

# The Journal of Insurance & Indemnity Law

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Hal O. Carroll, Journal Editor ■ [www.HalOCarrollEsq.com](http://www.HalOCarrollEsq.com) ■ (734) 645-1404

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

## From the Chair



Adam Kutinsky,  
Dawda Mann

Summer is upon us, which means we are half way through the 2017 term for our Section. As of June 2017, our membership has nearly reached the 1000 mark (960) and continues to grow as a result of the unique educational and networking opportunities we offer in the area of insurance law.

An area of focus for our section is attracting young lawyers and law students with an interest in our section's subject matter. We are incredibly fortunate to have the consistent energy of council member Laretta Pominville, who leads our section's activities at the annual Young Lawyers summit and ensures we maintain a presence at many important law school events.

The State Bar wisely offers law students the opportunity to join SBM sections and participate in our programs, meetings and events. We are exploring ways to increase student membership and involvement which will hopefully lead to more young attorneys becoming actively involved in our section.

### This Year's Program at the Annual Meeting

Our chair-elect, Larry Bennett, is organizing the program at the SBM "NEXT conference" f/k/a the SBM annual meeting and solo firm institute. This year's conference is on September 29th at Cobo Center and, like Larry's last program, this will be timely and informative. The program will have two topics; Cybersecurity and "Dumb Things Lawyers Do."

The program announcement in this issue contains more detailed information.

Our section strives to provide education and information on subjects of interest to our members and the program at the annual meeting will focus on ethics. We hope you will join us and participate in the program with questions and comments. Please do not shy away from raising a question out of fear of appearing uninformed. Many of our members are new to this area of practice and joined because they want to learn the "ins and outs." There is no experience requirement to be a member of our section and we hope to educate lawyers just entering the practice of insurance law as much as we serve the interests of more experienced lawyers. And, if you have a question, it is likely others do as well.

### Scholarship for Law Students

As mentioned in the last *Journal*, our section is creating a scholarship for law students interested in the exciting world of insurance and indemnity law. The initial funding will be around \$5,000 and most likely offered to 2L and 3L students. We expect a reasonable number of students to apply and will require a written submission as part of the selection process. The Council will use the submission as the primary if not sole criteria to select its scholarship recipient.

Thank you for your continued membership and involvement in our section. I hope you enjoy this issue of the *Journal*.

Best,  
Adam Kutinsky, Chairperson '17

### Editor's Notes



By Hal O. Carroll  
[www.HalOCarrollEsq.com](http://www.HalOCarrollEsq.com)

The *Journal* – now in its tenth year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The *Journal* – like the Section itself – takes no position on any dispute between insurers and insureds. All opinions expressed in contributions to the *Journal* are those of the author. But we welcome all articles of analysis, opinion, or advocacy for any position.

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

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



## The Covenant Case: The Past and Future of the Service Provider's Right of Direct Action

By Wayne Miller and Maureen Kinsella, *Miller & Tischler, PC*

### Introduction<sup>1</sup>

On May 25, 2017, the Supreme Court issued *Covenant Medical Center, Inc v State Farm Mut. Auto Ins. Co.*, \_\_\_ Mich \_\_\_; \_\_\_ NW2d \_\_\_ (2017). This decision is a true “game changer.” The court ruled that there is no statutory right of direct actions by healthcare providers against no-fault insurers under the no-fault law. With a stroke of the judicial pen, the court undid decades of case law to the contrary. The direct action was the primary mechanism for healthcare providers to protect their right of payment. In the weeks since *Covenant* was decided, there has been substantial chaos in the world of no-fault practitioners and in the trial courts.

As we try to divine the “new normal” that will emerge from the *Covenant* decision, we realize that *Covenant* did not change the no-fault law. Rather, *Covenant* merely removed a procedure for protecting the rights of healthcare providers. People continue to be injured in motor vehicle accidents, healthcare providers continue to treat them, and insurers continue to be in the business of adjusting and paying the charges. Therefore, we believe that the “new normal” must accommodate the roles and relationships that exist under the no-fault law. This includes allowing providers to bring their claims, and protecting patients from financial jeopardy of being caught in the middle of disputes between provider and insurer.

This article will discuss the history of the right of direct action, the *Covenant* decision, and the post-*Covenant* world.<sup>2</sup>

### The History of the Right of Direct Action

#### *Fundamental Relationships in No-fault Claims*

We begin by examining the parties involved in no-fault claims and the fundamental relationships between and among them. Three parties and their relationships are at the core of the no-fault law: patient, provider and insurer. The patient is an insured of the insurer, a recipient of services from the provider, and the provider's debtor. The provider renders services to the patient and becomes the patient's creditor. The insurer is a contractual or statutory insurer of the patient, and the payor of claims made by providers. These relationships can become complex. One of the fundamental rules of no-fault insurance is that insurers must provide financial protection for their insureds from claims of service providers. See discussion of OFIS Bulletin 92-03, *infra*.

#### *Provider Claims in the Early Years of the No-fault Act: 1973-2002*

The statutory right of direct action was not confirmed until 2002. How did providers bring their claims before then? The short answer: any way they could. In most instances, providers brought their claims in indirect and unsatisfying ways.

Providers were often relegated to working through their patient and their patient's attorney to enforce their claims for payment. This was often unsatisfactory for providers. Providers, without a seat at the “litigation table,” were subject to insurer defenses that the patient's attorney was unable to adequately defend or rebut without more intimate knowledge and understanding of the provider's practice and services.

On other occasions, patients' attorneys and insurers sometimes conspired to reduce payment on services provided. For example, lump sum settlements were negotiated between patient and insurer. The settlement proceeds were paid to patient and his attorney, with the provider getting whatever the patient and attorney thought they should get. This conflict between the patient's interest in minimizing exposure on his or her debt to the provider, and the provider's interest in maximizing its recovery, has long been at the core of many disputes between patient and provider, and their respective counsel. This conflict was discussed by the Court of Appeals in *Krywy v State Farm*, unpublished opinion per curiam of the Court of Appeals, issued April 24, 2008 (Docket Nos. 274663 and 277313) where the court opined that it did not “condone the reckless decision of plaintiff's trial counsel to remain employed by both [provider] CRCI (a creditor) and [patient] plaintiff (its debtor) on a matter directly related to the outstanding debt.” *Id.* at Fn 4.

Patients also suffered during this early period before direct right of action. Insurer defenses against provider claims often left the patient exposed to financial liability. The patient was left directly in the middle of the conflict between provider and insurer. In 1992, the Michigan Insurance Commissioner addressed the issue of patient exposure in billing disputes and issued Bulletin 92-03. The Commissioner stated some “ground rules” to be used in managing disputes involving the reasonableness of charges, including that insurers are required to provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance, and that insurers must act at all times to assure that

the insured or claimant is not exposed to harassment, dunning, disparagement of credit or lawsuit as a result of a dispute with a provider. While the context of this bulletin involves a duty of protection owed to an insured, it underscores the important point—that when a dispute over medical payments arises, resolution of the dispute should involve only the provider and the insurer. The Court of Appeals commented on this bulletin in *McGill v Auto Ass'n of Michigan*, 207 Mich App 402 (1995):

“While the Commissioner of Insurance’s Interpretative Statement, Bulletin 92-03 does not have the full force or effect of law, [Michigan courts] generally give deference to administrative agency interpretations. *Id.* at 407, note 1 (citing MCL 24.203(6); and *DAIIE v Commissioner of Insurance*, 119 Mich App 113 (1982).”

Accordingly, Bulletin 92-03 and *McGill* stand for the proposition that resolution of reasonable charge disputes between providers and insurers should occur in an action between the provider and the insurer—without the involvement of the insured. In 1995, the Attorney General also addressed this issue in Attorney General Opinion #6865 (8/18/1995), wherein the Attorney General expressed and noted that Insurance Bulletin 92-03 ordered insurers to defend the interests of the patients in billing disputes.

In *LaMothe v Auto Club Ins of MI*, 214 Mich App 577 (1995), the insurer promised to defend and indemnify the plaintiff from any collection efforts by the medical providers. Relying on *McGill*, the court held that this promise was legally binding. The court commented that such a promise could result in the provider being deemed a third party beneficiary of the contract between the insurer and insured. The result in that limited circumstance of a reasonable charge dispute was that the patient was not exposed to litigation or financial jeopardy.

The reasonable charge dispute discussed in *McGill* and *LaMothe* is just one of many areas of dispute in no-fault cases. Providers sought a broader right to challenge decisions made by no-fault insurers. Early efforts included the use of an assignment from the patient to the provider of the right to sue the no-fault insurer. This was approved in *Professional Rehabilitation Associates v State Farm*, 228 Mich App 167 (1998). But assignments were not panaceas to the problem of provider access to the courts. Assignments required the permission of the patient. That permission was not always readily given, as patients or their attorneys were often uncooperative.

Ultimately, the best solution for the provider was one that did not require the permission of the patient or the consent of the insurer. That solution was the right of direct action. Providers finally won the right to bring their claims directly through a number of cases starting in 2002.

### *The Right of Direct Action: 2002-2017*

The provider’s right to sue no-fault insurers directly and independently of the patient was clearly established through a number of published Court of Appeals decisions starting in 2002 with *Lakeland Neurocare Centers v State Farm Mutual Auto Ins Co*, 250 Mich App 35 (2002) and *Regents of the University of Michigan v State Farm*, 250 Mich App 719 (2002). These cases made clear that service providers could bring direct actions to recover benefits for unpaid medical expenses and also pursue no-fault penalty sanctions for interest and attorney fees. *Lakeland* was cited with approval in *Michigan Head & Spine, PC v State Farm*, 299 Mich App 442 (2013), and in *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389 (2014), lv den, 497 Mich 1029 (2015).

In the era between *Lakeland* and *Covenant*, the providers’ problem of getting a seat at the table and ensuring they were paid was largely solved. However, other problems began to arise. In particular, provider lawsuits proliferated. As the years passed since *Lakeland*, insurers and trial courts began to complain about an explosion of lawsuits from a single motor vehicle accident. It was not uncommon for a single accident to give rise not only to a case by the injured person but a number of other cases by different providers. A single injury claim could result in 6 or more separate lawsuits as each provider brought its own claim, sometimes in different venues, with little coordination between and among the various other providers. This drove insurers to challenge the right of direct action.

In *Wyoming Chiropractic*, the Court of Appeals soundly rejected an insurer’s public policy argument against provider standing based on the proliferation of provider claims:

In addition, the public policy goals of the no-fault act support allowing a healthcare provider to have standing to sue an insurer for PIP benefits. Auto Owners argues that this rule will force insurers to defend multiple lawsuits at different times and in different courts. Auto Owners also points out that insurers face an increased risk of having to pay penalty interest if healthcare providers have standing to sue because insurers will not be able to concentrate their efforts on paying insured individuals on time and at ‘fair and equitable rates.’ However, as discussed above, this Court interpreted the plain language of MCL 500.3112 as allowing health care providers to maintain direct causes of action against insurers to recover PIP benefits under the no-fault act. Thus, the Michigan Legislature addressed the public policy issues related to health care provider standing when it drafted MCL 500.3112. . . .

Furthermore, public policy favors provider suits. The goal of the no-fault act is ‘to provide victims of

motor vehicle accidents with assured, adequate, and prompt reparation for certain economic losses.’ the no-fault act was designed to remedy ‘long delays, inequitable payment structure, and high legal costs’ in the tort system. Allowing a health care provider to bring a cause of action expedites the payment process to the healthcare provider when payment is in dispute. Thus, provider standing meets the goal of prompt reparation for economic losses. Healthcare provider standing also offers a healthcare provider a remedy when an insured individual does not sue an insurer for unpaid PIP benefits, thus preventing inequitable payment structures and promoting prompt reparation.” *Id.*, 389 Mich App at 401

Insurers continued to challenge the right of direct action. Several attempts failed including the effort by Auto Owners in *Wyoming Chiropractic*. Prior to the Court of Appeals opinion in *Wyoming Chiropractic*, Auto Owners sought bypass leave to the Supreme Court to challenge the providers’ standing which was denied in 2015.<sup>3</sup> The insurers finally succeeded in *Covenant v State Farm*, the case that would end up being the insurers’ vehicle to strip away the single most effective method for providers to protect their interest in being paid for services provided motor vehicle accident injured patients.

## The Covenant Ruling

### *Basic Facts and Trial Court Ruling*

Jack Stockford was involved in a motor vehicle accident on June 20, 2011. He was a State Farm insured. He received care at Covenant Medical Center in 2012 and incurred expenses totaling approximately \$44,000. State Farm refused to pay the medical expense. Stockford filed suit against State Farm in Saginaw County Circuit Court and settled for \$59,000.00. Stockford executed a release which included all no-fault claims including the Covenant medical expenses through January 10, 2013. Not knowing about Stockford’s case or settlement, Covenant filed suit against State Farm in Kent County Circuit Court seeking to recover payment of the medical expenses. State Farm raised as a defense the Stockford release. The Circuit Court granted State Farm’s motion for summary disposition. Covenant appealed to the Michigan Court of Appeals.

### *Court of Appeals Ruling*

The Court of Appeals reversed the trial court and affirmed the long standing statutory right of direct action. *Covenant Medical Center v State Farm*, 313 Mich App 50 (2015). The Court of Appeals held:

MCL 500.3112 provides that if the insurer does not have notice in writing of any other claims to payment for a particular covered service, then a good-

faith payment to its insured is a discharge of its liability for that service. However, the plain text of the statute provides that if the insurer has notice in writing of a third party’s claim, then the insurer cannot discharge its liability to the third party simply by settling with its insured. Such a payment is not in good faith because the insurer is aware of a third party’s right and seeks to extinguish it without providing notice to the affected third party. Instead, the statute requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated. That was not done in this case. Accordingly, under the plain language of the statute, because State Farm had notice in writing of Covenant Medical’s claim, State Farm’s payment to Stockford did not discharge its liability to Covenant Medical” *Id.*, 313 Mich App at 53.

The result of the *Covenant* Court of Appeals decision was to make insurers doubt the finality of their settlements with injured plaintiffs. Insurers began to fear that they would be exposed to double payments. So insurers began to require allocation hearings following any settlements with injured persons. Now, not only were provider cases proliferating through our courts, but “Covenant Allocation Motions” were flooding the courts’ dockets on motion day. The Court of Appeals ruling was essentially the zenith of the provider rights under the no-fault act. However, this additional burden of Covenant Allocation Motions on the courts proved also to be the proverbial last straw, seeming to cry out for relief from the Supreme Court.

### *Supreme Court Ruling*

The Supreme Court held that the no-fault act does not explicitly grant providers an independent right of action against an insurer. In order to find that providers had an independent right of action, the Supreme Court’s brand of textual interpretation apparently required that the statute clearly state the existence of such a cause action. The court scoured the no-fault law for such a clear statement. Finding no such clear statement, the court held that there was no statutory right of direct action.

In sum, a review of the plain language of the no-fault act reveals no support for plaintiff’s argument that a healthcare provider possesses a statutory cause of action against a no-fault insurer. *Id.*, slip opinion at 23-24.

The Supreme Court’s opinion reversed the Court of Appeals decision and 15 years of remarkably consistent case law. Rather than parsing the rationale of the Court in *Covenant*, the remainder of this article will focus on the new post-*Covenant* world, and how the decision will affect future practice and procedure.

## Navigating The Post-Covenant World

### *Short Term Chaos*

Hopes that the end of a statutory right of direct action would end providers' efforts to pursue claims have proved to be false. In addition to the vast number of cases that were pending when *Covenant* was issued, providers continue to have bills for which reimbursement is sought. Since *Covenant*, trial courts have been bombarded with motions to get rid of provider claims, and motions to amend complaints to preserve provider claims. We now face a period of adjustment where all parties seek to understand what will be permitted now that a statutory right of direct action is no longer permitted.

