The Journal of Insurance & Indemnity Law

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From the Chair

Jason J. Liss
Fabian, Sklar, King & Liss

Our (Remote) Annual Meeting
October 27, 2020
Via Zoom

When I began serving my term as Chairperson of the Insurance and Indemnity Law Section of the State Bar of Michigan last October, I could never have imagined how radically our world was about to change in just a few short months or that our next annual business meeting would, of necessity, be held remotely. **At the end of this month, on October 27th to be precise, we will be holding our annual business meeting and educational program via Zoom.** The business meeting will be abbreviated and primarily focused on the annual election of incoming officers and council members.

Officer and Council Member Elections

Incoming council members will be elected to fill the five council seats which have two-year terms expiring this year. A copy of the ballot is printed in this issue.

Unlike incoming council members, incoming officers serve one-year terms and their election is pro forma since the previous year's officers each move up the food chain one spot. Therefore, no spoiler-alert is necessary for my hearty congratulations to Nicole Wilinski, our current Chair-Elect, on becoming our section's new Chair or my congratulations to Lauretta Pominville and Rabih Hamawi on becoming our new Chair-Elect and Secretary, respectively. My final congratulations is to Patrick Crandell, who has graciously agreed to serve as our section's incoming treasurer. Patrick has been an active member of the Council, serving as the Council's legislative liaison, providing legislative updates to the Council at each of our quarterly meetings and to our section membership as a whole through his regular *Legislative Update* column in our Journal. As discussed below, Patrick will also be a presenter at this year's educational program.

Scholarship Award

Before moving onto a discussion of this year's educational program, which was organized and will be introduced by our incoming Chair, I would like to note that during our business meeting, we will be formally announcing the winner of and awarding this year's $5,000 annual scholarship. Perhaps the most satisfying moment of my tenure as Chair was notifying this year's recipient that she had submitted the winning essay and in addition to the scholarship, her essay would be published in the January 2021 edition of our Journal. Our scholarship winner wrote an excellent essay addressing the legal tension workers' compensation insurers face when navigating the conflict between state and federal law concerning the use of medical marijuana. So, be sure to look for the winning scholarship essay in the next edition of the Journal.

Educational Program
Construction Defect Claims after *Skanska*

This year's educational program, like our business meeting (and most everything else we attend as lawyers these days), will be via Zoom video conference on October 27, 2020 from 4:00 p.m. to 5:00 p.m. This year's educational program is titled "**When is faulty workmanship covered? Understanding coverage for construction defect claims after *Skanska USA Building Inc., v. M.A.P. Mechanical Contractors, Inc. and Amerisure Mut. Ins. Co.***" By way of background, on June 29, 2020, the Michigan Supreme Court reversed longstanding precedent and held that unintentionally faulty subcontractor work that damages an insured's work product constitutes an "occurrence" under a commercial general liability (CGL) policy.

The program will explore the impact the *Skanska* decision will have on insurers and contractors alike. **Patrick Crandell, of Collins Einhorn Farrell PC**, will discuss the historical treatment of insurance coverage for construction defect cases, including the prerequisite of an "occurrence" to trigger coverage as well as the potential business risk exclusions that preclude coverage, even if an "occurrence" is established. **Edward Bouchard, of Kotz Sangster**, who represented the insured in *Skanska* before the Michigan Supreme Court, will walk attendees through the decision itself. Both speakers will provide their thoughts on what this decision will mean for insurers and contractors moving forward and will be available for a virtual question and answer session immediately following the presentation.

I will wrap up my last *From the Chair* column by thanking my fellow officers, council members and our membership as a whole for the privilege of serving as your Chairperson. I look forward to Nicole's leadership and, like my predecessor Gus Igwe, I plan to remain active on the council for the next year in my position as Immediate Past Chair.

Finally, as we all know, insurance is about managing risk. So, as always, be safe and stay healthy as we wind our way through the current pandemic to a brighter future. ■

Editor's Notes

A Special Note of Appreciation

By Hal O. Carroll
www.HalOCarrollEsq.com

Producing each issue of the *Journal* requires the cooperation of many persons, and we always appreciate the efforts of the many contributors – authors at the input end and our printer at the output end.

But it is especially appropriate to acknowledge the efforts of the many contributors now, with the disruption caused by the Covid19 virus. In spite of that disruption, the authors and commentators sent in their contributions, including even one that specifically address the effect of the virus on coverage. And our printer has arranged to send the issue out electronically.

Thanks to everyone!

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*. ■

Annual Meeting and Program

3:30 pm, October 27, 2020
Via Zoom

When is faulty workmanship covered?
Coverage for construction defect claims after *Skanska*.

The State Bar of Michigan Insurance & Indemnity Section will host its Annual Meeting and Educational Program on Tuesday, October 27, 2020 from 3:30- 5:30 p.m. via ZOOM. The business meeting will take place from 3:30-4:00 p.m. The educational program will begin at 4:00 p.m.

On June 29, 2020, the Michigan Supreme Court reversed longstanding precedent and held that unintentionally faulty subcontractor work that damages an insured's work product constitutes an "occurrence" under a commercial general liability policy. This year's educational program, "**When is faulty workmanship covered? Understanding coverage for construction defect claims after *Skanska USA Building Inc., v. M.A.P. Mechanical Contractors, Inc. and Amerisure Mut. Ins. Co.,***" will explore the impact that the *Skanska* decision will have on insurers and contractors alike.

Patrick Crandell, of Collins Einhorn Farrell PC, will discuss the historical treatment of insurance coverage for construction defect cases. He will address the policy requirement that damage be caused by an "occurrence" as well as the business risk exclusions that may apply to take away coverage if an "occurrence" is established.

Edward Bouchard, of Kotz Sangster, who represented Skanska before the Michigan Supreme Court, will walk attendees through the Skanska case and explain how the recent decision will impact insurance coverage for Skanska and other Michigan contractors.

Both speakers will provider their thoughts on what this decision will mean for insurers and contractors moving forward and will be available for a virtual question and answer session immediately following the presentation. ■

State Bar of Michigan Insurance and Indemnity Law Section Ballot for Election of Officer and Council Members

October 27, 2020

Officers

Officers are elected to one-year terms.

The candidates are:

Chairperson	Nicole Wilinski, Collins Einhorn, Farrell PC
Chairperson Elect	Lauretta Pominville, McNish Group
Secretary	Rabih Hamawi, Law Office of Rabih Hamawi, PC
Treasurer	Patrick D. Crandall, Collins Einhorn

Council Members

Vote For Not More Than Five

Council members are elected to two-year terms.

There are five vacancies, for terms that end in 2022.

The candidates are:

Douglas McCray*
Nina M. Jankowski*
Gail L. Storck*
Emily M. Mayer
Renee VanderHagen

* Indicates incumbent


Insurance and the GIG Economy:

The Repercussions of the Narrow Definitions Contained within the Limousine, Taxicab, and Transportation Network Company Act

By Michael J. Olcese, II and James McCoy, *Novaria, Tesija & Catenacci*

Introduction

In our modern society, the near-constant, rapid development of new technologies spurs new industries. Too often, the law has struggled to maintain pace with our technological advancements, sometimes even after these advancements have been widely-adopted by society. Our failure to timely craft legislation that satisfactorily addresses these new technologies can not only hamper the economic expansion of these new industries, but may also lead to unnecessary litigation. An example of our inability to timely address new technologies is evidenced by the regulation of "transportation network companies" and their progeny in the State of Michigan.

In the early 2010s, Uber, Lyft, and similar transportation network companies roared to life, offering the public a new method to obtain transportation services, such as peer-to-peer ridesharing services, via mobile applications accessed from an individual's smart phone. The Michigan No-Fault Act was silent as to the regulation of "transportation network companies" until it was amended by Public Act 347 of 2016, with an effective date of March 21, 2017. [1] Public Act 347 of 2016 also created the Limousine, Taxicab, and Transportation Company Act. [2] These regulations were not drafted until years after the transportation network companies had gained popularity and wide-use in Michigan, and after years of confusion and uncertainty regarding the obligations of these companies and their insurers, under the No-Fault Act. This lack of clarity resulted in injured drivers and passengers having their claims denied while costly and needless litigation wound its way through Michigan's court system.

However, the current definition of a "transportation network company" under the Michigan No-Fault Act and the Limousine, Taxicab, and Transportation Network Company Act is limited to those involved in the business of transporting riders or passengers through a prearranged ride.

Advancements In Technology Spur New Industries and New Business Models

Particularly popular and profitable advancements in technology tend to act as building blocks for further advancements. For instance, additional companies have piggybacked off the technology pioneered by transportation network companies to carve out their own place in our economy. But instead of transporting passengers, companies such as GrubHub, InstaCart, UberEats, and DoorDash provide novel food and grocery delivery services. These food and grocery delivery services had already been growing in popularity over the last several years, but they are being utilized now more than ever as we all adjust to life during the COVID-19 pandemic. [3]

The swift development of these technologies has helped drive new ways of doing business. Passenger transportation and food delivery services are part of what is now loosely being referred to as the "gig economy." In general, transportation network companies and similar gig economy entities provide individuals an opportunity to connect with consumers, via an online-enabled application, website, or similar system, to provide the individual an opportunity to provide consumers with certain services, like transportation or food delivery. Although the services offered by such entities seem similar, whether such a service is regulated depends entirely on whether a passenger is being transported.

