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This journal is published by the Insurance and Indemnity Law Section, State Bar of Michigan
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.
Greetings!

Many good things have been happening with our Section in the last few months. Our section was again a sponsor of the annual Young Lawyers Section event, which was held at the Crowne Plaza in Novi on June 4. The accomplishments of the young lawyers who received awards and recognition were nothing short of amazing. We also had the pleasure of being present at the event. Thanks to Doug Young, Loretta Pominville, Renee Vander Hagen and Hal Carroll for staffing the table at this event.

Our council officer, Larry Bennett, also had the opportunity again to attend the State Bar’s annual Leadership Forum on Mackinac Island, which focused heavily this year on the 21st Century Practice Task Force Report. Many great suggestions are being made to address the challenges lawyers face in today’s rapidly changing world.

Planning is also under way for the Annual Bar Meeting which will be held in September in Grand Rapids this year. Our meeting and program will take place on Thursday September 22, 2016 beginning at 9:00 am. The program this year focuses on Commercial Property issues. For a detailed description, look for the announcement elsewhere in this issue.

As always, we will begin with a short business meeting, at which we will elect new Council members and officers. Our practice is for officers to move up a “ladder” from Treasurer to Secretary to Chair-Elect and then to Chair. If you would like to be a candidate for our Council, please contact Hal Carroll at HOC@HalOCarrollEsq.com, so that you can be on the ballot.

We will also seek approval for revisions to our ByLaws. We have made changes to update them and clarify the responsibilities of committees. Please take a moment to review the summary and redline version of the revised ByLaws in this issue.

Under the revised ByLaws, the three standing committees are Program, Publications and Membership. If you are interested in serving on a committee, please contact me. If you’re new to the Section, serving on a committee is a good way to “get your feet wet” in learning how the Section operates.

Finally, we welcome our new members:

• Amanda Thompson
• Christine Constantino
• Justin Ebel
• Kelley Glish
• Ian Rothe
• Mark Johnson
• Nina Abboud

Thank you for joining!
ANNUAL MEETING AND PROGRAM
Thursday, September 22, 2016
DeVos Place, Grand Rapids, MI
9:00 – 9:30 a.m. Business Meeting
9:30 – 11:30 a.m. Program

Program Topic:
Commercial Property From Start To Finish

The Panelists:

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<tr>
<th>Don Balmes</th>
<th>Patrick King</th>
<th>Allen Philbrick</th>
<th>Bill Butler</th>
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<td><em>Willis Risk Solutions</em> Broker</td>
<td><em>Fabian, Sklar &amp; King</em> Policy-Holder counsel</td>
<td><em>Conlin, McKenney</em> Defense Counsel</td>
<td><em>Butler &amp; Associates</em></td>
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Back by popular demand! Our last program on commercial property was so well attended that we decided to offer it again with an expanded panel and a more comprehensive approach.

Insuring commercial property can involve complex risk factors. Insurance broker Don Balmes will discuss some common strategies to insuring commercial real property and what insurance coverage is available in the marketplace.

When a loss occurs, the insured initiates the claim process. Policy-holder attorney Patrick King will provide insight into the claims process and how he approaches recovery of a commercial property loss. He will also discuss his understanding of the policy coverages most frequently invoked in the event of a loss.

Defense attorney Allen Philbrick will provide the insurance company perspective and identify some policy provisions that are frequently invoked by insurance carriers during the claim process.

Finally, appraiser Bill Butler will explain the appraisal process that is frequently invoked in the event of a dispute between the insured and the insurer.

Please direct your inquiries concerning the program to the Insurance & Indemnity Section chair-elect Adam Kutinsky at akutinsky@dmms.com or (248) 642-7835.
Summary of Revisions - Proposed Second Amended Bylaws

Article I – Name and Purposes
• No changes proposed

Article II – Membership
• Section 1 - deleted $25.00 annual dues amount, and replaced by amount to be determined by Council
• Section 4 - added new section allowing for gratis law student membership

Article III – Organizational Meeting
• Deleted in its entirety

Article IV – Council (renumbered to Article III)
• Section 1(a) - added Council member terms shall be 1 year
• Section 1(b) - added limit to number of Council members to not more than 10
• Section 2 - deleted section regarding two-year term limits
• Section 3 - added that Council shall declare a Council position vacant if Council member misses three successive Council meetings

Article V – Officers (renumbered to Article IV)
• Section 1 - added Officer terms shall be 1 year

Article VI – Duties of Officers (renumbered to Article V)
• Section 3(b) - added Secretary duty to track Council member attendance or non-attendance at Council meetings
• Section 3(d) - added Secretary duty to serve as Commissioner of Elections and keep written record of Council member terms
• Section 4(c) - added Treasurer duty to submit proposed budget at annual meeting

Article VII – Duties and Powers of the Council (renumbered to Article VI)
• Section 3 - added section requiring Council members to actively participate in Committee or provide an article for publication in the quarterly publication

Article VIII – Committees (renumbered to Article VII)
• Section 1 - added requirement that committees meet no less than once per year and report to Council at the next Council meeting
• Section 2 - added Strategic Planning Committee to be formed the year prior to the expiration of the then current Strategic Plan
• Section 3 - added requirements that Program Committee present at least one educational program per calendar year, in addition to the annual meeting
• Section 6 - deleted Regulatory Law Committee
• Section 7 - deleted Indemnity Law Committee
• Section 8 - deleted Insurance Coverage Law Committee

Article IX – Meetings (renumbered to Article VIII)
• Section 1 - added requirement that Council meet not less than 4 times per calendar year, the dates of which shall be tentatively set at the annual meeting

Article X – Miscellaneous (renumbered to Article IX)
• Section 5 - added section allowing for formation of ad hoc or permanent committee concerning a Student Scholarship Program to be overseen by the Treasurer

Article XI – Amendments (renumbered to Article X)
• Section 1 - added language allowing for future amendment to the Bylaws by petition signed by not less than 18 members of the Section.
Second Amended
BYLAWS OF THE
INSURANCE AND INDEMNITY LAW SECTION
OF THE STATE BAR OF MICHIGAN

ARTICLE I
NAME AND PURPOSES

Section 1. The Section shall be known as the Insurance and Indemnity Law Section of the State Bar of Michigan.

Section 2. The purposes of the Section shall be:

(a) to provide a forum for the exchange of ideas among members engaged in the practice of law in the areas of insurance and indemnity law, with a view to:

   (i) improving the practice of law in the area,

   (ii) promoting, through the practice of law, the orderly development of the principles of law that govern this area of practice, and

   (iii) improving the quality of services provided to clients who seek services from members of the section.

(b) to serve as a forum and vehicle for the dissemination of specialized knowledge to practitioners engaged in the practice of law in this area.

(c) to coordinate its activities with those of other sections of the State Bar of Michigan whose activities and practice areas are complementary to those of this Section.

To accomplish these goals, the Insurance and Indemnity Law Section of the State Bar of Michigan will sponsor meetings and conferences of educational value and support the publication of articles that relate to the purposes of the Section.

ARTICLE II
MEMBERSHIP

Section 1. Any active member of the State Bar of Michigan, upon request to the State Bar of Michigan and upon payment of dues for the current year, shall be enrolled as a member of the Section. Each applicant shall pay to the State Bar of Michigan the then current section dues as shall be determined by the Council $25.00, and shall thereafter pay annual dues in the amount of $25.00 in the amount currently then due on or before October 1 of each year.
Section 2. As provided in Article VII Section 5 of the Bylaws of the State Bar of Michigan, any newly admitted member of the State Bar of Michigan shall become a member without payment of dues for the first two years of his or her admission to the State Bar of Michigan, upon submission of a written request to the State Bar of Michigan.

Section 3. To the extent permitted by Article VII Section 6 of the Bylaws of the State Bar of Michigan, the Council may create categories of non-voting membership for persons other than members of the State Bar of Michigan.

Section 4. As provided in the Bylaws of the State Bar of Michigan, any currently registered law student attending a law school located in the State of Michigan, accredited by the State Bar of Michigan, shall become a member without payment of dues so long as registered and actively taking courses through that law school, upon submission of a written request to the State Bar of Michigan.

ARTICLE III
ORGANIZATIONAL MEETING

Section 1. The organizational meeting of the Section shall be held during the period November 15-30, 2007 at a time and place to be determined by the acting chairman hereafter appointed.

Section 2. The Board of Commissioners of the State Bar of Michigan hereby appoints Hal O. Carroll of Troy, Michigan Acting Chairperson of the proposed Section, to serve in this capacity until the Bylaws of the Section are approved and the Council and Officers of the Section are duly elected as hereinafter provided.

Section 3. All active members of the State Bar of Michigan who have applied for membership in the Section and have paid dues or have otherwise qualified under Article II by November 19, 2007 shall receive written notice of the time and place of the organizational meeting and shall be eligible to vote at the meeting.

Section 4. Voting at the organizational meeting shall be in person and not by proxy.

Section 5. At the organizational meeting, the members shall elect 8 members to serve on the first Council, and shall elect the 4 officers of the Section. The terms of one half of the 8 members of the council elected at the organizational meeting shall be for 1 year and the terms of the other half shall be for two years.

ARTICLE IV
COUNCIL

Section 1. Members. The Council of the Section shall consist of
(a) the officers, ex officio, elected to one-year terms pursuant to Article IV,

(b) not more than ten members elected to two year terms by the membership of the Section at the annual meeting to fill the vacant and expiring Council memberships, in the following numbers: commencing with the annual meeting of the members in 2011, thirteen Council members; commencing with the annual meeting of the members in 2012, ten Council members, and

(c) the immediate past Chair of the Section, who will serve for a period of two-one years after the end of his or her term.

Section 2. Term Limits. No member of the council who has served for more than three consecutive full 2-year terms as a council member elected under Section 1(b) of this Article shall be eligible for election to the Council under Section 1(b) of this Article or appointment to the Council under Section 3 of this Article until at least one year has elapsed.

