I am pleased to announce that on June 28, 2011, our Council has adopted a two-year strategic plan to provide those services our members most want from this Section. This strategic plan was the culmination of an effort undertaken with the tremendous help of Anne Vrooman at the State Bar of Michigan, along with three of our Council members who devoted a significant amount of time to this project: Hal Carroll, Kathleen Lopilato and Elaine Pohl.

We began this project with the recognition that our section had grown tremendously in its short life and we needed to develop an organized and productive direction for it, as well as a process for promoting future leadership in the section. We started the process with a survey of our entire membership, followed by a focus group meeting with several members. The survey and focus group process gave us information about the things that our members most want to receive from the section and provided us with a solid understanding of our section demographics. From this information we were able to create a two-year plan that our entire Council looks forward to implementing for the benefit of our membership. I am also pleased to report that as we were adopting this two-year strategic plan our Council learned that our Section membership now exceeds 500 members. This makes our need for this kind of formalized plan all the more important.

The stated vision in our two-year strategic plan is that as a new section, we aim to develop an effective plan that will allow the section’s leadership to function and provide services in a way that it is an effective resource for our members. The stated values in our two-year strategic plan is that the guiding principles of the section will remain as they have from the inception of the section; namely, to provide an exchange of information and education across all areas of practice that are affected by insurance and indemnity issues and to do so in a way that fairly includes the viewpoints of both insurers and policy holders.

Our strategic plan hopes to both fulfill the section’s vision and to satisfy its values. Our plan includes a method for reducing the size of the Council from 21 current members to 15 members. The revised Council will include 10 elected members, four officers, and the immediate past chair. To put this plan into effect, the Council has adopted a proposed amendment to the bylaws to be presented for vote to the members at the section’s business meeting at the annual meeting of the State Bar of Michigan on September 15, 2011.

The reduction in the size of the Council will make its size more in line with other State Bar sections of similar and larger size and will serve to promote actual, hands-on work by functioning committees and Section members. Along those same lines, the plan adopts three core committees: Publications, Membership and Programs. I will be appointing chairs of each of those committees and we will be holding a special meeting sometime after
the annual meeting that will be open to all members with the hopes that people will volunteer to serve on these committees.

Ultimately, our plan seeks to create a structure where the Council acts more as a governing body and the actual work is performed by committees. The strategic plan also calls for the section to create a membership directory, present substantive programs at the annual State Bar meetings, and present two substantive presentations in conjunction with other bar organizations or recognized state bar sections in the next two years. This will all, hopefully, be carried out with the help of our members serving on the core committees.

Finally, the strategic plan has adopted a number of other measures to assist with future planning and leadership transfer including a formalized yearly budget, a yearly review of demographics, yearly scheduling of Council meetings and the stated goal of adopting a “macro” five-year strategic plan so that successive Councils create one-year strategic plans with specifically stated goals.

We look forward to providing you with these services and, as always, we want to hear from you and we want you involved.

Do You Have a Question?

Another very specific thing that we learned from the survey is that a member is interested in learning more about “excess insurance” and “reinsurance.” Because the primary purpose of the Section is to exchange information, this issue’s “Insurance and Indemnity Law 101” will respond to that question. If you have any questions that you would like to see addressed in future issues of the Journal, just let the editor know.

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The Journal would like to add regular contributors in two areas impacted by insurance and indemnity issues: professional liability and regulatory aspects of insurance. If you are interested in signing on as a regular contributor of case or legislative reports for these areas, please contact the editor ...

Case Reports

The Journal would like to add regular contributors in two areas impacted by insurance and indemnity issues: professional liability and regulatory aspects of insurance. If you are interested in signing on as a regular contributor of case or legislative reports for these areas, please contact the editor at bcarroll@VGPcLAW.com or bcarroll@chartermi.net.

Bear in mind that the Journal not only goes to Section members, but to state and federal trial and appellate judges, as well as all state legislators who are attorneys, so the Journal reaches decision-makers as well as advocates. Our reports are intended to be descriptive, in keeping with the Section’s position of neutrality as between insureds and insurers. What makes reports valuable to our members is the accuracy of description.

Articles

We also welcome articles on any topic that relates to our areas of practice. Unlike the case reports, articles are free to express any point of view, either for insureds or for insurers. So if you have a topic in mind, of course, just contact us at either of the above addresses.

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The Journal of Insurance and Indemnity Law is a forum for the exchange of information, opinion, and commentary from any perspective on any topic related to the law of insurance and/or indemnity. In addition to being distributed to members, the Journal is also sent to state and federal trial and appellate judges, and selected legislators and members of the executive branch. The Journal welcomes articles or other contributions from any interested person.

The Journal is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1).

—Hal O. Carroll
Insurance and Indemnity Law Section
Annual Meeting

Thursday, September 15, 2011
10:00 a.m.-11:30 a.m.
Hyatt Regency, Dearborn

Please join us at the meeting. We will have a short business meeting followed by a program:

Is There Bad Faith in Michigan?
A Panel Discussion of Claims and Defenses

What remedies are available to a policyholder when there is an insurance coverage dispute with its insurer? What defenses are available to the insurer? What are the consequences of pursuing those claims or defenses? How can an insurance coverage dispute affect parties in related underlying litigation? Join your colleagues of the Insurance and Indemnity Law Section for a panel discussion on this complicated issue, which impacts many different areas of the law.

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State Bar of Michigan Insurance and Indemnity Law Section 3
Senator Pominville, of Prime One Insurance Company, has provided copies of two Senate Bills relating to insurance. Both bills have been referred to the Senate Committee on Insurance.

**Senate Bill No. 70**

Introduced on January 26, 2011 by Senators Anderson, Young and Johnson.

A bill to amend 1956 PA 218, entitled “The insurance code of 1956,” (MCL 500.100 to 500.8302) by adding section 2229.

The People of the State of Michigan enact:

Sec. 2229. If an insurer refuses to pay, for any reason, under an insurance policy and the insured prevails after trial in an action to recover under the policy, the court shall award to the insured all costs and expenses in bringing the action, including, but not limited to, reasonable and actual attorney fees, interest, and taxable costs.

**Senate Bill No. 71**

Introduced on January 26, 2011 by Senators Anderson, Bieda, Gregory, Johnson, Young and Hopgood.

A bill to amend 1956 PA 218, entitled “The insurance code of 1956,” (MCL 500.101 to 500.8302) by adding sections 2203, 3149, 3400a, 3501a, 3600a, 4003, and 4403.

The People of the State of Michigan enact:

Sec. 2203. An insurer obligated to pay benefits or claims under a property and casualty insurance policy has a duty to deal fairly and in good faith with an insured claiming the benefits. An insurer that breaches this duty to deal fairly and in good faith is liable for compensatory, consequential, and exemplary damages proximately caused by the breach.

Sec. 3149. An insurer obligated to pay benefits or claims under an automobile insurance policy has a duty to deal fairly and in good faith with an insured claiming the benefits. An insurer that breaches this duty to deal fairly and in good faith is liable for compensatory, consequential, and exemplary damages proximately caused by the breach.

Sec. 3400a. An insurer obligated to pay benefits or claims under a policy of disability insurance has a duty to deal fairly and in good faith with an insured claiming the benefits. An insurer that breaches this duty to deal fairly and in good faith is liable for compensatory, consequential, and exemplary damages proximately caused by the breach.

Sec. 3501a. A health maintenance organization has a duty to deal fairly and in good faith with an enrollee claiming benefits under a health maintenance organization contract. A health maintenance organization that breaches this duty to deal fairly and in good faith is liable for compensatory, consequential, and exemplary damages proximately caused by the breach.

Sec. 3600a. An insurer obligated to pay benefits or claims under a group disability insurance policy has a duty to deal fairly and in good faith with an insured claiming the benefits. An insurer that breaches this duty to deal fairly and in good faith is liable for compensatory, consequential, and exemplary damages proximately caused by the breach.

Sec. 4003. An insurer obligated to pay benefits or claims under a life insurance policy has a duty to deal fairly and in good faith with any person claiming the benefits. An insurer that breaches this duty to deal fairly and in good faith is liable for compensatory, consequential, and exemplary damages proximately caused by the breach.

Sec. 4403. An insurer obligated to pay benefits or claims under a group life insurance policy has a duty to deal fairly and in good faith with any person claiming the benefits. An insurer that breaches this duty to deal fairly and in good faith is liable for compensatory, consequential, and exemplary damages proximately caused by the breach.

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**Invite someone you know to join the fun.**

Invite someone to join the section.

Section membership forms can be found at http://www.michbar.org/sections
Author's note: As of the last issue, when this column first appeared, the plan was to devote the column in this issue to the “intentional act,” i.e., “Expected or Intended Injury” exclusion. But when the Section conducted the member survey that Chairperson Mark Cooper refers to in his “From the Chair,” one member asked for a discussion of excess insurance and reinsurance, so that will be our topic. One of the purposes of our Section is to share information about insurance and indemnity law both among the experienced practitioners in this area and the lawyers who are new to the area. We want the Section to be a resource for all members. So if you want to suggest a topic for this column to address, we will do our best to cover it. Just contact the author.

