

The Journal of Insurance & Indemnity Law

A quarterly publication of the State Bar of Michigan's Insurance and Indemnity Law Section

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

From the Chair



Kathleen A. Lopilato,
Auto-Owners
Insurance Company

I would like to start my first address to the Section members with a statement of gratitude to the people who led the Section in the last several years. Many thanks to Elaine Pohl who kept us on track most recently and is now the immediate past chair still serving “ex officio.” She is an example of the type of leadership for which we should all strive. Also many thanks to Hal Carroll who has been an invaluable resource since his days as Chair. Hal

tirelessly works behind the scenes to make sure our meetings and events run smoothly. I could take up the whole column listing the many ways that he has contributed to the growth of this Section.

Speaking of that, it may interest you to know that when we began in 2007 we started out with 50 members and we are now enjoying membership of over 725 attorneys. We are also financially flush with enough resources to plan some spectacular events and programs.

I would also like to welcome our new slate of officers: Adam Kutinsky, Chair Elect; Larry Bennett, Secretary; and Gus Igwe, Treasurer. We are all looking forward to making the next two years productive and memorable for the Section.

For those of you who are new to the Section, here’s a quick overview. First, our Section is structured differently from most, in that our officers serve for two years. In most sections the officers serve for one year. Having two-year terms leaves more time for accomplishing things and less for training the newbies.

Second, our Section is always neutral as between insurers and policyholders. Some of us represent one side of that divide, some represent the other, and some have clients on both sides. The Section’s purpose is to share information on the topics and issues that arise in our area of practice, and provide resources for practitioners, but never to take a position on

those issues. You will see opinions expressed in issues of the *Journal*, but only the opinions of the authors.

If you have expertise and/or an opinion you would like to share in the form of an article, get in touch with the *Journal*’s editor, Hal Carroll, at HOC@HalOCarrollEsq.com.

One of the focuses for the next year is going to be development of our committee structure. We currently have the following committees: membership, programs, and publications. I want to encourage every member to take an active part in the Section. If you are interested in being on one of these committees, please contact me at Lopilato.kathleen@aoins.com.

Some of our members joins because this is their area of practice and they want to connect with colleagues. Others join because they are new to this practice area and hope to learn more of the ins and outs of insurance law. For those who are new to this area of practice, participation is an excellent way to learn.

If you are one of those who are new to the section, we are especially interested in you.

- If you have a question you would like to have answered, let us know.
- Do you have an idea for a program you would like us to present?
- Would you like to begin to network with experienced practitioners?

An excellent opportunity for participation is coming soon. Mark your calendars for our annual pre-Holiday meeting and event which will take place December 9, 2014. More details to follow!

I have a lot of ideas to keep our Section busy in the next two years and I look forward to sharing them with you on the 9th. Hope to see you there.

—Kathleen A. Lopilato

Editor’s Notes



By Hal O. Carroll
www.HalOCarrollEsq.com

The *Journal* – now in its seventh year – 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. ■



Michigan Bureau of Workers' Disability Compensation – Worldwide Jurisdiction?

By Lee M. Hoffman, CIC LIC CPIA, *Lee M. Hoffman & Associates, LLC*

When Kenneth Karaczewski started working for Farbman Stein & Company, he was a Michigan resident working for a Michigan resident employer. Sometime later he transferred to Farbman Stein & Company's Florida facility and he took up residency in Florida. While working there he sustained a compensable work related injury and sought Michigan benefits.

Karaczewski's request was heard by a magistrate who agreed that Michigan had jurisdiction. The Michigan Workers' Compensation Agency agreed, as did the Court of Appeals, basing its opinion on *Boyd v W G Wade Shows*,¹ which held that an employee need not be a resident of Michigan as long as the contract of hire was made in Michigan. However, the Michigan Supreme Court did not agree.

In *Karaczewski v Farbman Stein & Co.*,² the Supreme Court said that the law should be interpreted by its simple reading and that the conjunctive word "and" in the statute required that *both* the contract of hire *and* the worker's residency be in Michigan for jurisdiction to apply:

The bureau shall have jurisdiction over all controversies arising out of injuries suffered outside this state where the injured employee is a resident of this state at the time of injury **and** the contract of hire was made in this state. Such employee or his dependents shall be entitled to the compensation and other benefits provided by this act.³

Since there had been varying appellate interpretations before *Karaczewski*, the Legislature sought to add clarification to the existing law showing its intent to protect residents of Michigan or those hired in Michigan no matter where they worked. The problem is that the cure may end up killing the patient and the doctor.

The legislative change substituted the word "or" for the word "and," thereby making the employee's residence and the location of the contract of hire separate and independent bases for the attachment of jurisdiction. The revised statute continued to include the existing requirement that the employer must be subject to the act.

The worker's compensation agency shall have jurisdiction over all controversies arising out of injuries suffered outside this state if the injured employee is employed by an employer subject to this act and if

either the employee is a resident of this state at the time of injury or the contract of hire was made in this state. The employee or his or her dependents shall be entitled to the compensation and other benefits provided by this act.⁴

The *Karaczewski* ruling also established the revised code as a "new rule" and not a mere clarification. A clarification would have allowed retroactive application to ongoing cases.

The legislative change substituted the word "or" for the word "and," thereby making the employee's residence and the location of the contract of hire separate and independent bases for the attachment of jurisdiction.

So what's the problem? Oddly enough it's not just residency or contract of hire. It's all about interpreting the portion of the statute that states "if the injured employee is employed by an employer subject to this act." Simple? Not really.

By substituting the word "or" for "and," every employer in every part of the world who meets the Bureau's definition of an employer and hires a resident of the State of Michigan or enters into an employment contract in Michigan must provide the employee Michigan Workers Compensation Benefits. Why?

The statute's definition of an "employer" does not contain any geographical component; it does not specify where that employer must be located in order to be subject to the act. The statute defines employers subject to act (outside of those identified in section (a)), as follows:

(b) Every person, firm, limited liability company, limited liability partnership, and private corporation, including any public service corporation, who has any person in service under any contract of hire, express or implied, oral or written, unless those employees excluded according to the provisions of section 161(5) comprise all of the employees of the person, firm, limited liability company, limited liability partnership, or corporation.⁵

The author has been involved with two separate cases where employees received medical treatment for their injuries

in Indiana but requested disability benefits in Michigan where they resided. In both cases the employers were in close proximity to the state line and their employees commuted daily to work returning home to Michigan after work.

The employers were also domiciled in Indiana and had no presence in Michigan. In addition, the employees were hired (contract of hire) in Indiana, worked only in Indiana, and were injured on their jobs in Indiana. The nature of their injuries and relationship to work were not disputed.

In each case, the only connection with Michigan was that the employees at the time of injury were residents of the State of Michigan. The employers had no connection to this state.

The first case involved an employer with an Indiana assigned risk workers compensation insurance policy that did not include Michigan as a covered state. The injured worker had been treating in Indiana but sought Michigan disability benefits since Michigan benefits are higher than Indiana. He cited eligibility based on the revised language of MCL 418.845 and that by virtue of his residency alone was entitled to Michigan benefits. When the insurer refused to provide Michigan benefits the worker filed for a hearing. About the same time, the Michigan Workers Compensation Agency sent notice to the employer stating that they were in violation of the Michigan Workers Compensation Disability Act (section 418.615) and subject to a fine and criminal prosecution.

By substituting the word “or” for “and,” every employer in every part of the world who meets the Bureau’s definition of an employer and hires a resident of the State of Michigan or enters into an employment contract in Michigan must provide the employee Michigan Workers Compensation Benefits

However, before the issue could be heard by the magistrate, the employee sought additional treatment for his injuries in Indiana. For this reason his counsel withdrew the hearing request. Since the employee is still treating it is unclear whether or when the request for Michigan disability benefits will surface again.

The second case is currently ongoing and also involves an injured worker seeking Michigan disability benefits. However, in this ongoing case the attorney for the insurance carrier is refusing to fight the new code, citing a long history of cases favoring the employee when residency is not in dispute. In addition, the carrier is pointing to the extremely broad interpretation of what constitutes an employer and that having a location in Michigan is not required.

The attorney for the insurer reports that he spoke with other attorneys in similar situations and they also cited the broad

interpretation of employers subject to the act. The insurer’s attorney also spoke with the division manager of the Compliance & Employer Records Division of the Michigan Workers Compensation Agency. The division manager is also the person who assisted with the language of the new code.

The division manager’s response was that it was not the intent of the Department to expand its jurisdiction into other states, but rather to clarify the law due to the long history of its misapplication. But the effect of the statute is determined by the actual text, and that text has led to expansion of the scope of Michigan’s act, and uncertainty as to how it will be applied.

Practitioners in this area are becoming aware of the change in the act and until there is a clarification issued by the Michigan Workers Compensation Agency or case law giving guidance under this loophole, employees will continue to seek Michigan benefits.

The Indiana Compensation Rating Bureau (ICRB) is closely monitoring the developments involving Indiana employers of Michigan residents. They in turn have the ear of the Indiana Workers Compensation Bureau and the Indiana Department of Insurance. To date the officials at the ICRB and Compliance & Employer Records Division of the Michigan Workers Compensation Agency are unaware of any related cases that have gone to a magistrate or to trial. However, when the time is right the amicus briefs are likely to fly.

For now, however it appears that insurance companies do not have the appetite for challenging the revised code. They seem willing to entertain claims when Michigan is included as a covered state under Item 3A Workers Compensation Insurance or Item 3C Other States Insurance of a workers compensation insurance policy. Otherwise, they deny the claim as occurring in a state not covered by the insurance policy.

