I am happy to report that the Annual Meeting in September was a tremendous success. The topic of our substantive program -- “Is There Bad Faith in Michigan?” -- attracted not only our own members, but members from other sections and we filled the room. In keeping with our Section's policy of embracing both perspectives, the panel presented different views on the issue of the availability and viability of bad faith claims in Michigan. We had an impressive panel that provided a spirited debate and the substance of the program reflected very well on the Section. I would again like to offer the Section's sincere thanks to Elaine Pohl, the Section’s Chair-Elect, for putting together the program, as well as Lauretta Pominville, Larry Bennett and Hal Carroll, for providing valuable help with the program. We also would like to thank the speakers that graciously volunteered their time to our program. Those speakers were:

- Phil Yeager, managing partner of Yeager Davison & Day, P.C. and who has extensive litigation background in all aspects of property/casualty insurance law;
- David J. Cooper, who serves as expert on bad faith issues for both insureds and insurers;
- Dave Christensen, of Gursten Koltonow Gursten Christensen & Raitt, and who is the chair of the Negligence Section of the State Bar of Michigan;
- Mike Fabian, of Fabian Sklar & King, and who is an editor of ICLE’s *Michigan Insurance Law and Practice* and author of the chapter on property insurance; and
- Fran Wallace, the former chief deputy commissioner of the Office of Financial and Insurance Regulation.

The success of the program and annual meeting mirrors the success of the section itself. At a time when other State Bar of Michigan Sections are having trouble holding on to members, our membership continues to grow. We have now reached 538 members at last count, and the main impediment to growing even faster seems to be simply that some attorneys have not heard of us. So you can help the Section grow by telling other attorneys about it and inviting them to join. According to the statistics just released by the State Bar of Michigan, about 40% of our membership is in Oakland County, but we have members now in 33 other counties throughout the state, and we now have members that primarily practice law in eight other states than Michigan.

We have also moved forward with our restructuring by reducing the size of the Council, and relying more on committees to carry out the work of the Section. The planned
committee structure at this point is to have three core committees: Publications, Membership and Programs. An announcement will be coming soon on the appointment of chairs to those committees and we will be having a meeting in November at which we will invite our members to volunteer and actively serve on those committees, where we expect that going forward the “real” work of the Section will take place.

The Journal also has grown. In addition to the other regular features, this issue adds a report on insurance issues relating to professional liability policies.

Our treasury has also grown, and puts us in a position where we have the means to build on our past successes by expanding the range of our activities. We will be looking into presenting programs to members and non-members, and working with other sections where there are insurance and indemnity issues that impact their areas of practice.

Again, watch for an e-mail with details as we get closer to the planned date for our open meeting in November – we hope to hold the meeting somewhere to provide refreshments and an atmosphere to let everyone mingle and get to one another. We look forward to seeing you then.

From the Chair
Continued from page 1

The Journal of Insurance and Indemnity Law is a forum for the exchange of information, opinion, and commentary from any perspective on any topic related to the law of insurance and/or indemnity. In addition to being distributed to members, the Journal is also sent to state and federal trial and appellate judges, and selected legislators and members of the executive branch. The Journal welcomes articles or other contributions from any interested person.

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). If you have a proposal for publication, or would like to suggest a topic, please contact the editor, Hal Carroll, at hcarroll@VGpcLAW.com or at hcarroll@chartermi.net.

Editor’s Note

By Hal O. Carroll, Vandeveer Garzia, PC

The Journal of Insurance and Indemnity Law is a forum for the exchange of information, opinion, and commentary from any perspective on any topic related to the law of insurance and/or indemnity. In addition to being distributed to members, the Journal is also sent to state and federal trial and appellate judges, and selected legislators and members of the executive branch. The Journal welcomes articles or other contributions from any interested person.

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History and Mission

The Office of Financial and Insurance Regulation (OFIR) is the successor agency to the original Michigan Insurance Bureau, which was established in 1871. As the first state to coordinate regulation of financial institutions, insurance, and securities industries under the federal Financial Services Modernization Act of 1999, Michigan has long been a model for the harmonization of these regulatory functions. OFIR was created in April 2000 by Executive Order No. 2000-4, which merged the Michigan Insurance Bureau, the Financial Institutions Bureau, and portions of the Corporations, Securities, and Land Development Bureau.

OFIR is currently housed within the Department of Licensing and Regulatory Affairs. OFIR is responsible for regulating numerous financial industries, including insurers, financial institutions, securities, and consumer finance entities. OFIR is statutorily charged with administering approximately 50 different statutes, including the Consumer Financial Services Act, the Motor Vehicle Sales Finance Act, the Regulatory Loan Act, the Secondary Mortgage Loan Act, and other state and federal laws. OFIR regulates numerous entities, including Blue Cross Blue Shield, HMOs, banks, domestic insurance companies, credit unions, foreign insurance companies, investment advisors, securities broker-dealers, insurance agents, securities agents, investment advisor representatives, mortgage licensees and registrants, deferred presentment companies and numerous other consumer finance-related entities.

OFIR's mission is as diverse and broad as its statutory mandates, and includes numerous goals, including: educating, empowering, and protecting consumers; ensuring institutional solvency, safety and soundness; maintaining a regulatory environment that fosters a competitive financial services industry; and ensuring regulated entities' compliance with applicable state and federal laws. As part of its dedication to consumer assistance, OFIR works to help consumers who have questions or complaints about any of its regulated entities. OFIR also routinely provides consumers with tips about comparison shopping for insurance and other issues of public interest.

OFIR's website is www.michigan.gov/ofir. A variety of information is available at the site, including: licensing requirements and timelines; a licensee lookup function; procedures for filing a consumer complaint; examination requirements and information; financial statements; links to prohibitions and enforcement actions; bulletins, orders, PRIRA decisions, and declaratory rulings issued by the Commissioner; dates and information on public hearings; press releases; consumer guides; links to relevant statutes and rules; and information on seminars and reports offered to regulated industries.

The Commissioner of Insurance

The Commissioner of Insurance, as chief officer of the Office of Financial and Insurance Regulation, is statutorily charged with the execution of state and federal laws in relation to the insurance and surety industries and to perform such other duties as may be required by law. The commissioner is responsible for effectuating the purposes and executing and enforcing the provisions of the insurance laws of Michigan.

R. Kevin Clinton is the current Commissioner of OFIR, and was appointed by Governor Rick Snyder effective April 16, 2011. Before his appointment, Commissioner Clinton served for more than six years as president and CEO of American Physicians Capital, Inc., a publicly-traded medical professional liability insurance provider based in East Lansing. Before becoming president and CEO, he worked as the company's vice president and chief operating officer. Prior to 2001, Commissioner Clinton served as president and CEO of MEEMIC Insurance Company, a publicly-traded property and casualty insurance holding company based in Auburn Hills. He was also chief financial officer at ProNational Insurance Company. Commissioner Clinton's experience and expertise in the insurance industry also includes actuarial positions in the private sector as well as service as chief actuary for the Michigan Insurance Bureau in the 1980s.

Rules and Regulations

Many of OFIR's functions are carried out according to standards set by administrative rules and regulations. Under MCL 500.210, the Commissioner “shall promulgate rules and regulations in addition to those” specifically provided for by statute “as he may deem necessary to effectuate the purposes and to execute and enforce the provisions of the insurance laws” of Michigan. A “rule” is defined as
“an agency regulation, statement, standard, policy, ruling, or instruction of general applicability that implements or applies law enforced or administered by the agency, or that prescribes the organization, procedure, or practice of the agency, including the amendment, suspension, or rescission of the law enforced or administered by the agency.” MCL 24.207.

Rules promulgated by the Commissioner may be found within the Michigan Administrative Code. The Administrative Code is posted on the Office of Regulatory Reinvention (ORR) website: www.michigan.gov/orr. At that site, rules and regulations can be searched by department or by rule number. Proposed amendments to, or rescissions of, rules promulgated by the Commissioner can be found at http://www.state.mi.us/orr/emi/rules.asp?type=dept&id=LG.