Now, on to the topic of excess insurance and reinsurance.

Actually there are three concepts that are loosely connected, at least in that they have names that can easily cause confusion. One is excess insurance, sometimes also called umbrella insurance. The other is reinsurance. The third is an “other insurance” clause in a primary policy that says that its coverage is “excess” over another primary policy. These are easily confused, and the first and third confused the courts for a while.

The best place to begin is with a typical liability policy, the famous general liability (GL) policy, a/k/a commercial general liability (CGL) policy. Normally it provides primary coverage, and is the first to pay after the insured’s deductible. The size of the deductible can vary greatly. If the deductible gets large enough, it is often called a “retained limit” or an SIR (“self-insured retention”). But however large the deductible or SIR is, the primary policy is the first insurance policy to pay a claim. The primary policy will have a policy limit. For purposes of illustration, lets assume the limit is $1 million (often abbreviated “$1mm”).

Excess (Umbrella) Insurance

If the insured buys a policy that pays after the primary policy, that is an excess policy. The excess policy will normally refer specifically to the primary policy as the “underlying insurance.” For our illustration, we’ll assume the excess policy provides $4 million in coverage above the primary policy. The insured now has $5 million in coverage (minus its deductible or SIR). In the jargon of the trade, the insured’s excess insurance coverage is “$4mm XS $1mm.” Sometimes an excess policy is called an “umbrella” policy, especially if it is excess over two or more primary policies. For example, an individual might have an umbrella policy above his or her auto liability and homeowner’s policies.

Sometimes an excess policy is called an “umbrella” policy, especially if it is excess over two or more primary policies. For example, an individual might have an umbrella policy above his or her auto liability and homeowner’s policies.

Reinsurance

Getting back to the primary and excess policies, where does reinsurance fit in? Reinsurance might look like excess insurance at first glance, because it definitely is not a primary policy. But the big difference here is over who is the insured. Reinsurance is neither primary nor excess insurance because it is not bought by the insured person or business. Reinsurance insures the insurer. The reinsurer will reimburse the primary (or excess) insurer if that insurer pays a claim. In our hypothetical case it is probably the excess insurer that will buy reinsurance, though it could be either the primary or the excess insurer.

If the excess insurer decides that having $4 million of its assets at risk is too great a financial risk, it would buy reinsurance from a reinsurer. For example, the excess insurer might reinsure $3 million of its $4 million. The excess insurer pays a premium and the reinsurer issues its reinsurance agreement. By the way, the reinsurer can even buy reinsurance from another reinsurer.

The insured person or business plays no part in this reinsurance transaction and probably does not know or care whether its primary and excess insurers have reinsured their risk or not. Within the world of reinsurance there are some terms to learn. The excess insurer in our hypothetical is the “reinsured” or the “ceding insurer,” because it cedes some of its risk to the reinsurer.

In addition, there are two broad categories of reinsurance agreements: “facultative” and “treaty.” In treaty reinsurance, the reinsurer agrees to reinsure all of the policies issued by a particular insurer, where the policies are of a type agreed in the reinsurance treaty. In facultative reinsurance, the agreement is a one-off. The reinsurer agrees to reinsure some of the risk of a particular policy issued to a particular insured. In either
case, though, the reinsurer will want to know the exact terms of the ceding insurer's policy, so that it knows just what risks it is taking on.

Other Insurance Clause – Excess Type

Returning to the primary policy that insures the insured person of company, what if there is more than one primary policy? This is not at all uncommon. One insured won't buy two policies to cover the same risk (it's a little different for auto policies). The most common situation is the construction site accident, in which the general contractor will have its own policy and will be an “additional insured” under a subcontractor's policy. Actually the general contractor can easily have several subcontractors and be an additional insured under each subcontractor's policy. The principle is the same, though, so let’s assume there are two primary policies insuring our general contractor. Each primary policy will have an “other insurance” clause, the purpose of which is, as the name implies to describe what will happen if there is another policy.

Trucking policies, by the way, present the same issue, because the tractor and the trailer are each “autos” in the jargon of the trade, and each “auto” has its own primary and excess liability policies.

The effect of “other insurance” clauses deserves a separate column, but in brief, there are three types of “other insurance” clauses: pro rata (or “equal shares”), excess and “escape.” Under the first type, the policy says that it will share the loss with the other insurer either in proportion to their respective policy limits (“pro rata”) or by each paying half (“equal shares”).

Under the third type, “escape,” the clause says in effect, “this policy pays nothing if there is other insurance.”

It’s the second type of “other insurance” clause, the “excess” type, that caused the confusion. Under the second type, one primary policy says that its coverage is excess to the other primary policy's coverage. The question is this: If the “other insurance” clause says this primary policy’s coverage is excess to the other primary policy, does that change the primary policy into an excess policy? If so then primary policy no. 1 pays its whole limit, and primary policy no. 2, the one with the “excess clause, would pay – like any true excess policy – only after policy no. 1 has paid its limits.

Besides that, if primary policy no. 2 has been changed into an excess policy by virtue of the “excess” clause, then it must be up at the same level of any other excess (a/k/a umbrella) policies, and share the loss in some way with them. Excess policies also have their own “other insurance” clauses, by the way.

The issue is now resolved in Michigan. In Frankenmuth Mutual v Continental Ins, the Supreme Court said:

“True” excess insurance is analogous to umbrella insurance in that a single insured by specific design layers coverage. The logical rule that we adopt in “true” excess insurance cases is that the “true” excess insurer is liable for defense costs only after the primary insurer is excused under the terms of its policy.

In St Paul Fire & Marine Ins Co v American Home Assurance Co, Michigan's Supreme Court held that the language of the three types of other insurance clauses must be compared and given effect. Thus, for example, where one policy provides that it will pay “prorata” with other insurance, and the other policy states that its coverage is “excess” to other insurance, the “prorata” policy pays before the “excess” policy. However, the primary policy with the other insurance clause of the “excess” type is still a primary policy. In short, other insurance clauses do not move a policy to another level; they only operate to sort out priorities within that particular level.

Summary

Although “excess (i.e., umbrella) insurance,” reinsurance and “other insurance” clause of the “excess” type sound as if they must be related in some way, the three concepts are actually distinct, and should not cause confusion. Besides, there is enough potential confusion within each category that there is no need to add to it.

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. His practice includes civil appeals and indemnity and insurance coverage disputes, where he represents insureds as well as insurers. He is a frequent author on insurance and indemnity topics. His email addresses are hcarroll@VGpcLAW.com and hcarroll@chartermi.net.

Endnotes


4 Frankenmuth, 450 Mich at 435-436.

Preserving Common-Law Indemnity Claims in Cases of Active and Passive Fault

By Noreen L. Slank
Collins, Einhorn, Farrell & Ulanaoff; noreen.slank@ceflawyers.com

A common-law indemnity claim is filed by a vicariously liable principal against its at-fault employee or agent. The roots of the claim are planted in the equitable theory that when someone's wrongful act causes another to be held vicariously liable, the wrongdoer should pay restitution. Lakeside Oakland Development, LC v H & J Beef Co.1 Settling a case with the injured party while preserving your client’s common-law indemnity claim against an actively at-fault tortfeasor can be a tricky business. So is trying cases in a way that preserves your client’s common-law indemnity claim.

The root of the problem is that plaintiffs often pursue combined complaints of “active” fault and “passive” fault. The two concepts are more easily illustrated than defined. A plaintiff will argue that a car owner should be liable under the Owner's Liability Act, MCL 257.401. That is liability by operation of law, without regard to fault, and is a “passive” claim in the lingo of common-law indemnity. The same plaintiff argues that the owner knew the driver was unfit to drive. That is an active fault claim. And even if the claim is that the owner failed to discern the driver's unfitness, that too is considered “active” fault. A plaintiff may claim that a hospital should be vicariously liable for the malpractice of its employee. But the same plaintiff may also claim that the hospital failed to have adequate procedures in place to prevent the malpractice in the first place. Again, passive fault as contrasted with active fault.

How a vicariously liable party can settle with a plaintiff while preserving a common-law indemnity claim in cases of mixed active and passive fault was examined in St Luke’s Hospital v Giertz.2 Entitlement to common-law indemnity turns, first, on whether the active negligence claim was extinguished with finality (favorable to the defendant/wannabe indemnity plaintiff) before the settlement. If it was, then the issue of whether the party from whom indemnity is sought had the opportunity to participate in settlement negotiations influences the burden of proof in the later indemnity case.

Because “an indemnification action cannot lie where the plaintiff was even .01 percent actively at fault,”3 settling while active fault was still in play doomed the hospital’s common-law indemnity possibilities. The Supreme Court emphasized that the hospital did not “move for summary disposition regarding the allegation of active fault against it” before settling.4 The fact that the hospital failed to provide the doctor with an opportunity to participate in the settlement meant that the hospital’s “burden of proof would be higher in the subsequent [indemnity] action.”5 It would have to prove “actual liability to the original plaintiff rather than the lesser burden of showing potential liability.”6 Of course, there wasn’t going to be any subsequent indemnity action, so technically this is dicta. Proving actual liability, rather than just potential liability, is a significantly more difficult burden for an indemnity plaintiff.7 So the best practice will be to invite the at-fault party to participate in the settlement. They usually don’t want to and then you’re off to the indemnity races.