Meanwhile, problems are developing in the world of insurance, litigation and politics. Several insurance companies have already indicated their intent to automatically add Michigan and related classification codes to the workers compensation policies of employers who employ Michigan residents. However, the problem goes way beyond the resulting premium increases.

Employers with no Michigan presence often purchase workers compensation insurance from companies who are not filed to write business in Michigan. This is commonplace in Indiana and other states. As it now stands, employers using companies not filed to write in Michigan appear to be violation of Michigan Law just for hiring Michigan residents. Will employers faced with violations start suing their insurance agents, insurance companies or both for failure to inform or advise? While the law has been on the books since 2009, these complications are just surfacing and there are too many of them to cover in the span of just one article.

As an example, Michigan’s workers compensation rates are typically higher than Indiana’s and this will increase workers compensation premiums for affected employers. The differ-

ence can be substantial: \$2.64 per \$100⁶ of payroll in Indiana versus \$5.26 per \$100 in Michigan.⁷ Disability benefit levels are also higher. The higher benefits when claimed could affect an employer's workers compensation experience modification factor, even though Michigan is not a member of the National Council on Compensation Insurance (NCCI) and promulgates its own factors. The net result will be the same - higher premiums.

When faced with higher costs of doing business, Indiana employers may very well seek to employ Indiana residents, effectively locking out Michigan residents from employment. Extreme? Not if you are an employer and insurance premium is one expense totally within your control.

As Indiana employers (and employers in other states) discover the ramifications of employing Michigan residents will job offers start to dwindle? Will employers put pressure on their elected officials to retaliate against Michigan? Will insurers refuse to insure employers who employ Michigan residents if they do not readily write business in Michigan? Will insurers who are licensed in Michigan just pay Michigan benefits when requested or will there be challenges?

Hopefully Michigan will figure out a way to rein in its worker compensation jurisdiction to a manageable level. ■

About the Author

Lee M. Hoffman, *CIC LIC CPIA is an enterprise risk consultant and consultant for drafting insurance indemnification and risk transfer agreements. He has been in the insurance industry since 1971 and is President of Lee M. Hoffman & Associates (www.leemhoffman.com) and the American Association of Insurance Management Consultants (www.aaimco.com). His expertise includes insurance agents' E&O, controverted claims and assisting attorneys with risk transfer agreements and the drafting of insurance, indemnification and hold harmless agreements, and providing expert testimony. His email address is leehoffman@msn.com.*

Endnotes

- 1 443 Mich 515; 505 NW2d 544 (1993)
- 2 478 Mich 28; 732 NW2d 56 (2007)
- 3 MCL 418.845 - Out-of-state injuries; jurisdiction; benefits.
- 4 MCL 418.845 - Out-of-state injuries; jurisdiction; benefits, amended 2008, Act 499, Imd. Eff. Jan. 13, 2009 .
- 5 MCL 418.151.
- 6 See: http://www.icrb.net/rate_pages/1_1_2014_RatePages.pdf
- 7 See: <http://www.caom.com/rates/rates%20index/rates.html> - 2014 - Data Collection Agency Workers' Compensation Insurance Statewide Average Pure Premium Michigan - [Codes 0005 - 9620]

Announcement

The Insurance and Indemnity Law Section's Searchable Directory of Members Is Now Operational!

All Section members are invited and encouraged to register in the directory and indicate their areas of expertise and the services they can provide.

The directory will be a resource for attorneys and court personnel in Michigan to assist them in finding Section members to assist in the handling and/or resolution of litigation.

When you register you can include the following information, in addition to information on how to contact you.

Areas of Practice:

- Indemnity Issues, Contract Drafting, Insurance In-House, Insurance Policy Drafting,
- Insurance Coverage (Liability, First Party Auto, Third Party Auto, Life, Health, Disability)
- ERISA
- Regulatory Matters
- Corporate/Transactional

Services:

- Consultation
- Litigation and Appeals
- Contract Review
- ADR (Neutral Evaluation, Facilitation, Mediation)

Client Base (Percentage of work for insurers and insureds)

To JOIN the Searchable Directory, go to <http://mistatebar.com/add-me> check the appropriate boxes, enter your personal data, and click on "enter."

To SEARCH in the Directory, go to <http://mistatebar.com>, click on "find a lawyer," check as many of the boxes as apply. You can select by one or more of these:

Areas of Practice, Client Base (percentage of clients who are insurers, and insureds), Services Provided (e.g., ADR, Contract Analysis, Litigation), Location (by county).

Then Click on "Apply"



Don't Lose Your Appeal of Right: Final Orders, Merits Decisions, and Contractual Attorney Fees

By Michael Cook, *Collins Einhorn*

You just lost a dispositive motion on a high-stakes breach of contract action (perhaps an indemnity claim). You plan to appeal the (obviously wrong) ruling. But a contractual provision allows the other side to recover its reasonable attorney fees, which you still plan to contest. When do you file your appeal? Be careful. Your answer, which turns on whether the ruling on the dispositive motion is a “final order,” could have a disastrous result if you're wrong.

The savvy lawyer will tell you that, since the attorney fees are contractual damages, you don't have a final order until that last issue is resolved. So you wait, because the savvy lawyer has a good point. Unfortunately for him (and now, you), nine people who wear black robes in Washington D.C. just said that he was wrong and you lost your chance to appeal. You're too late; the appellate ship has sailed and you weren't on it.

But wait! I'm in state court, you say, so what those nine-black-robe-wearing people think doesn't matter. You're right (kind of) and there may still be hope yet. But all you have is hope because there is no clear rule in Michigan on when you will have a final order.

This factual set up isn't uncommon. In fact, it can arise frequently in cases litigating express indemnification provisions, which often contain an attorney-fee shifting component. Judges and the parties typically focus on the big issue—is there an obligation to indemnify—and only turn to quantifying the fees after the big issue is resolved. It might be surprising that Michigan doesn't have a firm answer to “When do you file your appeal?” and federal courts just got their answer earlier this year. But as the result in *Ray Haluch Gravel Co v Central Pension Fund of Int'l Union of Operating Engineers and Participating Employers*,¹ teaches, you don't want to be on the wrong end of the answer when it's given.

In *Ray Haluch Gravel*, a collective bargaining agreement required Haluch to make contributions to certain funds, which the Funds said Haluch failed to make. On June 17, 2011, the district court issued an order that the Funds were only entitled to certain contributions, not all that they had requested. The Funds, having obtained some relief, then moved for attorney fees, citing both a fee-shifting provision in the CBA and a statute. On July 25, 2011, the district court awarded attorney fees to the Funds. In federal court, parties generally have 30 days to file an appeal, so the Funds filed their appeal on August 15, 2011. The issue quickly became whether the Funds' appeal

was timely for the June 17 order. The First Circuit Court of Appeals said yes, but the Supreme Court said no.

The Supreme Court, following the lead of a prior decision that addressed statutory attorney fees, chose consistency and predictability over the niceties of what is and is not considered an element of damages. The Funds raised the savvy lawyer's argument: the fees were contractual damages intended to remedy the breach that gave rise to the action. But the Court was acutely aware of the legal abyss below the Funds' argument, which would require lower courts to grapple with whether a fee claim is part of the merits:

Some fee-shifting provisions treat the fees as part of the merits; some do not. Some are bilateral, authorizing fees either to plaintiffs or defendants; some are unilateral. Some depend on prevailing party status; some do not. Some may be unclear on these points.^[2]

The court, undeterred by concerns over “piecemeal” litigation, chose a rule that “ignores these distinctions in favor of an approach that looks solely to the character of the issue that remains open after the court has otherwise ruled on the merits of the case.”³ Accordingly, the rule in federal court is fairly straightforward: if the only thing left to decide is attorney fees, then you have a final order and need to file your appeal within 30 days of that order.

But the rule is not so clear in Michigan state court. The Michigan Court of Appeals decided an appeal involving the same basic set-up as *Ray Haluch Gravel* just last summer. In *TGINN Jets, LLC v Hampton Ridge Properties, LLC*,⁴ the Court of Appeals held that the appellant timely appealed a decision on the merits of a contract claim, even though they didn't appeal until 6 months later when the trial court awarded attorney fees under the contract. The appellees argued in both a motion to dismiss and their brief on appeal that the appeal was untimely. But the court rejected “their erroneous contention,” stating that the earlier “judgment did not resolve the issue of contractual attorney fees, which was a distinct claim in plaintiffs' complaint” and are “considered damages, not costs.”⁵

What can we learn from the opinion in *TGINN*? Unfortunately, the answer is, “Not much.” The opinion is unpublished and therefore not precedential, so no one (other than the parties in that appeal) is bound by it. That creates some risk. Consider the possible result if, for example, you get a

different panel of judges who are persuaded by *Ray Haluch Gravel's* preference for consistency and predictability over the vagaries of when attorney fees are or are not damages. You, like the Funds, will be left out in the cold with no one to hear your (obviously meritorious) appeal.

So what's the solution? To mitigate the risk, follow that timeless appellate adage, "appeal early and often." It is far better to be told, "you're too early" than it is to hear "you're too late." So while *TGINN* offers some comfort to anyone who currently has a decision on the merits and is awaiting a determination on attorney fees, the most conservative course will be to file a claim of appeal within 21 days of a decision on the merits. ■

About the Author

Michael Cook is an associate in the appellate practice group at Collins Einhorn Farrell P.C. He focuses his practice on state and federal court appeals and dispositive motion practice in civil

litigation matters, including professional liability, contractual indemnity, business torts, and general liability cases. Before joining Collins Einhorn, Mike was a law clerk for Michigan Supreme Court Chief Justice Robert P. Young, Jr. His email address is Michael.Cook@ceflawyers.com.

