From the Chair

Thank you very much for the opportunity to serve as chair of the Insurance and Indemnity Law Section. My first task has to be to thank outgoing chair Hal Carroll for his great leadership and extensive work for the section from its inception. Hal was a main co-founder of the section, along with Deborah Hebert, in 2007. He led the efforts to form this section, the first new State Bar section in approximately 10 years, including extensive work with the State Bar, preparation of the bylaws, organizing the first council, and laying the foundation for future growth of the section.

Hal served as chair from the inception of the section through our September 17, 2009 annual meeting. Under his leadership, the section has grown to over 350 members in that very short period of time, formed several committees, published this quarterly journal, of which Hal also serves as editor, presented two annual programs, and dealt with the filing of an amicus brief in the Michigan Supreme Court, among other activities. He will continue to serve as an ex officio member of the council, and fortunately for all of us, as editor of this journal. As a token of our appreciation, Hal was presented with a recognition plaque at the recent annual meeting. Thanks again, Hal.

Speaking of the annual meeting, we had an excellent presentation on the topic of “Risk Management—Using Indemnity and Additional Insured Provisions.” Our speakers included council member Amy Hobbs Iannone, deputy general counsel and director of risk management at Barton Mallow; Joanie Schneider, managing director at Marsh and the industry placement leader for Marsh’s construction practice; and David Yesh, vice president at Marsh, a claims consultant specializing in liability, construction, and financial and professional claims. The informative program explained some of the numerous types of indemnity and additional insured provisions and addressed various issues concerning interpretation of those provisions.

Officers and council members were elected at the annual meeting. In addition to myself, your new officers are: Mark Cooper, chair-elect; Elaine Murphy Pohl, secretary; and Kathleen Lopilato, treasurer. In addition to returning council members Marty Brown, M.J. Stephen Fox, Edward Freeland, Amy Iannone, Dan Steele, and Deborah Hebert, our expanded new council pursuant to amending the

Continued on page 3
The world of indemnity seems somehow to be destined to confuse courts, and recent research into Tennessee law pointed that out—the same language can have two different meanings in two states, and for each state, the meaning is “obvious.” Practitioners in Michigan are all familiar with MCL 691.991, which bars indemnity for one’s “sole negligence.” Well, Tennessee has the same statute, and Tennessee’s statute reads:

A covenant promise, agreement or understanding in or in connection with or collateral to a contract or agreement relative to the construction, alteration, repair or maintenance of a building, structure, appurtenance and appliance, including moving, demolition and excavating connected therewith, purporting to indemnify or hold harmless the promise against liability for damages arising out of bodily injury to persons or damage to property caused by or resulting from the sole negligence of the promisee, the promisee’s agents or employees, or indemnitee, is against public policy and is void and unenforceable.1

Since Tennessee’s “sole negligence” statute uses the same words as Michigan’s statute, it must have the same meaning, right? Wrong. In Tennessee, the court invalidates the entire clause, so that the indemnitee who overreaches gets nothing.

Pursuant to Tenn. Code Ann. § 62-6-123, the indemnity provision . . . is void in its entirety as contrary to public policy.6

One measure of the strictness of Tennessee’s approach is that every reported case where the statute has been applied has voided the clause.

This is a stark difference in interpretation, and those who think simple words (“sole negligence”) always have a clear meaning should think again.

What makes this interesting is that neither court had any problem interpreting the statute. The meaning was obvious in Michigan, and it was obvious in Tennessee. Neither court wrestled with two possible interpretations and then explained why its interpretation was the better one. The statute has only one meaning, and that meaning is obvious. Michigan and Tennessee agree that the statutory language obviously has only one meaning, but that obvious meaning is different in each state.

To some extent, the difference can be expressed as a matter of judicial public policy. Michigan takes a consciously neutral view of indemnity for one’s own fault, whereas Tennessee sees it as suspect. Tennessee adheres to the majority view that a contract that purports to grant indemnity for the indemnitee’s own fault must expressly say so.

[A] contract of indemnity cannot be construed under the law of Tennessee to indemnify the indemnitee against losses resulting from his own negligent acts unless such intention is expressed in clear and unequivocal terms or unless no other meaning can be ascribed to it. Also . . . general, broad and seemingly all inclusive language in an indemnity agreement is not sufficient under the law of Tennessee to impose liability for indemnitee’s own negligence.7

---

1. A Tale of Two Statutes

By Hal O. Carroll, Vandeveer Garzia, PC, hcarroll@VGpcLAW.com

The Drafting Table

Since Tennessee’s “sole negligence” statute uses the same words as Michigan’s statute, it must have the same meaning, right? Wrong.

In Tennessee, the court invalidates the entire clause, so that the indemnitee who overreaches gets nothing.

Pursuant to Tenn. Code Ann. § 62-6-123, the indemnity provision . . . is void in its entirety as contrary to public policy.

One measure of the strictness of Tennessee’s approach is that every reported case where the statute has been applied has voided the clause.

This is a stark difference in interpretation, and those who think simple words (“sole negligence”) always have a clear meaning should think again.

What makes this interesting is that neither court had any problem interpreting the statute. The meaning was obvious in Michigan, and it was obvious in Tennessee. Neither court wrestled with two possible interpretations and then explained why its interpretation was the better one. The statute has only one meaning, and that meaning is obvious. Michigan and Tennessee agree that the statutory language obviously has only one meaning, but that obvious meaning is different in each state.

To some extent, the difference can be expressed as a matter of judicial public policy. Michigan takes a consciously neutral view of indemnity for one’s own fault, whereas Tennessee sees it as suspect. Tennessee adheres to the majority view that a contract that purports to grant indemnity for the indemnitee’s own fault must expressly say so.

[A] contract of indemnity cannot be construed under the law of Tennessee to indemnify the indemnitee against losses resulting from his own negligent acts unless such intention is expressed in clear and unequivocal terms or unless no other meaning can be ascribed to it. Also . . . general, broad and seemingly all inclusive language in an indemnity agreement is not sufficient under the law of Tennessee to impose liability for indemnitee’s own negligence.
Michigan’s philosophy is different in that indemnity for an at-fault indemnitee is provided, “[a]though not ‘expressly stated in the agreement,” if “in light of the surrounding circumstances,” the court is “persuaded” that this is what “the parties intended.”8 Not exactly a textualist view, but still the current law.

But philosophy aside, there is a lesson here about careful use of words. Neither the Michigan courts nor the Tennessee courts had any problem reading the statute. Each gave the term “sole negligence” a drastically different meaning without any anguish over the phrase. To each court the meaning was obvious.

Is there a “true” meaning? Can we say one state is correct and the other not? There are two parts to look at. One is the phrase “the sole negligence of the promisee.” The other is the phrase “against public policy and is void and unenforceable.”

The second phrase is the easier one to critique. Tennessee wins. A court is entitled to take a neutral stance about public policy and contracts out of fastidious concern for freedom of contract, as Michigan's Supreme Court has done, but when public policy is declared by the legislature, judicial deference kicks in and the legislature's public policy must be enforced. If the legislature says a clause is “void and unenforceable,” the court should defer to the legislature's judgment, not invent a new clause that never existed, and pretend that the new clause actually asks for two types of indemnity, one of which is permitted and one which is not.9 A clause that offends the statute should be void, not trimmed to fit. Trimming the clause is explicitly inconsistent with the legislative declaration.

