From the Chair

I hope the summer finds you all well. I have several exciting developments to report in this issue.

Annual Meeting and Program

A 360 Degree Perspective on Reforming Auto Insurance in Michigan:
Can we find any Common Ground in the No-Fault Debate?

This year's Annual Meeting will take place at the Lansing Center, and our Section meeting and program will take place on Thursday, September 19 at 10:00 a.m.

Probably no topic in insurance law creates as much interest – and as much passion and confusion – as the proposed reforms to Michigan’s No-Fault law. That is why we chose it as our program topic for this year. Thanks to Chair Elect Kathleen Lopilato and our Programs Committee, it promises to be a great event.

As you know, our Section never takes a position on insurance issues in favor of either insureds and claimants or insurers. The purpose of our Section is to serve as a forum for the exchange of information. So, for our program, we plan to present the views of those who favor reform and those who oppose it. Come join us and express your views. Even if you don’t practice in the area of No-Fault, this should be a lively debate and we hope to see you there.

We have scheduled a special council meeting on August 20 in order to confirm our plans for the meeting.

Membership Directory Project

In the last issue, I explained our project to set up a directory of all of our members. The directory will be searchable, so that members with expertise in certain areas will be able to list that expertise, and other relevant information. Other attorneys, both in our Section, and State Bar members generally, will then be able to access the directory and search for Section members with the relevant expertise.

We have now received final approval from the State Bar, and we have hired a contractor to create the database that will gather the information for the searchable member directory. Our council voted unanimously to proceed with the project.

In the coming months, as the directory takes shape, each of you will receive notice and an invitation to fill out the data collection form and return it for uploading in the directory. This searchable directory is a member benefit that no other Section has.

continued on the next page
Young Lawyers Summit

On June 8, we participated as a Gold Level Sponsor at the 6th Annual Young Lawyers Summit. Cathy Heise, Hal Carroll, Kathleen Lopilato and I attended and it was a good opportunity to inform the young lawyers in attendance about the benefits of membership in our Section.

Bar Leadership Forum

On June 14 and 15, I attended the Bar Leadership Forum, where I met other Section and bar association leaders, State Bar Board of Commissioners, and State Bar staff. It afforded the chance to exchange ideas and continue to spread the word about our Section. After all, we are just in our seventh year of existence!

As always, if you have any suggestions or questions about these or any other Section issues, please feel free to contact me.

—Elaine M. Pohl, Plunkett Cooney
Introduction

This article concerns conflicts of interest between an insured person, his liability insurer, and the defense counsel appointed by the insurer to defend him. Under ordinary circumstances, an insurer has a contractual “right and duty” to defend the insured from covered claims, meaning that the insurer gets to select defense counsel for the insured and gets the final word on most litigation decisions. In most states, this right is not absolute, and may be forfeited because of conflicts of interest. While Michigan’s Supreme Court has characterized the insurer/insured/appointed lawyer relationship as “rife” with the “possibility of conflict,”1 it has not yet adopted a rule requiring an insurer to relinquish control of the defense in conflict situations.

The most well-known and well-litigated conflicts of interest involve those situations where “the interests of the insurer would be furthered by providing a less-than-vigorous defense.”2 Courts have found the insurer’s interest lacking in many situations, of which the below are the most common.

• An insurer assumes the duty to defend, but denies indemnity outright and files a parallel declaratory judgment action seeking a declaration that it has no duty to indemnify the insured.

• The insurer reserves the right to deny indemnity on the basis of an exclusion, and retains control of the defense, when the applicability of the exclusion may be determined by facts adduced in the underlying case.

• The insurer assumes the defense when the amount of covered damages is likely very small, but the uncovered damages (such as punitive damages) are quite large.

In these situations, the insurer’s interests are so divergent that it must yield control of the defense to the insured, including forfeiting its right to select counsel. This rule is frequently called the Cumis counsel rule, named after the well-known case of San Diego Navy Federal Credit Union v Cumis Ins Soc, Inc.3 In Cumis, the insurer assumed the duty to defend all claims against the insured, including a claim for punitive damages.4 However, it reserved the right to deny coverage at a later date, and specifically disclaimed coverage for punitive damages.5 Because the insurer’s liability might rest on conduct excluded by the policy, the court concluded that the appointed lawyers might reasonably act for the benefit of the insurer instead of the insured.

The State of Michigan’s Law

There are no modern Michigan appellate court decisions on point. Two federal district court cases in Michigan have acknowledged the problems of the Cumis situation (directing a defense while reserving rights under one or more exclusions) but have not provided clear guidance on how to address them.

In Federal Ins Co v X-Rite, Inc,6 the issue was presented to the court in an unsatisfying way. There, X-Rite had already selected defense counsel prior to tendering the claim to the insurer. The insurer agreed to defend under a reservation of rights, and attempted to appoint “independent” counsel to defend X-Rite.7 However, X-Rite completely ignored the insurer and continued to control the litigation through their chosen lawyers. After it had settled the case, X-Rite tendered its attorneys’ fees to the insurer and argued that they should be paid because of the conflict of interest, which required the insurer to relinquish its right to choose counsel.

The court found this argument unpersuasive, particularly because X-Rite made no effort to ascertain whether appointed counsel was indeed biased in favor of the insurer.8 Instead, X-Rite continued on the next page
Rite’s sole complaint seemed to be that appointed counsel was inferior to its chosen lawyers. The court concluded that, under the facts of the case, the insurer remedied any conflict by appointing “independent” counsel of its choice. Having failed to develop evidence that the appointed lawyer was not “independent,” the insured was unable to convince the court that the putative conflict was sufficient to divest the insurer of the right to choose counsel. Accordingly, the court held that “under the present facts” X-Rite had no right to counsel of its choice.12

Likewise, the insured in Central Michigan Board of Trustees v Employers Reinsurance Corp.13 seemed not to care about the “independence” of appointed counsel, but rather objected because he believed that his own lawyer could do better. There, the insured doctor was accused of inappropriate sexual contact with the plaintiff.14 The insured had been defended in pre-suit administrative proceedings by counsel of his choice, who obtained a good result.15 Upon suit being filed, the insurance company reserved rights on the basis of an intentional acts exclusion and appointed a different lawyer to defend the insured.  The insured declined the representation and proceeded with the litigation with his previous lawyer.

The court agreed that the reservation of rights created a conflict of interest, but held that it did not require the insurer to accept counsel chosen by the insured.16 Rather, the insurer remedied that conflict by appointing “independent counsel.” As in X-Rite, the court noted that the insured did not bother to investigate the “independence” of the appointed lawyer, and that he merely questioned that lawyer’s competence.17 The court observed that “any attorney selected by defendant, or anyone else, would not have satisfied [the insured] if it were not the person who successfully represented him at the University’s administrative hearing.”18

These cases did not present strong facts upon which a meaningful discussion of conflicts of interest and the Cumis rule could be had. Not only did the insureds fail to develop any evidence regarding the conflict, it appeared to the courts that the conflict of interest issues were pretextual. The insureds in X-Rite and Central Michigan wanted to be able to choose their own lawyer at the insurer’s expense, and sought to exploit the conflict in order to make that possible. The insureds in these cases were, in retrospect, less-than-ideal advocates for the Cumis counsel rule. These decisions should not be read as shutting the door forever on Cumis, nor does it appear that the courts intended them to be read thusly.

Both Central Michigan and X-Rite seem to hold, or at least strongly suggest, that conflicts can be cured by providing “independent” counsel that is selected by the insurer. X-Rite notes in dicta that “independent” counsel would represent only the insured, that it would “direct its efforts only to the best interests” of the insured, and that it would not be involved in coverage issues.19 The courts did not discuss, however, the kinds of problems that might arise in a conflict scenario, and therefore did not analyze whether “independent” counsel could reasonably address these concerns.

It would be burdensome for an insured to conduct discovery in order prove that the lawyer retained by the insurer will not provide fair, honest and vigorous representation. Additionally, many insureds probably know very little about the relationship between appointed counsel and the insurer, such that the potential conflict might not even occur to them.

**Problems that Might Arise in Conflict Scenarios**

Imagine a situation where a department store (“Store”) is sued for the misbehavior of a security guard (“Guard”). The allegations are that Guard wrongfully detained a 12-year-old boy on suspicion of shoplifting, and while the boy was in custody, subjected the child to verbal abuse and threats of physical harm. The detention was brief, however, and the child suffered very minimal physical injuries. The vast majority of damages will be for emotional distress and punitive damages (in states allowing punitive damages under these conditions).

Under the CGL policy issued to Store, there are two insureds, Store and Guard. The allegations of the complaint trigger the duty to defend the Guard (false imprisonment, negligent infliction of emotional distress) and the Store (negligent supervision of Guard, vicarious liability). The insurer agrees to defend both parties, while reserving rights on the following issues:

- There is no coverage for punitive damages;
- With respect to Guard, there is an intentional acts exclusion that applies if his conduct is found to be calculated to harm the plaintiff, and
- There is coverage for emotional distress, but only when such distress is directly attributable to otherwise covered bodily injury.

Under these facts, the insurer’s likely liability for a verdict is small. It will not pay for punitive damages, and its liability for emotional distress is negligible, as such damage will probably not be connected to bodily injury, and accordingly not covered. Moreover, there is a reasonable chance that the Guard’s...
behavior may trigger the intentional acts exclusion. These are classic conflict of interest problems.

These conflicts create the possibility of two related problems. One is that retained defense counsel could steer the litigation towards triggering the intentional acts exclusion, defeating coverage for the Guard entirely, and possibly allowing the insurer to withdraw the defense prior to trial. Second, the insurer may neglect the suit and may not allocate sufficient defense resources to it, as it has little (if any) liability for a verdict. In many states, these conflicts would cause the insurer to lose control of the defense, including the right to appoint counsel of its choice.

Presumption in Favor of Retained Counsel

The court in Central Michigan, for one, was not convinced that these concerns were significant enough to divest the insurer of the right to select counsel. The court reasoned that all appointed lawyers understand that their principal duty is to the insured, and courts should assume that an “independent” lawyer will never prefer the insurer’s interests in a conflict situation. The court credited the affidavit of the appointed lawyer, which affirmed that lawyer’s commitment to act in the interests of the insured, and noted that the insured offered no evidence to the contrary.

First, one might question whether this is a fair presumption in a conflict situation. When a lawyer’s loyalty and independence could realistically be questioned, it is not clear why the lawyer’s good conduct should be presumed (and not surprising that the lawyer would promise to behave himself). Central Michigan suggests that, so long as counsel promises to be independent, the insured must come forward with facts disproving this promise. It would be burdensome for an insured to conduct discovery in order prove that the lawyer retained by the insurer will not provide fair, honest and vigorous representation. Additionally, many insureds probably know very little about the relationship between appointed counsel and the insurer, such that the potential conflict might not even occur to them. Merely because the insured is in the dark about a particular conflict of interest does not mean that no danger exists.

Moreover, a presumption of fairness seems unjustified in light of the relationship between appointed counsel and the insurance industry. A liability insurer will very frequently assign the defense of insureds to a small number of pre-approved lawyers or firms, sometimes called “panel counsel.” Panel counsel enjoy a symbiotic relationship with the carriers. By virtue of their “panel” status they are eligible to be assigned cases by the insurer, and therefore need only compete with other “panel” firms for assignments. In exchange, they often must perform work at discounted rates and must abide by the insurer’s billing guidelines and regulations. The insurers’

guidelines for retained counsel (which are often treated as confidential by insurers) can be extensive, and may set limits on things like research time and partner involvement with certain tasks. It is fair to say that these guidelines exist to protect the insurers’ interests, not the policyholders’.