Endnotes

- 1 __ US __; 134 S Ct 773; 187 L Ed 2d (2014) (Docket No. 12-992).
- 2 *Id.* at 782.
- 3 *Id.* at 781-782.
- 4 Unpublished opinion per curiam of the Court of Appeals, issued Aug. 29, 2013 (Docket Nos. 294622 & 297844); 2013 WL 4609208.
- 5 *Id.*, 2013 WL 4609208, *2.

Scenes from the Annual Meeting



- ❶ Outgoing Chair Elaine Pohl with Incoming Chair Kathleen Lopilato
- ❷ Speaker Doug Young
- ❸ Chair Elaine Pohl calls the meeting to order



The Reservation of Rights Letter

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

What happens to an insurer that sends out a reservation of rights letter that doesn't make the grade? In *Advantage Buildings & Exteriors v Mid-Continent Casualty Co.*, ___ SW3d ___ (Mo. App 2014), docket no. 76880, [2014 WL 4290814], the Missouri jury awarded the insured \$3 million in compensatory damages against the insurer, and added another \$2 million of punitive damages for good measure. Such things don't happen in Michigan, so the points that follow won't be as dramatic as a multimillion dollar verdict, but they are useful to know.

By way of a brief detour, the information about the Missouri case comes from the September 10, 2014 issue of a bi-weekly newsletter called "Coverage Opinions." It is published by Randy Maniloff and available at "coverageopinions.info." Each issue is a source of useful information and – equally important – each issue is entertaining. That's not easy to do with insurance law, but Randy Maniloff accomplishes it with a style that few of us can equal. Every practitioner of insurance coverage law should sign up for Randy Maniloff's Coverage Opinions newsletter.

Michigan case law does provide some guidelines for the reservation of rights letter (in some states it's called a "non-waiver letter").

Content of the Letter

Our Supreme Court has held that general language such as "reserves all rights," without identifying the provisions on which the insurer relies, is insufficient. The insurer sent a letter with this language:

Now therefore you are hereby notified that the Company will defend said actions pending against you through its regular attorneys, and will pay its said attorneys for all services in connection therewith, but the Company in undertaking your defense, does so under a reservation of rights, and without prejudice, and subject to the conditions, limitations, exclusions and agreements of said policy, and subject to the express understanding that by so doing the Company does not waive any of its rights to rely upon the provisions of said policy, and does not waive any defense it may have to any claimed liability under said policy.

The Supreme Court said:

We hold the notice legally insufficient . . . The no-

tice was vague and uncertain. It smacks of bad faith for want of specific reference to that clause of the policy the garnishee has pleaded. In no field of law is legal duty more rigidly enforced than in instances as at bar. The insurer must fulfill its policy-contracted obligation with utmost loyalty to its insured; not for the purpose of developing, secretly or otherwise, a policy defense.¹

The Supreme Court held that "reasonable notice" required that "notice be given that in the event of certain facts being established it will disclaim liability."² The message is that the insurer must identify specific facts that are relevant to coverage and explain how those facts will affect coverage.

Timeliness

Here, the law is not entirely clear. Timeliness is decided on a case by case basis, so the cases provide some time limits at each end of the spectrum but leave a large "terra incognita" in the middle.

One month has been held to be timely,³ and even four months has been held to be sufficient.

We feel that four months is, as a matter of law, not an unreasonable length of time. We hold that issuance of the reservation of rights letter only four months after initiation of the litigation reasonably put defendant on notice that his claim might not be covered under his homeowner's insurance policy.⁴

At the other end, where the insurer waited some two and one-half years until the eve of trial, the Court of Appeals held that "under these circumstances, the rights of the insureds, and the consequential rights of appellees, were presumptively prejudiced," and the insurer "is estopped from asserting its policy exclusion."⁵

Unsurprisingly, a notice given after trial is too late.⁶

Note that these rules apply to the insurer and the insured. The insurer owes no duty to the tort claimant to advise it of coverage issues.⁷

Declination of Coverage

Timeliness rules apply to an insurer's declination of coverage. In addition, an insurer's declination of coverage will estop the insurer from asserting new grounds after the declination.

“Generally, once an insurance company has denied coverage to an insured and stated its defenses, the insurance company has waived or is estopped from raising new defenses.”⁸

The waiver and estoppel rule sounds pretty clear and even draconian, but the Supreme Court went on to qualify it so extensively that it’s not clear what vitality it has left. The Supreme Court went on to say that the doctrines of estoppel and waiver

will not be applied to broaden the coverage of a policy to protect the insured against risks that were not included in the policy or that were expressly excluded from the policy. This is because an insurance company should not be required to pay for a loss for which it has charged no premium.⁹

On the other hand, the Supreme Court said, sometimes coverage will be broadened.

For example, in situations in which the insurance company has misrepresented the terms of the policy to the insured or defended the insured without reserving the right to deny coverage, courts have extended coverage beyond the terms of the policy when the inequity to the insurer as a result of the broadened coverage is outweighed by the inequity suffered by the insured.¹⁰

Note the reference to equity. Although insurance law is contract law, in which equity plays no part, the nature of the relationship between the insurer and the insured – in which the insurer owes “utmost loyalty” to its insured, invokes principles of equity. ■

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 2014. He also consults with businesses and insurers on the drafting of contracts, represents insureds and insurers in declaratory actions, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His website is www.HalOCarrollEsq.com and his email address is HOC@HalOCarrollEsq.com.

Endnotes

- 1 *Meirthew v Last*, 376 Mich 33, 38; 135 NW2d 353 (1965).
- 2 *Id.* at 39.
- 3 *Kirschner v Process Design*, 459 Mich 587, 590; 592 NW2d 707 (1999); *Allstate Ins v Keillor*, 450 Mich 412, 416 note 2; 537 NW2d 589 (1995)
- 4 *Fire Insurance Exchange v Fox*, 167 Mich App 710, 714; 423 NW2d 325 (1988).
- 5 *Multistates Transport v Michigan Mutual Ins Co*, 154 Mich App 549, 557; 398 NW2d 462 (1986).
- 6 *Meirthew v Last*, 376 Mich 33; 135 NW2d 353 (1965)
- 7 *Kirschner v Process Design Associates, Inc, and General Accident Insurance Company of America*, 459 Mich 587, 595; 592 NW2d 707 (1999).
- 8 *Kirschner v Process Design Associates, Inc, and General Accident Insurance Company of America*, 459 Mich 587; 592 NW2d 707 (1999)
- 9 *Kirschner* at 594, citing *Ruddock v. Detroit Life Ins. Co.*, 209 Mich. 638, 654, 177 N.W. 242 (1920); *Lee v. Evergreen Regency Cooperative*, 151 Mich.App. 281, 285, 390 N.W.2d 183 (1986).
- 10 *Kirschner* at 594-595.



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**Insurance
Case
Summary**


Significant Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell*; Deborah.hebert@ceflawyers.com

6th Circuit Court of Appeals

Time for seeking judicial review expanded due to inadequate benefits termination letter.

Moyer v Metropolitan Life Ins Co

___ F3d ___ (6th Cir. 2014); 2014 WL 3866073

Met Life issued a letter revoking plaintiff's long term disability benefits without advising of the procedures or time limit for judicial review. ERISA, through its claims procedure statute, 29 U.S.C. §1133, specifically requires all adverse benefit determination letters to provide "[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action . . ." Because the plan administrator failed to substantially comply with the statute, its letter did not trigger the time bar set forth in the plan. (The dissent would not have considered this issue because it was not raised on appeal).

Michigan tax not preempted by ERISA

Self-Insurance Institute of America, Inc v Snyder

___ F3d ___ (6th Cir. 2014); 2014 WL 3804355

Plaintiff is an association of sponsors and administrators of self-funded ERISA benefit plans. Its lawsuit challenged the 2011 Michigan Health Insurance Claims Assessment Act, which imposes a 1% tax on all claims for services rendered in Michigan to Michigan residents. Plaintiff argued that the tax and reporting requirements violate ERISA's preemption clause but the 6th Circuit disagreed for two reasons: (1) state taxing authority is an important attribute of state sovereignty and (2) plaintiff failed to produce evidence that the provisions of Michigan's act did in fact interfere with the administration of benefit plans, or created an inappropriate administrative burden on core functions, or otherwise affected the relationship between plan administrators and beneficiaries.

Individual class member damages cannot be aggregated for jurisdictional purposes

The Siding and Insulation Co, Inc v Acuity Mut Ins Co

754 F3d 367 (6th Cir. 2014)

In this case, the 6th Circuit joined several other circuits in refusing to aggregate individual class member damage claims to satisfy the \$75,000 amount in controversy requirement for diversity of citizenship jurisdiction. The "separate and distinct claims of two or more plaintiffs cannot be aggregated in or-

der to satisfy the jurisdictional amount requirement," quoting *Snyder v Harris*, 394 US 332, 335 (1969). Claims may be aggregated for jurisdictional purposes only where multiple plaintiffs are enforcing a single title or right in which they have a common and undivided interest. The court declined to view class member rights to reimbursement from a single class fund as a single common claim, either from the perspective of the class members or from the perspective of the insurer financing the fund.

Michigan Supreme Court

Business use exclusion in bobtail policy is construed

Hunt v Drielick d/b/a Roger Drielick Trucking

496 Mich 366 (2014)

The business use exclusion in this bobtail policy applied in two circumstances: (1) where the covered auto is used to carry property in any business, or (2) where the covered auto is used in the business of anyone to whom the auto is leased or rented. Members of the court unanimously interpreted the first clause to mean that coverage is excluded "only during the time that a semi-tractor is physically attached to property and the property is carried in business." Because this semi-tractor was being driven without any property attached to it at the time of the accident, the first clause of the exclusion did not apply. As to the second clause of the exclusion, the court determined that more facts were needed about whether the parties had entered into a leasing agreement as contemplated by the insurance contract. The case was remanded the case for further proceedings in that regard.

