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This journal is published by the Insurance and Indemnity Law Section, State Bar of Michigan
Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.
Now that the annual meeting is past, it’s a good time to bring everyone up to date on what your Section has been doing.

Holiday Kick-Off Event, November 19

Please join us on November 19, 2013 at 4:30 p.m. for a holiday kickoff event featuring pizza, beer, wine and a speaker on a topic of current interest. We have invited the Negligence Law Section to join us at a location in the Oakland County area (to be determined). Please watch your e-mail or check our website for more details as our plans are finalized. We will also hold our Council meeting that day at 3:30 p.m. before the event starts. As always, our council meeting is open to Section members, so feel free to arrive early. We look forward to seeing you then.

Annual Meeting – Elections

We held our annual meeting on September 19, 2013 at the Lansing Center in conjunction with the State Bar’s annual meeting. We held elections and, consistent with our practice, the officers were elected to second terms. Unlike most other sections, we have adopted a policy of two-year terms for officers because the continuity allows the officers more time to be productive after the initial learning curve. We look forward to continuing to serve you during the coming year.

“Retiring” and New Council Members

Two of our Council members, Deborah Hebert and Daniel Steele, were term limited and have “retired.” They were on the Council from the beginning of our Section in 2007 and in fact were essential pieces to the formation of our Section. We appreciate their long-term hard work and dedication. Their spaces were filled by two new Council members, Douglas Young and Joshua Terebelo. We are pleased to welcome Doug and Josh and we look forward to their contributions to our Section.

Annual Program – No-Fault Reform

Our program at this year’s annual meeting focused on the proposed changes to No-Fault law. It led to a lively debate, under the careful moderating of Larry Bennett. Congratulations and thank you to Chair Elect Kathleen Lopilato for designing and planning the program. We also wish to thank our panel participants:

- Butch Holowell, Esq.
- Pete Kuhnmuench, Executive Director, Insurance Institute of Michigan
- Tom Shields, Marketing Research Group, Inc.
- Mark Morley, Secrest Wardle

We greatly appreciate their willingness to share their views and express their opinions on this timely and complex topic.

Our Searchable Directory is Up and Running

Your Section has been busy in other ways, as well. As I have previously reported, we have been working on our Searchable Directory of our members. I am happy that we can now announce that it is ready for members to sign up. Inside is an announcement with the details of how to sign up, and later we will send an e-blast to all of our members with a link. The purpose of the database is to make the expertise of our Section members available to other members of the Section, and also to other attorneys and to any courts that might find that expertise useful. In the coming months we will work on promoting the Searchable Directory to other Sections as a useful resource. The progress made is due to the efforts of Hal Carroll who continues to work on this exciting project.

Early Intervention and Business Courts

In connection with that, Hal Carroll and our prior Chair, Mark Cooper, recently attended a meeting sponsored by the Supreme Court Administrative Office, on the topic of early intervention, with special focus on the new Business Courts. Like some other issues that arise in business litigation, insurance coverage issues and indemnity issues are especially susceptible for early intervention. Insurance coverage and indemnity issues typically can be framed, evaluated and resolved without the need for extensive discovery. At that meeting, Hal and Mark promoted the expertise of our Section members to assist in those types of cases.

Section Chair Orientation

Finally, Chair Elect Kathleen Lopilato and I attended the Section Chair Orientation at the State Bar’s offices in Lansing. The Orientation provides an excellent way to network with other Sections and for us to learn about the many ways that the State Bar staff can help us to achieve our goals in the coming year. As always, if you have any suggestions or input, please let me know.

—Elaine M. Pohl, Plunkett Cooney
Our New Look


The Journal is finishing its sixth year, and it’s time to repaint the storefront. The new cover format will give greater prominence to the content of the Journal and the authors and contributors who provide it.

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. We welcome all articles of analysis, opinion, or advocacy. The Section itself takes no position on issues.

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

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

Pictures from the Annual Meeting
September 19, 2013, 9:30 a.m., Lansing Center, Lansing

A 360 Degree Perspective on Reforming Auto Insurance in Michigan
Can We Find Any Common Ground in the No-Fault Debate?

Moderator: Larry Bennett, Giarmarco, Mullins & Horton

Steve Hicks, Anti-Reform Speaker
Butch Holowell Esq., Anti-Reform Speaker
Pete Kuhnmuench, Pro-Reform Speaker
Mark Morley, Pro-Reform Speaker
Tom Shields, Pro-Reform Speaker
CUMIS Counsel

By James A. Johnson ©2013, johnsonajmf@hotmail.com

Introduction

“CUMIS Counsel” or independent defense counsel is a term that comes from the seminal conflict of interest case in California.1 This case holds that a liability insurance carrier must pay for independent counsel and not use its own selected counsel where coverage issues are reserved that create a conflict of interest between the carrier and the insured.

Under California law, the insurer has the right and duty to defend any suit against the insured and make such investigation and settlement of any claim or suit as it deems expedient. This gives the insurer the right to appoint counsel for the insured and the right to control the defense and settlement of the claims against the insured.2 The California Supreme Court in Blue Ridge Ins v Jacobsen held that a unilateral reservation of rights letter to the insured is valid and enforceable.3

By reserving the right to challenge coverage, an insurer creates a possibility that it will act adversely to the insured in the future. Such a conflict of interest is inconsistent with counsel’s joint representation of the insured and the insurer. The relationship of the insurer, insured, and defense counsel is known as the “tripartite relationship.” Potential privilege problems arise from this arrangement. Joint counsel may become privy to communications that would be of great interest to the insurer in any future coverage litigation. Thus, joint counsel is forced to walk an ethical tightrope by not communicating such relevant information to the insurer.

In 1987, California enacted Section 2860 of the California Civil Code, which codified the holding in Cumis.4 Section 2860 (d) states that “it shall be the duty of that counsel and the insured to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action.”5

Additionally, any claim of privilege asserted is subject to in camera review, privileged materials are not discoverable in subsequent litigation between the insurer and its insured and any information disclosed by the insured or independent counsel is not a waiver of privilege as to any other party.

As can be gleaned from joint representation, a bevy of issues arise, such as the common interest doctrine. Under the right facts, this doctrine together with the cooperation clause eliminates the insurer’s protection under the attorney-client privilege and may require discovery of otherwise privileged matters from an underlying action. Therein lies the purpose of this article which is to provide guidance and a starting point on the issues engendered by a reservation of rights letter by the insurance company to its policyholder.

Michigan permits the insurer, under its duty of good faith, to select independent counsel to represent the insured when a conflict of interest exists. In Federal Insurance Co v X-Rite, Inc, the insurer reserved its right to deny coverage for certain damages that were not covered by the policy and selected independent counsel to represent the insured. The court determined that the insurer’s right to defend the lawsuit must be viewed as conferring upon the insurer “some prerogative with respect to defense beyond simply paying the expenses.”6

New York follows Michigan in that the insured was not entitled to be represented by individual counsel of its choice. The insurer’s designation of a certain law firm as independent counsel satisfied the insurer’s obligation to provide independent counsel. This holding is premised on the assumption that the insurer acted in good faith and counsel was truly independent and capable of defending the insured.7

Only three states have codified the insured’s right to independent counsel in the context of insurance conflict of interest – California,8 Alaska9 and Florida.10 The following summary of case law demonstrates that the law in these respective jurisdictions that differ widely.

Summary of Case Law

Michigan

Federal Insurance Co v X-Rite, Inc, 748 F Supp 1223 (WD Mich 1990); Aetna Casualty & Surety Co v Dow Chemical Co, 44 F Supp 2d 847 (ED Mich 1997) The law is unsettled as to which party may choose the independent counsel when a potential conflict arises by an insurer’s reservation of rights. Central Michigan Board of Trustees v Employers Reinsurance Corp, 117 F Supp 2d 627, 635 (ED Mich 2000) - the insured has no absolute right to select the attorney himself so long as the insurer exercises good faith in its selection and the attorney is truly independent.

Ohio

Collins v Grange Mutual Casualty Co., 124 Ohio App 3d 574, 706 NE 2d 856; Red Head Brass, Inc v Buckeye Union
Ins Co, 135 Ohio App 3d 616, 735 NE 2d 48 (1999) – an insurer’s issuance of a reservation of rights letter does not necessarily result in a conflict of interest; an insurer may proceed to defend the insured so long as the situation does not arise that the insurer’s defense of the insured and the defense of its own interest are mutually exclusive.

Kentucky

Cincinnati Insurance Co v Vance, 730 SW 2d 521 (Ky 1987); Medical Protective Co of Fort Wayne, Indiana v Davis, 581 SW 2d 25 (Ky Ct App 1979). The insured is not required to accept a defense offered by the insured under a reservation of rights.

