich 851, 770 NW2d 357 (2009), the Supreme Court which will likely overrule the decision in Kreiner v Fischer, 471 Mich 109, 683 NW 2d 611 (2004), regarding interpretation of the no-fault threshold of serious impairment of body function.

One-Year-Back Rule

In Regents of the University of Michigan v Titan Insurance Company, lv. granted 484 Mich 852, 769 NW2d 646 (2009), the Supreme Court could potentially overrule the court’s decision in Cameron v ACIA, 476 Mich 55, 718 NW 2d 784 (2006), regarding tolling of the one year back rule set forth in MCL 500.3145(1).

Griffith – Causation Analysis for Allowable Expenses

Griffith v State Farm, 472 Mich 521, 697 NW 2d 895 (2005) has a new lease on life, at least for the time being. As previously reported, the Michigan Supreme Court had granted leave to appeal the Michigan Court of Appeals’ decision in Hoover v Michigan Mutual, 281 Mich App 617, 761 NW 2d 801 (2008). However, shortly after the Michigan Supreme Court granted leave to appeal in Hoover, and ordered the parties to brief the issue of whether Griffith was correctly decided, the parties agreed to settle and the Application for Leave to Appeal was dismissed on January 15, 2010. However, the Michigan Supreme Court recently granted leave to appeal in Wilcox v State Farm, docket number 138602 and, once again, the parties were ordered to brief the issue of whether Griffith was properly decided. Justice Young, joined by Justice Corrigan, authored a dissent, noting that the new Supreme Court majority was essentially undertaking a systematic review of all cases decided by the former majority from 1999 through 2008, with the intent to overrule those decisions, without regard to the doctrine of **stare decisis**.

Idalski – Reasonableness of Provision is for OFIR

On May 21, 2010, the Supreme Court granted oral argument on an Application for Leave to Appeal in Idalski v Schwedt and State Farm, Supreme Court docket number 139960. In the Order, issued over a strong dissent by Justice Young, the Court ordered the parties to address “whether Rory v Continental Ins. Co., 473 Mich 457, 703 NW 2d 23 (2005) should be reconsidered.” As readers will recall, in Rory, the former majority of the Michigan Supreme Court had approved the use of a one-year period of limitations for filing uninsured motorist claims and further ruled that the Courts have no role in determining whether a particular insurance policy provision is “reasonable.” Rather, that task is delegated to the Office of Financial and Insurance Regulation. In Idalski, Court of Appeals docket number 287279, unpublished decision released on 9/29/2009, the Court of Appeals ruled that Plaintiff was barred from pursuing a claim for uninsured motorist benefits by virtue of a contractually shortened limitations period in the policy of insurance issued by State Farm. Once again, another decision from the Taylor Court may soon be overruled by the new Supreme Court majority.

Spouse or “Significant Other” as “Owner”

On another issue, the Michigan Supreme Court denied Defendant’s motion for reconsideration of an earlier order denying an application for leave to appeal from the published Michigan Court of Appeals’ decision in Detroit Medical Center v Titan Insurance Company, 284 Mich App 470, 775 NW 2d 151 (2009). On the same day, the Court also denied Defendant’s Application for Leave to Appeal in two consolidated matters, Zoerman v Titan Insurance Company, Supreme Court docket number 140111, Court of Appeals docket number 285105 and Spectrum Health/Zoerman v Titan Insurance Company, Supreme Court docket number 140109 and Court of Appeals docket number 285104. These three cases dealt with whether or not a spouse (or “significant other”) of the titleholder to an uninsured motor vehicle could nonetheless be considered an “owner” of that vehicle under the statutory definition of the term “owner” set forth in MCL 500.3101(2)(h)(i). If the spouse or significant other has the use of the other spouse’s motor vehicle for a period of time greater than thirty days, that person could conceivably be barred from recovering no-fault benefits.
under MCL 500.3113(b). Justice Markman, joined by Justice Corrigan, dissented from these orders, arguing that the Court of Appeals engrafted a "regular" or "exclusive" use requirement onto the statutory definition of the term "owner" set forth in MCL 500.3101(2)(h)(i). Thus, it appears that the Supreme Court guidance on this issue, which is becoming more and more prevalent these days given the economic state of affairs in Michigan, will have to await another day.