Section 3. Attendance. If any elected or ex officio member of the Council shall fail to attend three successive meetings of the Council, the Council shall declare the position vacant. If a position of the Council becomes vacant for any reason during the term of a member, including resignation or the inability to perform the duties of the position, the remaining members of the Council shall select a replacement, who shall succeed to the position.

Section 43. Nominations. Prior to the annual meeting, the Chairperson may appoint a nominating committee to propose nominations for the positions of officers and members of the Council for election at the annual meeting. Other nominations may be made by members present at the meeting.

ARTICLE IV
ELECTION OF OFFICERS

Section 1. The officers of the section shall consist of the following, elected to one-year terms by the members at the annual meeting:

(a) a Chairperson,

(b) a Chairperson-Elect,

(c) a Secretary, and

(d) a Treasurer.

Section 2. If any office becomes vacant during the period between the annual meetings, the Council may select a replacement, who shall succeed to the full duties and responsibilities of the office.
Section 3. Subject to the approval of the members at the annual meeting, it is anticipated that the Treasurer shall succeed to the office of Secretary, the Secretary shall succeed to the office of Chairperson-Elect, and the Chairperson-Elect shall succeed to the office of Chairperson.

ARTICLE VI
DUTIES OF OFFICERS

Section 1. CHAIRPERSON. The Chairperson shall

(a) Preside at all meetings of the Council,

(b) Prepare and present at each annual meeting of the Section a report of the activities of the Section for the preceding year,

(c) Appoint the chairpersons and members of the committees of the Section, and

(d) Perform such other duties as are customarily associated with the office of chairperson, or as are assigned by the Council.

Section 2. CHAIRPERSON-ELECT. The Chairperson-Elect shall

(a) Preside at all meetings in the absence of the Chairperson,

(b) Assume and perform the duties of the Chairperson during the disability of or after the death or resignation of the Chairperson, and

(c) Be responsible for the development and presentation of an educational program at the annual meeting.

Section 3. SECRETARY. The Secretary shall

(a) Be the custodian of the books and records of the Section, apart from the financial documents,

(b) Keep a record of the annual meeting of the Section, and the meetings of the Council, which shall include information as to Council members then present and absent, and

(c) Preside at the meetings of the Council in the absence of the Chairperson and Chairperson-Elect.
(d) Act as Commissioner of Elections by keeping a written record of Council members’ terms to be disseminated to all Council members in preparation for the annual Section meeting.

Section 4.  TREASURER. The Treasurer shall:

(a) Keep a record of the money received and disbursed, and present a report at each meeting of the council,

(b) Present a financial report to the members at the annual meeting,

(c) Prepare and present a proposed budget for the consideration of the Council at the annual meeting, and

(d) Preside at meetings of the Council in the absence of the Chairperson, the Chairperson-Elect, and the Secretary.

ARTICLE VII

DUTIES AND POWERS OF THE COUNCIL

Section 1. The Council shall

(a) Have general supervision and control of the affairs of the Section subject to the Supreme Court Rules Concerning the State Bar of Michigan and the Bylaws of the State Bar of Michigan and the Bylaws of the Section,

(b) During the interim between meetings of the Section, have full power to do and perform all acts and functions, which the Section itself might do or perform,

(c) Authorize all commitments or contracts, and shall authorize or approve the expenditure of all monies, and

(d) Formulate and state the position of the Section on any matters relating to the Section’s purposes.

Section 2. A majority of the members of the Council shall constitute a quorum for the transaction of business. A vote of the majority of those Council members present and voting shall be required for action by the Council.

Section 3. Each member of the Council shall participate in one of the following per each year:

(a) Submission of an article for publication in the quarterly newsletter;

(b) Actively participate in a Section committee.
Section 34. Between scheduled meetings of Council, the Chairperson of the Section may, and on the request of any member of the Council shall,

(a) Schedule and convene a special meeting of the Council, or

(b) When the calling of a formal Council meeting is not practical, submit in writing to each member of the Council any proposition on which the Council may be authorized to act. Members of the Council may vote on such proposition by communicating their vote to the Secretary by any prompt or convenient means. The Secretary shall retain a record of the proposition submitted, when, how, at whose request submitted, and the vote of each member thereon, which shall be reported to Council at its next meeting and recorded in the minutes for that meeting.

ARTICLE VIII
COMMITTEES

Section 1. Membership of committees is open to any member of the Section. Officers and Council members may also serve on and act as chairpersons of committees. The Council shall determine the number of members of each committee. Each committee shall meet no less than once per year, and submit a report to Council of its meeting at the next Council meeting.

Section 2. In addition to the committees described below, the Council may from time to time create any ad hoc, including a Strategic Planning Committee the year prior to the expiration of the then current Strategic Plan, or permanent committees that it considers necessary to further the purposes of the Section.

Section 3. Program Committee. The Program Committee shall be responsible for the planning and presentation of at least one educational program per calendar year, not including the annual meeting.

Section 4. Publication Committee. The Publication Committee shall be responsible for the preparation and publishing of a quarterly newsletter publication to be distributed to the members.

Section 5. Membership Committee. The Membership Committee shall be responsible for promoting membership in the Section among members of the State Bar of Michigan through communications and liaisons with other Sections.

Section 6. Regulatory Law Committee. The Regulatory Law Committee shall be responsible for monitoring the status of and developments in the law pertaining to the regulation of insurers and insurance policies.
Section 7. **Indemnity Law Committee.** The Indemnity Law Committee shall be responsible for monitoring the status of and developments in the law pertaining to the law of indemnity.

Section 8. **Insurance Coverage Law Committee.** The Insurance Coverage Law Committee shall be responsible for monitoring the status of and developments in the law pertaining to the interpretation and application of insurance policies.

ARTICLE IX

MEETINGS

Section 1. The Council shall meet not less than quarterly four times per calendar year, the dates of which shall be tentatively scheduled at the annual meeting. A majority of the members of the council shall constitute a quorum. A majority of those present and voting shall be sufficient to take action on any matter before the Council. Members may attend in person or by telephone.

Section 2. The annual meeting of the Section shall take place during and in the same venue as the annual meeting of the State Bar of Michigan. A quorum shall consist of 18 members of the Section. A majority of those present and voting shall be sufficient to take action on any matter before the Section.

Section 3. Special meetings of the Council or the Section may be called by the Chairperson.

ARTICLE IX

MISCELLANEOUS

Section 1. The fiscal year of the Section shall be the same as that of the State Bar of Michigan.

Section 2. All bills incurred by the Section, before being forwarded to the Treasurer or to the Executive Secretary of the State Bar of Michigan for payment, shall be approved by the Chairperson or by the Treasurer, or, if the Council shall direct, by both of them.

Section 3. No salary or compensation shall be paid for serving as a Section officer, member of the Council, or member of any committee.

Section 4. Any action of this Section must be approved by the Representative Assembly or the Board of Commissioners of the State Bar of Michigan before the same becomes effective as the action of the State Bar of Michigan. Reports or recommendations of this Section or its committees may be released, announced, or published only as provided in the Bylaws of the State Bar of Michigan, Article VIII and Article IX.
Section 5. The Council may, as allowed by the Bylaws of the State Bar of Michigan, through creation of an ad hoc or permanent committee, implement, fund and promote a Student Scholarship Program to be overseen by the Treasurer.

ARTICLE X
AMENDMENTS

Section 1. Amendments to these Bylaws may be proposed by a majority vote of the Council, or by a petition signed by not less than 5-18 members of the Section. The Council shall cause a complete and accurate text of the proposed amendments to be published in the *Michigan Bar Journal* or otherwise communicated to the members of the Section not less than 30 days before the annual meeting.

Section 2. Proposed amendments shall be submitted to the membership at the annual meeting and shall be adopted upon a majority vote of those members present and voting.

Section 3. No amendment so adopted shall become effective until approved by the Board of Commissioners of the State Bar of Michigan.

Certification

Kathleen A. Lopilato, Larry Bennett, Secretary, certifies that these bylaws were amended as re-stated above by a majority vote of the members, a quorum being present, at the annual meeting of the membership of the Insurance and Indemnity Law Section held on September 15, 2011.

Larry Bennett, KATHLEEN A. LOPILATO
Insurance companies can find themselves out significant sums of money, both in indemnity and expense dollars, as a result of criminal wrongdoing by insureds or third parties. Arson, staged burglaries, or fraudulent inventories after a loss can result in increased claim expense as well as litigation expenses. Insurers, however, are not without a remedy in the event that the perpetrator is held criminally liable. This article will discuss the rights of the insurer to recover indemnity and/or expense dollars under state law, as well as provide a primer on how to prepare for the critically important restitution hearing after conviction.

The Right of Restitution

Article 1, Section 24 of the Michigan Constitution provides that victims of crime have a right to “restitution.” The William Van Regenmorter Crime Victim’s Rights Act (hereinafter “CVRA”) requires that the trial court order convicted defendants to pay restitution. Specifically, the statute states that “when sentencing a defendant convicted of a crime, the court shall order...that the defendant make full restitution to any victim of the defendant’s course of conduct that gives rise to the conviction.” The statute defines “victim” as including “a sole proprietorship, partnership, corporation, association, governmental entity, or any other legal entity that suffers direct physical or financial harm as the result of a crime.”

Additionally, the statute provides that the court “shall order restitution” to any “corporations” that have “compensated the victim or the victim’s estate for a loss incurred by the victim to the extent of the compensation paid for that loss.” This statutory provision allows the court to order restitution to insurers to the extent that they have compensated a “victim” for his or her loss.

The statute provides that the court “shall order restitution” to any “corporations” that have “compensated the victim or the victim’s estate for a loss incurred by the victim to the extent of the compensation paid for that loss.” This statutory provision allows the court to order restitution to insurers to the extent that they have compensated a “victim” for his or her loss.