For appointed counsel, representation of any individual insured is probably a “one-shot deal.” The insured is a stranger to the firm and likely not shopping for new lawyers. The repeat business comes from the insurance company, which often has a long history of assigning cases to the firm. In one hand, there is a client that has provided the firm with years of repeat business and thousands, if not millions of dollars, of billable fees over the years. In the other is an insured that the firm may never see again, and that may be resentful because counsel was chosen over its objection. The potential conflict of interest here is apparent.

There are a multitude of litigation decisions in which appointed counsel may take the insurer’s preferences into consideration, to the insured’s detriment. While the appointed lawyer is unlikely to openly throw the game to please the insurer, it is very reasonable to wonder whether the lawyer might cut corners in order to appease the entity paying the bills and try to increase the odds of another assignment from the insurance company. This behavior is economically (but not ethically) rational, would be incredibly difficult to detect, and almost impossible to prove. Moreover, once it occurs, the damage to the insured is done, and can only be remedied (if at all) by a malpractice suit.

Thinking back to our hypothetical, imagine that counsel must decide whether to hire an expert psychologist to undermine the emotional damages component of the case. The cost would be $100,000. There are pros and cons to hiring the expert, and either decision could be reasonably justified (meaning that the decision would not subject the lawyer to malpractice). However, counsel believes that the expert’s testimony may link the emotional distress to the (minimal) physical damage, making it substantially more likely that the insured would be liable for any emotional distress damages. More, counsel’s experience suggests that the insurer would not approve of hiring an expert in these circumstances, and fears that too much hiring of expensive experts will result in a loss of work for his firm. Is it unreasonable to wonder if counsel’s concerns will color his decision making with respect to this expert?

This is not meant to besmirch any attorney, panel counsel or otherwise, appointed by an insurance company. Certainly, it is true that most lawyers will try their absolute best to render unbiased representation to the insured, consistent with their ethical obligations. But the fact remains that temptations do exist, and human nature and experience suggest that someone will give in to them. In light of this, the

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question then becomes: what is the best way to remedy the problem?

**Bright-Line Rules Are Best**

Ultimately, it is impossible to evaluate the degree to which the judgment of any appointed counsel will be affected by loyalty to the insurance company; it is a fact-and-lawyer-specific inquiry. The court in *Central Michigan* cut this Gordian knot by simply crediting the appointed lawyer’s assurances of good behavior and requiring the insured to adduce evidence to the contrary. As argued above, placing the burden of proof on the insured seems unfair. It is the policyholder that needs protecting from conflicts of interest, and it is the insurance company and appointed counsel that are in possession of all the relevant information concerning conflicts of interest. It is questionable whether the policyholder should be tasked with the burden of prying this information from the insurer and counsel, at the very time when these entities are supposed to be protecting the insured in the underlying lawsuit.

*Cumis* and its progeny resolve the problem by promulgating a bright line prophylactic rule: when a conflict of interest exists, the insurer must yield control of the defense, including by accepting the insured’s counsel of choice. It is submitted that this is a preferable way of addressing the conflict. It resolves all doubts by assuring non-conflicted representation to the insured. It reduces litigation and debates concerning the relative “independence” of any specific lawyer or firm, which is inherently difficult to prove in any event. It also promotes the integrity of the judicial system by minimizing even the appearance of impropriety.

The most frequent response, and the concern that motivates many courts, is that the insured gave up its right to control the defense when it purchased a “duty to defend” policy, and that it has either contracted away its right to object, or implicitly assumed the risk of a conflicted representation. This response is unsatisfactory for several reasons.

First, the “right and duty to defend” language is very standard and usually silent about the possibility of a conflict of interest. There is seldom, if ever, policy language that establishes how such conflicts are to be resolved. This is a foreseeable coverage issue that could be addressed in the policy language with specificity. In most other coverage disputes, an ambiguity is resolved against the insurer. Absent very clear language waiving the right to object to conflicted counsel, it is hard to see why an insured should be deemed to have “contracted away” that right.

Second, it assumes a level of sophistication that most purchasers of insurance simply do not have. Typical policyholders know next to nothing about conflicts of interest, panel counsel fees, or the impact of coverage exclusions. They are individuals, families and small businesses that buy an insurance policy with the basic understanding that, for covered claims, the insurance company will defend them. The idea that the insurance company could furnish counsel that would not represent them faithfully is simply outside the knowledge and experience of the typical insurance consumer.

Third, conflicts of interest implicate more than merely the contractual relationship between the parties. Rather, they involve issues of lawyer conduct and the integrity of the judicial system. The Michigan Rules of Professional Conduct do not allow lawyers to accept conflicted representations absent, at minimum, full disclosure to the client and the client’s consent. It is hard to see how the client’s “consent” to the conflicted representation can be meaningful if it is not allowed the option to select other counsel.

Under the rule suggested by *Central Michigan*, a client can either accept the “independent” counsel provided by the insurer, or it can forfeit the protections of its insurance policy and pay for the defense itself (assuming it can). It is a stretch to say that the client’s consent is meaningful under these circumstances. Allowing insurance companies to force objectionable counsel on insureds, when the alternative is a forfeiture of coverage, creates considerable tension with the Rules of Professional Conduct. It also elevates the insurance contract above the Rules, allowing lawyers to disregard the “consent” requirement by assuming that, because the client purchased a standard liability insurance policy, it implicitly “consented” to any conflict.

In most other coverage disputes, an ambiguity is resolved against the insurer. Absent very clear language waiving the right to object to conflicted counsel, it is hard to see why an insured should be deemed to have “contracted away” that right.

It could also be argued that, if defense counsel could prove that it is truly “independent,” meaning having no previous allegiance or entangling relationship with the insurance company, there is nothing more the insured could realistically ask for. The answer is this: if the insurer indeed has no significant prior experience with the firm in question, it is essentially picking a lawyer based on marketing, hearsay or guesswork. In such circumstances, why shouldn’t the law prefer the insured’s
selection instead? For example, in Central Michigan, the insured’s preferred lawyer had already achieved a good result in pre-suit hearings and was familiar with the evidence that the plaintiff would offer. Nothing in that opinion suggests that the appointed lawyer was superior in any way to the one that the insured chose and had used with success. If the insurer is picking from a lineup of unfamiliar lawyers, and the insured already has a competent firm that it is comfortable working with, it is hard to articulate any real harm to the insurer when it does not get its way. Why should the law compel the use of a lawyer with whom neither party is familiar?

About the Author

Joe Sadler is a partner in the Grand Rapids office of Warner, Norcross and Judd LLP. He is the co-chair of its Insurance Practice Group, representing both policyholders and insurers in coverage litigation throughout Michigan. Mr. Sadler also specializes in trademark and copyright litigation and general commercial disputes. His email address is jsadler@wnj.com.

Endnotes

2 Nandorf, Inc v CNA Ins Co, 479 NE2d 988, 992 (Ill App 3d Div 1985)
4 Id. at 361-2.
5 Id. at 362.
6 Id. at 365.
7 Id. at 369.
8 Id.
10 Id. at 1225.
11 Id. at 1228.
12 Id. at 1229.
14 Id., 117 F. Supp. 2d at 629.
15 Id. at 630.
16 Id. at 634-5.
17 Id. at 635.
18 Id.
19 748 F. Supp. at 1228, n. 1.
20 See generally Cumis, at 364.
21 MRPC 1.7(b)(1-2).
The Mysterious Examination Under Oath

By Stanley A. Prokop, Plunkett Cooney, PC

Although many insureds may be surprised by receiving a request for an “Examination Under Oath,” after they have made a claim, an insurance carrier’s right to request an Examination Under Oath of its insured has a long legal history, and has been upheld by many courts in many jurisdictions. The right to an Examination Under Oath is set forth in most fire insurance and homeowners policies, and is helpful in resolving many types of insurer/insured disputes before litigation. Issues which often arise soon after a loss is reported, and how an examination under oath can help to resolve these issues, include the following.

Resolving a Policy Coverage Issue

Insurance carriers frequently ask counsel to do “coverage opinions” regarding whether there is coverage for a particular event. The quality of such a legal opinion given by coverage counsel is often a function of the facts upon which the opinion is based. Too often, there is not sufficient factual investigation to assist coverage counsel in drafting a good coverage opinion. If an examination under oath is conducted, all facts relevant to the coverage issue can be explored so that coverage counsel can render an opinion based upon unambiguous factual predicates.

Misrepresentations in Applications or Claim Submissions

One difficult decision facing insurers is the decision whether to void a policy based on material malpresentation in an application or whether to deny a claim based upon misrepresentation of the facts of the loss or the amount of the loss. This decision is often risky because of the requirements of Fair Trade Practice Acts. One of the most effective ways of determining whether a policy may be voided because of material misrepresentation is to take the examination under oath of the insured. By focusing on the representations deemed by underwriters to be material to the risk or deemed by claims executives as material to the cause of loss or amount of loss the decision can be made easier. By careful questioning at the examination under oath, counsel can determine both the source of representations and the accuracy of those representations. This also allows the insurer and counsel to assess the believability of witnesses and the materiality of representations.

The Amount of the Loss

In virtually every claim there is some disagreement, regardless of the cause of the loss, over the amount of the loss. Disputes over the amount of loss often cause claims to drag on for long periods of time, causing increased expenses for the insurance carrier and the insured. Often these disputes center on opinions of experts and the good or bad way in which a claim was presented or analyzed. An examination under oath can reveal discrepancies between the methods used by the insured and the insurer for computing the amount of damage. In many cases the examination under oath can discovery new or misunderstood ways of valuing damage and repair costs. In many instances, the insured will admit that he has “inflated” estimates expecting there to be some negotiation. When these issues are clarified by the examination under oath, meaningful adjustment can follow.

Property and Business Interruption Losses

An examination under oath is an ideal tool to get information about the history, use and value of property and normal business activities relevant to property and business interruption losses. These examinations under oath are very important in this context because it allows the insurance carrier to assess the claim and make its evaluation even before the insured may have committed to a position on a particular issue, such as replacement or extra expense.

The Legal Basis for Demanding an Examination Under Oath from the Insured

As early as 1884, the United States Supreme Court, which rarely addresses insurance issues, decided the case of Clafin v. Commonwealth Insurance Company, 110 US 81 (1884). In that case, the United States Supreme Court explained the basis for requiring an examination under oath.

The object of the provisions in the policies of insurance, requiring the insured to submit himself to an examination under oath . . . was to enable the insurer to possess itself of all knowledge and all information as to the sources and means of knowledge, in regards to the facts, material to their rights, to enable them to decide upon their obligations and to protect them against false claims.
In Michigan, MCLA 500.2833 provides for standard language to be contained in any fire insurance policy issued in Michigan. Lines 113 to 122 of the Standard Fire Policy states that “the insured, as often as may be reasonably required, shall . . . submit to examinations under oath by any person named by the company and subscribe of the same.”

Recent Michigan Cases Dealing with Examinations Under Oath (EUO) Refusal of an Insured to Appear for An EUO

In Thompson v. State Farm, 232 Mich App 38 (1998), the Michigan Court of Appeals affirmed dismissal of a case where an insured refused to appear for an examination under oath. The court held that if the refusal to appear is willful, the court will dismiss the plaintiff’s complaint and the claim with prejudice. If the noncompliance is not willful, dismissal may be “without prejudice,” entitling the insured to file the action in the future after submitting to an examination under oath.