Tennessee

Givens v Mullikin ex rel Estate of McElwaney, 75 SW3d 383 (Tenn 2002); Petition of Youngblood, 895 SW2d 322 (Tenn 1995). The insurer who has hired the attorney to defend its insured has no right to control the methods or means by which the attorney conducts that defense.

Illinois

Utica Mutual Insurance Co v David Agency Ins, 327 F Supp 2d 922 (ND Ill 2004). A proper reservation of rights is one that allows the insured to choose intelligently between accepting the insurer’s defense counsel and retaining its own counsel otherwise the insurer is estopped to assert a defense of non-coverage.

Indiana

All-Star Ins Corp v Steel Bar, Inc, 324 F Supp 160 (ND Ind 1971); Liberty Mutual Ins Co v Metzler, 586 NE2d 897 (Ind Ct App 1992); State Farm Mutual Auto Ins Co v Glasgow, 478 NE2d 918 (Ind Ct App 1985). Indiana courts have not directly discussed conflict of interest issues but have suggested in dicta that an insurer must either provide an independent attorney to represent the insured’s interest or pay for defense costs incurred by the insured hiring an attorney of his choice.

Wisconsin

Nowacki v Federated Realty Group, Inc, 36 F Supp 2d 1099); American Motorists Ins Co v Trane Co, 544 F Supp 669 (WD Wis 1982), aff’d, 718 F 2d 842 (7th Cir. 1983). When an insurer issues a reservation of rights letter the policyholder is permitted to select its own counsel at the expense of the insurer.

Minnesota

Mutual Service Casualty Ins Co v Luetmer, 474 NW2d 365 (Minn Ct App 1991) Insurer generally retains the right to select counsel and control the defense even where it has reserved the right to deny coverage. However, the insured does have the right to select its own independent counsel when an “actual conflict exists between the insurer and the insured; Prabh v Rupp Construction Co, 277 NW2d 389 (Minn 1979) Insurer has to pay reasonable attorney fees incurred by independent counsel in defending the insured.

Texas (New Law)

Downhole Navigator, LLC v Nautilus Ins Co, 686 F 3d 325 (5th Cir 2012); Coats, Rose, Yale, Ryman & Lee v Navigator’s Specialty Ins. Co., No. 12-10055, slip op (5th Cir, Oct. 15, 2012). A conflict justifying independent counsel exists only where the facts to be adjudicated in the underlying suit are the same facts upon which coverage depends. Thus, independent counsel is unavailable where there is only a potential or factual conflict based on the development of overlapping coverage.

New York

Public Service Mutual Ins Co v Goldfarb, 53 N.Y. 2d 810 (N.Y. 1981); Lardner v. Am. Home Assurance Co, 201 AD 2d 302; 607 NYS2d 296 (NY App Div 1994). Independent counsel is only required in cases where the conflict is directly apparent.

Connecticut


Massachusetts


Conclusion

A number of ethical issues arise for an attorney advising a client who has received a reservation of rights letter from its liability insurance carrier. Under California law, the terms of a standard comprehensive general liability policy provides that the insurer has the right and duty to defend any suit against the insured. This gives the insurer the right to appoint counsel for the insured. Moreover, this right is codified in California Civ. Code Section 2860. However, an attorney in all jurisdictions who advises a client has an ethical obligation.
Cumis Counsel
Continued from page 5

to educate that client as to his rights, obligations, conflicts, privileges and risks in demanding Cumis Counsel or choosing his own attorney.

The case law of the 50 states differs widely, including the 6th Circuit relating to Cumis Counsel under a reservation of rights. Michigan case law is unsettled as to who may choose independent counsel under a reservation of rights.

Should Michigan create a statute like California, Alaska or Florida? ■

About the Author

James A. Johnson of James A. Johnson, Esq., in Southfield is an accomplished trial lawyer. Mr. Johnson concentrates on insurance coverage under the Commercial General Liability policy. He is an active member of the Michigan, Massachusetts, Texas and Federal Court Bars. Mr. Johnson can be reached at 248-351-4808 or www.JamesAJohnsonEsq.com

Significant Insurance Decisions

By Deborah A. Hebert
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Sixth Circuit Cases

Fiduciary duties under ERISA
Pipefitters Local 636 Insurance Fund v BCBSM
722 F3d 861 (6th Cir 2013)
(Case No. 12-2265)

BCBSM breached its fiduciary duties under ERISA in assessing what it calls the “other-than-group” (OTG) fee against plaintiff, a self-funded benefits plan. The fee represents the 1% fee assessed by the State of Michigan against BCBSM to help pay for the cost of Medicare. The 6th Circuit concluded that even when BCBSM was providing administrative services only, it was acting as an ERISA fiduciary, and as a fiduciary, was obligated to act for the exclusive benefit of the plan. The OTG fee charged by BCBSM to fulfill its obligation to the State violated this fiduciary duty.

Endnotes

3 25 Cal. 4th 489 (2001)
4 Calif. Civ. Code § 2860 et seq.
5 Calif. Civ. Code § 2860(d)
7 New York State Urban Dev. Corp. v. VSL Corp., 738 F. 2d 61(2d Cir. 1984); See also, Norman v. Ins. Co. of North America, 239 S.E. 2d 902,907(Va. 1978)- an insurer may select independent counsel, if it discloses its reservation of rights to the insured and gives timely notice.
8 Supra, n.4
9 Title 21 Alaska Code § 21.89.100
10 Florida Claims Administration Statute, § 627.426

Michigan Court of Appeals –Published

Conflict panel to decide definition of employee for workers’ comp coverage
Auto-Owners Insurance Co v All Star Lawn Specialists Plus, Inc.
301 Mich App 515 (2013)
Submitted to Conflict Panel

In this published opinion released July 9, 2013, the Court of Appeals concluded that but for its prior opinion in Amerisure Ins Co v Time Auto Transp, Inc, 196 Mich App 569 (1992), it would hold that the injured claimant was an “employee” covered by his employer’s workers compensation policy. But because of the way Amerisure interpreted MCL 418.161(1)(n), the panel was obligated to conclude that the claimant was not an employee and was thus not entitled to benefits under the workers’ compensation policy. By order of July 26, 2013, the Court of Appeals has convened a special panel to resolve the conflict.

Motor Vehicle Exclusion Applies to Trailer
Pioneer State Mutual Insurance Co v Dells
301 Mich App 368 (2013)

The insured homeowner was driving a van and towing a trailer when the trailer broke free and crashed into a vehicle operated by the decedent. Pioneer’s homeown-
ers policy excluded coverage for liability arising out of the use of a motor vehicle. It also excluded coverage arising out of the use of a trailer unless the trailer was “not towed.” The estate argued that because the accident occurred when the trailer was detached from the van, the trailer was not towed and the trailer exclusion did not apply. The Court of Appeals held that regardless of the trailer, this accident arose out of the insured’s use of a motor vehicle. “[I]f the trailer had not been in tow, there would have been no accident and no injury. The runaway trailer certainly did not launch itself. The act of towing the trailer was a necessary ingredient in producing the horrific crash, as the act had a direct causal connection to the accident, setting into motion a series of events eventually resulting in bodily injury.” The motor vehicle exclusion thus applied.

Michigan’s “Retaliatory Tax” Applied to New York Insurers

Commerce & Industry Ins Co v Dep’t of Treasury
301 Mich App 256 (2013), lv app pending

A retaliatory tax “is a tax imposed by a state on foreign corporations, usually insurers, when the foreign state imposes a higher aggregate tax burden on actual or hypothetical out-of-state corporations.” The purpose of such a tax “is to encourage states to impose equal tax burdens on all insurance companies, whether foreign or domestic, thereby promoting interstate business.” Michigan’s retaliatory tax is MCL 500.476a. The Court of Appeals upheld the tax assessed against these New York workers compensation insurers despite claims that New York taxes were imposed on policyholders rather than the out-of-state insurers, and that New York charges were similar to those in Michigan.

The Insured’s Special Relationship with the Agency

Zaremba Equipment v Harco National Insurance Co
___ Mich App ___ (2013), reconsideration den 9/9/13 (Docket No. 298221)

Because this captive insurance agency presented itself as an expert in assessing the insurance needs of truck and auto dealerships, and because the agency used a software program to help the insured estimate the cost of reconstructing its facility, the agency developed a “special relationship” with the insured and the insured was entitled to a jury trial on the question of the agent’s alleged failure to act with due care. The jury would also have to decide whether the policyholder was comparatively negligent in failing to read its policy regarding the limits of coverage for damage to the building and its contents and to ascertain whether there was replacement coverage.