Michigan's regulations of "transportation network companies" do not address entities such as GrubHub, UberEats, and DoorDash which are therefore not required to provide PIP coverage.

Despite relying almost exclusively on automobiles to provide their services, "gig economy" food and grocery delivery entities like UberEats, GrubHub, InstaCart, and DoorDash are not regulated by the Michigan No-Fault Act or the Limousine, Taxicab, and Transportation Network Company Act. These Acts only regulate the transportation of **passengers** via a digital network—not the transportation of food or other tangible property. Consequentially, such entities are not mandated to provide personal protection insurance ("PIP") coverage for their drivers.

In Michigan, drivers are statutorily required to obtain auto insurance coverage to comply with the Michigan No-Fault Act.[4] Further, the Limousine, Taxicab, and Transportation Network Company Act requires transportation network companies to maintain primary PIP coverage for a transportation network company driver while he/she is logged onto the transportation network company's digital network.[5] However, the current definition of a "transportation network company[6]" under the Michigan No-Fault Act and the Limousine, Taxicab, and Transportation Network Company Act is limited to those[7] involved in the business of *transporting riders or passengers*[8] through a prearranged ride. [9] Consequently, such regulations are not applicable to those companies who are only transporting food, tangible goods, and/or other forms of property.

The current statutory scheme of the Michigan No-Fault Act and the Limousine, Taxicab, and Transportation Network Company Act does not mandate entities such as GrubHub, UberEats, and DoorDash to provide PIP coverage.

When interpreting statutes, "our obligation is to discern and give effect to the Legislature's intent as expressed in the statutory language."[10] "If the language is unambiguous, 'we presume that the Legislature intended the meaning clearly expressed—no further judicial construction is required or permitted, and the statute must be enforced as written."[11] "Statutes sharing subject matter or a common purpose are *in pari material* and must be read together as a whole."[12] Moreover, Michigan courts must "assume every word has some meaning and, as far as possible, give effect to every sentence, phrase, clause, and word, avoiding construction that would render any part of the statute surplusage or nugatory."[13]

By their plain language, neither the No-Fault Act nor the Limousine, Taxicab, and Transportation Network Company Act requires "gig economy" entities to provide PIP coverage if the gig economy driver is transporting food and/or tangible property. Courts are prohibited[14] from determining whether the Legislature intended for the Limousine, Taxicab, and Transportation Network Company Act and Michigan No-Fault Act to include mandated PIP coverage for all "gig economy" drivers, including food and grocery delivery drivers, as the plain language is abundantly clear that the typical mandated PIP coverage is only required to those who are in the business of transporting passengers through a prearranged ride. [15]

Employee or independent contractor? The economic reality test would be utilized for gig economy food/property delivery drivers.

Under the Limousine, Taxicab, and Transportation Network Company Act, a transportation network company driver is deemed to be an independent contractor, and not an employee, if five conditions are met.[16] However, for the reasons described above, MCL 257.2137 would be inapplicable to gig economy drivers who are connected to an entity's digital network for the purpose of transporting food and/or tangible property.

Generally, in determining whether an individual is an employee or an independent contractor, Michigan applies the economic realities test.[17] The crux of the economic realities test focuses on the work performed, with an emphasis on: "(1) control of a worker's duties, (2) payment of wages, (3) right to hire, fire and discipline, and (4) performance of the duties as an integral part of the employer's business towards the accomplishment of a common goal."[18] The list of factors is nonexclusive, and no one single factor is dispositive in determining whether one is an employee or an independent contractor.[19] An agreement between the parties stating that their relationship is that of an independent contract is not determinative, but is just one factor to be considered.[20]

For those drivers who are connected to a digital network for the purpose of delivering food and/or tangible property, the economic realities test would be applicable for determining whether one is an employee or an independent contractor. Of course, the analysis would not be quite so simple if the driver were transporting both passengers and property throughout the week. Although this would be an issue of first impression in the State of Michigan, it should be noted a California court recently ordered Uber and Lyft to reclassify its drivers as employees.[21] Similar to the underlying PIP insurance coverage issue, this inconsistency could result in needless litigation between the gig economy entities and drivers.

Tips for insurance agents

Generally, insurance agents owe a duty to procure the insurance coverage requested by the insured.[22] However, "under the common law, an insurance agent whose principal is the insurance company owes no duty to advise a potential insured above any coverage."[23] An exception to the "no duty" rule is when a "special relationship" arises between the agent and the insured.[24] A "special relationship" may arise in the following situations:

> (l) the agent misrepresents the nature or extent of the coverage offered or provided; (2) an ambiguous request is made that requires clarification; (3) an inquiry is made that may require advice and the agent, though he need not, gives advices that is inaccurate, or (4) the agent assumes an additional duty by either express agreement with or promise to the insured.[25]

If an insured requests "full" automobile insurance coverage, such a request could be deemed ambiguous under the circumstances and ultimately create a special relationship between the insured and the agent.[26] Consequently, in such a situation, an insurance agent should clarify how the vehicle is

being utilized. If the insured advises the motor vehicle may be used for the purpose of transporting passengers or property, it is important that the insured be advised of additional coverage that may be purchased.

Key inquiries for the claim management process

As more individuals are utilizing the services of our "gig economy," the initial claims handling process is more important than ever. It is critical that the claims adjuster investigate underlying facts of the motor vehicle accident to determine whether a claimant should be afforded PIP coverage for an alleged injury.

In the first initial contact with a claimant, it is now more important than ever for a claims adjuster to determine the purpose of the motor vehicle that was being utilized at the time of the accident. If a claimant mentions that he or she was working as an Uber and/or Lyft driver at the time of the accident, it is important for the claims adjuster to advise the claimant also submit a claim to with the appropriate insurance carrier, as the Limousine, Taxicab, and Network Transportation Company Act mandates the transportation network company to maintain *primary* automobile insurance coverage.[27] Additional review of the claimant's underlying personal insurance policy would be needed to determine if coverage is to be afforded for such a claim as such coverage could be excluded under a "Commercial Exclusion" or "Ride-Sharing Exclusion."

A proper investigation of these issues may allow adjusters to quickly identify critical information that determines whether coverage is to be afforded under the applicable policy. This will further the adjuster to further assist the claimant in making a claim with the proper insurance carrier.

Conclusion: Our laws must continue to adapt as our society exponentially advances

As demonstrated above, the current statutory language of the Limousine, Taxi, and Transportation Network Company Act limits its application to those utilizing a company's digital network for the purpose of transporting a passenger. Consequentially, gig economy companies that afford drivers an opportunity to connect for their digital network for the purpose of transporting food/property are not required to provide PIP coverage for its drivers. Moreover, gig economy drivers that are connected to a company's digital network for the purpose of transporting food/property are not statutorily deemed to be an independent contractor. Although this may not be what our Legislature intended, the Michigan case law mandates that the limited definitions must be applied as written.

The narrow definitions of a "transportation network company" and "transportation network company driver" will likely result in additional litigation, especially from those seeking PIP benefits under the Michigan No-Fault Act. Gig economy drivers injured while transporting food and/or tangible property will likely not be entitled to PIP coverage unless the driver: (a) previously updated his/her personal auto policy, or (b) the gig entity's insurance carrier voluntarily decided to provide PIP coverage that it is currently not required to provide. However, this additional litigation expense for PIP benefits would not be necessary if our new regulations are drafted with a sufficient understanding of how this new technology operates and plans to function in the future.

As new technologies advance, we must ensure that our laws are written with the proper understanding of how these new technologies will be utilized in the present, along with a reasonable anticipation of how these new technologies will be built upon and utilized in the near future. Failure to do so, could result in the inadequate regulations and protections for Michiganders, such as those currently present in our "gig economy." ■

About the Authors

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Endnotes

1 See MCL 500.3114

2 MCL 257.2101, et seq.

3 Civicscience, *Food Delivery Users Express Reluctance To Eat At Restaurants Again* <*https://civicscience.com/food-delivery-users-express-reluctance-to-eat-at-restaurants-again/*> (accessed September 13, 2020)

4 MCL 500.3101, et seq.

5 MCL 257.2123.

6 A "transportation network company" is defined as:

> [A] person operating in this state that uses a digital network to **connect transportation network company riders to transportation network** company drivers who provide transportation network company prearranged rides. Transportation network company does not include a taxi service, transportation service arranged through a transportation broker, ridesharing arrangements, or transportation services using fixed routes at regular intervals'

MCL 257.2102(l) (emphasis added).

7 A "transportation network company driver" is an individual who

(1) "receives connections to **potential passengers** and related services from a transportation network company in exchange for payment of a fee to the transportation network company;" and (2) "uses a personal vehicle to offer or provide transportation network company prearranged rides to **transportation network company riders** upon connection to through a digital network controlled by a transportation network company in return for compensation or payment of a fee." MCL 257.2102(n)(i), (ii) (emphasis added).

8 A "transportation network company rider" is defined as "an individual who uses a transportation network company's digital network to connect with a transportation company driver who provides a transportation network company prearranged ride to the transportation network company **rider** in the transportation network company driver's personal vehicle **between points chosen** by the transportation network company rider." MCL 257.2102(p) (emphasis added).

9 A "transportation network company prearranged ride" is defined as

> [T]he provision of transportation by a transportation network company driver to a transportation company rider, beginning when a transportation network company driver accepts a ride requested by a transportation network company rider through a digital network controlled by a transportation network company, continuing while the transportation network company driver **transports** the requesting **transportation network company rider**, and ending when the last requesting **transportation network company rider departs from the personal vehicle**. Transportation network company prearranged ride does not include a shared-expense carpooling or vanpooling arrangement or transportation provided using a taxicab, limousine, or other vehicle.