In Thompson, the court found that the non-cooperation was unintentional, because it arose out of a good-faith misunderstanding or lack of communication, rather than a willful or fraudulent frustration of an insurer’s reasonable pursuit of material information, and therefore affirmed a “without prejudice” dismissal.

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Refusal to Provide Requested Documents or Answer Questions

In Burkhalter v. State Farm Fire & Casualty Company, 2008 W.L. 418590 (E.D. Mich. 2008), the court held that where plaintiffs appeared for EUOs, but failed to answer specific questions about their financial conditions on the record and produce copies of individual income tax returns, the court could not rule, as a matter of law, that there had been a deliberate withholding of information or a pattern of noncooperation. In interpreting Thompson, supra, the court held that willful noncompliance refers to a failure or refusal by an insured to submit to an EUO or otherwise cooperate with an insurer as part of a deliberate effort or pattern of noncooperation.

In Musleh v. State Farm Fire & Casualty Company, 485 Fed. Appx. 79 (6th Cir. 2012), the Sixth Circuit held that the district court did not err in finding that policy holders had partially complied with their policy obligations, and that no willful compliance had occurred when the insureds appeared for their EUO, also produced two of their children for EUO, and did supply some information. The Sixth Circuit held that the district court did not abuse its discretion by dismissing the matter without prejudice.

The Insured’s right to invoke the Fifth Amendment Privilege

In Allen v. Michigan Basic, 249 Mich App 66 (2002), the court considered the situation where a party invoked her Fifth Amendment privilege to refuse to submit to an examination under oath arguing that her statements might tend to incriminate her in possible future arson proceedings. The insurance carrier denied the insured’s claim as a result of her refusal to appear at the examination under oath. After a criminal trial on the issue of arson concluded with a not guilty verdict in favor of the insured, she attempted to resurrect her claim but the insurance carrier refused, and the insured instituted suit. The court granted summary disposition in favor of the insurance carrier holding that the privilege against self-incrimination granted by the Constitution was irrelevant. The insured’s failure to appear for the examination under oath breached the contract entitling the insurance carrier to a dismissal of the insured’s case, with prejudice.

Allen was recently distinguished by Vertex Int’l Mgmt, LLC v State Farm Fire & Cas Co, 2011 US Dist LEXIS 156544 (ED Mich Jun 29, 2011). In Vertex, the insured’s case was dismissed because defendant’s requests for the owner’s financial documents were reasonable, and the owner did not substantially perform his obligations under the policy despite producing other requested documents and submitting to an EUO. The court distinguished Allen, noting that Vertex never made a definite and unwavering refusal to provide the requested documents. Rather, the owner voluntarily agreed, at the EUO, to provide them but then failed to do so before the insurer denied the claim. Failure to provide them before the claim was denied could hardly be deemed willful non-compliance.

Request for Examinations Under Oath Under an Automobile No-Fault Policy

In Cruz v St. Farm, 456 Mich 588 (2002), the Michigan Supreme Court discussed use of examinations under oath by automobile carriers in No Fault cases. In Cruz, the court held that a No Fault carrier could not refuse to consider a claim because an insured refused to appear for an examination under oath. The court ruled that the No Fault Act does not allow insurance carriers to refuse benefits if the insured refuses to...
appear at an EUO. Thus, making appearance at an EUO as a precondition to its duty to pay No Fault benefits brings the insurance carrier into conflict with the requirements of the No Fault Act. The majority ruled, however, that an EUO provision can be used by an insurer as a way of making sure that the insured provides information relating to the proof of the fact and the amount of the loss. The majority specifically rejected an argument that EUO provisions could never be inserted in a No-Fault policy.

Cruz was negatively referenced in Yaldo v Allstate Prop and Cas Ins Co, 641 F Supp 2d 644, 650 (ED Mich 2009). In Yaldo, a homeowner’s insurer sought a declaration that it was entitled to conduct an EUO of the insureds, and that, by failing to submit to an EUO, the insureds were in breach of the insurance contract. The EUO provision in the policy was a condition precedent to suit upon the policy and because the insureds did not comply with it, they were barred from bringing suit on the policy until they did. The insureds were not excused from complying with the insurer’s request for an EUO because the EUO provision was neither explicitly barred by Michigan law, nor was it contrary to the statutory scheme of the insurance code or violative of due process. However, since the insureds’ conduct did not constitute a willful breach of the policy, the correct approach was for the court to dismiss the insureds’ suit without prejudice and permit to comply with the policy provisions.

In specifically addressing the reasons why Cruz was distinguishable, the Yaldo Court noted: (1) Cruz dealt with EUO’s in the context of the no-fault act, rather than ordinary homeowner’s insurance; (2) the Court of Appeals in Cruz granted summary judgment to the insurer on the plaintiff’s claim for enforcement of the arbitrators’ award in the uninsured motorist context; and (3) the Cruz Supreme Court holding is limited by its terms to mandatory insurance policies such as no-fault auto policies. Property and fire insurance policies are not mandatory, and therefore can still require attendance at an EUO.

What is willful non-compliance?

The Court of Appeals addressed this issue in Preston v. Pioneer State Mutual, (unreported Michigan Court of Appeals decision, 10/9/2012.) After a fire destroyed Preston’s home, she made a claim under her homeowner’s policy issued by Pioneer. Pioneer requested Preston to submit to an EUO. Preston agreed to do so, answered questions for approximately three hours, and then refused to appear for a continuation at a later date. She initially stated that she was caring for a relative who was in the terminal stages of cancer, and that, therefore, her failure to attend an adjourned EUO was not “willful.” She further argued that she “substantially complied” with the policy provisions. Preston stated that even if her lawsuit was denied, it should be denied without prejudice, to give her an opportunity to appear for an examination at an adjourned date. The trial court rejected this request, and dismissed her case with prejudice.

The Court of Appeals affirmed the dismissal with prejudice. Although Preston provided an affidavit stating that she “temporarily refused to appear,” the record shows that she also stated earlier that her refusal was final. The court also found that Pioneer presented a persuasive argument for prejudice, because the trail of the criminal arsonist had gone cold during the nine-month delay caused by the insured’s failure to appear for the EUO.

Conclusion

Recent Michigan cases show that the Examination Under Oath is “alive and well” in Michigan, at least in fire and homeowners policies. Insurance carriers, in light of these recent Michigan cases, should consider the unique value of Examinations Under Oath in a variety of circumstances. Insurers should be careful, however, to give reasonable notice of the EUO, specify materials which are required to be brought to the EUO, and make sure that these materials and all questions of the insured are reasonably related to the insured’s claim.

Insurers should make sure that there are no misunderstandings or lack of communication which could result in an unintentional failure to appear or produce documents or answer questions. In such circumstances, courts will not dismiss a claim by the insured on the grounds of failure to cooperate, or may dismiss the case without prejudice, allowing the insured to appear for an adjourned Examination Under Oath before a case is dismissed with prejudice.

Insureds should be advised that if they refuse to cooperate as part of a deliberate effort to withhold information, or engage in a pattern of noncooperation with the insurer, they risk having their claim rejected, and that any lawsuit against the insurer may be dismissed with prejudice.

About the Author

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Executive Summary

As this Michigan Supreme Court nears the end of its current term, the Court has issued a number of decisions that have a direct impact on Michigan no-fault insurance claims. As a result, no-fault practitioners will need to analyze claims from a different analytical perspective – one that takes into account the injured party’s pre-existing need for the necessities of daily life. In addition, the Supreme Court has clarified the causal relationship required between a condition arising from a subsequent event and its relationship to a motor vehicle accident. The Supreme Court is also considering whether the user and/or the insurer was responsible for paying the entire cost of the van, including the base price. The Court of Appeals explicitly relied upon its earlier decision in Begin v Michigan Bell Telephone Co. and ruled that the base van and its modifications are “so blended . . . that the whole cost is an allowable expense if it satisfies the statutory criteria for being sufficiently related to injuries sustained in a motor vehicle accident . . . .”

The Michigan Supreme Court reversed the decisions of the lower courts, and reaffirmed the “incrementalist” approach first enunciated by the Supreme Court in Griffith. The court also reaffirmed the “set off” analysis enunciated by the Michigan Court of Appeals in Ward v Titan Ins. Co., 287 Mich App 552, 791 NW 2d 488 (2010) and Hoover v Michigan Mut'’l Ins. Co., 281 Mich App 617, 761 NW 2d 801 (2008). After examining these holdings, the Supreme Court clarified the scope of “allowable expenses” that are compensable under MCL 500.3107(1)(a) by noting:

“This language suggests that any product, service, or accommodation consumed by an uninjured person over the course of his or her everyday life cannot qualify because it lacks the requisite causal connection with effectuating the injured person’s care, recovery or rehabilitation. An ordinary, everyday expense simply cannot have the object or purpose of effectuating an injured person’s care, recovery or rehabilitation because it is incurred by everyone whether injured or not.”

Admire, slip opinion at page 14.

The court then went on to draw a distinction between a “combined” product or accommodation and an “integrated” product or accommodation:

“Special accommodations or modifications to an ordinary item present a particular challenge. A ‘combined’ product or accommodation results from an ordinary expense, unchanged as a result of the injury, . . . .

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being joined with an accommodation or product that is actually for the injured person’s care, recovery or rehabilitation. An ‘integrated’ product or accommodation involves the blending of an ordinary expense with one that it is for the injured person’s care, recovery or rehabilitation in a way that the resulting product or accommodation cannot be separated easily into unit costs. Unlike an integrated product or accommodation, a combined product or accommodation can be separated easily, both conceptually and physically, so that the fact finder can identify which costs are of a new character and are thus for the injured person’s care, recovery or rehabilitation and which costs are ordinary, everyday expenses that are unchanged after the accident.”

Admire, slip opinion at pages 15-16 (italics in original).

The Supreme Court went on to note that requiring an insured to pay for ordinary expenses (such as the base cost of a piece of transportation) “would destroy the cost-containment aspect of the No-Fault Insurance Act.” As a result, the Supreme Court concluded that the base cost of a van (which is essentially a piece of transportation that everyone needs, whether injured or not) is not compensable under the No-Fault Act.

“Applying this standard here, we conclude that the base price of the van is not an allowable expense under MCL 500.3107(1)(a). The statute only entitles Plaintiff to reimbursement for products, services and accommodations that are actually for his care, recovery or rehabilitation, and only the van’s modifications rise to that standard. The base price of the van is an ordinary transportation expense of the same essential character as Plaintiff would have incurred regardless of whether he was injured in an accident. While Plaintiff’s choice of transportation before his injury might not have been a van, the essential character of Plaintiff’s pre-injury need for transportation has not changed. Like Griffith’s need for sustenance, had Plaintiff never sustained his injury, or were he to fully recover, his need for ordinary transportation would be unchanged. Accordingly, the statute does not require that Defendant reimburse Plaintiff for the base price of the van.”

Admire, slip opinion at pages 19.

Accordingly, the Supreme Court concluded that only the cost of the modifications and reimbursement for “medical mileage” are compensable under the No-Fault Insurance Act, because these two expenses are “separable elements that actually represent a change in character from Plaintiff’s general pre-injury transportation requirements.”

