

The *Journal of*
Insurance & Indemnity Law

A QUARTERLY PUBLICATION OF THE STATE BAR OF MICHIGAN'S INSURANCE AND INDEMNITY LAW SECTION

October 2012

From the Chair

Volume 5 Number 4

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

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 section council or the membership.



Elaine Murphy Pohl

Benefitting the Section and You

It is with great pleasure that I write this as the new Chair of the Insurance and Indemnity Law Section of the State Bar. I am excited for the opportunity to continue the great work of my predecessors, work with my fellow council members, and get to know many of you over the next two years.

In our Section, unlike most of the other sections, the officers serve for two years, rather than one. This allows for more continuity of leadership and planning. Our outgoing chair, Mark Cooper, put his term to good use by developing a Five-Year Strategic Plan to expand the Section's services and scope of activities and create a clear blueprint of where we are headed. Under our bylaws, Mark will continue to serve on the Section Council as immediate past chair. On behalf of our entire Section, thank you Mark for all of your efforts.

As we move forward, I want to reiterate that our Section embraces all aspects of insurance and indemnity law and all perspectives. Some of our members represent primarily insurers and some represent primarily insureds, but the Section itself never takes a position for one side or the other. I hope to continue this tradition of unbiased service.

Our Section's unique orientation plays a large part in defining our activities as we move forward. Because insurance and indemnity law touch so many other areas of practice, we want to expand our outreach to other sections to work on presenting joint programs with them, or providing speakers for their programs.

In connection with this outreach, there are things that each of you can do to benefit the Section – and benefit yourself as well.

- Serve as a liaison to another section. If you are a member of another section that you think can benefit from working with our Section on a project or a program, let them know we are available and looking for ways to work together, and then work with that section and ours to develop the program or complete the project. This is a good opportunity for the Section and good networking for you.
- Contribute to our *Journal*. Our Section is neutral as between insureds and insurers, and most of our *Journal* consists of reports on developments in the law of insurance and indemnity. The *Journal* itself never takes a position, but authors are free to express their views, and the more viewpoints the *Journal* can express, the better it will be. If you think that a particular statute or court decision is an exemplar of fine reasoning or an abomination of excess, this is the place to express your view.

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From the Chair Continued from page 1

Or if you just want to explain some particularly arcane or subtle point of law or practice – and our area has a lot of those – the *Journal* is the place to share your expertise with your colleagues. Remember, the *Journal* goes to all the judges and to the legislators who are attorneys, so your article will reach decisionmakers. Contributing to the *Journal* benefits the *Journal* and the Section, of course, but it also benefits you as the author by spreading the word about your expertise. Plus, you will have the pleasure of working with our fearless editor and our Section's first Chair, Hal Carroll.

- Join a committee. We have four committees and we would be happy to have additional volunteers to serve on any of them. Our committees are: Programs, Membership, Publications, and Strategic Planning. Please

feel free to contact me or any other council member for more information on how to get involved. Joining a committee not only obviously benefits the Section but also provides you with an opportunity to work closely with other members of the Section on specific tasks and demonstrate your skills.

- Send us your questions. Some join our Section because they are experts, but many join because they aren't and want to learn. The basic purpose of our Section is to serve as a source of information, not advocacy, so if you have a topic you think we should address – in a program or in the *Journal* – send it along. We are open to new ideas and suggestions.

Our Section provides a range of opportunities for the member who wants to develop his or her practice. I look forward to working with you and serving as your Chair. ■

Editor's Note



By Hal O. Carroll, www.HalOCarrollEsq.com

The *Journal* is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. All opinions expressed in contributions to the *Journal* are those of the author. The Section itself takes no position on issues.

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

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Report of the Annual Meeting Program



The Panel: Doug Young, Judith Simonson, Chris Jelinek and Elaine Pohl

The title of this year's program was *"Insurance Coverage Conflicts and the Role of Independent Defense Counsel."* The program was presented as a panel discussion, with questions and comments from the floor.

The panelists reflected all aspects of the issue of coverage conflicts.

- Douglas Young, of Wilson Young PLC, represents policyholders in coverage disputes.
- Judith K. Simonson is in-house counsel for Hanover Professionals (Professionals Direct Insurance Company), and
- Christopher P. Jelinek of Garan Lucow Miller, PC serves as defense counsel retained by insurers to represent policyholders.

To provide our members with a brief summary of the topics that were discussed and the points of view that were expressed, we asked the panelists to provide brief responses to a few questions that were discussed in the program.

1. What is insurer-assigned counsel's role, with respect to the insured client, in terms of explaining the reservation of rights letter.

Doug Young: I believe that the insurer-assigned(paid) counsel must explain the full context of the assignment. This explanation must include a discussion of the insurer's ROR letter. MRPC 1.7 and 5.4 (c) make clear that the insured is the only client of the attorney in this tri-partite relationship. The ROR is central to the discussion because it often indicates areas of factual or legal concern or exclusions to coverage that may be implicated. These topics must be addressed with the client.

Judy Simonson: I don't have a problem if assigned defense counsel goes over the ROR with the insured/client but I don't think counsel should offer an opinion one way or the other about its merits. I think counsel

should inform the client of the damage exposure and be sure the client understands if it exceeds the limit of coverage. If the client has a question about the ROR, I think it is a good idea for counsel to inform the client to contact the insurance company representative for clarification.

2. How should an insurer-assigned counsel and a claims professional manage their communications so that counsel will not run afoul of MRPC 5.4(C), which says:

(C) A lawyer shall not permit a person who recommends, employs or pays the lawyer to render legal services for another to direct or regulate the lawyer's professional judgment in rendering such legal services.

Judy Simonson: The insurance contract says that the insurance company has the sole right to direct the litigation and the consideration for this is the fact that the insurance company pays both defense counsel and any settlement or judgment. Defense counsel should be clear in communications to the insurance company regarding his or her representation of the client, including what counsel needs to do and why. Any problem should be discussed. Defense counsel should be careful not to put the insured/client in the position of having breached the insurance contract by not disclosing material information regarding the case to the insurance company.

Doug Young: All communications must be to the claims adjuster and client. The only exception to this would be communications solely to the client on issues that may affect insurance coverage. Insurer-assigned (paid)

continued on the next page

Report of the Annual Meeting Program

Continued from page 3

should not telephone the insurance adjuster and discuss any sensitive areas of the case.

3. If only one count in a complaint is covered, can insurer-assigned counsel file an MSD that risks killing the client's coverage? Does it matter if the MSD is on all counts?

Judy Simonson: I would not and have not instructed defense counsel to file an MSD on only the covered count(s) unless I have obtained the insured/client's permission and/or agreed to continue to pay defense costs if the MSD is granted. The problem is, obviously, if the covered count has no merit, a judgment should not be allowed to enter on it. I have no problem with an MSD on all counts. To do otherwise it to leave the insured/client exposed for a judgment that can be avoided. Also, it may necessary to file an MSD to create an appealable issue. The issues involved have to be thoroughly explored with the insured and the insured's personal counsel.

Doug Young: The insurer-assigned(paid) counsel must explain to his client the ramifications of such a motion, i.e., that the client may be solely responsible for defense costs and indemnity if the sole covered count is dismissed. This count should not be dismissed absent an agreement with the insurer to continue the defense regardless of the outcome of the motion.

4. If insurer-assigned counsel takes a deposition that reveals coverage-defeating information, should the deposition summary (in writing or potentially by phone) omit that information? Why or why not?

Judy Simonson: The issue I have here is the same as mentioned in the response to #2 above. The insurance contract states that the insurance company has the sole right to direct the litigation and there is a clause in the policy that requires an insured to cooperate with the insurance company. To fail to disclose material information regarding the litigation that ends up being disclosed to the insurance company by some other means (especially if this happens after a settlement or verdict) could result in a lawsuit for breach of contract by the insurance company against the insured.

It is hard to imagine how the coverage-defeating information could be hidden from the insurance company. For example, what if it is mentioned in another party's motion or case evaluation summary? I think that defense counsel should inform the insured/client that the information may have an impact on the coverage issue and encourage the client to consult with his or her personal attorney. Ultimately, it has to be disclosed to the insurance company (without comment as to the coverage implications) because it is evidence in the case.

Doug Young: The insurer-assigned (paid) counsel must not advise the insurer of coverage defeating information. The insurer will be able to request a copy of the



Christopher P. Jelinek, *Garan Lucow Miller, PC*



Judith K. Simonson, *Hanover Professionals
Professionals Direct Ins. Co.)*



Douglas Young, *Wilson Young, PC*

deposition transcript and learn this information without the attorney harming his client's interests.

5. If a case is tried and includes both covered and uncovered counts, what is the best practice that insurer-assigned defense counsel should follow when drafting a verdict form?

Judy Simonson: I do not think that defense counsel should request that the verdict form break down the damages so as to differentiate between covered or uncovered counts, unless the insured/client agrees to do so because it is somehow helpful to the insured/client's case. . The coverage issues facing one party in a lawsuit don't control the actions of the other party(ies), so if another party requests such a verdict form, the insurance company representative should discuss the implications with the insured/client.

Doug Young: The insurer-assigned (paid) counsel must act in the best interest of his client and draft a general verdict form.

6. Can coverage issues be used effectively in settlement negotiations and, if so, how?

Judy Simonson: All the time. It is not uncommon to argue that, even if the plaintiff establishes liability and damages, the insurance company has no (or only some) coverage and won't pay the judgment. Sometimes this argument is stronger is a complaint for declaratory judgment has already been filed. Sometimes just the threat of a dec action is enough to make the parties (including the insured) more reasonable about settlement. The strategy to be employed in each case has to be evaluated by the insurance company but a valid coverage issue should not be ignored in settlement negotiations.