MCL 257.2102(o) (emphasis added).

10 *Gladych v New Family Homes, Inc*, 468 Mich 594, 597; 664 NW2d 705 (2003).

11 *Id.*, quoting *DiBenedetto v West Shore Hosp*, 461 Mich 394, 402; 605 NW2d 300 (2000) (emphasis added).

12 *Prime Time Int'l Distrib, Inc v Dep't of Treasury*, 322 Mich App 46, 51; 910 NW2d 683 (2017) (quotation marks and internal citations omitted).

13 *Pohutski v Allen Park*, 465 Mich 675 (2002).

14 *See DiBenedetto*, 461 Mich at 402 ("We begin by examining the plain language of the statute. Where that language is unambiguous, we presume that the Legislature intended the meaning clearly expressed—**no further judicial construction is required or permitted**, and the statute must be enforced as written.") (Emphasis added).

15 In the Oakland County Circuit Court case of *Algahim v James River Insurance Company, et al*, Case No. 2019-176920-NI, the court the held the plaintiff, a gig economy driver who was logged into UberEat's digital network at the time of the accident, was not entitled to PIP benefits from James River Insurance Company, UberEat's insurance carrier, as the underlying policy did not provide PIP coverage because UberEat's had no obligation to provide such coverage under the Limousine, Taxicab, and Network Transportation Company Act and Michigan No-Fault Act.

16 A "transportation network company driver" is deemed an independent contractor, and not an employee, of a "transportation network company" if all the following conditions are met:

(a) The transportation network company does not prescribe the specific hours during which the transportation network company driver is required to be logged in to the transportation network company's digital network[;]

(b) The transportation network company does not impose any restrictions on the network company's driver's ability to use other transportation network companies' digital networks[;]

(c) The transportation network company does not assign a transportation network company driver a particular territory within this state in which he or she may provide transportation network company prearranged rides[;]

(d) The transportation network company does not restrict a transportation network company drier from engaging in other occupation or business[; and]

(e) The transportation network company and the transportation network company driver agree in writing that the transportation network company driver is an independent contractor.

MCL 257.2137.

17 *Buckley v Professional Plaza Clinic Corp*, 281 Mich App 224, 234 (2008).

18 *Mantei v Mich Pub Sch Employees Retirement Sys*, 256 Mich App 64, 78-79 (2003).

19 *Buckley*, 281 Mich App at 235.

20 *Id.* at 234.

21 CNN, *Court Orders Uber, Lyft To Reclassify Drivers As Employees In California*, <https://www.cnn.com/2020/08/10/tech/uber-lyft-california-preliminary-injunction/index.html> (accessed on September 13, 2020).

22 *Hart v Farmers Ins Exchange,* 461 Mich 1, 8 (1999).

23 *Id.; See also Zarembra Equip Inc v Harco Nat Ins Co*, 302 Mich App 7, 18 (2013).

24 *Hart*, 461 Mich at 9-10.

25 *Id* at 10-11.

26 *Id* at 10 n 11.

27 MCL 257.2123(1), (5). Again, if a driver is connected to the digital network for the purposes of transporting food/property and not a passenger, such provision would be inapplicable.


No One Knows What "Physical Loss" Means:

All-Risk Insurance and the Coronavirus

By Chris Kozak, *Plews Shadley Racher & Braun LLP* and
D. Andrew Portinga, *Miller Johnson*

As the Covid-19 pandemic exploded, the key role of insurance quickly became apparent to both policyholders and insurers. This is particularly true for smaller businesses with less ready access to larger banks responsible for distributing money from the Paycheck Protection Program. But two words stand at the gateway between businesses and their insurance: "Physical Loss."

At least in Michigan, the conventional wisdom is that the words "physical loss" do not cover the havoc caused by the virus, on the theory that a virus does not result in tangible damage to property.[1] Recent orders out of the Ingham County Circuit Court[2] (on appeal) and the Eastern District of Michigan[3] (likely to be appealed), follow that view. This article asks whether these decisions are correct—in other words, whether a reasonable, coverage-preserving argument exists for reading the words "physical loss" to cover Michigan businesses' inability to use their property during the pandemic. If that is true, then these terms in an all-risk insurance policy are ambiguous and must be construed in favor of the policyholder.[4]

We do not here address the exclusions that appear in all-risk policies and that may negate coverage even if virus-based destruction is a "physical loss."[5] Those complex analyses are best left to individual cases. Our claim is, instead, that the term "physical loss" is not precise enough to bear the single meaning that insurers assign to it, and that properly worded exclusions are the proper place for insurers to eliminate the risk of pandemic-induced shutdowns.

All-risk policies and "physical loss" generally

"All risk" policies provide a species of coverage "not ordinarily present in other types of insurance, and recovery is allowed for fortuitous losses unless the loss is excluded by a specific policy provision."[6] Insurers have traditionally expressed that broad coverage by promising to pay for "direct physical loss or damage to property caused by or resulting from any Covered Cause of Loss," or some variant of that language.[7] "Covered Cause of Loss" is often defined circularly as "risks of direct physical loss or damage."[8] The Sixth Circuit recently observed that "one would struggle to think of damage not covered by this language."[9]

This breadth is intentional. It is designed to express the unique, universal property coverage provided by all-risk insurance, while protecting insurers from paying for purely sentimental, metaphorical, or intangible losses. For example, one court rejected a claim of "physical loss" by the owner of a golf course seeking coverage for changes to the "character" of a hole, finding that those losses were not "physical" in any sense.[10]

The elusive meaning of "physical loss"

Lawyers may be comforted in the knowledge that the basic dispute is not a new one. One classic case (*Hughes*) was decided in 1962 when rapid erosion swept the earth from underneath a house and left it "standing on the edge of and partially overhanging a newly formed 30-foot cliff."[11] The insurer denied coverage because the house itself was undamaged and there accordingly was no "physical loss or damage."[12] The California Court of Appeals disagreed, finding the policyholder's interpretation reasonable and holding that:

> To accept [the insurer's] interpretation of its policy would be to conclude that a building which has been overturned or which has been placed in such a position as to overhang a steep cliff has not been 'damaged' so long as its paint remains intact and its walls still adhere to one another. Despite the fact that [property] might be rendered completely useless to its owners, [the insurer] would deny that any loss or damage had occurred unless some tangible injury to the physical structure itself could be detected. Common sense requires that a policy should not be so interpreted in the absence of a provision specifically limiting coverage in this manner.[13]

In subsequent years, other state high courts rejected similar arguments by insurers in cases where a policyholder was ordered to vacate a church because of gasoline in nearby soil (*First Presbyterian*)[14] or where unstable rocks perched at the top of a hill prompted a government evacuation order (*Murray*).[15] Many other published cases, too numerous to discuss here, have held that the words "physical loss" are broad enough to encompass situations where the policyholder loses the use of a physical asset.[16]

There are certainly cases to the contrary. Two unpublished cases applying Michigan law take the alternate view, one from our court of appeals and one from the Sixth Circuit.[17] The

Michigan case has been criticized as "not particularly helpful" due to the lack of analysis.[18] The Sixth Circuit's unpublished opinion reasoned that mold in a structure did not cause a "direct physical loss" because "not a single piece of [the policyholder]'s physical property was lost or damaged as a result of mold or bacterial contamination."[19] Even under the "tangible damage" rubric, that reasoning is shaky; mold is a physical substance that, when present on property, causes appreciable damage. In any event, the court decided the case on alternative, factual grounds because the claim failed even if the policyholder's argument was correct. It did not purport to engage in a full-blown prediction of what the Michigan Supreme Court would do.[20]

The recent *Turek* case follows *Universal Image* while acknowledging that the issue was still unsettled.[21] Judge Ludington agreed that the "loss of use" argument "seems consistent with one definition of loss," but nevertheless held that the policy was unambiguous because it said "direct physical loss to covered property" rather than "direct physical loss of covered property."[22] He also distinguished other Covid-19 cases finding coverage by observing that those policies involved promises to insure against "physical loss *or* . . . physical damage," because the rule against surplusage would render the term "loss" meaningless.[23]

In *Gavrilides*, Judge Drananchuk of the Ingham County Circuit Court reached a similar conclusion. She ruled that "direct physical loss of or damage to the property has to be something with material existence, something that is tangible . . . something . . . that alters the physical integrity of the property." Judge Draganchuk noted that the complaint did not allege that the virus was actually present on the covered property. She also noted that the policy at issue contained a virus exclusion, which she ruled would apply. It is not clear how the court would have applied the policy if the virus had been present on the covered property, or if the policy has not contained a virus exclusion.

"Physical Loss" does not require tangible damage

As *Turek* acknowledged, losing the use of a physical asset is "consistent with one definition of loss."[24] Losing the use of a physical asset is the only thing required to preserve coverage in a typical property insurance policy, particularly in all-risk policies, the broadest of all insurance products. It is only through a cramped view of the modifiers (such as "physical" or "to") that coverage is destroyed. That view of all-risk insurance is unwarranted. "Common sense requires that a policy should not be so interpreted in the absence of a provision specifically limiting coverage in this manner."[25]

The loss caused by the virus is undeniably "physical." No one will soon forget how Americans were barred from non-essential *physical* spaces because of how dangerously transmissible the virus was. That is a physical, tangible "loss." Dissatisfaction with the now-ubiquitous Zoom lifestyle demonstrate that this is not a metaphorical or intangible concern. Something is irretrievably lost when you must give a lecture over Zoom, have a coffee date over Zoom, or attend church over Zoom.