Michigan Court of Appeals – Published

Contractual liability exclusion in CGL policy applies only to assumption of another's liability

Travelers Property Cas Co of American v Peaker Services, Inc

___ Mich App ___ (2014), lv app pending (Docket No. 315070)

In this published opinion, the Court of Appeals rejected a prior panel's unpublished decision in *Envision Builders, Inc v Citizens Ins of America*, which construed the standard CGL "contractual liability exclusion" as applying to any contractually assumed liability. This published decision holds that

the “contract liability exclusion” is limited to the insured’s assumption of a third party’s liability, such as the liability that is assumed in an indemnity or a hold harmless agreement. The exclusion thus did not bar coverage for the University of Michigan’s claim against the insured for breach of warranties in connection with the insured’s installation of an over-speed system at the university’s power plant. The Court decided that a reasonable interpretation of the policy language “assumption of liability in a contract is “assumption of another’s liability in a contract.”

This published decision holds that the “contract liability exclusion” is limited to the insured’s assumption of a third party’s liability, such as the liability that is assumed in an indemnity or a hold harmless agreement.

Michigan Court of Appeals - Unpublished

New trial ordered on fire loss claim

Welch’s Steak & Ribs, Inc v North Pointe Ins Co

Unpublished Court of Appeals Opinion of May 22, 2014
(Docket No. 310697)

This commercial fire loss claim was submitted to a jury on two claims of policyholder fraud - arson and inflated damage claims. The jury rejected the allegation of arson but found that the policyholder did misrepresent its losses with the intent to defraud. Plaintiff filed post-judgment motions for JNOV

and also for a new trial. The trial court granted both. It first held that the jury verdict of fraud was against the great weight of the evidence and directed a verdict for the policyholder in the amount of \$450,000 for building loss and \$175,000 for personal property loss. The trial court also ruled that if the directed verdict were reversed on appeal, a new trial should be granted because of the admission of confusing evidence and an erroneous jury instruction. The Court of Appeals reversed the directed verdict, finding that there was sufficient evidence to support the jury verdict on fraud, but it affirmed the order for new trial based on the introduction of confusing and irrelevant evidence at trial.

Claimant’s DJ action to bar coverage is rejected for lack of standing

Meisner Law Group, PC v Krispin et al.

Unpublished Court of Appeals Opinion of May 27, 2014
(Docket No. 313935)

Defendant condo association hired plaintiff law firm to represent its interests in a dispute with the condo developer over alleged construction defects. Three years later, the association fired plaintiff and retained new counsel, who resolved the dispute. Plaintiff sued the condo association and the officer who persuaded the association to terminate plaintiff’s services, claiming that the officer had engaged in defamation and had interfered with plaintiff’s business relationship with the association.

The association was insured under a CGL policy with Travelers, who defended the lawsuit by plaintiff under a reservation of rights. Plaintiff responded with this action for declaratory

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judgment – seeking a ruling that defendants had no coverage. Travelers moved for summary disposition, pointing out that plaintiff was attempting “to extract . . . retribution” for the firing by forcing the association and the individual officer to personally incur defense costs.

The Court of Appeals reviewed the DJ complaint and concluded that it “did not involve Meisner’s own rights,” as would be the case if plaintiff were seeking to enforce the terms of the policy to guarantee that his underlying claim would be satisfied. Rather, “Meisner effectively pleaded that it had no right to seek enforcement of the policy. Once Meisner conceded that it has and will have no right to seek enforcement of the policy, it necessarily conceded that it had no standing to seek a declaration of rights concerning the policy.” The court also pointed out that insurers can always opt to provide a gratuitous defense and/or coverage, and that Meisner’s attempt to prevent that seemed motivated “to cause Travelers – for whatever reason – to abandon its insured.”

Refusal to appear for EUO is not automatic grounds
for coverage denial

Villarreal v IDS Property Cas Ins Co

Unpublished Court of Appeals Opinion of May 27, 2014,
lv app pending
(Docket No. 314891)

Homeowners’ refusal to participate in an examination under oath regarding their fire loss claim did not automatically support the insurer’s decision to deny coverage. At the time of the refusal, the homeowners were under criminal investigation for arson, which ultimately concluded with the insured wife pleading no contest to an amended charge of insurance fraud. Following the plea, both homeowners agreed to an EUO but the insurer declined coverage and prevailed on its motion for summary disposition when the insureds sued for coverage. The Court of Appeals reversed on the ground that the insurer failed to establish any actual prejudice in its ability to investigate damages because of the delayed EUO. And because the insureds filed suit within the time allowed for by the contract, laches was not an available coverage defense. The case was remanded for further proceedings, including the insurer’s reliance on certain policy exclusions.

Insurer waived its right to assert coverage defenses

Woodruff v State Farm Mut Automobile Ins Co

Unpublished Court of Appeals Opinion of May 27, 2014
(Docket No. 314093)

While driving in Michigan, plaintiff was struck by a driver who failed to stop, but who was later identified by police. Plaintiff was driving her sister’s car, which was registered in Tennessee and insured with State Farm under a Tennessee auto policy. State Farm paid plaintiff’s PIP benefits but op-

posed her claim for UM benefits. When plaintiff filed suit, State Farm defended on several grounds, including plaintiff’s failure to file suit in a timely manner and failure to name the tortfeasor as a defendant in the lawsuit. The trial court granted State Farm’s motion for summary disposition but the Court of Appeals reversed. Plaintiff’s attorney had requested a copy of the State Farm policy on several occasions over a period of two years, but State Farm never provided it. State Farm was thus equitably estopped from asserting the requirements of the policy for bringing suit. The court also held that State Farm had waived its contractual limitations defense by failing to specifically plead the contract provision as an affirmative defense. It was not enough that State Farm generally pled a limitations defense.

Homeowners’ refusal to participate in an
examination under oath regarding their fire
loss claim did not automatically support the
insurer’s decision to deny coverage.

Overspray endorsement for added coverage not appli-
cable but duty defend applied

Township of Maple Forest v Clearwater Drilling, LLC

Unpublished Court of Appeals Opinion of May 29, 2014
(Docket No. 314798)

Plaintiff Township sued the insured drilling company for property damage caused by the escape of a mixture of water and bentonite into the septic system, where it combined with sewage and then flooded the township hall. The insured and its CGL insurer agreed that the pollution exclusion applied: “the substance that damaged the township hall was a ‘pollutant’ under the definition of the policy” because it included sewage. At issue was a limited give-back of coverage under an “overspray” endorsement, which provided coverage for property damage caused by “[o]verspray during your application or disbursement of ‘pollutants’ which are intended for and normally used in your operations.”

Because that overspray coverage was limited solely to the disbursement of pollutants and because the mixture of water and bentonite was not a pollutant, there was no coverage under the endorsement. The court held, however, that the insurer did have a duty to defend because the allegations of the complaint did not allege damage caused by a pollutant or by waste, but alleged damage caused by the invasion of drilling mud and water. In addition, there was initially a question of fact about whether the mixture of water and bentonite was a pollutant. Because of these unsettled facts and the broader duty to defend, the insurer should have provided a defense when the complaint was tendered.

Standard and ordinary loss payable clauses

Ken Holdings, LLC v Auto Owners Ins Co

Unpublished Court of Appeals Opinion of June 26, 2014
(Docket No. 312894)

Standard loss payable endorsements in commercial property policies generally provide that the property owner or lienholder will not lose coverage based on the policyholder's conduct, when that conduct results in the policyholder's loss of coverage. These provisions are typically interpreted as a separate contractual relationship between the insurer and the owner/lienholder. In this case, the policyholder was purchasing commercial property under a land contract and was denied coverage on its fire loss claim because of a suspicion that the fire was intentionally set. The commercial property contained both an ordinary loss payable endorsement (which is not a separate agreement between the insurer and the owner/lienholder) and a standard loss payable endorsement. The Court of Appeals determined that the combination of these two provisions created an ambiguity that had to be resolved on further proceedings.

Evidence of generous disability benefits properly admitted during UIM trial on damages

Schenck v Asmar and State Farm Mut Auto Ins Co

Unpublished Court of Appeals Opinion of July 1, 2014,
lv pending
(Docket No. 315053)

In this UIM case, plaintiff settled her claim with the tortfeasor for policy limits of \$25,000 and proceeded to trial against the UIM insurer on damages. The insurer asserted a malingering defense and was allowed to produce evidence of plaintiff's very generous disability benefits through her employer, along with evidence of her extensive travels, including trips to Europe and Alaska. The jury awarded only \$10,000 in damages and plaintiff appealed, arguing error in the trial court's admission of evidence of disability benefits. The Court of Appeals agreed that the evidence was relevant and material to the issues in dispute and affirmed.

TCPA claim covered as claim for advertising injury

State Farm Fire & Casualty Co v Kapraun

Unpublished Court of Appeals Opinion of July 3, 2014
(Docket No. 310564)

Defendant insured was sued in an Illinois state court class-action lawsuit for having hired a company to "mass fax" advertisements for a food supplement drink in violation of the federal Telephone Consumer Protection Act (TCPA). The Court of Appeals agreed with the CGL insurer that there was no coverage for bodily injury or property damage or personal injury, but decided that the insurer did have a duty to defend and indemnify under the coverage for advertising injury because the claim was for "oral or

written publication or material that violates a person's right of privacy."

