

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



Augustine O. Igwe,
Kaufman, Payton &
Chapa

I am honored to serve as the next chair of the Insurance and Indemnity Law Section of the State Bar of Michigan for the 2018-2019 year. I am grateful to follow in the footsteps of the past Chairs who have collectively moved this Section forward in their respective exceptional ways. Particularly, I thank our immediate past chair, Larry Bennett, for his help and guidance

in preparing me for this role and for the wonderful job he has done for the Section. I am grateful for the assistance of Laretta Pominville, our Section Treasurer, in organizing and preparing the Annual Meeting. We appreciate all the efforts and assistance of the Section's officers and council members for the active role they played and continue to play for the Section. As always, our special thank you goes to Hal Carroll, founding member of the Section, and editor of our esteemed Journal of Insurance & Indemnity Law.

Annual Meeting

The theme of our September 27, 2018 Annual Meeting program focused on the internal workings of a property and casualty insurance company operations. It was a resounding success. We are grateful for the presentation from Wayne Bates, President of Atain Insurance Companies, and Judge Catherine L. Heise, Wayne County Circuit Court. As expected, the discussion was engaging and informative. It covered a broad spectrum of insurance business operations, including underwriting, production, reinsurance, claims reserving, claims practices, etc. It advanced the goal of our Section in providing a well-rounded and neutral presentation to the participants and attendees.

Coming Programs

For the coming year, we are planning to have at least three main events, Annual Holiday Event (January 2019), Annual Spring Meeting (May 2019), Annual Summer Event (date and place to be decided). To the extent feasible, we will attempt to coordinate our council quarterly meetings to take

place immediately before or after these events. We will also continue to actively seek out and partner with other sections in presenting and hosting joint programs of interest. We plan to schedule one quarterly council meeting to occur outside of the planned events. As always, we welcome and appreciate any ideas, suggestions, themes, agendas, and topics that continue to advance our Section.

Other Matters

The insurance field is dynamic and changing rapidly in various ways. Our Section is neutral and comprises of members and leaders from all perspectives including, plaintiffs' trial lawyers, defense lawyers, regulatory lawyers, etc. This neutrality broadens the scope and direction of the Section in ways that allow for a well-rounded embrace of the ever changing and evolving insurance practice, and a valuable exchange of information among our members. If you want to be a part of this, you can submit an article or opinion piece to our editor for publication in our *Journal*.

For example, our No Fault system continues to engender passionate and conflicting interests for reform from all sides. In this issue you will find two analyses of the effect of the decision in *Bazzi v Sentinel Insurance Co.*

Technology changes continue to alter the insurance landscape. Cyber security and climate change continue to create uncertainties and yet unquantifiable exposures in the insurance arena. In this issue's "Selected Insurance Decisions," we have a summary of a case involving coverage for fraud using a computer.

The prospect of legalizing recreational marijuana in Michigan in November, and the interplay between such legalization and the continued Federal prohibition, is an area of unprecedented uncertainties and opportunities for lawyers.

I hope that our Section continues to grow in importance and relevance to meet the challenges of an ever changing insurance landscape and needs of our diverse membership. I am excited for the opportunities that lie ahead. I am counting on the collective support, assistance and active participation of everyone in advancing our Section into a truly preeminent, relevant and integral part of the State Bar of Michigan. ■

Editor's Notes



By Hal O. Carroll
www.HalOCarrollEsq.com

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, but we welcome all articles of analysis, opinion, or advocacy for any position.

All opinions expressed in contributions to the *Journal* are those of the author

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. ■



Scenes from the Section Annual Meeting

Our new officers: Nicole Wilinski, Laretta Pominville, Gus Igwe, Larry Bennett, and Jason Liss



Chairperson Larry Bennett calls the meeting to order



Larry Bennett presents the gavel to new chairperson Gus Igwe



Gus Igwe presents the plaque to immediate past chair Larry Bennett



Wayne Bates, President of Atain Insurance Company, speaking on underwriting practices



Hon. Catherine L. Heise addresses underwriting issues



Supreme Court Adopts Flexible Approach to Rescission of Insurance Coverage

By Bob June

In *Bazzi v Sentinel Insurance Company*,¹ the Michigan Supreme Court rejected strict rules proposed by the opposing sides for dealing with rescission of no-fault personal protection insurance (PIP) coverage. Instead, the court has adopted a flexible approach based on long-standing equitable jurisprudence that allows trial courts to mold their decisions to the special circumstances of each case. In a 5-2 decision written by Justice Wilder, the court rejected “the judicially created innocent-third-party rule,” which previously barred an insurer from rescinding PIP coverage as to a person injured in a crash who was not involved in fraudulently procuring the insurance policy. However, the Supreme Court also rejected the Court of Appeals holding that, “if an insurer is able to establish that a no-fault policy was obtained through fraud, it is entitled to declare the policy void *ab initio* and rescind it, including denying the payment of PIP benefits to innocent-third-parties.”²

Concluding that rescission should neither be barred nor granted automatically by virtue of either “rule,” the Supreme Court’s decision entrusts and empowers trial courts to exercise discretion in fashioning the right equitable remedy to fit the circumstances of a particular case. Consequently, rescission actions will require fact-intensive inquiries and balancing of the equities, requiring insurers and insureds to familiarize themselves with equitable jurisprudence as it applies to their particular dispute.

Basic Facts and Procedural Background

As recited by the Supreme Court, the core facts of the *Bazzi* case are relatively straightforward. Plaintiff Ali Bazzi was injured while driving a car leased by his mother, Hala Bazzi. The vehicle was leased for personal and family use, but Hala Bazzi purchased a commercial automobile policy from Sentinel, listing a shell company as the insured and failing to disclose that plaintiff would be a regular driver.³ Sentinel filed an action for rescission against Hala Bazzi, obtaining a default judgment. Sentinel then moved for summary disposition against plaintiff’s PIP claim on the grounds that the coverage had been rescinded, but the trial court denied the motion on the basis of the innocent-third-party rule, preventing post-accident rescission of PIP coverage for a claim by a third party who is innocent of fraud in the procurement of the insurance policy.⁴

After the Court of Appeals initially denied Sentinel’s application for leave to appeal, the Supreme Court remanded for consideration as on leave granted. The Court of Appeals

ultimately issued a split decision holding that the innocent-third-party rule did not survive the Supreme Court’s recent decision in *Titan Ins Co v Hyten*,⁵ which abrogated a similar doctrine known as the easily-ascertainable-fraud rule in the context of liability coverage. In doing so, the Court of Appeals ruled that Sentinel was categorically entitled to rescind coverage, even against innocent third parties, if Sentinel determined that the policy was procured through fraud.⁶ In addition to arguing that the innocent-third-party rule should be preserved in the PIP context, where benefits are mandated by statute, the Court of Appeals dissent noted that rescission is an equitable remedy that “is not granted as a matter of right and it will not be granted when it would accomplish an inequitable result.”⁷

Pivoting from *Titan Ins Co v Hyten* and Rejecting the Innocent-Third-Party Rule

In *Titan*, the Supreme Court had seemed to focus primarily on the distinction between insurance coverage that is mandated by statute and optional coverage:

[W]hen a provision in an insurance policy is mandated by statute, the rights and limitations of the coverage are governed by that statute. See *Rohlman [v Hawkeye-Security Ins Co]*, 442 Mich [520] at 524-525 (holding that because personal injury protection benefits are mandated by MCL 500.3105, that statute governs issues regarding an award of those benefits). On the other hand, when a provision in an insurance policy is not mandated by statute, the rights and limitations of the coverage are entirely contractual and construed without reference to the statute.⁸

Consequently, it is not surprising that the plaintiff in *Bazzi* argued that the mandatory benefits of the no-fault act control over the common law of contracts. But *Titan* involved a statute with an *express* provision: “The liability of the insurance carrier with respect to the insurance required by this chapter shall become absolute whenever injury or damage covered by said motor vehicle liability policy occurs.”⁹ While affirming that this prevents an insurer from avoiding liability after an accident to the extent coverage is mandated, the *Titan* Court limited this to the mandatory minimum coverage, finding that insurance policies can be reformed to eliminate optional liability coverage where there is proof of fraud in the procurement of the policy.¹⁰

Rejecting the plaintiff's argument, the Supreme Court in *Bazzi* clarified its *Titan* holding and shifted the focus to whether the statute expressly prohibits rescission:

We reject the premise that there is a controlling distinction between mandatory coverage, i.e., statutorily mandated PIP benefits, and optional coverage. Whether statutory benefits or optional benefits are at issue, each is predicated on the existence of a valid contract between the insured and insurer. Moreover, our reasoning in *Titan* was not dependent on whether the coverage at issue was mandatory or optional. Rather, we recognized that common-law defenses are available when there are contractual insurance policies but limited when a statute prohibits the defense. *Titan*, 491 Mich at 558, 572. Although PIP benefits are mandated by statute, the no-fault act neither prohibits an insurer from invoking the common-law defense of fraud nor limits or narrows the remedy of rescission.¹¹

The Supreme Court recognized our long appellate history of treating PIP coverage as absolute after a third party has suffered an injury.¹² But the court ultimately rejected this argument because the no-fault act does not contain the same type of express prohibition that was at issue in *Titan*:

However, although an innocent third party might have a reasonable right to expect that other drivers carry the minimum insurance required under the no-fault act, that expectation does not, by operation of law, grant an innocent third party an absolute right to hold an insurer liable for the fraud of the insured. In other words, an insurer has a reasonable right to expect honesty in the application for insurance, and there is nothing in the no-fault act that indicates that the reasonable expectations of an innocent third party surmount the reasonable expectations of the insurer.¹³

On this basis, the Supreme Court concluded that "*Titan* abrogated the innocent-third-party rule and that Sentinel is therefore not precluded from raising a defense of fraud."¹⁴

Rejecting Automatic Rescission and Adopting Equitable Balancing

Without more, this would seem to leave the Court of Appeals holding intact, but the Supreme Court went on to explain that rescission is an equitable remedy, not an absolute right: "While we agree with the Court of Appeals majority that *Titan* abrogated the innocent-third-party rule, we do not agree that Sentinel was categorically entitled to rescission."¹⁵ Importantly, the Supreme Court emphasized that the equitable remedy of rescission requires approval of the trial court:

"Because a claim to rescind a transaction is equitable in nature, it 'is not strictly a matter of right' but is granted only in 'the sound discretion of the court.'"¹⁶

Courts are not required to grant rescission in all cases. Rather than automatically granting a request for rescission of a contract, "the trial court must balance the equities to determine whether the plaintiff is entitled to the relief he or she seeks."¹⁷ The trial court should not grant rescission where it would be inequitable or infeasible, and "when two equally innocent parties are affected, the court is 'required, in the exercise of [its] equitable powers, to determine which blameless party should assume the loss.'" ¹⁸ Moreover, trial courts are instructed that, somewhat akin to good-faith purchasers in the real property context: "[W]here one of two innocent parties must suffer by the wrongful act . . . of another, that one must suffer the loss through whose act or neglect such third party was enabled to commit the wrong."¹⁹ The Supreme Court made it clear that these equitable principles are designed to protect innocent parties, and they should be limited to that purpose with the understanding that insurers and claimants may both be viewed as innocent parties in a given case.

Importantly, the Supreme Court emphasized that the equitable remedy of rescission requires approval of the trial court: "Because a claim to rescind a transaction is equitable in nature, it 'is not strictly a matter of right' but is granted only in 'the sound discretion of the court.'"