Summary disposition’s trial twin, directed verdict, is another appropriate way for a vicariously liable party to favorably dispose of active fault claims against it with finality and preserve a common-law indemnity claim.

The St Luke’s Court expressly declined to examine whether, if a case is settled while both active and passive fault are still in play, this impediment to common-law indemnity can be overcome merely by providing the indemnity defendant with an opportunity to participate in the settlement.8 More than a decade after St Luke’s release, it is still not known with assurance that the power of the invitation will be enough to preserve a common-law indemnity claim under these circumstances.

Summary disposition’s trial twin, directed verdict, is another appropriate way for a vicariously liable party to favorably dispose of active fault claims against it with finality and preserve a common-law indemnity claim. In Covenant Healthcare Systems v Fakih,9 the hospital successfully moved for directed verdict on the plaintiff’s active fault claims. It also entered into a high/low agreement where the parties waived post-judgment relief. The Court of Appeals accepted that directed verdict meant the active fault claims were sufficiently extinguished to allow the hospital to pursue a common-law indemnity claim against the doctor who allegedly committed the malpractice. The high/low was not seen as an impediment to pursuit of common-law indemnity because “there is no requirement that a potential indemnitee pursue an action through final judgment or that it pursue post-judgment relief.”

If a plaintiff decides to only pursue claims of vicarious fault at trial, essentially abandoning active fault claims, one...
might have thought this would be accepted as the functional equivalent of the defendant prevailing on active fault. But that was not the result in Proassurance Corporation v Nefcy—not the first time through the Court of Appeals, anyway.\(^1\) It was clear that the case was tried only on theories of vicarious fault. But the Court of Appeals decided the jury’s verdict was not enough to show that the wannabe indemnity plaintiff had “obtained a ruling in its favor in the underlying lawsuit that it was not actively negligent, such as in a motion for a directed verdict or summary disposition.” That ruling seems wrong. It is a view that eventually did not prevail because the Supreme Court examined the underlying complaint and decided that “at all stages of the litigation, the plaintiff alleged that the defendant was vicariously liable for the acts of its agent, not its own active negligence.”\(^11\) Your client may not be positioned for such a read of the record, however. If a plaintiff decides not to pursue active fault claims, the best practice would be to memorialize that decision on the record to assure preservation of the defendant’s common-law indemnity claim. And detail would be helpful. Such a stipulation should be sufficient to favorably extinguish claims of active fault, presumably absent collusion between the parties, leaving a defendant’s common-law indemnity claim intact.

Summary disposition’s trial twin, directed verdict, is another appropriate way for a vicariously liable party to favorably dispose of active fault claims against it with finality and preserve a common-law indemnity claim.

The March 22, 2011 case of Botsford Continuing Care v Intelistaf Healthcare,\(^12\) teaches much about how trials can complicate later common-law indemnity lawsuits. An underlying medical malpractice case was tried to judgment against Botsford only. It went to the jury on mixed theories of active fault (for Botsford’s own and its employees’ fault) and passive fault (for Intelistaf’s LPNs, under contract to Botsford). Botsford lost the appeal and paid the judgment. Then it sued Intelistaf on a number of theories, including common-law indemnity. A general verdict was used in the medical malpractice case. That made it “impossible” to know if Botsford had been held liable partly for its own active fault. The panel did not see that as a deal-killer in terms of pursuing common-law indemnity. But it rejected the trial court’s view that the issue was resolvable by summary disposition. Instead, “the trier of fact” in the indemnity case must decide “whether the jury in the underlying medical malpractice case considered and decided any claims of active negligence and whether the underlying jury’s verdict was based in any part on the active negligence” of Botsford or its own employees. Now that will be an interesting trial, for indemnity law geeks, anyway.

The takeaway from St Luke’s is that when a case that alleges both active and passive fault settles against a party later seeking common-law indemnity, the wannabe indemnity plaintiff should: (1) dispose of all claims of active negligence with finality before settlement, and (2) provide the party from whom indemnity is sought the opportunity to participate in settlement negotiations. And trying such cases of mixed claims of active and passive fault brings a new set of challenges: how to emerge from a loss and live to fight another day against the actively at-fault party. ■

About the Author

Noreen Slank is a shareholder in Collins, Einhorn, Farrell & Ulanoff. She specializes in insurance coverage and indemnity issues as well as civil appeals, and is a frequent contributor to the Journal. Her email address is noreen.slank@ceflawyers.com.

Endnotes

6. Id at 454.
7. This burden of proof ruling seems to have been borrowed from contractual indemnity law, see, e.g., Ford v Clark, 87 Mich App 270, 278 (1978) and Grand Trunk Western Railroad v Auto Warenhousing, 262 Mich App 345, 350 (2004).
10. unpublished opinion per curiam of the Court of Appeals, issued April 26, 2007 (Docket No. 272963).
11. 480 Mich 916 (2007). Eventually, the indemnity plaintiff was unsuccessful on appeal, for different reasons. See Proassurance v Nefcy, unpublished opinion per curiam of the Court of Appeals, issued June 10, 2008 (Docket No. 272963).
Michigan Supreme Court

Small Employer Group Health Coverage Act Allows Mandatory Minimums for Employer Premium Contributions

*Priority Health v Commissioner, OFIS__*  
_—_ Mich ___ (2011)(Case No. 139189)

HMO Priority Health requires employers who offer its health insurance plan to contribute a minimum percentage of the health insurance premium. The purpose is to combat “adverse selection,” which is “the tendency of healthy people to decline health insurance because of its cost.” The theory is that by reducing the cost of insurance through employer premium contributions, a greater number of healthy employees will purchase coverage. Following an administrative proceeding, OFIS declared that mandated employer contributions were unreasonable and contrary to the Small Employer Group Health Act. Both the Circuit Court and the Court of Appeals affirmed, but the Supreme Court reversed. It held that the guaranteed renewal provisions of MCL 500.3711 (on which OFIS relied to reject mandatory employer contributions) do not dictate what is reasonable for the initial policy. “Rather, they mandate renewal of the initial policy . . . once it is in effect.” Justice Young concurred, pointing out that the opinion did not decide whether a mandatory minimum employer contribution was reasonable or consistent with the act, only that it was not barred by the renewal provision as determined by OFIS.

MCCA is Not Obligated to Reimburse Where Surcharge Was Not Paid

*United Services Auto Association ASFC v Michigan Catastrophic Claims Association ASFC__*  
_—_ Mich ___ (2011)(Case No. 141867)

The Supreme Court vacated the Court of Appeals decision and reinstated the Circuit Court decision, both of which granted summary disposition in favor of the Michigan Catastrophic Claims Association (MCCA). The Circuit Court had ruled that this catastrophic claim was not reimbursable by the MCCA because the insurer failed to pay the MCCA assessment for that vehicle. The Court of Appeals affirmed on different grounds, relating to whether the vehicle was required to be registered in Michigan. With the Supreme Court’s order, the claim is now rejected for lack of payment of the MCCA surcharge.

Michigan Court of Appeals Published

Failure to Provide Timely Notice – Absence of Prejudice

*Defrain v State Farm Mutual Auto Ins. Company__*  

Failure to provide notice to UIM insurer within 30 days of this fatal hit and run accident did not preclude UIM coverage because there was no actual prejudice caused by the late notice. The court distinguished *Jackson v State Farm Mutual Automobile Insurance Company*, 472 Mich 942 (2005), in which the Supreme Court, in lieu of granting leave, vacated a Court of Appeals decision that similarly declined to enforce the 30-day notice requirement. The *Defrain* panel views *Jackson* as having been decided on the issue of ambiguity, even though the Supreme Court adopted the reasoning of the Court of Appeals dissenting judge, who wrote that the notice requirement was not ambiguous and that it was enforceable without regard to actual prejudice. According to *Defrain*, it was bound because there was no actual prejudice caused by the late notice. This fatal hit and run accident did not preclude UIM coverage. The *Defrain* panel views *Jackson* as having been decided on the issue of ambiguity, even though the Supreme Court adopted the reasoning of the Court of Appeals dissenting judge, who wrote that the notice requirement was not ambiguous and that it was enforceable without regard to actual prejudice. According to *Defrain*, it was bound because there was no actual prejudice caused by the late notice. This fatal hit and run accident did not preclude UIM coverage.

Criminal Acts Exclusion Applied

*Auto Club Group Ins Assoc v Andrzejewski__*  

Homeowners and their minor son were sued in tort for injuries suffered by another minor during a basketball game. According to the civil complaint filed, the homeowner’s 13-year-old son intentionally assaulted plaintiff and caused his head to hit the gym floor, which triggered a seizure. Juvenile proceedings were filed and resulted in a plea of nolo contendere, resulting in the 13-year-old aggressor spending two days in a juvenile detention center and performing 56 hours of community service. Auto Club defended the civil action under the criminal acts exclusion, which took away coverage for “an act . . . criminal in nature.” Describing the insured’s conduct as intentional, nonconsensual contact that resulted in injury to another, the Court found that the elements were...
met for a conviction of aggravated assault or assault and battery. The exclusion thus applied. The Court expressly did not rely on the juvenile court proceedings to find criminal acts because juvenile proceedings are not criminal in nature. And the Court distinguished this case from Allstate v McCarn, 471 Mich 283; 683 NW2d 656 (2004), because of the different policy language being construed.