The Rule-Making Process

The procedure for promulgating rules is found in the Michigan Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.201 et seq. While requests to commence rulemaking can come from professional boards or commissions, a department, or the public, rulemaking is usually initiated at the department or agency level. Once the proposed rule is drafted, a public hearing is held and public comments are solicited. The requesting entity (board, commission, department, or otherwise) then submits the final draft of the rule for certification by the ORR. ORR then submits the rule to the Legislature’s Joint Committee on Administrative Rules, which has 15 days to meet and object to the rule. If no objection is made, the rule is adopted and filed. A rule can be effective as of the date of filing, or at a later date specified in the rule.

In addition to administering the rulemaking process, ORR is also responsible for the “oversight and review of current rules and regulations, and proposed rule making and regulatory activities by all departments and agencies.” Executive Order 2011-5. In particular, ORR is charged with undertaking a “systematic review” of “all existing and proposed rules and rule making processes,” and sets forth factors for use in the review. Id.

As part of its review under Executive Order 2011-5, the Office of Regulatory Reinvention has identified approximately 575 rules promulgated by OFIR that will be reviewed by an advisory committee made up of 13 members representing regulated industries as well as consumers. The advisory committee will evaluate the rules based on factors set forth in Executive Order 2011-5, including but not limited to the health and safety benefits of the rules; the cost of compliance with the rules; whether the rules conflict with or duplicate similar state or federal rules or regulations; whether the rules are obsolete; and the degree, if any, to which technology, economic conditions or other factors have changed regulatory activity covered by the rules since the last evaluation. Public comments will also be taken into consideration. The advisory committee will submit its findings and recommendations to the Governor.

In addition to ORR’s mandate to undertake a systematic review of existing rules and regulations, ORR is also empowered to “exercise its oversight authority by selecting non-rule regulatory actions for review.” A “non-rule regulatory action” is defined by Executive Order 2011-5 as “a regulatory action not adopted by a department or agency as a rule” pursuant to the APA “that is utilized by a department or agency to govern or bind Michigan businesses, entities, or individuals including, but not limited to, guidelines, handbooks, manual, instructional bulletins, forms with instructions, and operational memoranda.” Id. In the course of its review, ORR may eliminate, suspend, or modify the “non-rule regulatory action” if: 1) ORR determines that a non-rule regulatory action is “being used to support a department or agency’s decision to act or refusal to act”; 2) ORR determines that a non-rule regulatory action “exceeds the department’s or agency’s constitutional or statutory scope”; and/or 3) ORR determines that a non-rule regulatory action “is unduly burdensome or otherwise not consistent with the purposes set forth” in the EO. ■

About the Author

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Endnotes

1 This article reflects the views of its author and should not be construed as an official agency statement, position, interpretation, or guidance.

2 MCL 500.202(1).

3 MCL 500.200.

Scenes from Our Annual Meeting

The topic at our annual meeting was “Is There Bad Faith in Michigan?” We had a full house, and the discussion was lively and spirited.

Phil Yeager
Phil Yeager, managing partner of Yeager Davison & Day, P.C. who has extensive litigation background in all aspects of property/casualty insurance law.

David J. Cooper
David J. Cooper, who serves as expert on bad faith issues for both insureds and insurers.

Dave Christensen
Dave Christensen, of Gursten Koltonow Gursten Christensen & Raitt, who is also the chair of the Negligence Section of the State Bar of Michigan.

Mike Fabian
Mike Fabian, of Fabian Sklar & King, and who is an editor of ICLE’s Michigan Insurance Law and Practice and author of the chapter on property insurance.

Fran Wallace
Fran Wallace, the former chief deputy commissioner of the Office of Financial and Insurance Regulation.

Elaine Murphy Pohl, Program Chair, introduces the speakers

Elaine Murphy Pohl and Mark Cooper
Many decades ago, professional liability policies were only issued to members of the “learned professions” of medicine, law, engineering, and accounting. However, the expansion of the service sector of our economy has led to increased specialization, regulation and licensing of other service occupations, thereby necessitating professional liability coverage in other occupational sectors. Although expansion of coverage may have begun with insurance agents and financial consultants, it has since expanded and is now offered to any occupation characterized by knowledge and skill that is predominantly mental as opposed to physical.

The types of businesses requiring professional liability policies, which depending upon the occupation are also called “errors and omissions” policies, continues to enlarge annually. In fact, the proliferation of this coverage has become so common that some occupations previously thought of to consist solely of manual labor are now purchasing the coverage. By way of example, general contractors that have limited in-house design services are now encouraged to purchase professional liability insurance to cover losses arising out of design flaws.

There are many distinctions between professional liability insurance and other types of policies. However, the most useful comparison is to general liability insurance, also known as commercial general liability (CGL) insurance. It is not enough to distinguish the two by types of injuries, since although CGL policies are thought of as covering bodily injury and property damage claims as opposed to economic losses, this is a false distinction. In fact, the two policies overlap enough to justify attaching an endorsement to a CGL policy excluding professional liability claims, when a professional liability policy is issued contemporaneously.

The greatest distinction between a professional liability policy and a CGL policy is the focus on the act or the failure to act by the insured, rather than the damages caused by the insured.

The greatest distinction between a professional liability policy and a CGL policy is the focus on the act or the failure to act by the insured, rather than the damages caused by the insured.

In contrast, CGL coverage is generally focused upon an occurrence, event or accident which cannot be expected nor intended from the standpoint of the insured. Related to this difference, since professional liability insurance focuses on acts or omissions and not the damages, the time between the wrongful act and the damages giving rise to a claim are more likely to be separated by time than they are for CGL claims. Note that it is common for a professional act in one year to cause recurrent damages in subsequent years, thereby culminating in a large loss identified much later.

Because of this difference in the coverage focus and how claims are likely to present, since the 1970s nearly all professional liability policies have been issued in the claims-made form to allow insurers to forecast their risk with greater accuracy and in turn charge more appropriate premiums. This is in contrast to the more easily understood occurrence-form found within CGL policies. In fact, the claims-made function of professional liability policies stands out as among the most misunderstood and complicated elements of insurance coverage.

Although the coverage trigger may be referred to as “claims-made,” it in fact requires a much more complex analysis than the label suggests. Certainly, it requires a more detailed analysis than whether or not the loss occurred during a finite period of coverage as with a CGL form. Although each policy must be read individually to determine when a claim triggers coverage, generally a claims-made policy requires consideration of three different time references:

1. The retroactive date (the “nose”);
2. The period of coverage; and
3. The extended reporting period (the “tail”).

The retroactive date is the date identified on the declarations page after which the loss must have occurred to be
covered and is occasionally referred to as the “nose.” The period of coverage then provides the time (usually 12 months) in which the claim must have been made by the claimant or made by the claimant and reported by the insured, depending upon the individual conditions and definitions of each policy. The claims-made period of coverage is similar to the period of coverage found within an occurrence form, but instead of being controlled by the date of loss, it is controlled by the date the injured party notifies the insured of a claim. Finally, the extended reporting period (the “tail”) provides an additional period of time in which a claim may be made and reported to the insurance company after the period of coverage expires. Most claims-made policies include an automatic extended reporting period for a specified period of time and also give the insured the option to purchase more time when the policy term ends.

Coverage under a claims-made policy cannot be determined without consideration of all three of these time references. Note that while it is generally considered “inferior” to occurrence form coverage, because of the long tail issue, claims-made coverage offers the advantage of allowing the insured to increase its insurance limits to match inflationary changes in the size of verdicts and settlements which took place between the time that an unknown act or omission happened and the when eventual lawsuit is filed.

The most well known and most frequently litigated professional liability policy is the healthcare professional liability insurance policy, also known as medical malpractice insurance. The insuring agreement (the provision found within an insurance policy that grants coverage) found within a medical malpractice policy generally provides coverage for liability for injury arising out of the insured’s professional services. One of the most important definitions found within a medical malpractice policy is the term “medical incident,” which controls the types of professional services that may result in a covered claim.