Standard of Proof of the Claim

The trial court is not required to hold a hearing to determine the type or amount of restitution. However, if there is a dispute over the type or amount of restitution, the standard of proof is not the criminal standard of “beyond a reasonable doubt,” but rather by a “preponderance of the evidence.” The prosecution bears the burden of establishing the amount of restitution owed under this “preponderance of the evidence” standard. The amount of loss, however, must still be based on evidence. Whether and to what extent a loss must be compensated is a matter of statutory interpretation, and the appellate courts review the proper interpretation of statutes de novo. The trial court’s restitution order, however, is reviewed for clear error, which is defined as when the higher court is “left with the definite and firm conviction that a mistake has been made.”

In interpreting the Crime Victim’s Rights Act, the Michigan courts have held that the term “course of conduct that gives rise to a conviction” must be given a “broad construction” to best effectuate the intent of the Legislature. Additionally, the courts have stated that the Legislature “plainly intended to shift the burden of losses arising from criminal conduct – as much as practicable – from crime victims to the perpetrators.”

“Financial Harm” – Investigatory Expenses

The Michigan Court of Appeals analyzed what constituted “financial harm” arising from “criminal conduct” in the case of People v Allen. In Allen, the defendant attempted to purchase a controlled substance from a pharmacy using a fraud-
ulent prescription, which contained a legitimate Blue Cross contract number. The defendant was employed by a Blue Cross vendor, and thus had access to two major databases that included private information about Blue Cross subscribers. When Blue Cross learned of the potential fraud, it undertook an investigation through one of its own employees. The investigating employee testified that Blue Cross spent $5,738 to investigate Allen's fraud, and that the investigator arrived at that amount by multiplying an hourly rate of $130.77 by the 44 hours that she spent working on the investigation. After being ordered by the trial court to pay $5,738 in restitution, the defendant appealed, contending that Blue Cross’ investigation did not amount to “financial harm” because the employee investigator would have been paid even in the absence of the defendant’s attempt to fraudulently purchase a controlled substance. The Allen court held that the loss to Blue Cross was not the investigator’s salary or budget, but rather the loss of time that constituted “direct financial harm.” The harm, according to the court, could be measured by assigning a value to the hours spent on the investigation.

A year later, in the case of People v Fawaz however, the Court of Appeals made a distinction between “financial harm” incurred as a result of “investigation,” and costs incurred as a result of a claim denial. The Fawaz court held that the amounts expended by the insurer in investigating the fire set in the insured home were recoverable, but that the litigation costs incurred as a result of the insured challenging the claim’s denial in court were not. Following the rule announced in Allen, the Fawaz court stated that the resources expended by Farmers in determining that the defendant’s claim was fraudulent were part of the “actual loss suffered” by the insurer, and should have been included in the restitution amount. The Fawaz found that costs for “origin and cause” investigation, along with “lab analysis” and “investigation expenses” should have been included in the restitution amount.

The court noted, however, that although Farmers did not pursue on appeal its requests for “legal expenses for defending suit filed by [defendant],” it continued to request restitution for expenses relating to the defendant’s deposition. The court noted that these costs appeared to be related to a civil suit filed by the insured after Farmers had completed its investigation, determined that the loss was fraudulent, and denied the claim. The court found that the prosecution “failed to explain” why the cost of the defendant-insured’s deposition was part of Farmer’s “investigation into whether” the claim was fraudulent, and thus properly included as an “actual loss” to the insurer as a victim.

Proving the Amount of Restitution

Read together, therefore, the Allen and Fawaz decisions demonstrate that the courts will look to when, during the life of the claim, the insurer incurred expenses, and whether those expenditures were “investigatory.” Although the burden of proving the amount of restitution by a preponderance of the evidence lies with the prosecutor, it is incumbent upon the insurer to provide the prosecution with sufficient evidence to support the award. As noted above, unless the amount of restitution is stipulated to, the court may hold an evidentiary hearing at or near the time of sentencing. From a practical standpoint, therefore, what should the insurer, seeking to recover its investigatory costs as a crime “victim,” be prepared to put forth at a restitution hearing?

Preparation by the testifying adjuster and thorough familiarity with the claim file are indispensable to effectively proving a compensable loss under the CVRA. There are few things more exasperating to a trial court attempting to fulfill its non-discretionary duty of imposing restitution than to hear “I don’t have the file with me,” or “I don’t know what that payment was for,” or “I don’t know - this wasn’t my file.” The testifying adjuster should be able to specifically identify by date, amount, and vendor every expense incurred during the investigation of a loss. The insurance witness should be able to identify, as did the investigator in the Allen case, the precise number of hours spent investigating the case and the basis for the claimed labor costs. If the insurer incurred legal expenses and costs for conducting an examination under oath, the adjuster should be able to identify the date of the exam, as well as the accompanying costs. If the claim for costs arises out of a fraudulent claim by the insured, the adjuster must be able to identify the date of the denial of the claim, and understand that expenses occurred after that date (such as defending a lawsuit brought by the insured) may not be considered “investigatory” under Fawaz and thus not recoverable. Ideally, the insurer representative will provide the prosecution with these proofs in sufficient time for them to be shared with defense counsel and possibly included in the pre-sentence investigation report. A thorough statement of investigatory expenses, provided in a timely fashion, may obviate the need for an evidentiary hearing.

Conclusion

Insurers, therefore, are entitled to restitution as “victims” under the CVRA. The insurer seeking restitution, however, must be cognizant of what is recoverable under the CVRA,
taking particular care to distinguish between “investigative costs” and money expended after the denial of a suspect claim. Although the proof required for a restitution order is only by a “preponderance of the evidence,” a thorough knowledge of the claim file and collaborative work with the handling prosecutor will make that burden much easier and perhaps avoid the need for a hearing altogether. Thus, the key to success under the CVRA, as in almost any endeavor, lies in preparation and more preparation.

About the Author

Catherine L. Heise is a former member of the Council of the Insurance and Indemnity Law Section. A Chartered Property Casualty Underwriter, she currently serves as a judge in the Criminal Division of the Third Judicial Circuit Court.

Endnotes

1 Const 1963, art 1, §24.
2 MCL 780.751 et seq.
3 MCL 780.766(2).

4 MCL 780.66(1).
5 MCL 780.766(8).
7 MCL §780.767.
8 People v Grant, 455 Mich 221, 243, 565 NW2d 389, 399 (1997).
12 Allen at 282, 813 NW2d at 809, citing People v Akins, 259 Mich App 545,564; 675 NW2d 863 (2003).
13 People v Gahan, 456 Mich 264, 270, n.6; 517 NW2d 503 (1997); Allen at 282; 813 NW2d at 809.
14 Allen at 282, 813 NW2d at 809.
16 Allen at 278, 813 NW2d at 807.
17 Id. at 279, 813 NW2d at 808.
18 Id.
19 Id. at 282, 813 NW2d at 809.
20 Id. at 283, 813 NW2d 810.
22 Fawaz at 66, 829 NW2d at 266.
23 Id. at 67, 829 NW2d at 266.
24 Id.
25 Id.
26 Id. at 68; 829 NW2d at 266.
The world of writing and drafting holds many mysteries. One is why so many people who can’t spell go into the sign-making business. Often this takes the form of the so-called “rural plural.” A sign that offers “Office Suite’s for Rent.” It’s a big sign for only one suite. Another sign at a local pub advises “biker’s welcome.” One at a time, apparently. A related mystery is why these are called rural plurals (should it be rural plural’s?) when they almost always appear in urban areas. One commentator was motivated to redefine the apostrophe as a diacritical mark that informs the reader the next letter will be an “s.”

Here’s another mystery, a new one. We now often hear that some person or thing is “one of the only ones.” How can there be more than one “only ones”? What does “one of the only widgets” mean? Is there somewhere a group of “only widgets,” separate and distinct from the non-only ones?

Then there’s “bi-” and “semi-.” Is a “bi-monthly” published twice a month or every two months? It should be “bi-monthly” for two months and “semi-monthly” for every half month. “Bi-” means “two.” You can ride a bicycle or a unicycle but not a semicycle.

These are all common solecisms that we see and hear in ordinary speech. They are either trivial, annoying or amusing depending on how fussy you are. Maybe only word nerds pay attention.

But not all solecisms are so benign. To ordinary folk the statements “all apples are not red” and “not all apples are red” may sound identical, but they are not. One means some are red, one means none is red. Again, in ordinary speech, we can skip over that, but put it in a document and it will lie in wait.

Here’s another mysterious usage that creeps into briefs and sometimes into opinions. This is the increasingly common slash splice. We will hear and read things like “my client will receive/accept the check.” The check was “signed/sent” last week.”

What in the world is this? Someone must know because more and more people use it. Does the slash (we may as well give it the fancy name “virgule”) mean “and”? Does it mean “and” or does it mean “or”? We have those words, and they are easy to say. Therefore we infer that it must mean something else. But if the virgule means something else, what does it mean? If the author knows, then the author has an obligation to tell us.

This is what is offensive about using the slash-splice. The author is saying, intentionally or not, that there is some kind of relationship between the two linked terms but that he or she can’t be bothered to explain it so it’s the reader’s job to figure it out. This is a per se violation of the writer’s code. It is always the writer’s job to make things plain.

In the drafting of legal documents, that kind of unclarity can be dangerous. Using the slash-splice in a contract, whether generic, indemnity or insurance, can be risky, just because it is unclear. And things that are unclear are made clear by litigation.

The cases that reflect this best are cases involving checks in which the payee is in the form “Fred Jones/Susan Smith.” The question is a simple one, but the answer is not. Does the slash as used here mean “and” or does it mean “or.” If it means “and,” then both must sign and the bank is liable if it pays when only one has endorsed it. If the virgule means “or” then either can endorse it and take all the money.

