# INSURANCE LAW

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## I. INTRODUCTION

Most Michigan Court of Appeals decisions regarding insurance law continue to be unpublished and, therefore, do not constitute binding precedent.[1] Unpublished opinions lie beyond the scope of this *Survey*. Insurance is involved in many aspects of everyday life, from the automobiles we drive, to the homes we live in, to the businesses we operate. The importance of insurance and its impact on society cannot be underestimated. Once again, the *Survey* period finds itself in the midst of changing membership on the Michigan Supreme Court. In November 2010, Mary Beth Kelly unseated then-Justice Alton Davis, who had only just been appointed in August 2010 by then-Governor Jennifer Granholm.[2] The appointment of Justice Davis created what was widely viewed as a liberal majority for the court.[3] His election defeat in November 2010 ushered that majority out as quickly as it was brought in. Further, in January 2011, Brian Zahra was appointed to replace then-Justice Maura Corrigan, who stepped down to take a position within the new administration of Governor Rick Snyder.[4] Thus, in little more than a year, the balance of the court shifted not once, but twice.

## II. DECISIONS OF THE MICHIGAN COURT OF APPEALS

### *A. The No Fault Act, MCL Section 500.3101, et seq.*

Michigan's No-Fault Act was the insurance topic that was before the Michigan Court of Appeals during the *Survey* period more than any other, with ten published decisions. As will be discussed, the Michigan Supreme Court also discussed the topic, reversing course regarding the threshold for tort liability.

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1. MICH. CT. R. 7.215(C).

2. Joe Swickard, *Kelly and Young win spots on the bench*, DETROIT FREE PRESS, Nov. 3, 2010, at E5.

3. Leonard N. Fleming, *Two Tea Party Groups Head to Court Battle*, DETROIT NEWS, Sept. 1, 2010, http://origin-www.detnews.com/article/20100901/POLITICS02/9010361/0/special/Two+tea+party+groups+head+to+court+battle.

4. Dawson Bell, *Snyder names Zahra to top court*, DETROIT FREE PRESS, Jan. 11, 2011, at A3.

### 1. MCL Section 500.3104—Catastrophic Claims

The obligations of the Michigan Catastrophic Claims Association ("MCCA") were at issue in several cases before the Michigan Court of Appeals. In *United Services Auto Association v. Michigan Catastrophic Claims Association*,[5] the MCCA challenged its obligation to reimburse a member based on whether the injured party was obligated to maintain No-Fault insurance.[6] Raoul Farhat, M.D., was involved in an automobile accident on August 9, 1996 in Florida while driving a Chrysler LeBaron.[7] Although Mr. Farhat was working in Florida at that time, and had been living there since sometime in 1995, he did own a residence in Michigan through his mother's trust.[8] Mr. Farhat had insured five vehicles through a Michigan No-Fault policy in 1995, but the insurer, USAA, mistakenly omitted the LeBaron from the policy and retroactively reformed the policy to include coverage for the LeBaron.[9] USAA paid $896,106.60 in benefits on behalf of Mr. Farhat and sought reimbursement for all amounts paid over $250,000, which at the time was the statutory MCCA threshold.[10] The trial court granted the MCCA summary disposition, relying on *Liberty Mutual Insurance Company v. Michigan Catastrophic Claims Association*,[11] which indicated that where an insurer does not make a premium payment to the MCCA for a vehicle prior to the accident, the insurer could not later reform the insurance policy to include the vehicle after the fact.[12] MCCA also argued that its reimbursement ability was limited to Michigan vehicles, registered in Michigan, which the MCCA argued excluded Mr. Farhat's LeBaron.[13] The trial court did not address this argument.[14]

The Michigan Court of Appeals began by addressing the issue ignored by the trial court, acknowledging that the Michigan Supreme Court had already held that the MCCA's obligations pursuant to MCL section 500.3104(2)[15] do not extend to amounts "paid to insureds who

5. 289 Mich. App. 24, 795 N.W.2d 185 (2010), *vacated*, 489 Mich. 869, 795 N.W.2d 594 (2011).
6. *Id.* at 27.
7. *Id.* at 26.
8. *Id.*
9. *Id.*
10. *Id.* at 27.
11. 248 Mich. App. 35, 638 N.W.2d 155 (2001).
12. *United Servs. Auto Ass'n*, 289 Mich. App. at 27.
13. *Id.* at 27.
14. *Id.* at 28.
15. MICH. COMP. LAWS ANN. § 500.3104(2) (West 2002).