Although definitions vary by policy, a medical incident generally includes an act or omission in furnishing medical care while providing professional services. As with all insurance policies, once the insuring agreement grants coverage, the conditions, limitations and exclusions refine it. By way of example, the Insurance Services Office (ISO), which issues standardized insurance policy forms and language, has issued a medical malpractice policy that excludes coverage for criminal acts, contractual liability, professional services rendered by others, liability arising out of other enterprises, workers compensation and employers’ liability. As with most policies, the exclusions are usually added for one of two reasons: Either the loss is more appropriately covered by another policy (workers compensation/employers liability) or the loss is not one that insurance is intended to cover (criminal acts).

Conventional professional liability and errors and omissions policies are not the only types of liability policies available to businesses seeking to protect against third party claims for economic damages. There are also policies based on acts and omissions designed to cover management and fiduciary claims (directors & officers - D&O), employment practices liability (EPL), design liability, and cyber-liability. Each of these policies is distinct from traditional professional liability insurance and from one another.

Recently, the insurance market has responded to the increased need for professional liability coverage by not only further developing traditional malpractice policies, but also by developing “miscellaneous professional liability” policies, which may be issued when a profession-specific form does not exist. These miscellaneous policies are new and will probably evolve at a more rapid rate than policies which have been in existence for many decades.

Although some professional liability losses could potentially fall within coverage under a CGL, an endorsement will usually be attached to a CGL policy excluding coverage that would normally be covered under a professional liability policy to avoid stacking (two or more policies providing primary coverage for the same loss).

Generally, professional liability insurance provides the insured with a defense to covered third party claims and indemnification for covered losses arising from those claims. Under Michigan law, an insurer is obligated to defend an entire lawsuit, including non-covered claims, so long as any allegation in the complaint falls within coverage. However, since the duty to defend is broader than the duty to indemnify, even if a defense is provided, the claim may not ultimately result in indemnification. Rather, depending upon the outcome of the claim, the insurance carrier may deny indemnification. For this specific reason, carriers routinely issue a reservation of rights letter in response to a claim; the letter usually informs the insured that the carrier will provide a defense, but reserves its right to deny indemnity (and even retract the defense), depending upon how the facts come out during the subsequent investigation and litigation.

The nature of our service oriented economy ensures that insurance for professional liability type claims will continue to grow in scope and variety. As a resource to its members, the Insurance and Indemnity Section will continue to provide information on the subject.

About the Authors

Greg Drutchas and Adam Kutinsky co-chair the insurance practice group at Kitch Drutchas Wagner Valittuti & Sherbrook. They may be reached at 313.965.7900 or greg.drutchas@kitch.com and adam.kutinsky@kitch.com.
Most policies that provide coverage for claims of liability that are asserted against the insured impose two obligations on the insurer: to defend the claim and to indemnify the insured against the loss if the plaintiff who sued the insured is successful. There are “indemnity-only” policies, but they tend to be written in special circumstances. Most of the time the policy will create both duties.

Because both duties are created by the policy they are obviously linked. “[I]f the policy does not apply then the insurer does not have a duty to indemnify or defend the insured.”

“The duty to defend . . . arises solely from the language of the insurance contract. A breach of that duty can be determined objectively” from the language of the contract.

The two duties also share the characteristic that the insured must take the first step and request that the insured defend and indemnify him or her. “[O]rdinarily, an insurer has no duty to defend an insured absent a request to defend.”

The differences between the duty to defend and the duty to indemnify begin to emerge when the analysis in each specific case starts, though they begin in the same way. The analysis of both duties starts with the underlying complaint that asserts that the insured defendant is liable to the plaintiff, and it is the factual allegations in that complaint, and not the labels the underlying plaintiff gives them, that drive the analysis.

The “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.”

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.

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.

Duty Extends to Claims Arguably within Coverage

The analyses diverge here, though, because the analysis of the duty to defend must go further. Although “[t]he insurer is not required to defend against claims expressly excluded from policy coverage,” “[t]he duty to defend is not limited by the precise language of the pleadings.”

The duty of an insurance company to provide a defense in an underlying tort action depends on the allegations in the complaint and extends to allegations which “even arguably come within the policy coverage.” The duty to defend is broader than, and not necessarily conclusive of, an insurer’s duty to indemnify. The court must resolve any doubt pertaining to the duty to defend in favor of the insured.

Insurer Must Investigate Beyond the Complaint

Michigan’s Supreme Court has said that the insurer cannot get summary disposition in its favor where the facts are not yet fully developed.

The duty to defend is distinct from and is broader than the duty to indemnify. Summary disposition for the plaintiff on the duty to indemnify is not proper where the evidentiary record is not fully developed or where there is a genuine issue of material fact.

A consequence of this principle is that the insurer cannot limit its analysis to the allegations of the complaint where the duty to defend is at issue. The insurer must look behind those allegations.

An insurer has a duty to defend, despite theories of liability asserted against any insured which are not covered under the policy, if there are any theories of recovery that fall within the policy. The duty to defend cannot be limited by the precise language of the pleadings. The insurer has the duty to look behind the third party’s allegations to analyze whether coverage is possible. In a case of doubt as to whether or not the complaint against the insured alleges a liability of the insurer under the policy, the doubt must be resolved in the insured’s favor.
The insurer cannot limit its analysis to the underlying complaint, but must conduct its own investigation to determine whether the claim should be covered.

“[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.12

The fact that the duty to defend extends to claims that may or may not be covered as long as they are “arguably” covered is one important characteristic of the insured’s duty to defend, and the insurer’s affirmative duty to investigate and look “behind” the complaint is another. The third major difference is that if any claim in the underlying complaint is sufficient to trigger a duty to defend, that duty extends to all of the claims made in the underlying complaint, even those that are not covered.

An insurer must defend its insured even if theories of liability asserted are not covered under the policy, if any asserted theories of recovery fall within the policy coverage.13

In a situation like this, the insurer will often issue a reservation of rights letter explaining that it will defend against all claims, but that if liability is ultimately found to exist on a claim that is not within the policy’s coverage, then the insurer will not indemnify the insured for the loss. This situation can sometimes lead to a quandary for the retained defense counsel. Defense counsel’s obligation is to the insured client, not to the insurer. What should defense counsel do if one of two claims is covered and the other is not, and if counsel can file a compelling motion for summary disposition on the covered claim? In theory dismissing that claim is a victory for the client-defendant-insured, but the result is that the insurer will then withdraw the defense of the remaining (not covered) claim. ■

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. His practice includes civil appeals and indemnity and insurance coverage disputes, where he represents insureds as well as insurers. He is a frequent author on insurance and indemnity topics. His email addresses are hearroll@VGpcLAW.com and hcarroll@chartermi.net.

Endnotes

7 Gorzen, supra, 207 Mich App at 578.
9 Allstate Ins Co v Freeman, 432 Mich 656, 662; 443 NW2d 734 (1989).
11 American Bumper, supra, note 10, internal citations deleted.
13 Citizens Ins Co v Pro-Seal Service Group, Inc, 477 Mich 75, 100; 730 NW2d 682 (2007).
No Statute of Repose for Construction Industry
Contractual Indemnity Claims

By Noreen L. Slank
Collins, Einhorn, Farrell & Ulanooff; noreen.slanke@ceflawyers.com

In 1967, architects and engineers secured the protection of a nifty if somewhat intricate statute of repose: MCL 600.5839(1) (see the text below). The statute sets a last date for filing suit as reckoned (typically) from a certificate of occupancy rather than from the date when someone is injured because of a defect in a building. It applies to lawsuits seeking recovery because of personal injury, death, or property damage. The statute sets a cut-off date for a timely lawsuit by counting 6 years from the date of occupancy (usually) or 1 year from discovery of the defect, whichever is later. But once 10 years from “the time of occupancy of the completed improvement, use, or acceptance of the improvement” has passed, an injured party cannot timely sue. That is true even if the party was first injured or damaged after the ten years already passed. Statutes of repose mostly set more firmly delineated rules as compared to statutes of limitation with accrual dates that are often more difficult to discern.