It is important to understand that the *Covenant* decision did not terminate the right of healthcare providers to participate in no-fault litigation. The holding is narrow: there is no statutory right of direct action. The Court made clear that "[t]his conclusion does not mean that a healthcare provider is without recourse." *Id.*, slip opinion at 24. The following will discuss the various options remaining after *Covenant*. These options have always existed, but have been less desirable to the provider (and often to the patient) than the right of direct action.

### *Suing The Patient*

The Court in *Covenant* specifically held that "...a provider that furnishes healthcare services to a person for injuries sustained in a motor vehicle accident may seek payment from the injured person for the provider's reasonable charges." This of course has always been true, as the patient is financially responsible to the provider for services rendered. This is also very troubling. One of the important public policies served by the no-fault law is to keep the patient out of the middle of disputes between providers and insurers. The Supreme Court's ruling actually promotes the very opposite concept. The Supreme Court's rather cavalier conclusion that providers can simply pursue their patients is directly contrary to the act's purpose as stated by the Court of Appeals in *Wyoming Chiropractic* where it found that direct actions by providers serve the public by protecting injured persons from exposure to litigation. Moreover, it is inconsistent with the Insurance Commissioner's statement in Insurance Bulletin 92-03, as adopted in *McGill, supra*. Of course, litigation between patient and healthcare provider can hardly be conducive to the intimate therapeutic relationship between patient and provider.

Ultimately, the option of suing the patient is also financially unsatisfying. Generally, the injured person does not have the financial ability to pay out of pocket for most medical bills. So the provider will continue to be interested in involving the no-fault insurer. So what is the Supreme Court's vision on how this plays out procedurally vis-a-vis the no-fault insurer? Is the insurer supposed to step in to protect the injured when the provider sues? If not, is the patient then expected to implead

the insurer as a third-party defendant? What is the insurer's liability to a judgment against injured patient?

Ultimately, the ability to sue the patient is rather a nugatory option for the provider. It doesn't do much for the patient either.

### *Third Party Beneficiary Theories*

The court in *Covenant* refused to rule out the potential for a provider's cause of action under the contract theory of third-party beneficiary, stating in Footnote 39:

We conclude today only that a healthcare provider possesses no statutory right to sue a no-fault insurer. While Defendant argues that a provider likewise possesses no contractual right to sue a no-fault insurer given that healthcare providers are incidental rather than intended beneficiaries of a contract between the insured and the insurer, this Court declines to make such a blanket assertion. That determination rests on the specific terms of the contract between the relevant parties.... Slip opinion at 24.

A third-party beneficiary may have the right to sue on a contract, despite not having originally been a party to the contract. Under MCL 600.1405, intended, not incidental, beneficiaries can sue for a breach of a contractual promise. Generally, a person is a third-party beneficiary of a contract when that contract establishes that a promisor has undertaken a promise directly to or for that person.<sup>4</sup> Thus, the language of the insurance contract at issue is important to determine whether the provider is an intended beneficiary and not merely incidental.

In the no-fault context, the third party beneficiary theory was recognized in the *LaMothe* case discussed above. This was in the context of a provider's claim for a balance beyond the amount paid voluntarily by the no-fault insurer. The no-fault insurer agreed to defend and indemnify the injured individual. Under such circumstances, the service provider could be found to be an intended beneficiary of the defense/indemnity contract between insurer and insured. It is not clear what other circumstances would satisfy the "intended beneficiary" requirement of MCL 600.1405. This is yet another area that awaits further appellate clarification.

### *Assignment of Benefits*

The Supreme Court in *Covenant* specifically mentioned assignments as a method of bringing a provider cause of action:

Moreover, our conclusion today is not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider. See MCL 500.3143; *Professional Rehab Assoc v State Farm Mut Auto Ins Co*, 228 Mich App 167; 172; 577 NW2d 909 (1998) (noting that only the

assignment of future benefits is prohibited by MCL 500.3143). *Id.*, slip opinion at 24, fn40.

No-fault section 3143 mentioned in *Covenant* states: “An agreement for assignment of a right to benefits payable in the future is void.” This section has been a backwater of the no-fault law since its inception. Now it has become very prominent, attracting great attention from all sides. Eschewing an analysis of purpose of the statute (probably to prevent unscrupulous lenders from exploiting a vulnerable injured person), the text of statute appears to focus on the timing of the assignment. That is, an assignment of benefits executed before treatment will be void; an assignment of benefits executed after treatment will be enforceable. Certainly, that was the holding in the *Professional Rehab Associates* case cited with approval in *Covenant*.

Other than the timing of the assignment, many other legal issues have been raised. A brief primer is therefore appropriate. All legitimate causes of action are assignable.<sup>5</sup> Upon assignment, the assignee becomes the real party in interest with respect to the thing assigned.<sup>6</sup> An assignee stands in the shoes of the assignor, acquiring the same rights as the assignor possessed.<sup>7</sup> Assignments are contracts and should, where possible, be given a logically acceptable construction that renders them legal and enforceable.<sup>8</sup> If the assignment is clear on its face, interpretation begins and ends with the actual words of the written agreement.<sup>9</sup> Consideration is not required in order for an assignment to be valid; instead, an assignment may be a valid transfer from the patient to the provider even if it is gratuitous.<sup>10</sup>

Insurers may argue that their “anti-assignment” clauses invalidate the assignment between provider and patient. However, Michigan follows the majority rule with respect to the validity of an anti-assignment clause in an insurance contract. An insurance policy prohibiting an assignment by the insured is ineffective to preclude the insured from making an assignment *after a loss* has occurred.<sup>11</sup> The rule recognizes the distinction between *pre-loss assignments*, which can be prohibited, and *post-loss assignments*, which cannot be prohibited, in that a pre-loss assignment involves a transfer of a contractual relationship, whereas a post-loss assignment is a transfer of a chose in action or a right to a money claim.<sup>12</sup> The general rationale for the rule is that an anti-assignment clause is intended to prevent an insurer from taking on an insurance risk for which it did not bargain. If an insurance policy could be bought by one individual and then assigned to another, the insurer would be liable for an outsized risk that it was not able to price into its policy premium.<sup>13</sup> By contrast, where the loss has already occurred, the insurer’s exposure is not in any way increased if the injured party’s right to benefits under the policy is assigned to some other party because the assignee simply gets to do exactly what the assignor was entitled to do: prosecute an accrued claim for known money damages.<sup>14</sup>

Further, the Michigan Legislature considered the prohibition of assignments under the no-fault act and plainly expressed in §3143 an intent to allow assignments of rights with past and presently due benefits. An insurance policy exclusion that conflicts with the requirements of the no-fault act is void as contrary to public policy. *Cohen v Auto Club*, 463 Mich 525; 620 NW 2d 840 (2001).<sup>15</sup>

Finally, anti-assignment clauses will not be operative in situations where the injured person claims no-fault insurance by operation of law and not from their own policy. Under the no-fault law, many people will claim no-fault benefits in such a fashion. For example, under MCL 500.3114(5), motorcyclists will claim coverage from the insurer of the motor vehicle involved in the crash. Any anti-assignment clause in the motor vehicle insurer’s policy will not be effective as against the person who was not party to the policy. See *Shelton v Auto Owners*, \_\_\_ Mich App \_\_\_ (Ct App #328473, 2017). Another example is where the injured person claims no-fault insurance on assignment from the Assigned Claims Plan, per MCL 500.3172.

The following is a sample and simple assignment that appears to comply with the §3143 and case law:

“I, \_\_\_\_\_ (patient), do hereby assign my right to collect (including the right to sue for) no-fault insurance benefits, for unpaid services rendered by \_\_\_\_\_ (provider) to date, to \_\_\_\_\_. This is an assignment for services already rendered only; this is not an assignment of benefits for services rendered in the future or after the date of this document. Patient agrees that as consideration for this assignment, Provider assumes the burden, otherwise borne by the Patient, to pursue payment for services rendered by Provider, from the insurance company or payor entity responsible to pay for such services. This assignment shall be irrevocable unless terminated by mutual agreement of Patient and Provider in writing.”

### Intervention

There are a number of methods for asserting provider claims that are not mentioned in *Covenant* but clearly continue to be available. For example, intervention under MCR 2.209 survives *Covenant*. Providers are entitled to intervene where: (1) the application is timely, (2) the provider claims an interest in the property or transaction at issue, (3) it is so situated that disposition of the action may as a practical matter impair or impede its ability to protect its interest, and (4) the provider’s interest is not adequately represented by the existing parties.

Already since *Covenant*, some insurers have argued that a provider must have an independent basis or cause of action in order to intervene. This is not so, there is no such requirement. Case law confirms that whether a provider could file an

independent action against the insurer is simply inapposite to the determination of whether intervention is appropriate. The fact that a provider as a proposed intervening plaintiff does not have a direct cause of action against the insurer does not preclude the provider's right or permissive ability to intervene. Rather, the right to intervene is premised merely on *having an interest* in the subject matter of the action. In analyzing the analogous federal rule (FRCP 24), the United States Court of Appeals for the Sixth Circuit stated:

"In this circuit we subscribe to a "rather expansive notion of the interest sufficient to invoke intervention of right." *Michigan State AFL-CIO v Miller*, 103 F3d 1240, 1245 (6<sup>th</sup> Cir. 1997). For example, an intervenor need not have the same standing necessary to initiate a lawsuit. See *id.*; *Purnell v City of Akron*, 925 F2d 941, 948 (6<sup>th</sup> Cir. 1989). We have also "cited with approval decisions of other courts 'rejecting the notion that Rule 24(a)(2) requires a specific legal or equitable interest.'" *Miller*, 103 F3d at 1245. (quoting *Purnell*), 925 F2d at 948). "The inquiry into the substantiality of the claimed interest is necessarily fact specific." *Id.* *United States v Tennessee*, 260 F3d 587, 595 (6<sup>th</sup> Cir. Tenn. Aug. 8, 2001).<sup>16</sup>

Some fairly recent cases suggest that the provider not only *may* intervene, but *ought* to intervene in order to protect their distinct interests under the no-fault law. See *Miller v Citizens Ins Co, et al*, 288 Mich App 424 (2010), *aff'd in part/rev'd in part*, 490 Mich 904 (2011); *Auto-Owners Ins Co v Keizer-Morris, Inc*, 284 Mich App 610' 773 NW2d 267 (2009).

Some trial courts may deny intervention based on the belief that the patient's attorney can adequately represent the provider's interest. The authors suggest caution and thoughtful consideration of the subtle but important different interests from patient, to provider and thus their counsel. At its core, the relationship between patient and provider is one of debtor and creditor. The provider renders services to the patient and

expects to be paid for them. The patient's interest is to minimize his or her exposure to debt. Thus the patient's attorney is motivated to maximize the patient's own recovery of no-fault benefits. When the provider is not present as an intervening party in an action, the provider's interest in maximizing its recovery for services provided to the patient is often compromised because it conflicts with the patient interest. Representing the patient and the provider may lead to concerns over conflict of interest.<sup>17</sup> There may, of course, be occasions where the patient and the provider interests are in consonance, rather than conflict.

### *Co-counseling with Patient Attorney*

While the authors believe that assignments are valid, anti-assignment clauses are invalid, third-party beneficiary theory remains, and intervention under MCR 2.209 permits the provider a seat at the proverbial table, we expect the insurers will be fighting these mechanisms for the next several years in the appellate courts. In the meantime, co-counsel arrangements between patient attorney and provider attorney may be desirable. Insurers can say little about co-counsel arrangements. The possible conflicts can be managed and waived. Covenants not to sue may be employed to minimize or eliminate conflicts. Cost-sharing arrangements can be crafted that make working together mutually beneficial for both patient and provider. Practically, there could certainly be issues to work through such as when insurers want to settle in bulk and patient/provider co-counsel are left to divide proceeds. Trial procedure questions will remain (e.g., who will make opening statements/closing arguments, question the jury, cross examine witnesses, etc.). These are issues that will require cooperation between patient and provider counsel. Accordingly, such agreements may not always be viable.

### *Prospective Application versus Retroactive Effect*

The Court in *Covenant* was silent as to whether the decision should be applied retroactively or prospectively. "Sometimes a court which announces a change of law will refrain



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from going the next step to indicate how its new rule is to be applied. In such a situation, the prospective-retroactive issue is left for decision in a later case.”<sup>18</sup> In *Pohutski v City of Allen Park*, 465 Mich 675, 695-696; 641 NW2d 219 (2002), the Michigan Supreme Court has stated four factors to consider as to whether a decision should be given full retroactive effect or prospective application. The test weighs: (1) “the purpose to be served by the new rule,” (2) “the extent of reliance on the old rule,” (3) “the effect of retroactivity on the administration of justice[,]” and (4) “whether the decision clearly established a new principle of law.” *Id.* at 696 (citations omitted).

It is presumed that the Court in *Covenant* sought to limit the number of provider suits against insurers. The Supreme Court’s agenda would still be served if the decision in *Covenant* is applied prospectively, while a retroactive application would severely undermine the administration of justice where providers relied on decades of established case law allowing a right of direct action. Providers were litigating actively in cases incurring time and cost in litigation. Provider remedies that continue post-*Covenant* (i.e., suing the patient directly, seeking an assignment, etc.) may be time-barred under different theories of law. Likewise, the patient may have relied on his provider having filed suit against the insurer relative to particular outstanding bills and may be time barred from his own action.

## Conclusion

*Covenant* is now the law: there is no longer a statutory right of direct action. *Covenant* is not good public policy. Short term chaos will give way to longer term options for providers. Those options are the ones that existed prior to 2002. These tools are flawed, and often impose significant barriers to provider recovery and prove contrary to the promise of the no-fault act: prompt reimbursement. Unlike the statutory right of direct action, each of the alternatives requires cooperation from the patient, the patient attorney or the court; none of which may be forthcoming in a given case. When cooperation of the patient or the patient attorney is withheld, providers may have no choice but to sue the patient.

Moreover, it remains to be seen whether *Covenant* will achieve the goal sought by the insurers: reduction in provider litigation. At this point, such litigation will potentially be available through mechanisms such as assignments. I.e., it seems to the authors that provider litigation will remain, but it will become more complex, more expensive, and likely increase involvement of the insured. That is why the Court of Appeals in *Wyoming Chiropractic* found that direct actions by providers serve public policy: they promote the public policy of protecting injured persons from exposure to damaging litigation.

Therefore, even though there is no longer a *statutory right* of direct action, it is hoped that insurers will recognize the

imperative and desirability of *permitting* direct actions so as to keep their insureds out of the middle of disputes. Otherwise, the “new normal” that we can expect will be one where providers will continue to care for their patients, but their collections will likely decrease and legal costs likely increase. This will likely lead to decreased availability of medical care and consequent increased cost. Such an outcome serves no one well. ■

## About the Authors

**Wayne Miller** is a partner in Miller & Tischler PC. He specializes in no-fault insurance claims for patients and providers. He can be reached at [wmiller@msapc.net](mailto:wmiller@msapc.net).