In summarizing its ruling, the Court recognized that trial courts must be given great flexibility in determining what equitable remedy suits the circumstances of a given case:

In this instance, rescission does not function by automatic operation of the law. Just as the intervening interest of an innocent third party does not altogether bar rescission as an equitable remedy, neither does fraud in the application for insurance imbue an insurer with an absolute right to rescission of the policy with respect to third parties. Equitable remedies are adaptive to the circumstances of each case, and an absolute approach would unduly hamper and constrain the proper functioning of such remedies. This Court has recognized that "[e]quity jurisprudence molds its decrees to do justice amid all the vicissitudes and intricacies of life" and that "[e]quity allows complete justice to be done in a case by adapting its judgments to the special circumstances of the case." *Tkachik v Mandeville*, 487 Mich 38, 45-46; 790 NW2d 260 (2010) (quotation marks omitted), citing *Spoon-Shacket Co, Inc v Oakland Co*, 356 Mich 151, 163; 97 NW2d 25,

and 27A Am Jur 2d, Equity, § 2, pp 520-521; see also *Lenawee*, 417 Mich at 29 (adopting a case-by-case approach to rescission when a “mistaken belief relates to a basic assumption of the parties upon which the contract is made, and which materially affects the agreed performances of the parties”), and Am Jur 2d, § 2, pp 548-549.²⁰

It is this flexibility, entrusting and empowering trial courts to exercise discretion in fashioning the right equitable remedy to fit the circumstances of a particular case, that will undoubtedly become the hallmark of the *Bazzi* decision.

A Few Observations on Rescission in the Aftermath of *Bazzi*

Both parties in *Bazzi* sought categorical “rules” governing attempts to rescind PIP coverage -- either a “rule” authorizing automatic rescission or a “rule” protecting innocent third parties injured in automobile accidents. In rejecting both of these approaches, the Supreme Court has emphasized the equitable nature of the remedy of rescission and the flexibility of trial courts in exercising their discretion when presented with such claims. This necessarily means that the parties and the trial courts will need to make fact-intensive inquiries to balance the equities and determine what equitable remedy may be appropriate. It should be noted that the *Bazzi* decision is not limited to rescission of PIP coverage, or insurance policies, but extends more generally to any claim for rescission of a contract in Michigan.

Perhaps most importantly, of course, the equitable remedy of rescission requires court action. An insurer should not assume that it has the absolute right to rescind coverage, and the proper method for accomplishing this is to file a complaint for rescission in an appropriate court.²¹ The rescinding party has the burden of proving the elements of “actionable fraud,” which may include fraudulent misrepresentation, innocent misrepresentation, and silent fraud.²²

It is well established that “[w]here a policy of insurance is procured through the insured’s intentional misrepresentation of a material fact in the application for insurance, and the person seeking to collect the no-fault benefits is the same person who procured the policy of insurance through fraud, an insurer may rescind an insurance policy and declare it void *ab initio*.”²³ The grey areas develop primarily when there is no evidence of intent, as in a claim for innocent misrepresentation, or where a third party is involved.

In those cases, the trial court evaluating a rescission claim must balance the equities to determine whether the remedy is appropriate, doing complete justice “by adapting its judgments to the special circumstances of the case.”²⁴ Although the innocent-third-party “rule” has been abrogated, this does not mean the innocence of the parties is irrelevant. Rather,

the trial court must weigh all of the equities to determine which innocent party must bear the loss,²⁵ and the trial court is not limited to either granting rescission or rejecting it, but has the flexibility to consider a range of appropriate remedies, as explained by the Supreme Court in a previous case:

The equitable court awarding a remedy must look to the most just result. Therefore, should the court on remand find there was innocent misrepresentation or silent fraud it must decide which remedy would be the most equitable under the unique circumstances of the case. The court is not confined to the polar opposite remedies urged by the opposing parties: full enforcement or total abrogation of the indemnity agreement. Other remedies, such as reformation, restitution, or partial enforcement of the contract, may be examined. We leave the resolution of the proper remedy, if any, to the court below.²⁶

Any number of factors come into play when a trial court exercises its discretion in this context, and the fact-intensive nature of the inquiry often requires the parties to engage in discovery regarding the circumstances surrounding the formation of the insurance contract.

Statute of Limitations for Rescission

As explained in a post-*Bazzi* Court of Appeals decision, rescission actions are subject to the six-year statute of limitations of MCL § 600.5813.²⁷ A claim for rescission “accrues at the time the wrong upon which the claim is based was done regardless of the time when damage results.”²⁸ In the insurance context, this would likely occur at the time coverage is provided on the basis of an alleged misrepresentation.²⁹ While a renewal policy is considered to be a new contract,³⁰ a claim for rescission based on a renewal policy may require evidence of a new misrepresentation in connection with that renewal.³¹ The discovery rule does not apply to actions based in fraud,³² and the limitations period can be tolled only if there is evidence of fraudulent concealment.³³

When presented with a claim for rescission, the insured may be able to assert equitable defenses, including most notably the defense of laches. In addition to statutory limitation periods, “courts have uniformly required a plaintiff in rescission to assert his right to rescind without any unnecessary delay.”³⁴ The right to rescission may be lost by laches in a much shorter period of time than the six-year statute of limitations because “[e]quity will not permit one possessed of a right of rescission to delay unduly in the exercise of that right and while so doing speculate on the outcome of the transaction at the risk of his adversary.”³⁵

Finally, because it is an equitable remedy, rescission may not be available where there is an adequate remedy at law.³⁶ In some cases, for example, insurance contracts expressly state

that the remedy for certain types of misinformation, such as vehicle uses or garaging locations, is retroactive adjustment of the premium. Also, the *Bazzi* decision confirms that an insurer may still seek damages in an action at law against the party allegedly committing fraud in procurement of the policy, even when rescission is deemed inappropriate.³⁷ Consequently, it would be proper for a trial court to evaluate whether a legal remedy is appropriate before proceeding with analysis of equitable remedies such as rescission.

In *Bazzi*, the Supreme Court has reaffirmed that our trial courts are entrusted with these equitable decisions, rather than attempting to establish a one-size-fits-all rule for dealing with rescission claims. These case-by-case determinations will challenge counsel and courts to educate themselves regarding the role of equitable balancing in reaching the right conclusion, and the Supreme Court is confident that our trial courts are up to the task. ■

About the Author

Bob June is an Ann Arbor sole practitioner focused on representing people throughout Michigan regarding insurance and ERISA claims. Bob is a past chair of the Litigation Section of the State Bar of Michigan, and he presently serves on the council of the Insurance & Indemnity Law Section. Bob has contributed to ICLE publications and presentations, and he is a co-chair of the Michigan Association for Justice Amicus Team. His email address is bobjune@junelaw.com.

Endnotes

- 1 ___ Mich ___; ___ NW2d ___ (July 18, 2018).
- 2 *Bazzi v Sentinel Ins Co*, 315 Mich App 763, 781-82; 891 NW2d 13 (2016).
- 3 Although not elaborated in the *Bazzi* opinion, Sentinel apparently contended that the premium for commercial use was lower than it would have been for personal use under these circumstances.
- 4 *Bazzi*, slip op at 3.
- 5 491 Mich 547; 817 NW2d 562 (2012).
- 6 315 Mich App at 781-82.
- 7 315 Mich App at 819.
- 8 491 Mich at 554.
- 9 MCL § 257.520(f)(1).
- 10 *Titan*, 491 Mich at 571-73.
- 11 *Bazzi*, slip op at 12.
- 12 See, e.g., *Darnell v Auto-Owners Ins Co*, 142 Mich App 1, 9; 369 NW2d 243 (1985).
- 13 *Bazzi*, slip op at 13.
- 14 *Bazzi*, slip op at 14.
- 15 *Id.*
- 16 *Id.*, quoting *Amster v Stratton*, 259 Mich 683, 686; 244 NW 201 (1932).
- 17 *Bazzi*, slip op at 16, quoting *Johnson v QFD, Inc*, 292 Mich App 359, 370 n 3; 807 NW2d 719 (2011).
- 18 *Bazzi*, slip op at 16-17, quoting *Lenawee Co Bd of Health v Messerly*, 417 Mich 17, 31; 331 NW2d 203 (1982).
- 19 *Bazzi*, slip op at 17, quoting *Zucker v Karpeles*, 88 Mich 413, 430; 50 NW 373 (1891).
- 20 *Bazzi*, slip op at 17.
- 21 *Id.*, at 15-17.
- 22 *Titan*, 491 Mich at 555-56.
- 23 *Bazzi*, slip op at 14, quoting *Darnell*, 142 Mich App at 9.
- 24 *Tkachik v Mandeville*, 487 Mich 38, 45-46; 790 NW2d 260 (2010).
- 25 *Bazzi*, slip op at 16-17; *Lenawee*, 417 Mich at 31.
- 26 *United States Fidelity & Guaranty Co v Black*, 412 Mich 99, 134; 313 NW2d 77 (1981)
- 27 *Maurer v Fremont Ins Co*, ___ Mich App ___, ___ NW2d ___ (Sept 18, 2018); citing *Adams v Adams*, 276 Mich App 704, 710; 742 NW2d 399 (2007).
- 28 *Maurer*, slip op at 6, quoting MCL § 600.5837.
- 29 *Id.*
- 30 See *Russell v State Farm Mutual Auto Ins Co*, 47 Mich 677, 680; 209 NW2d 815 (1973).
- 31 *Maurer*, slip op at 6-7.
- 32 *Boyle v General Motors Corp*, 468 Mich 226, 231-232; 661 NW2d 557 (2003).
- 33 MCL § 600.5855.
- 34 *Wall v Zynda*, 283 Mich 260, 265; 278 NW 66 (1938).
- 35 *Id.*; see also, *Loud v Federal Ins Co*, 195 Mich 60, 75-76; 161 NW 928 (1917); *Livingston v Krown Chemical Mfg, Inc*, 394 Mich 144, 151-152; 229 NW2d 793 (1975). For example, the laches defense may be particularly appropriate where a delay in rescinding coverage effectively denies an otherwise eligible person from making a timely claim with the Michigan Assigned Claims Plan.
- 36 *Laubengayer v Rohde*, 167 Mich 605, 610-11; 133 NW 535 (1911).
- 37 *Bazzi*, slip op at 16, n 11.

2018 State Bar of Michigan – Insurance and Indemnity Law Section \$5,000 Scholarship

In 2017, the Insurance and Indemnity Law Section established a \$5,000 Scholarship to be awarded to a current full time law school student who submits an essay on a chosen insurance-related topic. We intend to offer the Scholarship to a different law school in Michigan each year.

This year, we asked students to write on the following topic: *Bad conduct and disparate remedies: Are changes needed to Michigan's handling of insurer liability for bad faith?* The students were asked to research how Michigan courts and courts in other states address bad faith conduct of an insurer, and give their opinion on whether changes are needed in Michigan.

After reviewing the submissions, and speaking with each of the candidates, the Section awarded its first Scholarship to Kenneth Cody, who is in his first year at Thomas Cooley Law School. Mr. Cody accepted the invitation to receive his Scholarship at the State Bar's NEXT Conference during the Section's Annual Meeting on Thursday, September 27, 2018.

We congratulate Kenneth on winning the Scholarship. Thank you to Section Council members Larry Bennett, Jason Liss, and Renee VanderHagen for reviewing the essays and interviewing the Scholarship candidates. ■



The Basics of Stacking

By Daniel J. James, Wheeler Upham PC

Often more than one insurance policy or coverage may apply to a loss. Accordingly, policies usually include provisions to address how the policy and coverage applies in such cases. Such provisions can be found in a variety of policies, but this article will focus on auto insurance policies.

The concept of multiple policies and coverages applying to a single loss is generally referred to as “stacking.” Stacking is usually prohibited, or at least limited, by a variety of provisions that appear in different parts of the policy or coverage. “Anti-stacking” language can be found in provisions addressing “limits of liability” and “other insurance.” “Owned-auto” exclusions can also be considered anti-stacking provisions. Anti-stacking language is generally found in both uninsured motorist (“UM”) and underinsured motorist (“UIM”) coverages and in auto liability coverage.

Because both liability coverage and UM/UIM coverage is usually portable,¹ multiple policies may be in play anytime a person is driving or occupying a vehicle they do not own. In such a case, insurance may be available from the insurer of involved motor vehicle and from the person's own insurer. Multiple coverages may also be in play if a person has multiple vehicles insured under the same policy. Stacking might also be possible where a person is the named insured under different auto insurance policies covering separate vehicles insured by the same insurer or different insurers.