are not considered residents of this state."[16] "Resident" for purposes of MCL section 500.3104(2) extends not just to those who live within the state, but also to individuals who live outside Michigan and are still required to register and maintain No-Fault insurance on their vehicles.[17] For the court of appeals, the issue to be decided was whether Mr. Farhat was a "resident" of Michigan for purposes of the No-Fault Act.[18] In concluding that Mr. Farhat was not a "resident" for purposes of the No-Fault Act, the court found the following circumstances relevant:

> Farhat stated that he grew up in Michigan and lived with his wife in Michigan before their 1993 Michigan divorce. But Farhat moved to Florida in an effort to reunite with his ex-wife in 1995. On June 13, 1995, Farhat informed plaintiff that he had moved to Florida. Farhat was working in Florida at the time of accident. Farhat purchased the LeBaron in Florida, registered it in Florida, obtained Florida license plates for it, and never drove it in Michigan. In June 1996, Farhat called plaintiff to request a homeowner's policy for his Florida home. Also, in June 1996, Farhat updated his billing address to Florida. On the date of the accident, August 9, 1996, Farhat had a Florida driver's license. In early 1997, Farhat claimed a homestead exemption on his Florida home. While Farhat testified that he had a residence in Michigan through his mother's trust and had two cars garaged in Michigan, it appears that Farhat's intent at the time was to live in Florida indefinitely and that the bulk of his permanent connections were in Florida at the time of the accident.[19]

The court then considered the alternative question, whether the LeBaron was "otherwise 'required to be registered' in Michigan."[20] The court looked to the Motor Vehicle Code, in particular MCL section 257.216(a)[21] and MCL section 257.243(1),[22] which both indicate that nonresidents need not register their motor vehicles in Michigan.[23] Reading the Motor Vehicle Code sections regarding registration *in pari*

16. *United Servs. Auto Ass'n*, 289 Mich. App. at 29-30 (citing *In re* Certified Question (Preferred Risk Mut. Ins. Co. v. Mich. Catastrophic Claims Ass'n), 433 Mich. 710, 719-20, 449 N.W.2d 660 (1989)).

17. *Id.* at 30 (citing *In re* Certified Question, 433 Mich. at 719-20)).

18. *Id.* at 31-32.

19. *Id.* at 32.

20. *Id.*

21. MICH. COMP. LAWS ANN. § 257.216(a) (West 2008).

22. MICH. COMP. LAWS ANN. § 257.243(1) (West 2008).

23. *United Servs. Auto Ass'n*, 289 Mich. App. at 33.

*materia* with the No-Fault Act, the court found that since the LeBaron need not be registered in Michigan, it need not be insured in the state either.[24] Since the MCCA need only reimburse for benefits paid pursuant to a Michigan policy "that provided the required security under MCL 500.3101(1) for a vehicle required to be registered in Michigan," and Mr. Farhat's Lebaron did not need to be registered in Michigan and was not subject to the No-Fault Act, the MCCA owed no reimbursement to USAA.[25]

The court of appeals acknowledged the reasoning behind the trial court's determination, but stated the policy reformation question need not be answered, because the threshold requirement—the MCCA's need to indemnify the vehicle at all—was not met.[26] In short, the trial court was held to have reached the correct result, but for the wrong reason.[27] The Michigan Supreme Court disagreed and issued an order vacating the judgment of the court of appeals and reinstating the trial court's order granting summary disposition.[28]

The Michigan Court of Appeals also considered whether an insurer can include an insured's deductible in its "ultimate loss" for purposes of reimbursement by the MCCA.[29] The court considered the question in two different situations in a consolidated case: (1) where the insurance policy called for a deductible, and the insured actually paid the deductible amount, and (2) where the insurance called for a deductible, but the insurer had not required payment of that amount from the insured.[30] Where the deductible had been paid, the court reversed the trial court's determination that the deductible amount was not included within the "ultimate loss" as used in MCL section 500.3104,[31] however the end result did not change.[32] Though the deductible amount is included within an insurer's "ultimate loss," pursuant to article X, section 10.06 of the MCCA's Plan of Operation,[33] the insurer is obligated to turn over any amount received from a third party for which the insurer has received

