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This journal is published by the Insurance and Indemnity Law Section, State Bar of Michigan
Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.
As I take over the role as your Section chair, it is a turbulent time for our country politically. It is also a turbulent time in our profession with baby boomers reaching retirement age; the proliferation of technology resulting in concomitant cyber-security issues, and the continuing erosion of protections provided by the 7th Amendment right to a jury trial. It is a particularly turbulent time in our field with hearings on potential changes to our signature No Fault Act being conducted by the Michigan Legislature as this issue goes to publication.

Neutrality of the Section

During this time, I am reminded of the importance of inclusion. In 2010, I was the first plaintiff’s trial lawyer elected to the Council. It was the goal of the Section then, and remains the goal now, to ensure the neutrality of the Section and eradicate any perception that this Section is an instrumentality of the insurance industry. Since my inclusion as an officer, several other lawyers who represent claimants or policy holders have become officers, members of the Council or otherwise active in the activities of the Section. Without question, we have become a diverse group covering the full spectrum of those affected by insurance issues.

Watch for our Survey

Furthering our goal of inclusion, we want to make our Section more relevant to you and your practice. We have too little participation by our members beyond a core group who serve (or have served) on the Council. We will soon be reaching out to you through a survey seeking your input as to what you would like to see from your Council and your Section. We hope, among other things, that your input will help us plan meetings, networking events and seminars that will both attract and benefit our membership.

We will also become more involved with you through social media, making it easier for you to stay up to date on insurance related issues and providing you the ability to more easily communicate with others in the Section when you might need some help or suggestions. We also are going to bring our Section to you, having meetings or events in areas of the state outside of the Tri-County area. Finally, many of you are members of other Sections. We are reaching out to leaders of other Sections with whom we have common membership to have joint events to provide you with opportunities to enhance your skills and network.

I am inheriting a Section that has been expertly led by my predecessors. I have been fortunate to learn from the leadership skills of past Chairs Adam Kutinsky, Kathleen Lopilato, Elaine Murphy Pohl and Mark Cooper. I have benefitted from the advice and tutelage of Hal O. Carroll, one of our Section’s founders and publisher of our highly regarded Journal. I hope during this dynamic time in our field that I can continue their fine work. And, by including more of you, I hope that our Section will grow in prominence and relevance. It is my goal during my tenure to meet or talk with as many members as feasible. If at anytime you have questions, concerns or suggestions, please feel free to contact me directly by email (lbennett@seikalystewart.com) or my direct dial (248.419.3574).

Hope to see or talk to you soon.

Larry Bennett
Siekaly, Stewart & Bennett PC

The Journal – now in its eleventh year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The Journal – like the Section itself – takes no position on any dispute between insurers and insureds. All opinions expressed in contributions to the Journal are those of the author. But we welcome all articles of analysis, opinion, or advocacy for any position.

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.

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Scenes from the Annual Meeting

Adam Kutinsky presiding over the annual meeting
Larry Bennett, Incoming Chair
Adam Kutinsky presents leadership award to Larry Bennett
Janis Meyer of Hinshaw Culbertson, speaking on common lawyer mistakes in the digital age.
Larry Bennett presents Service Plaque to Adam Kutinsky

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Disability Insurance Primer

By James T. Mellon and David A. Kowalski, Mellon Pries, PC

“Disability insurance” can refer to several different types of insurance. The coverages required by the No-Fault Act, MCL §500.3101, et seq., include coverage for disabilities related to motor vehicle accidents meeting the threshold requirements of the Act. The coverages provided by the Worker’s Compensation Disability Act, MCL §418.101, et seq., also include coverage for work-related disabilities meeting the threshold requirements of the Act. Likewise, Social Security may also provide certain disability benefits to qualified individuals pursuant to 42 USC §416(i), 423, and related statutes and regulations (“SSDI”). Outside of these governmental entitlement programs, however, parties may contract for coverage for disabilities.

Statutory definition of disability insurance

Most attorneys probably think of disability insurance as the contract that employees, individuals, or others enter into with insurance companies. The Insurance Code provides the following definition:

“Disability” insurance is insurance against bodily injury or death by accident, or against disability on account of sickness or accident. Unless specifically excluded in chapter 34, disability insurance includes health insurance issued to an individual, family, or group, subject to limitations that are prescribed with respect to the insurance.1

The most common types of disability insurance provide either for a lump sum payment on the occurrence of an identified injury, or for periodic payments for a specified period of time, usually in compensation of lost income.2 Interestingly, though people are more likely to become disabled during their working years than to suffer death, life insurance is far more common than disability insurance.3

The coverage consists of all forms of insurance providing compensation for the insured’s partial or total disability, and may be provided by way of a separate policy, or as part of a broader health, accident or life insurance policy.4 Disability insurance began as an offer to waive premium payments under a life insurance policy in the event of a disability, and shortly thereafter, insurers added a periodic income benefit.5 Later, the income benefit was separated from the life insurance policy, enabling persons to purchase independent policies of disability insurance.6

Taxability of disability benefits

Disability insurance is often purchased by an employer for an employee as an employee benefit, or it can be purchased by the employee directly. The purchaser of the policy is important, as the benefits are not federally taxable if the employee pays the premium, but are federally taxable to the employee if the employer pays the premium.7

Disability insurance may be short term or long term; around 38% of American private workers received short term coverage through their employers, while 31% received long term coverage.8 When the individual market is considered, the percentage of employees with short term disability coverage rises to 49% and the percentage for long term disability coverage rises to 44%.9 Some reasons for the small individual market include the threat of adverse selection, moral hazard, and the availability of SSDI and workers compensation.10

The coverage provided by disability insurance is usually all or nothing, such that the injured person is either totally disabled and receives full coverage, or the person is not disabled, and, therefore, entitled to no coverage.11 In other words, partial disability is not compensable, unlike some governmental benefits, such as worker’s compensation.

“Total” disability and “total and permanent” disability

As with other insuring agreements, terms in a disability insurance policy are construed according to their plain, ordinary meanings, unless otherwise defined.12 A policy may provide coverage for “total disability,” a term which has been interpreted, absent definition in the policy, to mean the inability to perform the acts necessary to exercise one’s profession, as opposed to complete physical inability or helplessness.13 A policy may also provide coverage for “total and permanent disability,” a term which has been interpreted, absent definition in the policy, to require that both prongs be satisfied.14 “Permanent” is the opposite of “temporary,” such that a total disability, even for an extended period of time, will not be compensable, if the total disability ceases to exist.15

Definition of “disability”

As one would imagine, disability insurance policies frequently define “disability,” and the outcome of many disputes turn on the definition of that term. Presently, the basic types of coverage available include a general disability policy, defining “disability” in terms of inability to engage in any gainful employment; an occupational disability, defining “disability”
in terms of being unable to perform the duties of the insured’s particular occupation; or a hybrid type, which provides short term benefits (e.g., one to two years) if the insured cannot perform the usual duties attendant to the insured’s occupation and long term benefits after the short-term period, if the insured cannot engage in any gainful employment. Examples of common definitions of “total disability” include:

The inability to perform the material and substantial duties of your regular occupation, the insurance company will consider your occupation to be the occupation you are engaged in at the time you become disabled, they will pay the claim even if you are working in some other capacity.