Court of Appeals Action

Unlawful Taking – Injury to Passenger

On June 8, 2010, the Michigan Court of Appeals issued a published opinion in Henry Ford Health System v. Esurance Ins. Co., docket number 288633, which addressed the issue of whether or not a vehicle was "unlawfully taken." In Henry Ford, the medical facility provided services to one Travion Hamilton, who was severely injured while a passenger in a stolen Jeep Cherokee. Esurance Insurance Company insured the stolen vehicle. Esurance denied the claim on the basis that "there was no act transferring possession or control of the vehicle and that he had no reason to believe that he was entitled to take and use the Jeep. Plaintiff appealed, arguing that the lower court erred by submitting this matter to a trial by jury, when it should have granted plaintiff's motion for summary disposition.

On Appeal, the Michigan Court of Appeals took away the defense jury verdict and remanded the case back to the trial court for entry of judgment in favor of Plaintiff. In doing so, the Court of Appeals observed that Hamilton "never engaged or participated in an act through which he took possession or gained control of the Jeep." The Court further observed that "there was no act transferring possession or control of the Jeep from [the thief] or others to Hamilton, nor did Hamilton take possession of control of the vehicle that was unattended and not within anyone's control or possession."

In Henry Ford, slip opinion at page 4-5. In other words, Hamilton, the passenger at the time of injury, did not unlawfully take the Jeep, because "the taking was complete by the time Hamilton came into the picture." The Court of Appeals distinguished its earlier decision in Mester v. State Farm, 235 Mich. App. 84, 594 NW 2d 205 (1999) by observing that in Mester, the three young girls involved in the accident had all participated in the unlawful taking of the vehicle. Accordingly, in cases involving the "unlawful taking" exclusion found at MCL 500.3113(a), it is necessary for both plaintiff counsel and defense counsel to closely examine who was involved in the "unlawful taking" of the vehicle. The mere fact that the injured claimant "came into the picture" after the unlawful taking was completed will no longer be a basis for an insurer to deny payment of PIP benefits, even though the vehicle itself may have all the indicia of a stolen vehicle; i.e., ignition lock punched out, no keys, etc.

Cost of Housing - Paraplegic

Work Loss Benefits – "Under the Table" Employee

In another published decision, Ward v. Titan, docket number 284994, released March 16, 2010, the Court of Appeals addressed two issues that appear often in no-fault insurance claims – an insurer's obligation to provide housing to a paraplegic, and an insurer's obligation to provide work loss benefits in cases where the Plaintiff was working "under the table," with no supporting documentation from either the employer or the employee to substantiate the claimed work loss.

With regard to the first issue, the Court of Appeals unanimously agreed that Defendant was not obligated to pay the entire cost of Plaintiff's housing. Rather, pursuant to Griffith v. State Farm, 472 Mich. 521, 697 NW 2d 895 (2005), Plaintiff "must show that his housing expenses are different from those of an uninjured person, for example, by showing that the rental cost for handicapped accessible housing is higher than the rental cost of ordinary housing." In Ward, the lower court had ordered Defendant insurer to pay Plaintiff's rent, up to $800.00 per month, regardless of whether or not his housing was handicapped accessible. In this regard, the lower court had indicated that Griffith was just a "food case." The Court of Appeals disagreed with this observation.