Michigan Court of Appeals –Unpublished

BCBSM Access Fee Upheld

BCBSM v Genesee County Road Commission
Unpublished Court of Appeals opinion of June 13, 2013
(Docket Nos. 305512; 313023)

County of Midland v Blue Cross/Blue Shield
Unpublished Court of Appeals opinion of June 13, 2013,
 lv app pending
(Docket Nos. 303611)

Several governmental agencies have challenged BCBSM’s practice of assessing an “access fee,” which is calculated on the
basis of fees imposed on BCBSM by the State of Michigan, such as the obligation to pay 1% of revenues to help offset the cost of Medicare for Michigan seniors. The Court of Appeals affirmed this practice in Calhoun County v BCBSM, 297 Mich App 1 (2012), on the ground that the BCBSM contracts with the counties allowed for such fees, were reasonably calculated. Both of these unpublished cases followed Calhoun in upholding the access fee.

**Auto Policy Rescinded**

*Silvernail v Liberty Mutual Insurance Co*
Unpublished Court of Appeals opinion of May 23, 2013, lv app pending (Docket No. 308762)

Because Liberty was not informed during the application process that the insured vehicle was not owned by the named insured and would be regularly used by a friend, who was not added to the policy as a driver, Liberty was allowed to rescind the policy after the friend sought PIP benefits as the result of an auto accident. The named insured misrepresented her insurable interest during the application process.

**Abuse and Molestation Exclusion Not Illusory**

*Cincinnati Insurance Co v Hall*
Unpublished Court of Appeals opinion of June 20, 2013 (Docket No. 308002)

The policy definitions of “abuse” and “molestation” are not so broad as to exclude all activity from coverage and are thus not illusory. For example, “[i]t is still possible to recover under the policy for negligent conduct.” In this case, it was alleged that the named insured’s employee intentionally struck a patient. But if it were alleged that the employee had negligently injured the patient in attempting to assist him on or off the bus, coverage would not be excluded.

**Exclusion in Boat Owner’s Policy Presents a Question of Fact**

*Farm Bureau Mutual Ins Co of Michigan v Bowers*
Unpublished Court of Appeals opinion of July 9, 2013, lv app pending (Docket No. 311811)

The owners of a boat insured by Farm Bureau loaned it to their adult son and his wife for a period of several weeks. During that period, while the daughter-in-law was operating the boat, she accidentally struck and injured her husband who was in the water. He sued his wife and his parents, but the Farm Bureau policy excluded coverage for claims by “any insured within the meaning of insured as defined” in the policy. The policy defined an insured as any person legally responsible for the watercraft if that person had custody or use of the watercraft with the named insured’s permission. The Court of Appeals concluded that the wife had legal responsibility for the safe operation of the boat at the time of the accident but there was a question of fact as to “whether . . . [the son] was ‘legally responsible’ as a bailee.

**Statutory Appraisal Controls Valuation Conflicts under Fire Insurance Policies**

*Dupree v Auto-Owners Insurance Co.*
Unpublished Court of Appeals opinion of July 18, 2013, lv app pending (Docket No. 310405)

MCL 500.2833(1)(m) sets forth procedures to be followed when an insured and an insurer do not agree on the amount of loss covered by a fire insurance policy. Either party may submit a written demand for an appraisal, in which case each party is to select a competent, independent appraiser and notify the other of that appraiser’s identity. The two appraisers must then select a competent impartial umpire. If the first two appraisers cannot agree, they must submit their differences to the umpire who will then determine the amount of the loss. Judicial review of the umpire’s determination is limited to claims of bad faith, fraud, misconduct or manifest mistake. Defendant insurer challenged the award based on the policy language but failed to allege any of the allowed grounds for seeking judicial review and its appeal was therefore denied.

**Penalty Interest under the Unfair Trade Practices Act**

*Cincinnati Insurance Co v Venulapalli*
Unpublished Court of Appeals opinion of July 30, 2013 (Docket No. 309980)

This opinion sets forth the proper analysis to be applied in determining whether penalty interest at 12% can be assessed against an insurer under the Unfair Trade Practices Act. Courts must first determine whether the insurer complied with its statutory obligation to tell the insured what documents are needed to establish proof of loss. If the insurer complied with that obligation, the court must then determine whether the insured responded with satisfactory proof of loss. If so, the court must next decide whether the insurer paid the claim in a timely fashion. If not, penalty interest is to be awarded.
Commercial UIM Coverage Applies Only to the Vehicles Described

Nagy v Westfield Insurance Co
Unpublished Court of Appeals opinion of July 30, 2013
(Docket No. 311046)

Plaintiff was injured while operating a vehicle owned by her husband’s auto dealer business which bought and sold vehicles across state lines. The commercial auto policy issued to that business provided UM/UIM coverage for “symbol 26” vehicles. Symbol 26 vehicles were defined as those autos owned by the insured “that because of the law in the state where they are licensed or principally garaged are required to have and cannot reject Uninsured Motorists Coverage.” Plaintiff was operating a vehicle licensed and principally garaged in Michigan, which does not require UIM coverage. She was not entitled to UIM coverage.

CGL – No Occurrence for Defective Construction

Triangle Associates, Inc v LI Industries
Unpublished Court of Appeals opinion of August 13, 2013
(Docket No. 307232)

In a declaratory judgment action involving the CGL coverage for a subcontractor, the Court of Appeals again ruled that defective construction performed by an insured is not an “occurrence” and thus does not trigger coverage under the CGL insuring agreement. This case also presented a question of additional insured coverage, but because the defect occurred outside the policy period, the Court did not decide whether there is an “occurrence” for an additional insured that did not perform the work, in this case, the general contractor.

Adult Son Not a Resident of his Father’s Household

Fremont Insurance Co v Martin
Unpublished Court of Appeals opinion of August 15, 2013
(Docket No. 310906)

The named insured’s adult son, who was not a resident of his father’s household, hosted a party at his father’s home while his father was away. He served alcohol to his guests, one of whom was involved in an auto accident on the way home, resulting in serious injury to his passenger. The father’s homeowners policy did not cover the son for his liability. Coverage was limited to the named insured and “residents of your household” who are “your relatives.” Because the son was not a resident of the household, he was not an insured. The son had moved from his father’s home into an apartment with his girlfriend and no longer maintained a room at his father’s house. He did not file a change-of-address at the post office but he did supply his new address after moving and received mail at that new address.

Remitted Fire Loss Verdict

Haley v Farm Bureau Ins Co
Unpublished Court of Appeals opinion of August 27, 2013
(Docket No. 302158)

In this fire loss case, the Court of Appeals upheld the jury’s award of damages as supported by sufficient evidence on the record with the exception of the value of the dwelling. The jury had awarded up to $132,500 for the cost of repairs, but no repairs had ever been made and so the highest amount the evidence on the record supported was the cash value of the dwelling, which was $104,600. The jury award was remitted in this respect.

Shooting Incident Is Not an “Occurrence” Even for the Non-Shooter Co-Insured

Home-owners Ins Co v Chammas
Unpublished Court of Appeals opinion of September 10, 2013
(Docket No. 310157)

The owner of a mini-mart shot claimant in the store parking lot. In a prior opinion, the Court of Appeals ruled that the shooting was intentional and not accidental, and therefore the individual owner did not have liability coverage under the CGL policy issued to the business. The prior opinion remanded to the trial court for consideration of the question whether the “alter ego” theory could be used to impute the employee’s intent to the corporation. This opinion, after remand, looks at liability coverage for the business entity. Citing Mich Basic Prop Ins Ass’n v Wasarovich, 214 Mich App 319, 328 (1995), the Court of Appeals observed that it must consider “only the incident itself in determining whether there was an occurrence.” Because this incident was an intentional shooting and was not accidental, the Court concluded there was no coverage for the business entity, even though the policy included a “separation of insureds” provision.
Executive Summary

At the end of the Supreme Court’s 2012-2013 term, the court released two significant decisions, which change the way no-fault practitioners had viewed certain issues arising under the No-Fault Insurance Act. In one case, the Supreme Court did away with the “dual domicile” theory in cases involving the minor children of divorced parents.

In another case, the Supreme Court limited the ability of a motorcyclist, injured in a collision with a motor vehicle, to legally “double dip” from his health insurance carrier for medical expenses paid by operation of law under the No-Fault Insurance Act.

In addition, we have two unpublished decisions from the Michigan Court of Appeals that discuss what it takes for a motor vehicle to be “involved” in an accident with a motorcycle.

Finally, we have a very interesting case involving the interpretation of MCL 500.3113(c) – the non-resident non-admitted insurer exclusion.

As we celebrate the 40-year anniversary of the effective date of the No-Fault Insurance Act on October 1, 2013, it is remarkable to note that even after 40 years, no-fault continues to be one of the most heavily litigated areas of law.

