

The Journal of Insurance & Indemnity Law

A quarterly publication of the State Bar of Michigan's Insurance and Indemnity Law Section

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Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.

From the Chair



Kathleen A. Lopilato,
Auto-Owners
Insurance Company

Greetings!

How time flies! Hard to believe that we are now more than half way through this year.

Highlights from the last few months include our participation as a sponsor for the Young Lawyers Summit at Greentown on May 30, 2015. Special thanks to Laretta Pominville for all her hard work in putting that together, and to Gus Igwe, Adam Kutinsky and Hal Carroll for manning the table.

Gus, Adam and I also attended the Bar Leadership Forum on Mackinac Island on June 12 and 13, 2015. We were able to network with other leaders and came away with many fresh ideas. One important topic raised was what sections were doing to connect to the general membership. We have started a discussion thread on the section website. Please give us your thoughts so that we can better meet your needs.

Election of Council Members

Planning is also under way for the Annual Bar Meeting which will be held on October 8, 2015 and is in Novi this year. The program this year will be "Effective Advocacy When Facilitating Insurance and Indemnity Issues." We look forward to seeing you there!

In our Section, officers serve for two years and all of them will be continuing into their second year. But there will be

six seats on the Council up for election this year. I want to encourage everyone who is interested to put their name in the running, especially if you are new to the Section and this area of practice.

If you are new to this practice area, you can be an important asset on the Council because there are so many new members, and it is important to have their perspective reflected on the Council so that the Section can meet the new members' needs. Please contact one of the Council members if you are interested in being on the ballot or send an email to our "Commissioner of Elections," Hal Carroll at HOC@HalOCarrollEsq.com.

New Members

Our section continues to grow and our membership is now at 914! Welcome to our new members:

- Kurt Melvin George Rhodes kurt@kurtrhodes.com
- Mark Joseph Hynes mjhynes@umich.edu
- Michael C. Scharf, Jr. mscharf@scharflawgroup.com
- Quentin Docks, II qdocks@gmail.com
- Razvan Corneliu Radulescu razvanrad@gmail.com
- Robert A. Haertel haertellaw@gmail.com

Thank you for joining! ■

Editor's Notes



By Hal O. Carroll
www.HalOCarrollEsq.com

The *Journal* – now in its seventh year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. All opinions expressed in contributions to the *Journal* are those of the author. We welcome all articles of analysis, opinion, or advocacy. The Section itself takes no position on issues.

Copies of the *Journal* are mailed to all state circuit court and appellate court judges, all federal district court judges, and the judges of the Sixth Circuit who are from Michigan. Copies are also sent to those legislators who are attorneys.

The *Journal* is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at HOC@HalOCarrollEsq.com. ■

SAVE THE DATE
October 8, 2015



Effective Facilitation of Insurance and Indemnity Disputes

In conjunction with the
State Bar of Michigan Annual Meeting

STATE BAR OF MICHIGAN
INSURANCE & INDEMNITY LAW SECTION
ANNUAL MEETING AND PROGRAM
October 8, 2015 at 9:00 a.m.

Suburban Collection Showplace, Novi
46100 Grand River Ave, Novi, MI 48374

This event is FREE, but please register
(<http://www.michbar.org/annualmeeting.cfm>)
to allow for proper planning. Thank you.

THE PANELISTS:

- Kevin S. Hendrick, Clark Hill, PLC
- Martin G. Waldman, Martin G. Waldman, PC
- Hon. James J. Rashid, Jr., Judicial Resource Services, PC

THE PROGRAM:

Please join the Insurance and Indemnity Section for a meaningful discussion of effective facilitation techniques with a panel of experienced facilitators.

The program will help you improve your advocacy skills in alternative dispute resolution, including valuable practice tips from the mediators.

There will be an opportunity to ask questions of the panel and other experienced practitioners concerning their experiences with alternative dispute resolution and in particular what they found to be effective and ineffective.

Please direct your inquiries concerning the program to the Insurance & Indemnity Section chair-elect Adam Kutinsky, at akutinsky@dmms.com or (248) 642-7835.



Disaster Averted: The Affordable Care Act Survives Another Major Legal Challenge

By Lisa DeMoss

On June 29, 2015, the United States Supreme Court released its eagerly anticipated decision in the matter of *King v. Burwell*.¹ The world did not end. Millions of Americans continue to receive necessary health care services. Health care providers and the health insurance industry breathed a big collective sigh of relief. Life as we have come to know it under The Patient Protection and Affordable Care Act (ACA) has been preserved by edict of the Supreme Court or at least until Congress is able to achieve a consensus alternative palatable to the current President and the American public. It seems that the attention of the repealers and reformers will be redirected towards electing a like-minded candidate to the White House in 2016. This brief pause in the political and legal battle over the ACA provides an opportune time to assess what appears to be working well under the law and what could be prioritized for improvement.

The Legal History of the ACA

On March 23, 2010, President Barack Obama put his signature on an historic piece of social legislation that fundamentally changed the market for sale of individual and small group health insurance products in America. The Patient Protection and Affordable Care Act (ACA)² is a broad statutory framework, supported by hundreds of interpretive regulations, that affects individuals, employers, health care providers, insurers and state governments in a manner that creates complex financial interconnectedness and dependencies. It is also a lightning rod for discontent and fiery political rhetoric. The United States House of Representatives has voted 56 times since March of 2010 to repeal the ACA in its entirety. Scores of civil lawsuits have challenged different aspects of the law and its implementation. State and federal district court opinions have aligned around prevailing political sentiment. Repeated public polling on the American public's attitudes about the ACA has generally been negative, although for those who have acquired coverage through the exchanges, polling results are improving.³

Mandate Held Constitutional under the Taxing Power

The United States Supreme Court has considered three cases involving the ACA, resolving the first in June of 2012. In the first challenge, the individual health insurance cover-

age mandate, the cornerstone of access to affordable health insurance, was determined to be constitutional.⁴ In reliance on the Congressional power to levy taxes under the Commerce Clause, the majority of the court upheld the personal responsibility payment as a permissible tax, thus saving the coverage mandate and most likely, the ACA itself. As noted in the majority opinions in *NFIB* and the later *King v. Burwell* decision involving tax credits that subsidize premium cost for individuals purchasing health insurance on the ACA health insurance exchanges, the individual coverage mandate is an essential feature of the insurance market reform provisions of the statute and the ACA itself.

Religious Freedom Restoration Act

In the second case,⁵ the Supreme Court, relying upon the Religious Freedom Restoration Act, determined that the owners of a closely held corporation, when asserting sincerely held religious beliefs, could refuse to extend portions of the ACA contraceptive coverage mandate to employees and dependents enrolled in their employer group health plans. Contraceptive coverage is a required health plan benefit under the essential health benefits section of the ACA, and is applicable to insured health plans, generally.

King v. Burwell: "Established by a State"

The decision in the third case, *King v. Burwell*,⁶ was released on June 29, 2015. In *King*, the Court considered a rather straightforward question of the interpretation of the tax credit provisions of the ACA applied by the Internal Revenue Service. The IRS issued a regulation that extended premium subsidies to all eligible individuals regardless of whether coverage was purchased on state based exchanges or on the federally facilitated exchanges. In a surprising six to three majority opinion written by Chief Justice Roberts, the Court focused on four words of statutory text, "established by a State," and reached the conclusion that the language is ambiguous in the broader context of the statute. Petitioners argued that Congress clearly intended to limit the availability of refundable advance premium tax credits to purchases of individual health policies sold exclusively on electronic health insurance markets or exchanges established and operated by individual states. The court disagreed, finding that the many references in the stat-

ute to the exchanges support an interpretation that Congress intended that both state and federal exchanges act identically for most purposes and therefore should also provide the same financial assistance to consumers regardless of which exchange was used to process the application.

Citing its earlier decision in *NFIB*, the court again noted the interconnectedness of the individual mandate and insurance market reforms. Specifically, the court expressed concern over possible destabilization of newly reformed individual health insurance markets in the thirty-four states that chose not to establish their own health insurance exchanges. The tax credits at issue provide essential financial assistance to consumers throughout the country for whom private insurance coverage remains unaffordable, despite statutory efforts to better regulate loss ratios, premium increases and rating formulas. The premium tax credits (like the individual mandate in *NFIB*) were declared to be a major component of the statutory scheme, critical to the preservation of the ACA itself.

The premium tax credits work in tandem with the tax penalty to encourage participation in the health insurance market while offsetting the financial penalty linked to the mandate. Both are necessary to balance the new state-wide risk pools that eliminate health status discrimination among applicants by requiring guaranteed issue and community rating. These two rating changes remove fundamental controls historically exercised by insurers to protect their risk pools from adverse selection and premium deficiencies. The *King* court rejected a more literal interpretation of the phrasing with regard to the availability of tax credits, noting that denial of financial assistance to millions of consumers in a majority of the states would destabilize the individual insurance markets in those states and again render private insurance policies unaffordable to millions of consumers.

Because 87 per cent of all purchases made through exchanges operating in the fifty states plus the District of Columbia receive tax credit based premium assistance, millions of Americans would be exempted from the individual coverage mandate based on the unaffordability of coverage within their respective states. Such an interpretation of Congressional intent would frustrate the essential structure of the ACA which is intended to expand access to affordable health care to the majority of uninsured Americans. The court found that Congress passed the ACA for the purpose of improving health insurance markets, not destroy them.⁷

The Dissenting Opinion

Justices Scalia, Thomas and Alito offered a dissenting opinion replete with criticism of the methods deployed by the majority of the court in their efforts to again save the ACA from judicial repeal. They found no ambiguity in the critical statutory reference to the availability of premium tax credits, noting that the clarity of the language should not be affected

by considerations of the purpose of the law. Nor did the dissenters think much of the overall quality of the ACA drafters' efforts. Both opinions identified a number of contradictory statutory references to support their preferred meaning of the language pertaining to tax credits. Justice Scalia concluded the dissenting opinion with an admonition that acknowledges the court's challenges in interpreting unpolished statutory text. He advises Congress to be more careful, and to the extent that they fail in that responsibility, it is then up to the people to hold them accountable.

In a surprising six to three majority opinion written by Chief Justice Roberts, the Court focused on four words of statutory text, "established by a State," and reached the conclusion that the language is ambiguous in the broader context of the statute.

Litigants have had three at bats under the ACA at the Supreme Court. Partial victories were achieved limiting the states' expansion of Medicaid eligibility⁸ and the extension of contraceptive services viewed as abortifacients to those health plans whose sponsors who are able to claim an exemption under RFRA based on closely held religious objections.⁹ Thus far, the Supreme Court has denied the opposition any home runs. But, extra innings may be in order as new appeals raise potentially important issues regarding the division of power between Congress and the President regarding the manner in which the ACA has been implemented by the administration of President Obama.

To quell fringe demands for filing articles of impeachment against the President, in 2014, House leader John Boehner rallied House Republican support for litigation alleging that the administration illegally deferred, modified and avoided politically sensitive aspects of the roll-out of the ACA from and after 2010, notably the employer mandate.¹⁰ Additionally, Republicans are likely to continue efforts to generate broader support for repeal of unpopular provisions of the law such as the medical device tax, the employer coverage mandate, and the statutory definition of full time workers entitled to employer sponsored insurance coverage.¹¹ Moreover, as the Republican Party maintains or improves its majority in both chambers of Congress, it is likely that efforts will be renewed to reduce federal discretionary funding for departmental administration of the ACA and many of the programs and policies specified in the public health sections of the law.