On the second issue, in a 2-1 decision, the Court of Appeals' majority held that the issue of Plaintiff's entitlement to work loss benefits was an issue of fact to be presented to the jury. Therefore, the Court of Appeals ruled that the lower court erred when it dismissed Plaintiff's work loss claim as a matter of law. The Defendant had relied upon MCL 500.3158(1), which requires an employer to furnish a sworn statement or other documentation regarding the earnings of an injured person, in support of its argument that where there was no documentation to support a claim for work loss benefits, there could be no compensation. The Court of Appeals majority rejected this argument, noting that "nowhere do the statutes suggest that MCL 500.3158(1) is the only manner in which a wage loss claim may be proved or that MCL 500.3107(1)(b)'s right to a wage loss claim hinges on compliance with MCL 500.3158(1)."

Continued on next page
In a vigorous dissent, Judge Markey noted:

“When one chooses to accept employment for which he or she will be paid “under the table,” surely there may be some negative repercussions, and people who make such decisions should expect some. Because of his own and his employer’s actions, I believe Plaintiff forfeited his ability to claim work loss benefits under MCL 500.3158.”

She also observed that:

“It is profoundly unfair to allow a judicially created means to collaterally attack the requirement that such documentation be provided because it puts the no fault insurance carrier in an untenable position. It has no way whatsoever to dispute or prove – when it is not its burden of proof – the amount the Plaintiff was earning at the time of the accident. It creates a situation rife with the potential for fraud, frankly, what seems to be precisely the case here.”

Plaintiff filed an Application for Leave to Appeal with the Michigan Supreme Court with regard to the housing issue. At the same time, Defendant filed an Application for Leave to Appeal with regard to the wage loss issue. Both applications remain pending as of this date.

Fraudulent Claim – Res Judicata as to Provider of Attendant Care Services

Finally, in *TBCI, Inc. v State Farm*, docket number 288853, unpublished decision released 4/27/2010, the Court of Appeals ruled that a fraudulent claim for attendant care services barred a claim for medical expenses filed by one of Plaintiff’s medical providers in a separate, independent cause of action. In *TBCI*, the patient had filed a claim for attendant care service benefits with his no-fault insurer, State Farm. State Farm refused to pay the claim on the basis that the claims were fraudulent. The patient’s case went to trial in the Wayne County Circuit Court and the jury concluded that the claims were, in fact, fraudulent. In a separate action filed by the medical provider in the Oakland County Circuit Court, State Farm argued that the claims of the medical provider, TBCI, were barred by an exclusionary clause contained within the State Farm policy, which provided:

“There is no coverage under this policy if you or any other person insured under this policy has made false statements with the intent to conceal or misrepresent any material fact or circumstance in connection with any claim under this policy.”

After a judgment of no cause of action was entered against the patient in the Wayne County Circuit Court action, State Farm filed a motion for summary disposition with regard to the provider’s action in the Oakland County Circuit Court. The provider argued that its claim was “an independent cause of action,” involving a claim for services that “was not adjudicated in the Wayne County action.” The Oakland County Circuit Court rejected this argument and granted summary disposition in favor of State Farm.

The Court of Appeals held that the finding of fraud as against the claimant barred the provider’s cause of action under the doctrine of *res judicata*. The Court noted that when TBCI sought coverage under the State Farm policy, it was “essentially standing in the shoes of [the patient].” Therefore, even though it was not a party to the Wayne County Circuit Court action, it was nonetheless a “privity” of the patient. Therefore, pursuant to the clear and unambiguous exclusion set forth in the State Farm policy, TBCI was barred from recovering its medical expenses against State Farm.

Many commentators have discussed the possibility of medical providers being able to pursue their own independent causes of action against a no-fault insurer, without regard to any fraudulent conduct on the part of the patient, or even whether any of the various exclusions set forth in MCL 500.3113 might apply. By holding that the provider stands in privity with the patient, the Court of Appeals is clearly sending a signal that any such arguments will be rejected. Simply put, if an exclusion applies to the patient, then it will apply to his medical providers as well.

By the next edition of this *Journal*, we should know by then how the 2010 election for the Michigan Supreme Court is shaping up and how the outcome of that election could affect many of the no-fault cases currently pending on appeal before the Supreme Court. ■
Ohio Changes Requirements for Out-of-State Attorneys Arguing Temporarily in its Courts

In about six months out-of-state attorneys who want to appear temporarily in a proceeding in Ohio (pro hac vice) will notice some significant changes to the process.