Doug Young: Coverage issues can be useful in settling the underlying case. Often at facilitation, both the coverage case parties/attorneys and the underlying case parties/attorneys are present. The knowledge that the insurance coverage available to settle the underlying case is in jeopardy will encourage a more reasonable underlying settlement amount. Coverage counsel for the insured can assist in advising the underlying plaintiff that without insurance funds they will not have a viable recovery. In such cases, the insured, insurer, insurer-assigned(paid) counsel and the insured's coverage counsel are all aligned. However, the insured's coverage counsel also needs to make clear that despite this "united front," the insured will not be contributing any of its funds to the settlement and that the carrier must settle the entire case - if a reasonable opportunity is presented to do so. ■



Mark Cooper presents the gavel to incoming Chair Elaine Murphy Pohl

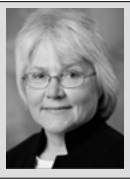


Elaine Murphy Pohl presents the plaque to Mark Cooper in recognition of two years' service as chair



Elaine Murphy Pohl (Chair), Larry Bennett (Treasurer), and Kathleen Lopilato (Chair-Elect)

Indemnity Law Case Note



Seeking Fees in Indemnity Cases

By Noreen L. Slank
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Michigan follows the “American Rule” when it comes to recovery of attorney fees. That basically means you don’t get them awarded “unless a statute, court rule or common law exception provides [to] the contrary.” *Nemeth v Abonmarche Development*, 457 Mich 16, 37-38 (1998) and *Dessart v Burak*, 470 Mich 37, 42 (2004). Statutes and court rules allowing attorney fees are easy to find and many of the main ones are easily called to mind. Case evaluation sanctions. Sanctions for frivolous filings. Statutes that award attorney fees to prevailing parties under certain conditions, such as Michigan’s “first party” system of No-Fault benefits. Civil rights claims.

The common law exceptions are where we find the roots of why an indemnity plaintiff can secure attorney fees. In contractual indemnity cases, of course, the right to recover attorney fees is a creature of contract as well. But we are so often immersed in the “nuts and bolts” that we don’t often need to stop to think about the common law “roots.” *State Farm v Allen*, 50 Mich App 71, 78-79 (1973), a coverage declaratory judgment action arising out of an underlying auto accident, is a significant case. Quoting from *McCormick on Damages*, the panel explained that where a defendant “by his wrongful conduct, be it tort or breach of contract, caused the present plaintiff to defend or prosecute previous legal proceedings, the law reverses its restrictive attitude and allows a plaintiff to recover all the expenses, including counsel fees, reasonably incurred by him in the prior litigation.”

There are two buckets of attorney fees to think about: (1) those incurred defending the underlying or principal case, and (2) those incurred prosecuting the indemnity case. An indemnity defendant will owe the first category of fees but not the second, and many cases say so.

The panel in *Warren v McLouth Steel Corp*, 111 Mich App 496 (1981) applied the *State Farm v Allen* rationale to allow a common law indemnity plaintiff to recover its attorneys fees incurred defending the principal litigation. This was the result even though the personal injury case and the common law indemnity case proceeded at the same time. The right to recovery of fees under the exception doesn’t hinge upon “the technical distinction between ‘prior’ litigation and ‘present’

litigation.” *Warren* at 509. *Hartman v Century Truss Co*, 132 Mich App 661 (1984) agrees with *Warren*. This common law exception “is broad enough to encompass the factual situation where a passive tortfeasor has been forced to defend against the claims of a plaintiff because of the injuries caused by the active tortfeasor.” *Warren* at 508.

Evidentiary hearings are allowed but annoy the daylights out of everyone (trial judges included). Prudent counsel will identify the legal issues that a trial judge must decide, perhaps what constitutes a reasonable hourly rate or whether particular categories of activities are compensable, and work out the rest.

Recovery of attorney fees is often the point in contractual indemnity lawsuits and such a recovery will almost always be part of the point. If one party agrees to defend and indemnify another for the circumstances that exist in some underlying or principal lawsuit, attorney fees are owed based on pure breach of contract or common law principles rooted in cases like *State Farm v Allen*. But there are two buckets of attorney fees to think about: (1) those incurred defending the underlying or principal case, and (2) those incurred prosecuting the indemnity case. An indemnity defendant will owe the first category of fees but not the second, and many cases say so.

State Farm at 78 applied the rule to a common law indemnity case: “for the expenses incurred in the present [indemnity] litigation...our law generally gives the successful party no recompense beyond the taxable costs which ordinarily include only a portion of his expense.” *Hartman v Century Truss* also accepted that the American Rule governs as to the fees incurred litigating the common law indemnity case.

Many cases apply the same apportionment of fees rule in the context of contractual indemnity litigation. See *Hayes v General Motors*, 106 Mich App 188, 201 (1981) (the indemnity plaintiff “should recover the attorney fees incurred in defending against the plaintiff’s principal action and not any attorney fees incurred in the indemnity action”), *Harbinski v Upper Peninsula Power*, 118 Mich App 440, 446 (1982) (remanding the case back to the trial court to apportion the fees between the injury and the indemnity case and award only the injury case fees), and *Redfern v R.E. Dailey & Co*, 146

Mich App 8, 20, 22 (1985) (the indemnitee may recover his “necessary defensive fees” and the reasonableness of those fees is relevant).

When the indemnity case and the principal case are pending at the same time, it is no easy task to apportion the fees between the two. If a defense attorney prepares for and attends the injured plaintiff’s deposition, is that time spent in defense of the principal case or in prosecution of the indemnity case? When the cases are tried together and clearly the preoccupation is to defeat the injured plaintiff’s case rather than build the indemnity case, how are such attorney fees to be apportioned? Case law will not help answer such questions. Evidentiary hearings are allowed but annoy the daylighters out of everyone

(trial judges included). Prudent counsel will identify the legal issues that a trial judge must decide, perhaps what constitutes a reasonable hourly rate or whether particular categories of activities are compensable, and work out the rest.

Before chiseling in stone the rule that the costs of successfully litigating the indemnity case are unrecoverable, be sure to examine the parties’ contract to see if it contains any “loser pays” term. Contract provisions requiring payment of attorney fees are judicially enforceable. *Central Transport v Fruehauf Corp*, 139 Mich App 536, 548 (1984), *Zeeland Farm Service v JBL Enterprises*, 219 Mich App 190, 195 (1996), *Fleet Business Credit v Krapohl Ford Mercury*, 274 Mich App 584, 589 (2007). ■

No-Fault Corner



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Supreme Court Action

As expected, the Michigan Supreme Court released a number of significant decisions impacting no-fault jurisprudence in this state at the end of the Court’s term on July 31, 2012. In its various rulings, the Supreme Court has abrogated the judicially created “Family Joyriding Exception” to the “unlawful taking” exclusion set forth in MCL 500.3113(1), limited the recovery of excess economic damages compensable in a tort action under MCL 500.3135(3)(c) to work loss benefits and survivor’s loss benefits, only, and affirmed a no-fault insurer’s ability to insist on timely notice of a claim for uninsured/underinsured motorist benefits, without requiring a showing, by the insurer, that it was prejudiced by the claimant’s failure to give the required timely notice. The Supreme Court also reaffirmed its earlier holding in *Keyes v Pace*, 358 Mich 74, 99 NW 2d 547 (1959), to the effect that an insurer is under no obligation to verify the representations made in an Application for Insurance.

In addition, the Court of Appeals has also issued its first published decision regarding a no-fault insurer’s ability to recover defense attorney fees, under MCL 500.3148(2). The Court of Appeals also issued a significant opinion interpreting the “unlawful taking” exclusion in MCL 500.3113(a), following the Supreme Court’s recent decisions interpreting that provision. What follows is a recap of these significant appellate court decisions, which will undoubtedly have a significant impact on no-fault jurisprudence in the years to come.

Court Overrules *Priesman v Meridian Mutual Ins Co*, 441 Mich 60, 490 NW 2d 314 (1992) and Abrogates the Judicially Created “Family Joyriding Exception” to the Unlawful Taking Exclusion

On July 31, 2012, the Michigan Supreme Court released its long-awaited decisions in *Spectrum Health Hosp. v Farm Bureau*, docket number 142874 and *Progressive Marathon Ins. Co. v DeYoung*, docket number 143330, regarding the scope of the “unlawful taking” exclusion found at MCL 500.3113(a). This statutory provision states:

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

- (a) The person was using a motor vehicle or motorcycle which he or she had taken unlawfully, unless the person reasonably believed that he or she was entitled to take and use the vehicle.”

In 1993, Justice Levin authored a plurality opinion in *Priesman v Meridian Mutual Ins. Co.*, 441 Mich 60, 490 NW 2d 314 (1992), in which he opined that a minor who had been using his parents’ automobile without permission was nonetheless entitled to recover no-fault benefits, even though there was no dispute that he was operating the vehicle in violation of the joyriding statutes found in the Michigan Penal Code, MCL 750.413 and MCL 750.414. This holding was

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followed by subsequent Court of Appeals' decisions in *Butterworth Hosp v Farm Bureau*, 225 Mich App 244, 570 NW 2d 304 (1997) (applying the "family joyriding exception" to adult family members), *Mester v State Farm*, 235 Mich App 84, 596 NW 2d 205 (1999) (refusing to extend the "joyriding exception" beyond family members), *Allen v State Farm*, 268 Mich 342, 708 NW 2d 131 (2005) (refusing to extend the "joyriding exception" to co-habiting adults) and *Roberts v Titan Ins Co*, 282 Mich App 339, 764 NW 2d 304 (2009). For years, the commentators have criticized Justice Levin's opinion in *Priesman*, as being in derogation of the clear and unambiguous statutory text found in MCL 500.3113(a).