Early Successes under the ACA

Regardless of the political lens through which one views such matters, the ACA has achieved early success in several

areas of Congressional concern. At the same time, some of the overly ambitious reform initiatives embedded in the 900 page statutory text and thousands of pages of regulatory detail have either failed or appear to be headed for the scrap heap of well-intentioned policy disappointments. The ACA is not unique in this regard. What distinguishes this policy reform effort from others is the extraordinary pressure to demonstrate immediate success or suffer wholesale demolition by the opposing political party. The ACA has not benefitted from a more traditional bipartisan effort to modify and correct the initial, imperfect legislative effort. This article explores two of the three primary statutory objectives and defers analysis of the third to allow for sufficient time to determine whether the quality initiatives are producing the desired health outcomes while reducing the total cost of health care.

Reform of the Insurance Market

Central to the promise of expanded access to affordable health care, the ACA fundamentally reformed the health insurance market. These reforms included:

- a “guaranteed issue” provision requiring insurers to issue health care coverage to any individual who applies,¹²

- a prohibition on excluding preexisting medical conditions from coverage or imposing a waiting period before their coverage begins,¹³

- a prohibition on the establishment of coverage eligibility rules that are based on health-status related factors,¹⁴ and

- the required use of a “community rating” system that prevents health plans from setting premium prices based on individual medical history and further limits permissible rating factors to age, geography, and tobacco usage.¹⁵

In combination, these market restrictions severely impact insurers’ ability to effectively manage the individual and small group risk pools against a very cogent threat of adverse selection.¹⁶ Congress acknowledged the threat that individuals would wait to purchase health insurance until they needed the care,¹⁷ and included a requirement that individuals purchase or acquire minimum coverage to broaden the risk pool to include healthy risks, which in turn would lower health insurance premiums. The Supreme Court accepted the premise that the individual mandate and the insurance market reforms are interrelated and has twice rejected challenges that would have the effect of eliminating or significantly impairing the coverage mandate.

The newly formed insurance markets under the ACA enrolled their first customers in January of 2014. Insurers have been allowed to perpetuate non-conforming individual

policies through October 1, 2017 pursuant to an extension of the ACA deadline to eliminate plans that do not comply with ACA requirements. To protect the new risk pools, many insurers voluntarily cancelled non-conforming plans. Others chose to retain non-compliant, grand-fathered plans despite the obvious risk that healthier risks would retain their more modest benefit designs while needier customers would select exchange products that offered no medical underwriting, more expansive benefits and premium subsidies.

Thus far, the Supreme Court has denied the opposition any home runs. But, extra innings may be in order as new appeals raise potentially important issues regarding the division of power between Congress and the President regarding the manner in which the ACA has been implemented by the administration of President Obama.

The ACA is designed to provide interim help, insulating insurers from unanticipated financial consequences of participation in the reformed state markets for individual and small group health coverage. Three different ACA programs¹⁸ were designed to protect the new risk pools from instability and huge premium increases based on the uncertainty of the projected claims experience among the new customer base. Under regulations finalized in February of 2015, health plans will contribute billions of dollars of premium assessments into re-insurance programs designed to offset initial, qualifying losses incurred by qualified health plans enrolling new individual insureds under the ACA between 2014 and 2017.

Moderating Trend in Health Care Spending

Lower overall claims costs has driven a moderating trend in total health care spending across all product lines between 2010 and early 2015. But, how has that trend impacted the cost of claims in the new individual markets under the ACA? Across the country during the first full year of exchange based transactions, there are two metrics that support a conclusion that the cost of health care services has moderated under the effects of the ACA. First, on average, there were minimal premium increases nationwide (2%) for exchange products between 2014 and 2015.¹⁹ This could be a result of a true reduction in the projected cost of claims or a function of the delay between the actuarial determination of projected claims costs and the finality of payment data. Data from eleven states, including Michigan and the District of Columbia reflect an average 4.4% premium increase between 2015 and 2016 for the benchmark Silver plans sold on the exchanges. Additionally, the number of qualified health plans in each state market

has remained steady or increased between 2014 and 2016. In Michigan, a higher than average number of plans participate. In 2014, nine plans offered products to Michigan exchange shoppers. For 2016, 12 different plans will sell products. And, during this initial three year period, only one plan withdrew from the Michigan market.²⁰

Michigan's Experience

Michigan experience would tend to support a conclusion of delayed actuarial analysis of cost trends. Double digit rate hikes have been requested for 2016 by several of the largest individual health plans. Local insurers attribute the cost increases to pent-up demand from new health consumers, as reflected in a full year's worth of paid claims data and the rising cost of drugs which are included in the essential health benefits required to be included in all exchange based policies.²¹

Eighty-eight percent of Michigan enrollees in ACA exchange products qualified for premium subsidies, so the effect of large premium increases will be blunted for the majority of exchange purchasers due to their eligibility for premium subsidies. Similar rate requests have been observed throughout the country, although most rate reviews for 2016 are still subject to final state regulatory approval. All requests to increase rates by more than 10% year to year must be accompanied by a Rate Filing Justification that addresses the statutory requirement that increases be "reasonable." Rate reviews are conducted by state insurance departments and CMS. To the extent that insurers are able to support their requested increase with actual paid claims data, they should have little difficulty achieving rate increases based on rising medical costs which form roughly 80% of more of base rate calculations.²² Further, with regard to application of the Medical Loss Ratio requirement under the ACA, it appears that insurers have been complying based on an analysis of declining rebates between 2011 and 2013.²³

If premium changes are not the optimal barometer of real reductions in the aggregate cost of covered claims, is there a better measure?

Projections for Future Spending

The CBO and the CMS Office of the Chief Actuary generally agree on projections for health care spending over the next several years. Spending by enrollee by private health plans is projected to increase 4.3% annually until 2019 when it will increase by 5.9% per year until 2025. Immediately before the ACA went into effect in 2010, the American economy was in a recession that many would argue had a significant impact on overall spending due to loss of employer sponsored health care coverage and moderated spending by health care consumers. In the interim, health plans have undergone significant modification, notably in the area of increased cost sharing between the health plan and their participants.

The purpose of cost sharing under a health policy is to foster more considered use of benefits. The benefit design change has increased out of pocket spending by privately insured consumers, particularly in the large group health plan market in which there was a 300% increase in the growth of high deductible health plans between 2009 and 2015.²⁴ For individual and small group health insurance products sold under the ACA, consumer out of pocket spending factors directly into the tiers of coverage available for purchase. Out of pocket spending is a function of the actuarial value of the specified products offering the identical benefits but at differing levels of consumer cost sharing represented by deductibles, co-payment and co-insurance amounts. Despite statutory caps on out of pocket spending, the burden placed on consumers is quite high. For 2016, the indexed maximums are \$6850 per individual or self-only coverage, and \$13,700 per family.²⁵ These cost sharing amounts, particularly the deductible amounts, must be paid by consumers before their health plans begin to pay health care providers directly.

CBO Projections

The Congressional Budget Office recently updated its projections of the federal government's cost for the ACA coverage provisions, reflecting a net cost during the period 2015 and 2019 that is 29 percent lower than predicted when the ACA was first enacted.²⁶ Analysts largely credit the unanticipated reduction in total claims costs as the basis for the change. The reduction in claims costs is a reflection of decreased utilization of services, which may contribute to a return to historic use levels due to pent-up demand for services foregone when millions of Americans lost their employer sponsored coverage. Others note that higher consumer cost sharing is influencing the provision of both unnecessary and necessary health services.

Premium Increases

There were dire predictions of significant premium increases, but these did not materialize between the first two years of the new, reformed marketplace. In fact, across the country, in many areas, there was no increase at all, year to year. Moreover, as an indicator of a healthy, competitive market, the number of insurers participating in the marketplace increased by 25 percent.²⁷ Insurers have adapted to the regulatory changes and are able to better manage and expand the new business opportunities presented by the exchange markets.

Expanded Markets

Additionally, the ACA presents new and expanded government sponsored insurance product markets. Enrollment in the Medicare Advantage products is increasing as baby boomers age into the Medicare program. The expansion of Medicaid eligibility in the sixteen states that have elected to participate,

has opened new markets, attracting more insurers into delivery of Medicaid managed care services. Now that the Supreme Court ruling in *King* has provided a period of certainty with regard to the future of the ACA, insurers are reacting by expanding their customer base in these programs through acquisition strategies. These are all positive signs that the health insurance industry not only has survived the initial challenge, but has begun to leverage the opportunities presented under the ACA.

Expanded Access to Affordable Health Care

Congress identified a primary goal of health care reform as reducing the number of uninsured Americans by expanding access to affordable health care.²⁸ In a complex and wholly interdependent structure, the ACA reconfigured the individual and small group health insurance markets to assure broad consumer participation in standardized, premium-regulated products. This was accomplished through a set of coordinated market reform measures, shared responsibility payments and premium tax credits for low and middle income purchasers. To assure insurance market stability and reduce the economic burden of cost shifting for uncompensated hospital services, all non-exempt individuals are required to purchase or enroll in minimum levels of essential health coverage or pay a financial penalty.

Congress specifically identified how achievement of these goals would reduce the federal deficit. These particular goals were couched in terms of their impact on the beneficial effects of these changes on the national economy:²⁹

By significantly reducing the number of uninsured Americans, the total economic cost of caring for those in poor health will be reduced by providing access to earlier, and more frequent preventive care. Additionally, life spans of the uninsured will increase;

Health care insurance premiums will be lowered by reducing the number of uninsured, which reduces the cost shifting of uncompensated hospital services to those with health insurance;

Health insurers' administrative costs will be reduced by increasing the size of the purchasing pools, providing economies of scale, and by eliminating medical underwriting.

The latest Congressional Budget Office enrollment projections identify 11 million individuals under the age of 65 covered by insurance exchange based policies in 2015.³⁰ Of the 11 million individuals with exchange based coverage, 8 million of those purchasers received premium subsidies totaling \$3,960,000,000, *Id.* The majority of insured Americans (57%) continue to access health insurance coverage under

their employer's group health plan. And, although difficult to predict, employment based coverage has declined at a slower rate than originally anticipated.³¹

There were dire predictions of significant premium increases, but these did not materialize between the first two years of the new, reformed marketplace. In fact, across the country, in many areas, there was no increase at all, year to year. Moreover, as an indicator of a healthy, competitive market, the number of insurers participating in the marketplace increased by 25 percent.

Reductions in the Uninsured

In total, the CBO estimates that the number of uninsured will be reduced in 2015 by 25,000,000 through a combination of ACA provisions including exchange purchases, new Medicaid and CHIP enrollment, reductions in employer based coverage, non-group and other coverage such as Medicare. Uninsured individuals include those who fall into one of the statutory exemptions (mostly, the inability to locate available affordable exchange products that cost less than 10% of their annual household income), unauthorized immigrants, individuals who are ineligible for expanded Medicaid because they live in states that chose not to expand Medicaid eligibility under the ACA, individuals who are eligible for Medicaid but choose not to enroll and those who forego insurance purchases to which they have access through an employer, exchange or directly from an insurer. At the end of 2014, about 30 million American adults remained uninsured, the majority of whom were eligible for premium assistance under the ACA.³² Future enrollment outreach efforts will be directed towards this target audience.