**Maureen H. Kinsella** is a Vice President of Miller & Tischler, PC. She represents medical service providers and injured persons. She can be reached at [mkinsella@msapc.net](mailto:mkinsella@msapc.net)

## Endnotes

- 1 The authors represent catastrophically injured people and health-care providers. This article will reflect that perspective.
- 2 The authors represent catastrophically injured people and health-care providers. This article will reflect that perspective.
- 3 *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co*, 495 Mich 866 (2013). See also *Detroit Medical Center v State Farm*, 495 Mich 917 (2013), where the Supreme Court denied leave to challenge the right of direct action.
- 4 MCL 600.1405; *Koenig v South Haven*, 460 Mich. 667, 677; 597 N.W.2d 99 (1999).
- 5 *Grand Traverse Convention & Visitor’s Bureau v Park Place Motor Inn, Inc*, 176 Mich App 445, 448; 440 NW2d 48 (1998), citing *Moorhouse v Ambassador Ins Co, Inc*, 147 Mich App 412, 421; 383 NW2d 219 (1985), citing 3 *Michigan Law & Practice, Assignments*, § 16, p 14.
- 6 *Cannon Twop v Rockford Pub Sch*, 311 Mich App 403, 413; 875 NW2d 242 (2015), citing *Barclae v Zarb*, 300 Mich App 455, 483; 834 NW2d 100 (2013)
- 7 *Professional Rehab*, 228 Mich App at 177.
- 8 *Universal Underwriters Ins Co v Kneeland*, 464 Mich 491, 497; 628 NW2d 491 (2001), quoting *Stillman v Goldfarb*, 172 Mich App 231, 239; 431 NW2d 247 (1988).
- 9 *Id.* at 496.
- 10 See *Johnson v Wynn*, 38 Mich App 302, 306; 196 NW2d 313 (1972). See also *Bay County Bar Ass’n v Finance System, Inc*, 345 Mich 434, 437-38; 76 NW2d 23 (1956); *Hickman v Chaney*, 155 Mich 217, 225; 118 NW 993 (1908) (“As to consideration, the assignor had a right to assign without consideration if he chose to do so . . .”); *Althea C Everard Trust v Ward*, 2005 Mich. App. LEXIS 694, \*16, 2005 WL 599814 (Mich. Ct. App. Mar. 15, 2005) (“Consideration is not required for an assignment if the assignor had a donative intent.”).
- 11 *Roger Williams Ins Co v Carrington*, 43 Mich 252, 253-54; 5 NW

- 303 (1880); *Marion v Vaughn*, 12 Mich. App. 453, 463 (1968); *Benson v Assurity Life Ins Co*, 2004 U.S. Dist. LEXIS 18953, \*10 n.3, 2004 WL 2106637 (W.D. Mich. June 16, 2004).
- 12 *Action Auto Stores v United Capitol Ins Co*, 845 F Supp 417, 422-23 (WD Mich 1993); *Watertown Fire Ins Co v Grover & Baker Sewing Machine Co.*, 41 Mich 131, 136-37; 1 NW 961, 963 (1879).
- 13 See, e.g., *McHugh v Manhattan Fire & Marine Ins Co*, 363 Mich 324, 327; 109 NW2d 842 (1961).
- 14 See also *Globecon Group, LLC v Hartford Fire Ins Co*, 434 F3d 165, 170 (2d Cir. 2006) (explaining rationale for rule); *Ocean Acc & Guar Corp v. Sw Bell Tel Co*, 100 F2d 441, 446 (8th Cir. 1939); *Wehr Constructors, Inc v Assur Co of Am*, 384 SW3d 680, 683 (Ky. 2012).
- 15 Among the many aspects of assignments under the no-fault law that will be litigated in the time to come is the impact of the Uniform Commercial Code (UCC). The UCC clearly contemplates the viability of assignments of rights from patients to health care providers. MCL 440.9408(1) renders ineffective anti-assignment clauses for an account assigned to a health care provider.
- 16 To the same effect is In *Michigan State AFL-CIO v. Miller*, 103 F.3d 1240 (6<sup>th</sup> Cir. 1997), the Sixth Circuit stated that “an intervenor need not have the same standing necessary to initiate a lawsuit.” *Id.*, at 1245
- 17 See *Krywy v State Farm* (C/A #274663, #277313; 4/24/2008), discussed above.
- 18 *Riley v Northland Geriatric Center* (After Remand), 431 Mich 632, 643; 433 NW2d 787 (1988) (citations omitted).



## INSURANCE & INDEMNITY LAW SECTION

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10:00 – 10:30 a.m. Business Meeting

10:30 – 12:00 Program

#### Two Topics That Will Help Your Practice:

#### Cybersecurity: Protecting Client Information and Yourself

#### How to Avoid Dumb Things Lawyers Do!

Speaker: Janis Meyer, Hinshaw & Culbertson LLP

This program will focus on two issues that are important to lawyers, one relatively new, one as old as the legal profession:

**Cybersecurity** -- As lawyers, we have an ethical obligation to protect our client’s information, yet increasingly that information is threatened by hackers, ransomware, and our own carelessness. Not understanding the technology is not an excuse and may be an ethical violation as well. This portion of the program will provide an overview of some of these issues and how to protect our client’s information as well as our own from attack.

**Dumb Things Lawyers Do!** – Regardless of education, experience and smarts, lawyers occasionally do dumb things. Mistakes with client funds, representing “bad” clients, and “dabbling” are just a few of the lawyer missteps we will discuss.

Janis Meyer is a partner at Hinshaw & Culbertson LLP where she focuses on professional ethics and risk management issues for lawyers, law firms and corporate legal departments. Prior to joining Hinshaw, she was the General Counsel of a global law firm and has broad experience with a variety of professional responsibility and risk management issues facing lawyers and law firms today, including the threats posed by cybersecurity concerns.

Ms. Meyer is a Special Professor of Law at the Hofstra University Maurice A. Deane School of Law, where she teaches Legal Ethics and “Practical Aspects of Lawyering.” She is also a member of the Law 360 Legal Ethics Editorial Advisory Board. She is a regular speaker at bar associations and industry conferences on issues of professional responsibility and risk management, women in the law, and the role of law firm general counsel.

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# Covenant Medical Center v State Farm; The End of Medical Provider Suits? Maybe . . . Maybe Not

Ronald M. Sangster, Jr.  
Law Office of Ronald M. Sangster, [rsangster@sangster-law.com](mailto:rsangster@sangster-law.com)

*Author's note: This article is based, in large part, upon this author's earlier article published in the Michigan Defense Quarterly in July 2017. However, it has been updated to reflect developing trends that are taking place in the trial courts throughout the state, in response to the numerous motions for summary dispositions and motions to amend complaint that have been filed since the Supreme Court handed down its ruling.*

## Introduction

On Thursday, May, 25, 2017, the Michigan Supreme Court released its long-awaited decision in *Covenant Medical Center v State Farm*, \_\_\_ Mich \_\_\_; \_\_\_ NW2d \_\_\_ (2017), Docket Number 152758. In a 5-1 decision authored by Justice Brian Zahra (with Justice Richard Bernstein dissenting and newly-appointed Justice Kurtis Wilder not participating), the Michigan Supreme Court ruled that medical providers do not have an independent, statutory right to file suit against a no-fault insurance carrier to recover payment of medical expenses incurred by their patients.

However, as discussed more fully below, the Michigan Supreme Court left open the possibility that medical providers could still file suit against no-fault insurers under other alternative theories. These include an allegation that the provider is a third-party beneficiary under the insurance contract between the insurer and the insured, or where the insured executes an Assignment of Benefits to the medical providers. However, a medical provider may face significant obstacles under either of these theories. As matters now stand, however, we can expect to see a short-term decrease in the number of provider suits that are filed in this state. On the other hand, though, attorneys representing the injured claimants will probably be demanding higher settlements when resolving PIP claims in order to satisfy the demands of medical providers (who are essentially reduced to the status of lien holders) because, as noted by the Michigan Supreme Court in the majority opinion, “a provider that furnishes healthcare services to a person for injuries sustained in a motor vehicle accident may seek payment from the injured person for the provider’s reasonable charges”—they simply cannot sue the no-fault insurer, subject to the exceptions discussed more fully below.

## Underlying Facts and Lower Court Rulings

The underlying facts are relatively straightforward. State Farm’s insured, Jack Stockford, was involved in a motor vehicle accident on June 20, 2011. He received medical treatment at Covenant Medical Center in Saginaw on various dates

in 2012, and incurred medical expenses totaling just under \$44,000.00. State Farm denied coverage and refused to pay the medical expenses at issue. Stockford subsequently filed suit against State Farm in the Saginaw County Circuit Court and ultimately settled with State Farm for \$59,000.00. As part of the settlement, Stockford executed a release which included all no-fault claims, including the medical expenses at issue, incurred through January 10, 2013.

Covenant Medical Center, which is based in Saginaw, filed suit in the Kent County Circuit Court (Grand Rapids) to recover payment of the medical expenses at issue, which probably explains why it had no knowledge of the Saginaw County Circuit Court litigation between Stockford and State Farm. The matter was later transferred to the Saginaw County Circuit Court. State Farm raised the release executed by Stockford as a defense to the claim—an argument that was accepted by the Saginaw County Circuit Court when it granted State Farm’s motion for summary disposition.

## Court of Appeals Opinion

Covenant Medical Center appealed to the Michigan Court of Appeals. In a published decision, the Court of Appeals reversed the decision of the Saginaw County Circuit Court and essentially ruled that State Farm would need to pay twice for the same medical expenses incurred by Stockford. In support of its holding, the Court of Appeals relied on the second sentence of MCL 500.3112, which provides:

Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.

According to the Michigan Court of Appeals, the fact that Covenant Medical Center had submitted its medical expenses directly to State Farm constituted “the claim of some other person” which State Farm was not free to ignore. Therefore,

the Court of Appeals ruled that this provision “requires that the insurer apply to the Circuit Court for an appropriate order directing how the no-fault benefits should be allocated.” This ruling, of course, gave rise to the numerous “Covenant Motions” that had been clogging the Circuit Courts’ motion dockets since the decision was released.

### The Supreme Court’s Opinion

In its opinion, the Supreme Court began its analysis by noting that there is nothing in the statutory text of the No-Fault Insurance Act which provides for an independent cause of action by a healthcare provider against a no-fault insurer. The Court went to some lengths to analyze various sections of the No-Fault Insurance Act, including MCL 500.3105(1) (dealing with the circumstances which give rise to a claim for no-fault benefits, otherwise referred to as the “gateway provision”), MCL 500.3107(1)(a) (defining what are “allowable expenses”), MCL 500.3157 (dealing with a healthcare provider’s obligation to charge “a reasonable amount for products, services and accommodations rendered”, with a *proviso* that “the charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance”), and MCL 500.3158(2) (regarding a medical provider’s obligation to submit medical records and billing records to a no-fault insurer). In the opinion of the Supreme Court, none of these statutory sections supported a healthcare provider’s independent right to file suit against a no-fault insurer.

Based on its analysis, the Michigan Supreme Court overruled decades of decisions from the Court of Appeals which had granted medical providers an independent cause of action against no-fault insurers, including *Wyoming Chiropractic Health Clinic v Auto-Owners Ins Co*, 308 Mich App 389 (2014), *Michigan Head & Spine, PC v State Farm Mut’l Auto Ins Co*, 299 Mich App 442 (2013); *Regents of the Univ of Michigan v State Farm Mut’l Ins Co*, 250 Mich App 719 (2002) and *Lakeland Neurocare Ctrs v State Farm Mut’l Auto Ins Co*, 250 Mich App 35 (2002). In its opinion, the Supreme Court noted that in the earlier cases, the Court of Appeals simply did not engage in a rigorous analysis of the statutory text, because the insurer did not actually contest the issue. Under MCR 7.215(J)(1), subsequent panels of the Court of Appeals were bound to follow these erroneous decisions. The Supreme Court, of course, was not so bound.

### The Court Rejects Reliance on MCL 500.3112 as A Basis for Medical Provider Suits

Not surprisingly, the court devoted most of its analysis to the proper interpretation of MCL 500.3112. Due to the importance of this analysis, the entire text of MCL 500.3112 is excerpted below:

Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:

- (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
- (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

The Supreme Court noted that “the foundation of any opinion interpreting a statutory provision is the parsing of the words of the pertinent act or statute under review.” *Covenant Medical Center*, Slip Opinion at 7. Accordingly, the Court carefully dissected all five sentences in MCL 500.3112 and concluded that reading the statute as a whole, there was nothing in that statute that provided a healthcare provider with an independent cause of action against a no-fault insurer. In discussing each sentence, the Supreme Court issued some significant rulings that will undoubtedly impact on an insurer’s handling of medical provider claims.

With regard to the first sentence, the Supreme Court noted that it simply sets forth who may receive payment of no-fault benefits, *at the option of the insurer*. Utilizing the dictionary definition of the term “payable,” defined as benefits that “may, can, or must be paid,” the Supreme Court ruled that “PIP benefits, which are paid by the insurer, ‘may, can, or must be paid’ either (1) to the injured person or (2) for the benefit of the injured person.” *Id.* at 16.

Obviously, “for the benefit of the injured person” means that an insurer is free to issue payment directly to the medical provider, which will discharge its obligation to pay benefits under the statute. The Supreme Court noted that simply be-

cause the insurer has a choice as to how a medical expense will be paid does not mean that a third-party, such as a healthcare provider, “has a statutory *entitlement* to that method of payment.” To put it in another way, it appears that the no-fault insurer has complete discretion as to how medical expenses can be paid. It is apparently free to ignore a Plaintiff’s attorney claim of a charging lien on payment of an undisputed medical expense, or it could issue payment to the injured Claimant and his or her attorney.

With regard to the second sentence of MCL 500.3112, regarding discharge of an insurer’s liability “unless the insurer has been notified in writing of the claim of some other person,” the Court rejected the healthcare provider’s argument that it qualifies as “some other person” for purposes of this section. Although not necessary for its decision, the Supreme Court strongly implied that this sentence “is likely applicable primarily to dependents and survivors given that the end of the statute pertains to the allocation of benefits to those groups of persons.” *Id.* at 18, fn 32.

With regard to the third sentence, the Supreme Court clearly rejected the “apportionment theory” that was at issue in the numerous “Covenant motions” that had taken place since the Court of Appeals issued its decision. In this regard, the Supreme Court rejected the notion that medical expenses can be “apportioned” between the injured claimant and a medical provider. Instead, the medical provider is a creditor, and the insured person is the debtor:

This sentence merely provides a procedure for resolving doubts about which persons are entitled to benefits; it does not itself confer a right or entitlement on any person, including a healthcare provider, to sue a no-fault insurer. And the sentence’s reference to “apportionment” cannot logically pertain to allowable expenses like the reasonable charges incurred for healthcare services, because an injured person owes the provider, and is entitled to PIP benefits for, the entirety of those allowable expenses under MCL 500.3107(1)(a), not an apportioned amount. [*Id.* at 18-19.]

In an important footnote, the Supreme Court again noted that the third sentence of MCL 500.3112 would “primarily pertain to dependent and survivor benefits” and then proceeded to describe situations where there could be competing claims of “dependency” under a survivor’s loss claim pursuant to MCL 500.3110. *Id.* at 19, fn 34.

The Supreme Court likewise rejected any reliance on the 4th and 5th sentences of MCL 500.3112 and noted that those two sentences, like the preceding two sentences, were intended to deal with survivor’s loss claims—not claims for the healthcare provider’s medical expenses.

To sum up, then, the Supreme Court rejected the idea that the fact that the insurer has a choice as to how it will satisfy its obligations to pay no-fault benefits, “it does not establish a concomitant claim enforceable by an insured’s benefactors.” *Id.* at 20. The Supreme Court went on to explain:

By permitting insurers to directly pay healthcare providers on an injured person’s behalf, MCL 500.3112 allows the insurer to eliminate the insured as a conduit in the payment process, relieving the insured from having to redirect to the healthcare provider payment received from the insurer. It is not surplusage for the statute to expressly permit an insurer to directly pay the insured’s healthcare bills in order to discharge its obligation to its insured. The fact that the statute grants that permission does not create a right in the providers to sue the insurer for payment. [*Id.* at 20-21, fn 36 (emphasis added).]

Simply put, although a healthcare provider has no statutory right to file suit against a no-fault insurer, it does not mean that all medical provider suits must be dismissed. Rather, the Supreme Court held open the possibility that alternative causes of action may exist which would allow a healthcare provider to nonetheless maintain a cause of action against a no-fault insurer, based on one or more of several alternative theories.

### Alternative Theory No. 1 –“Balance Bills”

Since the early 1990s, no-fault insurers have been utilizing third-party medical expense auditing companies such as ReviewWorks, Corvel, Mitchell, Rising Medical Solutions and the like to review and audit medical expenses for “reasonableness.” These audits frequently result in the insurer paying less than the amount charged by the provider. In many cases, the provider simply writes off the balance. However, the healthcare provider is not obligated to do so. It is permitted to file suit against the insured, or to initiate collection actions against the insured for payment of any remaining balance, and if it does, the no-fault insurer is obligated to fully defend and indemnify the insured in a claim for a “balance bill” payment under Insurance Commissioner Bulletin 92-3.