The first phrase is the tougher one, and the more interesting from a drafting perspective. If we read “sole negligence” against the common law background that applies in most states other than Michigan, that is the requirement that an agreement to indemnify someone for his or her own fault must expressly say so, then the best reading of the statute is again Tennessee’s. To put it another way, under a contextualist—as opposed to a textualist—view, Tennessee’s interpretation is better on this part as well.

What if we ignore context, as Michigan’s Supreme Court has done in recent years as a matter of judicial policy? This is tougher. If the phrase were “the negligence of the promisee,” without the word “sole,” then Tennessee’s interpretation would clearly be the only one.

So what does the word “sole” add, or detract, from the meaning? The answer you would get from someone who drafts contracts is: “Never mind; just tell me what you want to accomplish and I’ll give you the words that do it.” If we want Tennessee’s result, we will write “from the promisee’s own negligence or the negligence of the promisee’s agents or employees.” If we want Michigan’s result, we’ll write: “from the negligence of the promisee, the promisee’s agents or employees, if no other person was negligent.”

On balance, though, in this writer’s opinion, Tennessee’s construction seems more natural and less strained.

---

Endnotes
1 Tenn. Code Ann § 62-6-123.
3 Posey v Union Carbide v USF&G, 507 F Supp 39, 41 (MD Tenn, 1980).
5 87 Mich App at 276.

---

From the Chair
Continued from page 1

bylaws also includes Augustine Igwe, Nicholas LeFevre, Catherine Heise, Carmel Roberts, Adam Kutinsky, Ellen Jannette, Daniel Hale, Gary Bartosiewicz, and Sarah Wohlford.

Upcoming events include the section sponsorship of a table at the State Bar of Michigan Thomas M. Cooley Law School Fair in Grand Rapids on October 21, and co-sponsoring with the Real Property Section a roundtable addressing construction law issues, to be held in Birmingham on January 14, 2010. Given the growth of our section, we also will be considering a summer 2010 program.

Please feel free to contact any of the officers or council members with ideas, suggestions, or other comments on how we can continue to grow and improve the section. We look forward to a great year.
What’s Really in a Name?

By John Kyes, J. Kyes Consulting, Inc. jkyes@charter.net

“You can call me Ray, You can call me Jay, You can call me Ray J., but you don’t have to call me Johnson,” says Raymond J. Johnson, Jr., in the not-too-memorable 1976 movie comedy “Tunnel Vision.” It’s not the line so much as it was actor Bill Saluga’s delivery of the line that made the impression, and at the time, it was hilarious.

There is confusion, even in some insurance circles, as to the not-so-hilarious delivery of the names now given those involved in the sale of insurance, and there is little understanding of how the name changes originated. This article will attempt to clear up misunderstandings those in the legal profession may have concerning certain names or titles given those involved in the sale of insurance in Michigan.

The Gramm-Leach-Bliley Act (GLBA) of 1999 changed the regulation of the financial service industry. The GLBA included a deadline for states to adopt a uniform insurance licensing procedure or face (dreaded) federal regulation. The National Association of Insurance Commissioners (NAIC) undertook an extensive review of respective state laws in an effort to determine regulatory or statutory changes needed to meet the dictates of the GLBA. The efforts of the NAIC resulted in recommendations to the legislature, which were subsequently passed into law, known as the Producer Licensing Model Act (PLMA). The intention of PLMA was the advancement of national uniformity in agent licensing by creating uniform definitions, key exceptions, standards for agent appointments, and application processes for residents and nonresidents. On January 2, 2002, Michigan became the first state in the nation to sign into law the recommended Producer Licensing Model Act (the Act).

Approximately 120,000 individual producers, agencies, adjusters, counselors, foreign risk retention groups, managing general agents/agencies, purchasing groups, solicitors, surplus lines producers and agencies, and third party administrators licensed in Michigan were affected by adoption of the Act. This article will deal with changes to the titles given to “individual producers” in Michigan, previously known as “agents,” standards for producer appointments, and three systems through which they write property and casualty or life and health policies. Property and casualty policies include personal or business policies covering property, liability, workers’ compensation, autos, and motorcycles. Life and health policies include personal and business policies covering life, health, disability, and long-term care insurance and annuities. Several changes affect the way these companies do business.

Before adoption of the Act, individuals who sold property and casualty policies and life and health policies were licensed by the state as “agents.” Since adoption of the Act, those licensed to sell property and casualty and life and health insurance policies are now referred to as “producers.” Any qualified Michigan resident may sell insurance, without previously required company sponsorship, by passing examinations in property or casualty policies or both, and in life and health policies. Before adoption of the Act, one would license for property and casualty only. Now, one may be licensed to sell either property or casualty or both. Life and health licensing remains the same.

To write either property and casualty or life and health insurance policies, a producer must be appointed as an agent with the company through which insurance is to be written. The appointing insurance company must advise the Office of Insurance and Financial Regulation (OFIR) of the appointment. By its appointment, a company attests that it has investigated the applicant and has found the applicant to be worthy of the public’s trust. Under the Act, if a producer/agent mishandles a transaction, either through misfeasance or malfeasance, the insurer may be held accountable to the policyholder.

The primary job of the OFIR is to protect Michigan consumers, and in doing so, it regulates activities of producer/agents and insurance companies. The OFIR does not regulate activities between producer/agents and insurance companies.

Never think never, and never think always, is a good axiom to follow when attempting to define the three types of delivery system that are available, as the lines between the three can become somewhat blurred. The generally accepted defining terms are:

- **Independent Producer/Agents** are free to represent as many insurers as they wish and generally represent multiple carriers. Independent producer/agents own their book of business (expiration), and are free to transfer business from company to company and are paid on a commission basis. As a general rule, an independent producer/agent is deemed to be an agent of the insured.

- **Direct Writer Producer/Agents** are usually employees of an insurance company and only represent the employing insurer. The relationship between the parties involved is considered exclusive, and errors and omissions of producer/agents are generally binding on the company under principles of agency law.
• **Captive Producer/Agents** are independent contractors who are not employees of the insurance company but are usually restricted by contract to representing a single company or its affiliated companies. Though not always the case, captive producer/agents do not own a book of business (expirations). The relationship between the company and the captive producer/agent is considered exclusive, and the producer/agent is usually considered an agent of the insurer.

Producer/agents may be held responsible for acts of negligence, breach of contract, or misrepresentation, but as a general rule, under Michigan common law, “exclusive” producer/agents have no duty to advise a policyholder of the availability or adequacy of coverage unless a “special relationship” exists. Insurance companies of captive producer/agents may, likewise, not be held responsible for the acts of their producer/agents, unless a special relationship exists between the producer/agent and the insured.

The independent producer/agent, like those considered exclusive, has no duty to advise a policyholder of the availability or adequacy of coverage, but since the independent producer/agent is considered an agent of the insured, the term “special relationship” can take on a somewhat different meaning.

Independent producer/agent insurance companies will generally not be held responsible for the acts of the independent producer/agent. If the independent producer/agent's company negotiates a loss settlement with an insured, on its own behalf, the producer/agent will likely become responsible to the insured for the difference between the company’s settlement and the actual judgment or award.

So... You can call me producer, you can call me agent, but one can't sell insurance in Michigan unless first licensed as a producer and then appointed as an agent.

During his 46- plus year insurance career John Kyes has been an agent and agency manager for a captive insurance company, an independent agent and agency owner, and an active educator of insurance professionals. J. Kyes Consulting, Inc., established in 2001, is a company through which Kyes consults with attorneys on insurance-related matters and gives expert testimony in litigation involving insurance disputes. Kyes may be reached at jkyes@charter.net or (269) 673-3174.