Although the ACA greatly expanded the opportunity to access subsidized individual health insurance coverage, it has only been partially successful. Only half of the uninsured targeted for inclusion in 2010 have been covered under exchange products or expanded Medicaid eligibility in the few states that have chosen to enroll childless adults whose incomes fall between 100% and 133% of the Federal Poverty Level. Eleven million lives have been insured under exchange products, contrasted with more than 150 million individuals who are privately insured under large group health plans, 55 million Medicare beneficiaries, millions enrolled in other federal government programs, and 30 million who remain uninsured. Surely, those eleven million insured through the new individual markets would argue that their equal opportunity to enjoy good health has been worth the cost. But, if equal access

fails to impact the federal deficit or otherwise produce tangible and intangible improvement in health status and productivity, even staunch proponents of the ACA will have difficulty defending its cost.

Conclusion

Although many challenges remain with regard to achieving long term health care cost reductions under the ACA, initial results are promising. Millions of Americans have purchased coverage through the health insurance exchanges serving the new individual and small group markets. Insurers have adapted to the regulatory changes, as unpopular as they remain. The predictability of the regulatory environment afforded by the Supreme Court's efforts to rescue the ACA from an uncertain future will facilitate insurer experimentation, innovation, and focus on improving the overall health status of their enrolled populations. The financial return on these investments will take many years to capture and measure. The premium subsidy cost to the federal government will likely increase as premiums increase in the short term. As previously uninsured patients utilize their coverage to more timely and fully address chronic health conditions and avoid preventable health complications through earlier prevention and detection, the overall health status of these individuals should improve and the avoidance cost of treating catastrophic, episodic health system encounters should decline. The future of the ACA now returns to the political arena where the cost of health care should be the focus of further reform initiatives. ■

About the Author

Lisa DeMoss is an Associate Professor of law at WMU Thomas Cooley School of Law and the Director of Graduate Programs in Insurance Law and Corporate Law and Finance. She teaches several courses, including a course on Health Insurance and the Impact of Federal and State Reform Initiatives.

Endnotes

- 1 *King v. Burwell*, 576 U.S. ____ (2015)
- 2 Patient Protection and Affordable care Act of 2010, Pub.L.No.111-148, 124 Stat. 119(2010); Health Care Education and Reconciliation Act of 2010, Pub.L.No.111-152m 124 Stat.1029
- 3 See: <http://kff.org/interactive/tracking-opinions-aca/#?response=Favorable-Unfavorable&aRange=twoYear>; <http://kff.org/health-reform/poll-finding/data-note-predictors-of-positive-and-negative-attitudes-towards-the-aca-among-non-group-insurance-enrollees/>
- 4 *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) (No. 11-393), 2012 WL 72449; *King v. Burwell*, *Id.*
- 5 *Hobby Lobby v. Burwell*, 134 S.Ct. 2751 (2014)
- 6 *King v. Burwell*, *Id.*

- 7 *King*, *supra* .at
- 8 *NFIB*, *supra*
- 9 *Hobby Lobby*, *supra*
- 10 *United States House of Representatives v. Burwell*, 1:14-CV-01967 RMC (D.D.D. 2014)
- 11 <http://www.wsj.com/articles/fight-over-affordable-care-act-turns-to-medical-device-tax-1436209691>
- 12 42 U.S.C. §300gg-1 (PHSA §2702, as amended by ACA §1201(3)(A))
- 13 42 U.S.C. §300gg-3(PHSA §2704, as added by ACA §1201(2)(A))
- 14 42 U.S.C. §300gg-4 (PHSA §2705, as added by ACA §1201(4))
- 15 42 U.S.C. §300gg(a)(1) (PHSA §2701, as added by ACA§1201(4))
- 16 Adverse selection occurs because individuals, usually less healthy and older participants, generate higher than average claims costs. These individuals are much more likely to enter insurance markets than healthier individuals who prefer to self-insure medical costs until they anticipate greater medical need. Prior to the ACA market reforms, insurers uniformly engaged in extensive underwriting of risk, principally by identifying and rejecting or charging more to those applicants with prior claims histories or known medical conditions. Higher premiums charged to that class of applicants better matched their expected higher actual utilization of health care services. Without the ability to spread the cost of insuring less healthy claims risks across a broader premium base or the ability to charge higher premiums for less healthy risks, over time, claims costs would exceed collected premium reserves, and premium costs would increase beyond any measure of affordability.
- 17 42 U.S.C. §18091(2)(I)
- 18 For the claims period running from 2014 through 2016, The ACA reinsurance program reimburses insurers for disproportionately expensive claims risks. A second program limits insurer losses and gains through adjustment of risk, protects against inaccuracies in the setting of rates. A third program, which is permanent, functions to redistribute risk among exchange insurers by redistributing funding between high and low risk enrollees.
- 19 Cynthia Cox, Rosa Ma, Gary Claxton and Larry Levitt, Analysis of 2016 Premium Changes and Insurer Participation in the ACA's Health Insurance Markets, June 14, 2015, www.kff.org/health-reform/issue-brief/analysis-of-2016-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/
- 20 Kaiser Family Foundation, *Analysis of 2016 Premium Changes*, *supra*.
- 21 J.C. Reindl, Robin Erb, *Some Michigan Insurers Seek Hefty Hikes*, Detroit Free Press, June 4, 2015
- 22 Medical Loss ratio is the percentage of health insurance premiums that are spent by the insurance company on health care services. The ACA requires that small group and individual market plans spend 80% of premiums on clinical services and

- other activities for the quality of care for enrollees, NAIC *Glossary of Health Care Terms*.
- 23 In 2011, the first year in which Medical Loss Ratios were applied to premiums, insurers paid over \$900million to small group employers and individuals representing rebated premiums exceeding the 80% threshold for claims and quality improvements factored into base rates for individual or small group products under the ACA. Rebates paid by insurers for these same products in 2013 were reduced to \$325million, Michael J. McCue, Mark A. Hall, *The Federal Medical Loss Ratio: Implications for Consumers in Year Three*, The Commonwealth Fund, March, 2015
- 24 Health Research Institute, PwC, *Medical Cost Trend : Behind the Numbers 2016*, June 2015
- 25 <http://www.gpo.gov/fdsys/pkg/FR-2015-01-27/pdf/2015-03751.pdf>
- 26 *Updated Budget Projections : 2015 to 2025*, Congressional Budget Office, March , 2015
- 27 David Blumenthal, M.D., M.P.P, President of the Commonwealth Fund, *The Affordable Care Act at Five Years*, Testimony presented to the Senate Finance Committee of the United States Senate, March 19, 2015.
- 28 *NFIB, supra*; 42 U.S.C. §18091
- 29 42 U.S.C. § 18091(2)(C), (D), (F), and (J)
- 30 *Table 3, Enrollment in, and Budgetary Effects of, Health Insurance Exchanges*, Insurance Coverage Provisions of the Affordable Care Act-CBO's March 2015 Baseline, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf>, last accessed 4.14.15
- 31 *Table 4 Comparison of CBA and JCT's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, supra*.
- 32 <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>



Closing The Door On Michigan Consumer Protection Act Claims In Michigan No-Fault Cases

By Frederick M. Baker, Jr.*

Can a claimant who is receiving No-Fault benefits use the Michigan Consumer Protection Act and the Unfair Trade Practices Act to sue for alleged underpayment of the No-Fault benefits?

That is the question raised in *Wilson v Citizens Insurance Company of America and Auto-Owners Insurance Company*,¹ which arose from a December 4, 1977, automobile accident in which the Plaintiff, Gloria Wilson (“Gloria”), then aged 23, was catastrophically injured while driving an uninsured vehicle. Gloria was in a coma for many months after the accident; Gloria’s mother became Gloria’s guardian and applied to the Michigan Assigned Claims Facility (“the Facility”) for No-Fault PIP benefits to cover the cost of Gloria’s care, treatment, and rehabilitation. The Facility assigned Gloria’s claim to Auto-Owners Insurance Company (“Auto-Owners”), which serviced the claim for over 20 years before withdrawing from the Facility’s assigned claims program. Gloria’s claim was reassigned to Citizens Insurance Company of America (“Citizens”) in August 1998.

Almost 15 years later, in June 2013, Gloria brought suit in North Carolina against both Citizens and Auto-Owners,

claiming that each had underpaid the No-Fault benefits to which she was entitled. Both defendants urged that, to the extent that Gloria was eligible for PIP benefits, the No-Fault Act’s one-year statute of limitations and its damage limitation, the “one-year-back” rule, applied. MCL 500.3145(1).

Plaintiff’s Theory

Plaintiff’s complaint alleged an additional theory of recovery to circumvent these No-Fault defenses, recharacterizing her claim for underpayment of PIP benefits as one arising under the Michigan Consumer Protection Act (“MCPA”),² for alleged violations of the Unfair Trade Practices Act (“UTPA”),³ Chapter 20 of the Insurance Code (“Chapter 20”).

Defendant’s Response – No Consumer Transaction

In their motions for summary judgment, Auto-Owners and Citizens argued that the MCPA did not apply. Because no insurance policy had been purchased that applied to the accident vehicle, which was why Gloria was receiving benefits from the Facility, her MCPA claim did not arise from the “consumer

* The author thanks John Yeager, Esq., for offering constructive comments and suggestions, but the opinions expressed are solely his own.

transaction” that is a predicate to any MCPA claim. Rather, they argued, all No-Fault PIP benefits that Gloria claimed and received were payable under a non-profit, statutory, social welfare program that, in claims such as Gloria’s, applies only when no insurance policy affords coverage. Therefore, Auto-Owners contended,⁴ it was entitled to summary judgment on the alternative ground that, in the absence of any consumer transaction, Gloria could not evade application of the No-Fault Act’s one year statute of limitations and one-year-back rule to her claim against Auto-Owners by reframing her claim as one arising under the MCPA and Chapter 20.

Statutory Amendment – MCPA Does Not Apply to Insurance

Auto-Owners argued that Plaintiff’s MCPA claim failed not only because her claim involved no consumer transaction, but also because the MCPA was amended in 2001 to make it expressly inapplicable to insurance. Even if a valid MCPA claim theoretically could have been alleged as to any pre-1998 Auto-Owners conduct, Auto-Owners argued, Plaintiff’s claim was untimely as to Auto-Owners under the narrow exception to the 2001 MCPA amendment.

A little historical background is necessary to an understanding of this argument. Under the pre-2001-amendment version of the MCPA, a private action would lie under MCPA § 11 against an insurer for violations of Chapter 20.⁵ But even such pre-2001-amendment actions were subject to *the later* of MCPA § 11’s six-year and one-year-from-the-last-date-of-payment limitation periods.⁶ Under either limitation, Auto-

Owners argued, Gloria’s action was untimely as against Auto-Owners, because it had last serviced and paid Gloria’s claim in August 1998, almost 15 years before Gloria brought suit, in June 2013.