24. *Id.* at 34.
25. *Id.* at 35.
26. *Id.* at 37.
27. *Id.*
28. U.S. Auto. Ass'n v. Mich. Catastrophic Claims Ass'n, 489 Mich. 869, 795 N.W.2d 594 (2011).
29. Am. Home Assurance Co. v. Mich. Catastrophic Claims Ass'n, 288 Mich. App. 706, 795 N.W.2d 172 (2010).
30. *Id.* at 710-16.
31. MICH. COMP. LAWS ANN. § 500.3104 (West 2002).
32. *Am. Home Assurance Co.*, 288 Mich. App. at 720.
33. *Id.* (quoting MICH. COMP. LAWS § 500.3104(17)).

reimbursement from the MCCA.[34] This was another case of a trial court reaching the right result, albeit for the wrong reason.

Regarding the deductible that had not been paid by the insured, the court found it significant that the insurer elected not to recover amounts it was owed as a deductible.[35] "The MCCA was not set up to subsidize large commercial deductibles, and [the court] decline[d] to create a system that would require it to do so."[36] The court determined the MCCA was subrogated to the rights of the insurer, and could bring suit against the insured to collect the deductible.[37]

### *2. MCL Section 500.3105—Arising Out of the Ownership, Operation, Maintenance or Use of a Motor Vehicle as a Motor Vehicle*

In *Boertmann v. Cincinnati Insurance Company*,[38] the Michigan Court of Appeals considered the case of a plaintiff driving a motor vehicle behind her son, who was operating a motorcycle at the time.[39] The plaintiff observed another vehicle turn into the path of the motorcycle and collide with the bike.[40] The plaintiff then observed her severely injured son in the parking lot where he landed, and would eventually be pronounced dead.[41] A psychologist diagnosed the plaintiff as having suffered post-traumatic stress disorder, "caused by her witnessing of the collision which killed her son."[42] The defendant insurance company refused to pay No-Fault benefits, and the trial court initially agreed with the defendant.[43] However, upon reconsideration, the trial court determined that benefits were due and owing.[44] The question was whether the injury arose out of "the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle" so as to be compensable under the No-Fault Act.[45]

As has been the rule, "'[a]rising out of' means that the causal connection between the injury and the use of the motor vehicle must be

34. *Id.* at 720-21.
35. *Id.* at 723.
36. *Id.*
37. *Id.* at 724. In such an event, the MCCA would be entitled to reimbursement of costs from the insurer failing to collect the deductible. *Id.*
38. 291 Mich. App. 683, 805 N.W.2d 626 (2011).
39. *Id.* at 684.
40. *Id.*
41. *Id.*
42. *Id.*
43. *Id.* at 685.
44. *Boertmann*, 291 Mich. App. at 685.
45. *Id.* at 686 (citing MICH. COMP. LAWS ANN § 500.3105(1) (West 2002)).

'more than incidental, fortuitous, or but for.'"[46] The court of appeals previously found that a parent's psychological injury following the death of a child in a motor vehicle accident that the parent did not observe did not have a sufficient causal connection to the motor vehicle accident to come within the purview of the No-Fault Act.[47] The same result was found where the psychologically injured parent heard, but did not see, the child struck by a motor vehicle.[48] The distinction in the instant case was that the parent witnessed the collision.[49]

In the prior cases, the parent's injury arose out of the death of the child, which had arisen out of the operation of a motor vehicle; whereas in the present case, there was psychological testimony that the injury was the result of witnessing the collision, not the death.[50] The court cited to New Jersey case law for the proposition that there exists a "distinction between the grief suffered upon a loved one's death and the distress upon viewing a traumatic event that causes death."[51] "Physical contact" between the claimant and the motor vehicle is not required, and in this case, the undisputed evidence demonstrated the requisite causal connection.[52]

### *3. MCL Section 500.3107—Allowable Expenses, Work Loss, Replacement Services*

The court of appeals considered the payment of work loss benefits to people with non-traditional work schedules, such as teachers who often operate on a yearly contract but have portions of the year where they are not actively working.[53] A teacher injured in a motor vehicle accident had the option of being paid in twenty-one installments while school was in session, or in twenty-six biweekly installments throughout the year.[54] The teacher chose the year-round payment plan.[55] It was undisputed that the teacher missed an entire school year, and therefore one year's salary, but a dispute arose with her No-Fault insurer as to how work loss should

46. *Id.* (internal quotation marks omitted) (citing Thornton v. Allstate Ins. Co., 425 Mich. 643, 659-60, 391 N.W.2d 320 (1986)).