Because of sickness or injury you are unable to perform the material and substantial duties of your occupation, and are not engaged in any other occupation.

Because of sickness or injury you are unable to perform the material and substantial duties or your occupation, or any occupation for which you are deemed reasonably qualified by education, training, or experience. The first example is an occupational definition, while the third example is a general definition.

A policy may provide coverage for “total disability,” a term which has been interpreted, absent definition in the policy, to mean the inability to perform the acts necessary to exercise one’s profession, as opposed to complete physical inability or helplessness. The elimination period

Another common element in disability insurance is an “elimination period” of a set duration, which precludes an insured from receiving from disability benefits until the period expires. Also in line with interpretation of other insurance policies, while an unambiguous policy will be interpreted as written, ambiguities in disability insurance contracts will be construed in favor of the insured to maximize coverage. Thus, an emergency room physician who sustained a back injury, but was able to obtain part-time work as a prison physician, was found to be “unable to perform the material and substantial duties of the Insured’s regular occupation,” because the “regular occupation” was that of an emergency room physician, not a general practice physician.

Coordination of benefits

Effective July 1, 2016, the Michigan Legislature passed new legislation regarding the coordination of benefits for disability insurance policies, through Public Acts 275 and 276 of 2016. The new legislation provides:

Subject to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255, an insurer may include in a group or nongroup disability insurance policy a provision for the coordination of benefits otherwise payable under the policy with benefits payable for the same loss under other group or nongroup disability insurance. An insurer that does not include in a group or nongroup disability insurance policy a provision for the coordination of benefits as described in this subsection shall coordinate benefits under the policy in the manner prescribed in the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

The first sentence of the legislation, “Subject to the coordination of benefits act,” contains an important change. Prior statutory authority, as interpreted by the Michigan Court of Appeals, had determined that the prior coordination of the benefits statute for disability insurance, former MCL 500.3610a, controlled over the general Coordination of Ben-
benefits Act, MCL 550.251 through MCL 500.255. The present version of the statute, in contrast, makes the disability insurance coordination of benefits statute subject to the general Coordination of Benefits Act. Coordination of benefits with insurance coordination of benefits statute subject to the general version of the statute, in contrast, makes the disability in-

section clause for coverage by other insurers, it will be subject to third party liability coverage as other valid coverage. The statute provides:

For the purpose of applying the policy provision with respect to any insured, any amount of benefit provided for the insured under any compulsory ben-

Thus, if a disability insurance policy contains a coordination clause for coverage by other insurers, it will be subject to coordination with certain governmental benefits. However, practitioners should also be on the lookout for issues involving ERISA, as certain disability policies may fall under the federal statute, and, therefore, be subject to the rules, regulations, and procedures applicable to ERISA.

Reading a particular disability insurance policy or any disability provision is, of course, paramount and contract-specific. Furthermore, not all disability policies or provisions are created equal. Caveat emptor.

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Endnotes

1 MCL 500.606(1).

2 10A Couch on Ins (3d ed) $146:1.


4 Id.

5 Jerry and Richmond, Understanding Ins Law (San Francisco: Matthew Bender & Co, Inc) (5th ed), p 463.

6 Id.

7 Id. at 465.


9 Id.

10 Id.

11 Id. at 427.


13 Ebert v Prudential Ins Co of Am, 338 Mich 320, 332; 61 NW2d 164 (1953).

14 Brod v Detroit Life Ins Co, 253 Mich 545, 546; 235 NW 248 (1931).


16 10A Couch on Ins (3d ed) §146:3.


18 Jerry and Richmond, supra n3, p 465.


20 Id. at 383.

21 Id. at 385-86. In fact, the Michigan Court of Appeals noted that the physician had been able to practice his field for at least 20 years, despite the bipolar disorder, and that he would have been able to continue to practice, had he not voluntarily surrendered his license.


23 Id. at 447.

24 MCL 500.3402b(1).

25 Estabrook v Lincoln Nat'l Life Ins Co, 172 Mich App 450, 453-54; 432 NW2d 733 (1988). One of the then-enacted statutes relied upon by the Court of Appeals in reaching its conclusion, MCL 550.255, was repealed by Public Act 275 of 2016. The reference in present MCL 500.3402b(1) to MCL 550.255 as part of the Coordination of Benefits Act is somewhat odd, as MCL 500.3402b was enacted as part of Public Act 276 of 2016, which was concurrently passed with Public Act 275, repealing MCL 550.255.

26 MCL 500.3440(2) (emphasis added).
For those of us who practice in the nofault insurance arena, the past few months could best be characterized as the “Summer of Covenant” or “Covenant 24/7.” The courts have been inundated with motions for summary disposition, motions to amend complaint, motions to strike assignments and countless other motions—all stemming from the Michigan Supreme Court’s landmark decision in Covenant Med Ctr v State Farm, 500 Mich 191; 895 NW2d 490 (2017). Not surprisingly, there has also been a flurry of appellate court activity applying the Supreme Court’s holding in Covenant, to the effect that while medical providers no longer have a statutory cause of action to recover payment of medical expenses from a nofault insurer, the medical provider might be able to pursue alternative theories of recovery.

Covenant operates retroactively

The most significant decision handed down in the post-Covenant era thus far is WA Foote Mem’l Hosp v Michigan Assigned Claims Plan, __ Mich App __; __ NW2d __ (Docket No. 333360, issued August 31, 2017). This case was one of the first cases to be considered by the Michigan Court of Appeals after Covenant, as oral argument had already been scheduled to occur prior to the release of the Supreme Court’s decision in Covenant. As a result, the primary issue in WA Foote Mem’l Hosp was whether or not Covenant was to be applied retroactively or prospectively only. The importance of the Court of Appeals’ opinion was underscored by the fact that certain district court judges were applying Covenant on a prospective basis, only, thereby preserving the medical provider’s right to sue nofault insurers under pre-Covenant case law. In its published opinion, the Court of Appeals put a swift end to those decisions, and ruled that the Michigan Supreme Court’s decision in Covenant is to be given full retroactive effect, regardless of whether the insurer had actually raised a “Covenant” defense, based upon the provider’s purported lack of standing to commence litigation.

In its published opinion, the Court of Appeals put a swift end to those decisions, and ruled that the Michigan Supreme Court’s decision in Covenant is to be given full retroactive effect, regardless of whether the insurer had actually raised a “Covenant” defense, based upon the provider’s purported lack of standing to commence litigation.

that there was, in fact, a higher priority insurer in the picture but, because the insurer had not received notice within one year of the date of loss, the hospital could not initiate a claim against that insurer. The lower court had granted summary disposition in favor of the MACP, noting that the hospital could have identified a higher priority insurer if it had filed suit directly against the patient for the unpaid medical bills, if it had obtained the information from the patient at the time of the treatment, if it had obtained the police report regarding the accident, or had followed up on information that it had regarding actual ownership of the vehicle occupied by the patient.