**Endnotes**

1 MCL 500.006.
2 MCL 500.2008a.

---

**Complying with Medicare Second Payer Requirements—A Primer**

By Justin R. Peruski
Honigman Miller Schwartz and Cohn LLP, jperuski@honigman.com

Many attorneys and clients are unaware of the widespread implications of a recent amendment to the Medicare Secondary Payer (“MSP”) statute. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA 111") took effect on July 1, 2009 for certain liability insurers, self-insurers, no-fault insurers and workers’ compensation plans. MMSEA 111 was enacted to provide information to assist in the enforcement of the MSP rules. Under the MSP statutes, regulations, and guidance (collectively “rules”), Medicare is secondarily responsible for payment of medical expenses for Medicare beneficiaries who were also covered by another source of payment. Under MMSEA 111, entities are required to report any settlement, judgment, award, or other payment involving a Medicare beneficiary to the secretary of the Department of Health and Human Services or its designee, which in this case is the Centers for Medicare & Medicaid Services (“CMS”). The civil penalty for failure to comply with the new law is $1,000 per day per Medicare beneficiary, which dictates careful compliance. The first significant deadline was September 30, 2009, for entities to register with CMS; however, registration will remain open indefinitely. The following is a primer on compliance with the MMSEA 111 requirements.

**CMS Implementation**

The Secretary of the Department of Health and Human Services has designated the Centers for Medicare & Medicaid Services to implement MMSEA 111. CMS has provided written guidance and has established a dedicated website on its implementation of MMSEA 111. In addition, it holds regular “Town Hall” telephone conferences to provide informal answers to questions from the public. To date, information that is posted on the website includes:

- A supporting statement to MMSEA 111;
- An implementation timeline;
- Several interim record layouts;
- HIPAA guidelines for electronic transactions;
- Audio recordings and transcripts of certain town hall teleconferences;
- Two comprehensive user guides; and
- Several ALERTs on discrete compliance topics.

*Continued on next page*
Complying with Medicare . . .
Continued from page 5

Responsible Reporting Entities, Generally
CMS refers to entities responsible for complying with MMSEA 111 as “Responsible Reporting Entities” or “RREs.”
The statutory language in MMSEA 111 refers to such entities as an “applicable plan.” MMSEA 111 defines “applicable plan” as follows:

[T]he following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:
(i) Liability insurance (including self-insurance).
(ii) No fault insurance.
(iii) Workers’ compensation laws or plans.5


Liability Insurers and Self-Insurance
Liability insurance and self-insurance are coverage that indemnify or pay on behalf of an insured or self-insured entity against tort claims that result in injury or illness to an individual or damage to property. The User Guide states that this insurance includes, but is not limited to, the following:
• Homeowners’ liability insurance;
• Automobile liability insurance;
• Product liability insurance;
• Malpractice liability insurance;
• Uninsured motorist liability insurance; and
• Underinsured motorist liability insurance.

Attachment A of the Supporting Statement (as well as Appendix G of the User Guide) defines “liability insurer” as follows:
For purposes of the reporting requirements for 42 U.S.C. 1395y(b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether or not it uses another entity for claim processing.

No-Fault Insurance
No-fault insurance is insurance that pays for health care services resulting from injury to an individual or damage to property in an accident, regardless of who was at fault for the cause of the accident. The User Guide states that no-fault insurance includes, but is not limited to, the following:
• Certain forms of automobile insurance;
• Certain homeowners’ insurance;
• Commercial insurance plans; and
• Medical payments coverage/personal injury protection/medical expense coverage.

Attachment A of the Supporting Statement (as well as Appendix G of the User Guide) defines “no fault insurance” as follows:
Trade associations for liability insurance, no-fault insurance and workers’ compensation have indicated that the industry’s definition of no-fault insurance is narrower than CMS’ definition. For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. 411.50 is controlling.
Workers’ Compensation Laws or Plans

A workers’ compensation law or plan includes any law or plan administered by an employer, a state, or the federal government to provide compensation to workers for work-related injuries and/or illnesses. Most employees in the U.S. are covered under some form of workers’ compensation law or plan. Attachment A of the Supporting Statement (as well as Appendix G of the User Guide) defines “workers’ compensation law or plan” as follows:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), a workers’ compensation law or plan means a law or program administered by a State (defined to include commonwealths, territories and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses. The term includes a similar compensation plan established by an employer that is funded by such employer directly or indirectly through an insurer to provide compensation to a worker of such employer for a work-related injury or illness. Where such a plan is directly funded by the employer, the employer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). Where such a plan is indirectly funded by the employer, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8).

Who is a “Responsible Reporting Entity” (RRE)

The User Guide and the July 31, 2009 “draft” ALERT specifically identify scenarios where registration and reporting may or may not be required. The recent draft ALERT was released to provide CMS’ best interpretation on who is an RRE for purposes of MMSEA 111 and to allow for public comment by August 16, 2009. The interpretations in the draft ALERT expand on the guidance provided in the User Guide and are consistent with oral guidance presented during the town halls. Below is a summary of the draft interpretations, which are subject to change after CMS has reviewed public comments.

If an entity is self-insured for a deductible payment, but the payment of that deductible is done through the insurer, then the insurer is responsible for reporting and including the deductible amount in the amount it reports as a settlement, judgment, award, or other payment.

Corporate Structure. A parent entity may register for itself or any subsidiaries in its corporate structure, irrespective of whether the parent would qualify as an RRE; however, an entity may not register on behalf of its corporate parent or a sibling entity. In a May 8, 2009 Quick Reference Guide for Section 111 registration, CMS advised that if a parent entity is registering multiple subsidiaries, each entity must have a unique federal Tax Identification Number (“TIN”). While there is no limit to the number of subsidiaries that an RRE may register under each RRE ID, CMS representatives cautioned during the May 12, 2009 town hall that fewer RRE IDs are better than many if it is able to consolidate its quarterly submissions.

Third Party Administrators. A third party administrator (“TPA”), by virtue of its status as a TPA alone, is never an RRE for purposes of MMSEA 111; however, it may, under certain circumstances, also be an RRE. An RRE may not limit its reporting responsibility by contract with a TPA, but it may contract with a TPA (or other entity; see discussion on Account Designee below) for actual file submissions as an agent.

Reimbursements. If an entity is self-insured for a deductible payment, but the payment of that deductible is done through the insurer, then the insurer is responsible for reporting and including the deductible amount in the amount it reports as a settlement, judgment, award, or other payment. If payment is being made by a reinsurer or excess carrier to reimburse a self-insured entity, then the self-insured entity is the RRE for purposes of the payment made to the injured individual, and no reporting is required by the insurer reimbursing the self-insured entity.

“Fronting” Policies. Since the intent of a “fronting” policy is that the insurer will never pay a claim and the insured will pay claims, then the insured is the RRE. Perhaps the language in the ALERT could be better phrased as a conjunction to read, “if the intent of a fronting policy is that (i) the insurer will never pay a claim and (ii) the insured actually pays claims, then the insured is the RRE.

State Agencies. Where there is a state agency that resolves and pays claims using state funds or funds obtained from others for this purpose, then the established agency is the RRE.

Multiple Defendants. All RREs involved in a settlement, judgment, award or other payment remain responsible for their own reporting regardless of any contractual arrangements among the defendants.