Supreme Court clarifies scope of compensability of injuries suffered in subsequent loss

In McPherson v McPherson, docket number 144666, rel’d 4/11/2013, the Michigan Supreme Court clarified the issue of whether or not injuries suffered in a subsequent, non-motor vehicle accident can be compensable under a no-fault claim arising out of an earlier motor vehicle accident. In this case, Plaintiff developed a neurological disorder as a result of the injuries he suffered in a 2007 motor vehicle accident. In 2008, while riding a motorcycle, Plaintiff experienced a seizure arising out of his neurological disorder, which caused him to lose control of his motorcycle. As a result, he suffered a severe spinal cord injury that left him a quadriplegic. There was no motor vehicle involved in the motorcycle accident in 2008. Nonetheless, plaintiff sought payment of no-fault benefits, arising out of his quadriplegia, on the basis that the 2007 motor vehicle accident caused the seizure disorder which, in turn, caused the 2008 motorcycle accident which, in turn, caused the second injury; i.e., his quadriplegia. Plaintiff’s no-fault insurer, Progressive Michigan Insurance Company, filed a motion for summary disposition, which was denied by the trial court. The Court of Appeals affirmed.

The Supreme Court then ordered oral argument on Progressive’s application for leave to appeal. In a 5-1 decision, with Justice Viviano not participating, the majority of the Supreme Court ruled that the causal relationship between plaintiff’s first motor vehicle accident and the quadriplegia resulting from the second motorcycle accident, was simply too remote or attenuated to satisfy the “arising out of” requirement set forth in MCL 500.3105(1). In other words, the court ruled that the causal relationship between the 2007 motor vehicle accident and the quadriplegia stemming from the 2008 motorcycle accident was simply “incidental, fortuitous, or ‘but for,” citing Thornton v Allstate, 425 Mich 643, 391 NW 2d 320 (1986).

The court also rejected Plaintiff’s reliance on the Court of Appeals’ decision in Scott v State Farm, 278 Mich App 578, 751 NW 2d 51 (2008), which held that, for purposes of determining the causal relationship between a motor vehicle accident and a claimed injury, “almost any causal relationship or connection will do.” The court noted that the issue in Scott was whether or not there was sufficient evidence to support a finding that the first injury caused the second injury “in a direct way.” Although the Supreme Court majority stated that
it was “troubled by Scott’s use of a causal-connection standard this Court has never recognized,” the court nonetheless distinguished Scott on the basis that, in McPherson, the facts as asserted by plaintiff only supported a finding that the first injury directly caused the second accident, which in turn caused the second injury. Therefore, Plaintiff was not entitled to recover no-fault benefits stemming from his quadriplegia.

This case significantly narrows the scope of injuries that are compensable under the No-Fault Act. Assume, for example, that an injured claimant falls down the stairs due to a lower back injury that she suffered in a motor vehicle accident. As a result of this fall, she suffers a broken leg. Under the McPherson rationale, the no-fault insurer is no longer obligated to pay no-fault benefits associated with the broken leg, even though the second incident (the fall) was attributable to the motor vehicle accident. This case also calls into question a long line of cases dating back to the 1920’s, arising in the field of worker’s compensation, which have held that a new injury sustained as a result of medical malpractice, which is committed during the treatment of a worker’s compensation injury, is nonetheless compensable. See Oleszek v Ford Motor Co., 217 Mich 318 (1922); Staggs v Genesee District Library, 197 Mich App 571 (1992) and Gulick v Kentucky Fried Chicken, 73 Mich App 746 (1977).

The Supreme Court went on to note that requiring an insured to pay for ordinary expenses (such as the base cost of a piece of transportation) “would destroy the cost-containment aspect of the No Fault Insurance Act.” As a result, the Supreme Court concluded that the base cost of a van (which is essentially a piece of transportation that everyone needs, whether injured or not) is not compensable under the No Fault Act.

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Supreme Court grants oral argument to determine whether or not an injured claimant may be disqualified from recovering no-fault benefits arising out of the use of stolen motorcycle, even if he or she does not know that the motorcycle or motor vehicle has been stolen

In the October 2012 edition of this journal, this writer reported on the Michigan Court of Appeals’ decision in Rambin v Allstate Ins. Co., 297 Mich App 679, 825 NW 2d 95 (2012), in which the Court of Appeals had ruled that the injured plaintiff was entitled to no-fault benefits arising out of his use of a stolen motorcycle. In Rambin, plaintiff was riding a motorcycle which, unbeknownst to him, had been stolen. The Court of Appeals ruled that plaintiff was nonetheless en-titled to no-fault benefits, as “there is no dispute that plaintiff did not take the vehicle in violation of the Michigan Penal Code, and that, viewed from the plaintiff’s perspective, there was no ‘unlawful taking.’”

On May 1, 2013, the Michigan Supreme Court issued an order directing oral argument on whether or not to grant the application for leave to appeal filed by the no-fault insurer. The order specifically stated:

“At oral argument, the parties shall address whether the Plaintiff took the motorcycle on which he was injured ‘unlawfully’ within the meaning of MCL 500.3113(a), and specifically, whether ‘taken unlawfully’ under MCL 500.3113(a) requires the ‘person . . . using [the] motor vehicle or motorcycle’ to know that such use has not been authorized by the vehicle or motorcycle owner, see MCL 750.414; People v Laur, 128 Mich App 453, 340 NW 2d 655 (1983), and, if so, whether the Court of Appeals erred in concluding that Plaintiff lacked such knowledge as a matter of law given the circumstantial evidence presented in this case.”

A decision in this case is expected sometime in early 2014.

Court of Appeals

Court of Appeals clarifies scope of compensability of conservatorship fees and expenses

As readers of this column are undoubtedly aware, the issue of whether or not conservatorship fees and expenses are compensable under the No-Fault Insurance Act has been an ongoing issue of contention. In May/Carroll v ACIA, 292 Mich App 395, 807 NW 2d 70 (2011), the Court of Appeals squarely held, for the first time, that conservatorship fees and expenses are compensable as “allowable expenses” under the No-Fault Insurance Act. On December 5, 2012, the Michigan Supreme Court issued an order vacating the Court of Appeals’ decision and remanding the matter back to the Court of Appeals for reconsideration in light of the Supreme Court’s decisions in Johnson v Recca, 492 Mich 169; 821 NW 2d 520 (2012) and Douglas v Allstate Ins Co, 492 Mich 241, 821 NW 2d 472 (2012).

On April 2, 2013, the Michigan Court of Appeals released its decision, on remand, in May/Carroll v ACIA. Although the court ruled, in May/Carroll, that the particular services performed by the conservator were not compensable under the Michigan No-Fault Insurance Act, the Court of Appeals did leave the door open for the probate attorney to argue that certain types of services performed by the conservator are nonetheless compensable as “allowable expenses” under MCL 500.3107(1)(a).

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In its decision, the Court of Appeals initially reviewed the key holdings from the Michigan Supreme Court’s decision in Johnson and Douglas, and thereafter commented:

“After reviewing those decisions [Johnson, supra, and Douglas, supra], we conclude that a conservator’s fees do not necessarily constitute fees for an injured person’s care, recovery or rehabilitation, even where the injured person would not have needed the conservator’s services were it not for his or her injuries. Instead, the conservator’s fees will be compensable under MCL 500.3107(1)(a) only to the extent that the conservator’s services were directly related to the injured person’s care, recovery or rehabilitation.”

(Emphasis added)

After also reviewing the Supreme Court’s key holdings in Griffith v State Farm, 472 Mich 521, 697 NW 2d 895 (2005), the Court of Appeals applied the holdings from these three cases as follows:

“Exercising the evidence, we conclude that some of May’s services constituted replacement services under MCL 500.3107(1)(c) that were, accordingly, not compensable under MCL 500.3107(1)(a). However, we also conclude that some of May’s services were not replacement services and were otherwise necessary for Carroll’s care given the meaning of MCL 500.3107(1)(a).

The average member of a Michigan household manages his or her own estate on a day-to-day basis; ordinary people pay bills, make deposits, buy and sell property, hire brokers, and otherwise plan for their future needs. Carroll’s need for ordinary household management existed prior to his accident and continued to exist after his accident. As such, to the extent that May performed those services for Carroll, they would be compensable under MCL 500.3107(1)(c), rather than under MCL 500.3107(1)(a), because his need for ordinary household management is not specifically related to his injuries.

But Carroll also clearly had, and presumably continues to have, additional estate management needs as a result of his head injury – needs that go far beyond those that he required before he was injured. Carroll requires someone to manage his medical bills, negotiate with medical providers and insurers and marshal his assets and handle them in a way that will ensure that he can continue to receive the best possible physical and mental care. As the Supreme Court approvingly noted in Douglas, attendant care can include services that the injured person might have performed before he or she was injured as long as those services are not the type of ordinary tasks that a family member might perform for the benefit of the household as a whole.”

(Emphasis added)

However, the Court of Appeals held that because the conservator did not challenge the trial court’s finding regarding which specific services were compensable and which were not, the Court of Appeals simply affirmed the lower court’s ruling.

In short, what many observers were hoping for was a blanket statement, to the effect that conservatorship fees and expenses either were or were not compensable as “allowable expenses” under MCL 500.3107(1)(a). The Court of Appeals clearly rejected this “black and white” analysis. Instead, it left the door open for probate attorneys to argue that their conservatorship fees and expenses still constitute “allowable expenses” because they pertain to management of medical expenses, contacts and negotiations with medical providers and insurers and the marshalling of assets necessary for the injured person’s treatment.

In other words, it seems clear to this writer that simply paying routine household bills, balancing a checkbook and the like would not constitute an “allowable expense” under MCL 500.3107(1)(a). However, other services, particularly those that go beyond the routine management of an injured person’s financial affairs, could very well be considered “allowable expenses,” particularly if they deal with medical care and treatment.

About the Author

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Inland Marine Coverage—What is It For, How does It Work?

By Julia Baran, Hylant

Inland marine insurance is generally used to cover losses to moving or movable property. It is essentially a “catch-all” for many items that do not easily fit within the traditional concept of property and as a result, there is a lot of creativity in definitions, treatments and coverage. Inland marine coverage fairly recently evolved from marine insurance (property in transit overseas), because it covers from accounts receivables and builders risk to personal jewelry & fine arts collections to valuable papers. The wide range of coverage types deemed to be inland marine can make analyzing and understanding inland marine coverage a challenge. This article will focus on those features of an insurance policy that are specific to inland marine coverage.

The International Risk Management Institute (“IRMI”) defines inland marine coverage as “Property Insurance for property in transit over land (and inland waterways), certain types of moveable property, instrumentalities of transportation (such as bridges, roads, and piers), instrumentalities of communication (such as television and radio towers), and legal liability exposures of bailees.”

Including the inland marine policy as part of a package offers several benefits, such as fewer policies to purchase, administer, sell and maintain; substantial reduction in the chance of delay of settlement in the event of a loss due to disputes among insurers; and reducing adverse selection among insureds and risks in the package policy.

In the beginning, the companies that offered inland marine type of coverage originally were subject to very little regulation, especially when compared to those companies that offered fire and casualty. The absence of rigorous regulation gave rise to comparatively creative provisions within the policies issued and allowed for very profitable opportunities for the carriers that offered inland marine coverage.

In 1932, in response to what the fire and casualty insurance companies perceived to be the inequity, the New York Insurance Department issued a ruling to clearly define the powers of marine (and inland marine companies). In 1933, the National Convention of Insurance Commissioners (predecessors of the National Association of Insurance Commissioners, NAIC), issued the rule now known as the Nation-Wide Marine Definition, which is: “Qualifying property must be generally moveable, in transit, or bear some other relationship to transportation or communication”. This definition is the basis for the powers and current structure of both Marine and Inland Marine insurance companies (what could and could not be covered by marine insurance). The definition was revised in 1953 to further classify (vs. restrict) ocean marine business and revised again in 1976 to include inland marine policies, including “difference in condition” (DIC) policies; builders’ risk policies, and electronic data processing (EDP) equipment policies.