Plaintiff’s complaint alleged an additional theory of recovery to circumvent these No-Fault defenses, recharacterizing her claim for underpayment of PIP benefits as one arising under the Michigan Consumer Protection Act (“MCPA”), for alleged violations of the Unfair Trade Practices Act

To a limited extent, MCPA claims based on alleged violations of Chapter 20 have been permitted under what remained,⁷ after the 2001 MCPA amendment, of the holding in *Smith v Globe Life Ins Co*,⁸ allowing claims under the MCPA for violations of Chapter 20. The legislature promptly overruled *Smith* by amending the MCPA⁹ to provide that “[t]his act does not apply to or create a cause of action for an unfair, unconscionable, or deceptive method, act, or practice that is made unlawful by chapter 20 of the insurance code of 1956.” Though that amendment was effective on March 28, 2001,¹⁰ the Supreme Court held that it was not retroactive.¹¹ In theory, this combination of legislative action and judicial interpretation left open a small “window,” under the holding in *Smith, supra*, for claims arising *before* March 28, 2001.¹²

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Thus, by recasting her PIP claim as one arising under the MCPA, for alleged pre-March 28, 2001, violations of Chapter 20, Gloria sought to exploit MCPA § 11, which allows an action within one year after the last payment. But in this case, the last payment was *by Citizens*, in 2013.

Auto-Owners contended that Gloria's claim *against Auto-Owners* could not simply leapfrog over the more than 12 years between March 28, 2001, the effective date of the MCPA amendment prohibiting claims based on any "unfair, unconscionable, or deceptive method, act, or practice that is made unlawful by chapter 20 of the insurance code of 1956," and the filing of the complaint, on June 12, 2013. That would defy the MCPA's six-year statute of limitations, not to mention the "within one year of last payment" problem posed by the almost 15 years between *Auto-Owner's* last payment to Gloria, in August 1998, and the filing of the complaint.

Auto-Owners advanced alternative MCPA arguments.

Contractual Transactions versus Social Welfare Programs

First, the insurer argued that because Gloria's claim was one for statutory benefits payable under the assigned claims plan, based on no policy of insurance, and involving no predicate consumer purchase transaction, Gloria could not invoke the MCPA. There is a difference, Auto-Owners argued, between contractual transactions in trade or commerce, which are the subject of, and are subject to, the MCPA, and, social welfare programs, or what the Michigan Supreme Court has called, "vicarious philanthropy," which are not. In short, for the MCPA to apply, a transaction in trade or commerce is required: "[T]he MCPA applies only to purchases by consumers."¹³ Gloria was neither a consumer nor a purchaser; indeed, *she was a Facility claimant precisely because neither she nor anyone else had purchased insurance applicable to the accident vehicle.*¹⁴ Gloria thus was not a party to the predicate consumer transaction that must occur before the MCPA applies.

The MCPA applies to "trade or commerce," which the MCPA defines as "the conduct of a business providing goods, property, or service primarily for personal, family or household purposes" that "includes the advertising, solicitation, offering for sale or rent, sale, lease, or distribution of a service or property, tangible, real, personal, or mixed...."¹⁵ The polar opposite of offering insurance for sale is a social welfare program that provides benefits only when no insurance is available. Auto-Owners argued that the MCPA contemplates, and is triggered by, a consumer purchase, which, by hypothesis, did not occur here, *because, by law, a claim for PIP benefits against the Facility like Gloria's is expressly conditioned upon the absence of any insurance policy for which a premium was paid.* A sale to a consumer is the touchstone of the Consumer Protection Act's application.¹⁶

MCPA Cannot Apply Without a Sales Transaction

That a "sales transaction" is required before the MCPA can apply seemingly was suggested even by the plaintiff's argument in *Schwein, supra*, that if "*the sales transaction*" referred to in the MCPA has occurred, the MCPA also applies to "*post-sale transactions.*"¹⁷ The *Schwein* Court agreed, resting its decision in plaintiff's favor on a sale to which the defendant insurer's "post-sale" conduct could be linked. Auto-Owners argued that the MCPA did not apply to Gloria's claim because there was no insurance policy -- and thus no consumer transaction involving a sale of insurance to an insured -- to trigger the MCPA's application.

Even before the 2001 amendment, the MCPA did not purport to regulate social welfare programs that dispense statutory benefits available only in the absence of any sale of insurance to a consumer. It regulated the sale of an "insurance policy" by an "insurer" subject to the requirements of Chapter 20. Therefore, Auto-Owners contended, Plaintiff's reliance on the MCPA was misplaced, because the MCPA's requirement of conduct involving "trade or commerce" precluded its application to a claim for statutory assigned claim benefits that could be asserted only in the absence of a consumer transaction involving the sale of an insurance policy. Such a claim was, in Justice Brooke's phrase, nothing less than a request for "vicarious philanthropy" that is not insurance precisely because "no contractual relations whatever existed between the parties."¹⁸ In short, Michigan courts recognize not only the difference between insurance and "vicarious philanthropy," but also the difference between the right to recover contract damages and the right to receive benefits under statutory "social welfare" and "income maintenance" programs like the assigned claims plan. As the court put it in *Franks v White Pine Copper Range Co*, 422 Mich. 636, 654; 375 N.W.2d 715 (1985):

All the social welfare programs -- workers' compensation, unemployment compensation, social security old age, disability, and survivor's benefits, no-fault automobile benefits, aid to families with dependent children, and general assistance -- are directed to the same objective, income maintenance. All these programs are funded by impositions on employers and others of mandatory payments (to the government, insurers or, in the case of the self-insured, to the beneficiary), with statutorily prescribed benefits. (Emphasis added).

The MCPA does not apply to a claim for benefits under the assigned claims plan that is based on the absence of any insurance coverage for the accident vehicle, because (1) *no consumer transaction* is involved in such a claim to which the Michigan Consumer Protection Act can apply, nor (2) is an "insurer's" sale of an "insurance policy" involved to which Chapter 20's Unfair Trade Practices Act can apply. In the absence of a pol-

icy, a premium payment, an insurer, and an insured, there is no consumer transaction to which the MCPA and the UTPA can apply.

the insurer argued that because Gloria's claim was one for statutory benefits payable under the assigned claims plan, based on no policy of insurance, and involving no predicate consumer purchase transaction, Gloria could not invoke the MCPA.

Alternatively, Auto-Owners also argued that, in light of the MCPA's six-year limitations period, its requirement that claims be made within one year after the last payment, and its bar to actions based on conduct occurring after March 28, 2001, Plaintiff's MCPA claim against Auto-Owners was time-barred. Plaintiff's June 2013 complaint was not filed within one year of *Auto-Owners'* last payment, nor within six years after *Auto-Owners'* last serviced Gloria's claim, in August 1998. Auto-Owners contended that Plaintiff's implicit, though unarticulated, contention that *Citizens'* last payment, in 2013, could serve as a proxy "payment in a transaction" triggering a right of action under the MCPA *against Auto-Owners*, based on conduct that occurred *no later than August 1998*, was belied by Plaintiff's having named Auto-Owners and Citizens as separate defendants, and having included separate counts against each in her complaint. Therefore, Auto-Owners urged, the MCPA's six-year and one-year-after-the-last-payment limitations, MCL 445.911(7), barred Gloria's MCPA claims against Auto-Owners.

In her opinion and order in *Wilson, supra*, Judge Catherine C. Eagles, of the United States District Court for the Middle District of North Carolina, agreed with Auto-Owners' first alternative argument that the MCPA does not apply when the claimant has not purchased an insurance policy:

The MCPA prohibits more than 30 methods, acts, and practices "in the conduct of trade or commerce," *see* Mich. Comp. Laws § 445.903(1)(a)-(kk), some of which require a predicate consumer transaction. *See DiPiero v. Better Bus. Bureau of W. Mich., Inc.*, No. 316308, 2014 Mich. App. LEXIS 2319, 2014 WL 6679406, at *3 & n.1 (Mich. Ct. App. Nov. 25, 2014) (per curiam). In her complaint, Ms. Wilson lists eight prohibited acts she contends the defendants committed. (*See* Doc. 1 at ¶ 56.) The Court does not see how the conduct prohibited in § 445.903(1)(a), (c), and (e) would apply here. (*See* Doc. 1 at ¶ 56.) *The five other subsections Ms. Wilson cites require a transaction either by their plain language, (see* Doc. 1 at ¶ 56 (citing Mich. Comp. Laws

§ 445.903(1)(n), (x), (bb), (cc))), *or based on Michigan case law. See DiPiero*, 2014 Mich. App. LEXIS 2319, 2014 WL 6679406, at *4 (discussing Mich. Comp. Laws § 445.903(1)(s)).

A "transaction" under the MCPA "connotes the mutual and reciprocal acts typical of business deals that alter the legal relationships of the parties." *Id.* Here, there were no mutual or reciprocal acts between Ms. Wilson [Gloria's guardian] or Gloria and either defendant. The evidence is undisputed that Ms. Wilson applied to the Facility for PIP benefits, the Facility approved her request, and the Facility selected Auto-Owners to pay Gloria's benefits and later reassigned her claim to Citizens; *neither Ms. Wilson nor Gloria selected an insurer or negotiated or agreed to an amount of benefits.* (*See* Doc. 42-17 at 3; Doc. 42-16 at 5-6; Doc. 58-16 at 6-8, 17.) *Because there was no consumer transaction and because no other body of law allows these claims, Ms. Wilson's MCPA claims fail.* [*Wilson, supra*, at *26-*27 (emphasis added).]

Because the *Wilson* court held that the absence of a consumer transaction rendered the MCPA inapplicable, it was unnecessary for the court to address the MCPA statute of limitations and last-date-of-payment arguments that Auto-Owners had urged in the alternative. Instead, because the MCPA afforded no "back door" to prevent Auto-Owners from invoking *the No-Fault Act's* one-year statute of limitations and one-year-back rule, the court ruled that "the one-year-back rule limits Ms. Wilson's recovery to underpayments by Citizens since June 11, 2013 [the date the action was commenced]," and granted Auto-Owners' motion for summary judgment in its entirety. *Id.*, at 20.

Wilson was subsequently settled and dismissed with prejudice, so the unpublished decision in this case is the only known authority on the issue of whether a claim for Michigan No-Fault PIP benefits (in this case, an assigned claim) that is conditioned on the absence of No-Fault insurance can give rise to an MCPA claim. Nevertheless, though unpublished, Judge Eagles' decision is both persuasive and significant. Owing to (1) the decision in *Smith* allowing claims under Chapter 20 of the Insurance Code to be asserted under the MCPA, and (2) the decision in *Converse* holding the 2001 MCPA amendment to be non-retroactive, the No-Fault plaintiffs' bar has routinely employed an MCPA claim to reach back far beyond the No-Fault Act's one-year-back damage limitation to increase the value of the

claim and seek attorney fees recoverable under the MCPA. That theory of recovery, which is asserted only against *No-Fault* auto insurers, obviously subverts the *No-Fault Act's* cost containment objectives by allowing assigned claims to be reopened for assigned claim assessment years on which the books have long since been closed. The decision in *Wilson* appears to signal the demise of this tactic.