**Unpublished Court of Appeals Decisions**

**Claim Denied for Failure to File Timely Proof of Loss**

*Durall v Home-Owners Ins. Co.*

Unpublished per curiam of March 29, 2009, leave pending (Docket No. 293910)

Plaintiff was issued a homeowners insurance policy through defendant insurer on September 10, 2007. On October 31, 2007, plaintiff’s home was destroyed by fire. A day after plaintiff reported the fire, the insurer sent a letter instructing him, among other things, to review his policy and file a sworn statement of proof of loss within 60 days of the fire. Plaintiff failed to submit the proof of loss by the deadline and, therefore, the insurer denied benefits.

Plaintiff sued, arguing that he had no knowledge of the obligation to file a proof of loss, that he never received correspondence from the insurer advising of his obligation to file, and never received a copy of his insurance policy. Further, plaintiff argued that the insurer should be estopped from claiming lack of coverage because it made payments on the claim before and after the proof of loss deadline. Finally, plaintiff argued that he had provided the “functional equivalent” of a proof of loss thereby permitting the insurance carrier to thoroughly investigate the claim.

The Court of Appeals affirmed the summary disposition order for the insurer, holding that plaintiff was bound by the proof of loss requirement and no showing of actual prejudice was required. Plaintiff had signed a non-waiver agreement that specifically informed him of the proof of loss requirement, his policy plainly required that a proof of loss statement be submitted in writing within 60 days, and under Michigan law an insured is held to have knowledge of the terms and conditions of his insurance policy. The insurer was not required to show actual prejudice from the insured’s failure to provide a timely proof of loss. Further, the Court determined that plaintiff had not provided the “functional equivalent” of a proof of loss, but rather, had submitted a partial inventory, with no replacement estimates or receipts for personal property, no total loss tally and no demand for payment of a sum certain. Finally, the Court determined that the insurance company was not estopped by its conduct in making partial payments because the plaintiff had signed a non-waiver agreement.

**Summary Disposition Improper Where Motive and Intent are at Issue**

*Stein v Home-Owners Ins. Co.*

Unpublished per curiam of April 12, 2011 (Docket No. 295876)

This case provides a good explanation of the proper standard of review for consideration of witness testimony on summary disposition. Specifically, the case involved a fire that occurred at the Plaintiff’s residence and a subsequent claim for insurance benefits. The insurance carrier denied coverage based upon alleged concealment, fraud and false statements by the Plaintiff. Although, under Michigan law, an insurer may void a policy to the extent that the insured willfully misrepresented a material fact, a court may not dismiss a case based upon its own evaluation that a party “did not tell the truth.” Rather, summary disposition is inappropriate when motive and intent are at issue or where the credibility of a witness is crucial. For this reason, the dismissal was reversed and remanded to the circuit court.

**Allegations of Arson and Misrepresentation are Questions for the Jury**

*Cardinal v Farmers Mutual Insurance Company*

Unpublished per curiam of May 24, 2011 (Docket No. 293805),

Homeowner’s insurer denied coverage because its investigation revealed that the fire was intentionally set and that the plaintiffs had misrepresented inventory and monthly living expenses. The insured sued for breach of contract and the case was tried to a jury, which concluded that plaintiffs did not commit arson and did not make material misrepresentations about their losses. The verdict was affirmed because these questions were ultimately disputes of fact for the jury.

**Misrepresentation - No Innocent Co-Insured**

*Hicks v Auto Club Group Ins Co*

Unpublished per curiam of May 3, 2011, leave pending (Docket No. 295391)

Plaintiffs are a married couple whose home was destroyed by fire. They claimed damage to the contents in the amount of $70,000, even though the state police report revealed that only a few items were in the home when it burned down. Coverage was denied under a policy provision that voided the contract in the event of intentional concealment or misrepresentation.
Following a bench trial in the ensuing action by the insureds, the trial court found that the husband had misrepresented the inventory list and was thus foreclosed from coverage but that his wife was an innocent co-insured who could recover. The Court of Appeals majority reversed because “it does not seem possible [based on the wife’s own testimony] that she could have been unaware that most of the items on the [inventory] list were not actually in the house at the time of the fire.” The dissent stressed that the majority was invading the province of the trier of fact concerning the wife’s knowledge and misrepresentations.

Coverage Excluded by Concurrent Causation Exclusion

_Badger Mutual Ins Co v Ross Enterprises Inc, et al_,
Unpublished per curiam of March 3, 2011
(Docket No. 294489)

The insured is a gentlemen’s club, sued by the estate of a decedent who was fatally injured in a car accident caused by an intoxicated member. The club’s CGL policy had a liquor liability exclusion that expressly excluded coverage for claims of bodily injury or property damage for which any insured was liable by reason of causing or contributing to the intoxication of a person or the furnishing of alcoholic beverages to a person under the influence of alcohol. The exclusion applied regardless of other causes or events contributing to or aggravating the loss, and regardless of whether such other causes or events acted to produce the loss before, at the same time, or after the excluded event.

The trial court found coverage despite the concurrent causation exclusion for liquor liability. The Court of Appeals reversed, finding no dispute that the insured’s liability resulted from the sale of alcoholic beverages combined with another act or omission by the insured, and therefore, the concurrent causation exclusion precluded coverage. Additionally, the Court of Appeals found that a $50,000 sub-limit liquor liability endorsement to the CGL policy did not supersede the concurrent causation exclusion.

Breach of Contract Claim Against Insurance Agent Really a Mislabeled Negligence Claim Subject to 3-Year Statute of Limitations

_Whipperwill & Sweetwater, LLC v Auto Owners Ins. Co.,_
Unpublished per curiam of March 10, 2011, leave pending
(Docket No. 295467)

After a fire destroyed the insured’s commercial building and contents, the insured submitted a claim to its property insurer and was reimbursed up to the policy limits. Claiming that the coverage was inadequate, the insured filed suit against both the insurer and the insurance agent for failing to properly advise on the sufficiency of coverage.

The lawsuit was brought more than three years after the date of loss and, therefore, the trial court dismissed the negligence claim, leaving the breach of contract claim as the sole cause of action. The insurance agent argued that the breach of contract claim was a mislabeled claim for negligence and was thus subject to the three year statute of limitations, but the trial court disagreed. Its decision was reversed in the Court of Appeals on the ground that courts must look past the label chosen by a party for its cause of action in determining which period of limitations properly applies. In this case, the insured plaintiff was alleging claims and damages that flowed from the insurance agent’s failure to provide adequate and appropriate services. This, the Court found, constitutes a common law negligence claim as opposed to a breach of contract claim.

The insurer was not required to show actual prejudice from the insured’s failure to provide a timely proof of loss. Further, the Court determined that plaintiff had not provided the “functional equivalent” of a proof of loss...

UIM Coverage Afforded Motorcyclist

_Wellman v Homeowners Insurance Company_
Unpublished per curiam of the Court of Appeals of May 24, 2011
(Docket No. 294394)

Homeowners Insurance issued an auto policy to its insured covering both a Jeep Wrangler and a motorcycle. The insured sustained injury while operating the motorcycle and sought UIM coverage under the UIM endorsement to the policy. That endorsement was purchased solely for the Jeep Wrangler and expressly withheld coverage for injuries sustained in any accident involving an automobile owned by the insured, for which the insured did not purchase UIM coverage. The court held that whether the motorcycle was an “automobile” for which the insured did not purchase UIM coverage was determined by the definition of auto in the main policy rather than the policy declarations, which referred to the motorcycle as a covered auto and which the Court described as a “preamble” to the main policy.

In looking to the definition of “auto” in the main policy, the panel observed that one definition of an “auto” was any “other land motor vehicle.” After determining that the common understanding of a “land motor vehicle” would include a motorcycle, the panel held that certain endorsements to the policy altered that meaning and required vehicles with more than two wheels. Specifically, the Court alluded to “a special tort liability exclusion” and the motorcycle endorsement. Concluding that it had to read the policy as a whole, and that endorsements generally amend the main policy, the panel decided that a land motor vehicle necessarily meant a vehicle with more than two wheels. Alternatively, the definition was...
The insured's work on a construction project caused damage to “snow-melt tubing” underneath a slab of concrete installed by the insured. The “fix” required the removal of the concrete slab and the brick pavers on top of it in order to replace the damaged tubing. The insured made the repairs and then looked to its general liability insurer for payment of the cost of redoing the pavers and the cost of the cement (no issue was presented concerning coverage for the cost of the tubing). Both the trial court and the Court of Appeals found there was no coverage because of the lack of an occurrence, citing *Hawkeye-Security Ins Co v Vector Constr Co*, 185 Mich App 369; 460 NW2d 329 (1990). Both courts also concluded that any “expenses associated with the removal and replacement of the brick pavers [installed by another contractor] is excluded” under the impaired property exclusion. The court reasoned that the pavers were not actually physically damaged but only had to be removed and replaced so that the damaged tubing underneath could be repaired.