While the appeal was pending, the Michigan Supreme Court released its decision in Covenant, at which time the parties briefed the issue as to whether or not Covenant should be applied retroactively. In a rather lengthy opinion, the Court of Appeals issued the following key rulings:

- First, the court ruled that, in light of the U.S. Supreme Court’s decision in Harper v Virginia Dept of Taxation, 509 US 86, 113 SCt 2510, 125 LEd2d 74 (1993) and the Michigan Supreme Court’s decision in Spectrum Health v Farm Bureau, 492 Mich 503, 821 NW2d 117 (2012), Covenant was to be given full retroactive effect;
- The court rejected the provider’s argument that the insurer had failed to properly preserve the issue, noting that the court rules, specifically, MCR 2.111(F)(2), indicate that the defense of a “failure to state a claim upon which relief can be granted” is not waived even if not asserted in a responsive pleading or motion;
- Regarding the provider’s argument that it should be allowed to amend its complaint to assert an alternative theory of recovery, including the pursuit of benefits under an
assignment theory, the Court of Appeals noted that “the most prudent and appropriate course for us to take at this time is to remand this case to the trial court with discretion that it allow Plaintiff to move the amend its Complaint, so that the trial court may address the attendant issues in the first instance.”

WA Foote Mem'l Hosp, slip opinion at p. 20.

Now that the issue of Covenant’s retroactivity has been resolved, the author anticipates that the next round of appellate court activity will concern the validity of the various assignments that are being obtained by medical providers.

Cases remanded to Court of Appeals for reconsideration in light of Covenant

Since Covenant was released, the Supreme Court has vacated a number of prior decisions from the Court of Appeals, with instructions to the Court of Appeals to reconsider the case in light of Covenant. These decisions, along with a brief statement of what the case initially involved, include the following:

- Chiropractors Rehab Grp PC v State Farm, Supreme Court docket no. 152807 (Court of Appeals had allowed medical providers to pursue claims for medical expenses against a no-fault insurer, notwithstanding Claimant’s repeated failures to appear for IME’s and/or EUO’s);
- Detroit Med Ctr v MPCGA, ___ Mich ___, 900 NW2d 624 (2017) (Court of Appeals had reversed a summary disposition decision concerning an “unlawful taking” issue);
- VHS Huron Valley Sinai Hosp v Sentinel Ins Co, ___ Mich ___, 900 NW2d 628 (2017) (Court of Appeals’ decision dealt with whether a release of an uninsured motorist claim barred a provider’s suit for payment of PIP medical expenses);
- Spectrum Health Hosp v Westfield Ins Co, 500 Mich 1024, 897 NW2d 166 (2017) (Court of Appeals refused to consider two lower court decisions regarding the compensability of maintenance injuries under the Parked Vehicle Exclusion set forth in MCL 500.3106(1)(1)); and
- Bronson Methodist Hosp v Michigan Assigned Claims Facility, 500 Mich 1024, 897 NW2d 735 (2017) (Court of Appeals’ decision pertained to whether or not the Michigan Assigned Claims Plan could be forced to assign an insurer in a situation where the underlying patient was injured in an automobile accident while driving his own motor vehicle).

In perhaps an indication of what is to come, the Court of Appeals recently issued a peremptory order instructing the lower court to dismiss the lawsuit where the provider had failed to secure an assignment prior to filing suit. In Standard Rehab Inc v Grange Ins Co of Michigan, unpublished opinion per curiam of the Court of Appeals, issued September 5, 2017 (Docket No. 331734), the Court of Appeals had granted leave to appeal “to determine whether reports prepared for non-party independent medical examinations (IMEs) may be obtained during discovery for the purpose of establishing bias by the physician retained by Defendant insurer to prepare an IME report in the instant case.”

During the pendency of the appeal, the Michigan Supreme Court issued its decision in Covenant, and the matter was brought up during oral argument. At oral argument, counsel representing Standard Rehabilitation conceded that the underlying patient had not made an assignment of their claims to Standard Rehabilitation prior to the lawsuit being filed. Therefore, the matter was “remanded with direction to dismiss this case.” This order is actually in keeping with the trends in the circuit courts and district courts, which have been regularly dismissing lawsuits filed by medical providers where the provider has failed to obtain an assignment.

In Perkovic, the Michigan Supreme Court made it clear that by virtue of the plain language of MCL 500.3145(1), the notice requirement can be satisfied by a medical provider who submits medical records, billing records, and in appropriate cases, the police report

Other Supreme Court Action

Lost in the Covenant aftermath was the fact that the Michigan Supreme Court issued two other decisions that impact no-fault jurisprudence. One of these cases discusses what constitutes proper notice of a claim under MCL 500.3145(1). The second deals with the compensability of injuries arising out of a parked motor vehicle. These two cases are analyzed below.

Applications for Benefits

Perkovic v Zurich American Ins Co, 500 Mich 44; 893 NW2d 322 (2017)

In order to initiate a claim for no-fault benefits, most, if not all, no-fault insurers require that an application for benefits be filed. These applications usually provide information regarding the accident itself, as well as a description of the injuries, the places where the injured claimant received any hospital or medical treatment, and information regarding any claims for work loss benefits. The information included in an application for benefits is designed to comply with MCL 500.3145(1),
which contains a strict one-year notice provision:

An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. . . . The notice of injury required by this subsection may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits therefor, or by someone in his behalf. The notice shall give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place and nature of his injury.

Many insurers have been denying claims for benefits if the injured claimant fails to complete and submit a timely application for benefits. In Perkovic, the Michigan Supreme Court made it clear that by virtue of the plain language of MCL 500.3145(1), the notice requirement can be satisfied by a medical provider who submits medical records, billing records, and in appropriate cases, the police report, because taken together, these documents provide:

- The name and address of the Claimant (set forth on the billing statement from the medical provider);
- The name of the person injured (which appears in both the medical and billing records);
- The nature of his injury (contained within the medical records themselves); and
- The time and place of the injury (contained in the police report or in the medical records).

Perkovic initially involved a dispute among three insurers – Perkovic’s personal no-fault insurer (Citizens), his trucking fleet insurer (Zurich) and his bobtail insurer (Hudson) over which insurer would be responsible for payment of his no-fault benefits, arising out of a trucking accident. In an earlier proceeding, the Court of Appeals determined that the fleet insurer, Zurich American Insurance Company, occupied the highest order of priority for payment of Perkovic’s no-fault benefits. After a remand to the circuit court, Zurich filed a motion for summary disposition, claiming that it did not receive proper notice of the loss, even though it had received medical records and billings from the Nebraska Medical Center within one year. Both the circuit court and the Court of Appeals had granted summary disposition in favor of the insurer, determining that even if there had been technical compliance with the requirements of MCL 500.3145(1), the “purposes” behind the statutory provision were not satisfied because there was nothing in the claim submissions that would have put the insurer on notice that the provider was submitting a claim for Michigan no-fault insurance benefits.