Implications of the Decision

More significantly, the same logic that precludes an MCPA claim in the absence of a "consumer transaction" in the assigned claim context also would seem to apply to similar claims arising in another No-Fault context: When, under the coverage priorities prescribed by MCL 500.3114 and 500.3115, an occupant or non-occupant of a motor vehicle is entitled to recover No-Fault benefits from a No-Fault insurer with which the claimant had no insuring relationship, or from which the claimant purchased no policy, it would seem that claims for No-Fault benefits allegedly unpaid or underpaid before March 28, 2001, may not simply be recast as MCPA claims. The same reasons for precluding MCPA claims that the *Wilson* Court cited in its decision in the context of an assigned claim would apply with equal force to claims asserted by non-insureds that are based solely on the No-Fault Act's priority provisions. Though such claims are not numerous, they are commonly large, because they typically involve catastrophically injured claimants who were receiving benefits before the 2001 MCPA amendments. Future cases will surely assess the continued validity of such claims in light of the reasoning of Judge Eagles' decision in *Wilson*. ■

About the Author

Frederick M. Baker, Jr., served as a Michigan Supreme Court Commissioner from January 2005 through May 2013. Before that, he was a partner for 19 years in Honigman's Lansing office, in a litigation practice that included extensive appellate work. As an adjunct professor, he taught insurance and conflicts at Cooley Law School, and insurance and no-fault insurance at MSU Law School. He was a member of the full-time faculty of both Wayne Law School (as an instructor of legal writing, research and advocacy) and Cooley Law School (as an assistant professor of contracts, civil procedure, and legal writing and research). He is now of counsel to Willingham & Cote, P.C.; his email address is Fbaker@willinghamcote.com, and his website address is www.fbakerlaw.com.

Endnotes

- 1 No.: 1:13-cv-470, 2014 U.S. Dist. LEXIS (M.D.N.C., Oct. 17, 2014).
- 2 MCL 445.901, *et seq.*

- 3 MCL 500.2001, *et seq.*
- 4 With local counsel, Walter Brock, the author represented Auto-Owners.
- 5 See *Smith v Globe Life Ins. Co.*, 460 Mich. 446, 466-467; 597 N.W.2d 28 (1999).
- 6 "(7) An action under this section shall not be brought more than 6 years after the occurrence of the method, act, or practice which is the subject of the action nor more than 1 year after the last payment in a transaction involving the method, act, or practice which is the subject of the action, whichever period of time ends at a later date." M.C.L. § 445.911(7).
- 7 Note that, while *Wilson* was pending, the legislature enacted an additional amendment to MCL 445.904(3), 2014 P.A. 251, which was effective 91 days after the legislature's adjournment *sine die* in 2014. The 2014 amendment applies retroactively, from March 28, 2001, to actions based on violations of Chapter 20, but it contains a savings provision for actions pending when it was adopted. The amendment, which consisted of the language italicized in the quotation that follows, thus did not apply to *Wilson* or other actions in which similar claims had been asserted:

(3) This act does not apply to or create a cause of action for an unfair, unconscionable, or deceptive method, act, or practice that is made unlawful by chapter 20 of the insurance code of 1956, 1956 PA 218, MCL 500.2001 to 500.2093, if either of the following is met:

(a) *The method, act, or practice occurred on or after March 28, 2001.*

(b) *The method, act, or practice occurred before March 28, 2001. However, this subdivision does not apply to or limit a cause of action filed with a court concerning a method, act, or practice if the cause of action was filed in a court of competent jurisdiction on or before June 5, 2014.*

The compiler's notes include 2014 P.A. 251's enacting section 2, which provides: "This amendatory act is curative and intended to prevent any misinterpretation that this act applies to or creates a cause of action for an unfair, unconscionable, or deceptive method, act, or practice occurring before March 28, 2001 that is made unlawful by chapter 20 of the insurance code of 1956, 1956 PA 218, MCL 500.2001 to 500.2093, that may result from the decision on the Michigan Supreme Court in *Converse v Auto Club Ins Co*, No 142917, October 26, 2012 [493 Mich. 877; 821 N.W.2d 679 (2012)]."

- 8 460 Mich 446, 466-467; 597 NW2d 28 (1999).
- 9 MCL 445.904(3).
- 10 Apparently for that reason, Plaintiff's complaint contained generic allegations that the "[t]he actions of Auto-Owners and Citizens that violated Chapter 20 of the Insurance Code occurred prior to March 28, 2001, including misrepresentations, deceptions, failure to disclose and respond fully and truthfully, failure to investigate properly, failure to make prompt payment, etc." (Emphasis added).
- 11 See *Converse v Auto Club Group Insurance Company*, 493 Mich. 877; 821 N.W.2d 679 (2012).

- 12 See *Schwein v State Farm Mutual Automobile Ins Co*, 2014 US Dist LEXIS 17404, *1-*2 (E.D. Mich., 2-12-14). The *Schwein* Court provides a concise summary of the judicial and legislative responses to *Smith* at pp. *4 -*6 of its opinion.
- 13 *Slobin v. Henry Ford Health Care*, 469 Mich. 211, 216; 666 N.W.2d 632 (2003) (emphasis added).
- 14 See MCL 500.3172(1), allowing a claim like Gloria's, "if no personal protection insurance is applicable to the injury."
- 15 MCL 445.902(1)(g) (emphasis added).
- 16 *Accord, Forton v Laszar*, 239 Mich. App. 711, 715; 609 N.W.2d 850 (2000) (the MCPA is a remedial statute designed to "protect consumers in the purchase of goods and services."), overruled on other grds, *Liss v Lewiston-Richards, Inc*, 478 Mich. 203; 732 N.W.2d 514 (2007); *Zine v Chrysler Corp*, 236 Mich. App. 261, 270-271; 600 N.W.2d 383 (1999) ("The intent of the act is 'to protect consumers in their purchases of goods which are primarily used for personal, family or household purposes.'...") (cited with approval in *Slobin*, 469 Mich. at 216) (emphasis added).
- 17 *Schwein v State Farm Mutual Automobile Ins Co*, 2013 US Dist LEXIS 123096, *8-*9 (E.D. Mich., 8-29-13).
- 18 *Slobin, supra. Harper v Mich. Mut. Tornado, Cyclone & Wind-storm Ins Co*, 173 Mich. 459, 463; 139 N.W.2d 27 (1912) (When "no contractual relations whatever existed between the parties" when the loss occurred, the claimant's contention that he was entitled to recover for his building was "not insurance ... [i]t is vicarious philanthropy") (emphasis added). See also, *Mirunczak v Michigan Farmers Mut. Fire Ins. Co.*, 293 Mich. 65, 70; 291 N.W. 224 (1940) (Potter, J., concurring).

Annual Meeting Election of Council Members

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**Property
Law
Note**

Statutory Appraisal Under a Fire Insurance Policy Issued in Michigan

By Jason Liss, *Fabin, Sklar & King, PC*

All fire insurance policies issued in the State of Michigan are governed by statute and required to contain certain mandatory provisions.¹ One such provision is the “appraisal” clause.² The purpose of the appraisal clause is to provide an inexpensive mechanism for the resolution of disputes between insurers and insureds when the parties fail to agree on the value of a loss.

Appraisal as Arbitration

The term “appraisal” can be confusing to practitioners who do not regularly handle property insurance claims since the term evokes the notion of the fair market appraisals commonly used for mortgages and other real estate transactions. In the context of property insurance claims however, “appraisal” is a term of art used to describe a process akin to common law arbitration. Courts have described it as a “substitute for judicial determination of the amount of a loss [and] a simple and inexpensive method for the prompt adjustment and settlement of claims.”³

Generally, insurers are required to pay losses under fire insurance policies within 30 days after receipt of proof of the amount of the loss.⁴ If the insurer or the insured disputes the amount of the loss, either may demand appraisal to settle the dispute. In the author’s nearly 20 years of experience handling first party property insurance matters, an insurer that has accepted liability for a loss will usually pay its calculation of the loss, leaving the insured to demand appraisal if the amount paid is unacceptable.

The Demand and Appointment of Appraisers and Umpire

A demand for appraisal must be in writing and should identify the appraiser(s) selected by that party. Depending on the claims involved, it may be necessary for a party to appoint more than one appraiser. For example, a complex commercial fire loss may require separate appraisers for the building, personal property and business income losses; each bringing with them their own specialized knowledge.

Under the statute, the other party has 20 days to select its appraiser after receiving a written demand for appraisal. Once selected, the appraisers choose an umpire to act as the impartial member of the panel and preside over the proceedings. If the appraisers are unable to agree on an umpire, either party may file an action in the circuit court for the county in which

the loss occurred and request the judge assigned to the case to appoint an umpire. This is a simple process which includes an initial pleading advising the court of the particulars of the matter and the requested relief. The initial pleading is then followed by a motion to appoint an umpire. Each party pays the cost of its appraiser and one-half the cost of the umpire.

Depending on the nature of the dispute and the circumstances giving rise to the demand for appraisal, the appraisers and umpire on the panel may consist of contractors, adjusters, accountants, lawyers or a combination of these.

The Process Followed by the Panel

Once the panel is selected, the parties’ appraisers meet to discuss the loss. The written agreement of any two of the three panel members will result in a binding award. Accordingly, if the two independent appraisers are able to reach an agreement between themselves, they may enter a binding award without ever having to involve the umpire. If, however, they fail to agree, then it will be necessary for them to submit their differences to the umpire who, in one manner or another, will be the decider. In his concurring opinion in *White v State Farm Fire & Casualty Co*, Judge Douglas Shapiro aptly described the dynamic of an appraisal panel:

In an appraisal, the two party-selected appraisers, through argument and compromise, attempt to reach a resolution of the claim that they both believe is reasonable. If that cannot be accomplished, then the umpire either induces them to bridge their differences or makes the decision himself with one of the two party-selected appraisers providing the second vote.⁵

The rules of evidence do not apply to the appraisal process and the independent appraisers are free to introduce, and the umpire is free to consider, any evidence they wish. Because the appraisal process has been held to be akin to common law arbitration, judicial review of an appraisal award is limited to instances of bad faith, fraud, misconduct, or manifest mistake.⁶

The Award

In most instances, the appraisal award will simply identify a category of loss and a dollar amount. These figures represent the amount of loss for each category at issue irrespective of coverage limits, deductibles, and prior payments. Accord-

ingly, the appraisal award does not necessarily represent the amount that is owing to the insured. Rather, the insurer applies the terms, limitations and conditions of the policy, as well as any prior payments, to the appraisal award to calculate the amount that is owing. If necessary, the appraisal award may be reduced to a judgment.

Scope of the Appraisal Does Not Include Coverage Disputes

The purpose of appraisal is to resolve disputes as to dollar values only. The appraisal panel is not authorized to resolve coverage disputes. Any disputes as to coverage generally should be resolved by a court before appraisal occurs.⁷

Appraisal is an effective process to resolve disputed values in first party property insurance claims; and, in the majority of cases it is a relatively inexpensive and expedient process. ■

Endnotes

- 1 MCL 500.2833; also see MCL 500.2806 and MCL 500.2860.
- 2 MCL 500.2833(1)(m).
- 3 *Auto-Owners Ins. Co. v. Kwaiser*, 190 Mich. App. 482, 486, 476 N.W.2d 467, 469 (1991) (internal quotation and citation omitted).
- 4 MCL 500.2836(2).
- 5 293 Mich App 419, 431, 809 NW2d 637, 643 (2011).
- 6 *Kwaiser, supra.* at 486, 476 NW2d 467.
- 7 *Id.* at 487.

Business Court Report



By Kassem Dakhallah, AT Law Group PLLC

Scao Issues New Case Code For Business Court Cases

Effective June 1, 2015, all claims in which all or part of the action includes a business or commercial dispute under MCL 600.8035 must be filed with a “CB” case code. The CB case code used to be reserved for all claims involving partnership termination and other business accounting. These partnership termination and business accounting matters fall within the business court’s jurisdiction, so they will remain under the CB case code.