History

Statutes mandating auto insurance can impact the ability of insurers to exclude or limit coverage. Many states require UM or UIM coverage. Presently, Michigan is not one of them. This was not always the case. In 1965, the Insurance Code was amended to require UM coverage. While UM coverage was mandatory, “limits of liability” and “other insurance” provisions in UM coverage were void.² But the uninsured motorist requirement was repealed effective October 1, 1973, the same day the no-fault was enacted. Consequently, “other insurance” provisions that limit damages to the policy limits and provide that UM coverage applies pro rata where there is other applicable coverage are enforceable.³ Moreover, policies can provide that benefits cannot be stacked.⁴

In the absence of any statute prohibiting “anti-stacking” provisions, the unambiguous provisions of the policy will be enforced as written.⁵ But an ambiguous provision that attempts to limit an insurer's liability might be interpreted in the insured's favor.⁶

Scenario: Use of Insured Non-Owned Autos

One of the more common scenarios where multiple policies could be in play is where the insured is driving or occupying someone else's vehicle.

For example, in *American States Ins Co v Kesten*,⁷ the insured was a passenger in a non-owned vehicle when it was rear-ended by an uninsured motorist. The occupied vehicle was insured for UM coverage, and the insured had her own auto policy with UM coverage. However, there was no coverage under the insured's policy "while occupying a motor vehicle which provides the same or similar coverage." Because the occupied vehicle was insured for UM coverage, the insured was not entitled to any UM coverage under her own policy. The court rejected the argument that the UM coverages of the two policies were not the "same or similar" on the grounds that the limits were different. The court also rejected the argument that the exclusionary language conflicted with the policy's "other insurance" provision; because the exclusionary language applied, the "other insurance" language did not apply.

Similarly, in *DAIE v McMillan*,⁸ a minor was injured in a motor vehicle accident with a hit-and-run vehicle while occupying her grandfather's vehicle. The insurer covered her grandfather's vehicle, and the insurer had also issued a separate policy to her mother. The minor was insured for uninsured motorist coverage under both policies. However, her mother's policy provided that insurance afforded by the UM coverage did not apply if the non-owned involved motor vehicle had UM coverage. Specifically, her mother's policy stated there was no coverage:

(1) to bodily injury to an insured sustained while occupying any automobile, other than an owned automobile, except a non-owned automobile to which there is applicable and available to such insured no insurance similar to that afforded by this coverage.⁹

In other words, there was no coverage if the non-owned auto had UM coverage. Because her grandfather's vehicle was "non-owned" with respect to her mother's policy and had UM coverage, her mother's policy did not apply.

Excess Other Insurance Clause

Sometimes an insurer does not exclude all UM coverage where its insured is occupying a non-owned auto but rather makes its UM coverage excess of other applicable UM coverage. In *Galenski v Allstate Ins Co*,¹⁰ the policy provided that its UM coverage was excess over the insurance on a non-owned auto. In *Galenski*, the insured was a passenger in her daughter's vehicle when it was rear-ended by an uninsured motorist. The insured's policy provided:

If There Is Other Insurance

If the insured person was in, on, getting into or out of, or on or off of a vehicle you do not own which is insured for uninsured motorists, underinsured motorists, or similar type coverage under another

policy, coverage under Uninsured Motorists Insurance, Part 3, of this policy will be excess. This means that when the insured person is legally entitled to recover damages in excess of the other policy limits, we will pay up to your policy limit, but only after the other insurance has been exhausted. No insured person may recover duplicate benefits for the same element of loss under Uninsured Motorists Insurance, Part 3, of this policy and the other insurance.¹¹

Thus, the insured could not recover UM coverage under her own policy until she exhausted the UM coverage on her daughter's vehicle. Because the insured was time-barred from pursuing UM benefits under her daughter's policy, she could not exhaust that coverage and, thus, was precluded from recovering under her own policy.

In the context of liability insurance, an insurer can make its liability coverage excess over other applicable liability insurance where the insured is driving a non-owned auto. In *Citizens Ins Co of Am v Federated Mut Ins Co*,¹² the Michigan Supreme Court enforced Citizens' provision that its liability coverage with respect to its insured's operation of a non-owned vehicle was excess over any other collectible insurance. The Citizens policy provided:

If there is Other Insurance.

The Company shall not be liable under this Section Two for a greater proportion of any loss than the applicable limit of liability stated in the Declarations bears to the total applicable limit of liability of all collectible insurance against such loss; provided, however, the insurance with respect to a temporary substitute automobile or a non-owned Automobile shall be excess insurance over any other collectible insurance.¹³

Because the primary coverage on the vehicle had 20/40 limits, Citizens was only required to provide coverage above those limits.¹⁴

The policy language is important. Small changes can impact the case. For example, a policy can limit the application of its "other insurance" provision to cases only where the "named insured" has other similar insurance available.¹⁵ Under such language, if the injured person seeking coverage is not the named insured, then the anti-stacking provision does not apply.

Scenario: Owned Auto Exclusion

Auto policies generally provided coverage for both "owned" autos and "non-owned autos." These terms would, on their face, seem to be all inclusive. But this is not the case. These are defined terms, and the definition of a "non-owned auto"

* * *

Policy language providing that the policy applied separately to each vehicle simply meant the policy was applicable to whichever vehicle was involved in an accident. Moreover, the fact that the insureds paid separate premiums for UM coverage on each vehicle did not justify the insureds' expectation that the coverage on both vehicles would apply.

generally excludes autos that are furnished or available for the insured's regular use or are owned by the insured's resident relative. The policy, in essence, treats non-owned vehicles available for an insured's regular use or owned by the insured's resident relative as "owned" by the insured. Therefore, liability coverage is not provided if the vehicle is not listed on the policy. This type of language is often referred to as the "owned-auto" exclusion, despite the fact that this language appears in the definition of a "non-owned" vehicle.

In *State Farm v Ruuska*,¹⁶ the Michigan Supreme Court held that an "owned-vehicle" exclusion was not in theory contrary to the no-fault statute, although the exclusion at issue in that case was not enforced.¹⁷ The court also held that stacking was permitted.¹⁸

Scenario: Unlisted Autos

Some cases have involved language similar to the owned-auto exclusion, except that there was no specific requirement that the vehicle be "owned."

In *De Maria v Auto Club Ins Assoc*,¹⁹ the Court of Appeals enforced a liability "coverage applicability endorsement" that limited coverage to the limits applicable to one vehicle insured under the policy when the liability arose from the use of an unlisted vehicle. In *De Maria*, the insured struck and killed a person while driving a 1968 Dodge Coronet. The Coronet was the sole vehicle insured under "Policy 1," an auto policy issued to the insured's wife, under which the insured was listed as an insured. However, the insurer also insured two other vehicles, a Corvette and a Dodge Swinger, under a separate policy, "Policy 2," issued to the insured's wife, under which the insured was not listed as a named insured.²⁰

Policy 2 provided that where the involved motor vehicle was not listed on the policy, payment would only be made under the coverage purchased for any one vehicle insured under the policy. Specifically, Policy 2 provided:

Regardless of the number of automobiles insured under this policy, or the types, amounts, or limits of any coverage purchased in connection with any such automobile identified on the Declaration Certificate by a specific Vehicle Reference Number:

In the event a loss occurs to which this policy applies that does not involve an automobile identified on the Declaration Certificate by a specific Vehicle Reference Number or a temporary substitute therefor, the Company will only make payment for such loss in accordance with and subject to those coverages purchased in connection with any one automobile insured hereunder, the insured having the right to select the automobile whose coverages will be applied to the loss from any automobile insured hereunder with reference to which he would otherwise be entitled to coverage for such loss.

Under no circumstances will the Company be required to pyramid or duplicate any types, amounts, or limits of coverages purchased in connection with any automobile insured hereunder by virtue of the fact that more than one automobile is insured under this policy. However, this condition does not apply to Death Indemnity Coverage.²¹

The Court of Appeals initially held that the insurer was obligated to provide \$20,000 with respect to each of the three insured vehicles.²² The court reasoned that because separate premiums were paid for each of the two vehicles insured under Policy 2, there were in essence two policies. However, the Michigan Supreme Court vacated the ruling and remanded for further reconsideration.²³

On remand, the court held that there was only \$20,000 of coverage available under Policy 2.²⁴ Because the Coronet was not insured under Policy 2, coverage under Policy 2 was limited to the coverage for only one of the vehicles insured thereunder.

Scenario: One Policy – Multiple Insured Vehicles

People often insure multiple vehicles under one auto policy, where separate premiums are stated for the coverages on each insured vehicle. Insureds have argued that the coverage under each insured vehicle should apply to a single loss.

In *Citizens Ins Co v Tunney*,²⁵ the two insureds were injured in a head-on collision caused by an uninsured motorist. They sought UM coverage. Their single policy insured two vehicles, one of which the insureds were occupying when the accident occurred. The insureds paid a separate premium for 20/40 UM coverage on each of the two vehicles. They claimed they were entitled to recover UM benefits under the coverage afforded to both vehicles. The policy provided:

When two or more automobiles are insured hereunder, the terms of this policy shall apply separately

to each Neither the inclusion herein of more than one Assured nor the application of the policy to more than one automobile shall operate to increase the limit of liability stated in the policy (or in the Declarations) for any coverage.”

The Court of Appeals held that this “limit of liability” type language limited UM coverage under the policy to 20/40. Policy language providing that the policy applied separately to each vehicle simply meant the policy was applicable to whichever vehicle was involved in an accident. Moreover, the fact that the insureds paid separate premiums for UM coverage on each vehicle did not justify the insureds’ expectation that the coverage on both vehicles would apply.

In *Auto Club Ins Assoc v Lanyon*,²⁶ the issue was whether the \$20,000 per person liability limit for each of five motor vehicles insured under a policy applied where one of the insured autos was involved in an accident causing injury to a motorcyclist. The opinion did not quote the “anti-stacking” provision at issue, but it did state it was similar to the provision in *Fletcher v Aetna Casualty & Surety Co*,²⁷ which provided:

Regardless of the number of (1) persons or organizations who are Insureds under this policy, (2) persons or organizations who sustain bodily injury or property damage, (3) claims made or suits brought on account of bodily injury or property damage, or (4) automobiles or trailers to which this policy applies.

* * *

[The] limit for Uninsured Motorists Coverage stated in the declarations as applicable to ‘each accident’ is the total limit of [the insurer’s] liability for all damages because of bodily injury sustained by one or more persons as the result of any one accident.²⁸

Accordingly, this “limit of liability” language precluded the limits for all five motor vehicles from being stacked.

In *Lanyon*, stacking of liability coverage was not permitted where one of the five insured vehicles was responsible for accident. But if multiple vehicles insured under the same policy were responsible for the same accident, would multiple limits then be available? In *Inman v Hartford Ins Group*,²⁹ the answers was “no.”

In *Inman*, the injured person was a passenger, who was thrown from a vehicle illegally involved in a race with another vehicle. The drivers of the involved vehicle, who were brothers, were both negligent. Both vehicles involved in the race were insured under a fleet insurance policy. The “limits of

liability” provision stated that “[r]egardless of the number of the number of . . . automobiles to which this policy applies” the per person limit is the limit of liability for all damage sustained by one person because of one occurrence. The Court held that notwithstanding the fact that the drivers of two of the vehicles insured under the policy were negligent, the limits of liability provision limited the insurer’s obligation to pay to only a single per person limit; two limits were not triggered and could not be stacked.