Construction Defect Not an Occurrence

*Christman Company v Renaissance Precast Industries, LLC*
Unpublished per curiam of June 21, 2011
(Docket No. 296316)

Christman Company was the general contractor for the construction of a parking deck at Northern Michigan Hospital. It sought coverage as an additional insured under CGL policies issued to the subcontractors whose work turned out to be defective. Christman made the repairs and looked to the subcontractors’ insurers to reimburse. The trial court granted summary disposition based on a “voluntary payment” and “no action” clauses in the policy. Summary disposition was affirmed on appeal, but for different reasons. The Court of Appeals held that there was no “occurrence” as required by the insuring agreement. CGL coverage “does not give rise to coverage for the cost of correcting defective work.” Because “the damage at issue was damage to the components of the parking structure itself,” i.e., the insured’s own work, there was no occurrence and thus no coverage.

Coordination of Benefits

*Morris v Blue Cross Blue Shield of Michigan*
Unpublished per curiam opinion, April 21, 2011
(Docket No. 296343)

Plaintiff sustained injuries in a motorcycle/auto accident. His medical bills were paid by AAA pursuant to a no-fault policy of insurance. Because the policy did not coordinate benefits, plaintiff also sought payment of his medical bills from his health insurer, Blue Cross Blue Shield, which denied payment. The Court of Appeals upheld the order of summary disposition in favor of BCBS because there was at least one provision in the BCBS policy that precluded such double-dipping. That provision stated that BCBS will not pay for services for which the insured was not charged or did not have an obligation to pay.

Homeowners Policy – Repeated Leakage Exclusion

Unpublished per curiam of April 26, 2011
(Docket No. 296752)

Plaintiffs submitted a claim to their homeowners insurer for water damage caused by a leak in the upstairs plumbing. The slow seepage of water damaged the plywood and subfloors of two bathrooms and required both rooms to be “gutted.” Coverage was denied under the homeowners policy because of an exclusion for “continuous or repeated seepage or leakage of water or steam over a period of time from a . . . plumbing system,” including leaks from tubs and plumbing fixtures (the exclusion is quite extensive). After coverage was denied, plaintiffs sued for breach of contract and for violations of the Michigan Uniform Trade Practices Act, MCL 500.2001 *et seq.*, but summary disposition was granted for the defendant due to the exclusion and that decision was affirmed on appeal.

Title Insurance - Unrecorded Easements

*Dean v Fidelity National Title Ins. Co.*
Unpublished per curiam of March 1, 2011
(Docket No. 295762)

Plaintiff was sued by his neighbors for using an abandoned road across their property. He believed he had an easement to use that road. Plaintiff sought a defense and indemnity from his title insurer, because the title insurance policy insured against any claim for “lack of a right of access to and from the land.” An exclusion in the policy, however, precluded coverage for any “easements, liens or encumbrances or claims thereof, which are not shown by the public record.” Plaintiff
failed to present any evidence that the claimed easement was publicly recorded. The Court of Appeals determined that coverage was thus properly denied.

Domicile – Question of Fact

*Goodson v Farmers Ins. Exchange*

(Docket No. 292652), decided February 17, 2011

This is a dispute between two insurance companies over the domicile of an insured who was injured in an auto accident. The place of domicile determined priority of coverage between the two insurers. At issue was whether plaintiff resided with his parents or with his girlfriend at the time of the injuries. The Court of Appeals pointed out that domicile for purposes of MCL 500.3114(1) is legally synonymous with residence and is to be viewed flexibly. It requires the consideration of a number of different factors which in this case, presented questions of fact for the jury. Summary disposition was reversed.

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**No-Fault Corner**

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The New Supreme Court and Recent Precedent

The defeat of former Justice Alton Davis by Justice Mary Beth Kelly in the November 2010, along with the appointment of Judge Brian Zahra to the Michigan Supreme Court (replacing Justice Corrigan) on January 14, 2011, has the potential for making a significant impact on Michigan No-Fault jurisprudence. Although we are now six months into observing how the new majority is deciding cases, it appears that the new Supreme Court has shown little hesitation to re-examine the prior precedents of the "old" Supreme Court, decided between January 1, 2009, and December 31, 2010, under the tenure of former Chief Justice Marilyn Kelly. In order to get an idea of the new Court’s reaction to examining cases from the Chief Justice Marilyn Kelly era, the reader is urged to re-review the Supreme Court’s decision granting rehearing in *Anglers of the Ausable Inc v Dept of Environmental Quality*, docket number 138863, released April 25, 2011. In *Anglers*, the old Supreme Court majority issued an opinion, authored by former Justice Alton Davis on one of his last days in the Court, overruling significant judicial standing decisions issued by the old Taylor Court. The decision was released over the vigorous dissent of Justice (now Chief Justice) Young, who contended that the issues before the Court were moot. After Justice Mary Beth Kelly replaced Justice Davis on January 1, 2011, the attorney representing the losing party filed a motion for rehearing. The new majority granted the motion for rehearing and, in a 4-3 decision, vacated the earlier decision. While not an insurance case, the concurring opinion of Chief Justice Young and the dissenting opinion of Justice Cavanagh is an interesting dialogue over the use of a motion for rehearing to examine fairly recent precedent. Also of note is the concurring opinion of Justice Zahra, joined by Justice Mary Beth Kelly in which they present their views on motions for rehearing that ask the Court to re-examine recent, prior decisions of the Michigan Supreme Court.

Supreme Court Action

One-Year Back Rule

*Doreen Joseph v ACIA*, Docket Number 142615

Last year, during the tenure of former Chief Justice Marilyn Kelly, the Michigan Supreme Court issued its decision in *Regents of the University of Michigan v Titan Insurance Company*, 487 Mich 289 (2010). In that 4-3 decision, the court overruled the Taylor-Court era decision of *Cameron v ACIA*, 476 Mich 55, 718 NW 2d 784 (2006). In doing so, the Chief Justice Kelly Supreme Court majority had ruled that the One-Year-Back Rule set forth in MCL 500.3145(1) was a statute of limitations, not a damage limitation provision. As a result, the One-Year-Back Rule could be tolled in cases involving minors, persons who are deemed “insane” or, as in the case of the University of Michigan Medical Center, state institutions. Justice Markman, joined by Justice Young and Justice Corrigan, issued a vigorous dissent, complaining that the majority went out of its way to overrule *Cameron* and potentially open up claims for decades-old attendant care service benefits.
Like the proverbial phoenix, rising from the ashes, it appears that the new Supreme Court majority is on the verge of resurrecting Cameron's treatment of the One-Year-Back Rule as a damage limitation provision rather than a statute of limitation. On May 20, 2011, the Michigan Supreme Court issued an Order in Farmers Ins Exchange v Young, docket number 142615, granting Defendant AAA's application for leave to appeal. The order specifically notes that:

“The parties shall include among the issues to be briefed: (1) whether the minority/insanity tolling provision of the Revised Judicature Act, MCL 600.5851(1), applies to toll the “One-Year-Back Rule” in MCL 500.3145(1) of the No-Fault Automobile Insurance Act; and (2) whether Regents of the University of Michigan v Titan Ins. Co., 487 Mich 289 (2010) was correctly decided.”

Clearly, the Court is signaling a willingness to re-examine decisions emanating from the Court's 2009-2010 term including its significant third party threshold decision in McCormick v Carrier, 487 Mich 180 (2010).

“Unlawful Taking” Exclusion
Farmers Ins Exchange v Young, Docket Number 141571

On March 10, 2011, the Supreme Court heard oral argument on an application for leave to appeal filed by the injured claimant, Rufus Young, following an adverse ruling by the Michigan Court of Appeals. After hearing oral argument, the Supreme Court denied the application for leave to appeal by way of a written order dated May 6, 2011, thereby leaving intact the Court of Appeals decision in favor of the no-fault insurer. Despite the fact that the Supreme Court denied the application for leave to appeal, the case is nonetheless significant as it provides an indication as to how the new Supreme Court majority views the “unlawful taking” exclusion set forth in MCL 500.3113(a).

In Young, one Nicole Williams owned an uninsured motor vehicle. When she went on vacation, she asked her cousin to stay at her house and take care of her 7-year-old child. The owner told her cousin, Lee, that the vehicle was uninsured. Lee nonetheless drove the vehicle to Rufus Young's work place. Young was then involved in an accident while driving the intoxicated Lee home, in the uninsured vehicle owned by Nicole Williams. Young acknowledged that he did not receive permission from Williams to drive the uninsured vehicle, before Williams left on her vacation. Farmers was assigned to handle the claim for no-fault benefits arising out of the accident and promptly commenced a declaratory judgment action, arguing that Young was ineligible for no-fault benefits under MCL 500.3113(a) because (a) he did not have the permission of the owner to drive the vehicle; and (b) he was unlicensed and therefore not lawfully entitled to drive the vehicle. The trial court granted declaratory relief to Farmers and, in a 2-1 decision, the Michigan Court of Appeals affirmed in an unpublished decision released on August 3, 2010. Farmers Ins. Exchange v Young, docket number 275584.