In 1986, our legislature added “any contractor making the improvement” to the categories of professionals protected by MCL 600.5839(1) – a very useful amendment for the construction industry. If you litigating such lawsuits, you are already vigilant in terms of the possibility your client was sued too late.

Endnotes

1 Sec. 5839. (1) 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, against any state licensed architect or professional engineer performing or furnishing the design or supervision of construction of the improvement, or against any contractor making the improvement, more than 6 years after the time of occupancy of the completed improvement, use, or acceptance of the improvement, or 1 year after the defect is discovered or should have been discovered, provided that the defect constitutes the proximate cause of the injury or damage for which the action is brought and is the result of gross negligence on the part of the contractor or licensed architect or professional engineer. However, no such action shall be maintained more than 10 years after the time of occupancy of the completed improvement, use, or acceptance of the improvement.

Sec. 5839. (8) An action for indemnification for the necessary corrective work.” 285 Mich at 301. The Supreme Court included the comment that Miller-Davis “sought indemnification for the necessary corrective work.” 489 Mich at 359.

The pure contract statute of limitations set out in MCL 600.5807(8) is six years, which may sound a lot like the statute of repose. But the way the calculation works for the statute of limitation allows for disputes about when the six years start running. If the statute of repose applied, then the Miller-Davis lawsuit was clearly filed too late as reckoned from acceptance of the improvement.

The Supreme Court decided that the statute of repose did not apply to the Miller-Davis lawsuit for indemnification because it was not a tort claim, but a claim for breach of contract. “[T]he damages involved in this case were not to plaintiff’s person or property, but rather to its financial expectations.” 489 Mich at 370. A lawsuit “for damages for deficiencies in an improvement” is not a lawsuit trying to recover what the statute of repose applies to (“injury to property...or for bodily injury or wrongful death”). Miller-Davis’s lawsuit, including its contractual indemnity claim, alleged breach of contract, so the six-year contract statute of limitation applied. The Supreme Court remanded the case to the Court of Appeals with instructions for it to apply the contract limitations period and, if necessary, to resolve other issues that both sides are raising.
6th Circuit Court of Appeals

Umbrella Policy Not Triggered Until Underlying Policies Exhausted

*Federal-Mogul US Asbestos Personal Injury Trust v Continental Casualty Company*

___F3d___ (6th Cir. 2011) (Case No. 10-1290)

Plaintiff insured is a trust fund established by the bankruptcy court to handle asbestos claims against Vellumoid Company, a division of Federal-Mogul. The assets of the trust include three primary CGL policies and an umbrella policy. The umbrella policy specifically listed only one of the three underlying policies on its schedule (the “Travelers” policy). When the Travelers policy was exhausted, the trust sought coverage under the umbrella policy, even though it was still being defended under the other two primary CGL policies. The federal district court dismissed the claims for umbrella coverage and the decision was affirmed on appeal. The umbrella policy specifically stated that it would pay ultimate net loss, which by definition excluded all loss expenses and legal expenses. Further, the umbrella insurer’s duty to defend was triggered only if an occurrence “is not covered by the underlying insurance listed in the underlying insurance schedule or any other underlying insurance collectable by the insured.” Similarly, the duty to indemnify was triggered only if the ultimate loss was “in excess of . . . the underlying limits of liability of the underlying insurance policies as stated and described in the declarations and those of any underlying insurance collectable by the insured.” Because there was other collectible insurance available for providing both a defense and indemnity, the umbrella policy was not triggered.

Michigan Court of Appeals Published

UIM Policy Reformed Where Coverage is Only for Statutory Limit

*Ile v Foremost Insurance Company*

___ Mich App ___ (July 14, 2011), lv app pending (Docket No. 295685)

This decision holds that where the UIM liability limit is equal to the financial security requirements mandated for autos registered in this state ($20,000/$40,000), the policy is illusory and will be reformed. Following the lead of other state appellate courts, the panel refused to offset the liability limits of the underinsured vehicle because the insured had paid a single premium of $26 for two forms of coverage, UM and UIM, one of which could never be triggered. “[T]here exists no possibility . . . to collect underinsured motorist benefits at the selected level of coverage” given that an “underinsured” vehicle would necessarily have the mandated coverage. Because the contract was illusory, i.e., “an agreement in which one party gives as consideration a promise that is so insubstantial as to impose no obligation,” the court reformed the UIM coverage to provide $20,000 in UIM coverage over and above the $20,000 limit available under the tortfeasor’s liability policy.

Independent Appraisers in a Property Loss Dispute

*White v State Farm Fire and Casualty Company*


MCL 500.2833(1)(m) applies to coverage disputes under fire insurance policies. It provides that when the insured and the insurer cannot agree on the actual cash value of a property loss, either party may submit a written demand for an appraisal. Once an appraisal is requested, each party is required to select a “competent, independent appraiser.” The two appraisers select a neutral. The dispute in this case is whether a party may choose as his “independent appraiser,” the public adjuster previously hired by that party on a contingency fee basis. The Court of Appeals held that an independent appraiser merely means one who is not subject to control, restriction or modification by an outside source. The court held that an “independent appraiser” of a property loss may include a public adjuster previously hired by one party on a contingency fee basis, as long as he or she is able to exercise independent judgment. The opposing party’s due process rights are not violated because the appraiser is not a “quasi judge.”

Unpublished Court of Appeals Decisions

Products Completed Exclusion

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

Unpublished per curiam of June 28, 2011 (Docket No. 297657)

An endorsement to a CGL policy excluding coverage for “products-completed operations hazard” excluded coverage for this product liability claim against the insured, including the claim for breach of implied warranty.

continued on next page
Late Notice Requires Actual Prejudice  
*Smith v Farmers Insurance Exchange*  
Unpublished per curiam of June 21, 2011  
(Docket No. 297229)

The insured’s late notice of an uninsured motorist claim did not bar coverage because the insurer failed to demonstrate actual prejudice as a result of the late notice. Relying on *Defrain v State Farm Mutual Auto Insurance Company*, ___ Mich App ___ (Docket No. 294505) (March 10, 2011).

An Insurer’s Obligations to Indemnitees of an Insured  
*Lapham v Jacobs Technology, Inc.*,  
Unpublished per curiam of June 19, 2011  
(Docket No. 295482)

Defendant was owed a defense and indemnity by its subcontractor when an employee of that subcontractor was injured on the job and sued. The subcontractor’s insurer provided a defense and ultimately settled and satisfied the claim. Defendant, however, was unhappy that the defense firm had not filed a third-party complaint against the subcontractor and that the insurer had filed a declaratory judgment action regarding coverage. Defendant sued to recover the fees incurred in retaining separate counsel to file the third party complaint and for the fees expended in the dec action. The Court of Appeals rejected both claims. The duty to defend does not necessarily require the filing of a third party complaint. Here, the defendant had the ability to file a notice of non-party fault to divert the jury’s attention to the subcontractor. And the dec action was justifiable because of the potential that the injury was caused by defendant’s sole negligence, in which case there would be no duty to indemnify or insure.

Landlord Covered for Claim Arising Out of Defect in Property  
*Fire Insurance Exchange v Miller*  
Unpublished per curiam of June 23, 2011  
(Docket No. 297544)

This case involved a “landlord protector’s” policy issued to the owner of a building used as an adult group home. The policy excluded coverage for liability arising out of “business pursuits” and/or arising out of “professional services.” A resident in the home drowned in a bathtub and his estate filed suit against the company operating the home (the insured was part owner of that company) and also against the insured as landlord. Because the plaintiff alleged that the death was caused, at least in part, by a defective drain in the bathtub, the insured landlord’s liability arose out of a condition of the property and was not excluded by the business pursuits exclusion or by the professional services exclusion.