Supreme Court Action

Supreme Court Abolishes “Dual Domicile” Analysis in Cases Involving Minor Children of Divorced Parents

_Grane Ins Co v Lawrence_, 494 Mich 495, 835 NW 2d 363 (2013)

In _Lawrence_, and its companion case of _ACIA v State Farm_, Docket No. 143808, the Michigan Supreme Court considered the effect of divorce decrees on the issue of a minor child’s “domicile” for purposes of determining priority for payment of no-fault benefits under MCL 500.3114(1). In _Lawrence_, eight-year-old Josalyn Lawrence was seriously injured in a motor vehicle accident, which ultimately resulted in her death. At the time of this accident, Josalyn was living with her mother, Laura Rosinski, who was insured under a no-fault policy issued by Farm Bureau. Her father, Edward Lawrence, was the named insured on a no-fault policy issued by Grange. Josalyn’s parents were divorced approximately four years prior to the automobile accident. The divorce decree provided that both Lawrence and Rosinski would have joint legal custody of Josalyn, but the mother was given “primary physical custody” of Josalyn and her sister. After paying $30,000.00 in no-fault benefits, Farm Bureau sought partial recoupment from Grange, arguing that because the child was domiciled in both her mother and father’s households, Farm Bureau and Grange occupied equal orders of priority under MCL 500.3114(1).

Grange argued that Michigan law did not recognize “dual domiciles” based on a long line of cases dating back to the 19th century, which hold that although a person may have multiple residences, a person can only have one “domicile.” See _In Re Scheyer’s Estate_, 336 Mich 645, 59 NW 2d 33 (1953); _In Re High_, 2 Doug. 515 (Mich 1847). Both the Circuit Court and Court of Appeals rejected this argument, noting that because the Michigan Supreme Court, in _Workman v DAIIE_, 404 Mich 477, 274 NW 2d 373 (1979) had equated the term “domicile” used in MCL 500.3114(1) with “residence,” it naturally followed that an individual could have more than one “domicile.”

However, the Supreme Court rejected this analysis, noting that:

“Returning to the language of MCL 500.3114(1), there is no indication that the Legislature intended to deviate from this well-established common-law meaning of the term ‘domicile.’ And, because a person, from the moment of his birth onward, can only have one domicile within the traditional meaning of that term, it follows that a child, regardless of his parents’ marital status or his multiple legal residences, may also have only one domicile at any given point in time.

Indeed, rather than there being any indication that the Legislature intended to deviate from this common-law rule, there is, in fact, evidence that the Legislature favored this single-location rule. Had the Legislature intended to make insurers liable for PIP benefits for dual co-existing ‘domiciles,’ then it would have used the term ‘resided,’ not ‘domiciled,’ because, as previously explained, a person may have more than one residence at a time, but only one domicile. However, the Legislature instead expressly chose to use the more restrictive term, ‘domiciled,’ thereby limiting the universe of insurers that are potentially liable under MCL 500.3114(1). In fact, the Legislature specifically rejected use of the term ‘residence,’ as used in the uniform act on which the
no-fault act is modeled, in favor of the term ‘domiciled’ in defining those eligible for PIP benefits under MCL 500.3114(1). The Legislature thus affirmatively chose a term that it knew had a particular meaning, and we must accord this legislative choice its full weight when determining the Legislature’s intent.”

*Lawrence*, 835 NW 2d at 373-374 (italics in original).

In short, because the minor was “domiciled” with her mother at the time of the accident, the mother’s insurer alone was responsible for payment of the child’s no-fault benefits.

In the companion litigation, the Supreme Court ruled that a divorce decree that establishes domicile is conclusive on the issue regardless of the reality of the actual residence situation. In *ACIA*, the divorce decree stated that the injured minor, who was 16 years old at the time of the accident, was domiciled with her father in the State of Tennessee, notwithstanding the fact that for approximately 5 months leading up to the accident involving the minor, the minor had been living with her mother in Michigan. At the time of the accident, the minor was an occupant of a motor vehicle insured by State Farm. Her mother was insured under a policy with Auto Club Insurance Association (AAA). Under these circumstances, the Supreme Court ruled that because by operation of law (the divorce decree), the child was domiciled in the State of Tennessee, she was not domiciled in her mother’s household in Michigan. As a result, State Farm, as the insurer of the vehicle occupied by the minor at the time of the accident, was solely responsible for paying her no-fault benefits.

Clearly, when dealing with claims involving the minor children of divorced parents, it will be necessary to obtain the actual divorce decree to determine which parent has primary physical custody of the minor. In most cases, it will probably be the parent with whom the child was living at the time of the accident. However, as we see in the *ACIA v State Farm* case, that will not always be the case.

In its ruling, the Michigan Supreme Court has clearly signaled its unwillingness to extend duplicative recovery in cases where the plaintiff simply did not pay the applicable premiums for such coverage. This case could have a dramatic impact on the ability of injured motorcyclists to realize a double recovery on medical expenses which, if truth be known, was an unintended consequence of the 1981 legislation which changed the no fault priority scheme for motorcyclists.

Supreme Court Rejects Motorcyclist’s Argument that He is Entitled to “Double Dip” on Medical Expenses from His Health Insurer


In this case, the motorcyclist, Brent Harris, was involved in an accident with a motor vehicle insured by AAA. At the time of the accident, Harris had a health insurance policy with Blue Cross/Blue Shield of Michigan. However, the Blue Cross/Blue Shield policy contained a provision which provided that there would be no coverage under the Blue Cross/Blue Shield policy under the following circumstances:

“We do not pay for the following care and services: Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this certificate.”

Although Blue Cross/Blue Shield initially paid the medical expenses at issue, it retracted the payments and denied coverage, relying on the above-referenced provision. At that point, the no-fault carrier, AAA, paid the medical expenses at issue, at which point Harris filed suit against Blue Cross/Blue Shield, seeking to recover payment of the medical expenses at issue. The Circuit Court granted summary disposition in favor of Blue Cross/Blue Shield. The Court of Appeals, however, reversed in a 2-1 decision.

The Supreme Court reversed the decision of the Court of Appeals and reinstated the judgment of the Circuit Court. In doing so, the Supreme Court noted that the double recovery of medical expenses can only arise when the claimant has actually paid a premium for the non-coordinated coverage:

“Unlike the Claimant in *Shanafelt v Allstate*, 217 Mich App 625, 552 NW 2d 671 (1996)], and other cases in which a double recovery of insurance benefits was awarded, Harris is not claiming benefits under a no-fault insurance policy that he or anyone else procured. Harris is neither a third-party beneficiary nor a subrogee of a no-fault policy issued to the person that struck and thus he is not eligible to receive benefits under that policy. Rather, Harris’ right to PIP benefits arises solely by statute. . . Harris is entitled to PIP coverage because MCL 500.3114(5) (a) designates ACIA as the responsible insurer. This conclusion is consistent with our holding in *Smith v Physicians’ Plan Inc.*, 444 Mich 743, 514 NW 2d 150 (1994) where we concluded that an insured must pay a premium to obtain insurance policies that provide for a double recovery. Harris has simply not shown that he paid the necessary premiums to receive a double recovery.

Under MCL 500.3114(5)(a), Harris was not obligated to pay his medical expenses because, as a mat-
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ter of law, ACIA was liable for Harris’ PIP expenses.
. . Regardless of when Harris sought treatment for his injuries, those services are ‘those for which [Harris] legally [did] not have to pay . . .’ Accordingly, Harris is not entitled to a double recovery.”

Harris, 835 NW 2d at 361-362.

In its ruling, the Michigan Supreme Court has clearly signaled its unwillingness to extend duplicative recovery in cases where the plaintiff simply did not pay the applicable premiums for such coverage. This case could have a dramatic impact on the ability of injured motorcyclists to realize a double recovery on medical expenses which, if truth be known, was an unintended consequence of the 1981 legislation which changed the no-fault priority scheme for motorcyclists.

Court of Appeals Action

A Question of Fact Exists as to Whether or Not a Motor Vehicle was “Involved” in an Accident Involving a Motorcyclist

Braverman v Auto Owners Ins. Co., Docket No. 306492, unpublished decision rel’d 8/20/2013

In Braverman, a motorcyclist, Pamella Smutzki, was traveling on Haggerty Road when she saw a tractor-trailer unit traveling at a slow rate of speed. Smutzki tried to apply the brakes but they apparently locked, so she laid down the motorcycle to avoid hitting the tractor-trailer unit. She did not strike the trailer, but instead went off the road. She ultimately died from the injuries suffered in the accident. Her estate filed a claim for no-fault benefits with Auto Owners Insurance Company, which insured the tractor-trailer unit. Auto Owners denied coverage on the basis that the tractor-trailer unit was not “involved” in the accident. Following discovery, the trial court granted summary disposition in favor of plaintiff, noting that the tractor-trailer unit was involved in the accident, as a matter of law, “because plaintiff reacted to the truck as it proceeded so slowly on the road, essentially causing an obstruction on the roadway.” Braverman, slip opinion at page 2.