If one of those names is yours and the check is in the other payee’s hands, I think you would like to know. Well, the good news is that the question has been answered in several states. A Texas court said it means “or.” A federal district court in New York said it was ambiguous and therefore should be read as “and” to protect both parties. Tennessee seems to side with Texas. Connecticut joins Texas and Tennessee. So, by a majority of 4 to 1 it means “or.” Further research might change the percentage somewhat and Michigan does not seem to have weighed in on this issue. Everyone comfortable using it now?

The point is that in operative legal documents, a higher standard of language use is necessary. What might be annoying or amusing in everyday life can be dangerous in the world of legal documents. No lawyer should be happy with an 80%
chance of success on an issue when the issue should not even be an issue in the first place. The goal of drafting is not to win fights but to prevent them.

Besides, every drafter – especially every contract drafter – knows, or should know, that he or she is drafting for hostile eyes. The reader of your drafted legal document is not sitting down in a comfortable chair before a cozy fire looking to be entertained, and willing to overlook little slips of the pen. Just the opposite. The reader is sitting in an office chair, searching diligently for just those slips of the pen.

And the court that will end up reading it is just about the fussiest of all readers. Having to put reasons in writing in an opinion tends to concentrate the faculties, and when a judge is writing about writing, the analysis tends to be intense and critical.

That’s why the courts don’t really recognize slips of the pen as a category of contract language. The words are there and they mean what they say. When what they say is unclear, and the rule contra proferentem applies, leading to construction against the drafter. Even under Michigan’s recent change in this, where the rule is to be applied, not by the court, but by the trier of fact, the end result is the same, only it will cost your client more to get there.

What’s the point of all this? It is that this kind of sloppy word use can actually be dangerous to an insurer and an insured. If you see a rural plural in a manuscript policy form drafted by the insurer, it tells you something about the drafter’s skill. Or the author’s favorite find, a clause that authorized the use of “parole” evidence. More specifically, it tells the insured or the insured’s attorney seeking coverage to look even more closely for errors, because the drafter was language-challenged.

Good drafters are fussy about language because they have to be. To be honest, they probably start out fussy and then get into drafting, rather than the other way around. But fussiness is critical. So it’s not just your word choices that matter, it’s also the links/conjunctions you put between them.
Insurance Contract Enforced as Written – no Surprise to Insurance Claim Litigators

**Court:** Oakland County Circuit Court; Hon. James M. Alexander

**Case:** Amerilodge Group LLC v Home-Owners Insurance Company; Case No. 15-148935-CB

**Date:** June 29, 2016

**Issues:** 1. Is the insured’s claim time barred? 2. Does the policy afford coverage for the insured’s claim?

**Ruling:** During the Policy’s term, Plaintiff learned that an employee was stealing money from cash deposits between 2009 and 2013. Plaintiff terminated the employee on August 23, 2013, and a subsequent October 2013 audit revealed a total theft of some $80,578.62. On November 5, 2013, Plaintiff filed a claim for coverage. On January 30, 2015, however, Defendant only provided coverage for $16,203.19 of the claim. This amount represented only the losses that occurred when Defendant’s policy was in place. The evidence showed that the employee’s theft predated Defendant’s effective policy and in fact occurred in large part during the effective period of previous and successive policies with different insurers. Plaintiff filed suit on breach of contract and declaratory judgment claims, seeking the balance of its loss due to its employee’s theft.

The parties filed cross-motions for summary disposition, presenting two issues: First, is Plaintiff’s claim for the allegedly uncovered portion of its claim time barred? Second, does Defendant’s policy cover Plaintiff for its alleged losses predating Defendant’s period as insurer?


Here, the policy clearly had a two-year limitations period after the discovery of the loss for the insured to file suit. The insured filed suit after the expiration of the two-year limitation period. But that is not the end of the story. Plaintiff argues that, because Defendant’s comprehensive policy includes coverage for fire loss, the statutory tolling period found in MCL 500.2833(1)(q) acts to toll the limitations period for the time between Plaintiff’s notice of loss and Defendant’s decision to deny coverage. The statute provides in relevant part that “The time for commencing an action is tolled from the time the insured notifies the insurer of the loss until the insurer formally denies liability.” In this case, the time for Plaintiff to file suit was tolled for 302 days, putting the filing of the suit well within the two-year limitations period set forth in the policy.

Next, Defendant argued that it only had to pay for losses that occurred during the effective period of its policy. However, the policy included a provision stating, “If you . . . sustained loss during the period of any prior insurance that you or the predecessor in interest could have recovered under that insurance except that the time within which to discover loss had expired, we will pay for it under this insurance…” Plaintiff provided evidence of two successive policies with different insurers that covered employee theft for the entire period of the theft preceding Defendant’s effective policy period.

Accordingly, the Court granted summary disposition in Plaintiff’s favor and denied summary disposition in Defendant’s favor.

**Note:** Because insurance contracts will be enforced as written, attorneys for insureds and insurers are always well-served to read the full policy and advise their respective clients accordingly. This case is illustrative of the time and resources that can be needlessly expended litigating coverage over seemingly clear policy language.

A Litigant Pleads the Fifth in a Civil Case to his Own Peril

**Court:** Oakland County Circuit Court; Hon. Wendy Potts

**Case:** Robert Lorraine v Michigan Alternative LLC et al; Case No. 15-149656-CB

**Date:** June 21, 2016

**Issues:** 1. May a plaintiff enforce an illegal contract? 2. May a litigant plead the Fifth in civil litigation and maintain support for his claims?

**Ruling:** Plaintiff sued Defendants for alleged money owed and for constructive ownership of a marijuana growing and dispensing operation. Defendants argue that public policy for-
bids the enforcement of Lorraine's illegal contracts. In support of their arguments, Defendants cite to Mahoney v Lincoln Brick Co, 304 Mich 694, 706-07; 8 NW2d 883, 888 (1945) for the proposition that contracts that violate the public policy of the state are illegal and void regardless of whether an actual injury is present. Defendants argue that Lorraine's repeated use of his Fifth Amendment privilege shows that every aspect of his complaint is shrouded in illegality.

The assertion of his Fifth Amendment rights does not prohibit the inference that Lorraine's claims are premised on an illegal enterprise. Allen v Michigan Basic Property Ins Co, 249 Mich App 66, 74; 640 NW2d 903 (2001). Likewise, Plaintiff could not reasonably believe that it was appropriate to engage in the marijuana growing operation, and he does not provide any evidence showing that his business was a legal enterprise. The transcript of the deposition testimony also reveals that Lorraine repeatedly invoked his Fifth Amendment right against self-incrimination when he was asked about issues central to his claims. "The privilege against self-incrimination not only permits a person to refuse to testify against himself at a criminal trial in which he is a defendant, but also permits him not to answer official questions put to him in any other proceeding, civil or criminal, formal or informal, where the answers might incriminate him in future criminal proceedings. However, a party to a civil action who invokes his Fifth Amendment privilege does so to the peril of his claim." Allen v Michigan Basic Property Ins Co, 249 Mich App 66, 74; 640 NW2d 903 (2001).

Accordingly, the Court granted summary disposition in Defendants' favor.

**Note:** It's generally a bad idea to provide a blueprint to alleged illegal conduct in a civil suit, particularly when the prospect of prevailing in such a suit is minimal from the outset.

About the Author

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**ERISA Decisions of Interest**

**United States Supreme Court Update**

**ERISA Plans Must Act Quickly To Pursue Subrogation**

*Montanile v Board of Trustees of the National Elevator Industry Health Benefit Plan*, 577 U.S. _____, No. 14-723 (January 20, 2016)

ERISA health benefit plans typically contain a subrogation provision such that when a plan participant seeks payment under the plan to cover medical expenses, and that participant later obtains a settlement from or judgment against a third party related to the same expenses, the plan may be entitled to reimbursement. This commonly occurs in an automobile accident scenario in which an ERISA participant is injured and recovers from another driver. Under the Supreme Court's precedent in *Sereboff v Mid Atlantic Medical Services, Inc*, 547 US 356, 363 (2006), the ERISA plan was entitled to seek equitable relief pursuant to ERISA section 502(a)(3) in the form of subrogation of the participant's specifically identifiable settlement of recovery, so long as those funds could be segregated from the participant's general assets.

The Supreme Court's decision in *Montanile* took this subrogation issue one step further and addressed a Circuit split on the question of what happens when the plan participant has dissipated the funds on nontraceable items, such as food or general personal expenses.

In that case, the plan participant was seriously injured in an accident caused by a drunk driver. The participant recovered a $500,000 settlement from the lawsuit. The plan covered more than $120,000 for his medical expenses. After the settlement of the tort action, the plan sought reimbursement. However, the participant’s attorney refused and indicated that the funds would be transferred to the participant unless the plan objected. The plan did not immediately respond, and instead sued the participant six months later, seeking equitable relief to enforce the terms of the plan to place a lien on the settlement funds. By that time, the participant claimed that he had spent almost all of the settlement such that there was
no specifically identifiable fund against which the plan could enforce a lien.

The district court and the Eleventh Circuit both held that, even if the participant had completely dissipated his settlement funds, the plan was entitled to reimbursement from his general assets. The Supreme Court disagreed and held that under these circumstances, the plan was not seeking equitable relief. The Supreme Court explained that if a specifically identified fund was dissipated, the lien was eliminated and the plan was not able to reach a participant’s general assets to satisfy a lien.

The case was remanded for determination of whether the participant maintained his settlement funds separately from his general assets, and whether the settlement amount had been entirely dissipated on nontraceable assets.

This case demonstrates the need for plan administrators to act quickly if a participant may recover from a third party in order to enforce an equitable lien, and perhaps even to intervene in a tort action, where known. The same concept holds true for retirement plans as well. If a plan mistakenly overpays a participant, efforts to recover such an overpayment must be pursued quickly before the participant may use or spend the funds.