In a 4-3 opinion authored by Justice Zahra, the Michigan Supreme Court has disavowed Justice Levin's plurality opinion in *Priesman* "because the family-joyriding exception has no basis in the language of MCL 500.3113(a)." *Spectrum Health, Slip Opinion at page 5*. Accordingly, the Supreme Court has overruled the above-cited Court of Appeals' decisions applying the "family joyriding exception" enunciated in Justice Levin's plurality opinion in *Priesman*.

In *Spectrum Health*, the owner of the vehicle had specifically forbidden his son to operate the vehicle, because he did not have a valid driver's license. However, he did give permission to his son's girlfriend to operate the vehicle, but the girlfriend was instructed that the son was not to drive the vehicle. The son and his girlfriend went out drinking one night and the girlfriend eventually gave the keys to the vehicle to the son. The son was then involved in a serious automobile accident, and received treatment at Spectrum Health Hospitals. In its opinion, the Michigan Supreme Court examined the joyriding statutes, MCL 750.413 and MCL 750.414, and noted:

"Thus, both joyriding statutes make it unlawful to take any motor vehicle without authority, effectively defining an unlawful taking of a vehicle as that which is unauthorized.

Because a taking does not have to be larcenous to be unlawful, the phrase 'taken unlawfully' in MCL 500.3113(a) applies to *anyone* who takes a vehicle without the authority of the owner, regardless of whether that person intended to steal it."

Because the son was obviously using the vehicle without authority of the owner (his father), the son and his medical provider were barred from recovering no-fault benefits.

In *Progressive*, one Ryan DeYoung took his wife's vehicle while intoxicated, contrary to her express prohibitions and without her permission. In fact, the wife had gone so far as to designate Ryan DeYoung as a named excluded driver on the

In a 4-3 opinion authored by Justice Zahra, the Michigan Supreme Court has disavowed Justice Levin's plurality opinion in *Priesman* "because the family-joyriding exception has no basis in the language of MCL 500.3113(a)."

Progressive policy. Shortly after taking the vehicle, Ryan DeYoung was involved in a serious motor vehicle accident and, as a result of his injuries, he incurred almost \$300,000.00 at Spectrum Health Hospitals and Mary Free Bed Rehabilitation Hospital. Again applying the joyriding statutes, found at MCL 750.413 and MCL 750.414, as well as Justice Levin's rationale for creating a "family joyriding exception" in *Priesman*, the Supreme Court determined that *Priesman* decision had no basis in the statutory text of MCL 500.3113(a). Accordingly, the Supreme Court held that DeYoung and his medical providers were barred from recovering no-fault benefits from Progressive. Finally, the Supreme Court majority indicated that its decisions were fully retroactive.

Justice Cavanagh, joined by Justices Marilyn Kelly and Hathaway, authored a dissent. In the dissent, Justice Cavanagh opined that *Priesman* was correctly decided, and that there was simply no basis for the majority to overrule it 22 years later.

The Supreme Court Limits Damages Compensable in Tort Actions

MCL 500.3135(3)(c) provides:

"Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101 was in effect is abolished except as to:

* * *

(c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110 in excess of the daily, monthly, and 3-year limitations contained in those sections."

In *Johnson v Recca*, docket number 143088, the Supreme Court considered whether Plaintiff could recover household replacement service expenses in excess of the \$20.00 per day and three-year limitation set forth in MCL 500.3107(1)(c) in a third party automobile negligence action. The Court of Appeals had earlier ruled that household replacement service expenses were simply a sub-species of "allowable expenses" described in MCL 500.3107(1)(a). Therefore, household

replacement service expenses in excess of those provided in MCL 500.3107(1)(c) were compensable in a tort action.

In a 4-3 Opinion, authored by Justice Markman, the Michigan Supreme Court reversed the Court of Appeals' decision and held that excess household replacement service expenses were not compensable in a third party tort action. In doing so, the Supreme Court majority examined the language of MCL 500.3107 as it existed prior to the 1992 amendments and noted that household replacement service expenses were not included within the definition of the term "allowable expenses" described in MCL 500.3107(a). Rather, they were originally included as part of the work loss provision, found at MCL 500.3107(b). As originally drafted, the work loss section provided:

"Work Loss consisting of loss of income from work an injured person would have performed during the first three years after the date of the accident if he or she had not been injured and *expenses not exceeding \$20.00 per day*, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first three years after the date of the accident, not for income, but for the benefit of himself or herself or of his or her dependents."

In 1992, the legislature moved the section pertaining to household replacement service expenses into its own subdivision, MCL 500.3107(1)(c). According to the Supreme Court majority, this suggested that the legislature never intended for household replacement service expenses to be a sub-species of allowable expenses. Rather, it was formerly considered within the scope of work loss benefits. Therefore, because excess replacement service expenses are not mentioned in MCL 500.3135(3)(c), they are simply not compensable in a third party tort claim.

Supreme Court Clarifies Criteria for Determining Compensability of Attendant Care Service Expenses under the No-Fault Act

In *Douglas v Allstate Ins Co*, docket number 143503, released 7/30/2012, the Michigan Supreme Court, in an opinion authored by Chief Justice Young, clarified the criteria necessary for a Plaintiff to prevail on a claim for attendant care service expenses. In *Douglas*, Plaintiff suffered catastrophic injuries as a result of a motor vehicle-bicycle accident occurring in 1996. Allstate Insurance Company was assigned to handle Plaintiff's claim for benefits by the Michigan Assigned Claims Facility. Following a bench trial, the circuit court awarded attendant care service benefits at the rate of \$40.00 per hour, which was the rate being charged by the agency, TheraSupport, which employed Plaintiff's wife at the rate of \$10.00 per hour to provide the services. On appeal, the Supreme Court

vacated the lower court's decisions and remanded the matter back for a new trial.

In doing so, the Supreme Court majority emphasized that Plaintiff bears the burden of showing that the attendant care service expenses were *actually incurred* by Plaintiff, before they can be considered compensable under the No-Fault Insurance Act. The Supreme Court also emphasized that an insurer can insist on adequate documentation to support the claims for attendant care service expenses:

"This evidentiary requirement is most easily satisfied when an insured or a caregiver submits itemized statements, bills, contracts, or logs listing the nature of services provided with sufficient detail for the insurer to determine whether they are compensable. Indeed, the best way of proving that a caregiver actually 'expected compensation for [her] services' at the time the services were rendered is for the caregiver to document the incurred charges contemporaneously with providing them – whether an informal bill or in another memorialized statement that logs with specificity the nature and amount of services rendered – and submit that documentation to the insurer within a reasonable amount of time after the services were rendered. While no statutory provisions *requires* that this method be used to establish entitlement to allowable expenses – a caregiver's testimony can allow a fact-finder to conclude that expenses have been incurred – a claimant's failure to request reimbursement for allowable expenses in a timely fashion runs the risk that the One-Year-Back Rule will limit the claimant's entitlement to benefits, as occurred here when Plaintiff commenced a lawsuit to recover allowable expenses that were alleged to have been incurred more than one year earlier. Moreover, once a claimant seeks payment from the insurer for providing ongoing services, the insurer can request regular statements logging the nature and amount of those expenses to ensure that the claimed services are compensable."

Douglas, Slip Opinion at pages 25-26.

The lower court was instructed to consider whether the proofs presented by Plaintiff complied with this criteria.

The Supreme Court majority then addressed the rate of compensation and ruled that "the fact finder's focus must be on an individual's compensation package – not the rate charged by an agency. As stated by the Supreme Court majority:

"Accordingly, we hold that a fact-finder may base the hourly rate for a family member's provision of attendant care services on what health care agencies

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compensate their employees, but what health care agencies charge their patients is too attenuated from the appropriate hourly rate for a family member's services to be controlling."

Douglas, Slip Opinion at page 31.

However, the Supreme Court majority cautioned that the fact finder should not only consider the actual wages received by the employee, but also the benefits that a full-time attendant care service employee will receive as part of her total compensation package. Although conceding that the case did not involve the admissibility of agency rates, the Michigan Supreme Court nonetheless held that the fact-finder, in *Douglas*, "clearly erred by adopting that rate as the appropriate hourly rate for Mrs. Douglas' provision of attendant care services. *Douglas*, Slip Opinion at pages 32, footnote 79. In short, the *Douglas* decision provides much needed guidance to claims for attendant care services.

Plaintiff's Failure to Comply with 30-Day Notice Provision in Insurance Contract Bars Claims for Uninsured Motorist Benefits; Insurer Not Required to Show Prejudice

In *DeFrain v State Farm*, 491 Mich 349, 817 NW 2d 504 (2012), the Michigan Supreme Court reaffirmed its earlier order in *Jackson v State Farm*, 472 Mich 942, 698 NW 2d 400 (2005), and the general holding in *Rory v Continental Ins Co*, 473 Mich 457, 703 NW 2d 23 (2005), and held that a no-fault insurer could rely on a 30-day notice provision, contained in the policy, to preclude a claim for uninsured motorist benefits arising out of a hit-and-run accident.