An inland marine insurance policy can be written as a stand-alone policy, or more increasingly, as part of a “package” or multi-line policy. Including the inland marine policy as part of a package offers several benefits, such as fewer policies to purchase, administer, sell and maintain; substantial reduction in the chance of delay of settlement in the event of a loss due to disputes among insurers; and reducing adverse selection among insureds and risks in the package policy. Because of the scope of coverage included within the Nation-Wide Marine Definition, as revised, it continues to be as common to see a mono-line inland marine policy as it is to see this coverage with in a package.

“Filed” and “Non-Filed”

Inland marine insurance policies are written in either as “filed” or “non-filed”. Filed forms are those that have been filed with a state’s insurance department. These forms and the premium rates must be approved by the state’s insurance department before the insurance company can write business in that state. Filed forms characteristically have uniform exposures, and tend to be specialty coverages for narrowly defined exposures often unique to a particular business. Most personal lines carriers write “filed” business for categories like jewelry and coin collections. Examples of filed commercial inland marine business include car dealer floor plans, jewelers block, and equipment dealers.

Non-filed forms, as a result of not submitting to the approval process of a state’s insurance department, allow for a lot more flexibility in underwriting. Non-filed forms do not

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The non-filed forms must read carefully to insure that your client has the coverage it needs and to make clear what the parameters of that coverage are. There are opportunities to negotiate the coverages to provide fine tuning for your client’s particular situation that are not present with filed forms.

have a uniform list of exposures. Often these types of exposures are unique to an insured and so the carrier must have the ability to underwrite and price each risk individually. Examples of non-filed inland marine business include – but are definitely not limited to – builder’s risk, installation floaters, contractor’s equipment floaters and transportation insurance.

There are certainly times when the only source of insurance coverage is found on non-filed paper, but it means that that the non-filed forms must read carefully to insure that your client has the coverage it needs and to make clear what the parameters of that coverage are. There are opportunities to negotiate the coverages to provide fine tuning for your client’s particular situation that are not present with filed forms.

Open Perils and Named Perils

There are two general means of describing which perils (cause of loss) an inland marine insurance policy will cover: (1) Open Perils (which used to be call “All Risk”); or (2) Named Perils (or Specified Perils).

The Open Perils approach is more commonly used in inland marine insurance policies than Named Perils. It covers all perils, unless the peril is specifically excluded and is considered to be the broader form of coverage for insureds versus Named Perils. It is important for practitioners to review the list of exclusions carefully to determine whether their client has the proper insurance coverage for their situation. The term “All-Risk” is not used as often as it was in the past because the insurance companies wound up covering unanticipated types of losses due to the courts’ interpretation that “all” meant “all in the very literal sense,” and sometimes did not bother with the exclusions listed in the policy. For Open Perils, the burden of proof is on the insurance company to establish to the court that those types are excluded.

The Named Perils approach errs to the other side, narrowing the coverage to only those listed perils. Further, those perils are often further reduced by the definitions in the policy. For example, most policies define burglary as “taking of property, etc…from inside, leaving marks of forcible entry or exit.” If no signs of forcible entry or exit exist, then the policy would not cover the loss by burglary. The Named Perils approach puts the burden of proof on the insured. If the insured cannot provide proof of the loss, the insurer does not pay.

Parties Affected by the Coverage

In an inland marine policy, there are a number of parties that may be affected if property is lost, damaged or destroyed, not just the owner of the property. Others parties who may be affected include (1) those who use the property (someone who leases or rents equipment); (2) common carriers and bailees (such as the dry cleaner, trucking company or a repair shop; all these entities may become liable for loss or damage to property in their care, custody or control); or (3) those who lend money to the property owners.

In addition to the standard causes of loss found in a policy, the inland marine policy adds the loss of, or damage to, property that will have a negative financial effect on the insured, including: (1) reduction in property value, (2) loss of use of the property, (3) increase in expense to the owner or others who use the property while it is being repaired or replaced, and (4) reduction in the owner or other’s income.

Conditions

All commercial insurance policies include “common policy conditions,” but inland marine policies have two additional loss conditions specific to those items covered by inland marine policies. The Abandonment Clause gives an insured the right to abandon lost or damaged property and still claim full settlement form an insurer (subject to certain restrictions). The two types of losses to which this applies are “Actual Total Loss” and Constructive Total Loss.”

Actual Total Loss occurs when the subject property is so badly damaged that it is no repairable or unrecoverable. Causes of an Actual Total Loss include fire, sinking, windstorm damage, and mysterious disappearance. Constructive Total Loss occurs if the property is so badly damaged that the cost of repair far exceeds its restored value. In a typical inland marine policy, the insured can abandon the property if “the (a) repair costs are greater than 50% of the value of the property after it is repaired, and (b) the insurance company agrees to the insured’s intent to abandon.”

Valuation

The valuation provision in an inland marine policy may be
one of several types. Typically, “actual cash value” is the valuation approach under inland marine policies. Some other type of valuation approaches include replacement cost, functional replacement cost, cost to repair or replace with like kind and quality or the policy can pay the lower of the loss or the limit. The insured needs to know the options available to determine if they can negotiate for a valuation approach that best suits their needs.

**Duplication of Insurance, a/k/a “Other Insurance”**

Another area of caution for insureds and their advisors is the “duplication of coverage” provision found in inland marine policies. It tends to be very strict, more so than in with other, more standard coverages. Essentially, if an insured has an inland marine policy and one or more other policies that cover the same loss, then the insurer will pay only the excess over what the insured should have received from the other company, whether or not the insured can collect from the other company.

**Summary**

In summary, inland marine insurance fills numerous gaps among the more traditional areas of property & casualty insurance policies and therefore a very important tool for providing needed coverage to insureds. There are many situations where this type of policy is the only type of insurance available. The need for this “catch all” will likely continue to grow and evolve as the risks in the modern world do the same. The challenge for insureds and their advisors is to carefully read the policy provisions to determine whether the offered coverage best suits a given situation and that there are no exclusions or exceptions that narrow that offered coverage. In general, there is much more room for negotiation and creativity with non-filed forms and more so for commercial rather than personal policies. However, with more flexibility comes more risk of inadvertently eliminating or limiting a needed coverage. Inland marine insurance is another tool for addressing an insured’s risks.

**About the Author**

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**Endnotes**

1 The following is a list of wide range of additional types of coverages considered “inland marine”:

- Imports
- Exports
- Domestic Shipments (Goods in transit)
- Camera and photographic equipment
- Communication Vehicles (tunnels, bridges, piers and power transmission lines)
- Persona Property Floaters (coin & stamp collections, fine arts, musical instruments, silverware and furs)
- Commercial Floaters (accounts receivable, valuable papers, valuable records, and physician's and surgeon's instruments)
- Electronic Data
- Property in Bailee's custody
- Property for sale by a dealer (e.g. cameras, fine arts, jewelry)

2 [http://www.irmi.com/online/insurance-glossary](http://www.irmi.com/online/insurance-glossary)


4 [https://burnhamsystem.com/pdfs/samples/4122eo01.pdf](https://burnhamsystem.com/pdfs/samples/4122eo01.pdf)

5 [https://www.myceisonline.com/course/course.php?course=Inland%20Marine%20Coverage&courseAbr=inlandMarineCov&chapter=03&title=03Title](https://www.myceisonline.com/course/course.php?course=Inland%20Marine%20Coverage&courseAbr=inlandMarineCov&chapter=03&title=03Title)

6 [https://www.myceisonline.com/course/course.php?course=Inland%20Marine%20Coverage&courseAbr=inlandMarineCov&chapter=03&title=03Title](https://www.myceisonline.com/course/course.php?course=Inland%20Marine%20Coverage&courseAbr=inlandMarineCov&chapter=03&title=03Title)
Can the Tort Plaintiff Bring a Declaratory Judgment Action?


When there is a dispute over whether a policy covers a claim, and the parties can’t resolve it themselves, the next step is a declaratory judgment action. In the lingo of the business it’s sometimes called a “DJ,” but more often a “dec action.”

Here’s a question that came up recently: Can the tort plaintiff be the one to start the dec action? Normally the insurer sues the insured (a/k/a “policyholder”), or vice versa. When they do, if they want the tort plaintiff to be bound by the result, they will join the tort plaintiff. But what happens if they don’t start the dec action in the first place? Maybe the insured just doesn’t care; maybe he or she or it is judgment-proof or out of business. When that happens, can the tort plaintiff be the one to get this rolling?

Here’s the argument that the tort plaintiff cannot sue: MCL 600.1405 allows a third party beneficiary of a contract to sue on the contract, but a person is only a third party beneficiary if “the promisor of said promise had undertaken to give or to do or refrain from doing something directly to or for said person.”1 And, Schmalfeldt v North Pointe Ins Co, 469 Mich 422; 670 NW2d 651 (2003) held that person injured in a bar fight could not sue the tavern’s insurer for medical benefits because he was only a member of the public at large. The court said that

[T]he contract contains no promise to directly benefit Schmalfeldt within the meaning of 1405. Nothing in the insurance policy specifically designates Schmalfeldt, or the class of business patrons of the insured of which he was one, as an intended third-party beneficiary of the medical benefits provision. At best, the policy recognizes the possibility of some incidental benefit to members of the public at large, but such a class is too broad to qualify for third-party status under the statute.

Therefore, a member of the public, who was injured by an insured tortfeasor, cannot sue the tortfeasor’s insurance company directly.

That’s the argument that the tort plaintiff cannot sue to confirm that the tort defendant’s insurance policy covers the loss. It’s simple and straightforward, but it’s wrong. The argument fails as a matter of logic and as a matter of policy.

First, the logic. In terms of formal logic, the argument that someone who is not a third party beneficiary is barred from suing commits the classic fallacy of the form “If A implies B, then not A implies not B.” To put it in another format: “If A then B; therefore if not A then not B.” Both are incorrect. And to translate all of that back into real-world words, the Third Party Beneficiary Contract statute describes a situation in which a person can sue. It does not describe the only situation. The statute is permissive, not proscriptive. It contains no prohibitions.

The policy argument also defeats the claim that a tort plaintiff is powerless when the insurer and the insured agree not to contest coverage. Public policy is not a vague expression of a court’s feeling about a particular case. It is derived from “the policies that, in fact, have been adopted by the public through our various legal processes, and are reflected in our state and federal constitutions, our statutes, and the common law.” Terrien v Zwit, 467 Mich 56, 66-67; 648 NW2d 602 (2002).

Dec actions are controlled by MCR 2.605, which allows the filing of a dec action whenever there is a “case of actual controversy.”2 Obviously there is an actual controversy, because the tort plaintiff wants to collect from the insurance policy and the insurer does not want to pay.

Statutory law leads to the same result. MCL 500.3006 allows a tort plaintiff who has a judgment against the tort defendant to collect on the policy: “an action in the nature of a writ of garnishment may be maintained by the injured person, or his or her personal representative, against such insurer under the terms of the policy . . . .”3

The statute recognizes that the tort claimant has a legal interest in the existence of coverage, and MCR 2.201(B) states that “[a]n action must be prosecuted in the name of the real party in interest.”4

Case law also recognizes that the tort claimant has a legal interest at stake. If the insurer or the insured files the dec action, the tort claimant must be joined if he or she is to be bound by the result.

“This, if the insurer wishes to obtain a judgment that would bind the alleged tort victim, the insurer must make the victim a party to the action for declaratory judgment. See also Central High School Athletic Ass’n v Grand Rapids, 274 Mich 147, 153; 264 NW2d 322 (1936) (“We have grave doubts, that a declaratory judgment would be res judicata of anything with only the present
parties before us. All interested parties should be before the court”).”