**Sixth Circuit Update**

**Plaintiff Cannot Artfully Plead Around ERISA to Avoid Removal Based on Complete Pre-Emption**


The plaintiff sued the Life Insurance Company of North America under ERISA for denying her disability benefits claim. The federal district court granted judgment for the defendant, which was affirmed on appeal to the Sixth Circuit.

The plaintiff then filed a state court action against the two nurses who reviewed the plaintiff’s benefit claim and recommended that the claim be denied. She “carefully pleaded her claims in the second suit to avoid reference to the [insurer] or ERISA, alleging only that [the nurses] committed negligence per se by giving medical advice without being licensed under Kentucky’s medical-licensure laws.” The defendant insurer removed the action to federal court based upon complete, or field, pre-emption, and the plaintiff moved to remand.

The district court denied the motion, holding that the state law negligence claim was pre-empted by ERISA, and the Sixth Circuit affirmed. A state law claim is within the scope of ERISA §1132(a)(1)(B)’s remedy provision, and therefore is pre-empted, if (1) the plaintiff’s complaint arises “only because of the terms of an ERISA-regulated employee benefit plan,” and (2) the plaintiff does not allege violation of any “legal duty (state or federal) independent of ERISA or the plan terms.”

The Sixth Circuit first held that the plaintiff’s “negligence per se claim is merely an artful reassertion of her claim for ERISA benefits from” her first action because it “is necessarily premised on the existence of some relationship between herself and the defendants.” The “entire relationship between the parties was limited to the defendants’ review of [the plaintiff’s] medical file, which arose solely in conjunction with a disability benefits determination.”

Second, the court rejected the plaintiff’s argument that she alleged the violation of a duty independent of ERISA (i.e., the duty created by Kentucky’s medical license requirements). The court held “that a duty cannot have arisen out of thin air; instead, some relationship between her and the defendants must have created it,” and “[h]er careful pleading does not change the fact that this relationship arises solely from an ERISA-benefits plan.”

**Termination of LTD Benefits Based Upon 24 Months Limit for “Mental Illness” Was Not Arbitrary or Capricious**


The Sixth Circuit affirmed the district court’s determination that the defendant insurer did not act arbitrarily or capriciously in terminating the plaintiff’s LTD claim after 24 months where the plan had a 24 month limit for disabilities caused by “mental illness.” The plaintiff alleged that her major depression disorder had an “organic” cause and was therefore not subject to the plan’s 24 month limitation. Both the district court and Sixth Circuit assumed that the limitation did not apply to conditions with an organic cause. However, there was abundant evidence from the plaintiff’s treaters that her condition did not have any organic cause, as well as evidence from reviewing physicians of the insurer. Thus, the administrative decision was not arbitrary and capricious.

**Denial of Medical Benefits Not Arbitrary and Capricious Where Condition Was Incurred on the Job and Subject to Plan Exclusion Regarding Conditions Covered by Workers Compensation**

*Foltz v Barnhart Crane and Rigging, Inc,* 2016 WL 796965, No. 15-5907 (6th Cir, Feb 29, 2016)

The plan at issue, which vested discretion in the administrator to interpret the plan, provided that “[n]o benefits will be payable for charges incurred . . . [a]s a result of a disease or sickness or illness for which benefits are payable under any Worker’s Compensation Act or Occupational Disease Act or any such similar law.”

The Sixth Circuit affirmed the district court’s judgment in favor of the defendant plan administrator. The insured answered “yes” on the benefit application form’s question whether his condition was “due to injury or illness arising
out of [his] employment.” Although the district court erred in placing the burden of proof on the plaintiff, rather than the plan administrator, which relied on a plan exclusion in denying benefits, the Sixth Circuit held that the error was harmless because “the evidence in the administrative record clearly shows that . . . [the plaintiff’s] illness was, in fact, work-related.”

**Denial of Benefits Arbitrary and Capricious Where Plan Administrator Did Not Fully Consider All Medical Evidence of Disability.**

*Cannon v. PNC Financial Servs. Group,* 2016 WL 1781874, No. 15-6010 (6th Cir., April 7, 2016). The plaintiff, who worked in a sedentary job, developed pelvic and abdominal pain after surgery that prevented her from being able to sit. She received LTD benefits for a period of time, after which the insurer terminated them. The plaintiff sued under ERISA, and the district court granted the insured judgment upon concluding that the administrator’s decision was not arbitrary and capricious.

The Sixth Circuit reversed. Plaintiff’s “records from several physicians and from physical therapy reflected her complaints of severe” pain, “especially while sitting.” One doctor, Dr. McQuady, diagnosed “abdominal pain, intra-abdominal adhesions, and prudendal neuralgia.” The insurer terminated benefits based upon a medical reviewer who concluded that the plaintiff’s “impairments currently are subjective complaints of abdominal pain, no clear etiology.” However, the reviewer failed to “mention Dr. McQuady’s diagnosis of prudendal neuralgia.”

On administrative appeal, the plaintiff provided further medical evidence from Dr. McQuady, who stated that the plaintiff also had “pelvic floor muscle dysfunction” that is “associated with pain with sitting” and which prevented her from working while sitting.

The Sixth Circuit held that the termination of benefits was arbitrary and capricious for two reasons. First, the insurer failed to consider the plaintiff’s two diagnoses – prudendal neuralgia and pelvic floor muscle dysfunction – which are both the kind of “anatomic explanation we require for a demonstration of pain.” Second, the insurer failed to address Dr. McQuady’s letter on administrative appeal, nor did it obtain any supplemental medical opinion from its medical reviewer concerning that letter.

The Sixth Circuit reversed and remanded to the plan administrator for a full and fair review, rather than entering judgment for the plaintiff, because the court could not conclude that the plaintiff was clearly entitled to benefits.

**Denial of Benefits Arbitrary and Capricious Where Plan Administrator Ignored Objective Evidence of Disability**

*Zuke v American Airlines, Inc,* 20156 WL 1258220, No. 15-3465 (6th Cir March 31, 2016) The Sixth Circuit reversed and remanded the district court’s judgment in favor of the defendant plan administrator, holding that the administrator arbitrarily and capriciously denied the plaintiff long-term disability benefits. The plaintiff received long-term benefits for 13 years based upon back pain. The administrator’s medical consultants reviewed the plaintiff’s records and concluded that “the only objective data in the file to support any pathology in [the plaintiff] is her history of a prior cervical spine fusion from 2000.” The administrator denied benefits and, after completing unsuccessful administrative appeals, the plaintiff sued under §1132. The district court entered judgment for the defendant administrator.

On appeal, the Sixth Circuit made three relevant determinations.

First, the Sixth Circuit held that a plan administrator’s alleged violation of fiduciary duties cannot, by itself, change the standard of review from arbitrary and capricious to *de novo.* Second, the Sixth Circuit held that the plan administrator did not give the plaintiff’s claim a “full and fair review” because it “ignored reliable, objective evidence” from her treating physicians. Specifically, the Court explained that the administrator’s “conclusion that there was no objective evidence directly contradicts the record: [the plaintiff’s] cervical and lumbar MRIs indicate ‘fairly extensive degenerative disc disease’ and a ‘new disc herniation,’” her “positive Spurling test results indicate radicular pain, . . . and finally the record contains a physician’s notes on the reduced range of motion over the right shoulder.”

The Sixth Circuit held that “when a plan categorically states that there is no objective evidence when in fact there is such evidence – favorable or not – the plan acts arbitrarily and capriciously,” and the “effect is even more obvious when the plan heavily relies on findings from its own non-treating physicians, or reviewing physicians.”

Third, the Court held that the proper disposition upon reversal was to remand to the plan administrator, rather than to award benefits. The Court reasoned that “we cannot say that [the plaintiff] is clearly entitled to benefits, only that there is a want of a deliberate, principled reasoning process.”

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Annual Insurance & Indemnity Law Section Meeting and Program

Thursday, September 22, 2016
9:00 – 9:30 a.m. Business Meeting
9:30 – 11:30 a.m. Program

Program Topic:
Commercial Property From Start To Finish
(See page 3 for details)

www.michbar.org/annualmeeting  #SBMmeeting

Photograph courtesy of Experience Grand Rapids
Selected Insurance Decisions
By Deborah A. Hebert, Collins, Einhorn, Farrell PC; Deborah.hebert@ceflawyers.com

Michigan Supreme Court Orders & Decisions

Further briefing ordered re: Insured's UIM claim and 12% interest

**Nickola v MIC General Ins Co**
___ Mich ___ (2016)
Case No. 152535

The Supreme Court has ordered further briefing and mini oral arguments on “(1) whether an insured making a claim for underinsured motorist benefits may be considered to be a ‘third party tort claimant’ under MCL 500.2006(4) of the Trade Practices Act, thereby requiring the insurer to pay twelve percent interest for failing to pay the claim on a timely basis *only if* the claim ‘is not reasonably in dispute’; and (2) whether the Court of Appeals decision in this case is consistent with Yaldo v North Pointe Ins Co, 457 Mich 341 (1998), and Griswold Properties, LLC v Lexington Ins Co, 276 Mich App 551 (2007).” Yaldo held that the 12% interest rate for judgments rendered on a written instrument applied to a lender’s loss in insurance claim, regardless of the reasonableness of the dispute. Griswold Properties made the same ruling with regard to a first-party property damage claim.

**Perkovic v Zurich American Ins Co**
___ Mich ___ (2016)
Case No. 152484

This is another coverage case in which the Supreme Court has ordered further briefing and mini oral arguments. The issue of interest is “whether the plaintiff, or someone in his behalf, satisfied the notice requirements of MCL 500.3145(1),” simply by sending medical bills to the PIP insurer.