In *DeFrain*, Plaintiff William DeFrain was struck and seriously injured by a hit-and-run driver on May 31, 2008. The State Farm policy contained a provision requiring a Claimant seeking uninsured motorist benefits to report the accident "to the police within 24 hours and to [State Farm] within 30 days." DeFrain did not notify State Farm that he had been the victim of a hit-and-run accident until August 23, 2008, well after the 30-day notice period had lapsed. State Farm denied the claim on the basis that Plaintiff had failed to comply with the 30-day notice provision applicable to hit-and-run cases. Both the trial court and Court of Appeals denied State Farm's Motion for Summary Disposition, on the basis that State Farm had failed to show that it had been prejudiced by Plaintiff's failure to comply with the 30-day notice provision.

On appeal, the Michigan Supreme Court, in a 4-3 decision authored by Justice Zahra, concluded that the 30-day notice provision was enforceable as written, without a need for the insurer to demonstrate prejudice. In so ruling, the Supreme Court reaffirmed its earlier order in *Jackson*, which reversed

On appeal, the Michigan Supreme Court, in a 4-3 decision authored by Justice Zahra, concluded that the 30-day notice provision was enforceable as written, without a need for the insurer to demonstrate prejudice.

the decision of the Michigan Court of Appeals "for the reasons stated in the Court of Appeals' dissent." In addition, the Supreme Court distinguished its earlier decision in *Koski v Allstate Ins Co*, 456 Mich 439, 572 NW 2d 636 (1998) on the basis that the policy in *Koski* did not contain a specific time period for providing notice to the insurer. Recognizing that "there is an obvious distinction between a contract provision requiring notice "immediately" or "within a reasonable time," which are temporally imprecise terms, and one that requires notice "within 30 days," the Supreme Court held that the insurer is required to show prejudice only where the policy lacks a specific time period for providing notice. As a result, State Farm was entitled to enforce its 30-day notice provision without regard to whether or not it had been prejudiced by the Plaintiff's failure to comply with that notice provision.

Justice Cavanagh, joined by Justice Marilyn Kelly and Justice Hathaway, dissented from the majority's decision. Justice Cavanagh would have extended the prejudice requirement, enunciated by the Supreme Court in *Koski*, to all cases involving notice provisions contained in an insurance contract.

Supreme Court Rules that Insurer Has No Duty to Verify Representations Contained in an Insurance Application, Thereby Allowing Insurers to Reform Bodily Injury Policy Limits to \$20,000.00/\$40,000.00

In *Titan Ins. Co. v Hyten*, 491 Mich 547, 817 NW 2d 562 (2012), the Michigan Supreme Court, in an opinion authored by Justice Markman, reversed the published decision of the Michigan Court of Appeals and reaffirmed its earlier holding in *Keyes v Pace*, 358 Mich 74, 99 NW 2d 547 (1959), which held that an insurer was under no duty to verify the representations made in an Application for Insurance. In doing so, the Supreme Court specifically overruled the Court of Appeals' decision in *State Farm v Kurylowicz*, 67 Mich App 568, 242 NW 2d 530 (1976), in which the Court of Appeals acknowledged that it was not going to follow the 1959 Michigan Supreme Court decision in *Keys*. Rather, in *Kurylowicz*, the Court of Appeals announced that it would adopt the rationale of the California Supreme Court in *Barrera v State Farm*, 71 Cal 2d 659, 79 Cal Rptr 106, 456 P. 2d 674 (1969), and imposed a duty on an insurer to verify those representations, in an application for insurance, that are "reasonably discoverable

by the insurer.” In addition to overruling *Kurylowicz*, the Supreme Court overruled its progeny, including *Ohio Farmer Ins Co v Michigan Mutual*, 179 Mich App 355, 445 NW 2d 228 (1989), which imposed a duty on an insurer to verify those representations that were “easily ascertainable.” Simply put, the Supreme Court reaffirmed the holding in *Keys*, and determined that the insurer was entitled to reform its policy to provide only those coverages required by law in those situations where the insured makes a material misrepresentation in an Application for Insurance.

Justice Hathaway, joined by Justice Cavanagh and Justice Marilyn Kelly, dissented from the majority’s decision. Justice Hathaway concluded that the “easily ascertainable” rule was “consistent with this state’s policies,” and decried the fact that the Supreme Court majority had overruled 36 years of “thoughtfully analyzed and legally sound case law.”

Court of Appeals Action

Court of Appeals Permits Recovery of Defense Attorney Fees Under MCL 500.3148(2) Where Surveillance Showed that Attendant Care Services Being Claimed Were Not Being Performed.

In *Thomas v State Farm*, __ Mich __, __ NW 2d __ (2012) (Court of Appeals docket number 300288, rel’d 5/17/2012, app’d for publication 7/17/2012), the Michigan Court of Appeals issued its first *published decision* addressing an insurer’s right to recover defense attorney fees under MCL 500.3148(2). In *Thomas*, Plaintiff was injured as a result of a motor vehicle-pedestrian accident in 1997, when he was only 16 years old. State Farm paid attendant care service benefits at the rate of \$9.00 per hour, 24 hours per day, from April 2004 to July 22, 2008. No attendant care benefits were paid after that date, as State Farm accused the service providers of “misrepresentations in paperwork submitted to State Farm in regard to services supposedly provided.” At trial, Plaintiff sought an award of nearly \$800,000.00 in past due attendant care benefits and no-fault penalty interest. The amount of attendant care benefits requested by Plaintiff were based upon surveys of agency rates charged by home health care services. State Farm did not deny that Plaintiff suffered serious injuries as a result of the motor vehicle-pedestrian accident, and that the Plaintiff’s doctor had prescribed attendant care service 24 hours per day, 7 days per week. As stated by the Court of Appeals:

“The focus of the litigation was not on whether John had serious injuries necessitating attendant care service, than on whether Mr. and Mrs. Thomas were actually providing services as claimed, whether the care and services that were provided were adequate, and on whether the rate of pay for services was appropriate.”

In this regard, State Farm presented evidence that Mr. and Mrs. Thomas sought payment of attendant care service expenses during the time they were incarcerated and not watching him, while they were at a funeral and on a day when John was not at home. After the jury determined that no allowable expenses had been incurred by the Plaintiff, State Farm sought an award of no-fault defense attorney fees under MCL 500.3148(2). This request was denied by the trial court.

On appeal, the Court of Appeals vacated the lower court’s decision, and remanded the matter back to the lower court for a determination as to whether or not Plaintiff’s claims were in some respect fraudulent or without reasonable foundation. The trial court was specifically instructed not to focus on the actual injuries suffered by the Plaintiff, but rather on the proofs that were presented at trial, and the jury’s ultimate decision regarding those proofs.

The Court Holds that Person Who is not Involved in the “Unlawful Taking” of a Motorcycle is Entitled to Recover No-Fault Benefits.

In *Rambin v Allstate Ins Co*, __ Mich App __, __ NW 2d __ (2012) (docket number 305422, published decision rel’d 8/30/2012), the Court of Appeals held that an individual who was not involved in the “unlawful taking” of a motorcycle was entitled to recover no-fault benefits arising out of a motor vehicle-motorcycle accident. In *Rambin*, a motorcycle owned by Scott Hertzog was stolen on August 4, 2009. Eighteen days later, on August 22, 2009, one Andre Smith told plaintiff that he had an extra motorcycle at his home that Plaintiff could ride. Smith told Plaintiff that he owned the motorcycle and gave Plaintiff permission to use it. In fact, the motorcycle that Smith gave to Plaintiff was Hertzog’s stolen motorcycle. Plaintiff was involved in a motor vehicle accident while operating the motorcycle. Plaintiff filed a claim for no-fault benefits with Allstate Insurance Company. When that claim was denied, he filed a claim with the Michigan Assigned Claims Facility, which assigned the claim to Titan Insurance Company. The trial court ruled that Plaintiff’s claim for no-fault benefits was barred by the “unlawful taking” exclusion set forth in MCL 500.3113(a), and Plaintiff appealed.

On appeal, the Michigan Court of Appeals, in a published opinion, reviewed the Supreme Court’s rulings in *Spectrum Health Hospitals* and *Progressive Marathon Ins. Co.*, discussed above, and noted that because the “end user” of the motorcycle (Plaintiff Rambin) was not involved in the “unlawful taking” of the motorcycle, he was entitled to recover no-fault benefits:

“*Spectrum Health/Progressive Marathon* clarifies that MCL 500.3113(a) requires us to ‘examine the legality of the taking from the *drivers’* perspective’, and further requires that the ‘end user’ driver had taken

continued on the next page

No-Fault Corner Continued from page 11

the vehicle 'contrary to a provision of the Michigan Penal Code.' [Citation omitted]. In this case, there is no dispute that plaintiff did not take the vehicle in violation of the Michigan Penal Code, and that, viewed from the plaintiff's [the driver's] perspective, there was no 'unlawful taking.'

Applying the text of the statute and the case law discussed above, we therefore find, based on the record evidence, that there is no genuine issue of material fact that plaintiff did not 'take [the motorcycle] unlawfully' under MCL 500.3113(a), and that the first prong of the statutory analysis is not satisfied.

Simply put, plaintiff was not the person who took the vehicle unlawfully. He was a person who, with no unlawful intent and with no knowledge of any unlawful taking, used a vehicle that another person may have taken unlawfully."

Rambin, Slip Opinion at page 14.