Homeowner’s Ice/Wind Exclusion Applied  
*Kibbey v Auto-Owners Ins. Co.*  
Unpublished per curiam of July 19, 2011  
(Docket No. 297729)

Plaintiff homeowners submitted a claim to their insurer for $28,000 representing the cost of repairs to the foundation of their home after a winter storm. Coverage was denied based on several exclusions, and that decision was upheld on appeal. Engineers for the homeowners and for the insurer agreed that the foundation problems were caused by severe ice jamming and strong winds off the lake on which the house was situated. The engineer for the insurer added that the house was not sufficiently fastened to the foundation and thus could not withstand the winter conditions to which it was subjected. The policy expressly excluded coverage for loss resulting directly or indirectly from “freezing, thawing, pressure or weight of water or ice, whether driving by wind or not.”

Failure to Submit Proof of Loss Results in Lack of Coverage  
*Essa v Pioneer State Mut. Ins. Co.*  
Unpublished per curiam of July 5, 2011  
(Docket No. 297493)

Plaintiff homeowner’s insurance claim for water damage was properly denied because she failed to submit the required proof of loss in a timely fashion, even though the insurer timely provided a copy of her policy and notified her of the need to submit a formal proof of loss, which form was provided.

Fall on Snow Did Not Arise Out of Use or Maintenance of Vehicle  
*Grantham v Jiffy Lube International, Inc.*  
Unpublished per curiam of June 30, 2011  
(Docket No. 298673)

Plaintiff insured was denied PIP benefits for injuries sustained when he slipped and fell outside an oil change shop, as exited his vehicle to go into the office to pay. “In looking at the evidence in a light most favorable to plaintiff, there is no genuine issue of material fact regarding whether plaintiff’s injury arose out of the use or maintenance of his motor vehicle as a motor vehicle. Based on plaintiff’s own testimony, there is not a causal connection between plaintiff’s injury and his use of his vehicle as a motor vehicle.”
Assault Not an Occurrence Under Homeowner's Policy

*Auto Club Group Ins. Co. v Ramos*

Unpublished per curiam of June 30, 2011
(Docket No. 297397)

Regardless of whose testimony is believed, the homeowner’s actions in touching and massaging his adult niece in a sexual way is not an “occurrence” as required for liability coverage under the homeowner’s policy.

Policy Exclusion Limits Coverage for Family Member to $20,000/$40,000

*Hollenbeck v Farm Bureau Mut. Ins. Co. of Michigan*

Unpublished per curiam of June 30, 2011
(Docket No. 297900)

An exclusion in the insured’s auto policy reduced coverage to the statutory minimum of $20,000/$40,000 for a family member of the named insured. The exclusion limited liability coverage “to you or to any family member that exceeds the minimum statutory limits of the financial responsibility law.” The court held that the limitation of coverage was plainly stated in the contract and therefore enforceable and that the exclusion did not violate public policy.

Jury’s Rejection of Arson/Misrepresentation Charges Requires Coverage

*Williams v Auto Club Group Ins. Co.*

Unpublished per curiam of August 23, 2011
(Docket No. 294511)

In this fire loss case, a jury concluded that plaintiff insured did not commit arson or engage in fraud or misrepresentation or make false sworn statements to the insurer. Plaintiff was thus entitled to be compensated for the fire damage to the building and personal contents and to be reimbursed for the necessary additional expenses.

Professional Services Exclusion Bars Additional Insured Coverage

*Walgreen Company v RDC Enterprises, LLC*

Unpublished per curiam of August 23, 2011
(Docket No. 293608)

A worker on a construction site sued Walgreen and others for injuries suffered when he fell from a catwalk designed by Walgreen. Walgreen sought a defense and indemnity as an additional insured under a general liability policy issued to one of the contractors. That policy, however, excluded coverage for claims arising out of professional services, such as design services. Additional insured coverage was not afforded. Walgreen was also denied coverage as an additional insured under another contractor’s policy because that policy did not afford coverage for Walgreen’s own negligence.

Question of Fact Regarding Cause of Frozen Pipes in Vacant Home

*Kennedy v Auto-Owners Ins. Co.*

Unpublished per curiam of August 4, 2011
(Docket No. 294955)

Homeowner’s policy excluded coverage for damage to an unoccupied home unless the insureds took precaution to “maintain heat in the building.” The Court of Appeals found a question of fact about whether the insureds had allowed the propane tank to become empty and reversed the trial court’s summary disposition ruling in favor of insureds. On remand, the insureds were barred from seeking recovery for consequential damages such as the profits lost as a result of not being able to sell the house.

UM Coverage Not Extended to Resident Relative

*Owens v Auto Owners Ins. Co.*

Unpublished per curiam of August 11, 2011
(Docket No. 297590)

Plaintiff pedestrian was struck by an uninsured motorist and sought PIP benefits under the policy of his mother, with whom he resided. Because plaintiff owned his own vehicle, for which he was required to purchase his own auto policy, he was barred from receiving UM benefits under his mother’s policy. That policy extended UM coverage to a resident relative only if that relative did not own an automobile. Plaintiff argued that his vehicle was in the shop for repairs due to an accident and was later sold for parts. But the fact is that the plaintiff owned an automobile at the time of his accident and he was therefore excluded from coverage by the terms of the mother’s UM policy.

OFIR’s Revocation of Insurance Producer’s License is Reversed

*Salah v OFIR*

Unpublished per curiam of August 2, 2011
(Docket No. 298894)

In 1996, plaintiff applied for an insurance producer’s license, plainly disclosing his earlier felony conviction for possession of a controlled substance. The license was granted. Eleven years later, OFIR revoked the license in the belief that such action was required under a statute that now prohibits licenses for persons convicted of a felony. Relying on *King v Michigan*, 488 Mich 208 (2010), the Court of Appeals held that the statute in effect prior to 2002 gave the Commissioner discretion to issue licenses to persons with felony convictions and it was error for OFIR to revoke a license now in the belief that such action was mandatory. The case was remanded for further proceedings.
The New Supreme Court and Recent Precedent—Part II

By Ronald M. Sangster, Jr.
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In our last article, we pointed out that the “new” Supreme Court appeared to be willing to re-examine, on motions for rehearing, cases that were decided under the “old” Supreme Court. We noted that in Anglers of the Ausable, Inc. v. Dept of Environmental Quality (on rehearing), docket number 138863, the Supreme Court’s new 4-3 majority reversed an opinion of the “old” majority, authored by former Justice Alton Davis in a case involving judicial standing.

Shortly thereafter, the “new” Michigan Supreme Court majority reversed yet another decision issued by the “old” majority on December 29, 2010. In Michigan Education As’n v Secretary of State (on rehearing), docket 137451, rel’d 6/30/2011, Justice Markman, writing for himself, Justices Mary Beth Kelly and Brian Zahra and Chief Justice Young, vacated the “old” Supreme Court’s decision and affirmed the judgment of the Court of Appeals to prohibit the Michigan Education Association (MEA) from utilizing a payroll deduction plan from school districts for contributions to its political action committee. Although this was not a no-fault case, Justice Markman’s majority opinion, as well as the dissenting opinions of Justice Cavanagh and Justice Hathaway, shed a great deal of insight into the philosophical approaches utilized by the “new” majority and the “old” majority (now minority). Also of note is the concurring opinion of Justice Mary Beth Kelly, joined by Justice Zahra, in which they again present their views on motions for rehearing that ask the Supreme Court to re-examine recent, prior decisions of that Court.