UIM coverage not available to named driver who was not a "family member"

Vaughan v 21st Century Centennial Ins Co

Unpublished Court of Appeals Opinion of July 29, 2014
(Docket No. 315313)

UM benefits were properly denied for the named insured's adult daughter because even though she was a named driver for one of the insured vehicles, she was not "an insured" under the UM endorsement. That endorsement limited coverage to injuries sustained by "an insured," which included only the named insured and "any family member," defined in the policy as "a person related to you [named insured] by blood, marriage or adoption and who is a resident of your household." The Court concluded that the policy terms were neither ambiguous nor illusory nor in conflict with the policy declarations. UM coverage was available to the named insured and for any "family member" residing in his household, but not for the non-resident adult daughter.

Sexual molestation and criminal acts exclusions applied

Auto Club Group Ins Co v Worthey

Unpublished Court of Appeals Opinion of August 5, 2014
(Docket No. 315715)

Homeowners coverage was excluded for claim involving sexual assault by the homeowner's 14-year-old son against a 4-year-old guest in the home. The policy contained an exclusion for sexual molestation and another exclusion barred coverage for criminal acts. The 14-year-old had pled no contest to the charge of criminal sexual conduct as a result of the incident.

UIM claim filed too late

Swistak v Home-Owners Ins Co

Unpublished Court of Appeals Opinion of
September 9, 2014
(Docket No. 317178)

Plaintiff's complaint for UIM benefits, filed in January of 2012 and arising out of an accident that occurred in December of 2008, was dismissed as untimely. The policy required her claim to be filed within the time allowed under the "applicable" statute of limitations for bodily injury claims. This did not entitle her to select a limitations period applicable to any bodily injury claim (such as the five-year statute for assault and battery applied by the trial court). Plaintiff was limited by the statute applicable to her claim, which was the three-year period for auto negligence claims. "Applicable" means "relevant" or "suitable" or "appropriate."

continued on the next page

Employment contract terms not enforceable after order of rehabilitation

OFIR v American Community Mut Ins Co

Unpublished Court of Appeals Opinion of September 9, 2014
(Docket No. 312470)

Severance pay benefits (or alternatively, “change of control” benefits) were properly denied to the officers and directors of an insurance company subject to a Rehabilitation Order naming the Office of Financial and Insurance Regulation as Rehabilitator. MCL 500.8173(4) expressly limits payments due under employment contracts “to payment for services rendered prior to the issuance of an order of rehabilitation or liquidation” Because the conditions of employment for the claimant officers and directors were severed or altered after the rehabilitation order, they were not entitled to the benefits promised in their employment contracts. ■

No-Fault Corner



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Is the “Innocent Third Party” Rule Dead, as Applied to Michigan PIP Claims?

In 2012, the Michigan Supreme Court issued its landmark decision in *Titan Ins. Co. v Hyten*, 491 Mich 547, 817 NW 2d 562 (2012), which dramatically changed the landscape regarding an insurer’s duty to verify information in an insurance application, and what remedies were available to the insurer upon discovery of a material misrepresentation in the application. Before *Hyten*, insurers were forced to pay claims to “innocent third parties” on policies that had been procured through fraud committed by the applicant, if the fraudulent representation could have been “easily ascertained” by the insurer.

Hyten dealt with a situation where the applicant had purchased a policy of insurance through Titan, with policy limits of \$100,000/\$300,000. The applicant had a suspended driver’s license at the time of the application, but did not disclose this information on the application. She was subsequently involved in an accident with an “innocent third party” who sustained injuries which were worth well above \$100,000. After a tort claim was commenced against the insured, Titan Insurance Company filed a declaratory judgment action to reduce the applicable policy limits \$100,000/ \$300,000 down to the statutorily required minimum policy limits of \$20,000/\$40,000.

The Michigan Supreme Court ruled that an insurer could, in fact, avail itself of “traditional legal and equitable remedies” to avoid liability under an insurance policy – even against an innocent third party – when the insurance policy had been procured through fraud. The only restriction would be those

remedies imposed by statute, including MCL 500.3009, which requires that all policies sold in the State of Michigan must include minimum policy limits of \$20,000/\$40,000.

In its ruling, the Supreme Court took note of the interests between the applicant who committed the fraud and the insurer who was victimized by the fraud, and noted:

“As between the fraudulent insured and the insurer, there can be no question that the former should bear the burden of his or her fraud.”

Hyten, 817 NW 2d at 575.

The court also stated that:

“An insurer is not precluded from availing itself of traditional legal and equitable remedies to avoid liability under an insurance policy on the ground of fraud in the application for insurance, even when the fraud was easily ascertainable and the claimant is a third party.”

Hyten, 817 NW 2d at 576.

Thus, the insurer was permitted to reform its tort liability policy limits to the statutorily required minimum policy limits of \$20,000/\$40,000.

Ever since *Hyten* was released, numerous commentators have questioned whether or not the rationale enunciated by the Supreme Court in *Hyten* could be extended to the realm of PIP. For example, assume that the insured’s son or daughter is a passenger in a motor vehicle, owned by the named insured who procured the policy by misrepresenting the status of his

driver's license. Similarly, imagine a situation where a pedestrian is injured by a motor vehicle whose owner had procured insurance by falsely misrepresenting the garaging address on the vehicle. What about a situation where a motorcyclist is struck by a motor vehicle whose owner had procured insurance by falsely stating that he actually owned the motor vehicle? In those cases, the insurer could potentially face lifetime, unlimited exposure for PIP benefits to the "innocent third party" even though the policy itself may very well be subject to complete rescission.

It appears that the Court of Appeals has finally answered this question in *Frost v Progressive Michigan Ins Co*, docket number 316157, unpublished decision rel'd 9/23/2014. In *Frost*, the claimant's mother had procured insurance through Progressive, even though she made a material misrepresentation in the application. One month later, the vehicle insured under the Progressive policy was destroyed. Two months after the policy was issued, the applicant's minor daughter was injured in an accident while an occupant of an uninsured motor vehicle. Following these losses, Progressive rescinded the policy *ab initio* and Citizens was assigned by the Michigan Assigned Claims Plan to pick up the PIP claims for the minor daughter, who was admittedly an "innocent third party." The assigned insurer, Citizens, intervened in the suit. The Circuit Court ruled that because an innocent third party was involved, Progressive was precluded from rescinding coverage completely. As a result, the Court granted Citizens' Motion for Summary Disposition.

However, on appeal, the Michigan Court of Appeals held that denying the right if rescissions was "inconsistent with our Supreme Court's holding in *Hyten*." After citing the above-referenced excerpts from *Hyten*, the Court of Appeals noted that, "Accordingly, the claim by Frost's daughter did not bar Progressive from rescinding the policy in this case." The case was then sent back to the Wayne County Circuit Court to enable Progressive to "establish proper grounds for rescission."

Analysis. This case marks a significant shift in how PIP claims for "innocent third parties" have been handled, where a policy had been procured through fraud. If one thinks about it, the "Innocent Third Party" rule is actually designed to compensate individuals who have nowhere else to turn to for compensation for their injuries. This is why the Michigan Supreme Court noted that for purposes of tort liability, all policies sold in the State of Michigan must have the minimum policy limits of \$20,000.00/ \$40,000.00. This writer respectfully submits that, even where a total rescission is appropriate, the insurer must still afford tort liability coverage up to those limits. However, in PIP claims, there is always an insurer that would be responsible for payment of the benefits incurred by the "innocent third party" – the Michigan Assigned Claims Plan – just as the MACP picked up the claims of the "innocent third party" in the *Frost* case.

Counsel for Progressive will be requesting that this opinion be published. The author anticipates that this issue may ultimately find its way to the Michigan Supreme Court.

* * *

In addition to this important decision from the Michigan Court of Appeals regarding the application of the "Innocent Third Party" rule to PIP claims, we also have a number of interesting unpublished decisions from the Michigan Court of Appeals, touching on a variety of issues under the No-Fault Act.

Court of Appeals Decisions

Court of Appeals Determines that Named Insured Was No Longer an "Owner" of the Motor Vehicle in an Accident; As A Result, Non-Resident Son Was Barred From Recovering No-Fault Benefits

Carson v Home-Owner's Ins Co, Docket No. 308291,
Unpublished Decision Rel'd 4/15/2014

On August 16, 2009, Plaintiff's mother shipped a motor vehicle to her son, Plaintiff Carson, who was residing in Nevada. She signed the title as the "seller" but continued to maintain Michigan no-fault insurance on the vehicle through Home-Owners Insurance Company. Her son signed the title as purchaser but did not date his signature, contrary to MCL 257.233(9). Following an accident occurring in September 2009 in Las Vegas, Home-Owners denied coverage for the loss under MCL 500.3111, on the basis that its named insured was no longer the "owner" of the motor vehicle involved in the accident.

Although the trial court denied the insurer's motion for summary disposition, the Court of Appeals reversed and noted that, notwithstanding the fact that the title transfer provisions of MCL 257.233(9) had not been complied with completely (because the purchaser did not date his signature), "the failure to include the date of signature on the assignment of title, however, is a lesser title-transfer defect that does not void the transfer of title, especially because the parties' conduct indicates an intent to transfer title." Because the "objective and material evidence" presented to the court below clearly indicated that the parties intended to transfer title to the vehicle, the court concluded as a matter of law that Ms. Carson was not the "owner" of the vehicle under MCL 500.3101(2)(h)(ii). Therefore, Plaintiff was not entitled to coverage under the Home-Owners' Michigan policy.