In the seminal case of *LaMothe v ACIA*, 214 Mich App 577 (1995), the insured sued AAA over the fear that it would be responsible for payment of those “balance bills” that were incurred because AAA refused to pay the full amount of medical expenses charged by the provider. In compliance with Insurance Commission Bulletin 92-3, the insurer agreed to “defend and indemnify the insured from liability,” and even went so far as to issue a letter to the insured’s attorney, which was excerpted by the Supreme Court in *Covenant* in footnote 18:

The Court of Appeals quoted a letter that the insured sent the insured's attorney, which stated in part that "if any of the medical providers bring a claim against [the insured], [the insurer] will defend and indemnify him. In fact, [the insurer] will waive any technical defects and allow the provider to sue the [insurer] directly so that [the insured] won't even have to be a party to the litigation. [*Id.* at 8, fn 18.]

Because the no-fault insurer had agreed to "fully defend and indemnify the insured from liability" in cases involving balance bills, and had indicated that it would waive "any technical defects" to allow a direct action against the insurer, the insured's lawsuit had to be dismissed.

In the author's opinion, the insurance company has two ways to handle any "balance bill" lawsuits. First, it can allow its insured to be sued by the healthcare provider, but consistent with its obligations under Insurance Commissioner Bulletin 92-3, it must "fully defend and indemnify the insured" in that lawsuit. In this regard, the insurer needs to consider the ramifications of having its insured be sued by a healthcare provider who is not satisfied with the reductions being taken on its bills. The prospect of having the insured or the claimant being sued by a provider over an insurer's decision to pay less than the amount charged seems to be, in the opinion of the author, rather troublesome.

Therefore, in the author's opinion, the better way to approach these "balance bill" claims is for the insurer to advise the provider that it will "waive any technical defects" – namely, the holding in *Covenant* – and permit the healthcare provider to sue the insurer directly over the "balance bill." Either way, the insurer is still going to be obligated to defend any reductions taken pursuant to these third-party medical expense audits. The only difference is that the insurer gets to choose the method of defense. Either it defends itself in a direct action by the healthcare provider, that it has consented to, or it defends the insured in a lawsuit over a "balance bill."

### Alternative Theory No. 2 – Third-Party Beneficiary Theories

A typical medical provider suit contains the allegation that the insurer was in violation of the Michigan No-Fault Insurance Act when it refuses to pay the medical provider's medical expenses. This cause of action, of course, is no longer permissible under the Supreme Court's decision in *Covenant*, unless the insurer consents, as in the case of "balance bills."

However, many healthcare provider complaints assert that the provider is a so-called "third-party beneficiary" under the insurance contract between the insured and the insurer. In an important footnote, the Supreme Court made it clear that it was not addressing any potential liability under a "third-party beneficiary" theory, although it did emphasize that such causes

of action are necessarily dependent on the actual insurance policy language:

We conclude today only that a healthcare provider possesses no statutory right to sue a no-fault insurer. While defendant argues that a provider likewise possesses no contractual right to sue a no-fault insurer given that healthcare providers are incidental rather than intended beneficiaries of a contract between the insured and the insurer, this Court declines to make such a blanket assertion. *That determination rests on the specific terms of the contract between the relevant parties.* See *Schmalfeldt v North Pointe Ins Co*, 469 Mich 422, 428; 670 NW2d 651 (2003) ("A person is a third-party beneficiary of a contract only when *that contract* establishes that a promisor has undertaken a promise 'directly' to or for that person." (Citations omitted; emphasis added). This court need not consider whether Plaintiff possesses a contractual right to sue Defendant in this instant case because Plaintiff did not allege any contractual basis for relief in its Complaint. [*Id.* at 24, fn 39., emphasis added]

In other words, we need to examine the individual insurance contracts at issue to determine whether or not a medical provider is an "intended beneficiary," not an "incidental beneficiary" of the contract between the insured and the insurer.

The *Schmalfeldt* decision gives us some guidance. In *Schmalfeldt*, Plaintiff was playing pool at a bar when he was struck by another bar patron. As a result of his dental injuries, he asked the owner of the bar to pay his dental expenses totaling just under \$2,000.00, but the bar owner refused. *Schmalfeldt* then filed suit against North Pointe Insurance Company, which had issued a commercial liability insurance policy to the owner of the bar. This policy contained a medical payments provision, where North Pointe agreed to pay up to \$5,000.00 for medical expenses incurred as a result of a bodily injury caused by an accident so long as the injury occurred on or next to the insured's premises or because of the insured's operations. North Pointe refused to pay the medical expenses without a request from the bar owner. When the bar owner refused, *Schmalfeldt* filed a direct lawsuit against North Pointe.

After examining Michigan's Third Party Beneficiary Statute, MCL 600.1405, and the applicable policy language, the Michigan Supreme Court concluded that *Schmalfeldt* was, at best, an incidental beneficiary, not an intended beneficiary under the insurance contract. As noted by the Supreme Court:

Nothing in the insurance policy specifically designates *Schmalfeldt*, or the class of business patrons of the insured of which he was one, as an intended third-party beneficiary of the medical benefits provision. At best, the policy recognizes the possibility

of some incidental benefit to members of the public at large, but such a class is too broad to qualify for third-party status under the statute.

Only intended beneficiaries, not incidental beneficiaries, may enforce a contract under 1405. [Citation omitted]. Here, the contract primarily benefits the contracting parties because it defines and limits the circumstances under which the policy will cover medical expenses without a determination of fault. This agreement is between the contracting parties, and Schmalfeldt is only an incidental beneficiary without a right to sue for contract benefits. [For this reason, North Pointe is entitled to summary disposition. [*Schmalfeldt*, 469 Mich at 429.]

Obviously, each insurer will need to examine the terms of its contract to determine whether or not medical providers are intended beneficiaries, or only incidental beneficiaries, under the contract. Thus far, most district courts that have addressed this issue have denied provider claims based on a “third party beneficiary” theory, finding that the providers are, at best, an incidental beneficiary, not an intended beneficiary, under the contract between the insured and the insurer.

A special note on Michigan Assigned Claims Plan cases is in order at this point. In cases involving MACP Claimants, there is, of course, no insurance contract to deal with. Therefore, a healthcare provider who asserts rights as a “third-party beneficiary” under a non-existent contract should immediately be the subject of a motion for summary disposition.

### Alternative Theory No. 3 – Assignments

The issue of assignments came up rather frequently during oral argument before the Michigan Supreme Court on December 7, 2016. Although the author expected the Supreme Court to discuss the issue of assignments in some detail, the court instead relegated its discussion of this issue to a footnote found on page 24 of the slip opinion. After reiterating that a healthcare provider can always seek payment from the injured person for the provider’s reasonable charges, the court noted:

Moreover, our conclusion today is not intended to alter an insured’s ability to assign his or her right to past or presently due benefits to a healthcare provider. See MCL 500.3143; *Professional Rehab Assoc v State Farm Mut’l Auto Ins Co*, 228 Mich App 167, 172; 577 NW2d 909 (1998) (Noting that only the assignment of future benefits is prohibited by MCL 500.3143.) *Covenant*, Slip Opinion at 24, fn 40.

With this caveat in mind, let us examine how this may play out in the course of a typical lawsuit.

### Assignment Scenario 1: Assignment Before Settlement of a PIP Lawsuit.

Michigan courts have held that in order to create an assignment of benefits, there are no “magic words” that need to be invoked. However, in order to have a valid assignment, “the assignor must manifest an intent to transfer and must not retain any control or any power of revocation.” *Burkhardt v Bailey*, 260 Mich App 636 (2004). Further, the assignee acquires no greater rights than the assignor had, and is subject to the same defenses. *Professional Rehab Assoc v State Farm*, 228 Mich App 167, 177 (1998).

Under this scenario, the injured Claimant no longer has a right to claim medical expenses incurred with any provider to whom he has executed an assignment. Such claims should not be part of the Claimant’s lawsuit, and the only entity that has a right to collect under the assignment is the medical provider.

### Assignment Scenario 2: The Claimant Settles his Claim for Medical Expenses Through a Specific Date, but After the Settlement, the Provider Seeks to Obtain an Assignment for Medical Expenses Incurred Prior to the Settlement

Under this scenario, a medical provider would not have a valid cause of action, for the simple reason that the assignor had nothing to assign to the provider. Rather, the assignor’s claims for medical expenses extinguished when the release was signed. This scenario illustrates why it is absolutely necessary to determine precisely *when* an assignment was executed, and how the date of the assignment impacts on the terms of the Release.

### Assignment Scenario 3: Impact of MCL 500.3143 – The Prohibition Against an Assignment of Future No-Fault Benefits

Although there have only been a couple of cases interpreting this statute, the author anticipates that there will be much more litigation as nofault insurers examine assignments executed by their insureds to determine whether or not the insureds were assigning *future* benefits to the provider.

In *Aetna Casualty Ins Co v Starkey*, 116 Mich App 640 (1982), the insured executed an assignment prior to receiving medical treatment. The assignment purported to assign “any insurance benefits from Aetna which would become due and payable,” or “any benefits which would become payable.” The Court of Appeals noted that by virtue of this language, the assignment was referencing *future* nofault benefits. Therefore, under MCL 500.3143, this assignment was void.

By contrast, in *Professional Rehab Assoc v State Farm*, 228 Mich App 167, 173 (1998), the assignment provided for:

All of Clifford Lay’s rights to be reimbursed or to have counseling services expenses paid by State Farm Mutual Automobile Insurance Company and

any other insurer or self-insurer for services provided by Professional Rehabilitation Associates in connection with injuries to Clifford Lay arising out of an automobile accident.

The Court of Appeals found that this language was ambiguous because it denoted both past and future benefits. The Court of Appeals noted that to the extent that this assignment pertained to benefits previously incurred, the assignment was valid. However, to the extent that it pertained to future benefits, the assignment was void. The Court of Appeals went on to note that, “the failure of a distinct part of a contract does not void valid, severable provisions” and “the primary consideration in determining whether a contractual provision is severable is the intent of the parties.” *Professional Rehabilitation*, 228 Mich App at 174.

When examining the date that the assignment was executed and the dates of service in question, the Court of Appeals noted that the assignment was executed after State Farm had already denied payment of the medical expenses at issue. Therefore, this was an assignment of past due benefits, which was not barred by MCL 500.3143. As a result, the provider could still maintain the cause of action against the nofault insurer. This case illustrates why it is vitally important to obtain copies of the actual assignments and determine what date they were executed, and precisely which medical expenses the assignment was intended to encompass.

#### Assignment Scenario 4: The Insurance Policy Contains an Anti-Assignment Clause

Many insurance company policies contain an anti-assignment clause, which prohibits the insured from assigning a claim under the policy without the insurer’s consent. Most of our insureds have never read the policy and thus may be unaware of the presence of the anti-assignment clause in the policy.

As more and more providers are expected to rely on assignments in order to further their cause of action against a nofault insurer, it is incumbent upon the claims professionals and defense counsel to carefully examine the terms of the applicable insurance policy to see whether it contains an antiassignment clause. Thus far, this issue has been the most heavily litigated post-*Covenant* issue in the various district courts.

Healthcare providers are relying upon a Michigan Supreme Court decision from 1880, *Roger Williams Ins Co v Carrington*, 43 Mich 252 (1880), which concerned a post-loss assignment by an insured. Providers have cited the following language from the *Carrington* opinion in support of their assertion that such anti-assignment clauses are invalid – at least as applied in post-loss cases:

“The assignment having been made after the loss did not require consent of the company. The provision of the policy forfeiting it for an assignment without

the company’s consent is invalid, so far as it applies to the transfer of an accrued cause of action. It is the absolute right of every person – secured in this state by statute – to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.” *Id.* at 254 (emphasis added).

To the extent that the Michigan Supreme Court, in 1880, was relying upon a *legislative enactment* in support of its claim that such anti-assignment clauses are invalid as being against public policy, the court is quite correct. Particularly under today’s Michigan Supreme Court jurisprudence, it is the Legislature, not the judiciary, that sets public policy, and any provision in an insurance policy that is contrary to an express statute is, by definition, invalid and against public policy. Unfortunately, the Michigan Supreme Court did not cite the statute that it was referring to in the *Carrington* opinion.

Our research has disclosed that the Court may have been referring to section 5775 of the Michigan Compiled Laws of 1871, which provided:

“The assignee of any bond, note, or other chose in action, not negotiable under existing laws, which has been or may be hereinafter assigned, may sue and recover the same in his own name, upon such bond, note, or other chose inaction; and the Defendant in all such suits may set up and avail himself of any defense he may have, arising before due notice of such assignment, and which accrued prior to such action, in the same manner and with the like effect as if the assignor had prosecuted the same in his own name.”

This statute was also recompiled in Howell’s Annotated Statutes (1882) at §7344.

However, there is no modern equivalent of this statute! Our research has disclosed that it was actually repealed decades ago, when the Legislature enacted its first Revised Judicature Act in 1915. The historical notes in MCL 600.2041 make reference to the above-quoted statute, but the actual statutory text of MCL 600.2041 is quite different. Therefore, because the statutory basis for the Supreme Court’s holding in *Carrington* no longer exists, *Carrington* and its progeny may no longer be reflective of Michigan public policy – at least as reflected in legislative enactments.

Another interesting issue regarding these anti-assignment clauses, arises with regard to “strangers to the insurance contract.” I am referring to motorcyclists, pedestrians who have no insurance of their own in the household, or employees occupying employer-furnished vehicles, or passengers in another person’s automobile who do not have insurance of their own in the household. Are these individuals and their providers bound by any such anti-assignment clauses in the insurance contract? Based upon the recent Court of Appeals’ decision in *Shelton v*

*Auto-Owners Ins Co*, \_ Mich App \_ (2017) (Court of Appeals Docket No. 328473, rel'd 2/14/2017) and the answer appears to be no. In *Shelton*, the Court of Appeals held that a "stranger to the contract," whose benefits are derived based solely by statute, are not bound by the anti-fraud provisions in an insurance contract. If such "strangers to the contract" are not bound by the anti-fraud clauses in the policy, by analogy they would not be bound any anti-assignment clauses in that same policy.

With regard to MACP insurers, there is, of course, no insurance contract. Therefore, a provider need not be concerned with any anti-assignment clauses. In those cases, the insurer's defenses will be limited to the propriety of an assignment and the timeliness of the execution of any such assignment.

## Conclusion

What will be the practical effects of *Covenant*? First, there will be no more "Covenant motions" being heard in the circuit court. Plaintiff's attorneys will no longer be obligated to show how a settlement will be apportioned between the various providers.

Second, the author expects to see a sizable number of motions for summary disposition being filed pursuant to MCR 2.116(C)(8), for failure to state a cause of action upon which relief can be granted. When responding to such motions, providers have been filing motions to amend their complaints to assert that they have a valid assignment of benefits executed by the insured, at which point the burden will shift back to the insurer to determine if such an assignment is barred by any anti-assignment clause in the insurance policy or by MCL 500.3143. To the extent that providers fail to attach copies of any purported assignments, many district courts

have granted the insurer's Motion for Summary Disposition.

Third, it will be incumbent upon counsel on both sides of the aisle to quickly obtain copies of any assignments that were executed by the insured and to determine whether or not the assignment pertains to past due benefits or future benefits, in order to ascertain whether or not the provider has a right to maintain its cause of action against the nofault insurer. Simply because the provider asserts that there is an assignment, in a form medical provider complaint, does not necessarily mean that it is so. Absent an assignment, the provider simply has no cause of action against the nofault insurer.