Michigan Court Of Appeals – Published Decisions

UM coverage required direct contact with the hit-and-run vehicle

**McJimpson v Auto Club Group Ins Co**
___ Mich App ___ (2016)
Docket No. 320671

Where an uninsured motorist (UM) policy requires “direct contact” with a hit-and-run motor vehicle, there is no coverage for injuries caused by an object falling off a vehicle that fails to stop. Plaintiff was injured when her car was struck by a large piece of metal that flew off an 18-wheeler semi-truck on the road ahead of her. The trial court found the policy language ambiguous and awarded coverage because of the direct physical contact with the piece of metal. The Court of Appeals found the language unambiguous and reversed: the UIM policy afforded coverage “only where the unidentified vehicle makes ‘direct contact’ with the insured or her vehicle.”

Ambiguous CGL exclusion is construed in favor of insured

**Atlantic Cas Ins Co v Gustafson**
___ Mich App ___ (2016) (lv app pending)
Docket No. 325739

Plaintiff’s CGL policy contains a non-standard exclusion for claims of bodily injury to any “contractor,” which includes “any property owner.” The Court of Appeals found ambiguity in the term “any property owner” because it could mean anyone who owns any type of property and even the insurer admitted that was not the intended reach of the exclusion. Because ambiguous contract language is to be construed in favor of the insured, the Court concluded that “any property owner” was limited to “those that have a commercial interest in the [construction] project.” A residential homeowner on whose property work is being performed is not a contractor and so the exclusion does not apply to his claim.

Michigan Court Of Appeals - Unpublished

UIM coverage for named insured is not applicable to scheduled driver in a business auto policy

**LaChappell v Home-Owners Ins Co**
Docket No. 326003
Released May 24, 2016

UIM endorsement in a business auto policy covering a vehicle owned by the insured corporation, but driven by an employee listed as the scheduled driver, does not afford UIM coverage for injuries sustained by that employee as a pedestrian upon being struck by some other vehicle. The UIM endorsement restricts coverage to the “first named insured” for injuries sustained outside the covered auto. The employee is a scheduled driver, but not the first named insured, and his claim is not covered under the employer’s UIM policy.
“Actual replacement” requirement is not satisfied when new home is purchased by a land contract

_Glass v Farm Bur Gen Ins Co of Mich_
Docket No. 326461
Released June 14, 2016

Farm Bureau paid plaintiff the actual cash value of his home after it was badly damaged by fire. He had replacement cost coverage but only if “actual repair or replacement is completed.” Plaintiff entered into a land contract for a new home with the expectation that he would receive the additional replacement coverage. But Farm Bureau denied the claim because the home had not actually been replaced. The Court of Appeals agreed: “actual” replacement means more than potential replacement, which is what the land contract represents.

No homeowners coverage for damage caused by contractors

_Schwartz v Encompass Indemnity Co_
Docket No. 322702
Released March 15, 2016

Plaintiffs purchased a homeowners policy that covered first-party property damage due to any peril that caused “direct physical loss to property.” This did not include property damage caused by the unauthorized actions and faulty workmanship of their demolition contractor. In addition, the homeowners breached a condition of coverage on their mold claim because they failed to preserve evidence of the damaged property and failed to afford the insurer an opportunity to inspect.

UM claim presents issues of fact re lumber falling from truck

_Danhof v State Farm Mut Auto Ins Co_
Docket No. 324991
Released March 15, 2016

Plaintiff was injured in a motorcycle accident when he struck a large piece of lumber lying in the road. He claimed the lumber fell off a flatbed truck travelling in front of the vehicle just ahead of his motorcycle. The two UM insurers prevailed on summary disposition motions because no one had observed the piece of lumber falling off the truck. But the Court of Appeals found sufficient circumstantial evidence to create a question of fact for the jury.

Business use requirement in auto policy enforced

_Farm Bureau Gen'l Ins Co of Mich v Estate of Stormzand_ 
Docket No. 325326 (lv app pending)  
Released April 26, 2016

Business auto insurance policy providing liability coverage to a sole proprietor did not cover the liability claim of a passenger of the off-road vehicle (ORV) owned by the proprietor. The ORV was used for both business purposes and personal pleasure and it happened that the passenger was injured while riding in the ORV with the proprietor’s son for personal pleasure. The policy expressly stated that coverage applied only to claims arising out of the conduct of the insured business.

Case evaluation acceptance bars UIM coverage

_Bakkri v Sentinel Ins Co_
Docket No. 326109
Released June 21, 2016

The insured’s acceptance of a case evaluation award in his third-party auto liability case resulted in the loss of UIM coverage because that coverage did not apply if the insured resolved claims with the tortfeasor without the UIM insurer’s consent and without following the policy’s notice requirements in the event of a tentative settlement. The case evaluation award was not notice of a tentative settlement even where the UIM insurer was a party in the same case.

Faulty workmanship is not an “occurrence”

_Employers Mut Cas Co v Mid-Michigan Solar LLC_
Docket No. 325082
Released April 19, 2016

CGL insurer had no duty to defend or indemnify its insured contractor for claims of faulty installation of solar energy equipment. The only damage was to the equipment installed and so there was no “occurrence” as required for liability coverage.

6th Circuit Court Of Appeals Decisions

Misrepresentation claims not covered by auto dealer policy

_Preferred Automotive Sales, Inc v Motorists Mut Ins Co_  
Case No. 15-6183  
Released June 14, 2016 (unpublished)

Customer’s claims against insured auto dealer for misrepresentation and intangible harm are not covered under the liability policy issued by Motorists Mutual. The insured sold a vehicle to plaintiff, falsely verifying that it had not sustained any previous damage. Plaintiff learned of the undisclosed previous damage to the vehicle and sued, and the insured looked to Motorists Mutual for a defense and indemnity. The policy, however, limited coverage to claims of bodily injury or property damage and the customer’s claims were neither. The policy also excluded coverage for dishonest or fraudulent errors or omissions and expressly did not cover warranty claims.
Federal District Court Opinions – Unpublished
“Residence premises”
Skrelja v State Automobile Mut Ins Co
E.D. Mich Case No. 15-CV-12460
Released June 20, 2016

State Auto wrongly denied this fire loss claim under a homeowner’s policy where the insured had purchased the home several months earlier and was in the process of making repairs and improvements prior to moving in as a family. The insured was in the house 8 to 10 hours a day teleworking, meeting with contractors, and performing repairs himself. He stayed with his wife at her parents’ home in the evenings; she was pregnant and did not want to move in until most of the work was completed. The term “residence premises” in the policy was not defined and the court concluded that plaintiff’s presence in the house was sufficient to establish it as his residence.

Vitamin Health, Inc v Hartford Cas Ins Co
E.D. Mich Case No. 15-10071
Released May 19, 2016 (appeal pending)

Plaintiff manufactures eye care products and was sued by Bausch & Lomb for patent infringement and later, for false advertising. The court agreed with plaintiff’s CGL insurer about the lack of coverage for these claims because there were no allegations that the insured disparaged Bausch & Lomb’s products and because the alleged false advertising activities were expressly excluded.

About the Author
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No-Fault Corner

Death Knell For The “Innocent Third Party” Rule
Insurer’s Rescission Of Coverage Extends To PIP Benefits For Innocent Third Parties

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By way of background, the author was counsel for Titan Insurance Company in the seminal Michigan Supreme Court case of Titan Ins Co v Hyten, 491 Mich 547, 817 NW2d 562 (2012).

In Titan, the Michigan Supreme Court ruled that a nofault insurer could avail itself of the traditional common law remedies, including rescission and reformation, in cases involving misrepresentations in an insurance application. In Titan, the insured misrepresented the status of her driver’s license in an Application for Benefits. Due to the fraud that was perpetrated by the insured, Titan Insurance Company was allowed to reform its bodily injury liability limits down to the statutorily required minimum policy limits of $20,000.00/$40,000.00, notwithstanding the fact that the recovery of an “innocent third party” (in that case, the claimant who was injured as a result of the negligence of the insured) was affected.

In ruling that Titan could reform or rescind coverage to the minimum $20,000/ $40,000 policy limits, the Supreme Court indicated that the insurer was free to utilize whatever common law defenses were available, unless expressly prohibited by statute. The Supreme Court pointed out in a footnote that in the context of a bodily injury claim, MCL 500.3009 requires that all policies sold in the State of Michigan have liability limits of at least $20,000.00 per person or $40,000.00 per occurrence.

Court of Appeals Applies Titan to PIP Cases

Titan was admittedly not a PIP case. Ever since Titan was decided, though, the author has been asked by a number of prominent defense attorneys and clients as to whether or not the rationale expressed by the Supreme Court in Titan could be extended to claims for first-party, no-fault insurance benefits involving “innocent third parties.” Obviously, the stakes were substantial. Imagine, for example, that the insured strikes a motorcyclist, resulting in serious injuries (or even death) to the motorcyclist. Under MCL 500.3114(5)(a), the insurer of
the owner or registrant of the motor vehicle involved in the accident would occupy the highest order of priority for payment of the motorcyclist’s nofault benefits, which could easily be in the catastrophic range. However, if the policy is rescinded, due to a fraud in the application, why should the insurance company still face the prospect of paying out millions of dollars on a claim for the injured motorcyclist under a policy that never should have been issued?

In a 2-1 decision, the Court of Appeals ruled that, in light of the broad holding in Titan, supra, a no fault insurer could rescind PIP coverage, even as to an “innocent third party,” based upon the misrepresentations made by the insured. In other words, the “Innocent Third Party” rule has now been abrogated, including as it applies to PIP claimants.

The countervailing argument, of course, is that the innocent third party would need to then resort to a lower priority insurer or the Michigan Assigned Claims Plan, as the insurer of last resort. If the claim ends up with the Michigan Assigned Claims Plan, it will necessarily result in a higher assessment being charged to all Michigan motorists (who, after all, pay for the MACP claims), due to the influx of PIP claims involving an “innocent third party.”