In addition, to help identify business cases at the time of filing, a check box option has been added to the Summons and Complaint (form MC 01) to allow the filer to designate the case accordingly.

Note: Practitioners are well-advised to determine prior to filing whether a case belongs in the business court. By statute, the business court has exclusive jurisdiction over business or commercial disputes. Thus, practitioners who cause or allow a case to be litigated to conclusion on the general civil docket rather than in the business court run the risk of obtaining a judgment that lacks finality.

Statute of Limitation in Breach of Contract Matter Not Tolled during Permissive Grievance Procedure

Court: Oakland County, Hon. James M. Alexander

Case: *Blue Cross Blue Shield of Mich. Mut. Ins. Co., v Atallah*

Heart Center, P.C., No. 14-143430-CK

Date: April 1, 2015

Issue: Is a breach of contract matter equitably tolled during a party’s pursuit of permissive administrative processes?

Ruling: Plaintiff requested that equitable tolling apply while the parties were involved in Department of Insurance determination. Plaintiff claims that Defendants elected to pursue this appeals review process on June 12, 2009 and the process did not conclude until December 2013, when the Department of Insurance Regulation entered a final determination. The court held that the doctrine of equitable tolling has been recognized by Michigan courts; however it has a limited application. A limited time this applies is “when grievance procedures are mandatory – [then] the applicable period of limitations is tolled during the exhaustion of the mandatory procedure.” *Chabad-Lubavitch of Mich v Schuchman*, 305 Mich App 337; 853 NW2d 390 (2014). The operative language in the contract between the parties was:

“Disputes arising under this AGREEMENT may be appealed as follows.

“Disputes may be appealed to the Michigan Insurance Bureau or the Courts of this state.”

Finding that this language is permissive and not mandatory,

the Court refused to toll the statute of limitations for Plaintiff to bring a breach of contract matter during the time that the case was before the Department of Insurance.

Note: It is surprising how many cases are lost because a party fails to appreciate key contractual language.

Attorney fee award that is two-thirds of
verdict amount is proper

Court: Kent County, Hon. Christopher P. Yates

Case: *Naturipe Foods, LLC, v Siegel Egg Co., Inc.*, Case No. 12-10585-CKB

Date: April 3, 2015

Issue: Whether an attorney fee award of over \$200,000 was reasonable in a case where the jury verdict in favor of the plaintiff was slightly more than \$300,000.

Ruling: Pursuant to Michigan law, attorney fees generally “are not recoverable as an element of costs or damages unless expressly allowed by statute, court rule, common-law exception, or contract.” *Marilyn Froling Revocable Living Trust v Bloomfield Hills Country Club*, 283 Mich App 264, 297 (2009). Here, however, the parties’ contract provides Plaintiff Naturipe with the right to attorney fees.

Having found that the Plaintiff is entitled to an attorney fee award, the court bears an obligation to review the attorney-fee request for “reasonableness” under *Smith v Khouri*, 481 Mich 519 (2008). Under *Smith*, the Court first must determine a “reasonable hourly rate” that “represents the fee customarily charged in the locality for similar legal services[.]” *Smith*, 481 Mich at 531. The court next must establish “the reasonable number of hours expended in the case.” *See Smith*, 481 Mich at 531. Finally, the court must weigh several “factors to determine whether an up or down adjustment is appropriate.” *See Smith*, 481 Mich at 531.

The court undertook an analysis of these factors and determined that an attorney fee award of over \$200,000 was reasonable in this case, where the jury verdict was just over \$300,000.

Note: One of the main purposes of the business court is to quickly and economically resolve business disputes. Apparently, the defendant in this case would have been wise to take seriously the early settlement efforts employed by the business court. ■

About the Author

Kassem Dakhlallah is a senior partner and supervising attorney with At Law Group PLLC in Dearborn. Kassem is a Wayne County Circuit Court Business Court case evaluator and mediator. Kassem is also a board member of the Detroit Metropolitan Bar Association Barristers. Kassem is a Super Lawyer – Rising Star for 2014 in the Business Litigation category. Kassem’s

Announcement

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**Insurance
Case
Summary**



Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell*; Deborah.hebert@ceflawyers.com

Michigan Court Of Appeals – Published

Insurer's Termination of Agency Agreement Upheld

Beckett-Buffum Agency, Inc v Allied Property & Cas Ins Co
____ Mich App ____ (2015)
Docket No. 321273

Allied Property and Casualty properly terminated its Independent Agency Agreement with plaintiff for failure to produce a sufficient number of new insurance applications. The Insurance Code, MCL 500.1209(2)(e), expressly allows insurers to terminate a producer's authority when the producer submits "less than 25 applications for home insurance and automobile insurance within the immediately preceding 12-month period." Policy renewals do not count as applications.

Cgl Policy Covers Non-Profit Insured's Dram Shop Liability

Auto-Owners Ins Co v Olympia Entertainment, Inc
____ Mich App ____ (2015), app lv pending
Docket No. 315891

Auto-Owners issued a CGL policy to the insured non-profit corporation organized for charitable purposes. The insured sponsored a beer tent at the Detroit Hoedown Festival and was subsequently sued on a dram shop claim. This CGL policy excluded coverage for liquor liability but "only if you are in the business of manufacturing, distributing, selling, serving or furnishing alcohol beverages." Because the non-profit operated the beer tent as a fund-raiser and was not otherwise engaged in the business of selling or serving alcohol, the exclusion did not apply.

The court also considered and rejected Auto-Owner's reliance on the contractual liability exclusion to deny coverage for the insured's indemnity obligations in connection with the event. The Court found that the insured's agreement to indemnify others fit within the "insured contract" exception because the agreement was related to the insured's business, with the term "business" referring to the insured's entire operations, not just the beer tent fundraiser.

Sixth Circuit – Published Opinion

Disability Insurance And "The Important Duties" of an Occupation

Leonor v Provident Life & Accident Co.
____ F 3d ____ (6th Cir. 2015)

Case No. 14-2120, 2152

Disability policy was triggered for dentist whose disability precluded him from performing dental procedures, despite the fact that he was able to continue managing the dental practice as well as other businesses. The policy promised "total disability benefits" where the insured became unable to perform "the important duties" of his occupation. Because this language could be read to mean an inability to perform *most* of the important duties and not *all* of the important duties, coverage applied. Insurance policy terms that can be reasonably understood in two different ways are ambiguous and must be construed and applied in favor of the insured.

Michigan Court Of Appeals – Unpublished

Property Damage Limited to Residence Premises

Banks v Auto Club Group Ins Co
Unpublished Court of Appeals opinion as of June 18, 2015
(Docket No. 320985)

Homeowners insurer properly denied coverage for this fire-damaged home because the named insureds did not reside there. Its policy limited coverage for property damage to the "residence premises," which meant the named insureds had to be using the home as their private residence at the time of loss. Here, the home was being occupied by the insureds' son. The insurer also properly denied coverage for the personal property of the son and his wife because they were not members of the named insureds' household.

Actions Against Pip Insurers Where Medicare has Paid Benefits

Holmes v Farm Bureau General Ins Co
Unpublished Court of Appeals opinion as of May 19, 2015,
app lv pending
(Docket No. 320723)

Where a Michigan no-fault policy is not a coordinated policy, the insured may sue to recover PIP benefits even if the medical bills have been paid by Medicare. 42 USC 1395(y)(b)(3)(A) creates a private cause of action for individuals to recover amounts owed for medical expenses already paid by Medicare to encourage lawsuits that will lead to reimbursements for Medicare. The court rejected Farm Bureau's argument that a prior judicial determination or settlement is required prior to filing these lawsuits.

Occurrence-Based Liability Coverage Does Not Apply to Failure to Maintain Premises

Auto-Owners Ins Co v. NHYOF

Unpublished Court of Appeals opinion as of May 7, 2015
(Docket No. 320256)

The landlord's occurrence-based liability policy did not provide coverage for a tenant's lawsuit in failing to maintain the premises in safe condition. The tenant's bodily injury was the result of a rape by a third party, which was not an accident.

Duties of Independent Agents

Janndorbas Enterprises, LLC v Walker Ins Agency

Unpublished Court of Appeals opinion as of April 16, 2015
(Docket No. 320010)

The policyholder's claims against an insurance agency failed as a matter of law because the policyholder's ACORD application did not obligate the agency to advise the insured that it was purchasing ACV coverage rather than full replacement coverage. Nor did the agency have a duty to see that the insured received adequate coverage. Michigan law does not recognize an affirmative duty on the part of independent agents to consult with and advise insureds on the adequacy of coverage.

Landlord's Property Insurer Subrogation Rights Against Tenant's Liability Insurer

Markel American Ins Co v Gates

Unpublished Court of Appeals opinion May 28, 2015
(Docket No. 320587)

A tenant in an apartment building caused a fire that damaged both the building and the personal property of other tenants. That tenant's liability insurer interpleaded the full

\$50,000 in liability coverage for distribution among the claimants, which included the building owner (for its deductible) as well as its property insurer, and the two tenants whose personal property was destroyed in the fire. The trial court refused to consider the building insurer's claim but the Court of Appeals reversed and remanded. As subrogee of the building owner, the property insurer had the right to be included on the pro rata distribution of funds.

Pip - Alighting From a Vehicle

State Farm Mutual Auto Ins Co v Farm Bureau General Ins Co

Unpublished Court of Appeals opinion May 19, 2015
(Docket No. 321539)

In this PIP priority dispute, coverage turned on whether the injured party was an occupant of a parked vehicle or had already completed the process of alighting when he was injured. The court affirmed the trial court's decision that the issue was a question of fact for the jury and affirmed the jury's finding that the injured party had completed the process of alighting. The trial court properly instructed the jury on the meaning of "alighting" per the Court of Appeals decision in *Frazier v Allstate Ins Co*, 490 Mich 381 (2011).

UIM Coverage

Sutton v Williams

Unpublished Court of Appeals opinion June 18, 2015
(Docket No. 320090)

In this UIM case, the statutory owner of the vehicle had liability coverage in excess of the UIM coverage, but the court would not grant summary disposition to the UIM insurer because it did not have a copy of the UIM policy and was therefore uncertain whether the owner's liability statute controlled. ■



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No-Fault
Corner

The “Innocent Third Party” Rule Remains Alive, as Applied to Michigan Pip Claims . . . But for How Long?

Ronald M. Sangster, Jr.

Law Office of Ronald M. Sangster, rsangster@sangster-law.com

A few issues back, I wrote an article entitled “*Is the “Innocent Third Party” Rule Dead as Applied to Michigan PIP Claims?*” The article was prepared in response to a number of comments from no-fault practitioners who asked whether the Michigan Supreme Court’s holding in *Titan Ins Co v Hyten*, 491 Mich 547, 817 NW2d 562 (2012) could be extended into the realm of PIP claims. Regular readers of this article will recall that in *Hyten*, the Supreme Court held that a no-fault insurer could avail itself of traditional common law remedies, including rescission or reformation, where an insurance policy had been procured through fraud in the insurance application. *Hyten*, of course, dealt with a situation where the insurer attempted to reform its bodily injury policy limits of \$100,000.00/\$300,000.00 to the statutorily required minimum policy limits of \$20,000.00/\$40,000.00, based upon the misrepresentation in Ms. Hyten’s insurance application regarding the status of her driver’s license.