Davis v Great American Insurance Co, 136 Mich App 764; 357 NW2d 761 (1984) also recognized the right of the claimant to proceed as an assignee of the insured.

So, logic, court rules, statutory law and case law all add up to a recognition of the tort plaintiff’s right to proceed to protect his or her interest. In fact the argument against the tort plaintiff’s right to sue in his or her own name begins to look pretty strange. It puts the insurer in the position of saying that the tort plaintiff can sue to confirm coverage after he or she gets the verdict, but is prohibited from confirming coverage before that. It also means that two parties (the insurer and the insured) van, by their agreement negate the rights that the law confers on a third party (the injured plaintiff).

About the Author

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Health Insurance Market Reform under the Affordable Care Act

By Lisa DeMoss, Thomas M. Cooley Law School

Despite the constitutional and unrelenting political challenges to the Patient Protection and Affordable Care Act of 2010 (ACA),1 on October 1st, 2013, the portal doors will open for American consumers seeking a new shopping experience for health insurance products. For the health and financial well-being of the American public, Congress has specified unprecedented regulatory oversight of health insurers, their products, the rates they may charge for those products, their dealings with consumers, distribution channels for individual and small group health plans and the operation of the state wide markets in which these products will be offered.

The primary purpose of this sweeping market reform is to improve access to more affordable health insurance products by providing individuals and small group plans with aggregate purchasing power equivalent to large health plans,2 while addressing perceived abusive practices of health insurers. As with any significant regulatory intrusion into the free market, there are always uncertainties. This is a snapshot of market reform and its impact on insurers and consumers as of June 1st, 2013. Regulatory guidance continues to be issued daily.

A Newly Envisioned Market: Health Insurance Exchanges

In Michigan, there are approximately 745,000 residents eligible for refundable tax credits that may be applied towards the purchase of Health Benefit Exchange products in 2014. The refundable, advanceable tax credits provide in-

Endnotes

1 Sec. 1405. Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.

(1) A promise shall be construed to have been made for the benefit of a person whenever the promisor of said promise had undertaken to give or to do or refrain from doing something directly to or for said person.

2 (A) Power to Enter Declaratory Judgment

(1) In a case of actual controversy within its jurisdiction, a Michigan court of record may declare the rights and other legal relations of an interested party seeking a declaratory judgment, whether or not other relief is or could be sought or granted.

3 Sec. 3006. In such liability insurance policies there shall be a provision that the insolvency or bankruptcy of the person insured shall not release the insurer from the payment of damages for injury sustained or loss occasioned during the life of such policy, and stating that in case execution against the insured is returned unsatisfied in an action brought by the injured person, or his or her personal representative in case death results from the accident, because of such insolvency or bankruptcy, then an action in the nature of a writ of garnishment may be maintained by the injured person, or his or her personal representative, against such insurer under the terms of the policy for the amount of the judgment in the said action not exceeding the amount of the policy.

Health Insurance Market Reform
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Out-of-Pocket Liability Caps

Consumer out of pocket liability is capped for individuals and insured group health plans. Small group product deductibles are capped at $2000/$4000; there are no corresponding limits on individual product deductibles, although total cost sharing for both markets is capped in 2014 at $6400 for individuals and $12,800 for families. These amounts are adjusted annually to reflect growth in premiums. The group plan ceilings for consumer cost sharing apply to both small group plans which are defined as 50-100 or more enrolled lives, depending on State definitions of group size (Michigan defines small groups as those with between 2 and 50 enrollees) and large groups of 100 or more.

Insurers, HMOs or other product issuers under the ACA are not required to offer products on the Exchanges, but their products and their market conduct are nonetheless subject to new rules which have staggered implementations and different applicability to insured and self-funded plans, grandfathered or existing coverage, and group size. Although it was originally contemplated that in 2014, small groups would be able to shop for group coverage on the Exchanges, HHS deferred the launch of the Small Business Health Options (SHOP) Exchanges to focus on the implementation of the individual product markets. Those who are employed in small groups will be able to shop for individual coverage on the Exchange in 2014 and thereafter.

Consumers will complete an application on-line, with the assistance of agents, producers or individuals and non-profit organizations known as Navigators. Agents and brokers, including those selling on the internet, may enroll individuals, employers or employees in QHPs using the Exchange portal. Navigators, agents and brokers must be trained and registered with CMS or under applicable state legislation if the state is operating its own exchange. As of May, 2013, only 17 states have elected to run their own exchanges; 27, including the District of Columbia, have defaulted to a Federally Facilitated Exchange (FFE) to serve as the new marketplace for the resi-
dent[s of their states. The remaining seven states, including Michigan, will operate a partnership Exchange with the Federal government.7

Michigan’s State Plan Management Partnership Exchange allows the State Insurance Commissioner to retain regulatory oversight of insurance issuers, agents and brokers, while HHS performs the balance of the Exchange functions including administration of the web portal, and all consumer interactions. Although Michigan was conditionally approved on March 5, 2013, to establish a state based exchange, the Michigan Legislature declined to timely appropriate the requisite funding for the Consumer Assistance activity to be performed on the Exchange. Accordingly, Exchange based responsibilities other than those established under existing Michigan statutory authority regulating insurers, their products and their distributors will be assumed by HHS under the Federally Facilitated Exchange rules.8 Michigan may elect to expand the level of its participation in the Exchanges in subsequent years.

Fundamental Changes to Non-Group Health Insurance Products

Certified QHPs must conform to the new benefit mandates and cost sharing limitations which are specified as metal value tiers (bronze, silver, gold, platinum) that require actuarial equivalency of products offered within each of the four tiers. Consumers may purchase plans that offer payment of between 60 and 90% of the cost of providing the Benchmark plan benefits, with corresponding differences in premium. A catastrophic plan that pays only 50% of the actuarial value of the full benefit plan is available to eligible individuals under the age of 30.

New underwriting restrictions will be applied beginning January 1, 2014. The ACA specified guaranteed issue during open enrollment periods and guaranteed renewability thereafter. The initial open enrollment period will run from October 1, 2013 through March 31, 2014, with an initial coverage attachment date of January 1, 2014. When coupled with the elimination of medical underwriting and the pre-existing condition exclusion, these restrictions will likely produce significant premium impacts due to the high potential for adverse selection by those who have been denied access to affordable health care coverage in the past. Moreover, there is mounting concern that the individual and small group risk pools will not be adequately balanced by younger, healthier risks who will prefer to meet their Minimum Essential Coverage requirement by paying a $95 penalty in 2014 and a bit more in the years thereafter, until and unless the subsidized premium cost approximates the annual penalty for non-coverage.

Plan issuers (insurers, HMOs, and co-operatives) are subject to new discrimination rules, rate regulation and market controls. Non-grandfathered individual and small group plans inside and outside the Exchange are limited to four rating fac-

These Health Insurance Exchanges are internet based markets in which standardized individual and small group health products may be compared based on cost, provider network configuration, future quality ratings and consumer interest. Each product must be certified as a Qualified Health Plan (QHP), and once a product is certified, it must be offered at the same price whether sold on the Exchange or directly by the insurer to the consumer outside of the Exchange.

tors when compiling rates for review: age (based on a ratio of 3:1); geography (all products must be community rated); family size (individual or family); and tobacco use (based on a ratio of 1.5:1).9 Annual and lifetime benefit caps are eliminated for EHBs.10

Pre-existing condition exclusions are prohibited, as are policy rescissions except for fraud or intentional misrepresentation of material fact.11 After the initial premium payment, those consumers receiving a premium tax credit are entitled to a three month grace period for payment of overdue premiums, during which time coverage may not be cancelled. After the first month of premium default, claims are pended and claims payment collection shifts to the health care providers for services rendered in months two and three of the premium default.

Beginning January 1, 2011, issuers are required to calculate a Medical Loss Ratio (MLR) by market segment. The MLR constrains the allowable costs of these products by requiring consumer rebates for each year in which the issuer fails to meet claims cost and quality initiative spending targets. The targets are expressed as the percentage (80% for individual products and 85% for insured group products) of premium dollars spent on medical claims, clinical services and those issuer activities that are directed towards health care quality.12

In 2012, health insurers issued $1 billion in consumer and group rebates for 2011 performance under the new standard.13 While the Medical Loss Ratio is a retrospective readjustment of premium, insurers are also subject to premium justification both as a qualifying consideration for certification to sell products on the Exchange and as a measure of the reasonableness of annual rate increases. As interpreted by the Secretary of HHS, rate increases exceeding 10% per annum on non-grandfathered, insured individual and small group plans may not be “reasonable,” and for plan years 2010-2015, issuers must provide justification for increases exceeding 10% prior to implementation of a premium increase.14

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Other market reforms that represent significant changes relate to interactions between consumers and health plans. QHPs must be accredited by one of the major health plan accrediting bodies such as the National Commission for Quality Assurance (NCQA) or URAC, formerly known as the Utilization Review Accreditation Commission. QHPs must comply with non-discrimination provisions protecting consumers' rights under the ACA. For example, plans cannot be designed in a manner that discourages enrollment due to a significant health need, nor may they discriminate against individuals seeking coverage based on that individual's health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation, or expected length of life, degree of medical dependency or other health conditions.

Plan summaries must conform to drafting specifications limiting the description of benefits to four pages, written and delivered with linguistic and cultural sensitivity. Beginning in 2014, the Summary of Benefits and Coverage documents must also include a disclosure regarding the plan's provision of Minimum Essential Benefits, and whether it meets the affordability requirements of the ACA. “Minimum Essential Benefits” is a term used to describe the minimum threshold of coverage that will satisfy the individual coverage mandate under the ACA. If an individual has Minimum Essential Coverage, as certified by her private health plan or a government plan, she is exempt from penalties that will be collected beginning in 2014 to assure that all required individuals obtain health insurance coverage.

QHPs sold in and out of the Exchanges are subject to the same commission rates when the products are essentially the same. Provider directories must be linked to the exchanges and include specified data pertaining to each listed provider. Moreover, QHP issuers must continue to comply with all applicable State laws and regulation regarding the marketing of their products.

Conclusion

Structural changes to the individual and small group markets are essential to effectuate the basic purpose of the ACA: expand access to high quality health insurance at an affordable price. In the short term, the expansion of benefits, underwriting restrictions, new communication and consumer mandates, new industry taxes and lack of certainty over the claims risk presented by the newly insured, will drive significant and justifiable rate increases. The financial risk of participating in these new markets under difficult rules and restrictions has deterred many insurers from entering the Exchanges in 2014. As these markets stabilize, more insurers will reconsider their decisions to offer Exchange products. Further assuming that rates are correspondingly lowered, these products will become more attractive to healthier, lower cost risks. Only then, will the promise of the Affordable Care Act begin to be realized.

About the Author

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Endnotes

1 On March 23, 2010, the Patient Protection and Affordable Care Act, P.L. 111-148, was signed into law by President Barack Obama. The legislation itself consists of two bills, the PPACA and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, which became law on March 30, 2010. A third component of amendatory and supplemental legislation is found in the Manager’s Amendment to these two bills which became Title X. Collectively, these bills are referred to as the Affordable Care Act or ACA. The ACA is codified within various sections, as amended, of the Internal Revenue Code, 26 U.S.C. §1, et seq.; The Public Health Services Act, 42 U.S.C §201 et seq.; The Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq.; and the Social Security Act, 42 U.S.C. §301 et seq.

2 Testimony of Steve Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, July 28, 2011, United States House Committee on Small Business, Subcommittee on Healthcare and Technology.