47. Williams v. Citizens Mut. Ins. Co., 94 Mich. App. 762, 763-65, 290 N.W.2d 76 (1980).

48. Keller v. Citizens Ins. Co. of Am,, 199 Mich. App. 714, 715-16, 502 N.W.2d 329 (1992).

49. *Boertmann*, 291 Mich. App. at 687.

50. *Id.*

51. *Id.* at 689 (quoting Wolfe v. State Farm Ins. Co., 540 A.2d 871, 873 (N.J. 1988)).

52. *Id.*

53. Copus v. MEEMIC Ins. Co., 291 Mich. App. 593, 805 N.W.2d 623 (2011).

54. *Id.* at 595.

55. *Id.*

be paid.[56] The trial court took plaintiff's $63,985 salary, subtracted the fifteen percent required by MCL section 500.3107(b), and divided it by twelve months to arrive at $4525.90 per month.[57] The insurance company, however, offered a different calculation;[58] It divided the plaintiff's yearly salary by her 183 contract workdays, after taxes, and came to a daily amount of $296.78.[59] That amount was multiplied by the number of days actually worked in a thirty-day pay period, and accounted for two summer months where no payment was received.[60]

In upholding the trial court's determination, the court of appeals noted the remedial purpose of the No-Fault Act and its liberal construction in favor of beneficiaries.[61] The court determined that MCL section 500.3107(1)(b) is silent as to when work loss is deemed to occur.[62] In the instant case, the plaintiff missed twenty-six biweekly checks—the entirety of her yearly salary—and she lost the income from all of those checks as a direct result of missing work.[63] The insurance company's calculation was called "a fiction, completely unwarranted by anything in the statute, that plaintiff's lost income was something other than what it actually was."[64]

The court of appeals also cleared up what previously could be argued as dicta regarding whether the fees of a conservator could count as either allowable expenses pursuant to MCL section 500.3107(1)(a) or replacement services pursuant to MCL section 500.3107(1)(b).[65] Edward Carroll suffered a closed head injury as a result of an automobile collision, which eventually led his daughter to seek the appointment of a conservator.[66] After Mr. Carroll was placed in adult foster care, the conservator sought to recover his "fee[s] related to efforts to rent or sell Carroll's residence, liquidate his personal property, and sell his car."[67]

The court began by looking to its previous decision in *Heinz v. Auto Club Insurance Association*, in which it held that a fee for the services of

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56. *Id.* at 595-96.

57. *Id.* at 595. Eighty-five percent of $63,895 is $54,310.75, which is equal to the monthly amount determined by the trial court multiplied by twelve months.

58. *Id.* at 595-96.

59. *Copus*, 291 Mich. App. at 595.

60. *Id.* at 595-96. The monthly amounts arrived at using this formula often exceeded the statutory maximum for work loss, which would be reduced to the cap level. *Id.* Therefore, this formula resulted in a total payment of $44,268.64. *Id.*

61. *Id.* at 596.

62. *Id.* at 597.

63. *Id.*

64. *Id.*

65. *In re* Carroll, 292 Mich. App. 395, 397, 807 N.W.2d 70 (2011).

66. *Id.* at 397-98.

67. *Id.* at 398.

a guardian were allowable expenses under MCL section 500.3107(1)(a).[68] In *Heinz*, the court held that services for a guardian were reasonably necessary for the injured individual's care, and therefore allowable expenses.[69] "Care" as used in MCL section 500.3107(1)(a) is clearly not limited to medical care, and the court found no reason to distinguish between the "care" provided by a guardian and that provided by a conservator.[70] Where a conservator is required because an individual can no longer manage his own affairs as a result of injuries sustained in a motor vehicle accident, the fees of the conservator are allowable expenses.[71] The court further concluded that the services of a conservator are different from those deemed "ordinary" for purposes of replacement services under MCL section 500.3107(1)(c), such as "cooking, cleaning or doing yard work."[72] Indeed, the services are "extraordinary professional services" and therefore, outside the scope of replacement services.[73]