Out-Of-State Resident Barred from Recovering No-Fault Benefits, Based Upon His Failure to Insure the Vehicle as Required Under MCL 500.3102

Faison v Hartford Ins Co, Docket No. 313555,
Unpublished Decision Rel'd 6/3/2014

Plaintiff was involved in a motor vehicle accident in December 2010. He claimed to be a resident of the State of

Maryland, and the vehicle was insured under a Maryland automobile liability policy issued by Hartford. Hartford denied the claim and argued that because Plaintiff had been in the State since September 2010, and had failed to obtain no-fault insurance on his vehicle, he was barred from recovering Michigan no-fault benefits under MCL 500.3102(1). This statute requires that out-of-state residents who are present in the State of Michigan for more than thirty days are obligated to obtain Michigan no-fault insurance coverage on their automobiles. The lower court denied the insurer's motion for summary disposition, finding that there was a genuine issue of material fact as to whether or not plaintiff was, in fact, a Maryland resident.

On appeal, the Court of Appeals reversed and noted that the lower court's focus on the issue of "legal residency" was not the relevant inquiry. Rather, the court simply assumed that plaintiff was, in fact, a resident of the State of Maryland (as he claimed) and then looked to determine whether or not he had been in the State of Michigan for more than thirty days. Because he had been living in the State of Michigan for more than thirty days, he was required to obtain Michigan no-fault insurance coverage on his vehicle. His failure to do so barred his claim for no-fault benefits.

Analysis. This writer respectfully submits that the Court of Appeals may have been mistaken in its analysis. MCL 500.3113(b), which bars the owner or registrant of an uninsured motor vehicle from recovering no-fault benefits, only applies to an owner or registrant who has failed to insure their vehicle under MCL 500.3101 (generally applicable to residents, only) or to the owner or registrant of a motorcycle who fails to insure the motorcycle for liability coverages under MCL 500.3103. MCL 500.3102 applies to non-residents, and the only sanction available is a misdemeanor conviction. However, if the vehicle had been in the State of Michigan for more than ninety days, the out-of-state resident is required to register the vehicle in the State of Michigan. See MCL 257.243(4). MCL 500.3101(1) provides that all vehicles which are required to be registered in this state shall be insured for Michigan no-fault insurance benefits. Thus, if an out-of-state resident operates his own motor vehicle in the State of Michigan for more than ninety days in a calendar year, and is involved in a motor vehicle accident with that vehicle, the out-of-state resident would then be barred from recovering no-fault benefits.

Court of Appeals Clarifies Scope of Fiduciary Fees and Expenses Recoverable as an "Allowable Expense" Under MCL 500.3107(1)(a)

Findling v ACIA, Docket No. 314189,
Unpublished Decision Rel'd 5/29/2014

The Court of Appeals' decision in this case builds upon its earlier decision in *May/Carroll v ACIA*, (*on remand*), 300 Mich App 152, 832 NW 2d 276 (2013), which limited the

compensability of conservatorship fees and expenses under the No-Fault Insurance Act. Since *May/Carroll* was decided, most of the services performed by a conservator, which typically involve the routine management of the injured person's financial affairs, have been deemed to be "replacement services" subject to a \$20.00 per day/three-year limitation pursuant to MCL 500.3107(1)(c).

In *Findling*, the Court of Appeals determined that the services performed by the fiduciary could be broken down into four separate categories:

- Paying household bills and managing bank accounts;
- Settling matters related to a slip and fall, including payment of medical bills and liens arising out of the injuries suffered in that slip and fall;
- Maintaining the conservatorship, including preparation of the Annual Accountings and appearing in probate court;
- Pursuing payment of PIP benefits.

Regarding the first two items, the Court of Appeals determined that, under its earlier decision in *May/Carroll (on remand)*, 300 Mich App 152, 832 NW2d 276 (2013), those services listed in the first 2 categories were certainly not "allowable expenses" under MCL 500.3107(1)(a). With regard to the third category, the insurer conceded that those services were "causally connected to, and necessitated by" the injuries suffered by the claimant in the subject accident, and that "these services were provided for the care of Kowalski's peculiar needs as an injured person." However, with regard to the fourth category, the Court of Appeals noted that it was unclear as to the scope of the conservator's services regarding the attempted recovery of PIP benefits. The court further noted that only those legal services that were "directly related to petitioner's care" were compensable as an allowable expense under MCL 500.3107(1)(a). Given the services referenced in the conservator's 20-page billing statement, it did not appear that the legal services were, in fact, "directly related to petitioner's care." Therefore, the Court of Appeals vacated the probate court's award of nearly \$9,000.00 in fiduciary fees and expenses, and remanded the matter back to the probate court for further proceedings.

Court of Appeals Determines That There Exists a Genuine Issue of Material Fact as to Whether Plaintiff Had the Use of His Brother's Uninsured Mother Vehicle

Hill v Burch, docket number 314856,
unpublished decision rel'd 6/5/2014

Plaintiff instituted a tort action against the owner and operator of the motor vehicle which caused the accident. At the time of the accident, Plaintiff was driving an uninsured motor vehicle titled in the name of his brother. Defendant sought to bar Plaintiff's claim for noneconomic damages under

MCL 500.3135(2)(c), which bars the “owner” of an uninsured motor vehicle from recovering “pain and suffering” damages from the negligent tortfeasor. The lower court granted summary disposition in favor of Defendant and Plaintiff appealed.

After reviewing the applicable case law interpreting the definition of the term “owner” found at MCL 500.3101(2)(h)(i), including *Ardt v Titan Ins Co*, 233 Mich App 685, 593 NW 2d 215 (1999); *Kessel v Rahn*, 244 Mich App 353, 624 NW 2d 220 (2001) and *Detroit Medical Center v Titan Ins Co*, 284 Mich App 490, 775 NW 2d 151 (2009), the Court of Appeals determined that Plaintiff’s use of his brother’s automobile was not “regular” and that Plaintiff had to obtain permission from his brother to operate the vehicle. He also had to obtain the keys from his brother. The court further noted that, “considering Plaintiff’s sporadic use of the car for which he had to obtain permission, Defendants have not established that plaintiff used the vehicle on a regular basis for over a 30-day period, let alone that plaintiff’s use was exclusive.” Accordingly the matter was remanded back to the trial court for further proceedings.

Court of Appeals Determines That a Genuine Issue of Material Fact Existed Regarding Claimant’s Domicile, Thereby Precluding Summary Disposition for Either Insurer

Universal Rehabilitation Services Inc v State Farm,
docket no. 314273, unpublished decision rel’d 6/26/2014

Plaintiff was a passenger in a motor vehicle insured with Star Indemnity. There was some indication that Plaintiff may have been domiciled with her mother at the time of the accident, who was insured under a motor vehicle policy issued by State Farm. The lower court determined, as a matter of law, that the injured claimant was not domiciled with her mother at the time of the accident, and that Star Indemnity, as the insurer of the owner or registrant of the motor vehicle occupied by the injured claimant, was required to pay no-fault benefits pursuant to MCL 500.3114(4). Star Indemnity appealed.

After examining the applicable case law, including the recent Supreme Court decision in *Grange Ins Co v Lawrence*, 494 Mich 475, 835 NW 2d 363 (2013), the Court of Appeals noted that claimant may actually have had two residences – one in Southfield with her mother, and one at a residence in Detroit. Therefore, it would be up to the trier of fact to determine precisely where Plaintiff was domiciled at the time of the accident, thereby precluding summary disposition in favor of either insurer.

Court of Appeals Reverses Attorney Fee Award and Affirms Insurer’s Right to Retroactively Terminate Benefits as Being Unrelated to the Injuries Purportedly Suffered in a Motor Vehicle Accident

O’Leary v State Farm, docket no. 313976,
unpublished decision rel’d 7/29/2014

Plaintiff was involved in a motor vehicle accident on June 19, 2012. State Farm paid a number of claims associated with

the injuries purportedly suffered in that accident. Plaintiff was eventually seen by Dr. Martin Kornblum M.D., who performed one surgery on Plaintiff’s cervical spine in October 2009, and two surgeries on Plaintiff’s lumbar spine in November 2009 and February 2012. State Farm suspended all benefits in October 2009, pending further investigation based upon the fact that Dr. Kornblum’s notes were “not even very focused,” as well as the “very inconsistent” imaging studies. However, the IME was not carried out until February 2010. The IME physician, Dr. Philip Mayer M.D., determined that the need for the cervical spine surgery, as well as the first lumbar spine surgery, did not arise out of the injuries suffered in the motor vehicle accident, as the spinal conditions that Dr. Mayer observed on the MRI appeared to be degenerative. The jury returned a verdict in favor of Plaintiff, and the trial court, following an evidentiary hearing, awarded Plaintiff attorney fees totaling \$263,528.00.

“considering Plaintiff’s sporadic use of the car for which he had to obtain permission, Defendants have not established that plaintiff used the vehicle on a regular basis for over a 30-day period, let alone that plaintiff’s use was exclusive.”

In doing so, the lower court determined that State Farm’s retroactive termination of benefits, based upon an IME done four months after the surgery, was “unreasonable.” The Court of Appeals specifically reversed the lower court’s decision and noted that there is nothing in the No-Fault Act that required an insurer to schedule an IME within a particular timeframe. As stated by the Court of Appeals:

“However, the No-Fault Act does not stipulate the time period in which an examination must be scheduled to establish the reasonable proof of loss. It is important to note that no testimony or evidence indicated that Defendant had prior knowledge of the surgery and unreasonably delayed setting up the IME. There was no evidence to suggest that the four-month timeframe to schedule and perform the IME was unreasonable. Defendant must learn of the first surgery, Defendant must communicate the decision to conduct an IME to Plaintiff, an IME physician must be selected, and schedules must be coordinated to set up the actual appointment.

Accordingly, we conclude that the trial court clearly erred in holding that a four-month timeframe to complete an IME, with no other exacerbating

circumstances, constituted an unreasonable denial of benefits.”