Scenario: Multiple Policies Issued by the Insurer

Sometimes a person with multiple vehicles might end up insuring them under different policies with the same insurer. In *State Farm Mut Auto Ins Co v Tiedman*,³⁰ the Court enforced a provision limiting coverage to the policy with the higher limits. In *Tiedman*, the insured was involved in a motor vehicle accident while driving a Bronco his wife owned. The Bronco was insured by State Farm under “Policy 1,” under which the insured was a named insured. State Farm also insured a GMC pickup truck owned by the insured under “Policy 2,” under which the insured was the sole named insured. The question was the extent to which Policy 2 provided liability coverage for the operation of the Bronco insured by Policy 1. Both policies issued by the insurer provided:

If There Is Other Liability Coverage

1. Policies Issued by Us to You.

If two or more vehicle liability policies issued by us to you apply to the same accident, the total limits of liability under all such policies shall not exceed that of the policy with the highest limit of liability.³¹

The Court held that the language was unambiguous. The provision applied where State Farm issued multiple policies to the named insured. In *Tiedman*, the insured was a named insured under both policies. The Court rejected the argument the provision only applied if the named insureds under both policies were identical. Therefore, the policies could not be stacked.

Conclusion

As the foregoing discussion indicates, insurers are frequently successful in enforcing anti-stacking provisions, particularly for UM/UIM coverage, provided the provision is factually applicable. However, ambiguous provision will likely not be enforced. In any case, reviewing the policy is important because the specific language should control and subtle differences in the language may determine whether or not the anti-stacking language is applicable or enforceable. ■

About the Author

Daniel James practices primarily in the area of insurance coverage defense litigation and personal injury defense litigation. His experience includes representing clients in insurance coverage disputes, both property and liability, arising under a wide variety of policies, including CGL, auto, homeowner, renters, landlord, and professional liability. He has extensive experience with claims arising under the Michigan auto no-fault statute. His email address is james@wuattorneys.com.

Endnotes

- 1 *Stoddard v Citizens Ins Co of Am*, 249 Mich App 457; 643 NW2d 265 (2002).
- 2 *Boettner v State Farm Mut Ins Co*, 388 Mich 482; 201 NW2d 795 (1972).
- 3 *Bradley v Mid-Century Ins Co*, 409 Mich 1, 48; 294 NW2d 141 (1980).
- 4 *Id.*
- 5 *Twichel v MIC General Ins Corp*, 469 Mich 524, 533; 676 NW2d 616 (2004).
- 6 See *Yabr v Garcia*, 177 Mich App 705; 442 NW2d 749 (1989), rev'd on appeal 436 Mich 872; 461 NW2d 363 (1990).
- 7 *American States Ins Co v Kesten*, 221 Mich App 330; 561 NW2d 486 (1997).
- 8 *DAIIE v McMillan*, 159 Mich App 48; 406 NW2d 232 (1987)
- 9 *Id.* at 53.
- 10 *Galenski v Allstate Ins Co*, unpublished per curiam opinion of the Court of Appeals, issued May 11, 2006 (Docket No. 255604).
- 11 *Id.* at 2-3.
- 12 *Citizens Ins Co of Am v Federated Mut Ins Co*, 448 Mich 225; 531 NW2d 138 (1995).
- 13 *Id.* at 236.
- 14 *Id.*
- 15 *Wilkerson v Farm Bureau Gen Ins Co*, unpublished per curiam opinion of the Court of Appeals, issued Aug 17, 2004 (Docket No. 247834).
- 16 *State Farm v Ruuska*, 412 Mich 321; 314 NW2d 875 (1982).
- 17 *Id.* at 338-353 (LEVIN, J., concurring); *id.* at 353 (COLEMAN, J., dissenting).
- 18 *Id.* at 312-338 (opinion of the Court); *id.* at 338-353 (LEVIN, J., concurring).
- 19 *De Maria v Auto Club Ins Assoc*, 165 Mich App 251; 418 NW2d 398 (1987)
- 20 *Id.* at 254.
- 21 *Id.*
- 22 *Id.* at 262.
- 23 *De Maria v Auto Club Ins Asso*, 428 Mich 878; 402 NW2d 772 (1987)

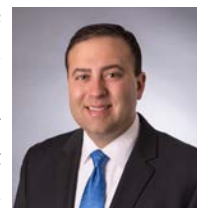
- 24 *De Maria*, 165 Mich App at 255.
- 25 *Citizens Ins Co v Tunney*, 91 Mich App 223; 283 NW2d 700 (1979).
- 26 *Auto Club Ins Assoc v Lanyon*, 142 Mich App 108; 369 NW2d 269 (1985).
- 27 *Fletcher v Aetna Casualty & Surety Co*, 80 Mich App 439; 264 NW2d 19 (1978).
- 28 *Id.* at 441, n 1.
- 29 *Inman v Hartford Ins Group*, 132 Mich App 29; 346 NW2d 885 (1984).
- 30 *State Farm Mut Auto Ins Co v Tiedman*, 181 Mich App 619; 450 NW2d 13 (1989)
- 31 *Id.* at 623.

Mission Statement of the Insurance and Indemnity Law Section

Issues arising out of insurance contracts and indemnity agreements affect a broad range of practice areas. In addition, insurance is a regulated industry, and state and federal regulations present specialized questions. The membership of the Insurance and Indemnity Law Section of the State Bar of Michigan consists of those who have expertise in this area of practice, as well as those whose expertise lies in other practice areas that are affected by insurance and indemnity issues. The mission of the Section is to provide a forum for an exchange of information, views and expertise from all perspectives on both insurance coverage issues and indemnity issues, and to provide information and assistance to other persons or organizations on matters relating to insurance and indemnity. Membership is open to all members of the State Bar of Michigan.

Correction

In our previous (July 2018) issue, we inadvertently omitted the biographical information about Matthew S. LaBeau, the author of "Consider Removing Your Next PIP Case to Federal Court." Matt is a partner at Collins Einhorn Farrell PC. He focuses his practice on defense litigation in first party No-Fault claims, uninsured and underinsured motorist claims, automobile negligence, premises liability, general negligence, and contractual disputes. Matthew has extensive experience in defending catastrophic No-Fault claims, as well consulting insurers regarding catastrophic claims prior to litigation. His email address is matthew.labeau@ceflawyers.com.





Legislative Update: The Calm Before the Storm

By Patrick D. Crandell, Collins, Einhorn, Farrell PC

The Legislature returned from summer recess and members now are in the final push to the mid-term elections, with the entire House and Senate up for election. Expect to see significant activity in the lame-duck session (*i.e.* the time following the November 6 election up to December 31, when all pending legislation expires).

Since the last update, the Senate Insurance Committee has not met, and the House Insurance Committee met once and only took testimony on three bills:

- **HB 6115** – eliminates certain reporting requirements in life insurance policies.
- **SB 898** – modifies the date when captive insurance companies must provide their annual reports. *Reported out of the Senate Insurance Committee on 5/24/18; Passed by the Senate (32-0) on 5/30/18; Referred to the House Insurance Committee on 5/30/18*
- **SB 1029** – permits a domestic stock insurer to divide into multiple insurers and describes the process for the division. *Reported out of the Senate Insurance Committee on 6/7/18; Passed the Senate (35-1) on 6/12/18; Referred to the House Insurance Committee on 6/12/18*

Additionally, the Legislature referred a few new bills to the respective insurance committees:

- **HB 6188** – extends the presumption of causation for occupational cancer to fire/crash rescue officers and forest fire officers, under the worker's disability compensation act.
- **HB 6263** – amends the no-fault insurance act to require an audit every five years of the Michigan Catastrophic Claims Association, and requires the MCCA to refund any amount determined to be surplus.
- **HB 6343** – amends the no-fault insurance act in a number of ways, including: (1) permitting insureds to select maximum PIP limits; (2) limiting the amounts providers can recover for medical services to the worker's compensation schedules; and (3) requiring insurers to file their premium rates and to provide justification if their rates do not result in certain premium savings.
- **SB 1059** – defines "telemedicine services" and permits such services to establish a physician-patient relationship.

- **SB 1087** – amends the insurance code to require insurers making payments (in excess of \$5,000) to an attorney to settle a claim, to provide notice to the claimant of the settlement payment.

Finally, one of my readers (yes, I have at least one) let me know that I switched the description of two bills back in the January 2018 issue and then carried that error forward into subsequent issues. So, the corrected information for those two bills is as follows:

- **SB 638** – modifies the eligibility for credit for reinsurance. *Reported out of the Senate Insurance Committee on 11/30/17; Passed unanimously in the Senate on 12/6/17; Reported out of the House Insurance Committee on 2/15/18; Passed by the House on 3/1/18 (108-1); Concurred in unanimously by the Senate on 3/6/18; Presented to the Governor for signature on 3/15/18*
- **SB 644** – clarifies the available tort liability for insurance agents. *Referred to the Senate Insurance Committee on 11/1/17* ■





ERISA Decisions of Interest

K. Scott Hamilton, *Dickinson Wright PLLC*, khamilton@dickinsonwright.com
 Kimberley J. Ruppel, *Dickinson Wright PLLC*, kruppel@dickinsonwright.com

Sixth Circuit Update

District Court Erroneously Affirmed Denial of Benefits Based on Record-Only Review of Medical File

Wagner v American United Life Insurance Co.,
 (6th Cir., May 3, 2018) (unpub),
 Case No. 17-4072, 2018 WL 2065076

The plaintiff broke his leg, spent two weeks in the hospital, and the pain prevented him from working in his occupation as a “service analyst,” which involved monitoring oil levels in his employer’s cranes. His disability plan paid total disability benefits for 36 months if he “cannot perform . . . his regular occupation,” and continues after 36 months only if he “cannot perform . . . any gainful occupation” for which he is reasonably suited. The insurer paid benefits for 34 months, then ended benefits when the administrator determined he could return to his regular occupation. The district court affirmed the administrative decision denying benefits.

The Sixth Circuit reversed, noting that “[e]very professional who met [the insured] agreed that he should not return to work.” The court rejected the insurer’s argument that the insured’s pain complaints lacked “objective medical evidence” because the policy did not require disabilities to be based on objective evidence, as opposed to the insured’s self-reported symptoms.

The Sixth Circuit also held that the opinions of the insured’s treating physicians deserved more weight than those of the insurer’s consulting physician who did not examine or interview the insured. The consultant disbelieved the insurer’s pain complaints based on a surveillance video showing him apparently acting inconsistently with the alleged severity of his pain. The video covered only a few minutes of activity, and was not inconsistent with the plaintiff’s statement that his leg pain “would come and go.” The court therefore held that he was disabled when the benefits were terminated.

As for a remedy, the Sixth Circuit held that the insured was entitled to benefits after the first 36 months when the definition of “disability” changes to “any occupation,” reasoning that the insurer could have decided whether the insured was disabled under the changed definition at month 36, but that it “chose to forego that opportunity when it (wrongly) decided that [the insured] was no longer entitled to benefits at month 34.”

District Court Properly Affirmed Denial Of Benefits Where Insured Failed to Exhaust Administrative Remedies

Kennedy v Life Insurance Co of North America,
 (6th Cir., April 13, 2018) (unpub),
 Case No. 17-5901, 718 Fed. Appx. 409

The insured had lung problems and neuropathy, and applied for short-term disability benefits. The insurer tried unsuccessfully to get records from his attending physician and denied his claim for benefits on that basis, telling him he could appeal - - and provide medical support for his claim - - within 180 days. He did not do so.

Two years later the insured’s attorney wrote to the insurer, asking for a decision on the insured’s entitlement to long-term disability benefits. Even though the insured never applied for long-term benefits, and the short-term claim had been denied two years earlier, the insurer reviewed the claim. It discovered that the insured no longer was an employee with his employer, and was therefore not eligible for plan benefits.

The insured sued, and the district court held that the insurer failed to exhaust his administrative remedies because he never applied for long-term benefits. Moreover, the Sixth Circuit held that the insurer was not obligated to consider an insured’s long-term disability claim simply because the short-term claim was denied.

Contra Proferentem Rule Does Not Apply Where Plan Administrator Has Discretion to Interpret Ambiguous Plan Provisions

Clemons v. Norton Healthcare Inc Retirement Plan,
 890 F.3d 254 (6th Cir. 2018)

The doctrine of “*contra proferentem*” is “[u]sed in connection with the construction of written documents to the effect that an ambiguous provision is construed most strongly against the person who selected the language.” Black’s Law Dictionary (5th Ed.).