The insurer raised the Michigan Supreme Court's decision in *Griffith v. State Farm Mutual Automobile Insurance Company*, wherein expenses for food were determined *not* to be "allowable expenses" under MCL section 500.3107(1)(a).[74] The court likened the claim to that of a nursing assistant who provided for an injured person's hygiene needs, which are compensable under MCL section 500.3107(1)(a), as those needs would be provided for the injured person *because* of the injury.[75] Just as the nursing assistant provided for hygiene, the need for a conservator "was causally connected to Carroll's injury and the expense is reasonably necessary for his 'care' and it too is compensable."[76]

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68. *Id.* at 401 (citing Heinz v. Auto Club Ins. Ass'n, 214 Mich. App. 195, 198, 543 N.W.2d 4 (1995)).

69. *Id.* (quoting *Heinz*, 214 Mich. App. at 198). *Heinz* did speak in terms of "the services performed by the guardian and conservator," however, since only the issue of a guardian was before the court in *Heinz*, reference to the conservator was considered dicta. *Id.*

70. *Id.*

71. *In re* Carroll, 292 Mich. App. at 402.

72. *Id.* at 404.

73. *Id.*

74. *Id.* at 405 (citing Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521, 697 N.W.2d 895 (2005)). The court in *Griffith* noted that the injured individual's diet had not changed as a result of the injuries, and while food may be necessary for the individual's survival, it was not necessary for his recovery and rehabilitation from the injuries sustained in the motor vehicle accident. *Id.* (citing *Griffith*, 472 Mich. at 535-36).

75. *Id.* at 407.

76. *Id.*

*4. MCL Section 500.3113(a)—Unlawfully Taken Vehicle*

Travion Hamilton was injured when a stolen Jeep in which he was a passenger was involved in a motor vehicle accident.[77] Mr. Hamilton did not participate in taking the Jeep from its owner; rather, he was picked up by his girlfriend who had acquired the vehicle, but his girlfriend did not have a key for the vehicle, which had its ignition cylinder removed and which was missing the door lock on the driver's side.[78] Mr. Hamilton was the only passenger in the vehicle, which was involved in an accident when it struck a utility pole.[79] The insurer argued that Mr. Hamilton was barred from recovery by MCL 500.3113(a), which prohibits a person who "was using a motor vehicle or motorcycle which he or she had taken unlawfully, unless the person reasonably believed that he or she was entitled to take and use the vehicle" from receiving No-Fault benefits.

The court concluded that Mr. Hamilton could not be said to have "taken" the vehicle, as he "merely joined in relative to the 'use' of the Jeep—a Jeep that had already been taken."[80] The taking had already been completed by the time Mr. Hamilton became involved. The statutory prohibition requires that "[t]he vehicle must be one that the injured person was 'using' *and* one that the injured person 'had taken.' The evidence presented in this case established use, not a taking."[81] While Mr. Hamilton may be said to have been joyriding in violation of MCL 750.414, to be excluded from No-Fault benefits, the person seeking benefits must have participated in the taking, "not mere use."[82] The court of appeals ended by concluding: "[i]f the Legislature desires to preclude an award of PIP benefits to persons engaged in criminal activity who did not take a motor vehicle, it is for the Legislature to amend the statute. It is certainly not within our authority to do so."[83]

*5. MCL Section 500.3135—Third Party Claims*

Following a motor vehicle accident, an injured pedestrian brought suit for payment of benefits for attendant care and replacement services provided by the injured party's ex-mother-in-law.[84] In particular, the

77. Henry Ford Health Sys. v. Esurance Ins. Co., 288 Mich. App. 593, 594, 808 N.W.2d 1 (2010).
78. *Id.* at 596.
79. *Id.*
80. *Id.* at 601.
81. *Id.* at 603.
82. *Id.* at 605.
83. *Henry Ford Health Sys.*, 288 Mich. App. at 607.
84. Johnson v. Recca, 292 Mich. App. 238, 807 N.W.2d 363 (2011).