4 Qualifying grandfathered plans are exempt from most of the reforms set forth in Subtitles A and C of ACA Title1, § 1251. These plans are not included in the mandatory single risk pools specified for the individual and small group markets beginning January 1, 2014. They are also excluded from the risk adjustment and temporary risk corridor programs, which are designed to provide market stability in the initial years of Exchange operation. ACA §1343(c); § 1342(a). Grandfathered plans lose their exempt status once they make substantial changes which change the character or scope of the benefits originally provided.

5 ACA § 1302 (1) and (2); PHSA § 2707 (b). Out of network, non-emergency services which result in balance billing are not included in the cost sharing limitations. Consumers are eligible
for means tested cost sharing subsidies when coverage is purchased through a State or Federal Exchange. IRC, Part 156, Sub A§155.20.

6 MCL 500.3701 (p).


8 http://ccio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf. Plan management functions retained by Michigan include; QHP certification, (which encompasses a determination of licensure, network adequacy, accreditation, actuarial value, discriminatory benefit design and rates), among other functions.

9 PHSA § 2701; ACA § 1301 (a) (1) (C) (iii).

10 PHSA § 2711 ; ACA § 1001.

11 PHSA § 2704; ACA § 1201 and PHSA § 2712.

12 PHSA § 2718.


14 45 C.F.R. 154.215; ACA § 1311 (e ) (2); 42 U.S.C. § 300 gg-94 . Additionally, beginning in 2016, the ability of an issuer to offer a large group QHP will be determined, in part, by excess recovery rule and the common fund doctrine. The High Court granted certiorari to resolve a circuit split on whether equitable defenses can override a plan’s reimbursement provisions.

In an opinion delivered this April by Justice Kagan, the Supreme Court clarified when equitable doctrines may apply in subrogation and reimbursement claims brought pursuant to ERISA § 502(a)(3), which authorizes plan administrators to recover subrogation and reimbursement claims brought pursuant to ERISA § 502(a)(3), which authorizes plan administrators to bring suit to obtain appropriate equitable relief to enforce the terms of the plan. Not surprisingly, the High Court held that express terms of an ERISA plan govern. However, the court expanded on its consideration of equitable defenses in the recent trilogy of cases including Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356 (2006); and Cigna Corp. v. Amara, 131 S.Ct. 1866 (2011), and found that, although equitable doctrines may not override the terms of a contract, where the terms of a plan leave gaps, courts may properly use equitable rules to construe the contracting parties’ intentions.

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Because the plan here provided for reimbursement of “any monies recovered from [the] third party,” the court found that the double recovery rule, which would only allow the plan to recover that portion of a payment to McCutchen representing medical expenses (differentiated from future earnings, or pain and suffering, for example), that equitable doctrine was contrary to the terms of the plan and was not a valid defense.

However, in considering McCutchen’s “common fund” defense, the court found that the plan was silent on the allocation of attorney’s fees. According to the court, the plan’s allocation formula could have been interpreted to apply to every dollar received from a third party. Yet, the court found the plan could also be interpreted to apply only to the final, true recovery, after all of the costs of obtaining it were deducted. Finding the plan ambiguous, the court agreed that McCutchen’s equitable defense applied to fill the gap in the express terms of the plan, and US Airways’ reimbursement would be limited by its proportional share of McCutchen’s attorney’s fees incurred in obtaining his third-party payment.

As with many of the cases in this area, the majority opinion can be read broadly or narrowly. The broader reading is stated above: that equitable defenses are not available to contradict the clear terms of the plan; i.e., the terms of the plan govern. The narrow reading is: ERISA 502(a)(3) authorizes actions that traditionally had been recognized in equity. One of those actions is an action to enforce an equitable lien by agreement. The court could not find any case in which the equitable defense of the double recovery rule had been applied; therefore the court held that this defense had not been traditionally recognized in equity. But that is not to say, according to this reading of the opinion, that there are no equitable defenses to other equitable actions that had been traditionally recognized in equity. Although plans are likely to trump the broader reading and it certainly behooves plan drafters to explicitly disclaim defenses where desired, it remains to be seen whether those disclaimers will be upheld in all cases.

Justice Scalia authored the dissent, joined by Chief Justice Roberts and Justices Thomas and Alito. The dissenting opinion differed from the majority only with respect to whether the plan terms were ambiguous such that the common fund doctrine should apply, arguing that McCutchen conceded in briefing that the plan allowed for reimbursement without contribution to attorney’s fees incurred in obtaining a payment. Accordingly, the dissent found this issue was not properly preserved, or included in the issue presented. The majority addressed this issue by indicating that McCutchen’s statement in question was actually a description of US Airways’ position in the District Court, and that McCutchen himself argued the same position that the majority adopted.

The court expanded on its consideration of equitable defenses in the recent trilogy of cases . . . and found that, although equitable doctrines may not override the terms of a contract, where the terms of a plan leave gaps, courts may properly use equitable rules to construe the contracting parties’ intentions.

This case emphasizes that benefit plans should be drafted to expressly define which party will bear the financial burden of recovering from a third-party, and what amounts constitute recovery. Some commentators have argued that a benefit plan’s exclusion of the payment of attorney’s fees from the amount determined to be recovered operates as a disincentive to the employee (or counsel) to bring suit against a third-party tortfeasor in the first instance. It remains to be seen whether plan drafters will both incorporate and enforce such terms, if that results in lesser recovery to the plan.

Sixth Circuit

Initial application of the wrong disability definition was properly corrected upon consideration during the administrative appeal

Judge v Metropolitan Life Ins Co,
710 F3d 651 (6th Cir. 2013)

The plan participant, Thomas Judge, was covered by his employer’s term life insurance policy which provided for early payment of benefits if an employee became totally and permanently disabled, which was defined by the plan as being unable to do the employee’s own job, and any other job for which the employee is fit by education, training or experience. After Judge underwent heart surgery, he applied for benefits under the policy, claiming he was not able to return to any type of work. His treating providers recommended lifting and certain other restrictions, but indicated that he was recovering well with no evidence of complications. Yet, Judge’s doctors advised against returning to work.

The plan administrator, MetLife, which was also the insurer of the benefits, initially denied the claim based on a nurse consultant’s review of medical records, but mis-stated the applicable definition of disability. Judge requested an administrative appeal, submitting no new medical records or information. Following a second nurse consultant’s review of the same medical records, noting the same inconsistencies and lack of objective evidence of disability, the denial was upheld but the correct definition of disability was referenced in the...
communication to Judge. The Sixth Circuit disagreed with the claimant’s argument that the initial mention of the incorrect definition of disability was arbitrary or capricious because the plan administrator corrected its error following the administrative appeal process.

Although the court did not expressly mention it, the court’s ruling was likely guided by the decision, Conkright v Frommert, 130 S Ct 1640 (2010), in which the Supreme Court held that “a single, honest mistake” does not render a determination arbitrary or capricious. The authors discussed that decision in the July 2010 Journal). Further, the court found that a remand to the administrator was unnecessary due to the objective medical evidence demonstrating that the claimant was not disabled under the appropriate definition.

The court also rejected the argument that a file review conducted by a nurse consultant was insufficient to support the decision which did not involve a credibility assessment or second-guessing of the claimant’s treating physicians.

Judge also argued that MetLife improperly denied his claim that he could not perform any job without obtaining vocational evidence. However, the court rejected this argument as well, relying on supporting case law authority from several other circuits and the medical record evidence to support a finding that the claimant was not totally and permanently disabled without obtaining vocational evidence in support.

Finally, Judge argued that the financial conflict of interest tainted MetLife’s decision to deny benefits. Because the claimant failed to identify anything more than a “general observation that MetLife had a financial incentive to deny the claim,” the court found no need to give the conflict significant weight.

Following a second nurse consultant’s review of the same medical records, noting the same inconsistencies and lack of objective evidence of disability, the denial was upheld but the correct definition of disability was referenced in the communication to Judge. The Sixth Circuit disagreed with the claimant’s argument that the initial mention of the incorrect definition of disability was arbitrary or capricious because the plan administrator corrected its error following the administrative appeal process.

No removal for tortious interference claim; although related to ERISA plan
Gardner v Heartland Industrial Partners, LP, 2013 WL 1920875 (6th Cir. May 10, 2013)

Federal courts are courts of limited jurisdiction. With a couple of minor exceptions, they may only consider cases where there is diversity or that arise under federal law. If a case that could have been filed in federal court is filed in state court, the defendant may “remove” it to federal court. For federal question jurisdiction, the general rule is that to be removable, the federal question must be apparent on the face of the plaintiff’s complaint. A federal defense is not usually sufficient to establish federal question jurisdiction. However, there is a narrow exception to this rule: if federal law wholly displaces state law, the state claim may be reviewed. ERISA is one of perhaps only three federal laws that have been found to qualify for this exemption. But to be removable under this exception, federal law must represent the exclusive remedy for the injury that is the basis of the complaint, plaintiff’s complaint must be cognizable under the federal statute, and plaintiff’s complaint must not allege any independent legal duty.

This case involved the sale of Metaldyne Corporation. Plaintiffs were high ranking executives of Metaldyne and were covered by a Supplemental Executive Retirement Plan (the “SERP”). The defendants were Metaldyne’s owner and the owner’s high-ranking executives. The defendants were trying to sell Metaldyne and had a buyer – until the buyer found out that the SERP required payment of $13 million to the plaintiffs if Metaldyne was sold. The defendants “solved” this problem by getting the Metaldyne Board of Directors to declare the SERP invalid. The plaintiffs sued in state court, alleging that by getting the Metaldyne Board to invalidate the SERP, the defendants tortiously interfered with the plaintiffs’ contractual rights under the SERP. The defendants removed to federal court.

The Sixth Circuit held removal was improper. The plaintiffs were not seeking their SERP benefits, and thus, they did not have a claim for benefits under ERISA. Rather, they were seeking damages from the defendants – and not from the SERP – for the defendants’ tortious activity. Although the SERP’s “terms would likely be relevant in measuring the amount of the Plaintiffs’ damages[,] that is beside the point,” the Court ruled.

Disability benefits already awarded when plan terms were amended are not protected as “vested” benefits
Price v Bd of Trustees of the Indiana Laborer’s Pension Fund, 707 F3d 647 (6th Cir., February 15, 2013)

One significant difference between ERISA governed welfare plan benefits and pension plan benefits is that welfare plan benefits are typically not “vested” and may be terminated at any time according to plan terms. This case considered whether plan language allowing amendment applied to disability benefits that had already been awarded before the plan was amended. The court held that the plan’s board of

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trustees’ interpretation of ambiguous plan terms was reasonable, and upheld the termination determination.

The plaintiff here, Mr. Price, received disability benefits beginning in 1990, after suffering work-related injuries. In 2001, Price was advised that he no longer qualified for regular disability benefits, but he would instead receive occupational disability benefits under the plan. In 2004, the plan’s Board of Trustees amended the plan to provide that occupational disability benefits which began prior to January 1, 2005 would terminate at the earlier of the participant’s early retirement age, or December 31, 2006. The plan terms expressly precluded any amendment which would reduce benefits for a participant whose rights had become vested as of the date of the amendment. Following the amended provision, the Board terminated Mr. Price’s occupational disability benefits after December 31, 2006 (his early retirement age was in 2012), after which he brought suit, claiming that the plan amendment as applied to him violated ERISA.

The dissent (District Court Judge Jonker) opined that the plan’s decision resulted in retroactive application of the plan amendment, terminating benefits that were previously awarded under terms providing for payment until early retirement age. However, the majority rejected that position, noting that the plan amendment was not retroactive where the amendment changed “the prospective application of a non-vested welfare benefit.”