On appeal, the Court of Appeals reversed the decision of the lower court and remanded the matter back to the Circuit Court for trial on the issue of whether or not the tractor-trailer unit was “involved” in the accident. In doing so, the Court of Appeals concluded that, as a matter of law, the motor vehicle was not “involved” in the accident because the causal relationship between the motor vehicle and the motorcyclist’s loss of control was incidental, fortuitous or “but for.”

Court of Appeals noted that in order for a motor vehicle to be “involved” in an accident, the vehicle must actively contribute to the accident, citing Turner v ACIA, 448 Mich 22, 528 NW 2d 681 (1995). In this case, there appears to be conflicting evidence as to whether or not the tractor-trailer unit was “involved” in the accident, thereby precluding summary disposition for either party.

Query – the entitlement provision of the No-Fault Act, MCL 500.3105(1) indicates that no-fault benefits are payable for accidental bodily injuries “arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle.” The issue of whether or not a motor vehicle is “involved” in an accident goes to the issue of priority under MCL 500.3114(5). By equating the phrase “arising out of” with “involved in,” the Court of Appeals appears to be equating these two terms – just as the Michigan Supreme Court appeared to do in its Memorandum Opinion in Utley v Michigan Municipal Risk Authority, 454 Mich 879, 562 NW 2d 199 (1997).

Court of Appeals Rules, as a Matter of Law, that a Motor Vehicle is Not Involved in an Accident with Motorcyclist

Detroit Medical Center v Progressive Michigan Ins. Co., docket no. 304622, unpublished decision rel’d 7/23/2013

In Detroit Medical Center, the motorcyclist was traveling “upward of 100 mph” on a dark and deserted side street that intersected with Jefferson, in the City of Detroit. The motorcyclist apparently saw bright headlights from an approaching motor vehicle. Startled by the lights, the motorcyclist applied his brakes, causing him to lose control of the motorcycle. As a result, he dropped the motorcycle on its side, hit the sidewalk and fell. The motorcycle never came into contact with the approaching motor vehicle. The Detroit Medical Center subsequently filed suit against Progressive, the motor vehicle insurer of the operator of the motorcycle, seeking to recover payment of medical expenses incurred by
the motorcyclist. The lower court held that, as a matter of law, the motor vehicle was sufficiently involved in the accident to trigger the motorcyclist’s entitlement to no-fault benefits under MCL 500.3105(1), even though there was no physical contact between the motorcycle and motor vehicle. However, on appeal, the Court of Appeals reversed and noted:

“We can find no causal connection between the motorcyclist’s injuries and the use of a motor vehicle as a motor vehicle sufficient to trigger entitlement to no-fault benefits under MCL 500.3105(1). The motorcyclist applied his brakes when he saw the vehicle’s headlights approaching. The motorcyclist’s evasive action in braking rapidly was in response to seeing the moving vehicle’s headlights and because of the braking he fishtailed and lost control of the motorcycle, ultimately causing him to crash. But this does not mean that the motor vehicle was causally connected to the motorcyclist’s injuries. . .

Rather, the evidence established that the causal connection between the motorcyclist’s injuries and the motor vehicle was merely incidental, fortuitous, or ‘but for.’ [Citation omitted]. We cannot say that the motor vehicle actively contributed to the accident rather than merely being present. [Citation omitted]. While it is true that a vehicle which is motionless in a lawful position is less likely to be considered involved,’ but that a ‘moving vehicle is much more likely to be held to be involved,’ [Citation omitted], that does not equate to a conclusion that the motor vehicle was involved merely because it was moving. There still needs to be a causal connection between the injuries and the motor vehicle. . .

In this case, there is no evidence that the motorcyclist needed to take evasive action to avoid the motor vehicle. Rather, the evidence only establishes that the motorcyclist was startled when he saw the approaching headlights and overreacted to the situation.”

Accordingly, the Court of Appeals concluded that, as a matter of law, the motor vehicle was not “involved” in the accident because the causal relationship between the motor vehicle and the motorcyclist’s loss of control was incidental, fortuitous or “but for.”

Clearly, the determination of whether or not a motor vehicle was “involved” in an accident with a motorcyclist is always a fact-intensive inquiry. Nonetheless, such an inquiry is absolutely necessary, given the significant amount of dollars at stake in accidents involving motorcyclists.

Out-of-State Resident can Recover No-Fault Benefits, Even Though the Motorcycle He Was Riding Was Not Insured by an Insurer Authorized to do Business in Michigan


This case involved the proper application of MCL 500.3113(c), which provides:

“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:

* * *

(c) The person was not a resident of this state, was an occupant of a motor vehicle or motorcycle not insured in this state, and was not insured by an insurer which has filed a certification in compliance with section 3163.”

In _Perkins_, the plaintiff was a resident of the Commonwealth of Kentucky. He was operating his motorcycle near Glen Arbor when he was involved in a collision with a motor vehicle insured with Defendant Auto Owners Insurance Company. Plaintiff’s motorcycle was insured with Progressive Northern Insurance Company, which did not file a certification under MCL 500.3163. However, the motorcyclist also owned a motor vehicle, registered in Kentucky and insured by State Farm. The motor vehicle owned by the motorcyclist, of course, was not involved in the accident.

Auto Owners denied the claim on the basis that Plaintiff was not a resident of the State of Michigan, was an occupant of a motorcycle not registered in this state, and the motorcycle was not insured by a Section 3163 insurer. Plaintiff countered that even though he was not a resident of the State of Michigan and was occupying a motorcycle not registered in this state, he was still insured by an insurer which did file a Section 3163 certification – his _motor vehicle insurer_, State Farm. The lower court granted Plaintiff’s Motion for Summary Disposition and ruled that Auto Owners was obligated to pay Michigan no-fault benefits to Plaintiff. The lower court also granted Plaintiff’s Motion for No-Fault Penalty Interest, Attorney Fees and Costs.

On Appeal, the Court of Appeals affirmed the decision of the lower court, noting that by virtue of the plain and unambiguous statutory language utilized in MCL 500.3113(c), the exclusion was simply not triggered. As stated by the Court of Appeals:

“We turn first to the actual language of the statute.
We find the terms of §3113(c) plain and unambiguous; for Plaintiff to be excluded from PIP benefits, all three conditions must be met. And the third condition has not been met. MCL 500.3113(c) precludes recovery if the out-of-state party ‘was not insured by an insurer which has filed a Certification in compliance with §3163.’ The simple fact remains that Plaintiff was insured by an insurer that had filed the required certification. Nothing in the statute requires that the insurer be the one that provided insurance for the vehicle involved in the accident. Indeed, as this Court observed in Farmers Ins. Exch. v Farm Bureau Gen’l Ins. Co. of Michigan, 272 Mich App 106, 724 NW 2d 485 (2006), under the No-Fault Act ‘persons rather than vehicles are insured against loss.’ And because plaintiff is a person insured by a carrier that had filed a certification under §3163, §3113(c) does not exclude him from PIP benefits.”

Again, the Perkins decision reaffirms an important concept in no-fault – for purposes of PIP coverage, no-fault is designed to insure persons, not vehicles. Obviously, in cases involving out-of-state residents, attorneys attempting to secure no-fault benefits for their out-of-state clients, or insurers hoping to deny coverage under MCL 500.3113(c), will need to look beyond the actual motor vehicle involved in the accident and determine whether or not the out-of-state resident owned any other motor vehicles, insured by different carriers who may have filed a certification under MCL 500.3163.

About the Author

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NO Fault: A Medical Fee Schedule is Reasonable and Necessary

By Nathan J. Edmonds and Alison M. Quinn, Secrest Wardle

The current legislative attempt to adopt medical fee schedules in the area of no fault law in Michigan has generated considerable controversy. Currently, no medical fee schedules exist under the Michigan No Fault Act. In contrast, Michigan workers’ compensation law has used fee schedules for decades. Under the Michigan Worker’s Disability Compensation Act, a medical provider is only allowed to receive what is allowed under the act. However, under the Michigan No Fault Act, providers are allowed to charge whatever they choose, and no fault insurers must pay the “reasonable and customary” amount.

The problem with the phrase “reasonable and customary” is that it is not susceptible to easy definition and understanding. It is so general that it fails to provide any workable guidelines that strike the balance of providing medical care while preventing unwarranted increases in medical costs.

Vague Criteria Lead to Excessive Reimbursements

Who determines what amounts are “reasonable and customary”? A brief answer could be it depends. It depends on who, what, whom, where, when, and how. Who is the judge and/or the jury pool. What are being charged for and who is doing the medical procedure. Where is the service being provided? When is the medical service provided and how much can the provider really expect to get? These statements, although dramatically simplified, illustrate how the multiplicity of factors can make it difficult or impossible to come up with a workable and uniform answer to what is “reasonable and customary” under current Michigan law.