Having reversed the award of no-fault penalty attorney fees under MCL 500.3148(1), the Court then addressed the attorney fee award under MCR 2.403(O), based upon State Farm’s rejection of the Case Evaluation award. The Court of Appeals noted that the trial court relied upon “letters from Plaintiff’s hand-picked seven attorneys” to support his claim for attorney fees at the rate of \$600.00 per hour. The trial court refused to rely on the 2010 Economics of Law Practice survey from the State Bar of Michigan (the most recent report available at the time), which indicated that the mean hourly rate for an attorney in Southfield was \$285.00 per hour. The court also took note of the fact that lead Plaintiff’s counsel had actually been a defense attorney, where counsel billed at an hourly rate between \$135.00 and \$175.00 per hour. In addition, the Court of Appeals held that the insurer would be entitled to discovery as to each and every line item on the Plaintiff attorney’s billing statement, because many of the billing entries were “flat out inaccurate, unreasonable, or impossible to happen.”

Clearly, this case is an important decision on many fronts and sets forth a road map as to how to combat a claim for attorney fees under the No-Fault Insurance Act.

Jeep That Has Been Heavily Modified So As to No Longer Render It Roadworthy is Not Considered to be a “Motor Vehicle” Under the No-Fault Act; Therefore, Plaintiff Was Not Entitled to Recover No-Fault Benefits

Gividen v Bristol West, docket no. 312082, unpublished decision rel’d 7/17/2014

Plaintiff was riding an ORV when it collided with a 1976 modified Jeep, operated by an insured of Bristol West. The Jeep was insured under a Texas automobile liability policy. Plaintiff argued that the Jeep was a “motor vehicle” and, as a result, he was entitled to benefits from the insurer of the Jeep pursuant to MCL 500.3163. Both the trial court and the Court of Appeals disagreed. The Jeep had undergone extensive modifications prior to the accident. The metal parts of the Jeep had been removed and replaced with a fiberglass shell. The Jeep did not have any doors or a rearview mirror. The only wiring in the Jeep that was still connected was the steering columns, brakes and emission switch. The tires were replaced with off-road tires. In holding that the modified Jeep was no longer a “motor vehicle,” the Court of Appeals commented that the vehicle had been modified to the extent that it was no longer designed for operation on the public highway. Therefore, Plaintiff’s injuries did not arise out of a “motor vehicle” accident, as required under MCL 500.3105(1).

Insurer of Vehicle Involved in the Accident Not Liable for No-Fault Benefits Arising Out of the Death of an Occupant of That Vehicle

Stone v Auto-Owners Ins Co, docket no. 314427, unpublished decision rel’d 8/5/2014

In our last article, we discussed the decision in *Newsome v ACIA*, docket no. 311367, unpublished decision rel’d 4/10/2014, in which the Court of Appeals determined that, based upon the policy language, and the particular facts in that case, the insurer of the vehicle occupied by the injured party was not required to pay no-fault benefits because that insurer was not the insurer of the “owner” or “registrant” or even “operator” of the motor vehicle occupied by the decedent at the time of the accident. We now have a factually similar case, with a similar outcome, in the *Stone* decision. Plaintiff sought payment of survivor’s loss benefits from Auto-Owners as a result of the fatal injuries suffered by his wife in the motor vehicle accident occurring in October 2010. At the time of the loss, the decedent was driving a 2002 Ford, which was owned and registered by the decedent. Two months before the accident, though, the decedent’s in-laws, John and Linda Stone, had added the decedent’s vehicle to their existing no-fault policy with Auto-Owners Insurance Company. Both Plaintiff and the decedent had been listed as drivers under that policy, but neither Plaintiff nor his deceased wife were listed as the “named insureds.” Furthermore, neither Plaintiff nor his deceased wife lived with Auto-Owners’ named insureds.

In finding that Auto-Owners was not obligated to afford coverage for this loss, the Court of Appeals reiterated the holdings in *Transamerica Ins Co v Hastings Mutual Ins Co*, 185 Mich App 249, 460 NW 2d 291 (1990) and *Dairyland Ins Co v Auto-Owners Ins Co*, 123 Mich App 675, 333 NW 2d 322 (1983), to the effect that simply being designated as a “driver” under a policy does not elevate the person’s status to that of being the “person named in the policy” or the “named insured.” In addition, relying on its earlier decision in *Dobbelae v Auto-Owners Ins Co*, 275 Mich App 527, 740 NW 2d 503 (2007), *Amerisure Ins Co v Coleman*, 274 Mich App 432, 733 NW 2d 93 (2007) and *Amerisure Ins Co v Auto-Owners Ins Co*, 262 Mich App 10, 683 NW 2d 391 (2004), there was nothing in the contractual language of the Auto-Owners insurance policy which would indicate that Auto-Owners was the insurer of the “owner,” “registrant” or “operator” of the motor vehicle occupied by the decedent at the time of the accident. This was true even though Auto-Owners undoubtedly insured the actual vehicle occupied by the decedent.

This case, like the *Newsome* case discussed in our last article, emphasizes the importance of closely examining the terms of an insurance policy to determine if coverage is warranted, particularly when dealing with vehicles that are (a) not actually owned by the named insured, or (b) not actually garaged at the insured’s residence. ■

**ERISA
Case
Summary**


ERISA Decisions of Interest

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US Supreme Court

Supreme Court allows employees to challenge ESOP's continuing investment in company stock

Fifth Third Bancorp v. Dudenhoeffer, ___ US ___, 134 SCt 2459 (June 25, 2014)

Generally speaking, individuals who have or exercise the authority to determine plan investments are considered to be fiduciaries under ERISA. They must decide whether to make an investment – and whether to keep an investment – solely in the best interests of the plan's participants and act at a level of prudence equivalent to that of a “prudent expert.” While fiduciaries are to follow the terms of the plan's documents, they must act otherwise if it would not be prudent to follow the plan's terms.

The conflict between the plan's terms and prudence arises frequently where the plan is heavily invested in employer stock – and is often the subject of lawsuits when the value of employer stock drastically decreases. (Rarely are lawsuits brought if the value of the stock increases.) An additional conflict arises when the stock is publicly traded and the fiduciaries are officers of the employer who have knowledge of non-public information. While ERISA requires them to act in the interest of plan participants, securities laws prohibit them from trading on “inside information.”

In this case, participants in an employee stock ownership plan (ESOP) sued their employer and some of its officers under ERISA, alleging that defendants were plan fiduciaries who breached their duty of prudence by continuing to buy and hold employer's stock when they knew or should have known that stock was overvalued and excessively risky.

The Supreme Court held that: (1) ESOP fiduciaries were not entitled to a presumption that their investment decisions were prudent, i.e., the so-called “Moench presumption”; (2) ERISA fiduciaries could prudently rely on market price of stock as assessment of its value in light of all public information; (3) an ERISA fiduciary is not required to violate securities laws by disclosing inside information; and (4) where an imprudence claim involves inside information, the complaint must also plausibly allege an alternative action that fiduciary could have taken consistent with securities laws that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm plan than to help it (i.e., would a prudent

fiduciary in the defendant's position have concluded that stopping purchases—which the market might take as a sign that insider fiduciaries viewed the employer's stock as a bad investment—or would publicly disclosing negative information do more harm than good to the fund by causing a drop in the stock price and a concomitant drop in the value of the stock already held by the fund).

While clearing up some issues, the Court gave no bright-line rules. Rather, it remanded the case with the quixotical direction [sic], “We leave it to the courts below to apply the foregoing to the complaint in this case in the first instance.”

Sixth Circuit Update

Plan that limits time for filing lawsuits must notify claimants of that limit in claim denial letter

Moyer v. Metropolitan Life, ___ F.3d ___, 2014 WL 3866073, No. 13-1396 (August 7, 2014).

MetLife initially approved Moyer's LTD benefits, but cut them off two years later. Moyer filed an administrative appeal, which was denied, and Moyer filed suit more than three years later. The district court dismissed the lawsuit based on a statute of limitations provision in the plan. (It was not included in any SPD.) The Sixth Circuit reversed, holding that because the denial letters did not notify Moyer of the plan's statute of limitations period, it did not substantially comply with the ERISA claim regs and thus could not be enforced against Moyer.

This is an interesting result, which may require the form of many denial notices to be changed. The court's reliance on the ERISA claim regs is interesting because those regs require denials to inform claimants of their right to file suit, but they do not explicitly require inclusion of any time deadlines for filing suit.

Of course, any limitation for filing suit is required to be included in the plan's SPD. Further, it might be argued that a claims fiduciary acting solely in the interest of plan participants should notify them of any impediment to seeking judicial review. But the Court did not base its decision on either of these grounds.

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Michigan's health insurance claims tax on TPAs is not preempted.

SIIA v Snyder, 761 F.3d 631 (6th Cir. Aug. 4, 2014)

In an attempt to partially solve its budgetary woes and increase federal Medicaid payments, in 2011, Michigan passed a 1% tax on health benefit claims paid by insurers and TPAs, including those administering claims for uninsured employer-sponsored ERISA-governed health plans. An association representing self-funded plans and TPAs brought suit seeking to have the tax preempted. The District Court rejected the claim, and SIIA appealed.

The Sixth Circuit also held that the tax was not preempted. It began its opinion, reflecting the judiciary's frequent lack of enthusiasm for ERISA cases, saying, "This case requires us, once again, to navigate the quagmire that is preemption." The Court held that the tax did not impermissibly interfere with the uniform nation-wide administration of the plans; impose administrative burdens in addition to those prescribed by ERISA; or interfere with the relationships between ERISA-covered entities. Thus, it was not preempted.