On appeal, the Supreme Court, in a 6-1 decision authored by Justice Bernstein, rejected any such reliance on the “purposes” behind the one-year notice provision. Instead, adopting a classic textualist argument, the Supreme Court determined that, “the documents transmitted to Defendant contained all of the information required by MCL 500.3145(1) and were sent in behalf of Plaintiff by the Nebraska Medical Center.”

Former Justice Young agreed with the reasoning of the majority opinion, but dissented from the results reached by the majority. Justice Young opined that the notice had to be given by “a person claiming to be entitled to benefits” at the time the notice was given.

Ironically, when seen in light of Covenant, a medical provider has the right to file a claim with a no-fault insurer “in behalf of the injured party,” but does not have the right to enforce payment of medical expenses incurred by that same party in whose behalf the notice was given, against that same no-fault insurer.

Issue of fact whether injury while unloading personal belongings was compensable

Kemp v Farm Bureau, 500 Mich 245; __ NW2d __
(docket no. 151719, issued 6/15/2017)

In a 4-3 decision authored by Justice Viviano, the Michigan Supreme Court reversed the judgment of the Michigan Court of Appeals and determined that there existed a genuine issue of material fact as to whether or not injuries suffered by an injured claimant while unloading his personal belongings out of a parked motor vehicle were compensable under the no-fault insurance act. In Kemp, Plaintiff opened the rear door of his extended cab pickup truck and reached into the vehicle to grab his belongings, including his briefcase, an overnight bag, a thermos, and a lunchbox. As he was lowering them from the vehicle, he suffered an injury to his calf muscle. He filed suit against his insurer, Farm Bureau, to recover no-fault benefits arising out of the incident.

Farm Bureau denied the claim and argued that (1) Kemp’s injury did not arise out of the ownership, operation, maintenance or use of the parked motor vehicle as a motor vehicle, (2) the injury did not arise as a direct result of physical contact with property being lifted onto or lowered from the vehicle in the loading or unloading process, as required by MCL 500.3106(1)(b), and (3) his injury did not have a causal relationship to the motor vehicle that was more than incidental, fortuitous, or “but for.” The circuit court granted summary disposition in favor of Farm Bureau and in a 2-1
In its opinion, the Supreme Court re-affirmed the three-step analytical framework initially enunciated by the court in *Putkamer v Transamerica Ins Corp of America*, 454 Mich 626; 563 NW2d 683 (1997). First, the injured claimant must demonstrate that the circumstances surrounding the loss falls within one of the three exceptions to the parked vehicle exclusion set forth in MCL 500.3106(1). Next, the claimant must show that the injury arose out of the ownership, operation, maintenance or use of the parked motor vehicle as a motor vehicle. Finally, the claimant had to demonstrate that the injury had a causal relationship to the parked motor vehicle that was more than incidental, fortuitous, or “but for.”

With regard to the first issue, the Supreme Court noted that there existed a genuine issue of material fact as to whether or not the injury was the “direct result” of physical contact with the property that Mr. Kemp had just removed from his pickup truck. In so ruling, the Supreme Court rejected Farm Bureau’s argument that the injury must be “due to” physical contact with the property. Instead, all that was required was that the injury was caused by contact with the property being loaded or unloaded. Second, the court determined that the unloading of one’s personal belonging out of one’s vehicle satisfied the “transportational function” requirement of *McKenzie v ACIA*, 458 Mich 214; 580 NW2d 424 (1998), as a matter of law. Finally, the court ruled that there existed a genuine issue of material fact as to whether or not the causal relationship between the injury and the motor vehicle accident was more than incidental, fortuitous, or “but for,” as required by its earlier decision in *Thornton v Allstate Ins Co*, 425 Mich 643; 391 NW2d 320 (1986).

Justice Zahra, joined by Chief Justice Markman and Justice Wilder, dissented from the majority’s opinion. Justice Zahra and his colleagues concluded that Plaintiff had failed to establish a genuine factual basis from which to conclude that “the injury was a direct result of physical contact with . . . property being lifted onto or lowered from the vehicle in the loading or unloading process,” as required by MCL 500.3106(1)(b). Justice Zahra also invited his colleagues to reexamine the causation element of the *Putkamer* analytical framework – an invitation that was declined by the majority.

Although perhaps these cases do not have the significance that the *Covenant* decision had, both *Perkovic* and *Kemp* clarify the proper type of notice that must be given under the NoFault Insurance Act, and under what circumstances Claimants can recover for injuries arising out of parked motor vehicles.
So You Say You Can Get Indemnity? It’s All About Agency

By James K. Thome, Vandeveer Garzia, PC

The underlying details are usually different, but the principles are the same. You own a small or medium-sized business. You may rent or lease equipment for use by others. You may hire a contractor to perform some work on your premises. You have a standard, written document for those purposes. It could be titled “Purchase Order,” “Sales Contract,” “Customer Leasing Contract” or something similar.

Your General Counsel, not being an ignorant person, drafted indemnity language to include in this standard form intended to provide the company a remedy in the event that some damage or injury occurs during the course of certain events. The form consists of one page, with writing on the front and back. You require someone to sign or execute the document before the work begins or at the time that you turn over possession of any rented equipment. Usually, a worker for your customer or vendor signs the signature line on the front of the document.

On the front of the document, directly above the signature line, in small print, is certain typical language. Let’s use equipment rental as an example. The language is the following:

Contract Agreement: Customer agrees, by receipt of the equipment listed above, that he/she is in agreement with the terms and conditions as set forth on the back of this leasing contract.

The back of the “Contract” includes the following heading:

Leasing Terms and Conditions

Under that heading, in small print, is the operative language in the Contract, designed to protect the company:

Customer agrees to defend, indemnify and hold the Company, its agents, employees and equipment manufacturers, harmless from all claims for bodily injury and property damage that may arise from the selection, location, use, placement or inability to use the product in the Customer’s care, custody and control. Customer further agrees to comply with all state, federal and local laws and safety construction site regulations in performing its contract.

One of your customer’s workers is injured in the course of his or her employment. He claims that the injury arose out of some defect in or failure of your leased equipment. He can’t sue his own employer, so he brings a claim against the company. No problem. You have an indemnity agreement. Or do you?

In Michigan, indemnity agreements and contracts are generally enforceable even though indemnity for the indemnitee’s own negligence is not expressly stated in the agreement.1

Is the Employee an Agent of the Employer?

So, will the agreement for equipment rental, signed by your customer’s worker, apply to provide indemnity for the injured party’s claim? Did the person who signed the agreement have the authority to bind the customer to the indemnity agreement located in small print on the back of the contract?

Restatement of the Law, Agency, 2d, Section 228 states:

General statement:

(1) Conduct of a servant is within the scope of employment if, but only if:
   (a) It is of the kind he is employed to perform;
   (b) It occurs substantially within the authorized time and space limits;
   (c) It is actuated at least in part, by a purpose to serve the master; and
   (d) If force is intentionally used by the servant against another, the use of force is not unexpected by the master.