court of appeals considered whether those replacement services which were rendered over three years after the date of the accident could be recovered as "damages for allowable expenses," an exception to the general abolition of tort liability pursuant to MCL section 500.3135.[85] The court noted that "replacement services" are treated separately from "allowable expenses" in MCL section 500.3107(1).[86] The court of appeals concluded that "replacement services" fit within the broad definition of "care," as that term is used in defining an "allowable expense," and, therefore, are a category of "allowable expenses," despite the separate treatment by MCL section 500.3107(1).[87] The reason the legislature treated "replacement services" separately was not to connote a distinction from "allowable expenses," but rather because it wanted to place limits on the amount which could be recovered at $20 per day.[88]

The Michigan Court of Appeals also addressed what constituted a "serious impairment of a body function," another exception to the general abolition of tort liability for motor vehicle injuries, pursuant to MCL section 500.3135(1).[89] The court had opportunity to consider the question in light of the Michigan Supreme Court's decision in *McCormick v. Carrier*, which the court of appeals stated "shifted the focus from the injuries themselves to how the injuries affected the plaintiff's body function," and, in reality, "eased the burden on the plaintiff to show how the impairment has prevented the plaintiff from leading a normal life."[90] The trial court submitted the question of

85. *Id.* at 244 (quoting MICH. COMP. LAWS ANN. § 500.3101(c) (West 2002)).

86. *Id.* at 245-46. Specifically, MCL § 500.3107(1)(a) states that "Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation," while MCL § 500.3107(1)(c) addresses "replacement services," stating, "Expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent." *Id.* at 243 (citing MICH. COMP. LAWS § 500.3107(1)(a), (c) (West 2002)).

87. *Id.* at 246 (quoting *Griffith*, 472 Mich. at 535) (defining "care" as "those products, services, or accommodations whose provision is necessitated by the injury sustained in the motor vehicle accident" and stating that "'[c]are' is broader than 'recovery' and 'rehabilitation' because it may encompass expenses for products, services, and accommodations that are necessary because of the accident but that may not restore a person to his pre-injury state.").

88. *Id.* at 247.

89. Nelson v. Dubose, 291 Mich. App. 496, 806 N.W.2d 333 (2011).

90. *Id.* at 498-99 (citing McCormick v. Carrier, 487 Mich. 180, 795 N.W.2d 517 (2010)). *McCormick* overruled the Michigan Supreme Court's previous pronouncements on the topic in *Kreiner v. Fischer*, 471 Mich. 109, 683 N.W.2d 611 (2004). *McCormick*, 487 Mich. at 197.

"serious impairment of a body function" to the jury, which determined that there was no such impairment.[91] The court of appeals found it significant that the jury instruction did *not* contain language "specific to *Kreiner*'s more stringent definition."[92] Therefore, there was no need to retry the case in light of *McCormick*.[93]

*6. MCL Section 500.3158 and MCL Section 500.3159—Dispute between a No-Fault Insurer and a Medical Care Provider*

A No-Fault insurer brought suit against a medical care provider seeking the medical records of an insured to whom medical care was provided.[94] The medical care provider moved to dismiss the "complaint for discovery" because there was no live dispute between the parties, and, therefore, no jurisdiction.[95] The court of appeals agreed that "there is no such thing as a 'complaint for discovery.'"[96] However, looking to the substance of the complaint, the court determined that what the insurer was really seeking was a declaration of rights and responsibilities under MCL section 500.3158 and MCL section 500.3159.[97] MCL section 500.3158 requires medical care providers to furnish medical records to a No-Fault insurer, if requested.[98] MCL section 500.3159 permits a court to enter an order for discovery in a dispute regarding an injured person's medical care.[99] The insurer has a statutory right to demand copies of medical records related to a No-Fault insured's claim; once that demand is refused, the "dispute" required to permit a court to enter an order for

91. *Nelson*, 291 Mich. App. at 499.

92. *Id.* at 500.

93. *Id.* The jury instructions were not found to be an abuse of discretion because the jury "did not hear anything prejudicial in reference to *Kreiner*." *Id.* The court further noted that while the accepted definition of "serious impairment of body function" has changed, the statute itself is the same. *Id.* at 499. Therefore, "serious impairment of body function" is a question of law only where "there is no factual dispute about the injuries or if any factual dispute is immaterial to the question." *Id.* In the case at issue, there were differing opinions on the plaintiff's injuries and, therefore, submission of the question to the jury was not error. *Id.* at 500.