In a concurring opinion, Justice Markman noted that he would “refine the holding” of the Court of Appeals’ earlier decision in Amerisure Ins Co v Plumb, 282 Mich App 417 (2009), regarding the analysis to be utilized for determining whether an injured claimant has “unlawfully taken” a motor vehicle, thereby disqualifying him from recovering no-fault benefits under MCL 500.3113(a). In Justice Markman’s view, an unlawful taking occurs when a person has taken a vehicle “without authority,” citing the joyriding statutes set forth in MCL 750.413 and MCL 750.414. In other words, the vehicle must be “unlawfully taken” without the authority of its owner. Justice Markman noted that an “unlawful taking” does not occur where a person is taking the vehicle without a valid driver’s license, the requisite insurance or in violation of another provision of the Michigan Motor Vehicle Code.

Justice Markman then noted that once an “unlawful taking” has been established, the next step is to determine whether or not the injured Claimant “reasonably believed” that he was entitled to take and use the vehicle. Justice Markman closed his remarks by noting that, “this analytical framework was compelled by §3113(a) and should aid in alleviating the legitimate concerns of the dissenting Court of Appeals’ judge in Plumb and in this case.”

Justice Marilyn Kelly dissented, noting that there was an unbroken chain of permissive use of the vehicle. Therefore, because Young had the “implied consent” to drive the vehicle, there was no “unlawful taking” and he would not be disqualified from recovering benefits under MCL 500.3113(a).

Court of Appeals Decisions
On April 26, 2011, the Court of Appeals issued two significant published opinions that impact on No-Fault jurisprudence in this state.

Attorney Fees – Failure to Keep Contemporaneous Records
Augustine v Allstate Ins Co,
Docket Number 296646, Rel’d 4/26/2011

In Augustine, the catastrophically injured claimant filed suit to recover payment of attendant care service benefits. At trial, Plaintiff recovered a jury verdict of $371,700.00 out of
the total of $929,000.00 that she sought. The jury also awarded her interest, totaling $42,254.00. Plaintiff subsequently sought attorney fees due to Allstate’s “unreasonable delay” in making benefit payments. The trial court awarded Plaintiff’s well-known counsel an hourly rate of $500.00 per hour, and the attorney’s colleagues $300.00 per hour, over the course of 543.75 hours, for a total attorney fee award of $312,625.00.

In a published opinion, authored by Court of Appeals Judge Pat Donofrio, the Michigan Court of Appeals vacated the trial court’s award of attorney fees and, in doing so, issued a number of significant holdings that need to be applied on these attorney fee cases.

First, the court ruled that there was an insufficient basis to award $500.00 per hour to the lead attorney on the case. The court noted that the trial court’s analysis was inconsistent with the guidelines set forth in the Michigan Supreme Court decision in Smith v Khouri, 481 Mich 517, 751 NW2d 472 (2008), because the lower court failed to find that the $500.00 per hour charge was the “fee customarily charged in the locality for similar legal services.” The Court of Appeals also noted that the lower court failed to make similar findings regarding each attorney whose fees Plaintiff sought to recover.

With regard to the hours that were charged, the Court of Appeals noted that the billings were prepared after the fact, not contemporaneous with the work being performed. The Court criticized Plaintiff’s attorneys for their failure to keep track of their time, noting:

Considering the fact that Plaintiff’s counsel requested attorney fees from the very outset of the underlying claim, we are befuddled by the fact that Plaintiff’s attorneys claim they had no billing protocol to account for those fees and did not set one up. In today’s technological world, it would be but a minute task to set up a spreadsheet detailing the date of the service, the service provided, time expended on the task and the amount charged for the specific service that could be updated and summed at any time. Indeed, it would seem a handwritten ledger might even do... We do find it inconceivable that attorneys of this caliber and experience would be unaware of the requirements of Smith and would not keep adequate records in support of their claim for attorney fees especially considering the amount of time and talent extended on this case.”

In light of this decision, it appears that Plaintiff’s counsel will need to keep track of their time (just like defense counsel) in support of any claim for no-fault penalty attorney fees. Under the Court of Appeals’ decision in Augustine, an after-the-fact analysis of the time spent handling a claim will no longer suffice.

Conservator Fees Are Compensable

(Application Pending)

In recent years, many insurers have taken the position that the services performed by a conservator, in managing a catastrophically injured claimant’s money, are not compensable under the Michigan No-Fault Insurance Act. These insurers have taken the position that managing a person’s money has nothing to do with their “care, recovery or rehabilitation,” necessary prerequisites to recovery under §3107 of the No-Fault Insurance Act, MCL 500.3107(1)(a). Support for this position was found in a written opinion issued by the Hon. Pamela Gilbert O’Sullivan of the Macomb County Probate Court, which denied conservator Alan May’s request for payment of conservatorship fees and expenses performed on behalf of a catastrophically injured individual, Edward Carroll.

On appeal, the Michigan Court of Appeals reversed the decision of Judge O’Sullivan, in a published opinion issued on April 26, 2011. In Carroll, the Court of Appeals acknowledged that it had never squarely addressed the issue of whether conservatorship fees and expenses were compensable under the Michigan No-Fault Insurance Act. The court held that conservator fees and expenses were compensable, and equated the services provided by the conservator, in managing a person’s money, with those of “a nursing assistant who handles an injured person’s intimate hygiene needs.” The Court of Appeals observed that because the need for the conservator was causally connected to Carroll’s injury, it was compensable under MCL 500.3107(1)(a). In its ruling, the Court of Appeals disregarded the insurer’s argument that the term “care” should be narrowly construed pursuant to the Michigan Supreme Court’s decision in Griffith v State Farm, 472 Mich 521, 697 NW 2d 895 (2005).

Readers should note that on June 7, 2011, the insurer in that case, AAA, filed an Application for Leave to Appeal with the Michigan Supreme Court.

About the Author

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United States Supreme Court

“Incomplete and Misleading” Documents Did Not Amend Plan But Might Provide Basis for Other Equitable Remedies.

CIGNA v Amara, 131 S Ct 1866 (May 16, 2011)

Although ERISA was enacted as a remedial statute to protect plan participants, the actual remedies available to those participants have been anything but clear. ERISA Section 502(a) lists more than a dozen possible causes of action, but the courts have limited their applicability and the remedies available under them. Amara was another decision addressing this issue.

CIGNA Corp. converted its traditional pension plan to a “cash balance” plan. As part of the conversion process, it provided information to its employees about the effect of the conversion on their pension benefits. The District Court determined that this information was “incomplete and misleading.” So, the question before the Supreme Court was, what is the remedy?

Two provisions of Section 502(a) were at issue. The first, 502(a)(1)(B), allows participants to sue to enforce the terms of the plan. The participants sued under this provision, arguing that they should get the benefits promised by the information CIGNA had distributed. Rejecting this argument, the Supreme Court unanimously held that this section of ERISA only allowed the enforcement of the actual terms of the plan as officially adopted, not as described by CIGNA. Since the distributed information did not officially amend the actual terms of the plan, those terms could not be enforced under this section.

But the Court’s majority went on to discuss the possibilities under the other provision of Section 502(a)-502(a)(3). That provision allows participants to sue for “appropriate equitable relief,” and the court had previously ruled that this language means relief that was traditionally available in courts of equity back in the days of the “divided bench.” The court commented that the Amara plaintiffs might be able to get the relief they sought depending on the exact form of equitable relief they sought. For example, if they sought reformation of the pension plan to be consistent with the distributed information, a court could order the plan so reformed and then allow the participants to sue for benefits under the reformed plan under Section 502(a)(1)(B). Alternatively, they might be able to allege detrimental reliance or seek to estop CIGNA from denying them the additional benefits. In this case, they might have to prove detrimental reliance. Finally, they might seek the equitable remedy of a surcharge against malfeasant plan fiduciaries. Under this theory, “make-whole” relief might be available; further, they would not have to show reliance, but they would have to show that they suffered harm that was caused by the malfeasance.

The take-away from this decision for different perspectives is as follows:

Employers and insurers can rely on the language that says terms that have not formally been adopted as plan amendments cannot serve as the basis of a claim for misrepresentations regarding plan benefits. However, they should also be aware of the other part of Amara that says those misrepresentations may be able to serve as the basis of an equitable claim.

Employers may also be well advised to formally adopt written plan documents – which has not always been the practice for non-retirement employee benefits.

Participants will focus on the language that the participant can get make-whole relief without needing to show reliance. (In fact, the U.S. Department of Labor has already filed at least two amicus briefs so arguing.) But that language referred to certain equitable claims that require other, more burdensome elements.

Fiduciary Exception to Attorney-Client Privilege Does Not Apply to US Government’s Indian Trust Duties.

United States v Jicarilla Apache Nation, 131 SCt 2313 (June 13, 2011)

While at first glance an Indian trust case may not seem relevant to ERISA practitioners, this case touches on a key ethics/professional responsibility issue for attorneys representing benefit plans: who is their client and when are their communications privileged?