(2) Conduct of a servant is not within the scope of employment is it is different in kind from that authorized, far beyond the authorized time or space limits or too little actuated by a purpose to serve the master.

To determine whether an activity is within the scope of employment, Restatement of the Law, Agency, 2d, Section 229 states:

(1) To be within the scope of the employment, conduct must be of the same general nature as that authorized, or incidental to the conduct authorized.

(2) In determining whether or not the conduct, although not authorized, is nevertheless so similar to or incidental to the conduct authorized as to be within the scope of employment, the following matters of facts are to be considered:
Scope of Agent’s Authority is a Question of Fact

The authority of an agent to execute an indemnity agreement or a similar type of agreement on behalf of a principal is normally a question of fact.6 It is the author’s experience that jury trials of third-party claims for indemnity held at the same time as the trial in the underlying case are extremely rare. In the author’s one trial involving such a case, the jury did not find for the indemnitee on contractual indemnity. One juror likened the small print on the back of the parking ticket, “and that’s bull****.”

An agency relationship must be proved from the acts or statements of the principal and cannot be established by declarations of the agent even though the agent is able to testify about his relationship with his principal or employer.8

Under Michigan law, the party attempting to establish an agency relationship has the burden of proof on that issue.9 So, what if the customer’s worker who signed the agreement testifies that he was simply signing what he believed was a receipt for equipment in order to pick it up for use on the job, that he did not read the back of the document that he signed, and that he has no idea what indemnity means anyway? In addition, his employer testifies that the worker is not a company officer or manager and that he has no authority to bind the company to anything, including indemnity.

There are several Michigan cases that apply to this scenario. In Reliance Insurance Company v Ingersoll-Rand & Kelsey Hayes Division, 2000 Mich App Lexis 313; 2000 WL 33388436 (unpublished Michigan Court of Appeals 2000) Cloverdale Equipment Company leased an air compressor to Ingersoll-Rand. Ingersoll-Rand loaned the compressor to its customer, Kelsey Hayes Division. Cloverdale delivered the air compressor to the Kelsey Hayes facility. At the time of delivery, a maintenance supervisor at Kelsey Hayes signed a document that he believed merely acknowledged receipt of the air compressor and indicated that it was in working condition. The plaintiff maintained that the document was a written lease agreement that contained an indemnity clause. The trial court dismissed the claim for indemnity. The Court of Appeals affirmed.

The trial court determined that the person signing for the equipment was not an agent. However, important language in the decision is the following:

In order for an enforceable written lease agreement to exist, Plaintiff must show that the maintenance supervisor at Kelsey Hayes was an agent for Ingersoll-Rand and possessed the authority to enter into a contract that added a significant term to the oral agreement between Ingersoll-Rand and Cloverdale. Plaintiff’s agency claim is unsupported by any of the common known theories of agency. For Plaintiff to prevail here, it is necessary to show that an employee of Kelsey Hayes, a company that is merely a customer of Ingersoll-Rand, could accept delivery of a leased item and in doing so bind Ingersoll-Rand to a lease agreement with a significant indemnity term over and above the terms orally agreed on by the contracting parties.10

In Koss v Aheppa 371 II, 2012 Mich App LEXIS 486; 2012 WL 882422 (Michigan Court of Appeals 2012) Ameri-
can First Aid Company d/b/a Cintas Fire Protection (“Cintas”) brought an action for indemnity against Natalie Bochet and her employer, AHEPA 371, II, Inc. (“AHEPA”). Bochet signed a work order and invoice that Cintas presented for fire alarm inspection services. AHEPA paid the invoice. There was an indemnity provision on the back of the work order and the invoice. The court held that:

Here, Bochet’s act of signing Cintas’s work order fails to establish that AHEPA and Bochet mutually assented to the indemnity provision. Bochet lacked authority from AHEPA to agree to the terms and conditions set forth on the back of the work order. Cintas has failed to identify acts of AHEPA establishing that Bochet’s authority extended to entering indemnity contracts on AHEPA’s behalf.11

The court indicated further that the evidence was that Bochet had the authority to make purchases up to $249.99 and that she could inspect the work of contractors for quality, accuracy, and completion for work up to $5,000. There were no circumstances surrounding the transaction that gave rise to an implied authority of Bochet to enter into indemnity agreements.12

Further, in Krupp PM Engineering, Inc v Honeywell, Inc, 209 Mich App 104, 530 NW2d 146 (1995), the court held that warranty language on the back of an invoice was not conspicuous partly because the language: “The Standard Terms and conditions on the reverse side are a part hereof” appeared in small, italicized print at the bottom of the invoice and that a reasonable person should not be held to have noticed the language. The court also observed that the language only appeared on an invoice, the provision was not bargained for, and did not become a part of the bargain.

Conclusion

In conclusion, an employee of a company who merely acknowledges receipt of a piece of equipment and takes custody of it does not have the authority to bind his or her employer to an indemnity agreement located on the back of a document when he takes possession of the equipment unless the employer admits that the employee had such authority or ratifies the indemnity agreement. The same principle should apply in similar situations. ■

About the Author

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Endnotes

1 Vandenbosch v Consumers Power, 394 Mich 428, 233 NW2d 1 (1975); Chrysler v Brencal, 146 Mich App 766, 381 NW2d 814 (1985). It should be noted that in Michigan, indemnity agreements that purport to indemnify the indemnitee for its own sole negligence in a construction or maintenance setting are not enforceable. MCL 691.991(1). This is a topic for another day.


5 In re Union City Milk Company, 329 Mich 506; 46 NW2d 361 (1951).


12 Koss, 2012 Mich App LEXIS 486 at p 6. Reliance Insurance Company and Koss are unpublished opinions of the Court of Appeals. Normally, unpublished opinions are not controlling precedents. However, trial courts do take note of them and often follow them.
The “Known Loss” Doctrine

By Jacob Joseph Sadler

The world of insurance is a subset of the world of contracts. As we all know, the plain language of a contract (or insurance policy) governs, and parties are generally not accorded any rights or privileges that are not clearly spelled out in the policy. These clear rules give certainty to contracting parties and simplify disputes.

The “known loss” or “loss in progress” doctrine is a judge-made exception to this rule. Essentially, the doctrine reads an implied exclusion into the policy pertaining to losses that have already occurred or are deemed to be “in progress.” The doctrine has been applied by some Michigan federal and appellate courts, but not the Michigan Supreme Court. Due to this uncertainty, insurers periodically rely on the “known loss” doctrine to disclaim coverage, with varying degrees of success.

This article will argue that the “known loss” doctrine should not be recognized as a valid defense in this State. While its goals are laudable, exclusions and careful underwriting practices, as well as the existing law of fraud and misrepresentation, provide all the protections required. Rewriting the policy through a judge-made doctrine undermines the certainty and simplicity of contract law and the reasonable expectations of policyholders.

Known Loss – An Overview

As articulated by the Sixth Circuit, the “known loss” doctrine provides that an insurer need not pay a loss that was “so immediate that it might fairly be said that the loss was in progress and that the insured knew it at the time the policy was issued or applied for.”