Despite the easy availability of digital "presence," people have fought tooth and nail to get back into classrooms, coffee shops, and churches—sometimes even to the U.S. Supreme Court. Wise or foolish, these efforts reflect the conviction that there is something important about being physically present in a space, designed for its purpose. The person who owns the space—typically the one seeking coverage—suffers this loss in an equal measure. When a pandemic bars access to that physical space for a time, it has foisted a real, tangible, "physical loss" on the policyholder.

Requiring the virus to be present on the property commits a similar error because it answers the wrong question. Coverage exists not because the virus molecules cause *"damage"* to the floor and walls in the way water or smoke would. It causes a "loss" because the risk of transmitting a deadly virus was so intolerable that humans could not be allowed to occupy the physical space together. Governor Whitmer did not close only businesses with the virus present. She shut all policyholders out of their property because of the very real risk that patrons might spread the virus while present in the establishment. That is the loss at issue, not any "damage" caused by the virus molecules themselves.

Neither does the distinction between "of" and "to" really make a difference. *Hughes*, *First Presbyterian*, and *Murray*—the leading cases rejecting insurers' arguments—each involved the word "to," and each refused to draw the distinction the insurers make.[26] If a person cannot use his property to serve food (mortal or spiritual) to others, then the policyholder can fairly say that it has suffered a "physical loss to" that property. As the *Hughes* court said, the property is "rendered completely useless" even though "its paint remains intact and its walls still adhere to one another."[27] Or, as in the case of the rocks threatening to fall on a house:

> The properties insured by Allstate and State Farm in this case were homes, buildings normally thought of as a safe place in which to dwell or live. . . . [A] ll three of the plaintiffs' homes became unsafe for habitation, and therefore suffered real damage when it became clear that rocks and boulders could come crashing down at any time. The record suggests that until the highwall . . . is stabilized, the plaintiffs' houses could scarcely be considered "homes" in the sense that rational persons would be content to reside there.[28]

That is no different from0 a case where the property is damaged by fire, wind, or other events traditionally covered by

property and casualty insurance. That severe deprivation falls comfortably within an all-risk policy, regardless of whether it says "loss of" or "loss to."

Conclusion

This ultimately returns to the point that these are general all-risk policies intended to insure against all fortuitous losses not specifically excluded. Courts should not allow insurers to shoehorn a new limitation into the vague (and often circular) definitions of "Covered Cause of Loss" and the broad coverage grant for "physical loss or damage." As is traditional for all-risk coverage, this issue should be litigated in the exclusions, not in the coverage grant. ■

About the Authors

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Endnotes

1 Rabih Hamawi, *Coronavirus (Covid-19) and Business Income Insurance: Can Businesses that are Forced to Close or Limit their Operations Recover their Income Losses?*, 13 Mich. J. Ins. & Indem. L. 1, 3 (Apr. 2020).

2 *Gavrilides Mgmt Co v. Mich Ins Co,* Case No 20-000258 (Ingham Cnty Cir Ct, 2020) (ruling from the bench), *video available at https://youtu.be/Dsy4pA5NoPw*.

3 *Turek Enters., Inc. v. State Farm Mut. Auto. Ins. Co.*, No. 1:20-cv-11655-TLL-PTM, Dkt. 23 (Sept. 3, 2020).

4 *Fragner v Am Cmty Mut Ins Co,* 199 Mich App 537, 540 (1993).

5 *O.L. Matthews, M.D., P.C. v Harleysville Ins Co*, No. 19-1994, Slip op. at 6 (6th Cir, Sept 9, 2020) (observing that under Michigan law, an "all risk" policy is tempered only by its limitations and exclusions).

6 10A Steven Plitt, et al., Couch on Insurance §148:50 (3d ed. 2019).

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8 *Id.*

9 *Id.* at 821.

10 *Crestview Country Club, Inc v St Paul Guardian Ins Co*, 321 F Supp 2d 260 (D Mass 2004).

11 *Hughes v Potomac Ins Co*, 18 Cal Rptr 650, 651 (Cal Ct App 1962).

12 *Id.* at 652.

13 *Id.* at 655.

14 *W Fire Ins Co v First Presbyterian Church*, 437 P2d 52, 55 (Colo 1968)

15 *Murray v State Farm Fire & Cas Co*, 509 SE2d 1, 4-5, 16-17 (W Va 1998).

16 *Port Auth of NY & NJ v. Affiliated FM Ins Co*, 311 F3d 226, 236 (3d Cir 2002); *Bd of Educ of Township High School Dist No 211 v Int'l Ins Co*, 720 NE2d 622, 601-02 (Ill Ct App 1999); *Mellin v N Sec Ins Co*, 115 A3d 799 (NH 2015); *Farmers Ins Co of Or v Trutanich*, 858 P2d 1332, 1335-36 (Or Ct App 1993); *Hampton Foods, Inc v. Aetna Cas & Sur Co*, 787 F2d 349, 352 (8th Cir 1986); *Wakefern Food Corp v. Liberty Mut Fire Ins Co* 1, 968 A2d 724 (NJ Ct App 2009); *TRAVCO v Ward*, 715 F Supp 2d 699, 701 (ED Va 2010).

17 *Acorn Investment Co v Mich Basic Prop Ins Ass'n*, No. 284234, 2009 WL 2952677 (Mich Ct App, Sept 15, 2009); *Universal Image Productions, Inc v Fed Ins Co*, 475 F App'x 569 (6th Cir 2012).

18 *Tooling Mfg & Techs Ass'n v Hartford Fire Ins Co*, 693 F3d 665, 676 (6th Cir 2012)

19 *Universal Image*, 475 F App'x at 573.

20 *Id.* at 574.

21 *Turek*, slip op. at 10.

22 *Id.* at 11-12.

23 *Id.* at 13-14. This analysis is suspect. If "physical loss" includes "loss of use" when the policy insures against "physical loss or damage," then it is unclear why the same words would mean something more restrictive in a pure "physical loss" policy, surplusage issues aside. The operative term, which provides coverage under both policies, is identical.

24 *Id.* at 11-12.

25 *Hughes*, 18 Cal Rptr at 651.

26 *Hughes*, 18 Cal Rptr at 651; *Murray*, 509 SE2d at 16; *First Presbyterian*, 437 P2d at 56.

27 *Id.*

28 *Murray,* 509 SE2d at 4-5, 16-17.

To Defend or Not to Defend: That is the Question

By Henry S. Emrich, *Secrest Wardle*

Failing to defend or otherwise participate in the defense of an insured where coverage is declined, while something coverage counsel usually cautions against doing, is not uncommon among insurers. However, the recent unpublished decision in the case of *Hamilton Specialty Ins Co v Transition Investment LLC*, 2020 WL 3397743 (CA 6, 2020), is an example of why such a course of action should very rarely be pursued. In the case of most insurance claims, an initial review is performed when the claim is received. Where coverage is established, the claim then moves to adjustment. In those cases where coverage is limited to certain claims only, a reservation of rights is issued detailing the basis for the coverage limitation, the covered claims are either adjusted or defended under the reservation, and a declaratory judgment action pursued independently. However, there are cases in which a coverage review results in a determination that no coverage exists. The claim is then denied because of the lack of coverage, the file closed, and any defense of the insured refused if and when litigation against the insured is pursued, which is what happened in the *Hamilton* case.

In *Hamilton, supra,* a faulty stove caused a fire to occur at a rental property rented by Transition, the policyholder, to a tenant. This fire resulted in the death of three people and serious injury to a fourth person. The allegations of the complaint alleged that Transition had failed to provide habitable premises and neglected to maintain the stove on the property. When notified by Transition of litigation over the loss by the estates of the decedents and the injured party, Hamilton declined to defend or otherwise participate in any of the litigated matters and did not pursue a declaratory action, which forced Transition to defend the cases on its own.

Eventually resolving all of the claims, Transition entered into a consent judgment in the amount of $3 million which was approved by the state court as being fair and reasonable. Plaintiffs then filed a writ of garnishment against Hamilton's insurance policy with Transition. Hamilton responded by pursuing a declaratory judgment action in the U.S. District Court – Eastern District of Michigan, claiming that the policy excluded coverage for several reasons. Even if coverage existed, Hamilton alleged that because Transition had assumed liability by entering into a consent judgment without obtaining Hamilton's permission in violation of language in the policy that excluded coverage where an assumption of liability in a contract or agreement occurred, coverage should be voided. The District Court granted summary disposition against Hamilton in the declaratory action because the court determined that Hamilton breached their duty to defend Transition, which it deemed "outrageous," stating that Hamilton could have defended Transition without giving up its rights. The District Court then ordered Hamilton to pay the amount of the consent judgment and all of the legal expenses incurred by Transition in defending the matters.

On appeal, the Sixth Circuit upheld the District Court's decision, indicating that where coverage is "possible" or "arguable," even when the allegations are groundless, false, or fraudulent, the insurance company must defend. And if the insurer does not provide a defense, the insurer becomes liable for the costs of defense and any reasonable, good faith settlement paid by the insured. The court in Hamilton based its decision on the fact that Hamilton breached its duty to defend Transition under a Reservation of Rights and left it to fend for itself. The Sixth Circuit also pointed to the insurance company's decision to deny the claim based on the allegations of the complaint, only without developing any "sure fire evidence" that the policy barred coverage.