Workers’ Compensation. CMS addressed a variety of scenarios involving workers’ compensation laws or plans. Where the applicable law or plan authorizes an employer or employers to: (i) purchase insurance from an insurance carrier and the employer does so, the insurance carrier is the RRE; (ii) self-insure and the employer does so independently of other employers, the self-insuring employer is the RRE; (iii) join with other employers in self-insurance pools, then the pools or the employer may be the RRE depending on a variety of factors. Where the applicable law or plan involves a state or federal...
agency and the agency has the sole responsibility to resolve and pay claims, the established agency is the RRE; however, if the agency supplements other insurance, then the agency or carrier may be the RRE depending on the circumstances.

Registration, Querying and File Submission

Deadlines for Registration, Testing, and First File Submission. CMS announced in May 2009 that it has extended its original registration time frame and delayed the testing and production file submission time frames.\(^7\) At present, RREs are required to:

- register with the Coordination of Benefits Contractor (“COBC”) between May 1 and September 30, 2009;\(^8\)
- fully test the data submission process during the first quarter of 2010; and
- submit the first production files no later than the second quarter of 2010 (however, RREs may submit their production files as early as the first quarter of 2010 if they have completed testing before their seven-day submission window as described below).

Registration. During the registration process, an RRE first must access the CMS Coordinator of Benefits Secure Web site (“COBSW”)\(^9\) and provide the following information:

1. Company’s TIN;
2. Company’s name and address;
3. Name, job title, address, phone and e-mail address of the authorized representative;
4. National Association of Insurance Commissioners (“NAIC”) company codes, if applicable;
5. Type of insurer reporting, which requires an RRE to select between liability insurance (including self-insurance), no-fault insurance, or workers’ compensation; and
6. Subsidiary company information to be included in the file submission for the registration.

After the above information is validated by the COBC, then the COBC will send a letter via the U.S. Postal Service to the named authorized representative with a personal identification number (“PIN”) and the COBC-assigned RRE ID associated with the registration. The authorized representative must give this PIN and RRE ID to their account manager to use to complete the account set-up. If an entity needs more than one RRE ID for MMSEA 111 reporting, then it must repeat this step for each additional RRE ID.

CMS has advised that each user of the MMSEA 111 application on the COBSW will have only one login identification and password, and with that information, may be associated with multiple RRE accounts.

Querying. One of the initial compliance questions CMS resolved was how an RRE should determine the Medicare beneficiary status of claimants. CMS developed a web-based, HIPAA-compliant, “query input” system that allows RREs to make batch file queries of CMS of its current claimants one time each month. Query input files submitted by an RRE for a claimant must contain the Social Security Number (or HICN as defined below), the first initial of the first name and the first six letters of the last name, date of birth, and gender of claimants.\(^12\) CMS has advised that (i) if there is a match in the CMS database for any claimant, it will issue a response file with the Health Insurance Claim Number (“HICN”) to be used for reporting the claim information of the Medicare beneficiary; and (ii) if there is a no match found for any claimant, the RRE should not interpret this as CMS confirmation that a claimant is not a Medicare beneficiary. There is no safe harbor available at this time for properly submitted queries of Medicare beneficiaries that do not return with a match. The query input system has been in operation and available for RREs to test since July 1, 2009.
Testing. Claim input file testing is scheduled to begin on January 1, 2010. During this process, an RRE must transmit test files to the COBC in the same transmission method that it will transmit production files. RREs must successfully perform the following functions to complete the testing process:

- post at least 25 new claims with add records in one file submission;
- complete at least five “updates” to previously posted records in one file submission; and
- complete at least five “deletes” to previously posted records in one file submission.

Reporting. CMS has identified over 100 data elements to be reported on a quarterly basis, which have been developed to assist CMS in its coordination of benefits. The following categories of information will be required to be reported as part of the claim input file layout:

1. Personal information of the injured Medicare beneficiary;
2. Injury, incident, or illness information;
3. Insurance (including self-insurance and workers’ compensation plan) information;
4. Injured party’s attorney information;
5. Settlement, judgment, award, or other payment information; and
6. Personal information of additional claimants.13

RREs will be assigned a seven-day window each quarter to submit files. When RREs begin submitting initial production files, it will be for (i) all liability insurance (including self-insurance), no-fault insurance, and workers’ compensation claims involving a Medicare beneficiary as the injured party where the settlement, judgment, award, or other payment date is January 1, 2010 or subsequent, and (ii) claims on which ongoing responsibility for medical payments (“ORM”) exists as of July 1, 2009, regardless of the date of an initial acceptance of payment responsibility.14 Note that for the latter, CMS has extended the period for compliance with this requirement until the third quarter of 2010 for ORM assumed prior to July 1, 2009, where such ORM continued as of July 1, 2009, since RREs may not have historically collected the information that is required to be reported.15 In addition, CMS has provided an exemption from reporting if an RRE meets certain payment conditions or a de minimis dollar threshold, which will reduce over time until January 1, 2014.16

Conclusion

In summary, MMSEA 111 obligates liability insurers, self-insurers, no-fault insurers, and workers’ compensation plans to register with CMS and report any settlement, judgment, award, or other payment involving a Medicare beneficiary on a quarterly basis. Companies that are unaware or otherwise fail to comply with the new law risk civil penalties of $1,000 per day per Medicare beneficiary. As stated above, MMSEA 111 compliance and reporting responsibilities are still under review by CMS and are subject to interpretation and change by CMS and possibly the courts. However, as CMS continues to implement the new reporting requirements, we encourage affected parties and their advisors to familiarize themselves with the intricacies of reporting and to regularly monitor the CMS website for new developments.

Justin Peruski is a partner in the Detroit Office of Honigman Miller Schwartz and Cohn LLP. He practices insurance and business law and specializes in captive insurance arrangements. His e-mail address is jperuski@honigman.com.

Endnotes

1 42 U.S.C. § 1395y(b)(7)&(b)(8).
2 42 U.S.C. § 1395y(b)(2).
3 42 U.S.C. § 1395y(b)(8)(E)(i). CMS has advised on many of its town hall teleconferences that at this time it is focused on complete and accurate reporting and not the penalty phase of this legislation, and before CMS enforces any penalties it would expect to publish procedures on how penalties will apply.
6 The Supporting Statement was originally published in the Federal Register on August 1, 2008 and was revised and republished in the Federal Register on February 12, 2009.
8 Entities that will have no expectation of having claims to report are not required to register; however, those who do not register initially for this reason must register in time to allow a full quarter for testing if they have future claims that would cause them to have a reasonable expectation of having to report. See Section 8.1 of the User Guide.

Continued on next page
This article addresses some general aspects of “reservation of rights” in connection with insurance claims involving coverage issues. The typical context for a reservation of rights is an underlying third-party liability claim. Assume, for example, that a claimant files a lawsuit against a policyholder, asserting bodily injury or property damage, and assume the policyholder has a commercial general liability policy with an insurance carrier. In that scenario, the policyholder presumably would provide notice to the insurance carrier and tender defense of the third-party suit to the carrier, pursuant to the insurance policy provisions obligating the carrier to defend and indemnify such matters, if within the terms of the policy.

An insurance carrier receiving such a tender has several options after evaluating whether the matter is within the terms and provisions of the insurance policy, including: accept the tender and provide a defense and indemnity without reservation; deny the claim and not provide a defense or indemnity; accept the tender and provide a defense under a reservation of rights to deny indemnity. In situations when the insurance carrier concludes that the matter is neither clearly covered nor clearly not covered but might not be covered (in whole or in part), the insurer may advise the policyholder that a defense will be provided, but that it is subject to a reservation of rights for the insurer to deny any payment on the claim if it is determined that no coverage is available for the claim. The essential purpose of the communication is to advise the policyholder that coverage might not be available so the policyholder can take any action it deems necessary, and to protect the carrier against a subsequent waiver or estoppel claim by the policyholder if the carrier defends but later denies it owes indemnity.