Although the attorney-client privilege is one of the strongest privileges known to the law, there are exceptions, one of which is the “fiduciary” or “trustee exception.” That exception holds that when a trustee obtains legal representation to guide her trust administration and not for her own defense, the trust beneficiaries are entitled to the production of documents related to that advice—particularly if the trust paid for the legal advice. This exception has two rationales: (1) the trustee obtained the advice as a “mere representative” of the beneficiaries, who are the “real” clients; or (2) the trustee has a fiduciary duty to release the information to the beneficiaries.
This applies in an ERISA context when the attorney is representing the employer while the employer is acting in a fiduciary capacity, such as deciding on an investment or the payment of a claim. It does not apply when the employer is acting in a non-fiduciary capacity, i.e., deciding on the creation, amendment, or termination of a benefit plan. Nor would it apply when the fiduciary was seeking advice as to his own legal exposure. United States v Mett, 178 F 3d 1058 (9th Cir 1999).

Although the Court held in this case that these principles did not apply to the trust relationship between the United States and Indian tribes, it recognized their general applicability (and specifically, their applicability in the ERISA context).

Sixth Circuit Court of Appeals

Not Actively at Work plus No Loss of Earnings Equals Overlapping Denials


The Sixth Circuit was recently faced with a long term disability claim that was denied for two different reasons by successive carriers. The plaintiff underwent unsuccessful back surgery and attempted to return to work thereafter, but his performance began to decline as a result of his unresolved condition. He also became ill with the flu and stayed home from work for a few weeks (unrelated to his back condition), during which time his employer changed disability carriers. The employer continued to pay the plaintiff his regular salary until finally terminating his employment. At that point, the plaintiff filed consecutive ability claims that were denied for two different reasons by successive carriers. The plaintiff underwent unsuccessful back surgery and attempted to return to work thereafter, but his performance began to decline as a result of his unresolved condition. He also became ill with the flu and stayed home from work for a few weeks (unrelated to his back condition), during which time his employer changed disability carriers. The employer continued to pay the plaintiff his regular salary until finally terminating his employment. At that point, the plaintiff filed consecutive ability claims for disability benefits with both carriers.

The first carrier denied his claim because the plaintiff had not sustained a “loss in earnings” as required by the policy, which the court upheld as rational. The second carrier denied his claim because he was not actively at work when the policy became effective (because he was home ill with the flu), and his disability began before the policy became effective - prior to his illness. Again, the court upheld the denial as a reasonable application of express policy terms.

One interesting twist to the case is that because the plaintiff successfully argued mid-stream that the case should be remanded for a policy clarification issue, the court awarded him attorney’s fees for his success in that regard, despite losing the ultimate merits of the case.

United States District Court

Attorney Fee Awards Calculated Based on a Proportional Measure of Success

Helfman v GE Group Life Assurance Co, Case no. 06-13528, 2011 U.S. Dist. LEXIS 41608 (E.D. Mich. April 18, 2011);

(“Helfman”) and


In these two cases, Judge Tarnow in Caudill and Judge Roberts in Helfman awarded the plaintiff recovery of attorney fees as a result of achieving some amount of success on the merits, applying the Supreme Court’s test set forth in Hardt v Reliance Standard Life Ins, 130 S.Ct. 2149, 2158 (2010). (See our discussion of Hardt in the July 2010 issue of this Journal, at p. 6). Judge Roberts in Helfman reduced the lodestar amount in relation to the plaintiff’s limited amount of success achieved overall in the case. Although the defendants in Caudill made a similar argument (that fees should be reduced to reflect limited success), Judge Tarnow enhanced the lodestar amount by 50% based on a twelve part test developed by the Fifth Circuit in order to ensure reasonable compensation for a particularly complicated class action in which the plaintiffs were awarded judgment in the amount of $2.6 million, which the judge noted was “very successful.”

The take-away from both of these cases is that judges seem to adopt a proportionality analysis when interpreting the Supreme Court’s test of “some amount of success.”

Death from Heroin Overdose - “Accidental” or Not?


Courts have recently been faced with the question of whether a death resulting from drunk driving satisfied a life insurance policy’s definition of “accidental” death. More recently, the court tackled this issue in a case involving a death resulting from a heroin overdose in a case involving the de novo standard of review. The carrier determined that, although the record contained no evidence that the insured intended to injure or kill himself, as a former addict, he could not have been unaware of the potential negative outcome associated with illicit drug use, and denied the widow’s claim for life insurance proceeds.

First addressing a choice of law dispute over whether the state of delivery controlled as expressly provided by the policy (California, with an insured-friendly definition of the term “accident”), the court ruled that federal common law must provide the rules of decision to maintain consistency.

Next, applying the Sixth Circuit’s reasoning in Kovach v Zurich American Ins Co, 587 F3d 323 (6th Cir. 2009), the court here applied a two-stage inquiry consisting of subjective and objective component, finding that where the policy did not expressly define “accident” (for example, to exclude illegal activities), then that term would be construed according to its plain meaning to an ordinary person. (See our discussion of Kovach in the July 2010 issue of this Journal, at pp. 7-8).
Here, the evidence established that the insured had no intention of killing himself. Further, because the insured had used heroin on prior occasions without suffering death, the court found that it was not objectively unreasonable to infer that the insured simply expected to get high while staying alive. The court rejected the carrier’s arguments regarding foreseeability and the lack of social utility related to heroin use. Ultimately, the court granted the widow’s motion to reverse the carrier’s denial of the claim.

A common scenario: a person gets injured, receives medical care that is paid for by a health plan, and then sues a third party, claiming that the third party caused the injury. The person recovers from the third party and the health plan claims that it should be reimbursed out of that recovery for the amounts it paid for the person’s medical care.

This was such a case. Chandler Vial was born with severe birth defects. His medical treatments cost about $100,000, which were paid by his father’s two health plans. (It is expected that significant medical and other expenses will continue throughout Chandler’s life.) He and his parents sued the hospital and his mother’s obstetrician, alleging malpractice. The case was settled with the hospital and obstetrician specifically denying liability, but agreeing to pay the family’s attorney fees, fund an annuity for Chandler, and pay his parents $60,000 to hold as conservators for Chandler. The total settlement was about $400,000.

Both health plans alleged entitlement to the amount of expenses each had paid. (There were two plans apparently because Mr. Vial’s employer changed plans during this time.) When the Vials refused to pay, the plans filed suit under ERISA.

The Court began by noting that relevant Supreme Court precedent allows a plan to make a claim for imposition of an “equitable lien” or “constructive trust” on settlement proceeds if the language of the plan identifies a particular fund and the share of that fund that is recoverable. While both plans had language addressing this, the first plan’s language was too narrow to permit recovery in this case.

The first plan limited recoveries obtained from a “responsible” or “liable” party. Since the health care providers denied any liability for Chandler’s injuries, the first plan could not recover absent a judicial determination of malpractice. “When a party disputes liability, it cannot be said to be ‘responsible’ or ‘liable’ for the claimed injury absent a judicial finding to that effect.”

However, the second plan referred to recoveries obtained from third parties “alleged” to have caused the injury. This was broader language, and since the Vials’ malpractice suit indisputably alleged the providers caused Chandler’s injuries, the second plan could recover its payments.

Two other interesting items. First, since the parents were the only defendants in this matter, the second plan could only recover amounts held by the parents -- and not those paid to the attorney or the annuity provider. (The Court did not address whether the plan had a claim against those others.)

Second, the Vials argued that as a minor, Chandler had no liability for his medical expenses, that he could not contract away his rights to the settlement proceeds, and that his parents could not contract away his rights to the settlement proceeds even on his behalf. The Court rejected these arguments, predominantly holding that those arguments were based on state law preempted by ERISA. (The Court did not, however, address whether those arguments were part of the federal common law, which would not be preempted.)

Subrogation and Rights of Recovery cases continue to be very difficult and very technical. Plan language addressing these issues must be carefully drafted. On the flip side, attorneys defending against claims must review the actual plan language very carefully to determine if it actually says what the Plan is claiming.

Michigan Court of Appeals

Estate Can Recover Pension Benefits Paid to Ex-Wife.

_Estate of Reed v. Reed_, __ Mich App __, No. 297528
(June 23, 2011)

Divorces continue to provide fertile ground for ERISA litigation. Often, one of the major assets in the marriage is a party’s retirement plan or life insurance. But even where distribution of those assets is addressed in the divorce decree (which is not always the case), the parties occasionally fail to have plan documents changed to reflect intended distribution. And after the employee dies, the ex-spouse will claim that the employee decided that the ex-spouse should get the benefits.

ERISA provides that divorce decrees can allocate retirement and perhaps other ERISA benefits through a “Qualified Domestic Relations Order” (QDRO). However, this requires that the decree contain certain elements and that it be presented to and approved by the plan. Often this isn’t done.
In this case, the parties separated after about 15 months, and later Mr. Reed filed for divorce. Although Mrs. Reed was served and informed about the proceedings, she defaulted. The divorce decree awarded each party full interest in their own benefit plans separate from any claim by the other. Mr. Reed died two years later without changing the beneficiary designation on his 401(k) plan. Mrs. Reed filed a claim for the same $150,000 of benefits, which the plan paid since she was still the designated beneficiary. Mr. Reed’s estate sued Mrs. Reed to recover those benefits.