Finally, the court declined to allow Hamilton to avoid liability for the settlement agreed upon to by Transition based on the policy language barring liability for same without Hamilton's approval because Hamilton had already breached its agreement with Transition by declining coverage and not defending, and therefore, could not be held responsible for Transition's breach. Thus, in addition to defending questionable liability claims, Hamilton was even prevented from arguing whether the underlying settlement was reasonable or not. In other words, a defense of questionable liability claims with counsel of the insurer's choosing was prevented because of the carrier's decision to not provide a defense.

Conclusion

The lesson to be learned here is that when coverage is reviewed, an adequate investigation of the facts must be conducted of any possible or arguable coverage under the policy. If none exists, denial correspondence which clearly articulates the bases for the denial of coverage and the facts that support each basis for denial must be sent to the insured. A declaratory judgment action against the insured should then be pursued

shortly after the denial, and in any case, no later than at the time any claim is pursued or formally litigated by a claimant. At the same time, the insurer should participate in any pre-suit attempts at resolution or provide a defense to the insured with independent counsel pursuant to a Reservation of Rights that reiterates the reason coverage has been denied. Finally, every legitimate effort should be pursued to challenge the damages being sought at every stage of the litigation. By doing so, the insurer has at least some control over the outcome in the liability case while preserving its right to avoid payment if it successfully establishes its coverage defenses, which they were prevented from doing in *Hamilton, supra*. ■

About the Author

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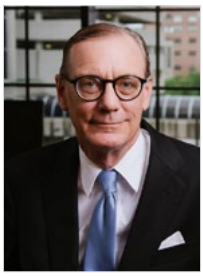

Spectrum Health: Court of Appeals Applies First Principles in Landmark No-Fault Decision

By Jack L. Hoffman, *Kuiper Kraemer PC*

Just before Labor Day weekend Court of Appeals Judge Jane Markey authored a published decision interpreting Michigan's No-Fault Act. In the opinion, Judge Markey applies the too often ignored principles that the court must give the language of the statute its plain meaning, and also calls out obiter dicta for what it is and refusing to allow obiter dicta to divert her from the authority of the text itself.

The case is *Spectrum Health Hospitals v Farm Bureau Mutual Ins Co of Mich, et al*, _____ Mich App _____ (2020) (Docket no. 354201, decided July 15, 2020)

The issue involved what evidence is relevant to whether a health care provider's gross charge was in excess of a reasonable charge within the meanings of sections 3107(1) (a) and 3157 of the no-fault act. Although the case arises under 1972 PA 294, it retains its importance for the interpretation of 2019 PA 21 for two reasons.

First and most simply, the identical language interpreted in the opinion remains in the new statute as the default and umbrella condition.

Second and on a deeper level, the opinion points the way to the future application of the reform statute.

Farm Bureau argued that health care finance data in the public domain and in common use in the industry relative to what the provider is actually paid in the health services market for the same treatment, and the cost to the provider of providing the treatment, were relevant to the issue of the reasonableness of gross charge. Spectrum denied that the data was relevant, citing *Mercy Mt Clemens Corp v Auto Club Ins Ass'n*, 219 Mich App 46, 54-55; 555 NW2d 871 (1996):

> The recognition and calling out of obiter dicta is a big deal. At the end of the day, Spectrum's argument in support of the evidentiary ruling of the trial court was that obiter dicta from the Court of Appeals are superior in authority to the text of the statute.

Defendant sought to obtain information regarding payments accepted by plaintiffs from third-party payers such as Medicare, Medicaid, worker's compensation, Blue Cross, HMOs, and PPOs in order to prove that plaintiffs' customary charges for medical services were in fact significantly lower than the amounts they charged defendant. Reimbursement from Medicare, Medicaid, and worker's compensation insurance is set by statutory and regulatory limitations. Reimbursement from Blue Cross, HMOs, and PPOs is set by contracts between those entities and health-care providers. Under Munson, Hofmann, Hicks, and Johnson, such information is not admissible to prove the customary charge that defendant must pay under § 3157. As stated in Hofmann, supra, p 109, "a trial court would not be justified in using amounts that are subject to third-party contractual or statutory limitations

as a benchmark for determining the extent of a health-care provider's customary charge." In light of this precedent, we conclude that the circuit court did not err in finding that the information sought on discovery was not relevant to whether the amounts charged by plaintiffs met the requirements of §§ 3107 and 3157 of the no-fault act and that it was not reasonably calculated to lead to the discovery of admissible evidence. The circuit court did not abuse its discretion by granting plaintiff's requested protective order.

Judge Markey wrote and the Court of Appeals ruled that customary charges are not necessarily reasonable and that an insurer need not automatically pay them:

> Very much like Munson, the decision in *Mercy Mt Clemens* mentioned reasonable charges and acknowledged that charges must be reasonable. Id. at 52. But, like Munson, the analysis then focused solely on the question of customary charges and whether third-party payments were relevant to determining a customary charge in cases not involving insurance. Id. at 52-55. Missing from Mercy Mt Clemens was a recognition that customary charges are not necessarily reasonable and that an insurer need not automatically pay a customary charge. Rather than assume Mercy Mt Clemens answered the reasonableness question presented in the instant case, we construe that decision as simply having resolved the customariness issue that it actually addressed and decided. And any incidental reference to "reasonable" in Mercy Mt Clemens was nothing more than dictum. See Aaron, 409 Mich at 722. Consequently, like the other cases cited by Spectrum, Mercy Mt Clemens does not provide the answer to the question in this case. [*Spectrum Health Hosps v Farm Bureau Mut Ins Co*, ___NW2d___; 2020 Mich. App. LEXIS 5804, at *47-48 (Ct App, Sep. 3, 2020)]

The recognition and calling out of obiter dicta is a big deal. At the end of the day, Spectrum's argument in support of the evidentiary ruling of the trial court was that obiter dicta from the Court of Appeals are superior in authority to the text of the statute. Hence, Spectrum could at one and the same time concede that the ratio decidendi of the decision in *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55; 535 NW2d 529 (1995) had nothing to do with the reasonable charge issue, yet pluck out of the opinion the sentence "ACIA's reliance on the amount that was 'paid' by BCBSM, as opposed to the amount that Plaintiffs 'charged,' is unwarranted," and argue as if this sentence itself were contained in the statute. Indeed, according to Spectrum's argument, remarks in an opinion of an appellate court are binding on lower courts and subsequent panels of the same court under the rule of stare decisis, to the extent that trial courts and later appellate courts are bound to follow, not the text of the statute, but the text of the obiter dicta Spectrum's conception of obiter dicta and stare decisis violates separation of powers under Michigan Constitution, art. 3, §2.

It is axiomatic under separation of powers that in the case of applying a statute, the statutory language must be enforced according to its plain meaning, and cannot be judicially revised or amended.[1] An exception to the rule is where by the *ratio decidendi* of a prior decision of a higher court or a precedentially binding decision of a Michigan appellate court of the same level[2], the judicial branch has fixed the interpretation of the statute by *stare decisis.* Under the common law rule the *ratio decidendi*[3] of a prior decision was binding on subsequent courts but *obiter dicta* were not:

> "It is a well-settled rule that any statements and comments in an opinion concerning some rule of law or debated legal proposition not necessarily involved nor essential to determination of the case in hand are, however illuminating, but *obiter dicta* and lack the force of an adjudication."[4]

The common law in this and other respects was incorporated into the Michigan Constitution of 1850.[5]

According stare decisis effect to obiter dicta, thereby elevating obiter dicta in authority over the text of the statute itself, is an infraction of separation of powers by the judicial branch into the constitutional sphere of the legislature.

"Judgments ought to be ever conformable to the letter of the law. Were they to be the private opinion of the judge, people would then live in society without exactly knowing the nature of their obligations." Such were the values expressed by the great Enlightenment legal philosopher Montesquieu. In modern times the basis of the English and American systems of law in Enlightenment thought has been challenged by the legal skepticism school of legal philosophy, which encourages judges to pay less attention to the values of separation of powers, judicial self-restraint, and a government of laws and not men and more attention to judicial prerogative and the expression of the judges' own "judicial philosophy."

Philosophers may argue whether the Enlightenment thinkers or the legal skeptics are right about the reality of values. The fact remains that the constitutional systems of the United States and the State of Michigan are based on Enlightenment values that motivated the separation of powers. The great mass of citizens who are governed under those systems accept those values. Those who accept office under those systems take an oath to uphold the same values.

We would be closing our eyes to reality if we did not recognize in our society that old paradigms are being tested and new paradigms are being born. The American legal system with an honorable record behind it has a crucial and necessary role to play in this process. But its greatest contribution will come

from adhering to its foundational values in Enlightenment thought and common law practice. ■

About the Author

Jack Hoffman *is a shareholder in Kuiper Kraemer PC. His practice focuses on provider charging issues under the Michigan no-fault act. He repesented the defendant appelllant in* Spectrum Health Hosps v Farm Bureau Mut Ins Co, _____ *Mich App _____: ___NW2d___; 2020 Mich. App. LEXIS 5804 (Ct App, Sep. 3, 2020). He can be reached at Hoffman@K2legal.com."*

Endnotes

1 This point is covered in MCR 7.215(J)(1) & (2). "(J) Resolution of Conflicts in Court of Appeals Decisions.

(1) Precedential Effect of Published Decisions. A panel of the Court of Appeals must follow the rule of law established by a prior published decision of the Court of Appeals issued on or after November 1, 1990, that has not been reversed or modified by the Supreme Court, or by a special panel of the Court of Appeals as provided in this rule.