In contrast to these two decisions, though, the Michigan Supreme Court has also denied two application for leave to appeal on cases which had the potential for reversing the “old” Supreme Court’s decision in McCormick v Carrier, 487 Mich 180, __ NW 2d ___ (2010). In Wiedyk v Poisson, docket number 138260, the Supreme Court issued an order denying defendant’s motion for reconsideration from the “old” Supreme Court’s order of December 1, 2010, remanding the matter to the lower court for reconsideration in light of McCormick. At the same time, in Brown v Blour, docket number 142159, the Michigan Supreme Court issued an order denying defendant’s application for leave to appeal the October 14, 2010, judgment of the Michigan Court of Appeals. In both cases, Chief Justice Young authored a concurring opinion, urging the Legislature to legislatively overturn McCormick and to reinstate the criteria enunciated by the Michigan Supreme Court in Kreiner v Fischer, 471 Mich 109, 683 NW 2d 611 (2004). Justice Markman also authored a concurring opinion, noting that it was premature for the Supreme Court to revisit McCormick, in the context of these two cases, because the lower courts have not yet had an opportunity to apply the McCormick criteria. Justice Cavanagh, joined by Justice Marilyn Kelly, issued concurring statements in support of the McCormick decision which, as previously noted, was authored by Justice Cavanagh. At this point, it appears that the Michigan Supreme Court is waiting for the proper case where application of the McCormick criteria, in contrast to application of the Kreiner criteria, will be outcome-determinative.

Important Insurance Decisions
Continued from page 12

One-Year Contractual Limitations Period Enforced

Johnson v Farm Bureau Ins. Co.
Unpublished per curiam of July 28, 2011 (Docket No. 298048)

Property insurance policy for a “country estate” provided coverage for the residence and for residential personal property but it did not cover farm buildings or farm property unless expressly scheduled. The insurer paid for an outbuilding on the property because it was scheduled, but refused to pay for its contents, which were deemed to be farm equipment. The insured disagreed with the insurer’s contents, which were deemed to be farm equipment. The insured was barred.

Rescission Cases

Thomas v Victoria General Ins. Co.
Unpublished per curiam of July 21, 2011 (Docket No. 298243)

A mother and son jointly applied for an insurance policy and misrepresented that one of the vehicles was titled to the mother. The vehicle was titled to the son (whose license had been suspended, another fact not reported on the application). The court held that the insurer was allowed to rescind the contract based on the misrepresentation of vehicle ownership and thus did not have to pay the son’s PIP benefits.

Great Lakes Mutual Ins Co v Kirschner
Unpublished per curiam of August 4, 2011 (Docket No. 295677)

Insurer was allowed to rescind a fire insurance policy due to misrepresentations on the insurance application. The named insureds were individuals who stated that they owned the insured premises and used it as their residence. The property was in fact owned by a limited liability company and, although not the basis for its decision, was not used as the insureds’ residence. The policy was rescinded.

No-Fault Corner

In our last article, we pointed out that the “new” Supreme Court appeared to be willing to re-examine, on motions for rehearing, cases that were decided under the “old” Supreme Court. We noted that in Anglers of the Ausable, Inc. v. Dept of Environmental Quality (on rehearing), docket number 138863, the Supreme Court’s new 4-3 majority reversed an opinion of the “old” majority, authored by former Justice Alton Davis in a case involving judicial standing.

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Experimental Medical Treatment Generally Not Compensable Under No-Fault

**Krohn v Home Owner’s Ins. Co., Docket Number 140945**

In this 4-3 decision, authored by Justice Brian Zahra, the Michigan Supreme Court summarized its key holding as follows:

“We conclude that if a medical treatment is experimental and not generally accepted within the medical community, an insured seeking reimbursement for this treatment must, at a minimum, present objective and verifiable medical evidence establishing that the treatment is efficacious. A treatment or procedure that has not been shown to be efficacious cannot be reasonable or necessary under the No-Fault Act. An insured’s subjective belief that medical treatment is efficacious, reasonable and necessary is not enough to create a question of fact.”

In **Krohn**, Plaintiff was involved in a motor vehicle accident on December 11, 2001, and was rendered a paraplegic. While investigating options for his medical treatment, Plaintiff came upon a procedure known as olfactory ensheathing glial cell transplantation, an experimental surgery performed in Portugal. Essentially, the procedure involved transplanting tissue from behind the patient’s sinus cavities to the injury site.

The procedure is not approved by the United States Food & Drug Administration, and cannot be legally performed in the United States. Furthermore, his attending physician at the Rehabilitation Institute of Michigan indicated that he could not endorse or in any way recommend the procedure because it was highly experimental, had not yet been approved by the FDA, could not be legally performed anywhere in the United States and lacked medical evidence to establish its efficacy.

Plaintiff decided to undergo the procedure anyway and billed his no-fault insurer for the cost. The insurer denied payment, on the basis that the procedure was not reasonable or necessary for the Plaintiff’s care, recovery or rehabilitation. A jury determined that the procedure was “reasonably necessary” and the circuit judgment entered judgment in favor of Plaintiff. The Court of Appeals reversed, on the basis that plaintiff failed to demonstrate that the procedure performed in Portugal had gained general acceptance in the medical community. The Michigan Supreme Court granted plaintiff’s application for leave to appeal.

In its analysis, the Michigan Supreme Court initially rejected Defendant’s “bright line” argument that all experimental treatments are not compensable under the No-Fault Act. However, the court did note that in order for an experimental treatment to be compensable, an objective standard must be applied to support a claim that the service is “reasonable” and “necessary” for the individual’s care, recovery or rehabilitation.

The Supreme Court also determined that Plaintiff has the burden of showing, utilizing “objective and verifiable medical evidence,” that the medical treatment is effective for the injured person’s care, recovery and rehabilitation. Under the facts of this case, the Supreme Court majority concluded that because the effectiveness of the treatment could not be measured objectively, it was not compensable under the No-Fault Insurance Act. Justice Hathaway, joined by Justices Cavanagh and Marilyn Kelly, dissented and charged the majority with re-writing the No-Fault Insurance Act in a manner that “elevates the standard for proving that treatment is ‘reasonably necessary’” under the No-Fault Act.

**Supreme Court to Examine Applicability of Parked Vehicle Exclusion**

**Frazier v Allstate Ins. Co., Docket Number 142545**

On June 17, 2011, the Michigan Supreme Court issued an order scheduling oral argument on whether to grant Allstate’s application for leave to appeal in **Frazier v Allstate Ins. Co.,** docket number 142545. In its order scheduling argument on the application, the Supreme Court indicated that the parties were to address the issue of whether whether Plaintiff is entitled to an award of attorney fees under MCL 500.3148(1).

According to the Court of Appeals’ unpublished decision, issued on December 21, 2010, Plaintiff slipped and fell on ice while in the process of shutting the door to her parked vehicle’s passenger door. She had apparently finished placing her workbag, coffee and purse on the passenger side of her pick up truck, and intended to walk around to the driver’s side of her vehicle to drive to work. She stepped aside to close the passenger door and, while in the process of shutting the door, she slipped and fell on the ice surrounding her vehicle. In apparent disregard of the Court of Appeals’ earlier decision in **Amy v MIC General Ins. Corp.,** 258 Mich App 94, 670 NW 2d 228 (2003), rev’d on other grounds **Stewart v State,** 471 Mich 692, 692 NW 2d 374 (2004), where the Court of Appeals had earlier ruled that a vehicle’s bumper did not qualify as “equipment permanently mounted on the vehicle,” the Court also ordered the parties to address the issue of whether Plaintiff is entitled to an award of attorney fees under MCL 500.3148(1).
dispute but that both of her feet were “planted firmly on the ground.” Therefore, the Court of Appeals affirmed the jury’s verdict that Plaintiff was entitled to recover no-fault benefits.

However, in a 2-1 decision the Court of Appeals reversed the decision of the trial court, which had denied a claim for No Fault penalty attorney fees, and held that Plaintiff was entitled to no-fault penalty attorney fees, under MCL 500.3148(1), due to the defendant’s “halfhearted and shoddy investigation.” The Court of Appeals majority did note that “when reasonable and reliable investigatory methods and practices are employed, a reasonable decision to deny benefits because of a legitimate question of factual uncertainty can exist.” However, due to certain issues with the investigation that was carried out by the insurer, the Court of Appeals ruled that no-fault penalty attorney fees were appropriate under the circumstances.