The Michigan Supreme Court weighed in on this issue when it instructed the Court of Appeals to hear an interlocutory appeal, filed by Sentinel Insurance Company, in Bazzi v Sentinel Ins Co, 497 Mich 886 (2014). The Michigan Supreme Court subsequently vacated two decisions of the Court of Appeals which had reached opposite conclusions regarding this issue. See Frost v Progressive Mich Ins Co, 497 Mich 980, 860 NW2d 636 (2015) (in which the Court of Appeals held that the carrier could rescind PIP coverage for an innocent third party) and State Farm v Michigan Municipal Risk Mgmt Authority, 498 Mich 870, 868 NW2d 898 (2015) (in which the Court of Appeals held that the carrier could not rescind PIP coverage for the innocent third party). The Supreme Court instructed the Court of Appeals to hold its decision in these cases in abeyance, pending its decision in Bazzi, supra. Therefore, all eyes were on Bazzi.

Oral argument took place on December 9, 2015. Six months later, June 14, 2016, the Michigan Court of Appeals released its published opinion in Bazzi v Sentinel Ins Co, _ Mich App _ _ NW2d _ (Court of Appeals docket no. 320518, rel’d 6/14/2016). In a 2-1 decision, the Court of Appeals ruled that, in light of the broad holding in Titan, supra, a nofault insurer could rescind PIP coverage, even as to an “innocent third party,” based upon the misrepresentations made by the insured. In other words, the “Innocent Third Party” rule has now been abrogated, including as it applies to PIP claimants.

The facts in Bazzi, as noted in the majority opinion authored by Judge David H. Sawyer, were as follows:

“Plaintiff Ali Bazzi (“plaintiff”) is seeking PIP benefits for injuries sustained in an automobile accident while driving a vehicle owned by third-party defendant Hala Bazzi (plaintiff’s mother). . . . The vehicle driven by Bazzi was insured under a commercial automobile policy issued by defendant Sentinel Insurance to Mimo Investments, LLC. Sentinel maintains that the policy was fraudulently procured by Hala Bazzi and Mariam Bazzi (plaintiff’s sister and resident agent for Mimo Investments) in order to obtain a lower premium due to plaintiff’s involvement in a prior accident. Sentinel maintains that the vehicle was actually leased to Hala Bazzi for personal and family use, not for commercial use by Mimo, and, in fact, that Mimo was essentially a shell company that had no assets or employees or was not otherwise engaged in actual business activity. Sentinel also alleges as fraud that it was not disclosed that plaintiff would be a regular driver of the vehicle. In fact, Sentinel successfully pursued a third-party complaint against Hala and Mariam Bazzi seeking to rescind the policy based upon fraud.”

Bazzi, slip opinion at p. 1.

For purposes of its decision, the Court of Appeals assumed that Ali Bazzi was truly an “innocent third party.” Given these facts, the Court of Appeals then held as follows:

“Resolution of this case begins and ultimately ends with our Supreme Court’s decision in Titan. Although Titan did not involve a no-fault insurance claim for PIP benefits, we nonetheless are convinced that Titan compels the conclusion that there is no innocent third-party rule as to a claim for those benefits. That is, if an insurer is entitled to rescind a no-fault insurance policy based upon a claim of fraud, it is not obligated to pay benefits under that policy even for PIP benefits to a third party innocent of the fraud.”

Bazzi, slip opinion at p. 3.

The Court of Appeals’ rationale for extending Titan into PIP claims is very interesting.

The “Innocent Third Party” Doctrine and the “Easily Ascertainable” Rule

First, the Court of Appeals had to address the issues, raised by Judge Beckering’s dissent that the “Innocent Third Party”
Rule was separate and distinct from the “Easily Ascertainable” rule, which was abrogated by the Supreme Court in *Titan*. The “Easily Ascertainable” Rule prevented an insurer from rescinding optional coverages as to “innocent third parties” where the misrepresentation was “easily ascertainable.” This rule, in turn, had its origins in the Court of Appeals’ decision in *State Farm v Kurylowicz*, 67 Mich App 568, 242 NW2d 530 (1976). The Court of Appeals’ majority concluded that, in fact, these “rules” were one and the same. The Court of Appeals noted that even if the “Easily Ascertainable” Rule and the “Innocent Third Party” Rule were separate and distinct, they both had their origins in the *Kurylowicz* decision, which was overruled by the Supreme Court in *Titan*. The Court of Appeals noted that *Kurylowicz*’ progeny included *Ohio Farmers Ins Co v Michigan Mut’l Ins Co*, 179 Mich App 355, 445 NW2d 228 (1989), which did rely on the “Innocent Third Party” Rule. Therefore, because *Kurylowicz* was overruled, so, too, was *Ohio Farmers* and with it, the “Innocent Third Party” Rule was abrogated.

Having disposed of the claim that the “Innocent Third Party” Rule is separate and distinct from the “Easily Ascertainable” Rule, the Court of Appeals then addressed the “public policy” rationale for maintaining the “Innocent Third Party” Rule. In this regard, the Court of Appeals first quoted extensively from the Supreme Court’s decision in *Titan* itself, regarding the proper role of the Judiciary vis-à-vis the Legislature:

“First, *Kurylowicz* justified the ‘easily ascertainable’ rule on the basis of its understanding of the ‘public policy’ of Michigan. In light of the Legislature’s then recent passage of the no-fault act, MCL 500.3101 et seq., *Kurylowicz* reasoned that

‘the policy of the State of Michigan regarding automobile liability insurance and compensation for accident victims emerges crystal clear. It is the policy of this state that persons who suffer loss due to the tragedy of automobile accidents in this state shall have a source and a means of recovery. Given this policy, it is questionable whether a policy of automobile liability insurance can ever be held void *ab initio* after injury covered by the policy occurs.’ [*Kurylowicz*, 67 Mich App at 574.]

This ‘public policy’ rationale does not compel the adoption of the ‘easily ascertainable’ rule. In reaching its conclusion, *Kurylowicz* effectively replaced the actual provisions of the no-fault act with a generalized summation of the act’s ‘policy.’ Where, for example, in *Kurylowicz*’s statement of public policy is there any recognition of the Legislature’s explicit mandate that, with respect to insurance required by the act, ‘no fraud, misrepresentation, . . . or other act of the insured in obtaining or retaining such policy . . . shall constitute a defense’ to the payment of benefits? MCL 257.520(f)(1). We believe that the policy of the no-fault act is better understood in terms of its actual provisions than in terms of a judicial effort to identify some overarching public policy and effectively subordinate the specific details, procedures, and requirements of the act to that public policy. In other words, it is the policy of this state that all the provisions of the no-fault act be respected, and *Kurylowicz*’s efforts to elevate some of its provisions and some of its goals above other provisions and other goals was simply a means of disregarding the stated intentions of the Legislature. The no-fault act, as with most legislative enactments of its breadth, was the product of compromise, negotiation, and give-and-take bargaining, and to allow a court of this state to undo those processes by identifying an all-purpose public policy that supposedly summarizes the act and into which every provision must be subsumed, is to allow the court to act beyond its authority by exercising what is tantamount to legislative power. Third-party victims of automobile accidents have a variety of means of recourse under the no-fault act, and it is to those means that such persons must look, not to a judicial articulation of policy that has no specific foundation in the act itself and was designed to modify and supplant the details of what was actually enacted into law by the Legislature.”

Bazzi, slip opinion at pp. 8-9.

Given this observation, the Court of Appeals noted, in line with recent Michigan Supreme Court precedent, that public policy decisions are left up to the Legislature, not the Judiciary:

“The policy concerns raised by Citizens [the insurer assigned by the Michigan Assigned Claims Plan to adjust Ali Bazzi’s claim for nofault benefits] may well have merit. But it is for the Legislature, and not this Court, to determine whether there is merit to those concerns and, if so, what is the appropriate remedy. While the Legislature might conclude that the appropriate response is to create an innocent third-party rule, it may choose to address the issue differently. While we can envision any number of policy issues, as well as solutions to those issues, we are judges, not legislators. It is for the Legislature, not this Court, to consider these issues and determine what, if any, response represents the best pub-
lic policy. We decline the invitation to legislate into existence an innocent third-party rule that, thus far, the Legislature has chosen not to adopt.”

_Bazzi_, slip opinion at p. 9.

Accordingly, the Court of Appeals remanded the matter back to the Wayne County Circuit Court for a determination as to whether or not the misrepresentations made by Hala and Mariam Bazzi conclusively established fraud, or whether there were genuine issues of material fact regarding the fraud issue.

The Court of Appeals majority again summarized its holding as follows:

“In sum, regardless whether there is one rule or two, and whether we consider a case involving liability coverage or PIP benefits, it all leads back to _Kurylowicz_, and the Supreme Court in _Titan_ overruled _Kurylowicz_ because _Kurylowicz_ ignored the Supreme Court’s decision in _Keys v Pace_, 358 Mich 74, 99 NW2d 547 (1959), which had itself involved arguably easily ascertainable fraud and an innocent third party. Accordingly, we conclude that: (1) there is no distinction between an “easily ascertainable rule” and an “innocent third-party rule,” (2) the Supreme Court in _Titan_ clearly held that fraud is an available defense to an insurance contract except to the extent that the Legislature has restricted that defense by statute, (3) the Legislature has not done so with respect to PIP benefits under the no-fault act, and, therefore (4) the judicially created innocent third party rule has not survived the Supreme Court’s decision in _Titan_. Therefore, if an insurer is able to establish that a no-fault policy was obtained through fraud, it is entitled to declare the policy void _ab initio_ and rescind it, including denying the payment of benefits to innocent third parties.”

_Bazzi_, slip opinion at p. 10.

Given the Court of Appeals’ extensive reliance on _Titan_ in the majority opinion, including the majority’s express deferral of “public policy” concerns to the Legislature, it seems unlikely that the Michigan Supreme Court would entertain an Application for Leave to Appeal, although one never knows.