(2) Conflicting Opinion. A panel that follows a prior published decision only because it is required to do so by sub rule (1) must so indicate in the text of its opinion, citing this rule and explaining its disagreement with the prior decision. The panel's opinion must be published in the official reports of opinions of the Court of Appeals."

3 Michigan is a *stare decisis* jurisdiction in which the ratio decidendi sets a precedent for the future. *Morse Chain Co v Formsprag Co*, 380 Mich 475, 483; 157 NW2d 244 (1968).

4 *Case*, *supra*, 220 Mich at 382-83. "*Obiter dicta* does not create a binding rule of law." *Luster, supra,* 239 Mich App at 730 n 5.

5 Michigan Constitution of 1850, Schedule, Sec. 1 "The common law and the statute laws now in force, not repugnant to this constitution, shall remain in force until they expire by their own limitations or are altered or repealed by the legislature." See also Const. 1963, art. III, § 7, "The common law and the statute laws now in force, not repugnant to this constitution, shall remain in force until they expire by their own limitations, or are changed, amended or repealed."

Pros and Cons of Self-Insured Retentions

By Renee Vander Hagen, *Crum & Forster*

There is often confusion about the differences between a deductible and a self insured retention (SIR) in a commercial general liability policy, and the confusion often comes at the worst time – when a claim occurs. A self–insured retention is a mechanism by which the policyholder and carrier share the financial exposure for a loss, and a greater share (greater than a deductible) is borne by the policyholder. In exchange for taking on a greater share of the exposure, the carrier gives the policyholder more control in the early stages of claim handling.

While there are benefits to a SIR for the policyholder, not every policyholder should have a SIR endorsement. There are differences in coverage issues, and differences in claim handling when a policy has a SIR versus a deductible. To avoid confusion, when an insured has a SIR endorsement on the policy and a claim occurs, communication between the insured and insurer from the date of loss going forward to the claim's conclusion, is paramount. This article explores some of the factors to consider when deciding if a CGL policy should have a self-insured retention or a deductible:

Difference number 1 – Amount

An SIR is like a deductible, in that each is an amount that the policyholder must pay before the carrier is obligated to provide indemnity. The SIR is larger than a deductible, often much larger, and the increased amount leads to several other important differences, because the larger amount of the SIR leads to a shifting of the risk toward the policyholder and away from the carrier. Because the cost of claim management or litigation is borne by the policyholder starting with the first dollar, the policyholder must have sufficient reserves to pay for the expense and indemnity if both are within the retention amount.

Difference number 2 – Lower Premium

Typically, the greater the SIR amount, the less premium the policyholder would pay. In this way, the policyholder shares in the exposure for a loss to a greater percentage, thereby reducing the amount of the policyholder's premium that is calculated by the carrier to insure the risk/exposure.

Difference number 3 – Claim handling

Since the policyholder is "self-insuring" up to the amount of the SIR, the policyholder is extended greater control over managing the claim. Sometimes a policy with a large SIR will put the burden of defense on the policyholder. When that happens, the carrier will typically retain the right to be involved in the defense. The higher the SIR, the longer the claim handling remains with the policyholder, and this could translate into resolutions more quickly.

Difference number 4 – The TPA

If the policyholder is going to be responsible for the defense, then the carrier may insist that the policyholder either has the ability "in-house" to defend the claim, or has hired a third-party administrator," or TPA, to provide the usual claim handling services.

It is not unusual for a policyholder and carrier to differ in how a claim is managed, especially when it comes to settling or taking a case to trial. So if the claim handling remains with the policyholder for the life of the claim, policyholder satisfaction presumably increases. However, that also presumes that the policyholder understands its increased risk, and has a person or team that understands risk and claim management (litigated or not), and knows how to negotiate the best resolution for the policyholder. This specialized team also needs to know when the claim will exceed the SIR, and when reporting the matter to the carrier is necessary. An investment in strong internal support, or a TPA, is essential when a policyholder manages its own claims.

Difference number 5 – Cleaner Claim History

Resolving claims within the SIR creates a "cleaner" claim history since any claim resolved within the SIR should appear on a loss run as a claim paid for $0. This is an important feature when a policyholder decides to seek other proposals for coverage from other carriers.

To SIR or Not to SIR – Making the Decision

Whether a policyholder is a proper candidate for a SIR should be considered when the policy terms are being discussed. If a policyholder has an established claim/risk manager that understands the nuances of a policy, maintains good practices with investigating claims, and can value claims accurately for being in or out of the self-insured retention amount, then a policyholder might be a good candidate for a SIR endorsement. If not, then the carrier risks getting late notices of claims, facing coverage issues and "control" issues when claims turn into lawsuits.

Reporting the Claim

Issues can arise when a claim arises involving an insured with a self insured retention, regardless of the amount of that SIR. This is where "communication is paramount." When should the policyholder report the claim to its carrier(s)? It is best to report every claim as soon as it occurs versus waiting until the SIR is exhausted. Reporting the claim when it occurs avoids any issue taken by the carrier regarding "late notice" as defined in the policy. Rather than taking the "go it alone" approach that the SIR might seem to invite, the policyholder might benefit from the carrier's input by welcoming a "team approach" when it comes to claim management, notwithstanding the SIR on the policy.

Communication is critical

This "team approach" will foster communication between the insured and insurer. Having a SIR is not giving the insured *carte blanche* to do whatever it wants in managing the claim pre-suit or after a lawsuit is filed. Understanding and not overstepping the boundaries that remain, as defined by the policy, is one benefit to open communication from day one. It is about balancing the expectations that the policyholder has within the SIR, with the expectations of the carrier as defined by the terms of the policy that remain in effect, notwithstanding the SIR. By keeping an open line of communication during the life of the claim, these expectations can be managed. The insured should not feel as if the carrier is intruding by requesting updates on the status of a claim, but should welcome the outreach that is likely to prevent or head off issues before they arise, especially if a matter is headed to trial.

Coverage Issues

Aside from claim handling issues, several coverage-related questions arise with SIRs that don't arise with deductibles. Having an SIR endorsement on a policy creates a condition precedent to coverage, to the extent that the claim is covered. The condition precedent is the exhaustion of the SIR before the policy's limits are opened, and typically, only the named insured can satisfy the SIR.

When should the carrier issue a letter outlining the potential for coverage limitations? It is probably best to do it at the outset when the claim is reported and coverage has been investigated. Otherwise, the carrier could risk facing an argument for estoppel or waiver, depending on the jurisdiction. Or, the policyholder might make decisions during the life of the claim that are outside the scope of coverages offered in the policy.

Priority Issues

SIRs can also trigger a discussion about priority of coverages, especially when another entity seeks additional insured coverage from your policyholder. All policies at issue should be reviewed for applicable endorsements, and the wording of "other insurance" clauses in order to see how the coverages stack up. Don't forget to factor in the "primary/non-contributory" endorsements into the analysis. In some instances, an endorsement that is added to the policy after a self-insured retention endorsement is applied could modify the policy terms, and affect the coverage analysis. If there is an excess policy involved, the language of the respective policies need to be read to factor in excess insurance as well.

A self-insured retention is an effective policy addition when its terms are known and understood by the policyholder, and when it is placed on the right policy/account. How it operates, and the coverage issues arising from self-insured retentions can be a bit tricky; but, with a good line of communication between the policyholder and carrier, issues can be addressed before they become problems. ■

About the Author

Having been in private practice with insurance defense firms, and in-house counsel for Citizens and Progressive Michigan Insurance Company before joining First Mercury Insurance Company's Claims Department, ***Renee Vander Hagen*** *now reviews coverage issues and oversees nationwide litigation involving the Crum & Forster group of companies. Her email address is Renee.VanderHagen@cfins.com*

Legislative Update: Quiet Until Lame Duck

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

There continues to be limited activity in the House and Senate Insurance Committee – expect that continue up through November – with the House scheduled to meet 19 days and the Senate 17 days between September 1 and the election. But there will be a flurry of post-election activity. As a reminder, we're nearing the end of the House's two-year legislative cycle (all pending legislation expires on December 31), so expect to see action on a variety of issues post-election through the end of the year.