Court of Appeals Decisions

No-Fault Attorney Fees Not Compensable Where No-Fault Insurer and ERISA Health Benefit Plan Voluntarily Resolve Their Differences


When Defendant insurer denied Plaintiff’s claim for underinsured motorist benefits, Plaintiff filed suit. When the matter was eventually tried, the court admitted two key pieces of evidence in support of Plaintiff’s claim that her injuries constituted a “serious impairment of body function.” First, the court admitted evidence that the no-fault insurer had paid for her “extensive medical treatment.” The trial court then admitted evidence that the insurer had consented to the settlement of the underlying tort claim, for the amount of the tortfeasor’s policy limits. The lower court then granted directed verdict in favor of Plaintiff on the issue of serious impairment of body function.

On appeal, the Court of Appeals reversed each of these rulings. First, the Court of Appeals determined that, “the identity of the payor of those [medical] benefits is not relevant to any proper purpose.” Therefore, although plaintiff could explain why she discontinued her medical treatments, plaintiff was not entitled to produce evidence that it was the defendant who had been paying for those medical expenses.

The Court of Appeals reversed on the basis that there were simply no benefits that were overdue at the time Plaintiff filed her lawsuit against Encompass. Therefore, because no benefits were “overdue,” there was no basis for an award of attorney fees.

Evidence of Defendant’s Payment of Medical Bills Inadmissible on Serious Impairment Issue.

Evidence of Defendant’s Settlement of Underlying Claim Inadmissible.


Plaintiff was involved in a serious motor vehicle accident in 2006. His medical expenses were initially paid by an employer-funded ERISA Plan, through his mother’s employer. His mother had a policy of no-fault insurance through Encompass, which provided for coordination of benefits. One year post accident, the ERISA Plan sued Encompass in federal court for reimbursement of the funds that it had paid to or on behalf of the injured party. Plaintiff likewise filed a complaint against the employer-funded ERISA Plan and Encompass in state court. The federal lawsuit between the ERISA Plan and Encompass was settled voluntarily, with Encompass agreeing to assume payment of the injured party’s benefits on a primary basis. However, Plaintiff refused to dismiss the state court action, prompting Encompass to file a motion for summary disposition. Even though Plaintiff had not been asked by any of her son’s medical providers, to pay a medical bill, and even though she had not actually paid a medical bill, the circuit court nonetheless found that the insurer was responsible for paying attorney fees to plaintiff’s counsel, because it did not immediately commence payment of medical expenses on a primary basis, but instead waited until the federal court lawsuit between it and the ERISA Plan was resolved.

The Court of Appeals reversed the basis that there were simply no benefits that were overdue at the time Plaintiff filed her lawsuit against Encompass. Therefore, because no benefits were “overdue,” there was no basis for an award of attorney fees.
UIM Carrier Not Bound By Amount Of Over-Limits Judgment

Dawson v Farm Bureau, ___ Mich App __, ___ NW 2d ___
(Docket Number 296790, released 8/16/2011)

Plaintiff was injured in a motor vehicle accident with a Defendant who only had minimal policy limits of $20,000.00. Plaintiff was also insured under a no-fault policy with Farm Bureau, which provided for underinsured motorist (UIM) coverage. When Farm Bureau denied the claim for benefits, Plaintiff filed suit against both the underinsured motorist and Farm Bureau. Farm Bureau was dismissed from the suit prior to the hearing on its motion for summary disposition, on the basis that Farm Bureau could not be sued until Plaintiff had exhausted all other available judgments or settlements. The matter proceeded to trial against the underinsured motorist, which lasted only 29 minutes. The underinsured motorist did not challenge negligence, and did not dispute that Plaintiff had suffered a serious impairment of an important body function. After stipulating to damages in the amount of $100,000.00, the trial court entered judgment in that amount in favor of Plaintiff.

Plaintiff then filed suit against Farm Bureau, and argued that Farm Bureau was bound by the judgment that had been rendered in the action against the tortfeasor. The trial court granted summary disposition in favor of Plaintiff.

On appeal, the Court of Appeals reversed the decision of the lower court and noted that Farm Bureau still had the right to litigate issues of liability and damages. In short, it was not bound by the judgment entered against the underinsured tortfeasor. Therefore, the lower court erred when it ignored the clear and unambiguous language, in the Farm Bureau policy, to the extent that Farm Bureau "will not be bound by any judgments for damages or settlements made without [Farm Bureau's] written consent."

It is important to note that the Court of Appeals did not say that Plaintiff's claim was absolutely barred. Rather, the Court of Appeals simply ruled that Farm Bureau was free to relitigate the issues of negligence and damages, if it so chose.

Court Strikes Reducing Clause in $20,000 UIM Insurance Contract

Ile v Foremost Ins. Co., ___ Mich App __, ___ NW 2d ___
(Docket Number 295685, Published Decision Rel'd 7/14/2011)

Plaintiff's decedent was killed after striking a parked vehicle while riding a motorcycle. The parked vehicle was insured with policy limits of $20,000.00, which were paid by the vehicle's insurer. Plaintiff then attempted to collect an additional $20,000.00 in underinsured motorist coverage from his motorcycle insurance carrier, Foremost Insurance Company. Foremost had bundled the uninsured and underinsured motorist coverages together, and had charged a $26.00 premium for both coverages. Both the lower court and Court of Appeals determined that the $20,000.00 underinsured motorist coverage was "illusory," because, according to the court, under no circumstances could such coverage be triggered, since Michigan law requires motorists to carry at least $20,000.00 in residual bodily injury liability coverage pursuant to MCL 500.3009. Relying on case law from outside the State of Michigan, the Court of Appeals determined that because the contract was "illusory," an exception existed to the general abolition of the "reasonable expectation of the insured" doctrine by the Michigan Supreme Court. Accordingly, the Court of Appeals struck the "reducing clause," found in the UIM portion of the insurance contract, which provided:

"The limit of liability shall be reduced by all sums paid because of the 'bodily injury' by or on behalf of persons or organizations who may be legally responsible."

As a result, the Court of Appeals allowed Plaintiff to recover $20,000 in underinsured motorist coverage, on top of the $20,000 previously received from the insurer of the parked vehicle.

Fractured Left Hip Suffered While Twisting to Exit a Motor Vehicle Compensable Under No-Fault


Plaintiff had undergone treatment for a bone infection in her lower leg and rendered her non-weight bearing for 4-5 months. Approximately 2 months after becoming weight bearing, Plaintiff was twisting out of her seat to exit a pick up truck when she felt a snap and experienced pain in her left hip. After she sought no-fault benefits, her insurer denied the claim, arguing that her injury did not arise out of the use of a motor vehicle as a motor vehicle. The lower court granted summary disposition in favor of plaintiff, but denied her claim for attorney fees, finding that there was a legitimate question of statutory construction. Defendant appealed the trial court's determination of coverage, and plaintiff cross-appealed the issue of the denial of her attorney fees.

On Appeal, the Court of Appeals affirmed the lower court's decision on both issues. With regard to the coverage issue, the Court of Appeals noted that in order to fulfill the "transportational function" of a motor vehicle, under McKenzie v ACIA, 458 Mich 214, 580 NW 2d 424 (1998), "it was essential that passengers [be] able to both enter and exit the vehicle." Because Plaintiff's injuries arose while exiting a parked vehicle, her injury did arise from the use of the parked vehicle "as a motor vehicle." With regard to the attorney fee issue, the Court of Appeals simply noted that due to the "unique set of facts" in this case, the lower court did not abuse its discretion when it denied Plaintiff's request for attorney fees.

continued on next page
Court of Appeals Reverses Denial of Work Loss Benefits, Despite the Lack of Any Direct Evidence Linking Injuries to Inability to Work


Plaintiff suffered second-degree burns to her right arm and a first-degree burn to her back when hot radiator fluid spewed onto her from a nearby vehicle. She filed a claim for no-fault benefits with Dairyland Insurance Company, seeking to recover payment for 10 days of lost work. Defendant filed a motion for summary disposition on the work loss issue, but attached documentation that described the burn and the treatment Plaintiff received, her work record that confirmed that she missed work for 10 days following the incident, and excerpts from her deposition testimony, in which she stated that she could not work for 10 days due to the pain from the burn, and the need to change her dressings. Nonetheless, the lower court granted summary disposition in favor of the no-fault insurer. On appeal, the Court of Appeals reversed in a 2-1 decision. The majority opinion noted that defendant had failed to present any evidence that would refute Plaintiff’s wage loss claim. In fact, defendant had actually submitted evidence in support of this work loss claim.