Finally, given the Michigan Supreme Court's repeated statements that the healthcare provider's remedy to collect an unpaid medical expense is to sue the patient, the author wonders how many medical providers would actually be willing to sue their patients? What about situations where the attorney refers their client to a particular medical provider, which proceeds to rack up five or even six figure medical expenses for questionable or even fraudulent medical treatment? Obviously, the attorney referrals to these dubious providers were made with the implicit understanding that the provider would not be suing its patient (and the referring attorney's client) to collect an unpaid medical expense, but would be suing the nofault insurer directly. With the focus now shifting back to the healthcare provider and the patient being placed in an adversarial position regarding payment of the medical expenses, brought about as a result of an attorney referral, the author cannot help but wonder if perhaps an unintended benefit of the Michigan Supreme Court's decision will be to cut back on the number of questionable or downright fraudulent nofault medical expense claims that, unfortunately, continue to plague the nofault system. ■


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## Insurance and Legalized Marijuana: Coverage, Crimes, Contradictions and Caveats

By Robert A. Hendricks

Wrigley, Hoffman & Hendricks, PC, CannaLex Lawyers and Counselors, [www.cannalexlaw.com](http://www.cannalexlaw.com)

Insurance coverage in the modern industrialized world is ubiquitous. Almost all aspects of life, whether personal or professional, public or private, individual or corporate, allow or require insurance coverage. Common examples of coverage include Automobile, Health, Homeowners, Workers Compensation, General Liability, Property and Casualty, Product Liability, and Directors & Officers insurance. Particularly in the business context, the decision to obtain or forego insurance coverage for any particular aspect of business is typically a serious exercise, often undertaken with input from financial experts, legal counsel and/or a trusted insurance agent.

In general, insurance coverage is available to mitigate almost any conceivable risk, tempered by the costs of such risk mitigation. However, the recent advent of state-legalized marijuana<sup>1</sup>, and the illegality of marijuana under federal law, have created a host of issues surrounding marijuana and insurance coverage including the scope of coverage, the availability of insurance, the enforceability of contracts, and criminal liability risk for insurers. In this article, we intend to highlight some of the most prominent of these issues, while disclaiming any suggestion that this is the last word or a definitive catalogue of all the marijuana/insurance issues.

As of this writing, 28 states and the District of Columbia have adopted some form of medical marijuana legalization. Eight of those states and DC have gone beyond medical marijuana and have legalized adult recreational use. One in five Americans now live in a state that has fully legalized marijuana, and 60% live in a state where some legalization is in place. Every indication is this state legalization trend will continue. At the federal level, however, marijuana remains a Schedule I controlled substance, and virtually all marijuana related activity, medical or otherwise, is unlawful<sup>2</sup>. The U.S. Congress has shown great reluctance to de-schedule marijuana or take any other action to change federal prohibition. This conflict between state legalization and federal prohibition is the primary factor which complicates insurance coverage for state-legal marijuana related activity.

In Michigan, this topic has taken on increased importance because of the newly adopted Medical Marijuana Facilities Licensing Act ("MMFLA"), MCL 333.27101 et seq. That law, which was approved by the Legislature and signed by Governor Snyder in September 2016, substantially increases the scope of state-legal commercial medical marijuana activ-

ity. The MMFLA established five types of medical marijuana facilities eligible for licensing and regulation: growers (further divided into classes A, B and C based on plant count), processors (who manufacture edible and other derivative forms of medical marijuana), retailers (called Provisioning Centers), testing labs, and secure transporters. The law requires that licensed and regulated marijuana facilities must obtain and maintain stipulated business insurance coverages.

Marijuana facility owners and developers, marijuana business lawyers, state regulators, and insurance executives and counsel, among others, have begun to ask precisely what insurance coverage are required by the State. The time frame for answering this question (with all of its permutations) is quite short. Before a license can issue to any applicant, insurance for that facility must be in place.

Under the MMFLA the Michigan Department of Licensing and Regulatory Affairs ("LARA") must begin accepting license applications for the five types of marijuana facilities on December 15, 2017. We estimate the approval process will take 30 to 90 days. So it's likely that the insurance industry will need to be ready to issue policies in Michigan shortly after the beginning of 2018. Is the industry ready to meet that deadline? Are a sufficient number within the industry willing and able to participate in the marijuana industry? Do carriers and underwriters know what they need to know to issue policies?

### Scope of Coverage

We begin with an examination of the types of coverage that may be required by the MMFLA. Four different sections of the law are applicable:

- First, under section 408(1), the applicant for a license must demonstrate ". . . proof of financial responsibility for liability for bodily injury . . . in an amount not less than \$100,000.00." This proof may be provided in several ways, including by ". . . a *liability* insurance policy." MCL 333.27408(1).
- Second, section 402(2)(e) provides that an applicant is ineligible for a license if "[t]he applicant fails to demonstrate the applicant's ability to maintain adequate *premises liability and casualty* insurance." MCL 333.27402(2)(e).

- Third, section 303(1)(j) empowers the Licensing Board to “[c]onsult with [LARA] as to appropriate minimum levels of insurance for licensees *in addition to the minimum established under section 408* for liability insurance.” MCL 333.27303(1)(j).
- Finally, section 206(b) empowers LARA, in consultation with the Licensing Board, to “. . . establish minimum levels of insurance that licensees must maintain.” MCL 333.27206(b).

From the language of these different sections of the MMFLA, it appears the rules and regulations may require licensees to carry several different types of coverage. Because the Licensing Board was just recently appointed (May 26, 2017),<sup>3</sup> the precise requirements of those rules and regulations have not yet been developed. Thus, while we know that the law requires *bodily injury liability insurance*, and *premises liability and casualty insurance*, we do not know what other types of insurance LARA and the Licensing Board may require for a licensee. Insurers who wish to enter this market must therefore proceed for now without a complete picture of the needs of the Michigan licensees.

### Availability of Insurance

As the pace of state legalization of marijuana grew, Lloyd’s of London apparently allowed its subscribers to underwrite insurance for some participants in the marijuana industry. However, in a May 29, 2015 memo Lloyd’s announced it had determined that it no longer would support insuring marijuana operations of any kind until marijuana is formally recognized by the U.S. government as legal. This exit was widely reported in the media<sup>4</sup> and caused disruption of the developing marijuana insurance market. Lloyd’s exit was generally based on uncertainty with the state law – federal law conflict and the unpredictability that flowed from that conflict.<sup>5</sup>

Is the void left by Lloyd’s departure being filled? A quick Google search for “marijuana insurers” indicates there are companies advertising their willingness to serve this market. The second Google listing is the *Marijuana Business Daily* list of Marijuana Business & Professional Insurance Providers.<sup>6</sup> Under the Michigan listings there are eight “providers.” So far, so good. The problem is that only four of the eight appear<sup>7</sup> to actually be involved in the insurance business. The other four are not insurers (one was a domain name for sale). Since the passage of the MMFLA, we have been attempting to assemble a database of Michigan agents, brokers and carriers willing to consider marijuana business insurance. Many calls, emails and letters to highly reputable and visible Michigan entities have so far yielded very few active providers. While this market looks to be a promising venue for the expansion of business, there are many risk-based reasons why insurers are not rushing to provide these policies.

### Enforceability of Contracts

The enforceability of insurance contracts is more a problem for the insured than for the insurer. That said, however, the legal issues that have swirled around insurer decisions to deny or challenge coverage of a marijuana based claim will probably cause some reticence by customers and will require clear and precise communication by those insurers who do wish to insure the industry.

The primary obstacle to the enforcement of an insurance policy for a marijuana-based claim is the federal law prohibition of marijuana and the generally recognized principle that courts may decline to enforce a contract that is illegal or contrary to public policy. Two recent decisions from two different Federal District Courts illustrate the approaches to this issue. In *Barbara Tracy v. USAA Casualty Insurance Company*, Civil No. 11-00487 LEK-KSC, D. Hawaii (March 16, 2012), the District Court resolved competing motions for summary judgment. The insured homeowner and her insurance company disagreed over whether the homeowner’s theft loss of several marijuana plants used under Hawaii’s medical marijuana law was a covered claim. While resolving a number of factual and legal questions in the homeowner’s favor, the Hawaii federal court ultimately concluded that it could not require the insurer to pay to replace property that was illegal under federal law.

However, the case of *Green Earth Wellness Center v. Atain Specialty Insurance Company*, Civil No. 13-cv-03452-MSK-NYW, D. Colo. (February 17, 2016) reached a different result. It upheld policy coverage. Based on the inconsistency of the Federal Government’s enforcement of the Controlled Substances Act’s marijuana prohibition, the court declined to follow the *Tracy* decision and allowed certain of the plaintiff’s claims under the policy to proceed to trial.

Other defenses to payment can arise out of the secretive way state-legal marijuana activity may be conducted, depriving the insurer of complete knowledge and resulting in the denial of claims arising out of the marijuana related conduct. For example, in *Nationwide Mutual v. McDermott*, No. 14-1623, Sixth Circuit Ct. App (February 24, 2015) (unpublished) the insurer paid a house fire claim by a Michigan policyholder. Nationwide later sought to recover this payment when it discovered the fire was caused when the homeowner’s then-husband was smoking a marijuana concentrate and ignited fumes from a marijuana butane extraction process he performed in the home. Nationwide asserted the manufacturing of the marijuana extract in the home was a use that increased the risk of loss and was required to be disclosed by the insured. They also argued the activity fell under an intentional acts exclusion and there was no accidental direct physical loss to property. The trial court and the Court of Appeals agreed with Nationwide and allowed the claim against the homeowner because the fire was the result of an increased hazard within the insured’s knowledge and control.

## Potential Criminal Liability

Insurance agents, brokers and carriers who choose to provide services to state-legal marijuana actors (business or personal) should recognize, like all other vendors and suppliers, that their activity could trigger the application of federal criminal law. Certainly the climate in the United States over the past few years has shown an increasing tolerance for marijuana activity. National media covers the topic regularly, and it's sometimes difficult to remember that federal law enforcement agents have many legal rights to enforce federal law. While anecdotally it seems that the risks of that federal enforcement are limited, they are not zero. Thus, forewarned is forearmed.

Two major areas of concern for criminal liability are the potential money laundering liability under the federal banking laws and criminal conspiracy under the Controlled Substances Act. The federal money laundering statutes make it a crime to conduct a financial transaction when the vendor knows that the money comes from defined illegal activity (like marijuana sales) and the vendor either intends to promote the illegal activity, is helping to evade taxes, or knows that the transaction is designed to conceal the source of funds. Simply knowing that the transaction will promote unlawful activity isn't enough for criminal liability. For that, the vendor must intend to promote the activity. If the vendor simply intends that their services perform as specified, and the specifications are not unique to marijuana, that is probably not enough to intend to "promote illegal activity." In addition, it is a crime to engage in these same financial transactions even without intent if the transaction is for greater than \$10,000. If a vendor provides services costing more than \$10,000, and if those services are purchased by a customer the vendor knows will use the services to make money by selling marijuana, this transaction may violate the money laundering rules.

Under the federal Controlled Substances Act, businesses that provide services to the marijuana industry may be violating federal law. The CSA's prohibition on "aiding and abetting" violations of the law means that anyone who assists in the production or distribution of marijuana is at risk. Because of the current federal illegality of marijuana, it is very unlikely that a vendor can be absolutely certain that their activity might not trigger a charge under the CSA.

By understanding the goals and objectives of the federal government regarding prosecution of marijuana-related activity in states which have authorized some sort of marijuana business, it is possible to assess the likelihood of criminal charges, and to take certain steps to make it more unlikely that law enforcement will pursue particular activity. In that regard, consult with a lawyer who is familiar with the current status of the "Cole Memo"<sup>8</sup> and other public positions of the Federal Government regarding marijuana law. The Cole Memo is a public memorandum issued by Deputy United States Attorney General James Cole on August 29, 2013 providing guidance to US Attorneys on when to use federal government

resources to investigate and/or prosecute state legal medical marijuana activity. While the Cole Memo does not create a "legal" defense to a federal marijuana prosecution, it does provide insight into the government's enforcement strategy for state legal medical marijuana activity.

## Conclusion

Nationwide repeal by states of marijuana prohibition seems likely to continue. Recent Gallop polling indicates that fully 60% of American's support such repeal. With legitimacy comes acceptance, which will invite insurance coverage for many facets of legalized activity. Michigan will require certain mandatory insurance, so there will definitely be customers. The question remains who will serve those customers. ■

## About the Author

**Robert Hendricks** (Wrigley, Hoffman & Hendricks, P.C.) is a business attorney in Grand Rapids where he has practiced since 1984. In response to Michigan's movement toward legalized marijuana, he and his partners developed a marijuana business practice called *CannalexLaw*. Bob is a member and officer of the State Bar of Michigan's Marijuana Law Section and the National Cannabis Bar Association.

Hendricks speaks regularly on marijuana and business including to the Food and Drug Law Institute, the Michigan Township Association, ICLE, the Public Corporation Law Section of the Michigan Bar, various business Sections of the Grand Rapids Bar Association, and to the Law & Justice Committee of the Michigan House of Representatives. He blogs on marijuana business issues at [www.cannalexlaw.com](http://www.cannalexlaw.com)

## Endnotes

- 1 California was the first state to legalize medical marijuana use for certain defined conditions when its citizens approved Proposition 215 in 1995. Many states followed in authorizing legalized medical marijuana. In 2012, Colorado was the first to take the next step by legalizing adult recreational use.
- 2 The Federal Drug Enforcement Agency can authorize research on marijuana. The types of research that have historically been allowed, and the controversies surrounding authorization, exceed the scope of this article.
- 3 Governor Snyder appointed the five-person Board on May 26, 2017.
- 4 See, <https://www.dallasnews.com/business/economy/2016/11/23/lloyds-london-exec-talks-texas-insuring-cowboys-medical-marijuana>.
- 5 Id.
- 6 <https://mjbizdaily.com/industry-directory/insurance-providers/>
- 7 None was headquartered in Michigan, and we attempted no contact to verify they could or did actually operate in Michigan.
- 8 <https://www.justice.gov/isolopal/resources/3052013829132756857467.pdf>

# Hydraulic Fracturing and Insurance

By James A. Johnson ©2017

Hydraulic fracturing involves pumping water at high pressure to create fractures in rock that allow oil and natural gas to flow more freely to the well bore. Energy companies using hydraulic fracturing are unlocking significant oil and natural gas trapped in shale throughout the United States. Fracking allows energy producers to extract oil and natural gas from places previously too expensive or too difficult to retrieve. Chemicals, water and other materials are forced into the ground to break up and release oil and gas.

Certain segments of the general public are expressing concern about the potential impacts on drinking water, public health and the environment. Environmentalists and property owners have raised concerns about groundwater contamination and other environmental problems. The complaints are tracked on the website of the Environmental Protection Agency.<sup>1</sup>

## Regulations of Fracking by Local Authorities

On September 11, 2016, the Southfield, Michigan City Council passed a revised City Zoning Ordinance Number 678, amending Article 20, Industrial Districts, Section 5.185 that keeps oil and gas well related activities out of residential areas. Oil and gas well-related activities will only be permitted in Southfield under a Special Land Use in the industrial (I-1) zoning district. Proof of insurance is one of the many requirements. Southfield Mayor Ken Siver applauded the passing of the ordinance in protecting the health and safety of its citizens.

However, in March 2016 Judge Michael Warren of the Oakland County Circuit Court dismissed a lawsuit by the City of Southfield against the Michigan Department of Environmental Quality for approving a permit application to drill an oil well on a church's property. Judge Warren ruled that the state Natural Resources and Environmental Protection Act's Part 615 gives the Supervisor of Wells authority to regulate oil and gas development in the state, and that Southfield's ordinance conflicts with Part 615.<sup>2</sup> It appears that City of Southfield's zoning ordinance that attempts to block drilling in the city is unconstitutional.