Accordingly, the matter was remanded back to the trial court for determination as to whether Plaintiff was entitled to PIP benefits and from which insurer. It is unknown, at this time, whether an Application for Leave to Appeal will be filed with the Michigan Supreme Court. ■

**Insurance
and
Indemnity
101**



The Often Misunderstood Certificate of Insurance

Hal O. Carroll, www.HalOCarrollEsq.com

It would be hard to find anything in the area of liability insurance that is more often misunderstood than the certificate of insurance. It's often called "the Accord form," by the way because those words appear at the top.

There are two misconceptions that are at the root of the misunderstanding. First, the insurance company issues the certificate. Not true. Second, the certificate amends the policy by adding insureds. Also not true. Yet attorneys who counsel businesses have a hard time convincing their clients that the certificate does not protect them, at least not as much as they think and in the way that they think.

Here's the scenario. There's a construction project, with a general contractor and one or more subcontractors. The general is worried about being sued if someone is injured, and being seen as the target defendant with the deep pocket. How does the general protect itself? First, of course, it buys a General Liability policy. But that's not enough. For one thing, that makes it even clearer that the general's pocket is deep, because it's actually the insurer that will pay.

So the general wants to be sure that the subcontractors have insurance, so their pockets will also be deep. To confirm that, the general insists on getting proof of insurance from each sub, listing its policies, and the amounts of coverage provided by each. That is what the certificate is for. It confirms

that the sub is insured. It is like the certificate of insurance we all carry in our vehicles. That certificate confirms to the Secretary of State that the vehicle is insured. But it does not make the Secretary of State an insured.

It's the same with the Accord certificate form. It shows that the sub is insured. That's all it does. The certificate itself says that that's all it does. At the top it says:

This certificate is issued as a matter of information only and confers no rights on the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policies below.

Then it says

This is to certify that the policies of insurance listed below have been issued to the insured named above for the policy period indicated.

Why the confusion, if the form is so clear? At the bottom is a box entitled "certificate holder." That is where the general contractor's name goes, in our example. But often, instead of just saying "XYZ General Contractor Company," the box gets filled in like this: "XYZ General Contractor Company is an additional insured on project 123."

Seeing that, the general thinks it is protected as an additional insured. The cases don't agree though, for two related reasons: the certificate is not a part of the policy and it is not issued by the insurer. As the Supreme Court said "The certificate is no part of the insurance contract."¹ The Court of Appeals made the same point.

"[T]he insurance certificate at issue did not purport to represent the terms, benefits, or privileges promised under the policy. Instead, the stated purpose was merely to certify that the listed insurance policies had been issued."²

The reason the certificate is not a part of the policy is that it isn't written by the insurer. At the top, in the space marked "Producer," the agent puts his or her name. But the agent is not the agent of the insurer. As a matter of law, an independent agent is the agent of the insured and not the agent of the insurer. "[T]he independent insurance agent or broker is considered an agent of the insured rather than an agent of the insurer."³ The agents that contractors deal with are independent agents. The contractor comes to the agent with a list of coverages it needs (typically vehicle, worker compensation, liability, and excess) and the broker solicits bids from various companies.

So on the certificate, the broker can list the policies it has obtained from various insurance companies, but it can't speak on behalf of them, and it can't change the policies those insurance companies have issued.

So is the certificate worthless? Not at all, though it is worth less than the general and the sub often think. Often the policy that insures the subcontractor will have a provision that identifies who else besides the sub is insured under the sub's policy. Commonly this is found in an endorsement called a "blanket additional insured (BAI) endorsement," or some variation on that title. The provision will say that an additional insured includes anyone the sub is "required to add as an additional insured under this policy under . . . an oral agreement or contract where a certificate of insurance showing that person or

organization as an additional insured has been issued."

So the certificate can have an effect, but note that it is the endorsement that really does the heavy lifting. Also, if the general contractor, or its attorney, is paying attention, somewhere in the contract that the general makes the sub sign there will be a requirement that the sub make its insurer add the general as an additional insured on the sub's policy. If that clause is in the sub's contract with the general, that alone is enough to make the general an additional insured, with or without a certificate. Because the BAI endorsement will also say that an additional insured anyone the sub is "required to add as an additional insured on this policy under a written contractor agreement.

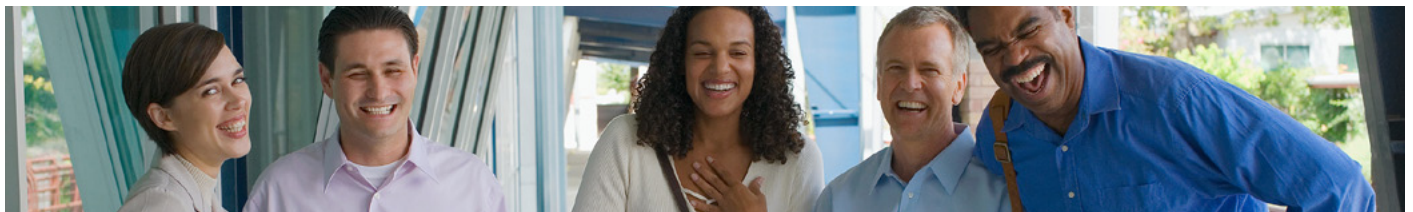
It's still important for the general contractor to get the certificate to confirm that the required policies are actually issued and in place. But it's important for the general contractor's attorney to let the general know that the certificate is only part of the puzzle and that more is needed. Frankly, this is often a hard sell; contractors tend to place great reliance on the certificate alone.

Because of that, it's also important for the contractor's attorney to read the general's contract forms themselves. They should specify the types of coverage, the minimum amounts of coverage, and whether the additional coverage is primary or secondary to the general's policy. The attorney also needs to look closely at the indemnification language, because that is another way to bring the sub's policy into the fray. Stay tuned.

For the practitioner, the problem. ■

Endnotes

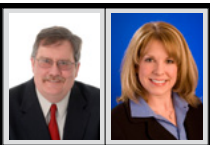
- 1 *Chrysler Corp v Hardwick*, 299 Mich 696, 700; 1 NW2d 43 (1941).
- 2 *West American Ins Co v Meridian Mutual Ins Co*, 230 Mich App 305, 311; 583 NW2d 548 (1998)
- 3 *West American*, 230 Mich App at 310.



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ERISA
Case
Summary

ERISA Decisions of Interest

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Sixth Circuit Update

Financial Institution That Held Misappropriated
 Funds Did Not Exercise Sufficient Control
 to be Considered a Fiduciary

McLemore v Regions Bank, 682 F.3d 414
 (6th Cir. June 8, 2012)

Barry Stokes, an investment advisor, misappropriated millions of dollars from employee-benefits plans that he managed through his company, 1Point Solutions, LLC. Stokes and 1Point held the fiduciary accounts of the defrauded plans with the Defendant-Appellant bank, Regions. Stokes' bankruptcy Trustee John McLemore and several former clients of 1Point filed suit against the bank, alleging that Regions negligently or knowingly allowed Stokes to steal from the fiduciary accounts held at Regions. In 2008, the district court dismissed the Trustee's ERISA claims, and then in 2010, the district court found that ERISA preempted both plaintiffs' state-law claims and granted judgment on the pleadings in favor of Regions.

On appeal, the Trustee challenged the district court's 2008 dismissal of its ERISA claims under Rule 12(b)(6); and both parties challenged the district court's 2010 grant of Regions' motion for judgment on the pleadings dismissing their state-law claims under Rule 12(c).

The Trustee challenged the district court's 2008 dismissal of his ERISA claims, arguing that the court erred in holding that Regions failed to qualify as an ERISA fiduciary. Regions argued that it was not a fiduciary and offered as an alternate ground for affirming the judgment that the Trustee lacked standing to pursue claims on behalf of the defrauded plans. The court rejected Regions' arguments that the Trustee lacked standing and then considered the Trustee's challenge of the district court's conclusion that Regions did not serve as a fiduciary to the victim plans.

The Trustee posited that Regions qualified as a fiduciary by exerting "authority or control respecting management of [plan] assets." and made a number of allegations describing Regions' authority or control over the ERISA-plan accounts. Namely, he alleged that Regions (1) knew that 1Point's accounts held plan assets; (2) should have recognized that 1Point managed these accounts differently than typical third-party administrators of employee-benefits plans; (3) failed to comply with banking regulations that would have uncovered Stokes's scheme; (4) advised 1Point to structure its accounts in a way that circumvented "know your customer" rules; and (5) withdrew over \$500,000 in "fees and analysis charges" from the plan funds.

In its analysis, the court found that the first three allegations did not establish liability as Regions merely held the funds on deposit and custody of plan assets alone does not establish control sufficient to confer fiduciary status. The Court also reasoned that Regions' advising on account structuring offered no basis for labeling it a fiduciary because control of the accounts remained with 1Point and Stokes. Finally, Regions' withdrawal of fees did not support a finding that it held fiduciary status because the Trustee simply alleged that Regions regularly withdrew its fees and analysis charges from the trust funds it held. The court concluded that Regions' withdrawal of routine contractual fees constituted no more an exercise of control than any other account holder's request effectuated by a depository bank and rejected the Trustee's argument that Regions' collection of fees rendered it subject to liability as an ERISA fiduciary.

As to the dismissal of the state law claims, the plaintiffs appealed the district court's dismissal of their respective claims against Regions, which alleged (1) negligence and recklessness, (2) unjust enrichment, and (3) violation of Tennessee's Consumer Protection Act, and all of which rested on common allegations of breach of duty to monitor and to exercise reasonable care in failing to comply with various regulations that would have uncovered Stokes' activities.