Among the current proposals for reform of No-Fault is a proposal to address this concern. In a stated attempt to rein in increasing costs for medical services and thereby lower automobile premiums and curtail the burgeoning amount of no fault medical provider litigation in Michigan, the proposal is to incorporate a medical fee schedule into the Michigan no fault law, similar to the current Michigan workers’ compensation medical fee schedule.

Proponents of reform point out that Michigan is the tenth most expensive state in the nation in terms of No-Fault costs. The average claim in Michigan was $44,000, whereas the next two states were $17,000 and $10,000, respectively.

Under the current version of the No Fault Act, providers are permitted to charge a reasonable amount not to exceed what it “customarily charges for like products, services, and accommodations in cases not involving insurance,” and the use of fee schedules is specifically prohibited.

HB 4612, if enacted, would contain costs by tying reimbursement for medical services to the fees paid to reimburse Medicare and “social welfare” payments. It would restrict providers to charging no-fault insurers no more than they customarily receive for like products, services, and accommodations in cases “that do not involve personal protection insurance, the program for medical assistance for the medically indigent under the Social Welfare Act, 1939 PA 280, MCL 400.1 to 400.119b, or the Federal Medicare Program established under Title XVIII of the Social Security Act, 42 USC 1395 to 1395KKK-1.”

The proposal would also place the burden of justifying fees on the provider. The proposal states that “any information needed by an insurer . . . to determine the appropriate reimbursement under this section shall be provided by the person providing the treatment or rehabilitative or occupational training.” If the information is not provided or is otherwise insufficient the insurer can pay an amount based on the Workers’ Compensation medical fee schedule. Many providers oppose use of a medical fee schedule with no-fault claims, but a compelling argument can be made that the change is timely and necessary.

The underlying problem is that “reasonable charge” has not been defined under statute or case law, and that has made it troublesome for both insurers and providers and has been the subject of much litigation.

This is not the first time that medical fee schedules have been proposed in Michigan. In the November 1992 and November 1994 elections, Michigan voters rejected proposals that would have enacted fee schedules for use with no fault claims.

The underlying problem is that “reasonable charge” has not been defined under statute or case law, and that has made it troublesome for both insurers and providers and has been the subject of much litigation. In 2003, in his concurring opinion in Advocacy Organization for Patients & Providers et al v Auto
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Club Insurance Association et al. Judge E. Thomas Fitzgerald of the Court of Appeals wrote separately to criticize the fact that the Michigan Legislature had not provided criteria with which to determine whether a charge was reasonable. Judge Fitzgerald “strongly recommend[ed] that legislation be enacted that required the Commissioner of Insurance to adopt medical-fee schedules . . .”9

Fee Schedules in Other States

Although the fee schedule issue is relatively new to Michigan, other states have used fee schedules for years, and Michigan is behind the times. Medical fee schedules have been utilized in other no-fault states for a number of years. Florida, for example, has gone through multiple statutory revisions since enacting a fee schedule for use in no-fault claims. Under the most recent revisions that took effect January 1, 2013, providers are now reimbursed for many services at 80% of 200% of the appropriate Medicare Part B schedule.10

New Jersey is another example. New Jersey lawmakers first enacted a fee schedule in 1990 and the statute provided that the fee schedule would “incorporate the reasonable and prevailing fees of 75% of practitioners within the region.”11 New Jersey made several changes over the years, including:

• changing the basis of the fee schedule from billed fees to actual amounts paid for services
• allowing the Department of Banking and Insurance to contract with Ingenix to determine fees paid and make fee comparisons with the Medicare Part B provider fee schedule and the New York workers’ compensation and no-fault fee schedule.12

Similar to the proposed changes in HB 4612, New York has utilized its workers’ compensation fee schedule for no-fault claims for decades, and the statute currently provides for its use “except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge.”13

Opponents of medical fee schedules argue that HB 4612 will reduce the amount and quality of care patients receive for their accident-related injuries, and this is the core of the controversy. In our opinion, this argument is misguided. The experience in States that have used fee schedules does not provide any instances of substandard medical care. The systems in place in New York, New Jersey and Florida have operated without any complaints from the persons receiving services. And even in Michigan, the services provided under the Worker’s Disability Compensation Act have not generated any complaints of substandard service.

A significant factor giving rise to the controversy is the anticipated revenue loss to medical service providers. But if the question is viewed from the perspective of public policy affecting the State as a whole, there is compelling evidence that change is needed. In fact, one study suggested that “it would cost an insurer 57 percent more to settle a claim from Michigan than it would to settle a claim from another state that involved similar crash circumstances, reported injuries, and claimant demographics.”14 A medical fee schedule would address this problem by containing costs and bringing consistency and stability to the no fault system.

Lower Benefit Caps

Michigan’s benefit caps are also far out of line compared to other states. Unlike Michigan’s current unlimited cap or the proposed $1 million cap on no-fault benefits under HB 4612, no fault insurers in Florida are only obligated to pay up to $10,000 in benefits per person in a motor vehicle accident. New York’s limit is higher, but capped at $50,000 unless the insured purchases additional benefits. New Jersey is the closest to Michigan, and allows drivers to purchase up to $250,000 in PIP benefits. Michigan no fault coverage is a lot more generous than other states. In addition, with a medical fee schedule in place, the $1 million cap will go a lot further than it would under the current law.

“Medically Appropriate and Necessary” as a Question of Law

Another change proposed by HB 4612 is to make the determination of whether a charge is reasonable or whether a product, service, or accommodation is “medically appropriate and necessary” a question of law to be decided by the court, with the requirement that any information needed by an insurer to determine the appropriate reimbursement must be given by the provider. In regard to the growing number of direct provider lawsuits, these changes will likely reduce the amount of jury trials and disputes over what information is discoverable. On the other hand, it will be interesting to see how courts decide the issue of reasonableness. Unlike the serious impairment of a body function threshold, the statutory language does not provide for any situation where the determination is a question of fact for the jury.15

As with any major change in a law that affects as many people as No-Fault affects, judicial challenges are likely. But appellate decisions in other states indicate that these lawsuits will not likely succeed in defeating the use of the proposed medical fee schedule, if it is adopted.16
In the authors’ opinion, although the enactment of HB 4612 in Michigan will undoubtedly bring challenges, the time is ripe for Michigan to join other states and enact a medical fee schedule for use in no fault claims for PIP benefits. Without a medical fee schedule, Michigan no fault insurance will continue to provide excessive compensation to medical providers to make up for shortfalls that medical providers incur from reimbursements from Medicare amounts and from treating uninsured. Moreover, fears of bankrupt or fleeing medical providers are unfounded.

About the Authors

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Endnotes
1 MCL 500.3101 et seq.
2 MCL 418.101 et seq.
3 MCL § 418.315.
4 MCL 500.3107
5 Michigan House of Representatives, Governor Snyder State of the State, 97th Legislature, January 16, 2013.
6 MCL § 500.3157 (emphasis added); Mercy Mt Clemens Hosp v Auto Club Ins Assn, 219 Mich App 46 (1996).
9 Id. at 386.
10 Fla Stat § 627.736(5)(a).
11 In re Adoption of N.J.A.C. 11:3-29 ex rel. State Dept. of Banking & Ins, 410 NJ Super 6, 15; 979 A2d 770, 775 (2009).
12 Id. at 16-19; NJ St Ann 39:6A-4.6.
13 NY Ins Law § 5108 (McKinney).
15 MCL § 500.3135(2).
16 See, e.g., In re Adoption of N.J.A.C. 11:3-29 ex rel. State Dept of Banking & Ins, supra, and Goldberg v Corcoran, 153 AD2d 113, 118; 549 NYS2d 503, 506 (1989) (holding that adoption of fee schedules in New York did not violate federal or state constitutions).

Insurance and Indemnity 101

If a Tree Falls in a Forest, Is It an Occurrence?

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

Everyone knows the old saw: “If a tree falls in a forest, and there is no one to hear, does it make a sound?” For an insurance coverage geek, the first response is: “Define ‘sound.’” If sound is defined as a series of pressure waves propagated through the atmosphere, the answer is yes. If sound is those pressure waves as sensed by a human auditory nerve, the answer is no.

Let’s look more closely at the second definition. Under this definition, “sound” has a perceptual – i.e. mental – component as well as pressure waves. Perception, under this definition, can only come from a human. Now suppose there are two humans involved. Andrew is standing 20 feet away and the pressure waves reach his ears; there was a sound. Veronica lives across the ocean and perceives no such pressure waves; there was no sound.

Was there a sound? There are two answers: Yes for Andrew and No for Veronica. Which one is correct? Both. Maybe only a coverage geek is comfortable with that result, but it makes sense.