United States District Court
Filing suit before exhausting plan appeals gets claim dismissed with prejudice

It is black-letter ERISA law that a claimant must exhaust his or her plan appeal remedies before filing suit seeking benefits. The claimant in this case, failed to do this, resulting in his lawsuit being dismissed with prejudice.

Charlie Beamon was injured while working and began receiving disability benefits. Later, he received a workers’ compensation award and social security disability payments. The disability insurer claimed it was entitled to deduct both awards from the benefits it was paying. Beamon and the insurer settled this claim as to the workers’ compensation award; it did not as to the second. As a result, the insurer stopped paying disability payments, and Beamon sued before completing the appeal process.

The court began by recognizing the general rule that a participant must exhaust the appeals process before filing suit. In recognizing this rule, it determined that failure to exhaust is an affirmative defense and a plaintiff is not required to affirmatively plead that he has exhausted his appeal rights.

The court recognized an exception to the exhaustion requirement – if an appeal would have been futile. But to qualify for the “futility” exception to the exhaustion of remedies requirement, the claimant must show that it was certain that his claim would have been denied on appeal – almost certain is not enough. Beamon did not show that denial was certain and thus the futility exception did not apply.

While normally, a court would stay or remand the case so that the claimant can exhaust his appeal, in this case, Beamon was required to appeal within 180 days of the initial denial and that deadline had passed. Therefore, the court dismissed the claim with prejudice.

Parenthetically, one wonders how much of the result was due to Beamon proceeding pro se. For example, the Court states, “Plaintiff’s unconventional Complaint consists of a one-page form Summons and Complaint, which discloses nothing about Plaintiff’s claims, and two letters” from Beamon to defendants.

A federal defense is not usually sufficient to establish federal question jurisdiction. However, there is a narrow exception to this rule: if federal law wholly displaces state law, the state claim may be reviewed. ERISA is one of perhaps only three federal laws that have been found to qualify for this exemption.

Other Decisions Of Note
The following are other recent decisions that the authors determined do not warrant a full write-up. Only certain aspects of the decision are mentioned.

Statute of Limitations
Schumacher v AK Steel Corp Retirement Accumulation Pension Plan, 711 F.3d 675 (6th Cir. 2013)
28 U.S.C. 1658 provides a catch-all statute of limitations of four years for federal causes of action that arise under federal law enacted after December 1, 1990. The court held that these claims pre-dated 1990 and thus Section 1658 did not
apply. Second, the court held that the lower court should not have “mechanically applied” the statutory pre-judgment interest rate of 28 USC 1961(a); rather it should have engaged in a case-specific inquiry that sets an interest rate that places the plaintiffs where they would have been but for the defendants misconduct but not penalize the defendants.

**Attempted Change of Vested Benefits**


This was a typical retiree health case where the employer tried to change unilaterally what the Court determined were vested lifetime retiree health benefits. The only different aspect of this case was that the employer tried to change the benefits from fully insured into a limited HRA for each retiree.

**Effect of Merger on Benefits**


Employer merged with another company. Before merger, it offered its employees enhanced benefits for those who voluntarily retired early. Union employee accepted offer, but claimed employer failed to provide the promised incentive benefits. Union had also filed grievance on same issue. Scott’s claim was dismissed so arbitration could continue.

**Denial of Disability Claim Overturned**


Insurer denied disability claim; Judge Rosen overturns denial as arbitrary and capricious.

**Michigan Court of Appeals - Unpublished**

Although your authors do not normally discuss unpublished decisions, there were three recent unpublished Michigan Court of Appeals decisions that may be of interest:


Discussed funding of the Wayne County Retirement System and the various obligations – fiduciary, anti-inurement, and others – under the Michigan Public Employee Retirement System Investment Act, which contains provisions similar to ERISA. The decision explicitly recognized that ERISA did not apply to a government plan, but it discussed two ERISA cases anyway.


The disposition of pension benefits in the context of a divorce continues to be litigated. In this case, there was a divorce and a QDRO entered at that time. Thirteen years later, after the employee died, his second wife, as personal representative of the employee's estate, filed a motion to amend the QDRO to decrease the amount of survivor benefits received by the first wife. After several hearings and other machinations, the trial court entered a revised QDRO, nunc pro tunc. The first wife appealed and the Court of Appeals reversed, holding that the matter was governed by MCR 2.612(C), and thus any requested change to the original QDRO had to be requested within one year.


Since Michigan enacted the State Correctional Facility Reimbursement Act (SCFRA), prisoners have objected to orders that pension benefits due the prisoner be sent to the prison and placed in the prisoner’s prison account so the state may collect the costs of incarceration pursuant to SCFRA. The prisoners have argued that ERISA preempts SCFRA. In this case, the Court of Appeals rejected the prisoner’s argument, being bound by *State Treasurer v. Abbott*, 468 Mich. 143 (2003). But see *DaimerChrysler Corp v Cox*, 447 F.3d 967 (6th Cir. 2006) (ERISA preempts state direction to plan, but does not prevent attachment of benefits once received).

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Significant Insurance Decisions

By Deborah A. Hebert, Collins, Einhorn, Farrell

Michigan Court of Appeals-Published

Serious impairment claims limited by the governmental immunity act

Hunter v Sisco
___ Mich App ___ (2013); (Docket No. 306018)
Reconsideration denied 5/21/13

The motor vehicle exception to the Governmental Immunity Act, MCL 691.1405, is limited to claims for “bodily injury” and “property damage.” Bodily injury “encompasses only ‘a physical or corporal injury to the body,’” and does not include pain and suffering or shock and emotional distress. Such damages are not recoverable against a governmental agency under this exception. But as to claims of serious impairment due to back pain caused by a herniated disc and a pinched nerve, plaintiff established a question of fact for the jury.

Michigan physician-patient privilege is not preempted by HIPPA

Meier v Awaad
___ Mich App ___ (2013); (Docket No. 310808)

This case addresses the privacy rights of non-party patients whose medical records are requested in a litigated matter. The court held that Michigan’s Statutory Physician-Patient Privilege Act, MCL 600.2157, was not preempted by HIPAA to the extent the state law was more protective of the patient’s privacy rights. Under the Michigan statute, medical records are subject to the physician-patient privilege and require patient authorization prior to release. This privilege may be asserted by parties to litigation even if they are not the patient because only non-privileged evidence is admissible. Plaintiffs improperly obtained privileged documents in discovery and were ordered to return all such information and destroy all electronic files containing that information in the absence of an authorized release from the patient.

Class action on health insurance reimbursement

Michigan Association of Chiropractors v Blue Care Network of Michigan, Inc.
___ Mich App ___ (2013); (Docket No. 304783)

Michigan Association of Chiropractors v Blue Cross Blue Shield
___ Mich App ___ (2013); (Docket No. 304736)

Supreme Court Application pending in both cases

These cases involve interlocutory appeals from class action rulings in two separate cases filed by the Michigan Association of Chiropractors. The lawsuits challenge the rules of reimbursement for chiropractic services and the discussion is primarily about class certification rather than insurance issues.
They are noted here for the benefit of those who may be following this litigation.

**Michigan Court of Appeals-Unpublished**

**Criminal acts exclusion not applicable to hunting accident**

*Auto Club Group Ins Co v Kondziolka*

Unpublished per curiam opinion of March 5, 2013 (Docket No. 308255)

The criminal acts exclusion in this homeowners policy did not bar coverage for an insured who caused injury to another in a hunting accident. The exclusion applied to claims arising out of “a criminal act or omission” or an “act or omission, criminal in nature.” MCL 750.235(1) makes it a misdemeanor to cause injury “by discharging a firearm pointed or aimed intentionally at another person,” even in the absence of malice. The court held that the statute requires the intentional pointing of the gun at a person. Because this insured thought he was shooting at a deer, the exclusion did not apply.

**Policy rescinded due to misrepresentations**

*Usewick v Safeco Ins Co*

Unpublished per curiam opinion of March 19, 2013 (Docket No. 300657)

The Court of Appeals affirmed the trial court’s rescission of a policy due to the insured’s material misrepresentations in the application for insurance. The insured and her husband were in the business of purchasing homes, which they repaired and then either sold or rented for profit. One of the homes and its contents and surrounding structures were badly damaged in a fire. Safeco denied coverage because in the application for insurance, the insured had signed off on a description of the home as being occupied and in “excellent” condition, with no major construction or significant renovations planned or underway. The house had been purchased with no drywall on the first floor, no flooring, and no kitchen cabinets or countertops. It was unoccupied and under construction at the time of the fire.

**Identifying “residents of the same household”**

*Secura Ins Co v Matthews*

Unpublished per curiam opinion of March 19, 2013 (Docket No. 308425)

This opinion provides a good discussion of the factors relevant to identifying “residents of your household” as insureds. Secura issued a farmowners protective policy to Helen Stasa for two adjacent parcels of property owned by her. Stasa was the only named insured on the policy. She occupied the home on one of the parcels and her adult son and his wife occupied a home on the other. The houses were a mile apart, each with its own driveway, mailing address and utilities. The insured saw her son about once a week. On these facts, the court held that the son and his wife “maintained a separate and independent household” from the named insured and were not insured under the policy. Secura did not have to defend or indemnify the son against a liability claim involving his dog.

**CGL coverage available for damage caused by roofer**

*Oak Creek Apartments, LLC v Garcia*

Unpublished per curiam opinion of March 21, 2013 (Docket No. 308256)

In this construction defect case, the court found CGL coverage for damage to property other than the named insured’s work. The insured was hired to repair the roof on an apartment building but failed to secure the open areas against inclement weather at the end of each work day, causing extensive interior damage, including mold. Some of the residents had to be relocated while the interior was demolished and rebuilt. At issue was whether the CGL policy covered claims for the cost of additional work required to bring the building up to code. The court relied on *Radenbaugh v Farm Bureau Gen Ins Co*, 240 Mich App 134, 147 (2000) and found coverage because the damage was to property other than the work. The court also refused to apply exclusions limited to “particular” parts of property because those particular parts of property were not at issue.

**Agency duty and lack of evidence of causation**

*Micheau v Hughes & Havinga Insurance Agency*

Unpublished per curiam opinion of May 21, 2013 (Docket No. 307914)

Plaintiff’s home was damaged in a fire while it was uninsured. After the fire, and before repairs were made, plaintiff purchased homeowners coverage through the defendant insurance agency. Soon afterward, another fire occurred, causing even more damage. Plaintiff was denied coverage because of the misrepresentations in the application about the state of the house and he sued his insurance agency for inaccurately describing the property. The Court of Appeals found that the agent owed a duty to plaintiff to exercise reasonable skill and ordinary diligence in performing its responsibilities in preparing the application. Whether the agent did so was a question of fact for the jury. However, the Court of Appeals affirmed summary disposition for the agent because of plaintiff’s inability to prove that the agent proximately caused his loss of coverage. The agency produced unrebuted evidence that no insurer would have issued a homeowners policy protecting against fire loss if the home had been accurately described in an application.
INSURANCE AND INDEMNITY LAW SECTION
ANNUAL MEETING

This event is offered in conjunction with the Bar’s Annual Meeting

Lansing Center, Lansing Michigan
September 19, 2013, 10:00-11:30am

- Election of Council and Officers
- Followed by our program:
  “A 360 Degree Perspective on Reforming Auto Insurance in Michigan; Can We Find Any Common Ground in the No-Fault Debate?”

Registration is requested to allow for proper facilities planning. Visit the Bar’s Annual Meeting page (www.michbar.org/annualmeeting) for more details.
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