Faced “solely with a mountain of dicta” in the Sixth Circuit on the issue, *Clemons* held that when a plan vests discretion in a plan administrator to make benefits decisions under *Firestone Tire & Rubber Co v Bruch*, 489 US 101, 111, 109 SCt 948, 103 LEd2d 80 (1989), “a court may not invoke *contra proferentem* to ‘temper’ arbitrary-and-capricious review.” However, *Clemons* held that “when it is not clear whether the administrator has, in fact, been given *Firestone* deference on a particular issue, we think the doctrine still has legitimate force.”

In concluding that a court cannot “apply *Firestone* deference and *contra proferentum* to the same case without contradiction,” *Clemons* noted that *Firestone* deference “must include the ability to choose between two reasonable interpretations of the Plan, and that is precisely the situation in which the traditional *contra proferentum* rule operates against the drafter.” The court explained that “applying *contra proferentum* when language is ambiguous generates a paradox where the administrator can only exercise his discretion when it is not needed, i.e., when the language is clear.”

Clemons further explained that *contra proferentum* cannot be “weighed” in the final analysis in determining whether there is an abuse of discretion.’” (quoting *Firestone*). If an administrator “*deliberately* makes the Plan ambiguous so that it can invoke deference to serve its own interests,” a court “might consider that fact under *Firestone*,” but it would be done “under the conflicts-of-interest rubric and the breach-of-trust doctrine, not because the plan was ambiguous.”

Clemons recognized “the wisdom of applying *contra proferentum* to the threshold question of whether *Firestone* deference exists,” as opposed to the substantive benefit decision, although noting that there was no dispute that *Firestone* deference applied and that the “issue can be resolved at a later time.”

Plan Beneficiary Had Article III Standing From Denial of Benefits, But Denial Was Proper For Failure to Obtain Precertification for Emergency Air Ambulance Services

Springer v Cleveland Clinic Employee Health Plan Total Care,
900 F.3d 284 (6th Cir. 2018)

The plaintiff arranged to have his son transported by air ambulance from Utah to Cleveland. The air ambulance was unable to confirm from the health care insurer whether the plaintiff was a covered plan member, and therefore did not obtain precertification for the air transport service. It nonetheless provided the transportation, then billed insurer \$340,100, which the insurer denied based on the lack of precertification. The transport service appealed to the plan administrator, which affirmed the denial. The transportation company sued, but the action was dismissed because the plan member did not assign his rights to the transport service.

The plaintiff then filed his own action. The district court affirmed the denial, holding that the plaintiff lacked Article III standing because he received the air ambulance service and was not billed for it. The district court alternatively held that benefits were properly denied because the plan required precertification, which was not obtained.

On appeal, the Sixth Circuit reversed the district court’s standing analysis, holding that the plaintiff “suffered an injury within the meaning of Article III because he was denied health benefits he was allegedly owed under the plan.” Noting

that every circuit “to consider this issue agrees that a plaintiff . . . does not need to suffer financial loss,” and that “the denial of plan benefits is a concrete injury for Article III standing even when patients were not directly billed for their medical services,” the court held the plaintiff had standing despite having received the medical service without having to pay for it.

Even though the plaintiff had Article III standing, the court affirmed the denial of benefits because the plan stated that “[i]f precertification is required and NOT obtained, [the insurer] is not obligated to reimburse for services even if it is a covered benefit.” The plan further said if “the member does not participate in the precertification process before obtaining the service there will be NO REIMBURSEMENT for the service.” The Sixth Circuit held that under any standard of review, denial was proper because the transportation was not an “emergency service” which would excuse the need for precertification.

District Court Properly Affirmed Denial Of Benefits Where Insured Failed to Exhaust Administrative Remedies

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About the Authors

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Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*
Amy Felder, *Atain Insurance Companies*

Supreme Court Decisions

Abrogation of innocent-third-party rule

Kaufman Payton & Chapa PC ___ Mich ___ (2018)

Relying on *Titan Ins Co v Hyten*, 491 Mich 547 (2012), the Supreme Court confirmed that insurers can assert traditional contract defenses available to any contracting party in challenging the enforceability of the agreement. The only limitations for auto insurers are those imposed by statute, and there is no statutory requirement of coverage for innocent-third-parties: “the plain language of the no-fault act does not preclude or otherwise limit an insurer’s ability to rescind a policy on the basis of fraud.” Nor is there any public policy reason to enforce an innocent-third-party rule. Rather, rescission is an equitable remedy to be applied on a case-by-case basis as the specific circumstances warrant. Whether to rescind a contract is within the discretion of the courts.

Michigan Court of Appeals – Published Decisions

Rescission subject to a six-year limitations period from date of misrepresentation MCL 500.3113(b) does not require a policy in the name of the owner/registrant

Mauer v Fremont Ins Co (Jansen, J. dissenting)

___ Mich App ___ (2018) (Docket No. 336514)

Released September 18, 2018

Plaintiff was catastrophically injured while operating her personal vehicle in the course of delivering mail for the U.S. Postal Service. She recovered on her tort claim, reimbursed the USPS for workers compensation benefits, and then sued Fremont for PIP benefits to replace the workers compensation benefits. Fremont countered with a rescission claim, based on the original application for insurance submitted in 2006. Plaintiff’s husband, the named insured, wrongly stated that none of the insured vehicles were used in the course of employment. The majority held that Fremont’s assertion of fraud was subject to the six-year statute of limitations provided under MCL 600.5813. And the claim accrued when the false statement was first made in 2006. Fremont’s rescission claim in 2014 was too late.

The majority also rejected Fremont’s reliance on MCL 500.3113(b) and *Barnes v Farmers Ins Exchange*, 308 Mich App 1 (2014). Based partly on principles of statutory construction and partly on factual differences in the two cases, the

majority concluded that MCL 500.5113(b) “doesn’t prevent a spouse from procuring insurance on a family car when the vehicle is registered to the other spouse.”

Michigan Court of Appeals – Unpublished Decisions

No CGL coverage for liquidated damages,
professional services

Westfield Ins Co v Jenkins Construction

Docket No. 337968

Released September 6, 2018

Jenkins Construction subcontracted with Westfield’s named insured for electrical work on a project for Wayne County. A flood event occurred, allegedly due to the failure of controls installed by the named insured’s subcontractor. The county sued Jenkins for property damage that occurred as a result of the flood, and for other economic damages. Westfield defended Jenkins as an additional insured against the county’s claims, but indemnified Jenkins only for the property damage caused by the flood. The Court of Appeals affirmed the trial court in finding no coverage for Jenkins’ contractual liability for liquidated damages, no coverage for surety bond expenses, no coverage for any indemnity Jenkins owed to the project engineer, and no coverage for Jenkins’ attorney fees in litigating these coverage issues.

Insured’s false statements result in a loss of coverage for
property damage

Rochlani v Sanford Aaron and Acujust, LLC

Docket Nos. 336651, 336768 and 336786

Released September 4, 2018

Plaintiff submitted a claim for damage to her home and personal property, allegedly caused by the freezing and sudden bursting of water pipes. She also claimed damage caused by the entry of raccoons into the garage. Pioneer denied the claim for several reasons, including untimely notice, fraud in plaintiff’s sworn statement of loss as well as during her examination under oath, and failure to cooperate in the investigation of the claim. Plaintiff reacted by first suing her insurance adjuster, Aaron, for negligence and breach of fiduciary duty. But none of the grounds for denial of the claim related in any way to Aaron’s services.

The Court of Appeals affirmed summary disposition for Aaron and affirmed the award of frivolous action sanctions in

The majority held that Fremont's assertion of fraud was subject to the six-year statute of limitations provided under MCL 600.5813. And the claim accrued when the false statement was first made in 2006.

his favor given that plaintiff undertook the litigation knowing why her claim was actually denied. Plaintiff was further assessed sanctions for the frivolous appeal. In a second lawsuit, plaintiff sued Pioneer, claiming that she substantially complied with the insurance contract and did not materially misrepresent her claim. But it was undisputed that plaintiff failed to notify Pioneer of the alleged loss until three months after it occurred, failed to submit a sworn proof of loss until nearly six months after the loss, and made no effort to mitigate the damage in the meantime. Plaintiff also falsely testified that no prior water losses had occurred at the home, and that she had no notice of any mold, or notice of damage to the garage prior to the frozen pipes. Because of plaintiff's false statements, Pioneer was entitled to void her policy.

Untimely notice and default bars coverage

Tudor Insurance Co v PM Services, Inc

Docket No. 335841, 335890

Released August 21, 2018

Tudor and National Union were the primary and excess insurers of PM Services f/k/a Altman Management, against whom plaintiff obtained a substantial arbitration award. The insurers denied coverage for the claim because Altman failed to provide timely notice of plaintiff's complaint, as required by both policies. The result was a default and ultimately, a \$3.5 million arbitration award. The insured argued that it provided notice to the insured's own broker, who failed to forward the suit onto Westrope, an insurance agency. While there was some dispute regarding the nature of the agency relationships, the court held that the insurance contract required timely notice of the lawsuit to the insurer and that requirement for coverage was breached.

Homeowner's insurer is not liable for insured's reaction to mold remediation

Abraham v Farmers Insurance Exchange

Docket No. 335353

Released August 21, 2018, S Ct app pending

The insured's home sustained considerable damage when a leak from the refrigerator allowed water to flood the kitchen, a hallway, and some areas of the basement. Farmers' policy covered remediation costs up to a certain limit, unless the insured used a remediation company referred by Farmers, in which

case the insured was obligated for the deductible only. The insured opted for the referred company, co-defendant in this case, which removed the water and set up drying fans. When co-defendant removed a portion of the linoleum flooring, it discovered mold in the subfloor and sprayed with an anti-microbial chemical to prevent that mold from spreading.

Plaintiff claims she subsequently developed serious pulmonary and auto-immune illnesses as a result of toxic mold that remained in the home. Plaintiff argued that Farmers owed her a duty to 1) hire a qualified company to mitigate the water damage, 2) warn her of the risks associated with mold and advise her to leave the home because of the mold, and 3) should never have directed or controlled the scope of the remediation company's work. The Court of Appeals held that Farmers owed none of the duties alleged and so plaintiff failed to state a viable cause of action against Farmers. As to co-defendant, the court found a duty of reasonable care and a question of fact as to whether that duty was breached.

Named insured is a constructive owner of insured vehicle

Willis v Fodal

Docket No. 338187

Released August 21, 2018

Plaintiff was involved in an accident while driving a vehicle owned by him and registered in his name. It was insured under a policy issued to his girlfriend, with whom he resided for many years. Both testified that the girlfriend could use plaintiff's vehicle without asking for permission and did so on many occasions. She also helped with the vehicle maintenance. Because she was a constructive owner who obtained the required security, plaintiff was not barred from applying for PIP benefits under MCL 500.3113(b). Nor was he barred from pursuing a tort claim under MCL 500.3135(2)(c).