There is no particular format required for a reservation of rights letter although typically, a reservation of rights usually will include: an acknowledgement of when the claim or suit was tendered to and received by the insurer; an acknowledgement of the insurance policy allegedly applicable; a recitation of the underlying facts as understood to date; a recitation and explanation of insurance policy provisions which may preclude coverage; and a general reservation of rights which may become known as the matter progresses. The letter often concludes with an indication to the policyholder to provide the carrier any additional information it deems pertinent to the matter for consideration by the insurer.

The best approach is for an insurer to set forth all known potential coverage issues in its reservation of rights correspondence. A carrier also should reserve rights, as appropriate, on matters not necessarily based upon a specific policy provision, such as the failure to pay premiums or for a possible rescission of the insurance policy based upon misrepresentations in the application. The carrier also may wish to reserve the right to recoup defense costs and any other costs incurred, if it later is established no coverage was owed. A reservation of rights letter may be supplemented by the carrier as the underlying matter progresses and/or as additional potential coverage defenses become known.

An insurer generally will convey its reservation of rights in writing and, while it is not required, a good practice would be to do so by certified mail, return receipt requested. The notification of reservation of rights is provided to the policyholder and its personal counsel, if one has been retained, and it is not necessary to provide the reservation of rights to a claimant.

---

Complying with Medicare . . .
Continued from page 9

9 Available at https://www.section111.cms.hhs.gov/MRA/LoginWarning.action.
10 See Section 8.2 of the User Guide.
11 See July 17, 2009, Alert—Authorized Representative and Account Manager Determination.
12 See Sections 6 and 11.1 of the User Guide.
13 See Appendix A of the User Guide.
14 See Section 6 of the User Guide. Note that the reporting of ORM settlements, judgments, awards, or other payments is not required by: (i) liability insurers (including self-insurers) where the date of incident (“DOI”), as defined by CMS, was prior to December 5, 1980, which is when the MSP provisions were enacted with respect to liability insurance; and (ii) workers’ compensation plans where the DOI, as defined by CMS, was prior to 1965, since Medicare has been a secondary payer to workers’ compensation benefit payments since the inception of the Medicare program in 1965.
15 See Section 11.9 of the User Guide.
16 See Section 11.4 of the User Guide.
An insurer that has agreed to provide a defense pursuant to the reservation of rights has the right to select defense counsel. A policyholder has the option of retaining its own counsel at its own expense to associate with the counsel selected by the insurer to represent the policyholder in the defense of the underlying matter.

A policyholder receiving reservation of rights correspondence may wish to retain its own counsel for advice with regard to the coverage issues, distinct from the defense counsel provided by the insurance carrier to defend the policyholder in the underlying matter. A policyholder is not required to respond to a reservation of rights letter, although if a carrier requests a response, requests additional information from the policyholder, or if the policyholder believes the carrier should consider additional information, then such appropriate response should be provided. A policyholder has the option of filing a declaratory judgment action requesting the court to determine the coverage issues. The insurer as well can file such a declaratory judgment action.

As a general rule, if an insurer undertakes the defense of an insured while having knowledge of facts which might preclude coverage, it will be deemed to have waived or be estopped from asserting its right to deny coverage, unless notice of the possible lack of coverage is provided to the insured. Those doctrines are limited, however, and generally will not be applied to broaden coverage for a risk that was not included in the policy coverage or that was expressly excluded.

The timeliness of a reservation of rights letter is a factor when evaluating possible estoppel. It has been held that estoppel applied when a carrier provided a defense for over two years without a reservation of rights, and on the other hand, a reservation of rights provided within four months of undertaking the defense of the policyholder in the underlying action has been held timely as a matter of law.

The carrier’s coverage defenses also can be asserted in a timely filed declaratory action, even if all defenses are not asserted in a reservation of rights letter. A declaratory judgment action may serve as an alternative to reservation of rights correspondence.

In summary, both the carrier and policyholder need to evaluate potential coverage issues when an underlying suit is presented, and consider the option of a defense under reservation of rights, when appropriate.

Editor's Note: This article is adapted from an article that first appeared in the July 20, 2009, edition of Michigan Lawyers Weekly.

Endnotes
4. MCR 2.605; Morelli, supra.
5. Kirschner, supra; Meirthew v Last, 376 Mich 33; 135 NW2d 353 (1965).
7. Meirthew, supra.

Casemaker Debuts at Annual Meeting

The State Bar of Michigan has announced a new partnership with Casemaker that will bring premium state and federal research materials to its membership. The new service will provide case law, constitution, and statutes for all 50 states, including the District of Columbia. In addition the service provides Michigan primary law, administrative code, state court rules, federal court rules, attorney general opinions, and the model civil jury instructions. The entire 50-state collection is offered free of charge for one year to the entire State Bar membership.

Members will also have access to several advanced legal research tools, including a case citatory tool, a tool that simultaneously runs a search for secondary and/or third part treaties and publications, and a tool capable of searching all customized books within any state and/or federal library in a single query.

In order to help members become familiar with Casemaker and their search engine, a community educational outreach program has been created that will include live city tours, continuing webinars, online tutorials and live support.

For members who wish to log into Casemaker to explore its many features, simply log in to our member area (http://e.michbar.org) and select the Casemaker tab on the left. There are several helpful user guides published within the Casemaker system.
Supreme Court Activities

As noted in our last issue, Justice Hathaway’s election victory over former Chief Justice Clifford Taylor, in the November 2008 election, continues to be felt throughout the no-fault world. In two decisions granting motions for reconsideration, the new majority on the Michigan Supreme Court has signaled their willingness to re-examine two hallmark decisions issued by the former majority—Kreiner v Fischer, 471 Mich 109; 683 NW 2d 611 (2004) and Cameron v ACIA, 476 Mich 55; 718 NW 2d 784 (2006). These 4-3 decisions, with bitter dissents being authored by members of the former majority, indicate that substantial changes in no-fault jurisprudence are on the way.

Kreiner Re-Examined

In Kreiner, the former majority of the Michigan Supreme Court interpreted the statutory definition of the phrase “serious impairment of body function,” found in MCL 500.3135(7), in such a manner as to heighten the threshold for recovering non-economic damages. The Supreme Court’s primary focus concerned lifestyle impairment. In order to recover non-economic damages, the plaintiff had to show that the objectively manifested impairment of an important body function affected the “course” of a person’s life. The Court noted that:

Although some aspects of a Plaintiff’s entire normal life may be interrupted by the impairment, if, despite those impingements, the course or trajectory of the Plaintiff’s normal life has not been affected, then the Plaintiff’s “general ability” to lead his normal life has not been affected and he does not meet the “serious impairment of body function” threshold.

Kreiner, 471 Mich at 131

Since then, there have been hundreds of appellate decisions, including published and unpublished Court of Appeals’ decision and, in some cases, preemptory reversals by the Michigan Supreme Court, where a plaintiff’s cause of action has been dismissed due to a lack of significant lifestyle impairment.