As noted in the previous article, the Michigan Court of Appeals, in *Frost v Progressive Michigan Ins Co*, docket no. 316157, unpublished decision rel’d 9/23/2014, the Court of Appeals concluded that the no-fault insurer could rescind coverage based upon the fraudulent misrepresentations of its insured, even though an “innocent third party” (the applicant’s 10-year-old daughter) could no longer recover PIP benefits through Progressive. Instead, the “innocent third party” would need to (and did) avail herself of no-fault benefits through the Michigan Assigned Claims Plan, which had assigned Citizens Insurance Company to handle the claim for benefits. In that case, the insured falsely represented that she lived in Eastpointe, when she applied for insurance through Progressive, when in fact she lived in Detroit. The Court of Appeals sent the matter back down to the Wayne County Circuit Court to allow Progressive to establish proper grounds for rescission.

Counsel representing Progressive Michigan Insurance Company asked the Court of Appeals to publish its decision, given the fact that it dramatically altered prior practice regarding PIP benefits for “innocent third parties.” The Court of Appeals denied this request. Citizens Insurance Company, the Michigan Assigned Claims Plan insurer, subsequently filed an Application for Leave to Appeal with the Michigan Supreme Court.

While Citizens’ application for leave to appeal in *Frost* was pending, another panel of the Court of Appeals ruled that a

no-fault insurer could *not* rescind coverage as to an “innocent third party” – reaching the opposite conclusion from the *Frost* panel. In *State Farm v Michigan Municipal Risk Mgmt Authority*, docket no. 319709, unpublished decision rel’d 2/19/2015, a motorcyclist was struck by an uninsured motor vehicle that was being chased by a Parchment Police vehicle. The vehicle that collided with the motorcyclist was owned by one Whitney Gray. Whitney Gray was the statutory “owner” of another motor vehicle, not involved in the accident, which was insured by QBE. State Farm, as the motorcyclist’s personal motor vehicle insurer under MCL 500.3114(5)(c) filed suit against QBE, arguing that QBE occupied a higher order of priority as the insurer of the “owner” of the motor vehicle involved in the accident with the motorcyclist. State Farm also filed suit against the insurer of the Parchment Police vehicle, Michigan Municipal Risk Management Authority (MMRMA), arguing that the police vehicle was likewise “involved” in the accident with the motorcyclist.

QBE argued that it was entitled to rescind the policy because Gray had supplied false information in the insurance application regarding ownership and registration of the vehicle. QBE asserted that if it had known that its insured was not the titled owner or registrant of the motor vehicle, it never would have issued the policy. The lower court denied QBE’s Motion for Summary Disposition and QBE filed an Interlocutory Appeal, which was granted by the Court of Appeals.

in *Hyten*, the Supreme Court held that a no fault insurer could avail itself of traditional common law remedies, including rescission or reformation, where an insurance policy had been procured through fraud in the insurance application.

In affirming the lower court’s decision, the Court of Appeals referenced a number of prior decisions that held that a no-fault insurer’s ability to rescind a policy “ceases to exist once there is a claim involving an innocent third party,” citing *Katinsky v ACIA*, 201 Mich App 167, 505 NW2d 895 (1993) and *Darnell v Auto-Owners Ins Co*, 142 Mich App 1, 369 NW2d 243 (1985). With regard to QBE’s argument that the “Innocent Third Party” Doctrine was abrogated by

the Supreme Court's decision in *Hyten*, the Court of Appeals disagreed with this interpretation and noted:

“In *Titan*, our Supreme Court held that an excess insurance carrier may avail itself of the equitable remedy of reformation (of contract) to avoid liability under an insurance policy on the ground of fraud in the application for insurance, even though the fraud was easily ascertainable and the claimant is a third party, so long as the remedies are not prohibited by statute.

Bongers's entitlement to PIP benefits is statutory, however, not contractual. See *Harris v ACIA*, 494 Mich 462, 472; 835 NW2d 356 (2013); MCL 500.3114(5). The insurer in *Titan* did not seek to avoid payment of statutorily mandated no-fault benefits; in fact, that insurer acknowledged its liability for the minimum liability coverage limits. . . . Nor did *Titan* address a claim for PIP benefits for an innocent third party. Thus, the holding of *Titan*, that an insurance carrier may seek reformation to avoid liability for *contractual* amounts in excess of statutory minimums, does not compel a finding that *Titan* overruled the many binding decisions of this Court applying the ‘innocent third-party rule’ in the context of PIP benefits and an injured third party who is statutorily entitled to such benefits. QBE has provided this Court with no authority for the proposition that *Titan* overruled these decisions. We therefore affirm the trial court's denial of summary disposition in Docket No. 319710 relative to the ‘innocent third-party rule.’ ”

It is unclear whether the court's earlier, unpublished decision in *Frost* was brought to the panel's attention or not. Because *Frost* was unpublished, and therefore not binding, it may not have made a difference in the long run. Michigan Municipal Risk Management Authority filed an application for leave to appeal to the Michigan Supreme Court in mid-March 2015, which remains pending as of the date this article is being prepared.

So where do matters stand now? Given the Supreme Court's order vacating the Court of Appeals' prior unpublished opinion, issued on September 23, 2014, it appears that the “Innocent Third Party” rule is very much alive, with regard to claims for Michigan PIP benefits – at least for the time being

Speaking of *Frost*, on March 31, 2015, the Michigan Supreme Court issued an Order regarding Citizens' Application for Leave to Appeal. In its Order, the Supreme Court vacated the September 23, 2014, Judgment of the Court of Appeals and remanded the matter back to the Court of Appeals for reconsideration. The Supreme Court's Order, in its entirety, is reproduced below:

“On order of the Court, the application for leave to appeal the September 23, 2014, judgment of the Court of Appeals is considered and, pursuant to MCR 7.302(H)(1), in lieu of granting leave to appeal, we VACATE the judgment of the Court of Appeals, and we REMAND this case to the Court of Appeals for reconsideration of the intervening plaintiff's issue of whether the insurance policy issued by the defendant can be voided *ab initio*. On remand, the Court of Appeals shall hold this case in abeyance pending its decision in *Bazzi v Sentinel Ins Co* (Court of Appeals Docket No. 320518). After *Bazzi* is decided, the Court of Appeals shall reconsider the intervening plaintiff's issue in light of *Bazzi*.”

Sentinel Insurance Company's Brief on Appeal, arguing in favor of a total rescission of the policy (which would require the MACP insurer to handle the claim for PIP benefits filed by the “innocent third party”) was filed in early June. The MACP insurer, Citizens' Insurance Company, is scheduled to file its brief on appeal sometime in early August, 2015. Given these timelines, oral argument probably will not be scheduled until sometime in early 2016.

So where do matters stand now? Given the Supreme Court's order vacating the Court of Appeals' prior unpublished opinion, issued on September 23, 2014, it appears that the “Innocent Third Party” rule is very much alive, with regard to claims for Michigan PIP benefits – at least for the time being. However, if no-fault practitioners encounter a situation involving an “innocent third party,” where the underlying policy may have been procured by fraud, it may be prudent to place the Michigan Assigned Claims Plan on notice of this issue within one year from the date of loss. If, in the end, an appellate court rules that a no-fault insurer is entitled to completely rescind coverage under a fraudulently procured insurance policy, even though an “innocent third party” may be affected, the “innocent third party” will still continue to receive their benefits through the Michigan Assigned Claims Plan.

New Legislation

In late 2014, the lame duck legislature passed two bills which amend the Michigan No-Fault Insurance Act in a number of important respects. These recent enactments will be discussed separately below.

2014 PA 489**Modification of “Unlawful Taking”**

Public Act 489, effective January 13, 2015, modifies the “Unlawful Taking” exclusion set forth in MCL 500.3113(a) and the Non-Resident exclusion set forth in MCL 500.3113(c). It also adds a new exclusion for “Named Excluded Drivers.”

The “Unlawful Taking” exclusion now reads:

“A person is not entitled to be paid personal protection insurance benefits for accidental bodily injury if at the time of the accident any of the following circumstances existed:

(a) The person was willingly operating or willingly using a motor vehicle or motorcycle that was taken unlawfully, and the person knew or should have known that the motor vehicle or motorcycle was taken unlawfully.”

This enactment appears to have been taken in response to the Michigan Supreme Court’s decision in *Rambin v Allstate Ins Co*, 495 Mich 316, 852 NW2d 34 (2014), where plaintiff claimed that he did not know the motorcycle that he was riding had been stolen. The action also appears to have been taken in response to a number of earlier Court of Appeals decisions where passengers who were occupants of a stolen vehicle would be able to claim benefits by simply claiming that they were not involved in the “unlawful taking” of the vehicle. Now, passengers who are riding in a vehicle with, say, a punched out ignition switch (or other tell-tale signs of a stolen vehicle) will be barred from recovering No-fault benefits.

The amendment to MCL 500.3113(c) was designed to legislatively reverse the Court of Appeals’ decision in *Perkins v Auto-Owners Ins Co*, 301 Mich App 658, 837 NW2d 32 (2013). In *Perkins*, a Kentucky motorcyclist was operating his motorcycle in the State of Michigan when he was involved in an accident with a Michigan resident insured by Auto-Owners Insurance Company. Perkins’ motorcycle was insured by Progressive Northern Insurance Company, which did not file a certification under MCL 500.3163(1) or (2). However, Mr. Perkins owned a motor vehicle in Kentucky that was insured with State Farm. The prior version of MCL 500.3113(c) precluded recovery of Michigan no-fault benefits if:

“The person who is not a resident of this state, was an occupant of a motor vehicle or motorcycle not registered in this state, and was not insured by an insurer which has filed a certification in compliance with §3163.”

In *Perkins*, the Court of Appeals held that the term “insurer,” as utilized in the last clause of MCL 500.3113(c), modified the noun “the person” which appears at the beginning of the statute. Therefore, because the “person” (Perkins) was “in-

sured by an insurer which has filed a Certification in compliance with §3163” (State Farm), Perkins was eligible to recover Michigan no-fault insurance benefits.

This holding has now been overruled, and the insurance requirement is now tied to the specific vehicle being operated by the non-resident. The current version of MCL 500.3113(c) now precludes Michigan no-fault benefits if:

“The person was not a resident of this state, was an occupant of a motor vehicle or motorcycle not registered in this state, and the motor vehicle or motorcycle was not insured by an insurer that has filed a certification in compliance with §3163.”

Accordingly, the loophole created by the legislature, when it originally drafted MCL 500.3113(c) has now been closed.

Named Excluded Operator

Finally, 2014 PA 489 adds an entirely new exclusion. This amendment precludes an individual from recovering Michigan no-fault insurance benefits if:

“The person was operating a motor vehicle or motorcycle as to which he or she was named as an excluded operator as allowed under §3009(2).”

This provision is designed to legislatively overrule Insurance Bulletin 79-11, where the Insurance Commissioner had ruled that except for owners of motor vehicles who designated themselves as a “Named Excluded Driver” under the policy, the “Named Excluded Driver” provision could not be used to preclude a claim for no-fault benefits incurred by that “Named Excluded Driver.” As a result, youthful drivers who may have been using the family vehicle under which they were designated as a “Named Excluded Driver” could still recover no-fault benefits (assuming that they were not regular operators of that vehicle) even the insurer would not be obligated to afford liability coverage for any accidents involving that vehicle. In light of this amendment, anyone who is operating a motor vehicle while a “Named Excluded Driver” is now barred from recovering PIP benefits, regardless of how often they were operating the motor vehicle.