Cancellation of agency agreement

Breton Insurance Agency v Secura Insurance Company

Docket No. 339428

Released June 26, 2018, S Ct app pending

This dispute arose out of Secura's termination of its agency agreement with Breton, an independent insurance agency. The agency agreement required Breton to submit no less than 25 applications during the 12-month period preceding termination. Breton argued that Secura's use of the "Mile-Stone" online system for submitting applications effectively prevented Breton from meeting its quota because the system was set up for "bundled" home and auto and Breton was more likely to sell single coverage policies, and submitted 5 such applications in the year preceding termination. Breton also stressed that it submitted 45 requests for quotes. The Court of Appeals affirmed the trial court's order of summary disposition for Secura because there was no dispute that Breton failed to submit

the required number of applications in the 12 months preceding the termination, and because mere requests for rate quotes did not substitute for applications. Breton also challenged Secura's right to send policyholders a notice of expiration. But the court found nothing factually incorrect in the notices and nothing that divested the agency of its "records and use of control of expirations," per the terms of the agency agreement

Due to insufficient load bearing capacity, certain parts of the building sustained damage, including a bulging west wall. Coverage, however, was limited to damage caused by a building "collapse," defined in the policy as an "abrupt collapse," a "falling down" or "caving in" of a building or any part of the building

Constructive ownership of uninsured vehicle bars claim for UM benefits

Cline v Allstate Ins Co

Docket No. 336299

Released June 21, 2018, S Ct app pending

Plaintiff failed to adequately rebut Allstate's evidence of his constructive ownership of a vehicle that was uninsured. Although plaintiff denied actually purchasing the uninsured vehicle, he did not dispute that he kept the vehicle at this mother's house where he lived, that he had unrestricted access to the vehicle and possessed the only key, and that the driver at the

time of the accident (his girlfriend who lived with him) had to ask permission to drive it. Because he was the constructive owner of an uninsured vehicle, he was barred from recovering uninsured motorist benefits under his mother's policy.

No "collapse" coverage

Community Garage Inc v Auto-Owners Insurance Co

Docket No. 339300

Released June 19, 2018, S Ct app pending

Plaintiff sought coverage under its commercial property policy for the cost of repairing its building, which was damaged as a result of latent construction defects in the trusses supporting the roof. Due to insufficient load bearing capacity, certain parts of the building sustained damage, including a bulging west wall. Coverage, however, was limited to damage caused by a building "collapse," defined in the policy as an "abrupt collapse," a "falling down" or "caving in" of a building or any part of the building. No part of plaintiff's building had fallen or caved in. The court agreed the cost of repairs were not covered.

Change of beneficiary for life insurance policy limited by consent judgment of divorce

Kowalsky v Kadzielawski

Docket No. 337531

Released June 14, 2018

Plaintiff took out a life insurance policy while married to defendant's mother. That policy included a rider for defendant's mother, naming defendant as the beneficiary. After the


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marriage failed, but before the judgment of divorce, plaintiff wrote to the insurer directing a change of beneficiary for the policy covering his life only. Defendant’s mother wrote to the insurer separately directing a change of beneficiary for the rider policy. But because plaintiff was the only person who could direct a change of beneficiaries, the instructions as to the rider were ineffective. When the couple executed the consent judgment of divorce, they agreed to terminate their rights to any life insurance policy applicable to the other party. So at the time of defendant’s mother’s death, defendant was still the beneficiary under the rider life insurance policy.

6th Circuit Court of Appeals Decisions

Criminal act exclusion

K.V.G. Properties, Inc v Westfield Ins Co
 ___ F3d ___ (2018)

Case No. 17-2421, Released August 21, 2018

The named insured property owner submitted a first-party claim for property damage caused by commercial tenants who used the property to grow large amounts of marijuana. “To accommodate their ‘business,’ the tenants removed walls, cut holes in the roof, altered duct work, and severely damaged the HVAC systems.” The commercial property policy contained an exclusion for damage caused by the criminal act of “anyone to whom you entrust the property for any purpose.” Westfield produced evidence of the criminal nature of the business, including raids by federal agents conducting a criminal investigation, and the insured’s own claims of illegality in other judicial proceedings. The insured argued that the activity could have been legal under Michigan’s medical marijuana laws but failed to produce any evidence that it was. The court found the exclusion applied, and further rejected the insured’s claim that an actual conviction was required. The exclusion applied to a criminal act, not a crime or criminal conviction.

Computer fraud coverage applies

American Tooling Center, Inc v Travelers Casualty and Surety Co of America
 ___ F3d ___ (2018)

Case No. 17-2014, Released July 13, 2018

Plaintiff subcontracted some of its manufacturing work to China. It later received e-mails, purportedly from its Chinese vendor, claiming that the vendor had changed bank accounts and directing plaintiff to wire payments to the new accounts. After transferring \$834,000 in payments, plaintiff learned that the emails were fraudulent. Plaintiff sought coverage for the loss under its insurance policy with Travelers, which provided coverage for “computer fraud.” Travelers denied the claim, stating that plaintiff did not suffer a “direct loss” as required by the policy, and that even if it did, the loss was subject to certain exclusions. The court disagreed, finding that the plain-

tiff’s loss was “directly caused by the computer fraud because it was that fraud that directly led to plaintiff’s loss. And none of the exclusions applied. Plaintiff did not “give or surrender money to the impersonator as part of an exchange or purchase between the two. Nor was this a loss caused by electronic data, which expressly does not apply to “instructions or directions” to a computer system.

Known circumstances exclusion in claims-made policy

Alterra Excess & Surplus Co v Excel Title Agency
 ___ Fed Appx ___ (2018)

Case No. 17-2186, Released July 26, 2018

Claims-made professional liability policy issued to defendant title agency excluded coverage for any service performed prior to the effective date of the policy if any insured knew or could have reasonably foreseen that the service would give rise to a claim. In its 2010 application for insurance, the insured denied knowing of any services rendered that might result in a claim but in mid-2009, the insured received a communication from one of its former clients expressly threatening a lawsuit if reparation was not made within 90 days. That investor did file suit after the policy inception and the exclusion barred coverage. ■



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No-Fault Corner

Death of the Innocent Third Party Rule? Well, Maybe Not . . .

Supreme Court rules that although innocent third party rule has been abrogated, insurer is not automatically entitled to rescind coverages as to an “innocent third party”

By Ronald M. Sangster Jr.

On July, 18, 2018, the Michigan Supreme Court released its long-awaited decision in *Bazzi v Sentinel Ins Co*, ___ Mich ___; ___ NW2d ___ (2018) (Docket No. 154442). In a 5-2 decision, the Michigan Supreme Court held that the so-called “Innocent Third Party” Rule was implicitly abrogated by the Court’s earlier decision in *Titan Ins Co v Hyten*, 491 Mich 547, 817 NW2d 562 (2012). However, the Supreme Court also ruled that despite the abrogation of the “Innocent Third Party” Rule, the insurer is not automatically entitled to rescind coverages as to an “innocent third party.”

Instead, because rescission is an equitable remedy, the Court will need to “balance the equities” involved in any rescission action to determine if the rescission would be an appropriate remedy. A case-by-case inquiry will be required. Unfortunately, there will likely be no consistency between the circuit court judges examining the issue, because what one judge may deem to be “equitable” in favor of the insurer may be deemed by another judge, even sitting in the same circuit, to be “inequitable.” Furthermore, the Supreme Court majority opinion provided no guidance as to how those equities should be balanced.

Bazzi Dissent Opinion

The dissenting opinion authored by Justice McCormack, joined by Justice Viviano, was quite direct and pointed. The dissent took issue with the majority’s stance on the trial of the equities and the expanding costs of litigation that will ensue. In her opinion, because the No-Fault Act was intended to be comprehensive legislation that provided for mandatory benefits – sometimes to those not party to the policy under which they claim benefits, i.e., innocent third parties – the compulsory nature precludes an insurer’s ability to seek equitable common law remedies, like rescission, that are inconsistent with the purposes of the act. Thus, she would have limited an insurer’s defenses to those available under the act, which would not include rescission as to an innocent third party.

A case-by-case inquiry will be required. Unfortunately, there will likely be no consistency between the circuit court judges examining the issue, because what one judge may deem to be “equitable” in favor of the insurer may be deemed by another judge, even sitting in the same circuit, to be “inequitable.” Furthermore, the Supreme Court majority opinion provided no guidance as to how those equities should be balanced.

Underlying Facts And Lower Court Rulings

In *Bazzi*, Plaintiff’s mother, Hala Bazzi, leased a vehicle for her personal and family use. Although the vehicle was leased in her name, individually, she procured a commercial auto policy from Sentinel Insurance Company, and the named insured was designated as Mimo Investment LLC. After Plaintiff was involved in a motor vehicle accident, Sentinel denied coverage for the loss, arguing that Mimo Investment LLC was a sham corporation, the vehicle insured under the policy was not being used for commercial purposes by Mimo Investment, and no one had disclosed to Sentinel that Plaintiff would be a regular driver of the vehicle.

Sentinel filed a Third Party Complaint against Plaintiff’s mother and aunt (who was the resident agent for Mimo Investment LLC), which resulted in a default judgment allowing Sentinel to rescind the policy as to Plaintiff’s mother and aunt. Thereafter, Sentinel moved for summary disposition of Mr. Bazzi’s claim, arguing that because the policy was void *ab initio* as a result of the rescission, it was under no obligation to afford coverage to Mr. Bazzi, who it conceded was an “innocent third party.” The circuit court denied Sentinel’s motion for summary disposition based upon the “Innocent Third

Party” Rule, which prohibited an insurer from rescinding its policy, based upon fraud in the procurement of the policy, after a person not party to the fraud had sustained injury. Sentinel filed an Application for Leave to Appeal to the Court of Appeals, which was initially denied; however, the Supreme Court remanded the matter back to the Court of Appeals for consideration as on leave granted. *Bazzi* at ___, slip op at 3.

On remand, the Court of Appeals determined in a 2 – 1 split decision that the “Innocent Third Party” Rule was implicitly abrogated by the Michigan Supreme Court’s decision in *Hyten*, *supra*. *Bazzi v Sentinel Ins Co*, 315 Mich App 763, 891 NW2d 13 (2016). Judge Beckering dissented, arguing that the “Innocent Third Party” Rule was separate and distinct from the “Easily Ascertainable” Rule that was abrogated by the Michigan Supreme Court, in its *Hyten* decision. *Id.* Plaintiff and his medical providers filed an Application for Leave to Appeal to the Michigan Supreme Court, which was granted by the Court.

The Bazzi Majority Opinion

The majority opinion was authored by Justice Wilder. Justice Wilder affirmed the Court of Appeals’ decision that the “Innocent Third Party” Rule did not survive the Court’s earlier decision in *Hyten*. In this regard, the Supreme Court affirmed the observation of the Court of Appeals’ majority that the “Innocent Third Party” Rule and the “Easily Ascertainable” Rule were two sides of the same coin. The rationale behind both rules were premised upon the protection of third parties despite misrepresentations made in the procurement of the policies at issue. See *Hyten* at 568 569. Thus, based upon the rationale in *Hyten*, the abrogation of the “Easily Ascertainable” Rule implicitly abrogated the “Innocent Third Party” Rule as both doctrines had their roots in the Court of Appeals’ decision in *State Farm v Kurylowicz*, 67 Mich App 568, 242 NW2d 530 (1976).¹

The Supreme Court majority also rejected any distinction between rescission of optional coverages, such as the excess residual liability coverages that were at issue in *Hyten*, and the statutorily mandated coverages, such as \$20,000.00/\$40,000.00 liability coverage and, in this case, statutorily mandated PIP benefits. As noted by the Supreme Court majority:

“We reject the premise that there is a controlling distinction between mandatory coverage, i.e., statutorily mandated PIP benefits, and optional coverage. Whether statutory benefits or optional benefits are at issue, each is predicated on the existence of a valid contract between the insured and insurer. Moreover, our reasoning in *Titan* was not dependent on whether the coverage at issue was mandatory or

optional. Rather, we recognized that common-law defenses are available when there are contractual insurance policies but limited when a statute prohibits the defense. . . . Although PIP benefits are mandated by statute, the NoFault Act neither prohibits an insurer from invoking the common-law defense of fraud nor limits or narrows the remedy of rescission. Additionally, because *Titan* considered only optional benefits, there was no reason for this Court to opine on any purported statutory limitations on common-law defenses for mandatory coverage. As such, any implication derived from *Titan*’s footnote 17 and accompanying text that MCL 500.3101(1) somehow limited the availability of rescission . . . was nonbinding *dicta*.”