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ERISA's anti-retaliation provision does not protect unsolicited complaints

Sexton v. Panel Processing, Inc., 754 F.3d 332 (6th Cir. May 9, 2014)

ERISA 510 is a general anti-retaliation provision. It prohibits interference in the attainment of a benefit (e.g., firing an employee the day before she becomes vested); retaliation against a plan participant or beneficiary for exercising his or her rights under ERISA or a plan; or for giving information or testifying in an ERISA-related inquiry or proceeding.

Sexton was an employee of Panel Processing and a trustee of its retirement plan. He campaigned for two employees who were elected to (but never seated on) Panel's board of directors. He was then removed as a plan trustee. He sent an e-mail to the board chair challenging the refusal to seat the elected directors and his own removal as trustee. The e-mail also threatened to report the Company to the government. Sometime later, he was fired as an employee. He brought suit claiming the firing violated ERISA 510.

The Sixth Circuit (2 to 1) held his claim did not fit within ERISA 510. The applicable portion of ERISA 510 only pro-

TECTED an employee who has given information or has testified or is about to testify in any ERISA-related *inquiry or proceeding*. The court majority held that there was no "inquiry or proceeding"; thus this section did not protect Sexton. A petition for certiorari has been filed.

The majority's opinion has an interesting review of the "roughly forty" federal anti-retaliation cases. It noted two types of clauses: (1) those that "protect employees who oppose, report or complain about unlawful practices"; and (2) those that "protect employees who participate, testify or give information in inquiries, investigations, proceedings or hearings." (Of course, some include both types of clauses.)

And, on a matter that only true ERISA litigation nerds could appreciate, the opinion arguably broadens the ability of defendants to remove ERISA cases filed in state court. The general rule is that a case filed in state court can only be removed to federal court if, within its four corners, the complaint states a claim that could have been filed in federal court (i.e., diversity or federal question). In *Metropolitan Life Ins Co v Taylor*, 481 US 58 (1987), the US Supreme Court held that a state-based lawsuit filed in state court could be removed if the cause of action was preempted by ERISA and if there was an applicable cause of action available under ERISA. The Sixth Circuit interpreted *Taylor* as only applying to claims for benefits and not to other claims which could be asserted under ERISA. *Warner v Ford Motor Co*, 46 F.3d 531 (6th Cir. 1995). Although not explicitly analyzed, this Court "was satisfied" that removal was proper – thus *sub silentio* overruling the *Warner* limitation.

United States District Court Update

Partial hearing loss resulting in reduction of billable hours was not objective evidence of total disability

Conway v Reliance Standard Life Ins., Case no. 13-11164, 2014 U.S. Dist. LEXIS 102369 (E.D. Mich., July 28, 2014)

A local personal injury defense attorney experienced a sudden loss of hearing in his left ear, which was accompanied by tinnitus and loss of balance. Although he continued working full-time, he filed a claim for disability benefits because he was no longer able to maintain his 70 hour workweeks and he could not continue to travel as much as was required by his actual job. The plaintiff also argued that he was precluded by his disability from continuing to represent clients in a court setting because he might not be able to hear and because he became off-balanced when walking in a confined space.

The plan at issue included definitions of "partially disabled" and "residually disabled." Accordingly, the court determined that in order to receive benefits, the plaintiff was required to at least show that he was unable to perform some (but not necessarily all) of his material duties during the 90 day elimination period following the onset of his purported disability. The court found that the plan appropriately consid-

ered the Department of Labor's Dictionary of Occupational Titles to define the plaintiff's material job duties, which were not substantially different from the plaintiff's actual job duties. The medical records provided in support of the plaintiff's claim established plaintiff's ability to hear a whispered voice, that his balance had improved over time, and that his anxiety did not impair his cognitive function. Perhaps even more significantly, the plaintiff returned to work three days after he first lost his hearing, and he continued to work a 50 hour week thereafter, where the plan defined "full-time" as a minimum of 30 hours per week. As a result, the court concluded that there was no evidence that the plaintiff was unable to perform any of his material duties, and even under the *de novo* standard of review, the plan's denial of benefits was upheld.

The plaintiff also sought specific indemnity benefits. This type of benefit was available to a claimant who sustained a particular type of loss from an accident resulting in an "Injury". The policy listed loss of hearing in one ear as one of the enumerated losses. However, the court held these benefits were properly denied because "Injury" was defined as causing total disability, which the plaintiff failed to establish.

ERISA preempts legal malpractice claim

Grimmett v. Dace, Case no. 13-13704, 2014 U.S. Dist.
LEXIS 102340 (E.D. Mich., July 28, 2014)

The plaintiff here sued his former legal counsel for malpractice related to a prior property damage lawsuit against the plaintiff's condominium association. The case was initially filed in state court, but the defendant removed the action to federal court based on ERISA preemption. If you are a devotee of this column, you might be wondering how this case involves ERISA.

As an employee of General Motors, Grimmett was a participant of the UAW-GM Legal Services Plan, which provides legal counsel at no cost to certain union hourly employees. After a flood at his condo, the plaintiff sought legal representation from the Plan to attempt to recover for his property damage. After a trial, the jury found neither Grimmett nor the condo association liable for any damages. However, because Grimmett's counsel did not timely respond to the condo association's post-trial motion for costs, judgment for costs was entered against Grimmett. Thereafter, Grimmett complained to the Plan that his counsel committed malpractice.

After some negotiation, the Plan agreed to pay the judgment entered against Grimmett in exchange for a full release of any claims Grimmett had against his former attorneys, the Plan, and any other Plan representatives. Nonetheless, Grimmett filed suit against the Plan, his former counsel and the Plan officer who processed Grimmett's administrative appeal. Among his claims, Grimmett alleged that his former counsel failed to file a discrimination claim against his condo association as he requested, and that the Plan and the Plan officer

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breached common law fiduciary duties owed to Grimmett. Grimmett moved to remand the case to state court and the defendants moved to dismiss altogether.

The court acknowledged the absence of case law authority as to whether ERISA preempts legal malpractice claims against an attorney provided by an ERISA plan to beneficiaries. For guidance, the court analyzed medical malpractice cases where the issue of ERISA preemption arose and found that those cases could be separated into categories of claims concerning the quality of benefits received (*e.g.* treatment) versus claims that the plan erroneously withheld a quantum of benefits, which claims were completely preempted.

Turning to Grimmett's allegations that the Plan attorneys failed to file a discrimination claim against the condo association, the court applied the quality/quantity analysis to the nature of this malpractice claim. According to the Plan, participants are entitled to free legal counsel for only certain, specified types of actions. The Plan provided that discrimination claims were not handled by Plan attorneys and instead participants would be referred to an outside attorney. Thus, the court concluded that Grimmett's request that his counsel file a discrimination claim was not a service provided by the Plan. Because Grimmett argued that the Plan should have provided this type of benefit, the court interpreted the malpractice claim as quantitative in nature. Accordingly, the court determined this count was a claim to recover benefits under the Plan which was therefore completely preempted by ERISA.

Next the court considered whether Grimmett's common law breach of fiduciary claim was preempted by ERISA. This analysis was more straightforward. Grimmett did not contest the defendants' argument that the Plan and the Plan officer were ERISA fiduciaries. Nor did Grimmett identify any basis under which the defendants owed him any duty other than under ERISA. Indeed, Grimmett's claim was based on the Plan officer's exercise of discretion in reviewing and resolving Grimmett's administrative appeal. Accordingly, the court concluded that ERISA completely preempted the breach of fiduciary claim, which provided an independent basis for the court's jurisdiction. The court thereafter exercised

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supplemental jurisdiction over the remainder of the claims and denied the motion to remand.

Turning to the defendants' motion to dismiss Grimmatt's claims as barred by the release, the court applied the "tender back" rule, in which a plaintiff must return any consideration before there is a right to repudiate a release, which Grimmatt failed to do here. Neither of the two exceptions to the rule applied here; in which a defendant excuses a plaintiff's performance, or fraud is proven in the execution of the release. Grimmatt argued that he was coerced into signing the release, which the court found still did not excuse him from tendering back the consideration he received. Accordingly, the court granted the defendants' motion dismissing the case.

Self-dealing fiduciary must repay compensation

Trustees of the Painters Local 1011 Health Reimbursement Arrangement Fund v. Anderson, Case no. 13-250, 2014 U.S. Dist. LEXIS 114043 (W.D. Mich., August 18, 2014)

ERISA prohibits plan fiduciaries from any transactions that solely benefit the fiduciary or that are contrary to the interests of the plan participants or beneficiaries. In this case, the court held that the fiduciary's good faith belief that he was entitled to reasonable compensation was not a meritorious defense to claims of self-dealing.

The plaintiff fund here provided benefits from trust assets to pay health care related expenses for participants and beneficiaries. The defendant was a trustee of the fund, and an employee of the union that was a participating member of the Fund. For five years the defendant performed administrative services for the Fund and was paid as an employee, but did not receive any compensation in connection with his role as

Trustee. After that period, the Fund entered into a contract with the union which provided for the defendant to administer the Fund. The defendant still received compensation in the course of his employment, but not in connection with his duties as Trustee.

Two years after the administrative services contract was executed, the defendant started to issue checks to himself, until he retired from employment and was removed as Trustee. When the defendant was asked to refund his final payment, he responded that he was entitled to keep the compensation pursuant to the contract terms. The court disagreed, and held that the defendant was liable for reimbursing the Fund for the amounts he wrongfully received plus any profits he may have received.

The opinion is somewhat thin on facts, and does not cite any of the terms of the administrative services contract or fully describe the nature of the defendant's employment. The main take-away here is that a plan fiduciary issuing payment to himself or herself must be mindful of the requirement to discharge duties solely in the interests of the plan's participants and beneficiaries. ■

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