The Supreme Court of Ohio adopted the pro hac vice amendments last year, which become effective January 1, 2011. Pro hac vice is a privilege granted by a tribunal to out-of-state attorneys not admitted to practice law in Ohio to appear before the tribunal on a limited basis.

Amendments to Gov. Bar R. XII of the Rules for the Government of the Bar will:

- Centralize the administration of pro hac vice admission through the Supreme Court’s Office of Attorney Services
- Require an out-of-state attorney to file an application and $100 annual registration fee before applying to appear pro hac vice
- Establish basic criteria for appearing pro hac vice before a tribunal, including acknowledgement of Ohio’s attorney disciplinary rules and a statement that the attorney has not been granted permission to appear pro hac vice in more than three proceedings before Ohio tribunals in the current calendar year
- Permit the administrative revocation of privileges to practice pro hac vice if the attorney does not comply with certain provisions of the rule

Susan Christoff, Attorney Services Division director, said the changes implemented in Ohio bring the state in line with how other states have handled temporary appearances by out-of-state attorneys.

“Attorneys who regularly practice in other states in the Midwest should be familiar with some of the requirements instituted by Ohio, because they are similar to what those other states require,” she said. “That being said, it’s important to note that pro hac vice has changed in Ohio, and we would hope that Ohio’s courts and administrative agencies as well as Ohio judges and attorneys are aware of these coming changes.”

She noted that attorneys seeking pro hac vice registration will be able to submit registration applications electronically. She also noted that the Office of Attorney Services will maintain an online public directory that includes the names of attorneys who have registered under the new rule and the cases in which they have received permission to appear pro hac vice.

New Trust Account Overdraft Notification Rule Takes Effect September 15

Lawyers with Trust Accounts are Impacted

New Rule 1.15A of the Michigan Rules of Professional Conduct, also known as the Trust Account Overdraft Notice Rule (TAON), takes effect on September 15, 2010. To review Rule 1.15A in its entirety, visit MRPC 1.15A PDF.

A brief summary of the requirements of the TAON Rule is provided below:

- Before the effective date of the TAON Rule, financial institutions doing business in Michigan must submit a signed agreement to the State Bar of Michigan to obtain approval to maintain lawyer trust accounts as defined by MRPC 1.15(a).
- Lawyers must confirm that their financial institutions are on the list of approved financial institutions posted on the State Bar’s website.
- No further action is required by lawyers for their preexisting IOLTA accounts; these accounts have already been identified as lawyer trust accounts by financial institutions when opened by lawyers.
- After confirming that their financial institution is on the State Bar’s list, lawyers must contact their financial institutions to change the name on their non-IOLTA accounts to include the term “trust” or “escrow” if not already included in the account name.
- After confirming that their financial institution is on the State Bar’s list, lawyers may download a form (Non-IOLTA Lawyer Trust Account Notice to Financial Institution) from the State Bar’s website and submit the completed form to their approved financial institutions for each non-IOLTA trust account and must send a copy to the State Bar.
- Lawyers must continue to safeguard client and third-party funds held in trust to avoid all overdrafts to their IOLTA and non-IOLTA accounts.
- Approved financial institutions maintaining lawyer trust accounts must submit overdraft reports within five banking days of any overdrafts to the grievance administrator of the Attorney Grievance Commission.

The State Bar is in the process of communicating with financial institutions to invite their participation in the TAON program. The State Bar expects to begin receiving signed TAON agreements from financial institutions in May and will begin posting its list of approved financial institutions at that time. The State Bar will update the list of approved financial institutions as signed TAON agreements are received from financial institutions.

Lawyers should wait until the name of their financial institution appears on the State Bar’s list of approved financial institutions before submitting a completed non-IOLTA notice form.
Insurance & Indemnity Law Section
2009 - 2010 Officers and Council