As an aside, it appears that Plaintiff was injured while the owner of the vehicle was in the process of maintaining it. This writer questions whether maintenance injuries are compensable under no-fault, where the injury does not fit within any of the three statutory exceptions to the Parked Vehicle Exclusion. See Willer v Titan Ins. Co., 480 Mich 1177, 747 NW 2d 245 (2008) (Markman, J. concurring and calling into question the analysis employed by the Michigan Supreme Court in Miller v Auto Owners, 411 Mich 633, 309 NW 2d 544 (1981)).

Dependents of the Owner of an Uninsured Motor Vehicle Are Entitled to Recover Excess Survivor Loss Benefits

Jago v Dept. of State Police, (Docket Number 297880, Unpublished Decision rel’d 8/2/2011)

Plaintiff’s decedent was killed in an automobile accident with a state police vehicle, while driving an uninsured motor vehicle that he owned. Plaintiff filed suit against the Department of State Police, seeking to recover damages due to the negligent vehicular operation by the state trooper. The lower court ruled that dependents of the deceased were barred from recovering survivor’s loss benefits for the three-year period immediately following the accident, based upon the statutory exclusion found at MCL 500.3113(b). However, the trial court did find that Plaintiff was entitled to recover excess survivor’s loss benefits, beyond the three-year period set forth in MCL 500.3108, from the Department of State Police. On appeal the Court of Appeals affirmed both holdings. The court held that survivor’s loss benefits were a form of economic loss, which were not precluded by either the statutory bar for first party benefits or the bar on non-economic damages. Simply put, excess economic damages are still available to a person who was injured while driving his or her own, uninsured motor vehicle.

Court of Appeals Applies Policy Provision to Bar Claim for UM Benefits

Owens v Auto Owners, (Docket Number 297590, Unpublished Decision rel’d 8/11/2011)

In Owens, Plaintiff was standing outside of a pub when he was struck by an uninsured motor vehicle. At the time of the accident, Plaintiff lived with his mother, who had a no-fault policy with Auto Owners Insurance Company. Auto Owners denied the claim for uninsured motorist benefits, based upon a policy provision which extended uninsured motorist coverage to a resident relative only if that person did not own a motor vehicle. Because Plaintiff owned a 1995 Buick Riviera, which was used for parts, Auto Owners denied the claim. Both the trial court and Court of Appeals ruled that Plaintiff was barred from recovering uninsured motorist benefits.

Endnotes

1 Krohn, slip opinion at page 2.
2 MCL 500.3106(1)(b)
3 MCL 500.3106(1)(c)
4 MCL 500.3106(1).
5 MCL 500.3113(b).
6 MCL 500.3135(3)(c).
Sixth Circuit Update

Cost Transfer Subsidy Fees, Breaches of Fiduciary Duty and Class Actions

Pipefitters Local 636 Insurance Fund v. Blue Cross Blue Shield of Michigan, Case no. 09-2607, __ F.3d __, 2011 U.S. App. LEXIS 16624 (6th Cir. August 12, 2011)1

The series of opinions in this multi-layered action runs the gamut from defining an ERISA fiduciary to an applying the recent Supreme Court's analysis of class certification.

In connection with administration of its customers’ self-insured health plans, the defendant collected a “cost transfer subsidy fee.” This fee is designed to help defray the cost of coverage for certain individuals that the defendant insures. The plaintiff, a multi-employer benefits fund, asserted that collecting a “cost transfer subsidy fee” was a breach of the defendant’s fiduciary duty and a violation of state law. Other similar cases have been filed in several state and federal courts.

In a prior ruling, the Sixth Circuit explained that an ERISA fiduciary was defined by the exercise of discretionary authority or control respecting management or disposition of plan assets, and denied the defendant’s motion to dismiss. In 2008, the plaintiff moved for certification of a class action to include similarly situated self-insured group plans which contracted with the defendant pursuant to an administrative services contract and were assessed the fee.

After the magistrate judge rejected certification, both parties filed objections and cross motions for summary judgment. In response, the district court held that the defendant was acting as a fiduciary when it assessed the fee, that the defendant breached its fiduciary duty because assessment of the fee was contrary to Michigan law, and denied summary judgment on the Fund’s claim that the defendant failed to disclose the assessment.

In the latest opinion rendered in this lengthy dispute, involving appeal of the class certification ruling, the Sixth Circuit found that, despite some commonality, the issues to be considered required individualized attention, applying the reasoning of the Supreme Court’s recent opinion in Wal-Mart Stores, Inc v Dukes, 131 S. Ct. 2541 (2011). Due to the fact that specific inquiry necessary to determine whether the defendant was acting in a fiduciary capacity with each potential self-funded group plan, the court would be required to examine the terms and funding arrangements of the contract for each customer.

Further, because the fee collected was used to subsidize insurance coverage for senior citizens, the court found that the public’s interest would be better served by individual suits. Finally, the amount of damages sought was significant enough not to preclude individual class members from seeking relief. For these reasons, the court found that the plaintiff failed to satisfy the superiority element of Rule 23(b)(3).

The court additionally considered whether class certification was appropriate under Rule 23(b)(1)(A) and found that a trial court could find that the defendant owed a fiduciary duty to one client but not another. As a result, prosecuting separate actions would not impair the defendant’s ability to pursue a uniform course of conduct and did not present a risk of inconsistent adjudication.

United States District Court Update

Actions after Distribution of Plan Benefits Not Preempted or Removable.


The payment of employee benefits after a divorce continues to be litigated. In a typical situation, an employee has named his spouse as beneficiary under his employer’s life or retirement plan; later they divorce. The divorce decree explicitly states — as provided by Michigan law — that it extinguishes each party’s right to benefits from the former spouse’s benefit plans and directs each to change the beneficiary designations on their own benefit plans. Of course, the employee never gets around to changing the designation. He then dies and the ex-wife (as well as the estate, maybe a new wife, and others) claim the benefits.

The law is now clear that ERISA preempts the terms of the divorce decree (unless it is a Qualified Domestic Relations Order) and Michigan law; therefore, the plan must pay the benefits to the person named as the beneficiary in the plan’s records, i.e., the former spouse. The question then becomes, what can the other claimants do about this?

In our last issue, we reported on Estate of Reed v Reed, in which the Michigan Court of Appeals recognized that even though the plan properly paid the proceeds to the ex-spouse, the estate of the dead employee could sue the ex-spouse to recover those benefits pursuant to the terms of the divorce
decree. That is what happened in this case. The plan paid the benefits to the ex-wife; the Personal Representative of the estate filed suit to recover the benefits from the ex-wife, based on the divorce decree. The ex-wife removed to federal court and the Personal Representative moved to remand.

Generally, a case filed in state court cannot be removed to federal court unless there is diversity or the complaint -- as written -- raises a federal cause of action. A federal defense to a state cause of action (e.g., preemption) generally does not permit removal. However, there is an exception in the case of ERISA: if the state action is preempted and if there is a cause of action under ERISA 502(a)(1)(B) (a claim for plan benefits), then it may be removed. This is the distinction between “preemption” and “complete preemption.”

In this case, the court held that this case did not involve a claim for plan benefits, since the benefits had already been paid and the plan was not a party to the action. Thus, the action did not arise under ERISA 502(a)(1)(B) and was not properly removed.

The personal representative also sought costs and attorney fees for the improper removal. The court declined, holding the removal was objectively reasonable although incorrect.

Note: although the Sixth Circuit limits complete preemption to cases involving a claim for plan benefits, other circuits include any action arising under ERISA (i.e., including fiduciary breach claims).

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Endnotes

1 One of the co-authors’ firm represented the defendant in this matter.