One such case was McCormick v Carrier, Unpublished Court of Appeals decision, docket number 275888, March 25, 2008. In that case, plaintiff was injured when a co-worker backed a truck over plaintiff’s left ankle. The plaintiff required two surgeries to repair the fracture and was off work for one year. Both the trial court and the Court of Appeals majority acknowledged that plaintiff had suffered an objectively manifested impairment and that it impacted an important body function. However, the plaintiff was able to fish and golf; just as he had done prior to the accident. He was able to continue driving his truck and did not require assistance with his personal care needs. He was able to work, after being cleared to do so by his doctor, at his same rate of pay and required no further medical treatment after returning to work. He also admitted that, except for some residual ankle pain, his life was “relatively normal.” In light of these facts, the Michigan Court of Appeals, in a 2-1 decision, noted that, because the plaintiff’s injury did not affect his ability to lead his normal life, the lower court properly granted summary disposition in favor of defendant. Judge Alton Davis dissented, arguing that plaintiff’s injuries presented a question of fact for the jury to resolve.

Plaintiff filed an application for leave to appeal with the Michigan Supreme Court. On October 22, 2008, just before the November 4, 2008, election, the former majority denied plaintiff’s application. Justices Cavanagh, Weaver, and Kelly would have granted the application.

After Chief Justice Taylor lost his bid for re-election, plaintiff immediately filed a motion for reconsideration. The motion remained pending for more than nine months. Finally, on August 20, 2009, the court, in a 4-3 decision (with Justices Cavanagh, Weaver, and Kelly now being joined by newly elected Justice Hathaway in the majority) granted plaintiff’s motion for reconsideration and, as noted by Justice Corrigan’s dissent, the new majority may very well overrule Kreiner. Justice Corrigan’s call for restraint, joined by Justices Young and Markman, has been seemingly ignored by the new majority.

As my colleagues have observed in other recent cases, I wish only to re-emphasize that the practice of reconsidering final orders due merely to a change in the Court’s composition runs afoul of the historical principles and precedent of this Court. As is particularly applicable here, in Peoples v Evening News Ass’n, 51 Mich 11, 21, (1883), this
Court explicitly and unanimously concluded that “a rehearing will not be ordered on the ground merely that a change of members on the bench has either taken place or is about to occur.

For these reasons, I reiterate the call for caution in the wake of our newly reconstituted Court. I would not grant reconsideration of this otherwise final case or overrule the Court’s 2004 Kreiner decision, which sought to bring clarity and finality to a very complex area of law.

McCormick, Slip Opinion at page 3 (Corrigan, J. dissenting)

It appears likely that by this time next year, the no-fault world will be operating under a different threshold analysis, and the reader is advised to examine Justice Cavanagh’s dissent in Kreiner for a preview of what will probably be the new threshold analysis.

Cameron Revisited—the One-Year-Back Rule

In Cameron v ACIA, 476 Mich 55; 718 NW 2d 784 (2006), the Michigan Supreme Court, in a 4-3 decision authored by former Chief Justice Clifford Taylor, ruled that the “one-year-back” rule, set forth in MCL 500.3145(1) was a damage limitation provision, not a statute of limitation. As such, application of the one-year-back rule was not affected by any of the tolling provisions found in the Revised Judicature Act, MCL 600.1 et seq. This decision, along with the Supreme Court’s prior decision in Devillers v ACIA, 473 Mich 562, 702 NW 2d 539 (2005) prevented catastrophically injured claimants from going back years, or even decades, to recover allegedly underpaid attendant care service benefits.

Following the Michigan Supreme Court’s decision in Cameron, the Michigan Court of Appeals released its decision in Liptow v State Farm, 272 Mich App 544, 726 NW 2d 442 (2006). Liptow involved a claim for no-fault benefits for a catastrophically injured five-year-old, along with a claim for reimbursement filed by Medicaid. Given the Supreme Court’s ruling in Cameron, supra, the Court of Appeals concluded that neither plaintiff nor the Michigan Department of Community Health could recover PIP benefits incurred more than one year before the filing of the complaint.

In University of Michigan Regents v Titan Insurance Company, unpublished Court of Appeals decision, docket no. 376710, June 5, 2008, the University of Michigan attempted to recover medical expenses incurred more than one year prior to the date of filing the complaint. Suit was filed against Titan Insurance Company, as assignee of the Michigan Assigned Claims Facility. The University of Michigan argued that MCL 600.5821(4) exempted them, as public entities, from application of the one-year-back rule set forth in MCL 500.3145. Both the lower court and the Court of Appeals, applying Liptow and Cameron, ruled that the University of Michigan was barred from recovering medical expenses incurred more than one year back from the date of filing the complaint. Once again, Judge Alton Davis dissented, noting that the Court’s decision in Liptow “takes an irrationally and improperly narrow view” of MCL 600.5821(4) because it exempted the University of Michigan from the one-year limitation on bringing an action, but not from the one-year limitation on recovering such medical expenses.

Plaintiff filed an application for leave to appeal with the Michigan Supreme Court. On November 26, 2008, after former Chief Justice Taylor lost his bid for re-election but before Justice Hathaway took the bench, the Supreme Court, in a 4-3 decision, denied the application. Once again, Justices Cavanagh, Weaver, and Kelly indicated that they would grant leave to appeal. Plaintiff filed a motion for reconsideration and, on July 31, 2009, the new majority granted plaintiff’s motion for reconsideration. This time, Justice Young authored a highly critical dissent, joined by Justices Corrigan and Markman. In his dissent, he observed that, as with the Supreme Court’s decision in USF&G v MCCA, (USF&G II), 484 Mich _____, _____ NW 2d _____ 2009 (discussed in our last issue), the only basis for the change in outcome was the change in membership of the Supreme Court.

Given the new philosophical majority of the Supreme Court, we can only wonder how many other decisions rendered by the 1999-2008 Supreme Court majority will be reconsidered and potentially overruled by the current court.

---

Don’t forget to check the website

Important section information, including this newsletter, can be found at http://www.michbar.org/insurance/
Defendant Ahrens Construction’s roofing work on a YMCA natatorium project allegedly caused what the parties called a “NMP” (natatorium moisture problem). Plaintiff Miller-Davis was the general contractor. The case was “BT’d” (bench-tried). The “TJ” (trial judge) awarded “BB” (big bucks/$348,851.50) in favor of Miller-Davis and against Ahrens for breaching its contract by performing nonconforming and defective work. The damages were the dollar amount of the “correcting work” Miller-Davis performed. The trial court found Miller-Davis’s contractual indemnity claim defective as a matter of law. Ahrens appealed the judgment. Miller-Davis cross appealed and challenged the indemnity ruling.

Ahrens finished all its work by the end of February 1999. The work was a wood deck system, to which another subcontractor attached roofing felt and an outer steel-seamed skin. Ahrens “certified” that its work was finished on April 26, 1999, and Miller-Davis paid Ahrens the next day. A temporary certificate of completed work and its payment of Ahern’s work was in “use” or “in use” when the sub that was attaching roofing felt and the steel skin was at work on the site “in February, 1999.” The panel thought it was wrong for Miller-Davis to argue that the “use” contemplated in the statute was use by the owner of the real property. The panel also decided that Miller-Davis’s acceptance of the certificate of completed work and its payment of Ahern’s bill constituted “acceptance” under the statute, even though Miller-Davis had not yet discovered the contractually non-compliant work. The breach of contract complaint was filed too late. Judgment reversed.

Miller-Davis’s contractual indemnity ruling is very succinctly rendered. In a construction context, the statute of reposite applies because the statute does indeed reference “indemnity.” MCL 600.5839(1) says:

No person may maintain any action to recover damages for any injury to property, real or personal, or for bodily injury or wrongful death, arising out of the defective and unsafe condition of an improvement to real property, nor any action for contribution or indemnity for damages sustained as a result of such injury…

The work was an “improvement.” “Use” and “acceptance” don’t have to mean use or acceptance by the owner of the property. It doesn’t matter that the certificate of occupancy didn’t have to mean use or acceptance by the owner of the property. It doesn’t matter that the certificatе of occupancy came within six years of suit. “Injury to property” can mean what the general contractor spent to fix the non-conforming work. Now, the indemnity ruling is a piece of cake. Citing the statute, including the indemnity phrase: “[c]onsequently, plaintiff’s claims against defendant are time-barred.”