Bazzi at ___, slip op at 12.²

The *Bazzi* majority also found it important to point out that an insured’s honesty in procuring insurance is of utmost importance. The court stated:

“. . . [A]lthough an innocent third party might have a reasonable right to expect that other drivers carry the minimum insurance required under the No-Fault Act, that expectation does not, by operation of law, grant an innocent third party an absolute right to hold an insurer liable for the fraud of the insured. In other words, an insurer has a reasonable right to expect honesty in the application for insurance⁹, and there is nothing in the NoFault Act that indicates that the reasonable expectations of an innocent third party surmount the reasonable expectations of the insurer.”

⁹ *Jacobs v Queen Ins Co*, 183 Mich 512, 520; 150 NW 147 (1914) (Noting that “a contract of insurance is one in which the utmost good faith is required of the insured”) . . . See also *Barry Zalma*, Lexis Nexis Legal News Room, *the equitable remedy of rescission: a tool to defeat fraud*, . . . (posted April 21, 2015) (Accessed June 11, 2018) (Stating that “insurance contracts, unlike common-run-of-the-mill commercial contracts, are considered to be contracts of *utmost good faith*” and that “each party to the contract of insurance is expected to treat the other fairly in the acquisition and performance of the contract”).

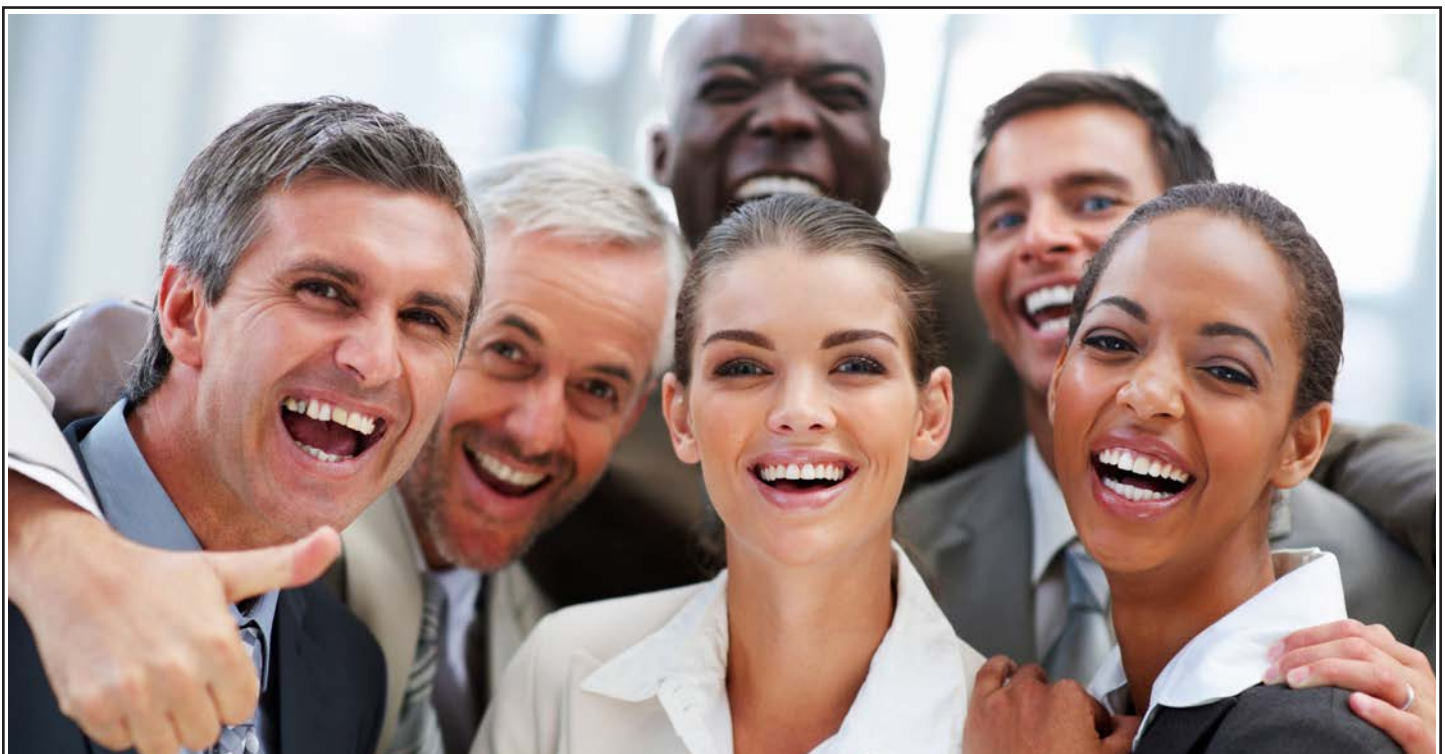
Id. at 13.

In this age where insureds are constantly trying to lower their already-high insurance premiums by, say, misrepresenting actual ownership of the vehicles to be insured under the policy, or failing to disclose youthful drivers in the household, insureds and their agents (particularly independent agents) need to be aware that such actions will result in a rescission of the policy, and perhaps an Errors and Omissions claim against the insurance agent.

The second part of the Court's holding is more problematic. Although the Supreme Court ruled that the "Innocent Third Party" Rule was abrogated by the Court's decision in *Hyten*, the majority also ruled that the insurer was not automatically entitled to rescission as to the innocent third party. Rather, the Court noted that "fraud in the inducement to enter a contract renders the contract *voidable* at the option of the defrauded party . . ." *Bazzi* at ___, slip op at 14 (citations omitted). Therefore, the insurer has the option of declaring a policy void *ab initio*, depending on the circumstances surrounding procurement of the policy. Where a policy is rescinded, it is as if the policy never existed, thereby, placing the parties in the same position they would have been in if the policy had never been issued. *Id.* at ___, slip op at 14 -15.

The court noted, however, that rescission is an equitable remedy and, as such, the equities must be balanced between the defrauded insurer and the innocent third party. The court held that "although the policy between Sentinel and the insured, Mimo Investment, is void *ab initio* due to the fraudulent manner in which it was acquired, the trial court must now determine whether, in its discretion, rescission of the insurance policy is available as between Sentinel and plaintiff." *Id.* at ___, slip op at 18.

It is this point by the majority that is problematic because the court does not elaborate on how a non-party to a contract (i.e., Mr. Bazzi) has standing to challenge the rescission of the policy. Even more, the court fails to indicate legally how a policy can be rescinded as to the original parties (i.e., the named insured, Mimo Investment, and the insurer, Sentinel) yet still exist for the benefit of the plaintiff, Mr. Bazzi. If the policy between Mimo Investment and Sentinel is void *ab initio* and each is, presumably, returned to the position they would have occupied had the policy never been issued, what remains? Thus, despite indicating previously that rescission returns the parties to the contract to the status quo, it would appear that Sentinel was not.



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Other than a few generalized statements regarding the nature of equitable remedies, the Supreme Court majority provided no concrete examples as to how those equitable considerations should be applied in any given case. As noted by the Supreme Court majority:

“When a plaintiff is seeking rescission, the trial court must balance the equities to determine whether the Plaintiff is entitled to the relief he or she seeks. Accordingly, courts are not required to grant rescission in all cases. For example, rescission should not be granted in cases where the result thus obtained would be unjust or inequitable, or where the circumstances of the challenged transaction make rescission infeasible. Moreover, when two equally innocent parties are affected, the court is required, in the exercise of [its] equitable powers, to determine which blameless party should assume the loss[.] [W]here one of two innocent parties must suffer by the wrongful act . . . of another, that one must suffer the loss through whose act or neglect such third party was enabled to commit the wrong. The doctrine is an equitable one, and extends no further than is necessary to protect the innocent party in whose favor it is invoked.

In this instance, rescission does not function by automatic operation of the law. Just as the intervening interest of an innocent third party does not altogether bar rescission as an equitable remedy, neither does fraud in the application for insurance imbue an insurer with an absolute right to rescission of the policy with respect to third parties. Equitable remedies are adaptive to the circumstances of each case, and an absolute approach would unduly hamper and constrain the proper functioning of such remedies. This Court has recognized that [e]quity jurisprudence molds its decrees to do justice amid all the vicissitudes and intricacies of life and that equity allows complete justice to be done in a case by adapting its judgments to the special circumstances of the case.” [Internal quotations and citations omitted]

Id. at __; slip op at 16 – 17. With that, the Supreme Court remanded the matter back to the Wayne County Circuit Court with instructions for the court to “exercise its discretion” in determining whether or not rescission was appropriate under the circumstances of this case.

The second part of the Court’s holding is more problematic. Although the Supreme Court ruled that the “Innocent Third Party” Rule was abrogated by the Court’s decision in *Hyten*, the majority also ruled that the insurer was not automatically entitled to rescission as to the innocent third party.

The Dissenting Opinion

In her dissent, Justice McCormack, joined by Justice Viviano, indicated that there is an inherent distinction between rescission of optional insurance coverages, such as the excess liability coverages at issue in *Hyten*, and statutorily mandated coverages, such as the \$20,000.00/ \$40,000.00 liability limits required by MCL 500.3009(1) and, in this case, PIP benefits. *Bazzi* (McCormack, J., dissenting) at __; slip op at 1 – 2. She reasoned that the no-fault act was a comprehensive legislative scheme mandating the availability of PIP benefits to all eligible claimants, which an innocent third party “always” is. *Id.* at __, slip op at 2. “PIP benefits arise out of the no-fault act . . . and we must construe a no-fault policy and the Act together as though the statutes were a part of the contract.” *Id.*, citing *Rohlman v Hawkeye-Security Ins Co*, 442 Mich 520, 524-525; 502 NW2d 310 (1993).

Thus, given the comprehensive and mandatory nature of the PIP benefits provided under the act, Justice McCormack would have held that the No-Fault Act limits rescission where an innocent third party is involved because rescission is not consistent with the compulsory nature of the act. *Bazzi* (McCormack, J., dissenting) at __; slip op at 2. Further, she would have held “that Sentinel may not independently seek to rescind the PIP coverage mandated by the no-fault act but that Sentinel may seek to avoid or reduce its obligations relative to the assigned claims insurer, Citizens Insurance Company, by raising defenses permitted by the Act.” *Id.*

However, as in the majority opinion, Justice McCormack’s opinion is problematic as well because the act does not provide – as suggested – an avenue in these situations for an insurer “to avoid or reduce its obligations relative to the assigned claims insurer . . . by raising defenses permitted by the Act.” *Id.* Entitlement to and application for benefits under the assigned claims plan rests with the injured claimant, not a defrauded insurer. See MCL 500.3172(1).³ The only avenue an insurer possesses to place the assigned claims plan on notice is where there is a dispute between “2 or more automobile insurers” but not where an insurer is disputing its own obligation. See MCL 500.3172(3). Thus, the remedy Justice McCormack suggests simply does not exist because the assigned claims plan has no

statutory obligation to respond to the notice of a defrauded insurer and need not get involved until the innocent third party claimant applies for benefits from the MACP. Justice McCormack also describes a number of “remedies for insurers,” in the event they pay benefits out of priority, but in many cases, those remedies do not exist either. In her opinion, the insurance company should “pay first and haggle later.” *Bazzi* (McCormack, J., dissenting) at __; slip op at 12. But that is not an option where the only other potential payee of PIP benefits is the assigned claims plan and the defrauded insurer has no direct means to bring them into the fold.

The Practical Impact of the *Bazzi* Decision Moving Forward

So what do we do now? Certainly the timing of the rescission action will be extremely important. For example, assume a situation where the innocent third party is occupying a motor vehicle whose owner procured an insurance policy through fraud. The insurance company pays benefits to the “innocent third party” for two years, but, after litigation ensues, the insurer discovers the fraud in the insurance application. By that time, it is too late for the innocent third party to file a claim with the MACP. Should an insurer nonetheless be permitted to rescind coverage under those circumstances? In balancing the equities between an insurance company that failed to timely detect the fraud in the application with those of the innocent third party, who is suddenly left without insurance, the outcome seems clear – the insurer would be estopped from rescinding coverage.

In her dissent, Justice McCormack, joined by Justice Viviano, indicated that there is an inherent distinction between rescission of optional insurance coverages, such as the excess liability coverages at issue in *Hyten*, and statutorily mandated coverages, such as the \$20,000.00/ \$40,000.00 liability limits required by MCL 500.3009(1) and, in this case, PIP benefits.