There's only been movement on one bill since the last update:

- **Reimbursement for chiropractic services –** HB 4449 removes certain chiropractic services from the list of non-reimbursable personal injury protection benefits ***Passed by the House (102-5) on 12/10/19; Passed by the Senate (38-0) on 6/11/20; Signed by the Governor on 7/21/20 (PA 104'20 with immediate effect)***

Referred to Insurance Committees

And here are the new referrals to the House and Senate Insurance Committees:

- **Disclosures regarding health insurance –** HB 4460 requires a nonparticipating medical provider who is providing nonemergency services to give the patient certain disclosures regarding the potential lack of health coverage for those services (part of a bill package to regulate nonparticipating providers – HB 4459, 4460, 4990, 4491) ***Passed the House (106-0) on 6/24/20; Reported out of the Senate Insurance and Banking Committee on 9/9/20***
- **Grounds for disciplinary action –** HB 4490 amends the Public Health Code to include violating HB 4459 and 4460 as grounds for disciplinary action, beginning 1/1/21 (part of a bill package to regulate nonparticipating providers – HB 4459, 4460, 4990, 4491) ***Passed the House (107-0) on 9/10/20***
- **Fines for noncompliance –** HB 4491 amends the Public Health Code to proscribe fines for violating HB 4459 and 4460 (part of a bill package to regulate nonparticipating providers – HB 4459, 4460, 4990, 4491) ***Passed the House (104-2) on 9/10/20***
- **Property insurance – Business interruption from Covid-19 –** HB 5928 requires property loss insurance policies issued in Michigan to include coverage for loss of use and occupancy, loss or income or other business interrup-

tion coverages related to COVID-19; prohibiting denials based on lack of physical damage and a virus exclusion

- **PIP benefits for bicyclist –** HB 5934 requires unlimited PIP benefits for an injured bicyclist seeking coverage under the assigned claims plan
- **Regulating annuity providers –** HB 6112-6115 creates the suitability in annuity transaction model act; regulates annuity producers; proscribes duty of care; creates penalties for violations
- **Reinsurers –** SB 1015 amends the insurance code regarding reinsurers, requirements for reciprocal jurisdiction of assuming insurer and other technical amendments ***Passed the Senate (37-0) on 9/2/20*** ■

Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*

Michigan Supreme Court

Limited application of anti-fraud provisions in no-fault policies

Meemic v Fortson
Docket No 158302
___ Mich ___, July 29, 2020

Meemic's named insureds submitted false statements of attendant care provided for their son who was injured in a car accident. A majority of justices held that Meemic could not enforce its antifraud provision to bar the son's claims for benefits because he was neither a party to the contract nor a party to fraud and did not benefit from the fraud since the fees were paid to his parents. The court's holding was rooted in the premise that anti-fraud provisions were enforceable only to the extent they are recognized "statutory defenses or common-law defenses that have not been abrogated." The no-fault act does not recognize a fraud-based defense and common law only recognizes rescission for (1) fraud in the formation of the contract or fraud in the performance of an essential term. Plaintiff was not involved in the formation of the contract and did not fail to perform an essential condition of coverage. In a footnote, the court stated that its decision did not address fraud by a beneficiary.

Michigan Court of Appeals – Unpublished Decisions

CGL coverage for damage to property other than insured's product
The impaired property exclusion does not apply

Cardinal Fabricating, Inc. v Cincinnati Insurance Company
Docket No. 348339
June 18, 2020

Plaintiff supplied steel for the construction of columns *intended* to support a visual screen at the end of a runway for the Wayne County Airport Authority. The columns cracked, caused panels to fall off the screen, and damaged some of the concrete pads at the base. The subcontractor who purchased the steel owed contractual indemnity to the general contractor. It sued plaintiff for indemnity under their contract. Plaintiff presented the claim to its CGL insurer, Cincinnati Insurance, but Cincinnati denied coverage, citing the lack of an occurrence and the impaired property exclusion. Both the trial court and the court of appeals held that Cincinnati owed a duty to defend because the damage to property other than its own work (the panels and concrete pads) was unforeseen, unexpected and unintended. And the impaired property exclusion did not apply because the property was physically injured, and the exclusion was not asserted as an affirmative defense in Cincinnati's answer to the complaint.

A moped is not a "motor vehicle" as required by the "owned auto" exclusion in this UM policy

Johnson v State Farm Mutual Automobile Insurance Company
Docket No. 347507
June 25, 2020

Thirteen-year-old plaintiff was injured while riding his moped when it was struck by an uninsured motor vehicle. He was covered by his mother's auto policy with State Farm, which excluded UM coverage for bodily injury sustained "while occupying a motor vehicle or a motorcycle" not listed on the policy. State Farm denied coverage on the ground that the moped was a motor vehicle not listed on the policy. The policy did not define "motor vehicle," so the court applied the dictionary definition of motor vehicle, which limited the meaning of the term to automobiles, trucks, buses and similar conveyances and determined that the exclusion did not apply to a moped.

Insured's waiver of lessor's owner liability is binding on insurer

Home-Owners Ins Co v Amco Ins Co
Docket No. 347089
June 25, 2020

This is a priority dispute. Amco insured the lessor of the at-fault vehicle. The lease was short-term (less than 30 days) and stated that the lessor would assume liability up to the statutory limits of $20,000/$40,000, but only if the vehicle was being operated in accordance with the terms of the lease agreement. That agreement limited use of the vehicle to authorized drivers. This accident occurred when an unauthorized driver, the lessee's 16-year-old son, failed to obey a stop sign. The court held that because the lessee father, Home-Owners insured, agreed to waive his right to hold the lessor responsible under the owners liability statute, Home-Owners was bound by that agreement and owed primary coverage for the accident.

A motorcycle is a motor vehicle as defined in this UM/UIM "owned-auto" exclusion

Holland v Springer
Docket No 347562
June 25, 2020
Reconsideration denied August 14, 2020

Plaintiff-decedent was killed in an accident while riding his motorcycle. His auto policy expressly excluded UM and UIM coverage for injuries sustained by an insured while occupying a motor vehicle owned by the insured and not covered under the policy. The policy did not define the term "motor vehicle" so the panel applied the plain and ordinary meaning of that term, rather than the statutory definition under Michigan's no-fault act. It concluded, consistent with prior case law, that a motorcycle fits the common view of a motor vehicle. The estate had no claim for UM/UIM coverage under the insured's umbrella policy because that policy expressly excluded such coverage absent an endorsement expressly adding it. There was no such endorsement.

Anti-fraud provisions and false statements during litigation

Haydaw v Farm Bureau Insurance Company
Docket No. 345516
July 9, 2020
Reconsideration denied August 24, 2020

In this first impression but unpublished opinion, the court decided that fraud provisions in no-fault insurance policies cannot be applied to false statements made by the insured during first-party litigation. Plaintiff was injured in an automobile accident and sued his insurer for PIP benefits. During the course of litigation, he signed authorizations for the release of his medical records and testified by deposition. He also underwent two independent medical examinations. At the close of discovery, Farm Bureau moved for summary disposition based on plaintiff's false statements during discovery regarding his medical history. Plaintiff had denied prior problems with his back, neck, and shoulder but his medical records revealed that he treated for those conditions prior to the accident. The panel relied on an 1871 United States Supreme Court decision and a series of early federal and other state court decisions to hold that "false statements made during discovery do not provide grounds to void the policy because, by that time, the claim has been denied and the parties are adversaries in litigation. Once suit is brought, what is truth and what is false is a matter for a jury or a judge acting as a factfinder. And if it can be shown that a party intentionally testified falsely, it is up to the Court to determine what, if any, sanction is proper."

Title insurance policy does not apply to adjoining alley

Shower Curtain Solutions, Ltd., LLC v First American Title Insurance Company
Docket No. 346549
June 18, 2020

Plaintiff purchased a parcel of property in Detroit. It was separated from another parcel of property by an alley that had been vacated by the City of Detroit and was being used by the other property owner. Plaintiff sued for quiet title to the northern half of the alley and prevailed. It also sued its title insurance company and its insurance agency on theories of negligence and breach of contract. As to the title insurer, the court looked at the terms of the insurance contract and concluded that it did not cover title to the alley, so there was no breach of the insurance contract. As to the agency, the court held that it was not a party to the insurance contract, which eliminated the breach of contract claim. And Michigan does not recognize negligence as a viable cause of action against insurance agents.

UIM limit is reduced by settlements with other responsible parties

Estate of Malaj v. Citizens Insurance Company of America
Docket No. 348408
July 16, 2020

Plaintiff estate applied for UM and UIM benefits following an accident with a vehicle titled to someone without a policy, but possessed and maintained by constructive owners who did insure the vehicle. The court held that because the vehicle was insured, it did not meet the policy definition of an uninsured motor vehicle. The estate was not entitled to UM benefits. Nor was the estate entitled to UIM benefits. The policy had a per person limit of $250,000 and allowed

the insurer to offset any amounts the insured collected from others for bodily injury as a result of the same accident. The estate had settled with other legally responsible parties for a total amount that exceeded his UIM limits.

Complaint for social host liability did not describe an occurrence

Estate of Wells v. State Farm Fire and Casualty Company
Docket No. 348135
July 16, 2020
Supreme Court application pending

State Farm's homeowner's policy does not cover claims of social host liability where the complaint alleges that the insureds knowingly furnished alcohol to minors and knowingly allowed the alcohol-impaired operation of a motor vehicle. The complaint also expressly claimed that the motor vehicle accident was the reasonably foreseeable and direct result of the insured's intentional act of furnishing alcohol to minors. That conduct does not qualify as an occurrence or an accident under Michigan law. The dissenting opinion would have found a duty to defend because of a question of fact about whether the insureds expected or intended the injury.

Question of fact as to whether injury occurred during unloading

Ford Motor Company v. Centra, Inc.
Docket No. 349212
July 23, 2020

Per the terms of an indemnity and insurance agreement, Ford sought coverage from the commercial insurer of the transportation company whose employee was killed at a plant in Missouri while unloading vehicle seats. The insurer denied coverage so Ford defended the underlying claim and then commenced this action for contractual indemnity against the transportation company and the supplier of seats, and sued their insurer for coverage. The trial court granted summary disposition for the insurer finding that the CGL policy excluded coverage for claims arising out of the use of a motor vehicle, including loading and unloading, while the commercial auto policy contained an exclusion for claims involving negligence on the part of the customer, which was Ford. The Court of Appeals found a question of fact on whether the employee was killed while unloading the vehicle seats, which triggered the potential for CGL coverage and a duty to defend. It affirmed the lack of coverage under the auto policy because Ford's own negligence was established in the underlying action.