This could be some powerful stuff, particularly in bodily injury cases. Sometimes an injured construction worker might...
wait nearly three years to sue a general contractor. In fact, Michigan’s generous death tolling statute, MCL 600.5852, allows a timely lawsuit within two years after the appointment of a personal representative, but not later than three years after the deceased’s own statute would have run. Gosh, in a negligence case that can be six years just to get out of the blocks. And indemnity actions are sometimes filed after a party litigates an injury case and either settles it or pays a judgment. The breach of the indemnity contract occurs and the six-year statute of limitation begins to run when defense is tendered and refused. That is still as true as it ever was. But if the contractor on the stickee end of the indemnity obligation finished its work and another contractor put it to use more than six years before the indemnity lawsuit was filed, that statute of repose is going to come in mighty handy. The statute of repose has a discovery rule: “one year after the defect is discovered or should have been discovered” but not longer “than ten years after the time of occupancy of the completed improvement, use or acceptance of the improvement.” The discovery rule is not generous and could be tricky to rely on.

October is Pro Bono Month

The American Bar Association has designated the week of October 25-31 as National Pro Bono Week, and all across the country lawyers will be taking part in events to educate the public and the legal profession about pro bono. This will be an opportunity to also honor those in the legal profession who routinely provide free legal help to improve the lives of the needy.

In order to facilitate increased focus on pro bono activities across the state, the Pro Bono Initiative of the State Bar of Michigan is extending the celebration through the entire month of October. We are encouraging you to join us and celebrate the efforts of Michigan’s pro bono attorneys. This will be an opportunity to promote pro bono activities, including recruitment and training and to celebrate the value of pro bono service. A member of the Pro Bono Initiative will be contacting you to hear your thoughts and find ways in which we can partner and make the Michigan celebration a success.

To ensure that your local pro bono efforts are recognized and publicized by the State Bar, contact Dionnie Wynter at dwynter@mail.michbar.org or (517) 346-6412. For more information on the national pro bono effort, visit www.celebrateprobono.org. To find out how to obtain a referral for a pro bono case, contact the State Bar or your local legal aid program. To make a financial donation through the Access to Justice Fund to support legal aid, visit www.atjfund.org.

Join our Section!

The Insurance and Indemnity Law Section is the newest section of the State Bar of Michigan.

Insurance and indemnity law touches many, if not most, areas of practice.

Whether you are an expert and want to share your expertise, or want to learn from the expertise of others, joining the Insurance and Indemnity Law Section is a worthwhile investment.

Use the registration form at http://www.michbar.org/sections/pdfs/app_03v2_ext.pdf and join your colleagues!

Insurance Coverage Counsel

Opinions ▲ Claims-Handling Agreements
Settlements ▲ Litigation ▲ Appeals

Kelley, Casey & Moyer, P.C.
Attorneys and Counselors

Timothy Casey
(586) 563-3500
tcasey@kcmlaw.com

Experienced. Resourceful. Results.
Insurance Decisions of Interest

By Deborah A. Hebert, Collins, Einhorn, Farrell & Ulanooff, deborah.hebert@ceflawyers.com and
Adam Kutinsky, Kitch, Drutchas, Wagner, Valitutti & Sherbrook, adam.kutinsky@kitch.com

Sixth Circuit

No “safe harbor” from ERISA for “hybrid” benefit programs

Helfman v GE Group Life Ass Co, 573 F.3d 383 (6th Cir 2009)

Employers cannot create “hybrid” benefit programs that would allow some employees (those who reimburse the employer for insurance premiums) and not others to avoid ERISA. “[I]f an employer contributes to any employee’s payment of premiums, ERISA must apply to the entirety of the particular insurance program, regardless of whether one or more employees pays his own premiums in full.” Sl Op, p 10.

The Court also went on to find that the plan administrator’s denial of disability benefits was arbitrary and capricious on the whole record. The case was remanded for a “full and fair review” by that administrator.

Michigan Supreme Court

Revisited: MCCA must indemnify for catastrophic claims even if it believes the payments are unreasonable

USF&G v MCCA
___ Mich ___ (2009)

The Supreme Court has changed its mind on the authority of the Michigan Catastrophic Claims Association to assess the reasonableness of a member insurer’s payments on catastrophic claims. The MCCA may not second-guess these payments. In its decision on rehearing, issued July 21, 2009, the Supreme Court held in a 4-3 split that the “indemnification obligation set forth in MCL 500.3104(2) does not incorporate the reasonableness standard that MCL 500.3107 requires between claimants and member insurers. Furthermore, the powers granted to the MCCA in §3104(7) are limited to adjusting the ‘practices and procedures’ of the member insurers and do not encompass adjustment to the payment amount agreed to between claimants and member insurers. Moreover, we hold that the power granted to the MCCA under MCL 500.3104(8)(g) is limited to furthering the purposes of the MCCA and that determining reasonableness is not one of its purposes.” Sl Op, pp 2-3.

Michigan Court of Appeals—Published

Dec Actions and a claimant’s standing to intervene

Auto-Owners Ins Co v Keizer-Morris, Inc,

Auto-Owners issued a general liability policy for the defendant manufacturer of construction equipment. Appellant/intervener was a worker injured when the defendant’s equipment exploded on the work site. Auto-Owners denied coverage for the claim and commenced this declaratory judgment action against the named insured, a company no longer in business. The Court of Appeals held that the appellant-injured worker could intervene because of his substantial interest in the outcome of the litigation, particularly in light of the dissolution of the named insured and the lack of any meaningful defense. The Court reiterated that the injured claimant was neither an insured nor “a third party beneficiary to the contract.” He was, however, “an incidental beneficiary” of the insurance contract, with standing to seek a judicial determination of its terms.

“Other insurance clauses” and their limited use in auto policies

Auto-Owners Ins Co v
Martin and State Farm Mut Auto Ins Co,

This is a priority dispute between two auto liability insurers. Auto-Owners insured a used car dealer; State Farm insured the customer who took one of the dealer’s vehicles for a test drive and was involved in an accident. Through its “other insurance” clause, Auto-Owners attempted to shift primary responsibility to the policies of its insured’s customers. The Court found this violative of the no-fault statute, which expects coverage from the insurer of the involved vehicle. See Citizens Ins Co of America v Federated Mut Ins Co, 448 Mich 225 (1995) and State Farm Mut Automobile Ins Co v Enterprise Leasing Co, 452 Mich 25 (1996). Auto-Owners argued that even if it was primary, its coverage would be limited to the mandatory minimums of $20,000/$40,000. The Court of Appeals rejected this argument, holding that “Auto-Owners knew or should have known that the exclusionary clause in the policy at issue was void. . . . Consequently, in keeping with this Court’s ruling in
Kurzmann [Farmers Ins Exchange v Kurzmann, 257 Mich App 412 (2003)], we find the exclusionary clause was ambiguous. . . . As such, the policy must be construed in favor of the insured and provide coverage of policy limits to both the owner of the vehicle and its permissive users.” Sl op, p 11 (emphasis added).