The court reasoned that under ERISA, a plan "participant, beneficiary, or fiduciary" may seek an injunction against a non-fiduciary who knowingly participates in a fiduciary's violation of ERISA. (29 U.S.C. § 1132(a)(3).) The Trustee originally sought disgorgement of the bank fees, a remedy in equity, from Regions under ERISA's civil enforcement provision, but the district court had dismissed that claim, finding that there were no "specifically identifiable" funds in Regions' possession and such equitable relief was therefore unavailable. The Plaintiffs then reasserted the claims in amended complaints as state-law claims for unjust enrichment. The appellate court agreed with the district court's finding that Plaintiffs' unjust-enrichment claims were merely a recasting of their ERISA claims and that ERISA preempted the plaintiffs' state law claims. The court reasoned that as to non-fiduciaries, ERISA confines plaintiffs to equitable relief and that by re-styling their ERISA claim as a state-law claim, the plaintiffs sought to hold a non-fiduciary bank personally liable, and such attempts to supplement the remedies available under ERISA had been rejected by the U.S. Supreme Court in *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004).

Importantly, the majority was dismissive of Plaintiffs' complaint that the affirming the ruling of the district court would

leave them without a remedy against Regions. The court reasoned that “the availability of a remedy under ERISA is not relevant to the preemption analysis.”

Judge Merritt disagreed with that reasoning, and dissented with the appellate court’s opinion, stating, “The primary purpose of ERISA is to protect the individual who has a pension or health plan from certain kinds of losses, *i.e.*, “to increase the likelihood that participants . . . will receive their full benefits.” 29 U.S.C. § 1001b(c). It is not to protect a depository bank from general state laws concerning malfeasance in connection with the bank’s handling of the bank accounts of participants. In this case, we have no idea whether the bank is liable for misfeasance under state law. The case against the bank has not been tried or the facts proved or the state law analyzed and applied. I dissent because our court is using a doctrine of ERISA preemption not to protect the ERISA participants but to shield the bank from any investigation of the claims against it. The court has given the bank an immunity from general state law liability no matter what its conduct, as though the bank has the status of a sovereign.”

Plan Sponsor Protected by Safe Harbor Rule Against Breach of Fiduciary Claim for Unilateral Transfer into a Qualified Default Investment Alternative

Bidwell v. Univ. Med. Ctr., Inc., 685 F.3d 613
(6th Cir., June 29, 2012)

By way of background, some retirement plans allow participants to select their own investments, often giving them a broad array of options. It used to be that if a participant failed to elect how to invest his or her account, the employer would have to invest those accounts in low-risk, low-return stable value funds. However, financial “experts” have long believed that it is more appropriate – particularly for younger participants – to invest a significant amount of their retirement funds in higher-return, albeit riskier, investments. In 2007, employers were allowed to (and, in fact, encouraged to) place these unallocated assets into a Qualified Default Investment Alternative (QDIA). QDIAs were invested in higher-return, higher-risk assets, based on the participant’s age (*i.e.*, the number of years until the participant’s expected retirement). The older the participant, the less risky the investments, but they would still be riskier (and, hopefully, more lucrative) than the pre-QDIA default. If the QDIA met the “safe harbor” regulations established by the US Department of Labor (DOL), employers would be protected from employee claims if the actual investment returns were unfavorable.

In 2008, Defendant UMC sought to take advantage of the new DOL regulation by changing its default investment vehicle from a stable value fund to a QDIA. Because UMC did not maintain records as to which participants elected to invest in the stable value fund in contrast to those who were investors by default, UMC sent notice of the change to all inves-

tors with 100% of their investment in the stable value fund. The notice indicated that all stable value investments would be transferred to the QDIA by a certain date unless participants gave instruction otherwise.

The plaintiffs here were two plan participants who claimed not to have received the notice and were unaware of the change until receipt of their quarterly statement, when they each transferred their investment back to the stable value fund. However, during the interim period, both plaintiffs suffered significant financial loss. As a result, the plaintiffs asserted a claim for breach of fiduciary duty under ERISA against UMC and its administrator.¹

UMC claimed immunity from liability because it was entitled to protection under the Safe Harbor regulation, and the Sixth Circuit agreed. The Court gave deference to the DOL’s explanation of the regulation as applying to situations including automatic enrollment as well as the failure of a participant to provide investment direction following the elimination of an investment alternative or any other failure to provide investment instruction. The DOL has emphasized that plan fiduciaries may avail themselves of Safe Harbor protection when participants are provided the opportunity to direct investment but fail to do so, including when plan administrators ask participants who had previously elected a particular investment to confirm continued investment. The Safe Harbor contains other specific requirements which were not at issue here. *See*, 29 C.F.R. § 2550.404c-5.

Here, the plaintiffs claimed they never received the notice of the change in the default investment option that was sent via first class mail by UMC’s administrator to all participants with 100% of their investment in the stable value fund. Under ERISA, a fiduciary is obligated to take measures reasonably calculated to ensure actual receipt of materials by plan participants, expressly authorizing distribution by first, second or third-class mail. Because the plaintiffs were not able to establish that UMC took inadequate action in issuing the notice, the Court rejected this argument. Judgment was affirmed in favor of defendants, dismissing the plaintiff’s claims.

Claim Administrator Found Liable for Breach of Fiduciary Duty for Misappropriation of Plan Funds

Guyan Int’l., Inc. v. Professional Benefits Administrators, Inc.,
689 F.3d 793 (6th Cir., August 20, 2012)

Each of the plaintiffs was a plan sponsor and administrator of an employee health benefit plan and each hired Professional Benefits Administrators, Inc. (“PBA”) as a claims administrator to pay medical providers for claims incurred by plan participants. Each of the plaintiffs had a similar contract with PBA requiring establishment of segregated bank accounts into which PBA would deposit funds received from each plaintiff and then issue payment for medical claims. Each contract

continued on the next page

ERISA Decisions of Interest Continued from page 15

also provided that PBA was not to commingle the plan's funds with PBA's assets, and that PBA would not use plan funds for its own purpose. PBA violated each one of these contractual provisions, and kept for itself over a million dollars of collective plan funds.

In response to the plaintiffs' allegations of breach of fiduciary duty, PBA argued that each plan's contract expressly indicated that PBA was *not* a fiduciary, and that the plaintiffs' breach of contract claims were preempted by ERISA.²

ERISA provides that "a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets." 29 U.S.C. § 1002(21)(A). Thus, the threshold for being considered a fiduciary is lower for entities managing plan assets than for entities administering the plan.

Applying these principles, the Court found that, because PBA clearly used plan funds in ways contrary to its agreements with plaintiffs, PBA had practical control over plan funds and thus had fiduciary status with respect to its management of plan assets. After reaching that conclusion, the Court easily determined that PBA breached its fiduciary duties by its failure to act solely in the interest of the plan participants and beneficiaries, and by its blatant self-dealing in violation of 29 U.S.C. § 1104(a)(1) and 1106(b)(1).

Although PBA next argued that the plaintiffs had no claim for relief under ERISA sections 1109(a) and 1132(1)(2) because they sought relief for themselves instead of on behalf of each respective plan, the Court found that PBA forfeited this argument for failure to raise it at the trial court level.

United States District Court Update

Michigan's Health Insurance Claims Assessment Act is Not Pre-Empted by ERISA

Self-Insurance Institute of America v. Snyder, E.D. Mich. Case no: 11-15602-CV (Cook, J.), Aug. 31, 2012

In an attempt to partially address Michigan's budget crisis, Michigan adopted the Michigan Health Insurance Claims Assessment Act, MCL 550.1731, et seq., (the "Act"). In general, the Act imposes a 1% assessment on the amount of health care claims paid by insurers for medical services rendered in Michigan to Michigan residents. This 1% assessment is also assessed on claims paid by group health plans, even if uninsured, and "third party administrators" (TPAs), which are entities that process claims for self-funded or uninsured group

health plans. The revenue from the 1% assessment is used to pay the state's share of Medicaid, thus increasing federal Medicaid funding. (Medicaid is a joint state-federally program to provide health care to poor individuals. In Michigan, it is roughly 75% federally funded. It was estimated that the 1% assessment will produce about \$400 million, thus providing federal funding of about \$1.2 billion.)

As we have discussed in earlier articles, ERISA (subject to several exceptions and caveats) generally preempts state law that "relates to" employer-sponsored health benefit plans. The Self-Insurance Institute of America (SIIA), a trade association of self-funded plan sponsors and TPAs brought an action alleging that the Act was preempted by ERISA to the extent that the Act imposed an assessment on uninsured ERISA-governed plans or their agents, the TPAs.

The Court rejected this claim, holding that the Act imposed a tax of general applicability rather than something directed at ERISA plans. Nor does the Act mandate a particular structure for plans or mandate how claims are to be processed or what benefits will be paid as did other state laws that had been held preempted. The authors understand that SIIA is likely to appeal the decision, so we may hear more in the future. ■

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Endnotes

- 1 The claim against the administrator was dismissed on the basis that it was not a fiduciary under the plan.
- 2 After finding that PBA had breached its fiduciary duty, the Court agreed (and the plaintiffs conceded) that the state law breach of contract claims were preempted by ERISA.