Why does the law recognize this doctrine? The evident concern is one of fraud on the insurer, as it precludes coverage for losses that are both ongoing and known to the policyholder at the time of policy issuance. It presumes that such losses are not also known to the insurer, because a risk that is known to the insurer can (and should) be accounted for in the underwriting process. The insurer cannot be victimized with respect to hazards it is aware of.

Is Any Protection Required?

In analyzing and justifying the doctrine, it is important to distinguish between losses that are “in progress,” such as a leak of polluting materials from a lagoon, and those that are completed, such as a house that burned down before the fire insurance policy was issued. Everyone can see why an insurer need not pay for the burned-down house. But all insurance policies restrict coverage to losses or claims that occur during the policy period or after the policy inception. Indeed, it would be underwriting malpractice to not include temporal restrictions on coverage. Insurers should not need special help from the courts to deal with completed losses. Accordingly, the doctrine should be justified with respect to losses “in progress” only.

Accordingly, we must now examine how losses “in progress” are different than other types of losses covered by a policy, because the difference should determine the degree of protection afforded for such exposures. If losses “in progress” are no different from any other, then there is no need for a special doctrine to protect insurers from them.

Consider, for example, a newspaper that purchases insurance that includes coverage for defamation claims. Shortly before the policy was issued, it had been accused of defamation by a plaintiff who had threatened to sue. After the policy was issued, the paper repeated some of the defamatory statements, resulting in a lawsuit. Should the insurer be excused from covering this “known loss”? The First Circuit Court of Appeals thought not. The First Circuit expressly found that there was no public policy reason preventing an insured from obtaining coverage for past business operations that might create a loss in the future. Defamation risks were part of the insured’s usual business activities and it obtained insurance coverage precisely to address those risks.

The First Circuit’s reasoning is persuasive. Every day a business operates, it is exposed to risk of one kind or another. The risk that it might be sued in June, for things it did in January, is a good reason to buy insurance coverage in April. There is no public policy reason that these risks cannot be shifted to an insurer. If there were, then claims-made coverage would be against public policy.

Indeed, how does the insured’s subjective knowledge of its prior activities harm the insurer at all? Going back to the newspaper case; from the insurer’s perspective, it had contracted to insure against defamation claims, which are an ordinary risk inherent in running a newspaper. And the defamation occurred, at least in part, within the policy period. The insurer had contracted to protect against exactly this kind of claim. It could still rely on any applicable exclusions, such as a pri-
or publication exclusion, and could still seek apportionment with the prior insurance carrier through the “other insurance” clause or similar methods. Has the insured’s prior knowledge of the defamation changed the risk in any material way?

The insurer may argue that the likelihood and magnitude of the loss was greater than it believed when issuing the policy, because it did not know about the pre-policy defamation. But this seems unconvincing. The possibility that a defamatory statement that had already been published would be repeated after the policy was issued would seem obvious, particularly since the industry had developed an exclusion (prior publication) that addresses this risk exactly. The risk should have been accounted for in the underwriting process. Indeed, the possibility that claims are more severe than predicted is a core risk assumed by insurers in writing any policy. Courts do not need to save insurers from ordinary business risks.

This does not mean that an insured can mislead the insurer, of course, or violate a duty to disclose that it assumes in the application process. An insurer is entitled to underwrite a risk using truthful information. So, while the insurer of the newspaper was apparently not harmed by its lack of knowledge of the prior defamation, it may very well have been harmed if it sought information related to that risk in the application process, and the paper provided incomplete or false answers.

The Law Already Provides a Remedy for Fraud in the Application Process

Michigan law has long provided a remedy for insurers who have been induced to issue a policy based on an insured’s misrepresentation – rescission of the policy. Rescission is available for both knowing and inadvertent misrepresentations, because of the prejudice incurred by reasonable reliance on the misrepresentation. Any misrepresentation, so long as it is material, can be the basis for rescission. The materiality standard is an objective one, requiring the insurer establish that the information, if known, would have caused a reasonable underwriter to reject the coverage or charge an increased premium.

It is difficult to see why the law of misrepresentation does not adequately protect insurers. Arguably, if insurers are asking the appropriate questions in their applications – meaning, they are exploring issues that are material to their underwriting decisions, including the existence of potential “known losses” – then they cannot be unfairly surprised by an ongoing loss. In the D&O/E&O context, insurers routinely ask about circumstances that could be expected to give rise to a claim in the coming policy year. Similar questions can be posed with respect to any liability insurance. And exclusions have been developed specifically to address these hazards, such as prior acts, prior knowledge, and prior publication exclusions.

In conclusion, the risk of “known losses” is well-known and can be accounted for in the application and underwriting processes. Any misrepresentation made by the insured with respect to these losses gives rise to a claim for rescission. And if the insurer neglected to ask about known losses before issuing the policy, it has assumed those risks and has no cause to complain. No law compels an insurer to issue a policy before its underwriting processes are complete.

The Known Loss Doctrine Places an Unfair Burden on Insureds and Misaligns Incentives

There are two critical differences between the law of misrepresentation discussed above and the “known loss” doctrine. First, the “known loss” doctrine does not require the insurer to have asked for information about existing or expected losses in the application process. Second, it does not require that the unknown information be material to the insurer’s underwriting decisions. In other words, the doctrine allows an insurer to disclaim coverage based on the insured’s failure to provide information that was not asked for and which, had it been provided, would not have made any difference.

This seems unfair. There is no reason to permit disclaimer based on the insurer’s lack of immaterial information. Nor is there a reason for the courts to assist an insurer that could ask for material information in the application, but elects not to. If anything, the lack of a “known loss” defense provides an incentive for insurers to conduct better investigations prior to issuing policies, and to adjust premium pricing accordingly.

Additionally, limiting insurers to prior knowledge-type exclusions and rescission is more equitable from the customer perspective. An organization, presented with a policy containing prior knowledge-type exclusions, might reasonably try to avoid them by providing additional information about potential losses prior to policy formation. However, where the “known loss” doctrine is in effect, the insured may not be aware of the issue at all, and may feel blindsided by a later disclaimer based on this implied exclusion. Courts require exclusions to be explicit and unambiguous for very good reasons. Imposing an exclusion that unsophisticated policyholders may be unaware of is contrary to the law of policy exclusions in general.

Courts should also consider the one-sided nature of this remedy, which essentially allows insurers to avoid coverage for losses that were (allegedly) not factored into the underwriting decision (but could have been), resulting in claims being greater than expected. But insureds have no ability to revisit the underwriting process under the same circumstances. For example, they cannot retroactively increase the limits, or remove exclusions, if losses are greater than anticipated. Nor do they have a right to return of premium if losses are fewer than

The First Circuit expressly found that there was no public policy reason preventing an insured from obtaining coverage for past business operations that might create a loss in the future.
expected. Customers are stuck with the contract they signed, even if it turns out to be a bad bargain in hindsight. Why should insurers, alone, get a second bite at the underwriting apple though the “known loss” doctrine?