Lack of competent evidence of a hit-and-run accident for UM coverage

Candella v Liberty Mutual Insurance Company
Docket No. 348146
August 13, 2020

Plaintiff claimed he was struck from behind by another vehicle while sitting at a traffic light, but there was no physical damage to his car. He produced no police report, no photographs of the other vehicle, and no witnesses. He did produce a license plate number of the vehicle that struck him, but that number failed to match up with any registered vehicle. Plaintiff's UM policy with Liberty Mutual stated that if there was no direct physical contact with the hit-and-run vehicle, the facts of the accident had to be proved by "competent evidence other than the testimony of a person making a claim." There was no such evidence. The trial court granted summary disposition and the Court of Appeals affirmed.

Liability coverage excluded for vehicle used to transfer persons for a fee

Farm Bureau General Insurance Company of Michigan v. HORE
Docket No. 347918
August 20, 2020

Farm Bureau's insured agreed to help his niece transport several passengers to work in the course of her transportation business. It was the first time he ever assisted his niece with her business, and he did not receive any fees for his service. The insured lost control of his vehicle that day and collided with a delivery truck, leading to bodily injury lawsuits by the passengers. Farm Bureau's policy excluded liability coverage "for liability arising out of the ownership of operation of a vehicle while it is being used to carry persons or property for a fee." The exclusion did not require that the insured received the fee charged, only that the service was being provided for a fee. The trial court applied the exclusion, and the Court of Appeals affirmed. The fact that the insured had only volunteered to help his niece did not alter the fact that his vehicle was being used to transport passengers for commercial purposes. The dissenting opinion would not apply the exclusion because the insured was not compensated.

A rescission analysis under *Bazzi*

AAA Membership Select Ins Co v Auto Owners Ins Co
Docket No 349608
Reconsideration pending

Plaintiff AAA insured a vehicle responsible for causing an accident while transporting passengers to northern Michigan to visit individuals incarcerated there. Two passengers sued the insured owner for bodily injury and AAA defended. It also filed this lawsuit for rescission based on the named insured's failure to report that he used the vehicle to transport passengers. Auto Owners insured one of the passengers and intervened, likely because of its exposure for UM coverage. The trial court applied the *Bazzi* analysis and declined to rescind based on the equities involved. It noted that the insured listed multiple vehicles on the policy with one driver, which should have alerted the insurer of the need for investigation, the innocent parties had no knowledge of any fraud and were in no way reckless or negligent, and it was not clear that the passengers would have PIP or UM coverage under their own policies. The fact that the named insured would be relieved of liability for his bad acts did not outweigh the other factors. The Court of Appeals affirmed, stating that even if it would have reached a different conclusion, the trial court's decision did not fall outside the range of reasonable and principled outcomes.

Plaintiff is a third-party beneficiary of the insurance contract but its lawsuit is time-barred

Pontiac School District v Travelers Indemnity Co
Docket No 347614
September 3, 2020

The Pontiac School District was a member of a self-insurance group, Middle Cities Risk Management Trust (MCRMT), which was the named insured on an excess policy with Travelers. MCRMT covered losses up to $2 million after which Travelers' policy provided coverage. In 2011, the District discovered substantial damage to one of its school buildings, a high school that had been closed and was vacant. It submitted a claim to MCRMT several months later. MCRMT denied the claim, after which the parties spent nearly five years engaged in administrative appeals, which ended with a replacement cost assessment of roughly $6,000,000. Travelers denied the excess claim for $4,000,000 stating that the District was not an insured under the policy issued to MCRMT and further asserting the two-year contractual limitation for filing suit. The court of appeals rejected Travelers' first argument, holding that members of MCRMT were third-party beneficiaries of the insurance contract with rights of coverage. But the court did apply the two-year limitations provision, which stated: "in no event will this period of time [for filing suit] exceed 2 years after the date on which the direct physical loss or damage occurred." The exceptions to the time limitation did not apply.

No property damage coverage for home no longer used as "residence premises"

Hassanein v Encompass Indemnity Co
Docket No 347544
Released September 10, 2020

Encompass denied coverage for fire damage to plaintiffs' property because it was not being used as their "residence premises" at the time of the fire. The homeowners' policy only covered damage to the residence premises, which was defined as the place where "the named insured resides and which is principally used as a private residence." Plaintiffs had resided in the insured location from 2005 to 2015 but leased it to a tenant toward the end of 2015 when they began spending more time in Egypt. The fire occurred in 2016. The Court of Appeals affirmed summary disposition for Encompass because the damaged property was not plaintiffs' "residence premises" at the time of the fire. The terms of the contract were not ambiguous. The court also affirmed summary disposition for the independent insurance agent who sold plaintiffs the policy because plaintiffs never informed the agent of the change in use of the property and there was no special relationship creating a duty on the part of the agent to make sure plaintiffs had the correct coverage.

Sixth Circuit Court of Appeals

No property coverage for damage caused by an old leaky roof

O.L. Matthews, MD v Harleysville Ins Co
Case No 19-1994
___ Fed Appx ___
September 9, 2020

This is a property damage claim arising out of an old and poorly maintained roof on plaintiff's medical office building. Harleysville's policy promised to "pay for direct physical loss of or damage to Covered Property . . . caused by or resulting from any Covered Cause of Loss." A covered cause of loss was any cause other than one expressly excluded by the policy. The court agreed that two of the three coverage exclusions asserted by Harleysville applied. One of the exclusions barred coverage for loss or damage resulting from wear and tear. "The record shows that wear and tear was a cause of loss here," and that evidence included plaintiff's own expert report. The roof was years past its useful life. The second exclusion that applied was the "Leakage" exclusion, which applies when the property has previously been damage by the intrusion of rain.

Federal District Court – Eastern District of Michigan

"Prior and Pending" exclusion in EPL policy does not apply

City of Grosse Pointe v US Specialty Ins Co
Case No 18-cv-13428
July 13, 2020

In 2011, US Specialty covered the city under an Employment Practices Liability (EPL) policy. It provided a defense and indemnity in response to a Title VII/ELCRA lawsuit filed by a female employee, who claimed she was denied a promotion and otherwise discriminated against on the basis of her sex, and retaliated against for having filed an EEOC claim. That lawsuit was settled in 2015. In 2018, the same employee filed a second lawsuit claiming discrimination and retaliation, again on the basis of sex. As to the discrimination claim, plaintiff complained that the city failed to promote her to a position that opened up in 2018, and failed to grant a request for accommodation in 2017. US Specialty denied coverage for the second lawsuit based on a "Prior and Pending" exclusion in the EPL policy. The court examined the second complaint, and concluded "that the City is potentially liable for damages from an 'employment practices wrongful act'" committed in 2017 or 2018 or both. Those allegations triggered a duty to defend. And although the "Prior and Pending" exclusion could limit indemnity coverage for the retaliation claim, it would not apply to the sex discrimination claims arising out of actions taken in 2017 and 2018.

Retentions apply per occurrence and per policy period

Livonia Public Schools v Selective Ins Co
Case No 16-cv-10324
July 17, 2020

This opinion resolves the coverage owed for defense costs incurred in an underlying lawsuit filed by three physically or mentally handicapped children alleging physical, verbal, and emotional abuse by a special-needs teacher. Selective covered plaintiffs for these claims, which alleged incidents occurring over two policy periods, 2010 – 2011 and 2011-2012. In prior proceedings, the court held that Selective owed defense costs and indemnity but only after the insureds exhausted their $500,000 retention per policy period and per occurrence. Each occurrence consisted of the claims by each separate plaintiff during a policy period. After the abuse claims were resolved in the underlying case, Selective, in this declaratory judgment action, moved to confirm that its defense obligations were satisfied. Plaintiffs argued that there was never any evidence of abuse during the second policy period and asked for reimbursement of its three retention payments for that period. The court denied the request. It was the allegations in the underlying complaint that triggered the duty to defend, without regard to the merits of those claims. Plaintiffs were obligated to exhaust their retentions for each "time on the risk" and that included the second policy period.

Lack of a fire alarm results in loss of coverage

New Hamilton Liquor Store Inc v AmGuard Ins Co
Case No 17-cv-13077
July 23, 2020
Reconsideration pending

Plaintiff purchased a commercial building and consulted with an insurance agent about coverage for the business. They met on three separate occasions and at one of the meetings, plaintiff told the agent that the building was equipped with alarms. He then purchased an insurance policy that included an endorsement with a section titled: "Protective Safeguards Symbols Applicable." The endorsement excluded coverage for fire damage if the insured failed to maintain an automatic fire alarm on the premises. Plaintiff only had motion-detecting alarms near the doors so when a fire occurred on the premises, it was not immediately identified as a fire. The cause of the fire was arson. Someone had climbed onto the roof and cut a hole through the roof with a power saw and then poured gasoline into the building. When AmGuard denied coverage, the insured filed suit claiming that the definition of a fire alarm includes motion detectors that can detect fires. The court disagreed. It held that a fire alarm is an alarm specifically designed to detect fires, and that the policy clearly required such an alarm as a condition of coverage. ■

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