New York takes a different approach. In 2014, New York's highest court upheld the right of towns to ban fracking by zoning ordinances because of concerns of potential injury to health, environment and character of the towns.<sup>3</sup>

## Fracking Distinguished From Injection Wells

High Volume Hydraulic Fracturing is defined in Michigan as a well completion operation that uses over 100,000 gallons

of primary carrier fluid. As compared to typical oil and gas development High Volume Fracking creates additional concerns because of increased use of chemical additives and greater water usage. Michigan's Administrative rules governing oil and gas development activities have been revised to address the additional concerns associated with HVHF well completions.<sup>4</sup>

In *Hughes v Dept. of Environmental Quality*, Michigan's Court of Appeals held that Michigan Administrative Rule 324.102(x) which defines the term "injection well," does not include wells completed using hydraulic fracking. Accordingly, fracked wells are not subject to the environmental regulations applicable to injection wells. For a well to be categorized as an injection well under Rule 324.102(x), the well must be used for the purpose of recovering hydrocarbons before and after the injection of fluid. Hydraulic fracking wells are not used for the purpose of recovering hydrocarbons *before* the injection of fluids.<sup>5</sup>

## Contamination from Fracked Wells

The Environmental Protection Agency, in a 2015 draft report, examining studies of fracking conducted throughout the United States concluded that fracking activities have impacted drinking water through subsurface fluid migration and surface spills.

There have been many lawsuits involving fracking nationwide. The primary focus of these lawsuits is water contamination. The defendants in fracking claims are drilling companies, suppliers of fracking fluids, equipment suppliers and other contractors. Each of the participants in the fracking process may be subject to property and bodily injury claims.

On December 12, 2016 the EPA released its 5-year study on Hydraulic Fracturing for Oil & Gas and its Potential Impact on Drinking Water Resources. It concluded that fracking for oil and gas can contaminate drinking water under "some circumstances."<sup>6</sup>

## Fracking and Litigation

Water contamination claims from fracking fluid have been made in numerous states, including Ohio, New York, Texas and Pennsylvania.<sup>7</sup> The United States Environmental Protection Agency in a 2015 draft report examining studies of fracking conducted throughout the United States concluded that fracking activities have impacted drinking water through subsurface fluid migration and surface spills.<sup>8</sup>

The majority of lawsuits are commenced by private

landowners and citizen groups under various federal environmental statutes. The theory of liability for water contamination ranges from nuisance, breach of contract, trespass to hazardous and abnormally dangerous activities. For example, in *Boggs v Landmark*,<sup>9</sup> an Ohio case, the plaintiffs allege that toxic chemicals used in the defendant's hydraulic fracturing operations were discharged into ground water. Plaintiffs further allege that the defendants were negligent by not exercising reasonable care to protect defendant's property. Of course, in any negligence case, the plaintiff must show a legal duty to plaintiff, a breach of that duty and that the breach proximately caused the plaintiffs injury. In *Boggs*, the trial court denied a motion to dismiss and the case is currently pending as of this writing.<sup>10</sup>

In a case in Colorado, the plaintiff sued fracking companies alleging that gas drilling activities polluted air, water and soil near their home causing headaches, bloody eyes, nausea and coughing. The Colorado Supreme Court in 2015 ruled that plaintiffs in fracking litigation do not have to provide evidence of injury and causation before obtaining discovery.<sup>11</sup>

In Pennsylvania, the trial court dismissed a complaint by EQT Production Company appealing a \$1.27 million dollar fine levied by the Pennsylvania Dept. of Environmental Protection. EQT is an energy company that includes fracking.<sup>12</sup>

In Oklahoma, the state Supreme Court allowed a homeowner to proceed in a lawsuit alleging that fracking activities caused earthquakes and injury. The plaintiff alleged that fracking activities caused a 5.0 magnitude earthquake that shook her house and caused rocks from a two-story fireplace to fall on her.<sup>13</sup> The question that came before the Supreme Court was whether the district court had jurisdiction to hear this type of case. The Supreme Court held that the district court had jurisdiction because the plaintiff alleged a private cause of action.<sup>14</sup> There is some support for the Oklahoma plaintiff's claims. It has been reported that fluid injection operations can trigger minor earthquakes. Some geologists believe that when a fault is overpressured, it can reduce the stress that is pinning the fault into place, causing earthquakes to happen.

## Insurance Coverage Issues

Relevant issues of coverage in these claims will probably include various forms of pollution exclusions, proper and timely notice and long-tail coverage issues. A long-tail claim is one that potentially triggers multiple policies over an extended period.

Most companies will have either general liability coverage or claim additional insured status on another company's policy. However, there is a question as to which insurance policies are implicated in the loss. When multiple policies are potentially involved, it raises issues of "trigger" and "allocation." The term trigger is generally defined as the operative event that gives rise to the insurer's duty to cover a loss under

a specific policy. Allocation is concerned with how a covered loss will be apportioned among two or more policies whose coverage has been triggered. The two common approaches are the "all-sums" approach or "pro rata" approach.

## Finding Coverage – the Insured's Duty of Notice

General liability policies have a provision requiring the insured to provide notice to the insurers of events or occurrences that *may* give rise to a claim. This notice is in addition to notice of lawsuits or claims actually made against the policyholder. The policyholder who anticipates a potential claim must be vigilant and promptly notify the insurer of any event that *may* lead to contamination or accidents.

## Coverage Issues - Exclusions

Keep in mind that most of the current general liability policies have various forms of absolute or total pollution exclusions. The standard absolute pollution exclusion states in pertinent part:

This insurance does not apply to:

1. "Bodily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants:
  - (a) At or from any premises you own, rent or occupy;
  - (b) At or from any site or location used by or for you for the handling, storage, disposal, processing or treatment of waste.
  - (c) Which are or were at any time, transported, handled, stored, treated, disposed of.....
  - (d) At or from any site or location on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations:
    - (i) if the pollutants are brought on or to the site or location in connection with such operations; or
    - (ii) if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize the pollutants.
2. Any loss, cost or expense arising out of any governmental direction or request that you test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants.

"Pollutants" means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.<sup>15</sup>

The total pollution exclusion states, in relevant part:

This insurance does not apply to:

f. Pollution

1. “Bodily Injury” or “property damage” which would have not have occurred in whole or in part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of “pollutants” at any time.
2. Any loss, cost or expense arising out of any:
  - (a) Request, demand, order or statutory or regulatory requirement that any insured or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of “pollutants;” or
  - (b) Claim or suit by or on behalf of a governmental authority for damages because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing, or in any way responding to, or assessing the effects of, pollutants.<sup>16</sup>

## Conclusion

Most of the cases involving hydraulic fracking lawsuits are in their early stages. Given the current climate of environmental concerns, fracking litigation is certain to increase. This article is a guide and sets out the high points and does not cover many issues involved in hydraulic fracking litigation. This is an area that promises a developing body of law that practitioners will want to follow as principles emerge and evolve.

Much of the developing law will be in the area of regulation. Michigan and other states have comprehensive laws and rules that regulate hydraulic fracturing. The Michigan Department of Environmental Quality - Office of Oil, Gas and Minerals enforces the rules and works to consider the risks of hydraulic fracturing. The MDEQ is the primary agency regulating fracking in Michigan and issues permits under authority Part 615.<sup>17</sup> The staff of the Office of Oil, Gas and Minerals inspect sites regularly during drilling and completion activities. Energy and drilling companies, suppliers, contractors and others involved in this activity should have significant liability insurance in place before commencing this activity. The exposure to liability and accidents in both the surface and subsurface estates are numerous.

Insurance coverage is another area that will develop along with the liability litigation. It is the unknown that fracking operators need to be protected against and that is what insurance is all about – the fortuitous event. ■

## About the Author

**James A. Johnson** of James A. Johnson, Esq. of Southfield is a trial lawyer. He concentrates on Insurance Coverage under the Commercial General Liability Policy, and on sports and entertainment law and federal crimes. Mr. Johnson is an active member of the Michigan, Massachusetts, Texas and Federal Court Bars. He can be reached at [www.JamesAJohnsonEsq.com](http://www.JamesAJohnsonEsq.com)

## Endnotes

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**Insurance  
Case  
Summary**



## Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*; [Deborah.hebert@ceflawyers.com](mailto:Deborah.hebert@ceflawyers.com)

### Michigan Supreme Court

Wrongful denial of UIM benefits subject to penalty interest

*Nickola v MIC General Ins Co*

\_\_\_ Mich \_\_\_ (2017) (Docket No. 152535)

Released May 12, 2017

*Wrongful denial of UIM benefits subject to penalty interest*

The 12% penalty interest imposed by Michigan's unfair trade practices act applies to UIM claims even if the claim is "reasonably in dispute." UIM claimants seek benefits directly from the insurer. They are not third-party claimants despite having to prove a residual liability claim. "[T]he plain language of MCL 500.2006(4) [interest penalty statute] distinguishes the identity of the claimant, not the nature of the claim." Slip op, p 15. Because the statute eliminates penalty interest only for reasonably disputed third-party claims, penalty interest cannot be avoided for reasonably disputed but wrongly denied UIM claims. On the other hand, penalty interest does not commence until "60 days after satisfactory proof of loss was received by the insurer." This case was remanded for a determination of the date of a satisfactory proof of loss.

Exclusion for fraud or dishonesty not applicable

*Employers Mut Cas Co v Helicon Associates, Inc,*

\_\_\_ Mich \_\_\_ (2017) (Docket No. 152994)

Order released May 10, 2017

A provision in plaintiff's "linebacker" and umbrella policies excluded coverage of liability was "based on a determination that acts of fraud or dishonesty were committed by the 'insured.'" These insureds were found liable in federal court for making false statements in violation of Connecticut's Uniform Securities Act. That act, however, did not limit liability to false statements that were knowingly made; violations could also be based on false statements that were negligently made. Because the federal court action did not necessarily base liability on acts of fraud or dishonesty, the exclusion did not apply. The case was remanded for consideration of other policy exclusions raised by the insurer but not decided by the Court of Appeals.

### Michigan Court Of Appeals – Published Decisions

No-fault exclusion for property damage occurring in the course of a business servicing motor vehicle does not apply

*Hastings Mut Ins Co v Grange Ins Co*

\_\_\_ Mich App \_\_\_ (2017) (Docket No. 331612)

Released May 16, 2017

An employee of a family-operated farm "regularly used the barn and its equipment to provide repairs and maintenance to the farm's vehicles as well as to the vehicles of family members." While working on a vehicle, the employee started a fire that destroyed the barn and all of its contents. The farm's property insurer paid for the damage and then subrogated against the no-fault insurer of the vehicle being serviced at the time. At issue was whether the farm was in the business of repairing, servicing, or maintaining motor vehicles. If so, no-fault property protection insurance would not apply. MCL 500.3121. The court held that this exclusion for property damage to businesses that service motor vehicles was "not meant to cover just *any* business that peripherally participates in these activities or any person that performs these activities." Property protection insurance applied because this was a claim for damage to farming business, which was not also in the business "of repairing, servicing, or otherwise maintaining motor vehicles."

Earth movement exclusion applies to "any earth movement," regardless of cause

*Home-Owners Ins Co v Andriacchi*

\_\_\_ Mich \_\_\_ (2017)

(Docket Nos. 331260, 332457; 333695)

Released June 8, 2017

In this first-impression interpretation of the earth movement exclusion in a business-owners policy, the Court of Appeals applied the plain words of the contract and concluded that it was not limited to earth movements caused by natural events, but would also include earth movements caused by street repairs, as occurred in this case. The exclusion, by its own terms, applied to any "loss or damage caused directly or indirectly by any of the following . . . Any earth movement (other than sinkhole collapse), such as an earthquake, landslide or earth sinking, rising or shifting."

Employee's tort claim barred where worker's  
compensation policy was reinstated with no lapse  
in coverage

*Walrath v Witzenmann USS*

\_\_\_ Mich \_\_\_ (2017) (Docket No. 331953)  
Released June 8, 2017

In another first-impression case, the Court of Appeals held that where a worker's compensation policy is cancelled for nonpayment of premium but is subsequently reinstated by the insurer "with no lapse in coverage," the employer is in compliance with the WDCA for injuries that occur between cancellation and reinstatement. The employer thus is not subject to tort liability for those injuries. The WDCA mandate is for the employer "to secure the payment of compensation" for an injured employee. "[W]hen an employer secures compensation from an insurer pursuant to a reinstated policy, it has secured compensation as required by MCL 418.161(b)." This is because reinstatement of a lapsed policy is not a new policy, but the continuation of a policy already issued. This employer's insurer promptly processed and compensated the plaintiff-employee for his injury; he had no tort claim to pursue.

#### Michigan Court Of Appeals - Unpublished Decisions

##### Equitable estoppel justifies homeowners coverage

*Yu v Farm Bureau Gen'l Ins Co of Michigan*  
Docket No. 331570  
Released April 11, 2017, lv app pending

Plaintiff homeowners discovered extensive water damage in their vacant home and submitted a claim to their homeowners insurer, Farm Bureau. Coverage was denied because the house was no longer the insureds' "residence premises" as required by the policy; and it had been vacant for more than 60 consecutive days. Plaintiffs sued under the terms of the policy but also asserted a claim for equitable estoppel, which is how the majority found coverage. Farm Bureau was estopped from denying the claim because its adjuster had responded to a smaller claim nine months earlier, at which time she learned that the plaintiffs were "in the process of moving." The adjuster saw packed boxes in the home and saw that plaintiffs were making repairs before placing the house on the market. "It would therefore be logical to conclude that defendant understood that plaintiffs were no longer residing in the house and that it was unoccupied and vacant within defendant's proposed interpretation of those terms in the insurance policy. And certainly defendant should have understood 10 months later when defendant renewed the policy and accepted plaintiff's premium payment." The majority faulted the adjuster for failing to inform the company's underwriters of the insureds'

impending move, and for failing to advise the insureds of their need to purchase a different form of coverage. The dissenting judge would have applied the terms of the policy to find lack of coverage.

##### Constructive ownership of a motor vehicle

*Adams v Curtis*

Docket No. 330999  
Released April 11, 2017

In this case, the court found a question of fact as to whether plaintiff's grandfather was a "constructive owner" of the vehicle titled to his granddaughter. If plaintiff's grandfather was not a constructive owner, plaintiff would be barred from recovering noneconomic damages in her lawsuit against defendant because she had no policy of her own. MCL 500.3135(2)(c). But if any other vehicle owner obtains no-fault insurance, the bar against recovering noneconomic damages does not apply. Plaintiff's vehicle was one of four vehicles listed on her grandfather's policy. Plaintiff resided with her grandfather, who had his own set of keys to plaintiff's car. He drove it "every couple of weeks," when plaintiff was not using it, to make sure it was running smoothly. The jury will decide whether the grandfather had "proprietary or possessory usage" of plaintiff's car or whether his access to the vehicle was mere "incidental usage under the direction of or with the permission of another."

##### Wrongful act coverage

*Michigan Twp Participating Plan v Charter Twp of Harrison*  
Docket No. 331109  
Released April 13, 2017

Plaintiff's liability policy with Harrison Township fully covered a federal court judgment issued against the Township and in favor of a local business, whose request for a construction permit was mishandled by the Township's building official. The official failed to timely respond to the business owner's requests for the permit. The official also delayed issuing the permit for reasons other than those allowed by the zoning ordinance. At issue was whether the Township's conduct was a violation of civil rights involving the "Regulatory Taking of Private Property." If so, a lower policy limit applied and the insurer could recoup a portion of the judgment paid. The policy defined "Regulatory Taking of Private Property" as "the enactment or enforcement of any regulation or ordinance which unconstitutionally and temporally restricts the use of private property." The court concluded that the business owner's claim was not premised on the Township's enactment or enforcement of an unconstitutional ordinance, but rather, on the official's failure to properly perform his duties. The lower limit did not apply.

*CGL “temporary worker” need not be furnished  
by a third party*

*Kemp v Pioneer State Mut Ins Co*  
Docket No. 330968  
Released June 6, 2017

Plaintiff was injured while working for the insured painting and power washing business. Plaintiff worked for the insured for a period of ten years, but on an irregular and sporadic basis only. The insured’s CGL policy covered its liability as an employer only if the claim was brought by a “temporary employee.” The term “temporary employee” was defined in the policy as “a person who is furnished to [the insured] . . . to substitute for a permanent ‘employee’ on leave or to meet seasonal or short term workload conditions.” At issue was whether the language “furnished to” the insured required that the employee be provided by a third party, such as a temporary staffing company. The panel concluded that nothing in the policy language required third party involvement. Coverage applied.