So it is with insurance policies. The trigger of coverage under a General Liability policy is an “occurrence.” “Occurrence” is defined as an “accident.” An accident is defined in the case law as “‘an undesigned contingency, a casualty, a happening by chance, something out of the usual course of things, unusual, fortuitous, not anticipated and not naturally to be expected.’”

Thus, “intent” is an inherent element in the finding of an occurrence, because the presence of intent equals the absence of occurrence. Now assume that Andrew is an employee who committed some action and did so with “intent.” His
co-employee, Veronica, was nowhere near and had no intent. Both are sued. Was there an occurrence? No and Yes. No as to Andrew, Yes as to Veronica.

Does that seem odd? It shouldn’t. Insurance policies are practical documents, not philosophical treatises. They are written to provide protection for real-world situations. To say that Andrew’s intent bars coverage for all insureds is what is odd.

Any employer wants and needs protection against liability created by the acts of an employee, even – perhaps especially – if those acts are “intentional.” Likewise, every employee wants and needs and is entitled to protection against liability that may flow from the acts of another employee, even intentional acts.

In the case of the falling tree, the answer – actually, both answers – come from the definition of sound. For a policy, the answers come, sensibly enough, from the policy provisions, and separately from case law.

[W]e have also held that the definition of accident should be framed from the standpoint of the insured, not the injured party. Thus, in the instant case, we hold that the accident must be evaluated from the standpoint of the Masters, not those harmed by their actions.2

In Masters, both insureds intentionally set a fire and attempted to collect on a property damage policy, and coverage was denied to both.

What happens when, as with Andrew and Veronica, one had “intent” and the other did not? This is where policy language comes into play. All liability policies contain an exclusion for “expected or intended injury.” These fall into two distinct types. One excludes coverage for expected or intended injury from the standpoint of “an insured, and the other applies to “the insured.” These are sharply distinct.

In Allstate Insurance Co v Freeman,3 the policy contained an exclusion for intentional acts of “an insured.” The Supreme Court reviewed cases in other jurisdictions and concluded that the term “an insured” was the equivalent of “any insured.”4

But the phrase “the insured” leads to the opposite conclusion. In Vanguard Insurance Co v McKinney,5 the policy was a homeowner’s policy. The insureds were father and son. The son committed murder using the father’s gun; there was no indication of any participation by the father, and the issue was whether the father was insured, where the “expected or intended injury” exclusion used the phrase “the insured.” The Court of Appeals relied on the analysis in Allstate v Freemen, supra, and concluded that coverage for the father was not barred.

[W]e conclude that the distinction between “an insured” and “the insured” is not, as plaintiff suggests, irrelevant, but, rather, highly relevant. Accordingly, we conclude that, consistent with Freeman, supra, exclusionary language referring to the conduct by “an insured” excludes coverage to all insureds on the basis of the conduct of any insured.” However, where, as in the case at bar, the exclusionary clause refers to the conduct of “the insured,” coverage is only precluded as to the particular insured who engaged in the conduct and not as to any other insured covered by the same policy.6

Note that the murder was not an “occurrence” from the perspective of the son, but coverage was provided to the father. If coverage were always extinguished because the actor-insured had intent, then the distinction between “the insured” and “an insured,” so carefully enunciated by the courts, would never arise.

But wait, there’s more. Many policies have a “Separation of Insureds” clause. These can take different forms, but they all have the same purpose, which is evident from the title. One formulation is:

5. Separate Insureds. Coverage provided under the Commercial Liability Coverage applies separately to each “insured” against whom claim is made or suit is brought.

This is the formulation used in the 2003 version of the Insurance Services Office’s Commercial General Liability form:

Separation of Insureds

Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:

a. As if each Named Insured were the only Named Insured; and

b. Separately to each insured against whom claim is made or “suit” is brought.

This brings us back to the underlying principle. Insurance policies are practical documents written to address practical problems. The analysis of insurance coverage is not a philosophical inquiry in which categories of the absolute must be
defined once and for all time. A business that has employees wants to be protected from the liability that can flow from the acts of the employees. A wife who has an interest in property is entitled to rely on the policy to protect here, even if her husband committed a wrongful act.

A policy that excludes all coverage for every insured based on the fact that one insured acted with intent will, as a practical matter provide much less coverage than the insureds think they are buying. In the case of a business, where liability will almost always spring from the act of one employee, it shrinks coverage so close to nothing as to defy measurement.

Insurance companies are aware of this need, and they address it by specific policy language designed to limit the effects on one insureds acts. That is why policies seldom bar coverage for all based on the intentional act of one, and why the Separation of Insureds clause is standard.

Apart from the confusion over the proper approach to analysis of a policy, treating the act of one insured as barring coverage for all insureds, on the theory that the act was not an occurrence, in some absolute sense, bumps up against the principle that a policy is read as a whole and meaning given to all of its parts. If coverage is barred for all insureds whenever the actor insured has “intent,” then the distinction between “the insured” and “an insured,” and the Separation of Insureds clause, become meaningless embellishments.

The interpretation of insurance policies is in no sense ethereal; it's a pretty humble exercise. That's why we insurance coverage geeks never get any dramatic war stories. Imagine trying to make knee-slapping humor out of “the insured” vs. “an insured.”

The principles of construction of insurance policies are all designed to give practical, real-world effect to language written to address intensely practical – and distinctly unphilosophical – problems. Remembering the purpose of insurance is a good way to understand the principles of construction, and the policy language, and apply both correctly.

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. Mr. Carroll practices extensively in the area of insurance coverage and indemnity law, and was designated a “Super Lawyer®” again in 2013. He also consults with businesses and insurers on the drafting of contracts, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His website is www.HalOCarrollEsq.com and his email address is HOC@HalOCarrollEsq.com.

Endnotes

1 Allstate Insurance Company v McCarn, 466 Mich 277; 645 NW2d 20 (2002).
3 432 Mich 656; 443 NW2d 734 (1989)
4 Id at 694-695.
5 184 Mich App 799; 459 NW2d 316 (1990)
6 Vanguard at 809.

ERISA Decisions of Interest

Michael R. Shpiece, Kitch Drutchas Wagner Valitutti & Sherbrook
Kimberley J. Ruppel, Dickinson Wright

Sixth Circuit Update

An Insurance Policy May Constitute a “Plan Instrument”

Frazier v. Life Ins. Co. of N. Amer.
__ F.3d __ (6th Cir., 2013) (Case No. 12-6216)

When welfare plan benefits are insured, the plan document typically incorporates the policy document and defines the insurer's role with respect to claim determinations. If an insurer is to be given fiduciary duties, that must be spelled out in a plan instrument. 29 U.S.C. § 1102. This case addressed the question of whether an insurance policy constituted a “plan instrument” where the policy – but not the plan – named the insurer as a claim fiduciary.

The plaintiff in this long term disability benefit termination challenge argued that because the plan document did not define the insurer as a claim fiduciary and likewise did not delegate discretionary authority to the insurer, the court should apply the less deferential de novo standard of review to the claim determination. The Sixth Circuit rejected that argument, finding that the ERISA statutory framework does not prohibit an insurance policy from being both a plan document and a plan asset.

The plaintiff also argued that the policy did not expressly confer the insurer with discretionary authority. However, the court found that the requirement for claimants to provide the insurer with “satisfactory proof” of disability was sufficiently clear to grant discretionary authority. Further, the court
found that an advisory opinion issued by the state Insurance Commissioner requiring de novo review was not binding.

With respect to the substantive disability determination, the court found that the insurer reasonably gave greater weight to the plaintiff’s pain doctor’s opinion that she could work as opposed to the family physician’s opinion that she could not work because the pain doctor’s opinion was supported by more detailed and objective evidence, whereas the family physician’s notes were not specific and referenced no supporting objective tests or clinical findings.

although the plaintiff argued that her occupation required her to be able to lift more than was required according to the Department of Labor’s standards for that occupation, the court found that the insurer rationally relied on the job description provided by the plaintiff’s employer, which corresponded to the DOL’s exertion requirements.

Further, the policy provided that a claimant’s “own occupation” was defined according to the duties of that occupation as it was normally performed in the national economy and not necessarily by a claimant’s actual job requirements. Thus, although the plaintiff argued that her occupation required her to be able to lift more than was required according to the Department of Labor’s standards for that occupation, the court found that the insurer rationally relied on the job description provided by the plaintiff’s employer, which corresponded to the DOL’s exertion requirements.

The court rejected the remainder of the plaintiff’s arguments that the insurer’s decision was procedurally flawed, alleging that: the insurer was motivated by bias; the insurer took an inconsistent position when providing assistance to the plaintiff in applying for Social Security disability benefits; and the insurer improperly made credibility determinations concerning the complaints of pain. In particular, regarding the Social Security factor, the court noted that the insurer assisted the plaintiff in her application for benefits only until the insurer rendered its decision to discontinue payment of benefits, which was not an inconsistent position. Ultimately, the court held that the insurer’s determination was supported by the weight of the evidence in the record and there was no evidence to support a claim of bias.