Finally, issues of proof are simplified under the law of misrepresentation, which merely asks (a) was the information false or omitted, and (b) was it material based on a reasonable person standard? In some instances, this is a one witness case; an underwriting expert testifying as to whether the false or omitted information was material. The “known loss” doctrine, on the other hand, requires an investigation into the insured’s subjective understanding with respect to whether a loss was likely. This investigation may be hopelessly muddled and complicated when applied to corporate insureds and their many officers, employees and agents. A court makes everyone’s life easier by keeping the proofs simple.

Conclusion

A “known loss” or “loss in progress” is not qualitatively different from any other loss that may be covered under a policy of insurance. There is no public policy reason why such losses should not be insurable. These risks can, and should, be addressed through exclusions and premium pricing. And, to the extent the insurer has been misled by its insured, the law already provides a remedy. It is unnecessary, and arguably unfair, for courts to grant additional protections to insurers for these foreseeable business risks.

About the Author

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Endnotes

1 Inland Waters Pollution Control Inc v Nat’l Union Fire Ins, 997 F2d 172, 178 (6th Cir 1993).


4 Keys v Pace, 358 Mich 74, 82-83 (1959).
within the walls or ceilings or beneath the floors or above ceilings of the structure.” The Court of Appeals concluded that the exclusion did not apply because the terms “seepage” and “leakage” suggested a slow or “gradual or low water event,” meaning that the exclusion was intended to “avoid coverage for losses that are caused by a homeowner’s neglect, failure to maintain, and failure to occupy a home.” Because this damage was caused by a sudden release, the exclusion did not apply.

UM coverage not available for use of unlisted owned vehicle

Toder v Progressive Mich Ins Co
Docket No. 332786
Released August 3, 2017

Plaintiff was involved in an accident with an uninsured motorist while riding his motorcycle. His policy for that motorcycle included UM coverage up to a limit of $20,000. That limit was tendered. Plaintiff was also insured with defendant under an auto policy with UM coverage up to a limit of $50,000. But that policy did not apply to bodily injury sustained while using a motor vehicle (including a motorcycle) not listed in the auto policy if that vehicle was owned by the insured and available for his regular use. Defendant properly denied plaintiff’s claim for UM coverage under his auto policy.

Wrongful act exclusion applies

Employers Mut Cas Co v Helicon Asc (On Remand)
Docket No. 322215
Released September 7, 2017

This case was remanded back to the Court of Appeals after the Supreme Court determined that the fraud or dishonesty exclusion in a “Linebacker” policy did not bar coverage for the insured’s liability on a negligent misrepresentation claim. On remand, the Court of Appeals considered the other three exclusions asserted by plaintiff and determined that one did apply—the exclusion for a wrongful act resulting in personal profit or advantage to which the insured is not entitled. The insureds were involved in a bond financing scheme.

Lack of evidence of physical contact to support UM coverage

Parker v Progressive Marathon Ins Co
Docket No. 332461
Released September 12, 2017

The trial court properly granted summary disposition to insurer on plaintiff’s claim for UM benefits where she “believed” that her vehicle was struck by another as she attempted to merge into traffic but where she produced no evidence of physical contact with her vehicle and did not otherwise rebut the police report indicating that no physical damage was apparent at the time of the accident.

Reimbursement for amounts paid under a surety bond

Auto-Owners Ins Co v Campbell-Durocher Group Painting & General Contracting, LLC
Docket No. 331384
Released October 12, 2017

Plaintiff issued a surety bond on behalf of the defendant contractor who failed to timely perform its contract to restore a public building and also failed to pay contractors. After settling the claims against the contractor, plaintiff commenced this lawsuit for reimbursement. The Court of Appeals ruled that plaintiff was entitled to recovery because the surety contract promised reimbursement “for all liability and expenses sustained by reason of the execution of the bonds.” And there was no evidence that the plaintiff abused its discretion in settling and paying the claims it did.

6Th Circuit Court Of Appeals Decisions – Unpublished

Benefits not available under an “occupational” policy

Filek v National Union Fire Ins Co
Case no. 16-2527
Released August 23, 2017

Insured truck driver was insured under a “Truckers Occupation Accident” policy when he died of a pulmonary embolism while sitting in his truck at a truck stop. His estate sued for benefits, which were available for injuries sustained as a result of occupational accidents or occupational cumulative trauma. The court concluded that neither form of coverage was triggered. The insured was not killed in an accident as that term is normally defined. And his pulmonary embolism was not the result of occupational trauma, as required by the policy. Repeatedly sitting for extended periods of time in cab did not establish occupational trauma.

Policy is rescinded due to misrepresentation of property value

AMI Stamping, LLC v Ace American Ins Co
Case No. 16-2341
Released October 5, 2017

Plaintiff’s application for commercial property insurance included an appraisal of the business equipment at roughly $140,000. Plaintiff had other, significantly higher appraisals at that time but did not share them with defendant. When the equipment was stolen, the insured’s appraiser estimated a replacement cost value of nearly $2,000,000. Ace denied the claim, rescinded the policy, and returned the premium. Plaintiff claimed an honest mistake, but the court applied Michigan rescission law, which does not require intent to defraud, and concluded that because property value was falsely reported and resulted in a significant disparity between premium and risk, rescission was allowed.
United State District Court Decisions – Unpublished

No homeowners coverage for defamation claim

_ State Farm Fire and Cas Co v Stone_
E.D. Mich Case No. 16-12831
Released July 17, 2017

Plaintiff had no duty to defend its insured against a defamation claim where the liability policy covered liability for bodily injury or property damage only. The defamation complaint alleged emotional suffering and no resulting bodily injury.

No “direct loss” as required for computer crime coverage

_ American Tooling Center v Travelers Cas and Sur Co of America_
E.D. Mich Case No. 16-12108
Released August 1, 2017

Plaintiff-insured’s policy included computer fraud coverage for the “direct loss of, or direct loss from damage to, Money, Securities and Other property directly caused by Computer Fraud.” Plaintiff received fraudulent emails from someone impersonating one of its vendors, convincing plaintiff to transfer payments to a new bank account. The court agreed with Travelers that the scam did not result in a “direct loss” as a result of computer fraud, such as the loss that results from hacking. This computer fraud coverage was not intended to cover losses caused by fraud or misrepresentation merely because a computer was used to transmit information.

All-peril horticulture policy provides coverage

_ Shoreline Growers, Inc v New Hampshire Ins Co_
W.D Mich Case No. 1:16-cv-1124
Released August 30, 2017

Defendant issued an agribusiness policy to plaintiff, covering property and income loss from all perils unless expressly excluded. Plaintiff sustained significant damage to ornamental plants and shrubs growing in 300 greenhouses when the blower fans failed and caused a spike in temperature. An endorsement to the policy provided coverage for damage to “growing stock.” But an exclusion in the policy excluded coverage for “stock” damaged by temperature and humidity. The court determined that the terms “growing stock” and “stock” were used differently in the policy and so had different meanings. Coverage was provided by the endorsement for damage to “growing stock” and was not subject to the exclusion for “stock” damaged by high temperatures.