*Homeowner policy – underage drinking – criminal act and  
negligent supervision exclusion*

*Auto Club Group Ins Co v Johnson*  
Docket No. 330669  
Released June 8, 2017

Defendant homeowners were sued for an injury that occurred on their premises, allegedly as a result of underage drinking. Their homeowners insurer asserted two exclusions, one for criminal acts and the other for negligent supervision. The court held that the criminal acts exclusion was unambiguous but did not necessarily apply because there was a question of fact about whether the insureds knowingly allowed a minor to consume alcoholic beverages on the premises. As

to the exclusion for negligent supervision, the panel found it ambiguous because “the duty [to supervise] would change based on the status of the injured person and the conduct at issue.” The panel also found a question of fact as to whether the exclusion would apply because there was a question of fact about whether the homeowners were unaware of the underage drinking.

**6<sup>th</sup> Circuit Court Of Appeals Decisions**

**Insured vs insured exclusion applies**

*Indian Arbor Ins Co v Clifford Zucker* (16-1695)  
\_\_\_ Fed 3rd \_\_\_ (6<sup>th</sup> Cir 2016)  
(Case Nos. 16-1695, 1697, 1698)  
Released June 20, 2017

The “insured v insured” exclusion in this management liability policy barred coverage for officers of the insured company when they were sued for mismanagement. Suit was filed by the “Liquidating Trust,” which had been assigned the causes of action in a bankruptcy proceeding. The fact that the entity bringing the claims was the trustee of the debtor-in-possession did not prevent the exclusion from being applied. The trustee was standing in the shoes of the debtor-in-possession, who was in turn acting for the insured company (it *was* the insured company). The suit was effectively a suit between insureds. The majority opinion explains that “insured vs insured” exclusions are intended to limit liability coverage to claims by outsiders. In this policy, for example, the exclusion barred coverage for any claim “by, on behalf of, or in the name or right of, the Company or any Insured Person, against an Insured Person.” As explained by the court, “[a] company thus cannot hope to push the costs of mismanagement onto an insurance company just by suing (and perhaps collusively settling with) past officers who made bad business decisions.” (Donald, B. dissenting). ■

**Insurance & Indemnity Law Section Mission**

Issues arising out of insurance contracts and indemnity agreements affect a broad range of practice areas. In addition, insurance is a regulated industry, and state and federal regulations present specialized questions. The membership of the Insurance and Indemnity Law Section of the State Bar of Michigan consists of those who have expertise in this area of practice, as well as those whose expertise lies in other practice areas that are affected by insurance and indemnity issues. The mission of the Section is to provide a forum for an exchange of information, views and expertise from all perspectives on both insurance coverage issues and indemnity issues, and to provide information and assistance to other persons or organizations on matters relating to insurance and indemnity. Membership is open to all members of the State Bar of Michigan.

ERISA  
Case  
Summary

## ERISA Decisions of Interest

K. Scott Hamilton, *Dickinson Wright PLLC*, [khamilton@dickinsonwright.com](mailto:khamilton@dickinsonwright.com)  
 Kimberley J. Ruppel, *Dickinson Wright PLLC*, [kruppel@dickinsonwright.com](mailto:kruppel@dickinsonwright.com)

## United States Supreme Court Update

## High Court Unanimously Upholds ERISA Exemption for Church-Affiliated Pension Plans

*Advocate Health Care Network et al v. Stapleton et al*,  
 581 U.S. \_\_ (2017)

In one of the last opinions to be rendered this session by the United States Supreme Court, hospital pension plans maintained by religiously affiliated pension plan committees secured the Court's blessing to maintain beneficial exemptions from Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* (as amended) ("ERISA").

ERISA obligates employers to follow a set of rules designed to ensure plan solvency and protect plan participants. Some of these rules, particularly rules regarding pension plan design and funding, may seem more burdensome to employers than protective of employees. The outcome of this case was a blow to those seeking to hold church affiliated hospitals accountable to the same ERISA requirements as their secular counterparts.

The original ERISA statute provided an exemption for "church plans", defined as "a plan established and maintained . . . for its employees . . . by a church." 29 U.S.C. §1002(33)(A). Congress amended the statute in 1980 in part to add a section that formed the basis of the dispute before the Court as follows: "A plan established and maintained . . . by a church . . . includes a plan maintained by an organization . . . the principal purpose . . . of which is the administration of funding of [such] plan . . . for the employees of a church . . . , if such organization is controlled by or associated with a church." 29 U.S.C. §1002(33)(C)(i). The Court condensed this description as a plan maintained by a "principal purpose organization".

For decades, the IRS, Department of Labor and the Pension Benefit Guaranty Corporation, which are the three federal agencies responsible for administering ERISA, have read the two definitional sections together and allowed church affiliated hospitals, such as the parties in these three consolidated disputes, exemption from ERISA.

Recently, three separate class actions were filed by current and former hospital employees challenging their employers' pension plan exempt status. The Courts of Appeals for the Third, Seventh and Ninth Circuits agreed with the employees' argument that a pension plan must have been established by a church to be exempt. The high court granted *certiorari* in these

similar disputes to resolve the question of whether a church affiliated hospital employee benefit plan that was maintained by internal benefit committees, but not established by a church, satisfied the exemption definition.

In the opinion, Justice Kagan explained that the use of the word "include" in the amended definition indicated that a different type of plan should receive the same exemption benefit as the original definition. Accordingly, since Congress deemed the category of plans "established and maintained by a church" to "include" plans maintained by a principal purpose organization, all such plans are exempt from ERISA's requirements.

It is important to note that hospital plans may still be subject to attack under state law theories of liability with respect to allegations of underfunding or other irregularities. However, church based hospital plans, maintained by an internal benefit committee but not established by a church such as those in these consolidated disputes, remain exempt from ERISA's funding, reporting and design requirements.

## Sixth Circuit Update

## Denial of Benefits Was Arbitrary and Capricious Where Disability From Headache Was Established by Objective Medical Evidence

*Corey v. Sedgewick Claims Management Servs., Inc.*,  
 858 F.3d 1024 (6<sup>th</sup> Cir. 2017)

The plaintiff was a machine operator who had long-standing "cluster headaches," very painful attacks that occurred several times per day, and often lasting for weeks. His employer's disability plan provided that "[o]bjective findings of a disability are necessary to substantiate the period of time your health care practitioner indicates you are unable to work because of your disability," and said that "[o]bjective findings include . . . Physical examination findings (functional impairments/capacity); Diagnostic test results/imaging studies; Diagnoses; X-ray results; Observation of anatomical, physiological or psychological abnormalities; and Medication and/ or treatment plan."

The benefits administrator denied the plaintiff disability benefits based upon an independent file reviewer's conclusion that cluster headaches "do not result in any neurological, physical exam abnormalities," and therefore the disability was not supported by objective findings.

The district court affirmed the administrative decision under arbitrary and capricious review. On appeal, the Sixth Circuit reversed. The administrative record showed that the plaintiff's "physicians treated his headaches by prescribing prednisone, injecting Imitrex (a headache medication), administering oxygen therapy, and performing an occipital nerve block." 858 F.2d at 1024. The Sixth Circuit summarized its reason for reversing as follows:

. . . [T]he plan identifies "[m]edications and/or treatment plan" as examples of "objective findings." [The plaintiff's] physician supplied evidence detailing his cluster-headache treatment. Yet the Administrator denied [the plaintiff's] application due to a lack of objective findings. It never explained why his medications and treatment plan failed to satisfy the plan's objective-findings definition. Nor did its rejection letters offer any other explanation for the benefits denial. Accordingly, the Administrator's decision was arbitrary and capricious.

The Sixth Circuit said that "the record leaves us guessing as to how the Administrator interpreted the plan's objective-findings definition."

#### Denial of Benefits Was Not Arbitrary and Capricious Where Record Evidence Showed the Claimant Was Not Unable to Perform Sedentary Occupational Duties

*Rothe v. Duke Energy LTD Plan*, (6<sup>th</sup> Cir., May 2, 2017), Case No. 16-4225 (unpub)

The plaintiff worked as a gas controller at Duke Energy Corporation and suffered from various ailments, including spinal fusion and backache. The defendant's vocational consultant determined that his "own occupation," as performed in the national economy, was most analogous to a "Gas Dispatcher" under the DOL's Dictionary of Occupational Titles, and that such occupation is sedentary. Three of the plaintiff's physicians concluded that he was permanently disabled from performing the essential elements of his job. The insurer, Liberty Mutual, had an independent medical examination done of the plaintiff by a physician who opined that the plaintiff was not unable to work in his occupation. Two other physicians who reviewed the plaintiff's records concluded the plaintiff could perform sedentary occupational duties. The insurer denied the claim, and upheld that denial upon administrative appeal.

The district court held that the denial was not arbitrary and capricious, and the Sixth Circuit affirmed.

First, the Court held that "an occupation" is "a general term that refers to categories of work as opposed to the employee's particular duties," and that the vocational consultant "reasonably compared [the plaintiff's] job duties, as described in the Duke job description, to the [Definition of Occupa-

tional Titles] to determine" the duties as performed in the national economy.

Second, there was substantial evidence that the side-effects of medication did not adversely impact him, and it was insufficient for the plaintiff to simply point to the listed side-effects of medication without showing that they actually occurred in his case.

Third, the Sixth Circuit held that although there were competing medical opinions about the plaintiff's ability, or inability, to work, "Liberty had to weigh the conflicting reports," "relied on substantial medical testimony in its decision, and did not disregard any expert." Its decision was therefore not arbitrary and capricious.

#### United States District Court Update

##### Denial of Multiple Untimely Claims Was Not Arbitrary or Capricious Where the Claimant Failed to Follow Plan Requirements

*Holmes v Aetna Life Ins. Co.*, 2017 WL 2645784 (Case no. 16-cv-11538) (E.D. Mich. 2017) (slip copy)

This case presents a fairly complicated set of facts concerning a familiar type of claim for disability benefits. The plaintiff filed a claim for disability benefits while performing one position, was denied, returned to work in a different position, filed for benefits and was denied again. Ultimately, because he did not follow the requirements of the plan language, and because he did not provide objective evidence of functional impairment, the court upheld the denial of his claim.

Plaintiff worked for UPS and was covered by a benefit plan that offered self-funded short term disability benefits and fully insured long term disability benefits. After working for UPS for approximately ten years, the plaintiff changed positions. Three days into his new job, he stopped working and filed a claim for short term disability benefits based on ankle, foot and knee pain as well as depression. His claim was denied, which he initially appealed, but did not timely pursue all of his administrative remedies. The Plan provided that any lawsuit challenging a benefit denial must be filed within six months of the adverse decision, which the plaintiff failed to do.

Several months later, the plaintiff returned to work for UPS in a different position, with a lesser exertional requirement to accommodate his foot and ankle restrictions and limitations, and a lower salary. The Plan allowed for a residual disability benefit if a claimant worked in a lower paying, accommodating position. Further, the Plan allowed benefits for successive periods of disability. However, the plaintiff did not to seek benefits under either of these provisions. Instead, the plaintiff claimed that he was filing a new claim for short term disability benefits based on stress, panic and anxiety. Because he failed to substantiate a functional mental or physical impairment, his claim was denied once again.

Plaintiff argued to the court that his second claim should have been construed as a claim for long term disability benefits because it arose out of the same conditions as his original claim. However the Plan provided that long term benefits are only available to employees who have exhausted their short term benefits. Because plaintiff was eligible for six weeks of remaining coverage, the Court found he had not exhausted his short term disability benefits and therefore was not eligible for long term benefits.

Plaintiff also argued that his second claim for benefits should have been considered in light of his previous, more physically demanding position. However, when plaintiff applied for benefits the second time, he listed his occupation as the less demanding job and did not inform the defendants that he was filing a claim for residual benefits related to his previous position. Again, the Court rejected his argument as unavailing.

Not to be deterred, plaintiff filed a third claim, this time for long term benefits related to his previous job. By that time, plaintiff had not worked at that position for over fourteen months and still had not exhausted his short term benefits related to that position. The Plan required a claim for long term benefits be filed within 90 days after the end of the elimination period, which had long since passed. Accordingly, the Court found plaintiff's claim for long term disability benefits based on his previous position was time-barred.

Notwithstanding the plaintiff's procedural failings in attempting to pursue his claim, the Court found that the defendants' denial was well supported by peer review and the lack of objective evidence of both mental and physical functional impairment. All in all, the Court held that none of plaintiff's theories of liability had merit and the defendants' denial of the claim was not arbitrary or capricious.

### Denial of Benefits Was Proper Under De Novo Review Where the Plaintiff Failed to Provide Medical Authorizations

*Ketowa v Unum Life Ins Co. of America*,  
(E.D. Mich., May 19, 2017), Case No. 2:16-cv-12205

The plaintiff had several conditions, including ulcerative colitis, perirectal abscesses, anxiety, depression, and Crohn's disease. The insurer needed to determine whether the plaintiff's disability was caused by a "pre-existing condition," meaning a condition for which the plaintiff sought treatment during the 3-month period before he began employment, because the plan excluded coverage for disabilities caused by pre-existing conditions.

Several times the defendant insurer requested the plaintiff to sign and submit specific medical authorizations so it could determine whether his disability was caused by a pre-existing condition, and the plaintiff refused to do so. Because of that, the insurer withheld benefits.

The plaintiff sued, and the district court, applying *de novo* review, held that the insurer's decision was proper in light of the plan's requirement that claimants must give the insured "authorization to obtain additional medical information . . . as part of your proof of claim." ■

### About the Authors

**K. Scott Hamilton** is a Member and commercial litigator in Dickinson Wright's Detroit office. He specializes in ERISA, insurance, business and appellate litigation.

**Kimberly J. Ruppel** is a Member and commercial litigator in Dickinson Wright's Troy office. She specializes in ERISA, insurance, healthcare and probate litigation.

## Legislative Update



## The Legislative Committees Get to Work

Patrick D. Crandell, *Collins Einhorn Farrell PC*

With the House now well into its two-year term and the Senate approaching the end of its four-year term (both conclude in December 2018), the members continue to introduce bills (773 in the House and 468 in the Senate) while the Committees focus on addressing those bills.

Typically, once a legislator introduces a bill, it is sent to the committee that handles the subject matter of that bill. The chair of the committee (a member of the majority party) determines which bills get a hearing and when. The committee members review, modify and debate the bills during the hearings, and ultimately they vote whether or not to report the bills out of Committee and to the full legislative body.