Again, these changes took effect on January 13, 2015.

2014 PA 492

This legislative enactment added a number of new definitions to the No-Fault Insurance Act. These changes likewise took effect on January 13, 2015. As a result, certain devices which can be operated on a public highway and which are powered by something other than muscular power are no longer considered to be “motor vehicles.” Furthermore, this legislation adds a statutory or constructive “ownership” definition for motorcycles. Each of these provisions will be analyzed below.

Golf Carts, Mobility Devices and Quadricycles

No-fault practitioners are already aware that a “motor vehicle” does not include motorcycles, mopeds, farm tractors or other implements of husbandry, or ORVs. Three more items have been added to the list of things that are not “motor vehicles” under the Michigan No-Fault Insurance Act, and are thus not required to be insured if they are operated on the public highways of this state. These additional items include golf carts, “power-driven mobility devices” and “commercial quadricycles.” See MCL 500.3101(2)(h)(v), (vi) and (vii). A “golf cart” is defined as “a vehicle designed for transportation while playing the game of golf.” See MCL 500.3101(2)(c). A “power-driven mobility device” is defined as “a wheelchair or other mobility device powered by a battery, fuel, or other engine and designed to be used by an individual with a mobility disability for the purpose of locomotion.” See MCL 500.3101(2)(l). Finally, a “commercial quadricycle” is defined as a vehicle which has “fully operative pedals for propulsion entirely by human power,” has “at least four wheels and is operated in a manner similar to a bicycle” and is powered “either by passenger providing pedal power to the drive train of the vehicle or by a motor capable of propelling the vehicle in the absence of human power.” See MCL 500.3101(2)(b).

“Owner” of a Motorcycle

With regard to the definition of the term “owner,” previously set forth in MCL 500.3101(2)(h)(i), the provision regarding those individuals who “have the use” of a motor vehicle for

a period of time greater than thirty days remains unchanged, except for being re-designated as MCL 500.3101(2)(k)(i). This definition of the term “owner” is reproduced below:

“A person renting a motor vehicle or having the use of a motor vehicle, under a lease or otherwise, for a period that is greater than 30 days.”

However, with regard to *motorcycles*, the legislature added the following definition, which provides more specificity regarding the criteria used to determine whether or not one is a statutory or constructive “owner” of a *motorcycle*:

“A person renting a motorcycle or having the use of a motorcycle under a lease for a period that is greater than 30 days, or otherwise for a period that is greater than 30 consecutive days. A person who borrows a motorcycle for a period that is less than 30 consecutive days with the consent of the owner is not an owner under this subparagraph.”

This provision legislatively overrules the Court of Appeals’ earlier decision in *Auto Owners v Hoadley*, 201 Mich App 555, 506 NW 2d 595 (1993), which held that the only “owner” of a motorcycle was one who “holds the legal title” to the motorcycle. This was because prior to therecent amendment, the “having the use” definition of the term “owner” pertained only to “motor vehicles” and, as we all know, motorcycles are not “motor vehicles” for purposes of the No-Fault Insurance Act.

Again, these new definitions took effect on January 13, 2015. ■

ERISA Case Summary



ERISA Decisions of Interest

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United States Supreme Court Update

Trust Law Principles Should be Applied to Determine if Fiduciary Committed Breach with Respect to Investment Options

Tibble v. Edison Int’l, Inc., 135 S. Ct. 1823 (May 18, 2015)

As we wrote last time, the Supreme Court granted a petition for *writ of certiorari* in a case from the Ninth Circuit Court of Appeals to hear the question of whether ERISA plan fiduciaries breached their duty of prudence by continuing to offer higher-cost retail-class mutual funds to plan participants, even though identical lower-cost institution-class mutual funds later became available. Justice Breyer delivered

the opinion for the unanimous Court, holding that the Ninth Circuit erred and remanding the case.

Under the applicable ERISA statute of limitations, a breach of fiduciary duty complaint is timely if filed no more than six years after “the date of the last action which constituted a part of the breach or violation” or “in the case of an omission the latest date on which the fiduciary could have cured the breach or violation.” 29 U.S.C. §1113. The plaintiffs argued that the plan fiduciaries, who convened on a quarterly basis to review plan investments, had an ongoing duty to review prior decisions, and make modifications as appropriate. The Ninth Circuit affirmed the trial court’s holding that the plaintiffs’ claims were barred by the statute of limitations because the

fiduciaries initially chose the plan investments more than six years before the claim was filed, and there was no evidence of a change in circumstances that triggered an obligation to review the initial investment decision.

The question considered by the High Court was whether a fiduciary's allegedly imprudent retention of an investment is an "action" or "omission" that triggers the running of the 6-year limitations period. The court concluded that the Ninth Circuit erroneously based its decision solely on the initial selection of the funds and failed to apply principles of trust law to the role of the fiduciary's duty of prudence.

The court and the parties agreed that the duty of prudence under trust law involves a continuing duty to monitor investments and remove imprudent ones. However, the court expressly declined to decide whether a review of the contested mutual funds was required in this case, and, if so, just what kind of review, offering little practical guidance from the final holding.

Cert denied in "Would Have/Could Have" Breach of Fiduciary Dispute

RJR Pension Investment, et al. v. Tatum, Case no. No. 14-656, 2015 WL 2473481 (June 29, 2015)

The High Court denied *certiorari* in a case decided by a divided panel of the Fourth Circuit which held that because the plaintiff proved the plan fiduciaries acted imprudently by liquidating the stock fund without the benefit of a proper investigation, the burden of proof shifted to defendants to show that a prudent fiduciary *would* have made the same decision. In contrast, the lower court found in favor of the defendants after they demonstrated that a prudent fiduciary *could* have made the same decision.

At the Court's invitation, the Solicitor General filed an *amicus* brief, encouraging the Court not to review the questions presented, arguing that the Fourth Circuit correctly decided the issue and that there was no Circuit split to resolve.

Although the Supreme Court did not rule on the issue, the implication is that the Court approved of the Fourth Circuit's "would have" holding, such that an imprudent fiduciary bears the burden of proving that, after an adequate investigation, a prudent fiduciary would have objectively reached the same investment decision.

Sixth Circuit Court of Appeals Update

Existence of ERISA plan is not jurisdictional, insured's claim was not time-barred, and administrator's decision was not arbitrary and capricious.

Russell v Catholic Healthcare Partners Employee Long Term Disability Plan, 2015 WL 3540997 (6th Cir., June 8, 2015)

In *Russell*, the Sixth Circuit, following *Daft v Advest, Inc.*, 658 F3d 583 (6th Cir. 2011), first held that "the existence of a

ERISA plan is a nonjurisdictional element of Plaintiff's ERISA claim." Thus, the insured forfeited the argument she tried to raise on appeal, which was that the plan was a "church plan" under 29 U.S.C. §1132(e)(1), and that the district court's adverse decision was without jurisdiction.

Russell then held that because the administrator's denial letter "did not include notice of the time limit for Plaintiff to seek judicial review," the "plan's time limit cannot foreclose judicial review of the merits of Plaintiff's claim."

Lastly, *Russell* noted that although the "usual procedure when an insurance company fails to comply with" the notice requirement "is that the substantive claim should be remanded to the appropriate body for review," the district court summarily held that the administrative decision was not arbitrary and capricious, and the parties fully briefed the substantive claim on appeal. Therefore, the panel in *Ross* held that it could properly decide the merits of the claim on appeal.

On the merits, *Russell* concluded that "[g]iven that both of Plaintiff's treating physicians found her to be capable of sedentary/seated work immediately before Defendant terminated benefits, we cannot say that the termination was arbitrary and capricious."

United States District Court Update

Administrator's termination of benefits based on plan's 24 month limitation for "Mental or Nervous Disorders" reversed on *de novo* review.

Ross v Reliance Standard Life Ins Co, 2015 WL 3559876 (WD Mich, June 5, 2015).

The disability benefit plan in *Ross* limited benefits to 24 months for disabilities that were "caused by or contributed to by mental or nervous disorders," which included depressive, anxiety and somatoform disorders. The insured became unable to work as a forklift operator after he began "shaking all over," a condition that had "come on gradually over the past 1-2 years," and which was accompanied by pain, inability to sleep, loss of balance, and memory loss. His doctor diagnosed him with "neurologic disorder, tremor." Reliance notified the insured that benefits would end after 24 months because "it appears that your primary diagnosis is that of a mental or nervous disorder."

The insured sued, and Reliance argued that (1) the insured did not have any organic neurological disorder, (2) that he had a "nonorganic psychogenic tremor" and a likely "somatization disorder," and (3) even if he had an organic disorder, his disability was "contributed to by" depression and anxiety.

The insured argued that (1) Reliance relied on no competent medical opinion tying his disability to a mental or nervous disorder, and (2) even if it had done so, Reliance failed to demonstrate that the insured's disability was "caused by or contributed to by" a mental or nervous condition, as opposed to having arisen as a by-product of his disability.

The district court reversed Reliance's administrative decision. It first held that the medical opinions upon which Reliance relied did not *establish* that the insured had a nonorganic nervous or mental condition, but instead only equivocally posited that a somatization disorder was a "very reasonable diagnosis" of the insured's condition. In contrast, the court found, the insured's physicians said he was disabled for physical, not mental, reasons on the basis of a neurologic disorder such as possible Parkinson's disease, idiopathic Parkinsonism, young onset Parkinsonism, or "executive dysfunction" involving specific areas of the brain.

Lastly, the court held that the insured's anxiety was a by-product of his disability, not a contributor to it, because his measured levels of anxiety doubled six months after his disability caused him to stop working.

Defendant's motion for remand to administrator denied based on "clear and positive indication of futility"

Davidson v Henkel Comp, 2015 WL 1322547 (ED Mich March 24, 2015)

The district court in *Davidson* granted the plaintiff summary judgment on the class representative's claim that the defendant improperly reduced retirement benefits, leaving only the question of remedy. The defendant moved to have that

issue remanded for the administrator to decide.

The court denied the motion to remand, finding that there was a "clear and positive indication that remanding this case would be purposeless and futile." It first noted that the plaintiffs "were forced to litigate this case over a two-year period because" the defendants "either failed to comprehend the true nature of the [p]laintiffs' claims or merely chose to mischaracterize them." Second, the court held that the defendants "indicated that they plan to appeal the Court's decision regardless of the results of the administrative process." Balancing ERISA's purpose of ensuring "a full and proper assessment of claims" with its purpose of ensuring "a *fair* and *prompt* assessment of claims," the court denied the motion to remand because it would be futile and added unnecessary time and expense to the ultimate resolution of the case. ■

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Insurance and Indemnity Law Section Calendar of Section Events

2015

- September 1** Due date for articles for the September issue of the *Journal*
- September 15** Due date for members to declare candidacy for Council seats
- October 8** Annual meeting and program
9:00 Business meeting – election of council members and officers
9:30 Program – Effective Facilitation of Insurance and Indemnity Disputes
- December 1** Due date for articles for the January 2016 issue of the *Journal*



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