Office of
Financial &
Insurance
RegulationOrganizational Structure and
Division ResponsibilitiesSarah G. Wohlford, Office of Financial and Insurance Regulation¹

The Office of Financial and Insurance Regulation (OFIR) often receives questions about its organizational structure and the distribution of responsibilities among its various line divisions. The following is a description of the OFIR's current regulatory structure, including all line divisions within OFIR and each division's primary regulatory and administrative duties.

The **Consumer Services Division** is the division with which most consumers are familiar. Consumer Services oversees the OFIR communication center, which serves as the initial point of contact for all incoming calls and visitors. This division is responsible for managing consumer outreach, and hosts numerous public seminars on diverse topics, including the Affordable Care Act, avoiding insurance scams, and assessing insurance needs. Consumer Services also handles inquiries and complaints, and performs investigations of insurance agents/entities.

The **Insurance Evaluation Division** is responsible for all aspects of monitoring and regulating the financial condition of risk-bearing insurance entities. This division oversees the processing of applications for licensure filed by insurance companies; performs on-site financial examinations of domestic insurance companies; conducts ongoing financial monitoring of licensed insurance companies; and works with insurance companies that report negative trends to take appropriate corrective measures. The Insurance Evaluation Division is also responsible for the licensing, monitoring, and examination of captive insurers.

The **Insurance Rate and Forms Division** is responsible for enforcing Michigan insurance statutes and regulations pertaining to rates and forms submitted by insurance companies and other licensed entities. This division is responsible for the regulatory oversight of individual and group health plans, health maintenance organizations, Medicare supplement, life, long term care, credit life, personal and commercial automobile, personal and commercial property and casualty, workers' compensation, general liability, professional liability, personal and commercial inland marine, legal expense, title, and surety and fidelity contracts.

The **Insurance Licensing and Market Conduct Division** is responsible for licensing individual and agency insurance producers, solicitors, counselors, risk retention groups, pur-

chasing groups, reinsurance intermediaries, and third party administrators. The division is also responsible for market conduct reviews and investigations of insurance agents and other licensed entities.

The **Bank and Trust Division** undertakes safety and soundness reviews of banks, savings banks, trust banks, and business and industrial development companies (BIDCOs).

The **Securities Division** oversees the licensing, registration, examination, and investigation of securities entities as required by the Michigan Uniform Securities Act.

The **Consumer Finance Division** regulates numerous statutory consumer finance programs. This division performs licensing, registration, examination, and investigation of entities doing business under these statutes.

The **Credit Union Division** is responsible for the regulation, examination, and supervision of Michigan state-chartered credit unions. The Credit Union Division is also responsible for processing corporate applications filed by depository financial institutions.

OFIR's **Office of General Counsel** provides legal advice to the line divisions. It also represents the Commissioner and OFIR staff with respect to enforcement actions and formal administrative hearings. The Office of General Counsel drafts orders, rules, statutes, regulations, bulletins, and declaratory rulings. It also processes appeals under the Patient's Right to Independent Review Act (PRIIRA). The General Counsel serves as FOIA coordinator, represents the Commissioner on the State Employees Retirement System board, and acts as liaison with the Attorney General and other state/federal agencies. The Office of General Counsel also provides assistance on special projects, such as the implementation of the Affordable Care Act and other long-term projects affecting OFIR.

The **Policy Division** develops and implements regulatory policy, and performs research and analysis of regulatory and legislative matters. ■

Endnotes

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

Insurance
Case
Summary

Significant Insurance Decisions

By Deborah A. Hebert

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Michigan Supreme Court

“Easily ascertainable” falsehood no bar
to policy rescission

Titan Ins Co v Hyten

___ Mich ___ (June 15, 2012)

In *State Farm Mut Auto Ins Co v Kurylowicz*, 67 Mich App 568 (1976), the Court of Appeals adopted the “easily ascertainable” rule for limiting an insurer’s right to reform insurance contracts based on policyholder misrepresentations. *Kurylowicz* held that as a matter of public policy, insurers must investigate insurability within a reasonable period of time after accepting a policyholder application. The impetus behind this rule was to protect third parties benefitting from the insurance. “[W]here an automobile liability insurer retains premiums, notwithstanding grounds for cancellation reasonably discoverable by the insurer . . . , the insurer will be estopped to assert that ground for rescission.” 67 Mich App at 579.

The Supreme Court has now overruled *Kurylowicz* and its progeny. In this case, the policyholder filled out an application expressly denying that anyone in her household had a suspended license. When her daughter was involved in an accident several months later, the insurer learned that the daughter’s license had been suspended at the time of the application (though not at the time of the accident). The insurer sued to reform the policy to limit liability coverage to the statutory limits. The lower courts rejected the rescission request under the “easily ascertainable” rule but the Supreme Court reversed. Rescission requests must be evaluated under the traditional common law rules applied to contracts generally. These rules do not impose a duty on contracting parties to investigate the veracity of each other’s statements. This case was remanded to the trial court for an evaluation of the rescission request on traditional contract grounds.

6th Circuit Court of Appeals

Employee dishonesty coverage applied

First Defiance Financial Corp v Progressive Cas Ins Co

___ F3d ___ (6th Cir. 2012)(Ohio)

Progressive issued a policy covering several entities for a “[l]oss resulting directly from dishonest or fraudulent acts committed by an Employee, acting alone or in collusion with oth-

ers.” An employee transferred money from customer investment accounts to his personal account. When the theft was discovered, the insured replaced the stolen funds and sought coverage for the loss from Progressive, who denied coverage. Both the District Court and the majority opinion of the 6th Circuit found coverage under the Progressive policy. The 6th Circuit held that all three conditions of coverage were met. The stolen money was “covered property” because it was owned and held by others under circumstances that made the insured responsible for the loss. The court rejected Progressive’s claim that the property was not covered because no insured was responsible for the customer’s money *prior* to the loss. Second, the loss was found to be a direct loss to the insured. The court rejected Progressive’s claim that the stolen money was a direct loss to the customers, only. Third, the employee had a manifest intent to cause the insured a loss. There was no possibility that the taking of funds would benefit the insured. Criticizing the majority opinion as too simplistic, and concluding that the majority had transformed this policy into something it was never intended to be, the dissent concluded that “the policy required a direct loss to [the insured] and [the employee’s] theft from non-custodial customer investment account does not qualify as such a loss.” Customer accounts were not “covered property.”

Michigan Court of Appeals - Published

BCBSM third party administrator fees upheld

Calhoun County v BCBSM

___ Mich App ___ (2012)(lv pending)

(Docket No. 303724, June 5, 2012)

The Court of Appeals resolved what appears to be a widespread dispute between self-insured governmental health plans and Blue Cross Blue Shield of Michigan as the administrator of those plans. For some years, BCBSM had been charging an “access fee” for its administrative services, as allowed by its contract with these health plans. This fee included a subsidy for Medicare insurance policies issued to persons who were not members of the health care plan. When Calhoun County obtained a specific breakdown of the access fees and learned of the subsidy, it objected and ultimately filed suit. As established by BCBSM, the subsidy was paid from the savings achieved by the County in benefiting from the “power of the Blues” discounts. The Court of Appeals determined that this Medicare

component of the access fee was an enforceable term of the contract, and rejected claims that the fee description was so vague and indefinite as to be unenforceable.

Selected Unpublished Decisions of the Michigan Court of Appeals

Statutory tolling for fire loss

Smitham v State Farm Fire & Cas Co
Unpublished per curiam of August 9, 2012
Docket No. 304600

MCL 500.2833(1)(q) creates a one-year period of limitation for actions to recover for property loss under a fire insurance policy. That one-year period is tolled “from the time the insured notifies the insurer of the loss until the insurer formally denies the liability.” Denial of liability is not a *condition* for tolling, however. Tolling occurs whether or not a claim is ultimately denied. Where the insurer underpays a claim, tolling of the one-year period continues until the insurer informs the insured that the underpayment is a final decision on the claim.

No liability coverage for assault and battery claim

Mieseke v Secura Ins
Unpublished per curiam of July 31, 2012
(Docket No. 304346)

Claimant sued this policyholder for injuries inflicted during a bar fight. The policyholder sought coverage under the

CGL policy issued to his excavation company and also made a claim under his “Farmowners Protector Policy.” Both policies covered claims arising out of an “occurrence.” Because the claim was assault and battery, neither insurer had any duty to defend or indemnify due the lack of an occurrence-based injury. The fact that policyholder claimed he only intended to push claimant away did not change the “occurrence” analysis.

No coverage for construction defects

Envision Builders, Inc v Citizens Ins Co
Unpublished per curiam of July 24, 2012, *lv pending*
(Docket No. 303652)

“Occurrence-based” commercial general liability policy did not cover general contractor for damage caused by the collapse of roof trusses, improperly installed by a subcontractor. The property damage was to the insured’s own work and was thus not an “occurrence” under Michigan law. In addition, certain exclusions applied. To the extent the policyholder was liable to the property owner under the terms of their construction contract, the CGL policy excluded coverage for contractually assumed liability (the exclusion is not limited to indemnity liability). In addition, the policy excluded coverage for damage to property owned by the policyholder and for damage to “that particular part of real property on which you or any contractor or subcontractor working directly or indirectly on your behalf is performing operations.” Because the building was not yet completed and accepted by the customer, the trusses were still owned by the general contractor. And “performing

continued on the next page

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R E S O U R C E F U L | E X P E R I E N C E D | R E S U L T S

Significant Insurance Decisions Continued from page 19

operations” did not require the presence of someone on the premises at the moment of the damage. Finally, coverage was excluded because it was damage to “your work.”