**Judge Boonstra’s Concurring Opinion**

Judge Boonstra issued an interesting concurring opinion. Judge Boonstra was on the panel of the Court of Appeals that decided _State Farm v Michigan Municipal Risk Mgmt Authority_, docket no. 319710, unpublished decision rel’d 2/19/2015, which had held that a no-fault insurer could not rescind PIP coverage even as to an “innocent third party.” Judge Boonstra went to great lengths to explain his change of opinion. Judge Boonstra explained that, after examining the briefs submitted by the parties on appeal (including the _amicus_ briefs) and closely examining the Michigan Supreme Court’s decision in _Titan_, Judge Boonstra became convinced “that the judicially-created doctrine that has become known as the ‘ Innocent Third Party’ Rule” was indeed part and parcel of the “Easily Ascertainable” Rule that the Supreme Court abrogated in _Titan Ins Co v Titan_, 491 Mich 547, 817 NW2d 562 (2012).” Judge Boonstra explained that an insurer is only obligated to pay benefits pursuant to a contract, and it makes no sense to enforce contractual liabilities against an insurance company in a case where, simply put, no contract exists! As stated by Judge Boonstra:

“Said differently, if, as _Titan_ says, we must construe the insurance policy and the statute (here, the no-fault statute) together as though the statute is part of the contract, _id_. and there is nothing in the statute to the contrary, the common-law fraud defense remains available to effect a rescission of the policy, and with it, the applicability of the statutory provisions that are otherwise incorporated into the contract. After all, if an insurer only has PIP obligations because it entered into a contract with its insured, and if it is entitled to rescind the contract because of the insured’s fraud, then there is no basis for enforcing against this contracting insurer the statutory PIP liabilities that only derive (as to that insurer) from the contract that has been rescinded.”

_Bazzi_, slip opinion at p. 4 (Boonstra, J. concurring)

Lastly, Judge Boonstra pointed out that the “Innocent Third Party” Rule was based, in part, on a now-repealed statutory provision that used to be incorporated into fire insurance policies regarding the defense of fraud by the insured. See _Morgan v Cincinnati Ins Co_, 411 Mich 267, 307 NW2d 53 (1981). Simply put, Judge Boonstra, like Judge Sawyer, found no basis to continue to apply the “Innocent Third Party” Rule in the context of a claim for PIP benefits.

**Judge Beckering’s Dissent**

Judge Beckering authored a 19-page dissent. In her opinion, she expressed concerns over the timeliness of any given insurer’s decision to rescind coverage even as to “innocent third parties,” and alluded to the possibility that many individuals who would otherwise be entitled to nofault benefits could be left without a claim for nofault benefits, should the insurer rescind after the One-Year Notice provision set forth in MCL 500.3145(1). As noted by Judge Beckering:

“Furthermore, I am not convinced that it is equitable to require the innocent third-party otherwise
covered by a policy to seek PIP benefits through the assigned claims plan in the event the insurance carrier claims fraud by the procurer and seeks rescission, as Sentinel contends should occur in this case. As Sentinel impliedly concedes in its briefing, the payment of benefits through the assigned claims plan might be unavailable for certain innocent third parties. And I note that statutory deadlines for giving notice of claimed PIP benefits could prevent an innocent third party, through no fault of his or her own, from receiving mandatory PIP benefits. Notably, a person claiming benefits through the assigned claims plan “shall notify” the assigned claims plan of his or her claim within one year. See MCL 500.3174; MCL 500.3145(1). See also Bronson Methodist Hosp v Allstate Ins Co, 286 Mich App 219, 225-226; 779 NW2d 304 (2009) (examining MCL 500.3145(1) and MCL 500.3174). I pose the question of: what happens when an innocent third party tries to obtain PIP benefits through the insurer listed on the policy, only to have that insurer subsequently rescind the policy based on fraud in which the innocent third party did not participate, and the innocent third party then misses the one-year deadline for notifying the assigned claims plan? At least one panel on this Court has held that, unless notice is given to the assigned claims plan within one year of the accident, the claim is barred, even when the injured person first sought benefits from what she thought was the correct insurer. See Visner v Harris, unpublished opinion per curiam of the Court of Appeals, issued December 6, 2012, (Docket No. 307507). This bolsters the position that permitting the remedy of rescission with regard to PIP benefits payable to innocent third parties has the potential to work an inequitable result. Moreover, allowing insurance companies to rescind their contracts with respect to PIP benefits owed to innocent third parties could encourage gamesmanship and delay tactics on the part of an insurer; insurance companies are the recipients of claims under the assigned claims plan, and waiting to rescind an insurance policy until after the assigned claims plan claim deadline passes means fewer claims filed under the assigned claims plan. This also runs afoul of the no-fault act’s purpose of ensuring prompt and adequate payment for the types of injuries and losses encompassed under the category of PIP benefits. [Citation omitted]. Put simply, I do not agree that the equitable remedy of rescission trumps the equitable remedy of the innocent third-party rule such that it is appropriate to apply to first-party statutorily mandated PIP benefits, and I decline to extend Titan in such a fashion.”

Bazzi, slip opinion at pp. 18-19 (Beckering, J. dissenting)

Instead, Judge Beckering would reaffirm case law dating back 30 years and maintain the “Innocent Third Party” Rule as is.

So Now What?

First, it is unknown at this time whether the claimants or the MACP-assigned insurer will file an Application for Leave to Appeal with the Michigan Supreme Court. For our part, we will be monitoring further filings on this case in the next few weeks. Claimants and/or the MACP-assigned insurer have until the July 26, 2016 to file an Application for Leave to Appeal with the Michigan Supreme Court.

Second, the insurer is still obligated to prove that it has a valid basis for rescinding coverage. Generally speaking, an insurer must demonstrate some type of fraud or misrepresentation (and these are not necessarily one and the same) in the application, and show that if the true state of affairs had been made known, the insurance company either would not have accepted the risk, or would have charged a higher premium. See, e.g., 21st Century Ins Co v Zufelt, _ Mich App _, _NW2d _ (Docket no. 325657, rel’d 5/24/2016) (Court of Appeals rules that a failure to disclose moving violations in an application for insurance justified rescission of the policy, even though the policy had been subsequently renewed.)

Third, the timing of the insurer’s decision to rescind coverage should be carefully examined. For those claims that are less than a year old, an insurer is now free to rescind coverage as to “innocent third parties.” In the rescission letter sent to the “innocent third party,” the nofault insurer should, as a matter of good business practice, provide the “innocent third party” with the contact information for the Michigan Assigned Claims Plan. If a lower priority insurer is known to the rescinding insurer, it would probably be a good idea to point out that information to the claimant as well.

Fourth, what about claims that are over one year old? This remains an open question. At this point, it is too early to tell whether the Michigan Assigned Claims Plan will agree to accept claims that are over one year old from rescinding insurers. After all, MCL 500.3174 makes it clear that the Michigan Assigned Claims Plan must be placed on notice of a claim for nofault benefits within one year from the date of accident. If, after all, the Michigan Assigned Claims Plan were to agree to
accept these claims notwithstanding the one-year notice provision, referenced above, so much the better. If, however, the MACP declines to accept such claims, would Judge Beckering’s predictions about “innocent third parties” suddenly having no coverage, as stated in her dissent, suddenly become true? What about the argument that because rescission is an equitable remedy, the rescinding insurer cannot have “unclean hands”? The author recommends that an insurance company faced with this decision should be on the watch for a counter-argument to the effect that it is acting “inequitably” when it rescinds coverage, and it is too late for the injured claimant to obtain his or her benefits from another source.

Perhaps the middle ground in cases where the insurer attempts to rescind more than 1 year post accident is for the MACP or the next higher priority insurer to pick up the claim, so that a legitimately injured “innocent third party” is not left without benefits. The MACP or next highest priority insurer would have to agree to waive application of the One Year Notice Provision set forth in MCL 500.3145(1) (as to policy insurers) and MCL 500.3174 (as to MACP insurers). At that point, the lower priority insurer or the MACP would file a subrogation action against the rescinding insurer, challenging its ability to rescind more than 1 year post accident. Given the scope of the Bazzi decision, it will be interesting to see how these issues work themselves out.

Finally, we can expect to see more claims being filed with the Michigan Assigned Claims Plan. Contrary to Judge Beckering’s opinion, not all insurers participate in the Michigan Assigned Claims Plan system. Currently, there are only seven insurers who participate as assigned insurers for the MACP. Those insurers can certainly expect to see an increase in the claims being handled by the MACP and, of course, more litigation.

Conclusion

In conclusion, what had been accepted as settled law for 30 years (according to Judge Beckering’s dissent) has now been abrogated by the Michigan Court of Appeals. As noted above, there are certainly competing public policy perspectives from the points of view of the rescinding insurer, the MACP and the injured “innocent third party.” For rescinding insurers, they are no longer “on the hook” to pay potentially millions of dollars in claims to “innocent third parties” until a policy which either never should have been issued in the first place, or would have been issued only in exchange for payment of a higher premium.

From the standpoint of the MACP and its assigned insurers, we can expect to see higher claims payouts, as the responsibility for handling claims of “innocent third parties” are shifted away from rescinding insurers and on to either a lower priority insurer or, more likely, the MACP as the insurer of last resort. To the extent that the MACP assumes handling of these claims, we can expect to see an increase in the statutory assessments that are utilized to fund the operation of the MACP and its claims payments. From the standpoint of the injured “innocent third party,” it remains to be seen whether or not the insurer will actually rescind coverage on a claim that has been paid for more than one year and, if so, how the MACP or a lower priority insurer will react to such a move. It will be interesting to see how matters shake out in the next few years. Whatever perspective the reader may have, perhaps the following quote from Joseph Chamberlain says it all:

“I think that you will all agree that we are living in most interesting times. I never remember myself a time in which our history was so full, and which day by day brought us new objects of interest, and let me say also, new objects for anxiety.”
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