Property coverage denied where property was vacant
Vushaj v Farm Bureau General Ins Co of Mich,
rel’d for publication on June 18, 2009 (Docket No. 283404)

Plaintiff’s home was damaged by fire. His homeowner’s policy with Farm Bureau excluded coverage if the home was vacant and unoccupied for more than 30 days. It was undisputed that for two years immediately preceding the fire, plaintiff would generally spend one night in the house every other week. There were no beds; plaintiff would use a sleeping bag stored in his car. The trial court’s denial of coverage was affirmed.

Selected Unpublished Decisions of the Michigan Court of Appeals

Court refuses to reform insurance policy even where the insurer’s error greatly increased the limits of coverage
Estate of Couture v Farm Bureau General Ins Co, et al,
Unpublished per curiam of the Court of Appeals, issued August 6, 2009 (Docket No. 281441)

Rodney Daniels purchased a no fault policy from Farm Bureau, through agent Lansky. Subsequently, Daniels asked Lansky to see what he could do to lower the premium. Farm Bureau responded by making medical coverage excess instead of primary. As a result of a “keying” error, however, it also changed the limits of coverage from $20,000/$40,000 to $300,000 per person and per occurrence. Daniels did not examine the amended policy other than to confirm that his premium decreased. When his wife was involved in a collision resulting in a fatality to plaintiff’s decedent, Farm Bureau discovered its error and retroactively changed the policy back to the original limits of $20,000/40,000. The Court of Appeals made four rulings of note in the ensuing dec action: (1) the estate had standing to seek a declaration of coverage because it was an injured third party with rights adversely affected by Farm Bureau’s decision, even though it was not an intended third party beneficiary of the insurance contract (see also Auto-Owners Ins Co v Keizer-Morris, Inc, discussed above); (2) Michigan courts may reform an unambiguous insurance policy to reflect the true intent of the parties where the policy is the result of fraud, mistake, accident, or surprise (it is not against public policy for the insurer to do so after a loss); (3) parol evidence is admissible to prove the policy was the product of fraud or mistake, and (4) no reformation was warranted in this case because Farm Bureau failed to meet its burden of proving mutual mistake under a clear and convincing standard.

Land contract balance does not affect policy limits
Utica Mut Ins Co v Hastings Mut Ins Co,
Unpublished per curiam of the Court of Appeals, issued August 25, 2009 (Docket No. 281441)

Liability insurer Utica Mutual filed this subrogation action against homeowner’s insurer Hastings Mutual, for claims arising out of a fire-damaged home. The title holder to the home was Hastings’ insured; he was selling the house under a land contract, and the buyers were paying the insurance premiums. When the homeowner submitted his claim, Hastings Mutual would only cover for the actual loss, i.e., the balance on the land contract rather than the value of the home. The homeowner eventually sued the independent agent who sold him the policy, insured by Utica Mutual under an errors and omission policy. Utica Mutual settled the claims and took an assignment against Hastings and prevailed. The Court held that Hastings Mutual was liable up to its full policy limits on the ground that a land contract does not control the insurance policy’s limits. “It is undisputed that the insurance policy covers the residence and that the premiums were based on it, not the secured debt. Thus, there was no increased risk as a result of the land contract.” Hastings Mutual was also obligated to pay 12 percent interest on the judgment, irrespective of whether the reasonableness of the claim in dispute.

Mortgagor not entitled to insurance proceeds on rebuilt home
Firstbank Corp v Wolverine Mutual Ins Co,
Unpublished per curiam of the Court of Appeals, issued August 13, 2009 (Docket No. 285850)

A fire damaged a residence encumbered by a $140,000 mortgage held by Firstbank. The house was insured by Wolverine for its actual cash value of $119,127.13, or alternatively, a replacement cost of $185,859.51 if the home was rebuilt. The homeowners elected to rebuild, and so Wolverine issued its initial check for $119,127.13, without including Firstbank as a joint payee. The balance was to be paid upon completion of the house. During construction, Firstbank sued Wolverine for failing to include Firstbank on the check, claiming it was entitled to use the insurance money to satisfy its mortgage under the “Mortgage Clause” in the insurance policy. The Court determined that Firstbank was an intended third party

Continued on next page
beneficiary under the insurance policy, but concluded that the insurance proceeds were to be paid to the insured to facilitate the new construction, and not to satisfy the mortgage.

Short List of Other Unpublished Opinions of the Michigan Court of Appeals

- **Citizens Ins Co of America**, issued July 21, 2009 (Docket No. 283557)—discussion of business and professional services exclusions in personal line policies.


- **Ludlow v Hackett**, July 2, 2009 (Docket No. 283189)—limited title insurance coverage.

- **Glenn v First American Title Ins Co**, issued June 25, 2009 (Docket No. 285669)—discussion of the police power exclusion in a title insurance policy.

- **Great Northern Ins Co v Ngo**, issued June 25, 2009 (Docket No. 285569)—garnishment action deciding that a theft of rings by the insured’s employee was not an “occurrence.”

- **Auto Club Group Ins Co v Mitchell**, issued June 18, 1009 (Docket No. 284335)—criminal acts exclusion in a homeowner’s policy enforced.

- **Mosher v Essex Ins Co**, issued June 16, 2009 (Docket No. 279135)—CGL auto exclusion applied.

- **Progressive Mich Ins Co v Rozafa Transport, Inc**, issued June 9, 2009 (Docket No. 283395)—commercial auto policy covered claim caused by unloading of transport truck; genuine question of fact about whether the mechanical device exclusion applied.

---

**Need a Speaker?**

Want to Be a Speaker?

If you belong to a group that would like to have a speaker from the Insurance and Indemnity Law Section address your group on a topic of interest, just let us know the topic, and we’ll try to arrange a speaker. If you are not sure of a topic, call anyway, and we’ll work something out.

If you are a member of the section and would like to be on our list of speakers, please contact:

Hal O. Carroll
hcarroll@VGpcLAW.com
or call at
(248) 312-2800

---

Advertise in The Journal of Insurance & Indemnity Law

For details, contact:

Hal O. Carroll
hcarroll@VGpcLAW.com
(428) 312-2800
Insurance & Indemnity Law Section 2009 - 2010 Officers and Council

Timothy F. Casey, Chairperson
Kelley, Casey & Mayer

Mark G. Cooper, Chairperson-Elect
Jaffe Raitt Heuer & Weiss

Elaine Murphy Pohl, Secretary
Plunkett Cooney

Kathleen A. Lopilato, Treasurer
Auto-Owners Insurance Company

Hal O. Carroll, Immediate Past Chairperson
Vandeveer Garzia

Daniel P. Steele
Vandeveer Garzia

Deborah A. Hebert
Collins, Einhorn, Farrell & Ulanoff

Augustine O. Igwe
Kaufman, Payton & Chapa

Nicholas LeFevre
Shareholder Services, LLC

Catherine L. Heise
Amerisure Insurance

Carmel M. Roberts
Hagerty Insurance

Adam B. Kutinsky
Kitch, Drutchas, Wagner, Valuturi & Sherbrook

Ellen Bartman Jannette
Plunkett Cooney

Daniel P. Hale
The Cambridge Group

Gary P. Bartosiewicz
Lennon, Miller, O’Connor & Bartosiewicz

Sarah E. Wohlford
Honigman, Miller, Schwartz & Cohn

Marty Brown
Foremost Insurance Company

M. J. Stephen Fox
Fox & Associates

Edward M. Freeland
Garan Lucow Miller

Amy H. Iannone
Barton Malow

State Bar of Michigan Insurance and Indemnity Law Section 2009 - 2010 Officers and Council