Since the last legislative update, the House and Senate Insurance Committees have held hearings on and reported out a number of bills:

- **Copy of vehicle registration is sufficient.** HB 4013 amends the Michigan Vehicle Code to allow an electronic copy or photograph of a vehicle registration to satisfy the requirement that registration must be carried in the vehicle or by the driver. *Passed unanimously by the House on 3/14/17; Passed unanimously by the Senate on 6/15/17*
- **Suspension of insurance producer's license.** HB 4117 permits the DIFS Director to place on probation, sus-

pend, revoke and/or refuse to issue an insurance producer's license, if that producer was convicted of a felony involving dishonesty or a breach of trust. *House Committee hearing held on 3/16/17*

- **Continuing education hours carryover.** HB 4325 permits an insurance producer to carry over continuing education hours into the next reporting period; permits the DIFS Director to revoke or suspend approval of or place a continuing education provider on probation under certain circumstances. *Passed by the House (106-2) on 4/26/17; Passed unanimously by the Senate on 6/15/17*
- **Alternative case reserve for public health benefit plans.** SB 43 permits an alternative cash reserve option for pooled public employee and officers' health-benefit plans. *Passed unanimously by the Senate on 3/23/17; Passed unanimously by the House on 5/31/17; Presented to the Governor on 6/13/17*
- **Auto theft prevention authority assessment.** SB 168 expands the auto theft prevention authority assessment to commercial vehicles. *Passed unanimously by the Senate on 3/28/17; Passed by the House (103-4) on 5/17/17; Presented to the Governor on 6/8/17*

#### Referred to Insurance Committees

Additionally, the House and Senate have referred the following bills to the Insurance Committees since the last legislative update:

- **No-Fault changes.** HB 4488 amends the No-Fault Act to: limit required attendant care benefits in certain circumstances; permit an insured to select their limits of personal protection benefits; create an insurance fraud and theft prevention authority.
- **Prohibition against basis rates on credit history, et al.** HB 4617 prohibits automobile insurers from basing rates or premiums on credit history, education, occupation or residency.
- **Online verification of auto insurance et al.** HB 4622-4623 establishes a system for online verification of automobile insurance; requires insurers to provide information to verification system; provides for sanctions for failing to maintain insurance; imposes fees to reinstate vehicle registration; and permits for license revocation or suspension.
- **Requirements for claims against the Assigned Claims Fund.** HB 4624-4627 modifies the requirements, procedures and timeline for submitting a claim to the Michigan Assigned Claims Plan, including: requiring claimant to provide a reasonable proof of loss; prohibiting penalty interest while claim is reasonably in dispute; requiring the claimant to cooperate with the claim investigation; setting a 1 year statute of limitations on making a claim. *Reported out of Committee on 5/25/17*

- **Creation of Insurance Fraud Authority.** HB 4672 creates and provides authority for the Michigan Automobile Insurance Fraud Authority.
  - **Creation of Insurance Fraud Authority.** HB 4715 creates and provides authority for the Michigan Automobile Insurance Fraud Authority.
  - **Repeal of abortion insurance opt-out.** HB 4761 repeals the Abortion Insurance Opt-Out Act of 2013.
  - **Required coverage for cranial hair prosthetics.** SB 234-235 requires private health insurers and Medicaid to cover cranial hair prosthetics for individuals under 19 years old with hair loss due to a medical condition.
  - **Changes to Catastrophic Claims Association.** SB 240-241 modifies the catastrophic claims association to: change its membership; require annual audits; and make it subject to the Open Meetings Act and FOIA.
  - **Prohibits refusal to reimburse for chiropractic.** SB 282-283 eliminates authority to refuse reimbursement for chiropractic services under the workers' compensation and no-fault acts.
  - **Regulation of pharmacy benefits.** SB 287 creates framework for regulation of pharmacy benefits; requires licensing of pharmacy benefit managers; defines relationships between pharmacies and pharmacy benefit managers.
  - **Prohibition against requiring a repair shop to use specific vendor or parts.** SB 291 prohibits an automobile insurer from requiring a repair shop to use a specific vendor or process to obtain parts or other materials.
  - **Auto insurance rates can only be based on repair costs, moving violations, loss experience and prior claims.** SB 312 eliminates all of the factors that an automobile insurer currently can rely on when setting rates or premiums, except for: the anticipated cost to repair the vehicle; moving violations; loss experience and prior claims.
  - **Mandated coverage for birth control.** SB 458 requires health insurers to provide free coverage for birth control.
- Finally, while the following bill has been before Senate and House Judiciary Committees, it's relevant to insurance and indemnity practitioners because it addresses whether Business Courts have jurisdiction to hear declaratory judgment actions:
- **Business Court jurisdiction expanded to include declaratory actions.** SB 333 modifies the business court statute to, among other things, specify that business courts would have jurisdiction over business and commercial disputes in which equitable or declaratory judgment relief was sought, assuming the matter otherwise meets the jurisdictional requirements. *Passed unanimously by the Senate on 5/16/17; Reported out of the House Committee on 5/30/17* ■



# NEXT

C O N F E R E N C E

**SBM**  
STATE BAR OF MICHIGAN  
ANNUAL MEETING  
**September 27–29, 2017**  
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## Opening Keynote

Dan Abrams

THURSDAY, SEPTEMBER 28  
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## More Useful Citations For Your Toolkit

Hal O. Carroll, *Law Office of Hal O. Carroll*

Everyone who practices in the area of insurance coverage sooner or later develops a set of useful citations. There are two criteria for including a citation in your personal set. First are those that you will use a lot. Second are those that you won't use very often but they are hard to find, so you should save them just in case. The previous column contained a list several useful citations. Here are a few more.

### Agent - Independent Agent Is Agent of the Insured

As a matter of law, an independent agent is the *agent of the insured* and not the agent of the insurer. The rule is laid down in *Mayer v Auto-Owners Ins Co*, 127 Mich App 23; 338 NW2d 407 (1983). In that case the insured sued the insurer for negligent handling of the claim. The negligence was that of Kirkpatrick the insurance agent. The court said:

At trial, Kirkpatrick testified that he was an independent insurance agent and had the power to place insurance with various companies. An independent insurance agent, or broker, is ordinarily the agent of the insured, not the insurer,

*Mayer*, quoting *16 Appleman, Insurance law and Practice*, §8722, pp 322-324.

### Certificate of Insurance Is Not Part of the Policy

"The certificate is no part of the insurance contract."

*Chrysler Corp v Hardwick*, 299 Mich 696, 700; 1 NW2d 43 (1941).

Certificates are issued by the agent, not by the insurer, and "the independent insurance agent or broker is considered an agent of the insured rather than an agent of the insurer."

*West American Ins Co v Meridian Mutual Ins Co*, 230 Mich App 305, 310; 583 NW2d 548 (1998)

. . . the insurance certificate at issue did not purport to represent the terms, benefits, or privileges promised under the policy. Instead, the stated purpose was merely to certify that the listed insurance policies had been issued." *Id.* at 311.

### No Duty to Defend Unless Requested

"Absent a request, an insurer has no duty to defend an insured." *DAIE v Higginbotham*, 95 Mich App 213, 218; 290 NW2d 414 (1980), citing *American Mutual Liability Ins Co v*

*Michigan Mutual Liability Co*, 64 Mich App 315, 323; 235 NW2d 769 (1975); *Eastman v United States*, 257 F Supp 315, 319 (S.D.Ind.1966).

### Insurer Must Defend All Claims if Any Claim Is Covered

"[I]t is not necessary that all claims which are brought against the insured in the suit be covered by the policy. If there are any theories of recovery that fall within the policy, the insurer owes a duty to defend the suit.

*Reurink Bros Star Silo, Inc v Maryland Casualty Co*, 131 Mich App 139, 142; 345 NW2d 659 (1983)

### Duty to Defend Applies if Coverage is Even Arguable

"If the allegations of a third party against the policyholder even arguably come within the policy coverage, the insurer must provide a defense."

*Polkow v Citizens Ins Co*, 438 Mich 174, 178, 180; 476 NW2d 382 (1991); *Allstate Ins Co v Freeman*, 432 Mich 656, 662; 443 NW2d 734 (1989).

### Duty to Defend Requires Insurer to Investigate

The insurer's duty to defend is not limited to the allegations of the underlying complaint.

"Whether a defendant can obtain a defense from his insurer must depend not on the caprice of the third party's draftsmanship, nor the limits of his knowledge, but on a potential shown in the complaint that the facts ultimately proved come within the coverage."

*Jonesville Products Inc v Transamerica Insurance Group*, 156 Mich App 508, 513; 402 NW2d 406 (1986) (emphasis added)

"[T]he duty to defend is broader than the duty to indemnify," and an insurer who wrongfully refuses to defend its insured becomes liable on any judgment against the insured "despite theories of liability asserted against any insured which are not covered under the policy." An insurer's duty to defend, then, includes the duty to investigate and analyze whether the third party's claim against the insured should be covered.

*Koski v Allstate Insurance Company*, 456 Mich 439, 445 note 5; 572 NW2d 636 (1998), citing *American Bumper*, *supra*.

### Breach of Duty to Defend - Settlement

[W]hen the policy does apply, “an insurer breaches its own policy of insurance by refusing its duty to defend the insured [and] is bound by any reasonable settlement entered into in good faith between the insured and the third party.” *Alyas v Gillard*, 180 Mich App 154, 160; 446 NW2d 610 (1989). See also *Clay v American Continental Ins Co*, 209 Mich App 644, 647-650; 531 NW2d 829 (1995).

### Denial of Coverage – New Grounds after Judgment Not Permitted

In *Meirthew v Last*, 376 Mich 33; 135 NW2d 353 (1965), the insurer issued a general reservation of rights before the judgment, but asserted specific grounds for denial only after the judgment was entered. The insurer had defended under its reservation of rights, but when it received the writ of garnishment, it asserted for the first time an exclusion for claims arising out of the “transportation of passengers for a specific charge.” *Id.* at 35.

The Supreme Court held that the insured was barred from asserting this new ground as a matter of law:

This insurer’s notice failed the quoted ‘reasonable’ test because it was unreasonably and prejudicially tardy. It failed that test because it left Last [the insured] in the dark as to the nature of the policy defense or defenses the insurer had in mind; if indeed it had any in mind save such as might be conceived later as the principal case proceeded.

*Id.* at 39

### Duty of Good Faith

There is an “implied covenant of good faith and fair dealing which arises from the contract between the insurer and the insured.” *Commercial Union Ins Co v Medical Protective Co*, 426 Mich 109, 116; 393 NW2d 479 (1986) (failure to settle claim).

### Substance of Allegations in Underlying Complaint, Not Form or Label

It is the *underlying facts* that the underlying plaintiff alleges that determine coverage, not the legal theories that the underlying plaintiff alleges. *Gorzen v Westfield Ins Co*, 207 Mich App 575, 578; 526 NW2d 23 (1994). Thus, coverage is determined by examining the underlying basis of the claim, rather than any specific theory of liability. “[I]t is necessary to focus on the basis for the injury and not the nomenclature of the underlying claim in order to determine whether coverage exists. . . . [So] must the allegations be examined to

determine the substance, as opposed to the mere form, of the complaint.” *Allstate Ins Co v Freeman*, 432 Mich 656, 662-663; 443 NW2d 734 (1989). It is the substance of the allegations, not their mere form, that must be examined. *State Farm v Johnson*, 187 Mich App 264, 268; 466 NW2d 287 (1991) (citations omitted).

“The allegations contained in the underlying complaint generally determine an insurer’s duty to defend. However, mere allegations of negligence in a transparent attempt to trigger insurance coverage by characterizing intentionally tortious conduct as negligent will not persuade the court to impose a duty to defend.” *Iowa Kemper Ins Co v Ryan*, 172 Mich App 134, 137; 431 NW2d 434 (1988).

“The injuries resulting from the car accident are excluded from coverage regardless of the label the allegations were given in the complaint. We must look to the underlying cause of the injury to determine coverage and not the theory of liability.” *Gorzen v Westfield Ins Co*, 207 Mich App 575, 578; 526 NW2d 23 (1994).

“Further, [plaintiff’s] characterization of [defendant’s] conduct as being mere negligence does not control the applicability of the exclusionary clause, because the duty to defend is not limited to the precise language of the pleadings. Rather, it is the substance of the allegations, not their mere form, that must be examined.” *State Farm v Johnson*, 187 Mich App 264, 268; 466 NW2d 287 (1991) (citations omitted).

### “An Insured” Versus “the Insured”

The distinction between “the insured” and “an insured” has long been recognized in Michigan. “The insured” refers only to the actor, whereas “an insured” means “any insured.”

We . . . hold “that by excluding insurance coverage for injury or damage intentionally caused by ‘an insured person,’ Allstate unambiguously excluded coverage for damages caused by the intentional wrongful act of *any* insured under the policies.”

*Allstate v Freeman*, 432 Mich 636, 694-695; 443 NW2d 734 (1989) (citations omitted, italics in the original).

Applying *Freeman*, the Court in *Vanguard Ins Co v McKinney*, 184 Mich App 799, 804-805; 459 NW2d 316 (1990) held that the distinction between “the insured” and “an insured” is dispositive.

While plaintiff dismisses this distinction [between “an insured” and “the insured”] as being irrelevant semantics, we conclude that the distinction is dispositive.

“If Citizens Insurance wished to exclude coverage arising out of the violation of a penal statute, regardless of which insured committed the violation,

it could have done so by using the phrase “any insured.” Because the phrase “the insured” was used, it is plain that the application of the exclusion must be determined by reference to a particular insured.

*Paylor v First Mountain Mortgage, et al.*, unpublished Court of Appeals, 278076, October 9, 2008, page 8, emphasis added. ■

## About the Author

*Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. Mr. Carroll practices extensively in the area of insurance coverage and indemnity law, and was designated a “Super Lawyer®” again in 2016. He also consults with businesses and insurers on the drafting of contracts, represents insureds and insurers in declaratory actions, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His email address is [HOC@HalOCarrollEsq.com](mailto:HOC@HalOCarrollEsq.com).*

## LinkedIn Revisited—Still the Place to Be

By Roberta M. Gubbins

In 2003, Reid Hoffman, after six months of back-end work, officially launched LinkedIn. Because he needed to build a user base of 1M people, he began with all 13 employees inviting a total of 112 users. Once they added the technology for users to upload their address books, there was more direct user-to-user marketing—an online form of word of mouth. LinkedIn’s success was made possible by following its own concept—networking.

Fast forward to 2017; LinkedIn is said to be one of the most powerful social networking tools available for lawyers. Statistics bear this out:

- 80% of law firms maintain a LinkedIn presence (ABA 2016 Tech Report)
- 74% of those on LinkedIn use it to research companies and people
- LinkedIn drives 64% of all social media visits to websites

To be effective on LinkedIn, you need a plan.

Start by asking yourself what you want to accomplish with LinkedIn. Do you want to build your client base, cultivate relationships with particular businesses, search for a position in a law firm or a company, or establish your expertise in your area of practice? Next, decide what audience you want to attract. If your plan is to build your client base in your area of practice, your profile and publications should provide information prospective clients can use.

### Your Profile

LinkedIn makes it easy to create a profile that will increase your visibility and help to place your brand in the legal community. If your profile has been up for a while, it may be time to update it. Perhaps you’ve added a new practice area, moved your office, or added staff.

The following techniques make your LinkedIn profile

stand out:

- Use a recent, professional photo. Wear professional attire, use a simple background, add a friendly look, and it’s good.
- Create an interesting headline, your name plus adding a short statement about your practice can add information and draw the reader in for more.
- Write your profile in first person as if you were talking to the client.
- Add to your profile using LinkedIn sections.
- Upload a video or a link to a podcast.
- If you volunteer, add those community organizations.

Your profile should bring your personality to the forefront. If you are formal or the more casual type, your profile should reflect that. Be genuine and whatever you share will hit the mark. Now that you’ve updated your LinkedIn profile, stop by your SBM Member Directory profile to be sure it, too, is ready for prime time.

LinkedIn is about networking and building relationships. Join groups and check your home page for news about others in your network. Respond with a congratulatory note or information that can help them further a project. Taking a few minutes to scan your home page, respond to updates, and send comments can bring good results when done with your goals in mind. And, remember to include a link to your LinkedIn profile on your SBM Member Directory profile and on your website.

*Roberta Gubbins Roberta Gubbins has served as the editor of the Ingham County Legal News. Since leaving the paper, she provides services as a ghostwriter editing articles, blogs, and e-blasts for lawyers and law firms. She is the editor of Briefs, the Ingham County Bar Association e-newsletter, and The Mentor, SBM Master Lawyers Section newsletter. ■*

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Rabih Hamawi, *Fabian, Sklar & King*  
RHamawi@fabiansklar.com Term Ends 2018

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shicks@speakerlaw.com Term ends 2017

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lpominville@primeoneinsurance.com Term ends 2018

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StorkG1@nationwide.com Term ends 2018

James K. Thome, *Vandevveer Garzia, PC*  
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*First Mercury Insurance Company*  
Renee.Vanderhagen@firstmercury.com Term ends 2017

Nicole Wilinski, *Collins Einhorn Farrell, PC*  
Nicole.Wilinski@ceflawyers.com Term ends 2018

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STATE BAR OF MICHIGAN

Michael Franck Building  
306 Townsend St.  
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