Claims of Estoppel and Breach of Fiduciary Duty Rejected Where Plan Terms Unambiguously Allowed for Modification

Haviland v. Metropolitan Life Ins. Co. __ F.3d __ (6th Cir. 2013) (Case No. 12-1958)

This is yet another in a series of benefit reduction challenges arising in the wake of the various automotive manufacturer bankruptcies in recent years. Plaintiffs here were salaried retirees of General Motors (or its affiliates) who sought to enforce plan terms that provided for life insurance benefits to be continued for the retirees’ lifetime at a set coverage amount, with no cost to the retirees. In connection with the bankruptcy proceeding, GM’s plan was amended such that salaried retirees’ continuing life insurance benefits were capped at $10,000, much lower than the pre-bankruptcy values.

The plaintiffs proceeded upon theories of promissory estoppel, breach of fiduciary duty, breach of the plan terms and unjust enrichment, each of which was rejected in turn by the Sixth Circuit, which also found that no equitable relief was warranted.

The court held that the promissory estoppel claim was governed by Sprague v. GM, 133 F.3d 388 (6th Cir., 1998) because the plan documents at issue unambiguously and expressly reserved the right to amend, modify, suspend or terminate the plan at any time. The court further held that estoppel could not be used to vary the terms of unambiguous terms under the exception articulated in Bloemker v. Laborers’ Local 265, 605 F.3d 436 (6th Cir., 2010), because this case did not involve a complex calculation of benefits which the plaintiff were unable to understand and none of the extraordinary inequities were present as in Bloemker.

In support of the breach of fiduciary duty claim, the plaintiffs argued that the insurer failed to act in good faith when it advised them in writing that the benefits would remain in effect for life, when the benefits were actually contingent on GM’s payment of future premiums. Without deciding that the insurer was, in fact, a fiduciary, the court held that the insurer’s correspondence to participants accurately reflected the terms of the plan and did not contain any misrepresentation upon which to support a breach of fiduciary claim.

The court upheld the district court’s finding that the breach of plan terms claim sounded in state law and was therefore preempted by ERISA. Dismissal of the unjust enrichment claim was also upheld because the court found that the plaintiffs did not pay the premiums, GM did, and also because the insurer presumably paid some death benefits during the policy period for which premiums were paid.
MPPAA effectively changed the obligation of a “withdrawing” employer from that of paying, e.g., 10 cents per hour to paying 10 cents per hour plus whatever is necessary to fund the vested benefits of employees of that employer. Needless to say, particularly with poorly funded plans, this withdrawal liability can be very significant (even millions of dollars) and comes as a shock to the employer.

The dissent disagreed regarding dismissal of the breach of fiduciary and promissory estoppel claims, noting that the plaintiffs stated plausible claims that warranted further factual development. In particular, the dissent was critical of the insurer’s correspondence to plan participants for the failure to include any reference to GM’s right to change the plan terms, emphasizing that a fiduciary has the affirmative duty to inform when silence may be harmful.

$10 Million Withdrawal Liability Upheld for 20 Teamsters

Findlay Truck Line v. Central States Pension Fund
726 F.3d 738 (6th Cir. Aug 9, 2013)

In 1980, Congress adopted the “Multiemployer Pension Plan Amendments Act” (“MPPAA”) as an addition to ERISA. Multiemployer plans are plans that are maintained pursuant to collective bargaining agreements with more than one employer. Typically, the collective bargaining agreement will require the employer to contribute a certain amount based on the amount of work covered employees performed (e.g. 10 cents per hour worked). MPPAA provides that if an employer “withdraws” from a multiemployer plan (i.e., stops contributing to the plan or significantly reduces its contributions), it must pay its share of that plan’s unfunded vested benefits. (MPPAA sets out a payment schedule.)

In other words, MPPAA effectively changed the obligation of a “withdrawing” employer from that of paying, e.g., 10 cents per hour to paying 10 cents per hour plus whatever is necessary to fund the vested benefits of employees of that employer. Needless to say, particularly with poorly funded plans, this withdrawal liability can be very significant (even millions of dollars) and comes as a shock to the employer.

If there is a dispute over the amount of withdrawal liability assessed by the plan, MPPAA has a special dispute procedure that requires the employer to (1) request a redetermination by the plan, and then (2) request arbitration. Generally, the employer must continue to pay the withdrawal liability during this dispute procedure. (This has been called “pay now, dispute later.”)

This case illustrates the application of many of these rules. Findlay was obligated to contribute to the Teamsters’ Central States Pension Fund on behalf of 20 employees covered by the fund. The employees went out on strike and Findlay stopped contributing. Six months later, the union “disclaimed” interest in the 20 employees, and the Fund issued a notice of withdrawal and a demand for the payment of withdrawal liability in the amount of over $10 million.

Findlay filed suit claiming the withdrawal was “union-mandated” and paying would create “irreparable harm.” On appeal, the Sixth Circuit held that the “pay now, dispute later” provisions of MPPAA divested the federal courts of jurisdiction to issue preliminary injunctions, the “union-mandated” as well as any other issues were required to be considered in arbitration, and the employer must pay the withdrawal liability according to the schedule. Although the court held that the “pay now, dispute later” was supreme, it noted that it had previously recognized three minor exceptions to the arbitration requirements: a facial constitutional attack, a verifiable claim that arbitration would lead to irreparable injury, and a determination of whether a company is an “employer” within the meaning of MPPAA. In the author’s experience, these exceptions come up only rarely.

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Open enrollment in Michigan's Health Insurance Marketplace (also known as the Exchange) opened on October 1 and will run through March 31, 2014. Coverage begins on January 1, 2014 for consumers who have enrolled by December 15, 2013.

The Marketplace (Exchange)

The Health Insurance Marketplace is a federally operated insurance marketplace where individuals and small businesses can shop for and compare health insurance plans. Michigan's Marketplace is a "plan management" partnership Marketplace and is largely operated by the federal government. In Michigan's plan management Marketplace, the Department of Insurance and Financial Services (DIFS, previously the Office of Financial and Insurance Regulation or OFIR) retained control over the insurance plans offered in the Marketplace, including each plan's rates and forms. The federal government will operate all other aspects of the Exchange, including the website and consumer assistance functions.

Over the summer, DIFS reviewed 170 separate health plans submitted by 14 insurance companies, as well as 164 stand-alone dental plans submitted by 13 insurance companies. Eleven companies submitted plans for the small group market, and nearly all the companies submitted plans for the individual market. In both the health plan market and the dental plan market, plans will be available at four tiers of coverage, labeled according to their expected actuarial value. Bronze plans will cover 60% of expected health care costs; silver plans will cover 70%; gold plans will cover 80%; and platinum plans will cover 90%.

An additional level of coverage will be available in the Marketplace: a catastrophic plan. Catastrophic plans are available only to people under age 30 and to people who have received certain hardship exemptions. Catastrophic plans will generally have lower premiums and higher deductibles. Catastrophic plans offered in the Marketplace will cover three annual primary care visits and preventive services at no cost. People with catastrophic plans are not eligible for federal tax credits to lower their monthly premiums.

Most people will access the Marketplace via the federal website: www.healthcare.gov. However, a paper application and consumer assistance will be available at the federally-operated Health Insurance Marketplace Call Center: 1-800-318-2596. Assistance will also be available from "navigators" and "certified application counselors." Licensed health insurance agents may assist consumers as well.

The Tax Credits

Any individual or family, except for illegal or undocumented immigrants and incarcerated people, may buy coverage in the Marketplace. Coverage will continue to be available outside the Marketplace as well. However, federal tax credits will be available to help with the cost of coverage only for plans sold within the Marketplace. Consumers can access the Marketplace website to determine whether they are eligible for a tax credit. In general, the tax credits are available for those with income between 100 percent and 400 percent of the federal poverty level who are not eligible for other affordable coverage. In 2013, 400 percent of the poverty level for Michigan residents was about $45,960 for an individual or $94,200 for a family of four.

The Penalty for Not Buying Coverage

In 2014 and beyond, the individual mandate provision of the ACA requires that people obtain health insurance or pay a federal tax penalty. Medicare and Medicaid are considered to be adequate coverage and those beneficiaries will not pay a penalty. The amount of the penalty for an individual is phased in over three years. In 2014, the penalty is the greater of $95 per adult or 1% of taxable income. In 2015, it is the greater of $325 per adult or 2% of taxable income. In 2016, it is the greater of $695 per adult or 2.5% of taxable income. Exemptions from the penalty are available if a person has a financial hardship, religious objection, belongs to a health care sharing ministry, or if it would cost more than 8% of the individual's income to purchase coverage. ■

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