“Business purpose” exclusion in auto policy is ambiguous

_ Esurance Property and Casualty Ins Co v Johnson_
E.D. Mich Case No. 16-cv-11880
Released September 22, 2017

Provision in personal auto policy excluding coverage for an insured “[m]aintaining or using any vehicle while that insured is employed or otherwise engaged in any business” was found to be ambiguous because it did not necessarily exclude coverage for the named insured owner where another insured – a permissive user – was operating the covered auto in a business unrelated to the owner.

ERISA Decisions of Interest

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**Sixth Circuit Update**

Denial of benefits not arbitrary and capricious where claimant failed to present objective evidence of disability


In a split decision the Sixth Circuit reversed the district court’s determination that the plaintiff was entitled to disability benefits based on back pain. The plan required that disability “must be supported by objective medical evidence,” defined as “[o]bjective medical information sufficient to show that the participant is disabled . . .” The district court held that the plan arbitrarily and capriciously denied benefits because it ignored or discounted her treating physicians’ statements that back pain prevented her from working.

Reversing, the Sixth Circuit held that the plan administrator “neither ignored nor arbitrarily refused to credit the opinions of [the plaintiff’s] treating physicians.” The plan’s reviewing physician noted the treating physician’s statement “document[ing] that [the plaintiff] had severe low back pain, neck pain, kidney pain and bilateral leg pain,” but went on to
observe that the treating physician’s “form does not include a detailed physical examination” or “documentation of well-defined focal physical findings commensurate with a specific disability.” The plan furthermore contacted the plaintiff three times, and her treating physician twice, to obtain such documentation, without response from either.

Lastly, the plaintiff’s medical records noted that the plaintiff suffered no neurologic defects and maintained ‘5/5’ motor strength.”

The Sixth Circuit concluded that “although the claims administrator did not embrace [the plaintiff’s attending physician’s] conclusions, it did not arbitrarily discount them – it refused to credit them because they lacked support by objective medical evidence, as required by the Plan.”

The Sixth Circuit also held it was not arbitrary or capricious for the plan to conduct a file-only review, rather than having the plaintiff examined, because the Plan placed the burden of producing objective evidence of disability on the plaintiff in the first instance and the “employee cannot then shift their responsibility to the insurance company” if it fails to meet that burden.

United States District Court Update

Tribal plan covering non-employees not governed by ERISA

Saginaw Chippewa Indian Tribe of Michigan v Blue Cross Blue Shield of Michigan,
2017 WL 3007074 (Case no. 16-cv-10317)

Whether or not a healthcare plan is governed by ERISA can be difficult to discern. This is an important factor in determining whether a plan administrator owes fiduciary duties to plan participants. Outside the construct and protections of the ERISA statutory framework, a dispute over the terms of a plan may be governed simply by contract law. The court found that was the case for one of the plans at issue here.

Here, the plaintiff established two group health insurance policies with the defendant, one which was limited to employees of the tribe, some of whom were not members of the tribe, and another which was limited to members of the tribe, not all of whom were employees of the tribe. The plaintiff argued that the two plans represented different coverage options within the same overall plan, much like offering an HMO option and a fee for service type of coverage. However, the two plans were created at different times, via different contracts, had different eligibility requirements and different purposes. Accordingly, the court found that because the plan for the tribal members was not established by an employer with the intent of providing benefits to its employees, that plan was not subject to ERISA. As a result, the plaintiff’s ERISA-related breach of fiduciary duty claims relating to the Tribal member plan were dismissed.

On behalf of the tribal employee plan, plaintiff argued that the defendant breached its fiduciary duties with respect to the administrative service contract. With respect to the claim of “hidden” administrative fees, the court followed established precedent and agreed that the plaintiff was entitled to judgment. The plaintiff also challenged the defendant’s performance-based reallocation of existing provider payments into the Physician Group Incentive Program, known as “PGIP”. The plaintiff was not charged an additional amount because of this program and none of the funds collected were retained by the defendant. Moreover, the plaintiff received a financial benefit from the program in the form of negotiated provider discounts and overall improved healthcare services. As a result, the court dismissed the claims related to this program.

Preserving plan assets as a fiduciary obligation

Grand Traverse Band of Ottawa and Chippewa Indians v Blue Cross Blue Shield of Michigan,
2017 WL 3116262 (Case no. 14-cv-11349)

Similar to the previous case, the plaintiff here was a party to an administrative service contract with the defendant for the purpose of administering health insurance claims. Federal regulations provide that Medicare-participating hospitals must accept no more than Medicare rates of payment for authorized services to tribal members, known as Medicare-like rates, or “MLR”. The plaintiff here alleged that the defendant breached its fiduciary duties under ERISA for failing to obtain the MLR discount to which tribal members were entitled as part of the defendant’s claims administration services.

The Sixth Circuit has previously held the process of negotiating rates is not considered to be a fiduciary function. The Court distinguished this case and found that the defendant should have pursued the MLR discounts in its fiduciary requirement of preserving plan assets.

The court next considered the statute of limitations defense to the MLR claims. The parties had entered into an agreement separate from the administrative services contract with respect to the claims subject to the MLR discount. The defendant argued that plaintiff had actual knowledge the MLR rates had not previously been obtained as of the date of that contract in 2009. The court applied the three year statute of limitations and because the complaint, which was filed in 2014, did not allege any facts to indicate plaintiff lacked actual knowledge it was not receiving the MLR discount, the MLR-based claims were time barred.

Finally, the court held the remaining state law claims were either pre-empted by ERISA or duplicative of the breach of contract claim and were properly dismissed.
Prejudgment interest on an award of benefits is based on 5-year treasury rates plus one percent, compounded annually.


By way of background, in 2015, the Sixth Circuit in this case vacated the trial court’s novel decision allowing disgorgement of the defendant’s profits as “appropriate equitable relief” for violation of the terms of an ERISA plan under Section 502(a)(3). The matter was remanded “for consideration of whether and, if so, to what extent, award of prejudgment interest is warranted under §502(1)(1)(B) to make Rochow whole.”

Back at the District Court level, the plaintiff sought an award of 12% interest pursuant to MCL 500.2006, for failure to pay benefits on a timely basis, which the court denied. In a motion for reconsideration, the plaintiff argued that the court applied the wrong analysis to find that the state statute was preempted by ERISA. The court explained that preemption was appropriate because the Michigan statute is designed to punish insurers for dilatory actions, not to compensate a plaintiff for delay in recovering benefits to which he or she is entitled, and the remedial scheme of ERISA is designed to make a claimant whole.

The Court also rejected the plaintiff’s efforts to apply the Illinois state statute for imposing an interest calculation, as well as the plaintiff’s effort to raise a new theory regarding compounding interest on a monthly basis as a method of calculation.

As a result, the Court’s prior ruling stands with respect to calculation of prejudgment interest, following the method set forth in Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Michigan, 722 F.3d 861 (6th Cir. 2013). Prejudgment interest is to be calculated on the stream of benefits payments due before final judgment based on five-year Treasury rates plus one percent, in accordance with MCL § 600.6013, and compounding annually.

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