The Court of Appeals held that although the plan administrator properly paid the benefits to Mrs. Reed, Mr. Reed’s estate could sue Mrs. Reed under state law to recover those benefits. It further held that Mrs. Reed could waive her right to the plan benefits and that her default constituted a “voluntary and intentional relinquishment of a known right” to those benefits. It ordered that she return all funds obtained from the plan to the estate.

About the Author

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Endnotes

1 One of the co-authors represented the defendants in this case.

2 One of the co-authors was involved in this case representing the defendants.

Construction Defect Claims
As Occurrences: Part II

By James A. Johnson, johnsonjajmf@hotmail.com

“You can guard against the high percentage of risk but you can’t guard against risk itself.”

Introduction

In order to fully appreciate this article you should read Part I, which is “Construction Defect Claims as Occurrences” in the January 2011 issue of the Journal. It can be accessed online in the State Bar of Michigan Section archives. Also, if the reader practices any type of insurance, medical or dental malpractice, business disputes or intellectual property, and is not a member of the Insurance and Indemnity Law Section, he or she is missing out on an invaluable opportunity. First, you will get to network with the President, Officers, Council, general members and the Editor. Secondly, you will broaden your knowledge and acumen of insurance and related legal subjects by reading the Journal quarterly. Moreover, if you secure a money judgment or settlement (almost always covered by insurance) and cannot collect on it, members of this Section can possibly show you the steps and particulars on how to get your money.

The judicial trend in many jurisdictions appears to be focusing on the actual terms of the policy such as the Property Damage Exclusion.

Tennessee

For example, in Bituminous Casualty Corp v Kenway Contracting, Inc.1 the court held that exclusions j(5) and j(6), the operations and faulty workmanship exclusions, did not apply to a claim which arose out of the unintentional demolition of an entire home when only the carport was to be demolished. Because the policy did not define the terms “that particular part of real property” or “operations,” both exclusions were ambiguous. And, there were no allegations that any of the work on the carport itself was faulty.

Similarly, the Tennessee Supreme Court in Travelers Indemnity Co of America v Moore & Associates Inc2 applied the subcontractor exception to exclusion (L) to uphold coverage for the insured general contractor for property damage resulting from water caused by faulty workmanship of its window installer. The court rejected the insurer’s argument that defective work installed pursuant to contract is foreseeable and not an occurrence. The alleged water penetration from faulty window installation by the named insured’s subcontractor was unexpected and unforeseen, and thus an “accident” and an “occurrence” within the meaning of the commercial general liability policy. Thus, if the resulting damages are unintended, the resulting damage is accidental even though the original act was intentional.

Kentucky

Lenning v Commercial Union Ins Co,3 which involved a homeowners policy, is consistent with the majority view. The Kentucky court held that there was
no duty to defend the lawsuit because the third party complaint did not allege an occurrence. The court examined the language in the complaint and the known facts and held that a purely economic claim cannot constitute an occurrence. This case sets out a detailed analysis of the occurrence requirement, property damage and breach of contract. It also cites a bevvy of cases in Kentucky and other jurisdictions in reaching its decision and worth reading in its entirety.

Indiana

An interesting case, not within the 6th Circuit, but in a neighboring state to Michigan is Sheehan Construction Co Inc v Continental Insurance Co. The Indiana Supreme Court on Sept. 30, 2010 changed insurance law in Indiana regarding construction defect claims. The decision in Sheehan holds that claims against a contractor for defective work of its subcontractor, can constitute an accidental “occurrence” and thus trigger coverage under the standard CGL policy. The Indiana court found that there was an “occurrence” because the resulting damage was an event that occurs without expectation or foresight. If the faulty workmanship is unexpected and without intention or design and not foreseeable from the viewpoint of the insured, then it is an accident within the meaning of a CGL policy.

New York

In Jakobson Shipyard, Inc v Aetna Casualty and Surety Co, the insured, a shipyard owner, brought a declaratory action under a CGL policy after warranty claims were asserted by the purchaser of two tug boats. The court stated that defects in the boats’ steering systems did not constitute an “occurrence” because the policy definition of that term made no reference to liability from an insured’s breach of contract. Moreover, the court held that faulty installation of the steering components does not constitute an occurrence because the definition of occurrence cannot be construed to encompass mechanical failure due to faulty design, construction or installation. The phrase “continuous or repeated exposure to conditions”, refers to the repeated action of external forces resulting in damage.

Another interesting New York case decided in July 2010 that vividly demonstrates what is an “occurrence” is Metropolitan Property & Casualty Ins Co v Marshal. This case involved a civil action for negligence under a homeowner’s policy where the insured’s son committed murder against a neighbor and dismembered her body. Metropolitan commenced a declaratory action seeking a declaration that it had no obligation to defend or indemnify the insured in the civil action because intentional acts are excluded under the policy. The Nassau County Supreme Court ruled that murder under the homeowner’s policy should be deemed “an accident” as defined in the policy. Since the insured did not expect and could not foresee her son murdering the underlying claimant that act was in fact an accident from her point of view.

Ohio

In Heille v Hermann, Heille alleged that multiple defects in their home developed within 1 year of their occupancy. The plaintiff alleged that the defects were caused by negligence of Hermann and his suppliers and contractors. The defects included deterioration of the driveway, walkway, leaking of the roof, basement, hardwood flooring, dry wall and bathroom tile. The court stated that these claims are not caused by an occurrence. Again, defective workmanship does not constitute an “occurrence.” All of the plaintiff’s claims allege defective workmanship to their home and nothing more. The court went on to say that there is no coverage because a CGL policy does not cover business risks caused by the insured’s own work and they do not even need to address the issue of exclusions in the policy.

About the Author

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Endnotes
2 216 SW 3d (Tenn. 2007).
3 260 F. 3d 574 (6th Cir 2001).
4 935 N.E. 2d 160 (Ind. 2010).
6 Slip WL 265138 (July 2010)
7 736 NE 2d 566 (Ohio App. 1999).
Michigan Supreme Court Issues Major Revision of Jury Practices

The Michigan Supreme Court recently adopted major rewrite of the court rules concerning jury practices, to take effect September 1. The changes adopt many reforms that have been in effect on a provisional basis in pilot projects throughout the state for the past two years. The new rules consolidate jury practices for both civil and criminal proceedings in a new MCR 2.513. Download the order at http://sbmblog.typepad.com/files/2005-19_06-29-11_order.pdf. The Court will review the changes in 2014. Several changes adopted today were opposed by the State Bar.

This month’s Michigan Bar Journal contains an article by one of the pilot court judges on the rule changes, Muskegon Circuit Court judge Timothy Hicks, “The Jury Reform Pilot Project - The Envelope, Please” (http://www.michbar.org/journal/pdf/pdf4/article1864.pdf).

Justice Hathaway dissented from the Court’s order, saying that the changes “contain multiple procedures that are highly controversial and are likely to prove problematic, particularly when litigants are forced to use them by a trial judge.” Specifically:

The new rules include controversial procedures such as using deposition summaries in lieu of testimony, interim jury deliberations, and interim commentary by attorneys. I agree with the overwhelming majority of public comments that oppose most of these procedures. Those comments were submitted by a broad spectrum of the legal community, and reflect a host of valid, practical and legal issues that have not been resolved. While I will not summarize those lengthy and detailed concerns here, I urge trial judges and litigants to review the comments submitted to this Court before utilizing these procedures.

Justice Markman, in response, said that the rules will accomplish the following:

“make evidence more accessible to jurors, and thereby enhance the ability of jurors to render intelligent and informed decisions concerning the significance of such evidence; second, they will afford jurors a better opportunity to discern the ‘big picture’ of cases in which they are sitting, and thereby enable them to better understand and more effectively carry out their responsibilities; third, they will enhance the quality and accuracy of juror deliberations; fourth, they will diminish opportunities for gamesmanship in the courtroom, potentially distracting and confusing jurors; fifth, they will more deeply engage, and maintain the attention of, jurors in the proceedings that they are to judge; and sixth, they will render at least somewhat less true Robert Frost’s observation that ‘a jury consists of twelve persons chosen to decide who has the better lawyer.’”

Supreme Court Amends Lawyer Advertising Rule

The Michigan Supreme Court has enacted amendments to a lawyer advertising rule that will take effect September 1, 2011. The revisions to Rule 7.3 of the Michigan Rules of Professional Conduct include a 30-day prohibition on targeted written solicitations following an injury, death, or accident that may give rise to a claim and require the labeling of letters and circulars, whether targeted or non-targeted, as advertising material. Three justices dissented from the order. You can view the Court’s Order at http://courts.michigan.gov/supremecourt/Resources/Administrative/2002-24_05-19-11_formatted%20order_FINAL.pdf.
Save the Date

2011

State Bar of Michigan
Annual Meeting

&

Solo and Small Firm Institute

Insurance and Indemnity Law Section
Annual Meeting

Thursday, September 15, 2011
10:00 a.m.-11:30 a.m., Hyatt Regency, Dearborn
Details on page 3