UIM insurance not provided

Wiley v United Service Auto Assc

Unpublished per curiam opinion of July 19, 2012
(Docket No. 304992)

The plain terms of this auto policy did not afford underinsured motorist (UIM) coverage. While the policy did provide uninsured motorist (UM) coverage for certain covered autos, the policy definition of an uninsured motorist expressly did not include underinsured motorists, which was a separately defined term. The policyholders’ belief that they had purchased “full coverage,” which they expected would include UIM insurance, did not alter the terms of the contract. The court also rejected the policyholders’ claim of a “special relationship” with the insurer.

Recreational vehicle exclusion in homeowner’s policy applied

Home-Owners Ins Co v Downs

Unpublished per curiam of July 10, 2012, reconsideration den 9/4/12
Docket Nos. 301105, 301775

This insurer properly denied a defense and indemnity to homeowners sued for their alleged negligence in allowing a minor child to operate one of their off-road recreational vehicles. The homeowners policy covered liability for such claims only if it arose out of the use of an insured-owned recreational vehicle on the insured premises. The limiting language was not ambiguous.

Exclusion in medical malpractice policy for hospital services not applicable

Gifford v MHA Insurance

Unpublished per curiam of July 5, 2012, reconsideration den 8/17/12
Docket Nos. 301759, 303157

Because the allegations against the insured physician involved treatment before surgery, during surgery and after surgery, an exclusion in the physician’s medical malpractice policy for services performed in the hospital did not defeat coverage for the claims of malpractice occurring prior to and after surgery, when the claimant was seen and treated in the insured’s office. Because the insurer had a duty to defend and failed to do so, it was bound by the consent judgment negotiated by its insured.

Late notice bars coverage

Williams v Travelers Prop & Cas Co of America

Unpublished per curiam of June 28, 2012
(Docket No. 301454)

This policyholder, owner of an apartment building, was sued by a tenant for injuries sustained in a fall on snow and ice on the leased premises. The policyholder knew of the incident when it occurred but did not notify its liability insurer. Nor did the policyholder promptly inform the insurer of the lawsuit when it was filed. The insurer’s first notice of the claim was five years after the incident took place. By that time, a default judgment had been entered against the policyholder, which was later set aside. The Court of Appeals held that the delay deprived the insurer of “an opportunity to investigate the incident properly, particularly in light of the sparse documentary record of events surrounding” the fall. The EMS and police records provided only “brief descriptions of the incident.” There were no statements from witnesses at the time, and there were no photographs of the scene of the fall. The mere fact that the default had been set aside, allowing the insurer to participate in all phases of the litigation, was not enough to eliminate the prejudice caused by the delayed notice.

Auto policies not triggered because covered autos were not “involved in” the accident

Community Assoc Underwriters of America, Inc v Safeco Ins Co of Illinois

Unpublished per curiam of June 28, 2012
(Docket No. 303544)

Safeco insured an auto involved in a police chase. After eluding the police, the driver of the insured auto collided with a SMART bus, and then drove into a condominium complex and hid in an open garage. The police found the car and the driver by following a stream of smoke coming from under the hood of the car. As the police were making their arrest, the car caught on fire and caused damage to the garage and two condominium units. The condominium’s property insurer paid for the repairs and then filed suit against the owner of the Safeco-insured vehicle, the police and SMART, claiming that all vehicles were “involved” in the accident that caused the property damage. Safeco settled with the condo insurer and then attempted to recover from the other two insurers of the other defendants. Michigan’s no-fault statute requires auto policies to cover “accidental damage to tangible property arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle. MCL 500.3121(1). A person suffering accidental property damage may seek to recover against the “insurers of owners or registrants of vehicles involved in the accident.” MCL 500.3125. To be “involved”

in an accident, the vehicle must actively contribute to its happening, though not necessarily through physical contact. The majority held that the police cars and Smart bus were not “involved” in the accidental damage to the garage. They did not “actively contribute” to that fire. The dissenting opinion would hold that the police cars were involved in the accident, but not the SMART bus.

Question of fact regarding fraud in the application for life insurance

Langley v Auto-Owners Life Ins Co
Unpublished per curiam of June 28, 2012
(Docket No. 300517)

Questions posed in the insurance application were not ambiguous and those questions were, for the most part, answered truthfully and in good faith. But the court found a question of fact concerning the answer to one question concerning the decedent’s heart condition. The case was remanded for a trial on the good faith veracity of that answer. The Court also held that if a judgment were entered against the insurer, the proper judgment interest rate was 12% under the uniform trade practices act, MCL 500.2001.

Ambiguous insuring agreement in professional liability policy; but exclusions apply

Coral Reef Productions, Inc v Axis Surplus Ins Co
Unpublished per curiam of June 19, 2012,
reconsideration den 8/17/12
(Docket No. 302706)

Plaintiff policyholder purchased a “Miscellaneous Professional Liability Insurance Policy” protecting against liability incurred while “performing Insured Services for others.” The policy definition of “Insured Services” was ambiguous and was thus construed in favor of coverage for the insured. But several

exclusions applied for dishonest acts, unfair competition and conduct resulting in a gain, profit or advantage to which an insured was not legally entitled. This insured was sued for having hacked into a competitor’s website to solicit its customers.

Late notice defeats coverage

Huntington Nat’l Bank v First American Title Ins Co
Unpublished per curiam opinion of May 24, 2012,
lv pending
(Docket No. 303496)

Plaintiff bank held a mortgage on certain property as security for a loan. When the bank was sued by two construction lien holders, it tendered the claim to its title insurer. But the tender was not made until 16 months after suit was filed, by which time the bank had stipulated to orders resolving issues for trial, including the date of the recording of the liens and the lien amounts. The majority held that this late notice resulted in actual prejudice to the insurer, even though no judgment had been entered. The insurer was not obligated to appear and defend.

Duty to defend based on negligence claims

Erie Ins Exchange v Lake City Industrial Products, Inc.
Unpublished opinion of May 17, 2012, lv pending
(Docket No. 302889)

Allegations of “blast faxing” in violation of the Telephone Consumer Protection Act (TCPA) triggered a duty to defend under the insured’s occurrence-based liability policy because the allegations in the complaint were not confined to intentional misconduct. The complaint also referred to negligent faxing and the policyholder contended that it believed it was faxing solely to willing recipients. Whether the insurer would also have to indemnify for any judgment obtained would depend on the facts determined in the underlying case. ■

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For the fourth year, the State Bar of Michigan has designated October as Pro Bono Month, joining the American Bar Association and many other states in selecting October as a time to highlight the need for and importance of pro bono civil legal assistance to low-income people. All across the country, lawyers will be taking part in events to educate the public and the legal profession about pro bono legal services.

Our goal this year is to increase the number of visible pro bono events held in October.

If you already have a pro bono event planned, make sure to register your event here on the State Bar's Pro Bono Month website. If you haven't planned an event yet, please join us in celebrating pro bono month this year by organizing an October event. Our website includes much more information, suggestions for organizing events, and links to talking points for Michigan's "Now more than ever" theme. Keep visiting for updates that will be posted as they are developed. We will publicize your event on the State Bar's Pro Bono Month website.

If you have any questions or would like additional information, please contact Robert Mathis, SBM's Pro Bono Service Counsel, at (517)346-6412 or rmathis@mail.michbar.org.

INSURANCE & INDEMNITY LAW SECTION SEMINAR

Successful Mediation: Is It All About The Money?

Brian A. Pappas and Edward H. Pappas will define success and give you their top ten tips on increasing your chances of success. In the insurance context, they will discuss the importance of dealing with the appropriate decision makers and potential conflicts between the insurance carrier and the insured. The speakers will also tell you things that your mediator may never tell you.

Date: November 14, 2012

Time: 3:00 p.m. presentation and Q&A;
4:30 p.m. networking cocktails

Location: Jaffe Raitt Heuer & Weiss PC,
27777 Franklin Rd. Suite 2500
Southfield, MI 48034

There is no charge to attend, but RSVP online in the Bar's Member Area (<http://e.michbar.org>)

Bios

Brian A. Pappas, LL.M., J.D., M.P.P., is assistant clinical professor of law and associate director of the ADR program at Michigan State University College of Law where he teaches a variety of negotiation and mediation courses. Mr. Pappas is a qualified Civil Mediator under MCR 2.411 and a qualified Domestic Relations Mediator under MCR 3.216. He is a SCAO-approved civil and domestic relations mediator and trainer and is trained in both facilitative and transformative mediation techniques in both civil and family contexts. Mr. Pappas has trained over one hundred domestic relations and civil mediators. Additionally, he has completed over 300 hours of mediation training and mediated over two-hundred fifty cases. Pappas serves as co-chair of the ADR Section of the Washtenaw County Bar Association, as a member of the Council of the State Bar of Michigan ADR Section, as chair of the ADR Section's Government Task Force, and as the co-chair of the Law Schools Committee of the ABA Section on Dispute Resolution.

Edward H. Pappas is the chair of Dickinson Wright and focuses his practice in complex commercial and business litigation, arbitration, and mediation. He has authored various publications, including the definitive treatise, Michigan Business Torts, and is a frequent speaker on litigation, arbitration, and mediation issues. Mr. Pappas is a past president of the State Bar of Michigan and the Oakland County Bar Association. He is also a fellow of the American College of Civil Trial Mediators and International Society of Barristers, and serves as a mediator and arbitrator for the American Arbitration Association, the International Institute for Conflict Prevention and Resolution, and the National Academy of Distinguished Neutrals.

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