Imagine, as well, a situation where a child is an occupant of a motor vehicle owned by a neighbor. The child will normally file a claim for nofault benefits with his parents’ insurer under MCL 500.3114(1). Again, the parents’ insurer pays benefits for a few years, only to discover that the parents made a fraudulent misrepresentation in the application for insurance. Can the insurer rescind coverage and force the child to resort to the neighbor’s insurer, which would be the next

highest order of priority under MCL 500.3114(4)(a)? Under those circumstances, because the One-Year Notice provision is tolled, due to the claimant’s minority status, it would not be too late to resort to the neighbor’s insurer, although the child may lose entitlement to certain benefits that may have been incurred more than one year back from the date the neighbor’s insurance company is notified of the loss. MCL 500.3145(1). However, what if the neighbor has moved and his insurer cannot be identified? What if the child is actually 18 years old, as that child would no longer be able to avail himself or herself of any tolling of the one-year notice provision?

Each of the above examples demonstrates that time is of the essence in discovering and asserting any defenses based upon fraud that could result in rescission. And, the majority may have suggested as much in its opinion. Although the “Easily Ascertainable” Rule was abrogated by *Hyten*, the majority indicated that “where one of two innocent parties must suffer by the wrongful act . . . of another, that one must suffer the loss through whose act or neglect such third party was enabled to commit the wrong.” (Emphasis added, citation omitted) *Bazzi* at __, slip op at 17. Is the Court alluding, here, that it would behoove an insurance company to verify various information in the application for insurance in order to protect its equitable interests so that it cannot be argued that its “neglect” in failing to do so “enabled” the defrauding party? Conversely, a similar question may be asked of an injured claimant who was in a position to know of or who should have known of fraudulent acts of another in procuring a policy. Needless to say, it is not beyond the pale to say that the quotation above could be argued as an equitable version of the “Easily Ascertainable” Rule.

Furthermore, it seems that the Supreme Court’s majority opinion would appear to invite forum shopping by both insureds and insurers, thereby driving up the cost of litigation. As pointed out by Justice McCormack, in her dissent:

“The result of the majority’s opinion only fuels my skepticism: It recognizes that there are no *per se* rules in equity and therefore remands for the trial court to balance the equities. Although *Sentinel* prevailed here, its right to raise equitable defenses may prove to be a hollow victory.¹² The innocent-third-party doctrine allowed courts to cut short fruitless litigation. In addition to ensuring the speedy payment of benefits as the statute requires, the doctrine operated as equitable shorthand. In other words, it described the equitable balance of certain archetypal relationships, thus saving the parties (and courts) the time and expense of balancing the equities case-by-case. That certainty, efficiency, and stability is now lost.”

¹² Beyond ballooning legal expenses, the possibility of rescission also injects uncertainty that will warp an insurer's risk calculus. As we have recognized before, "The uncertainty associated with subjecting insurers and insureds to the whims of individual judges and their various conceptions of 'equity' would *increase* overall insurance costs because insurers would no longer be able to estimate accurately actuarial risk." *Devillers v Auto Club Ins Ass'n*, 473 Mich 562, 589 n 62; 702 NW2d 539 (2005).

Bazzi (McCormack, J. dissenting) at ___, slip opinion at p. 22. Justice McCormack went on to note:

"The majority instead remands for equitable balancing, but it is mum on what that proceeding will entail. Its silence allows it to avoid confronting the burdensome realities of its remedy. The majority states that 'equitable remedies are adaptive to the circumstances of each case, and an absolute approach would unduly hamper and constrain the proper functioning of such remedies.' It further points out that 'equity jurisprudence molds its decrees to do justice amid all the vicissitudes and intricacies of life' and that 'equity allows complete justice to be done in a case by adapting its judgments to the special circumstances of the case.' 'Complete justice' sounds good to me. But the remand order with instructions that the trial court *please ensure that complete justice is done, thank you*, does not paper over the problems with the remedy."

(Italics in original) *Id.* at ___, slip op at 22-23.

Justice McCormack would then described what may invariably occur in light of the majority's failure to provide guidance as to how an appropriate remedy should be fashioned:

"A remedy that is adaptive to the circumstances of each case requires that a court consider each case's unique circumstances. All of them. Parties will be required to litigate a new set of factual and legal disputes. Since no one factor is dispositive and any factor may be relevant, each party is incentivized to pursue every argument of conceivable merit, to fight each battle to its end, to concede nothing. And summary disposition is not a tool in a court's toolkit in disputes over equity, where any fact can

be material and no rule is absolute. Thus, parties will litigate trials within a trial to demonstrate to the court that their opponent is the more blameworthy party. They will dispute whether the insurer exercised reasonable diligence to discover the insured's misrepresentations in her application before issuing a policy, whether the third party knew that the policy was obtained by the insured's fraud, and even whether the third party was driving negligently at the time of the accident; they will also litigate all possible legal avenues of relief, all possible alternative sources of recovery, and the third party's likelihood of success on the merits in each. And I don't expect smart lawyers to stop there in pursuing their clients' goals."

(Emphasis added) *Id.* at ___, slip op at 23.

Perhaps Justice McCormack summed it up best by noting that "Lawyers, on the other hand, have lots of new litigation to pursue." *Id.* at ___, slip op at 25. Not to mention, the emphasized section above clearly shows the dissent's position on whether the majority effectively adopted an equitable version of the "Easily Ascertainable" Rule.

Just as we saw when the Supreme Court released its decision in *Covenant Med Ctr v State Farm Mut Auto Ins Co*, 500 Mich 191, 895 NW2d 490 (2017), there will probably be a learning curve as litigants and the courts learn how to apply the Supreme Court's holding in *Bazzi* to a variety of factual circumstances. With no clear guidance from the Supreme Court majority as to how the equities are to be balanced, each insurer which considers rescission of a policy will need to weigh the equities with the assistance of counsel to assess the strength of any potential rescission action. Such considerations may include:

- What is the basis for the rescission (i.e., the fraudulent act);
 - How egregious was the fraud;
 - If the accurate (i.e., non-fraudulent) information was known, would the insurer have not undertaken the risk of the policy or would it have simply charged a higher premium;
 - If only a higher premium would have been charged, how much more;
- Did the alleged innocent party know or should he/she have known of the fraudulent activity;

- Who is the perpetrator of the fraud;
 - What is the relationship between the perpetrator and the innocent party;
 - What is the relationship between the vehicle that the policy covers and the innocent party;
 - What is the relationship between the vehicle that the policy covers and the perpetrator;
- Was the fraud intended to benefit the alleged innocent party (e.g., obtain cheaper coverage on his/her behalf, such as a parent for a child);
 - Does the innocent party have another source of PIP benefits available;
 - When was the innocent party (or counsel) notified of the potential rescission;
 - Is there another potential insurer in the chain of priority;
 - Was the innocent party (or counsel) advised to notify the assigned claims plan and the deadline and contact information to do the same;
 - When was the defrauded insurer notified of the claim;
 - Was there sufficient time under the statute to identify and notify another insurer potentially in the chain of priority;
 - Was there sufficient time under the statute to advise the innocent party (or counsel) to notify the assigned claims plan;
 - Did the insurer know (or should have known) about the fraud;
 - Was the information *easily ascertainable* from the resources reasonably available to the insurer;

Although this is by no means an exhaustive list and although it is a virtual certainty that each judge is going to assess the equities differently based upon his or her own experiences and biases, it would be wise for the insurers and counsel alike to be prepared to continually add to this list over time, for as Justice McCormack surmised, the iterations of relevant factors in an action for rescission are virtually limitless. ■

Endnotes

1 “[W]here an automobile liability insurer retains premiums, notwithstanding grounds for cancellation reasonably discoverable by the insurer within the 55-day statutory period as prescribed by [MCL 500.3220]. . . the insurer will be estopped to assert that ground for rescission thereafter.” *Kurylowicz* at 579, overruled by *Hyten, supra*. Thus, misrepresentations in the procurement of the policy (e.g., suspension of one’s operator’s license) would not prevent recovery against the insurer by third parties injured by the insured. *Id.*

2 This line of reasoning is consistent with past decisions rendered by the Court where it was sought to abrogate a common law doctrine by implication based upon the language of a statute. For example, see *People v Moreno*, 491 Mich 38; 814 NW2d 624, 627–28 (2012).

The common law remains in force unless it is modified. We must presume that the Legislature knows of the existence of the common law when it acts. Accordingly, this Court has explained that the abrogative effect of a statutory scheme is a question of legislative intent and that legislative amendment of the common law is not lightly presumed. While the Legislature has the authority to modify the common law, it must do so by speaking in no uncertain terms. Moreover, this Court has held that statutes in derogation of the common law must be strictly construed and shall not be extended by implication to abrogate established rules of common law. (Internal citations and quotations omitted; emphasis added).

Id. at 46. The No-Fault Act addresses circumstances after the potentially triggering event (i.e., injury arising from the ownership, maintenance or use of an automobile) but is virtually silent regarding issues that may arise at the time the contract is entered, such as fraud in the procurement of the policy that, like here, is not discovered until after the loss occurs.

3 MCL 500.3172(1)

A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may obtain personal protection insurance benefits through the assigned claims plan if no personal protection insurance is applicable to the injury, no personal protection insurance applicable to the injury can be identified, the personal protection insurance applicable to the injury cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss, or the only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed. In that case, unpaid benefits due or coming due may be collected under the assigned claims plan and the insurer to which the claim is assigned is entitled to reimbursement from the defaulting insurers to the extent of their financial responsibility.

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Six Ways to Improve Your LinkedIn Profile

SBM Clear & Convincing article by Roberta M. Gubbins

If you haven't visited LinkedIn in the last three months to review your profile, it's time for an update. LinkedIn is one of the most powerful social networking tools for lawyers. Consider that more than 93% of lawyers use LinkedIn (ABA 2016 Tech Report). Seventy-four percent of those on LinkedIn use it to research companies and people, and LinkedIn drives 64% of all social media visits to websites.

General counsel, in-house attorneys, and potential clients are frequent LinkedIn users. It is often the first place they look to learn about you. That means your profile must be current and accurately reflect you and your practice. Here are some suggestions.

- 1. Add a current photo.** particularly if your photo is four or five years old. Clients meeting you for the first time and people you meet at events should recognize you. Use a professional photo, a selfie won't work.
- 2. Write a great tagline.** At the top of the page under the banner, readers see your name and a tagline or headline. Make it brief and professional, but make readers want to click on your name.
- 3. Make your summary stand out.** The summary is the first thing readers see when they land on your page. The first 30 to 35 words are the most important. You have only three lines of copy to get readers to click on read more. Tell people who you are and what you do. Prospective clients want to know what it's like to work with you and

what drives you to practice law. Keeping your reader in mind, use phrases and terms they might use to find you.

- 4. Your experience and education.** Simply listing positions doesn't tell readers what you accomplished for your clients. Write about how your work affected others (within the bounds of the ethics rules.) Stuck for ideas on what to write? Review profiles of other professionals for ideas. Also, read your reviews to find opinions on your work.
- 5. Add new articles.** Add links to your blog posts and other published articles. There are multiple benefits to doing this; they add dimension to your profile and show your professional expertise. Include any speaking engagements and links to webinars or podcasts.
- 6. Community involvement.** Update the community events you've been involved with this year.

Your profile should bring your personality to the forefront. Whether you are formal or more casual, your profile should reflect that. Be genuine and whatever you choose to share will hit the mark. Now that you've updated your LinkedIn profile, stop by your SBM Member Directory profile to be sure it is also current. ■

Roberta Gubbins After years practicing law, Roberta Gubbins served as editor of the Ingham County Legal News. Since leaving the paper, she provides writing services to lawyers ghostwriting content for websites, blogs, and articles. She is editor of *The Mentor*, the SBM Master Lawyers Section newsletter.

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