94. State Farm Mut. Ins. Co. v Broe Rehab. Servs., Inc., 289 Mich. App. 277, 278, -- N.W.2d -- (2010).

95. *Id.* at 279. The insurer was not involved in any litigation with its insureds, but rather wanted access to the medical records to determine the propriety of billings and diagnoses to determine the reasonableness and necessity of continuing treatment. *Id.* at 278-79.

96. *Id.* at 279.

97. *Id.* at 280.

98. MICH. COMP. LAWS ANN. § 500.3158(2) (West 2002).

99. MICH. COMP. LAWS ANN. § 500.3159 (West 2002).

discovery arises.[100] The court found a very real dispute between the parties existed so as to grant a court jurisdiction to hear the case, and seemed to chastise the medical provider by noting that "given defendant's history of fraud and alleged misdiagnoses, plaintiff is not merely embarking on a fishing expedition."[101] Further, when a No-Fault insurer exercises its statutory right to demand medical records, the insureds are interested persons entitled to notice.[102]

*B. Uninsured/Underinsured Motorist Benefits*

In *Bradley v. State Farm Mutual Automobile Insurance Company*,[103] the Michigan Court of Appeals considered an insurance dispute based on an underlying accident involving an uninsured motorist. Ms. Bradley brought suit against an uninsured motorist and the vehicle's owner, Ms. Bowen, who was dismissed when it was revealed the motorist was charged with stealing Ms. Bowen's vehicle and, therefore, was excluded from her insurance.[104] The uninsured motorist failed to defend the underlying action, and a default judgment was entered against him.[105] Ms. Bradley brought the instant action to obtain benefits pursuant to an uninsured motor vehicle provision in her own policy.[106] Ms. Bowen's policy required her to join all of the tortfeasors in any suit brought against State Farm, and because Ms. Bowen did not do so, the trial court entered summary disposition in favor of State Farm.[107] Ms. Bowen claimed that because the insurer suffered no prejudice as a result of the failure to join, State Farm should nonetheless be obligated to pay uninsured motorist benefits.[108] Unlike No-Fault insurance, uninsured motorist coverage is not required by statute and, therefore, the terms of the contract control.[109]

The court of appeals noted that the purpose of the joinder provision at issue is similar to a notice provision in that both are meant to give the insurer "opportunity to protect its financial interests by exercising

100. *State Farm Mut. Ins. Co.*, 289 Mich. App. at 281. Pursuant to MCL § 500.3159, the dispute required is one "regarding an insurer's right to discovery of facts," not a dispute regarding the actual payment on the claim or the extent of any benefits owed. *Id.*

101. *Id.* at 282.

102. *Id.*

103. 290 Mich. App. 156, 158, 810 N.W.2d 386 (2010).

104. *Id.*

105. *Id.*

106. *Id.* at 158-59.

107. *Id.* at 159.

108. *Id.* at 160.

109. *Bradley*, 290 Mich. App. at 160 (citing Stoddard v. Citizens Ins. Co. of Am., 249 Mich. App. 457, 460, 643 N.W.2d 265 (2002)).

investigatory, defense, and subrogation rights."[110] The Michigan Supreme Court has held that where an insurer seeks to deny responsibility based on failure to comply with a notice provision, the insurer must establish actual prejudice by the failure to notify.[111] Given the similar purpose of the joinder provision to the notice provision, the court of appeals found no reason not to apply the rule requiring actual prejudice to cut off responsibility for benefits.[112] State Farm suffered no prejudice, as the uninsured motorist was not released from liability; in fact, the default judgment entered against him *exceeded* the State Farm policy limits for uninsured motorist coverage.[113] However, the court did not find entirely for Ms. Bradley.[114] In this action, she still had to prove her tort case, which requires that she establish a serious impairment of body function relative to the accident.[115] Collateral estoppel was inapplicable as State Farm was not a party to the underlying action.[116] Judge Hoekstra dissented, finding that prejudice is not a traditional contract defense and that the contract should be enforced as written, pursuant to the Michigan Supreme Court's decision in *Rory v. Continental Insurance Company*, as the most recent decision on insurance contract interpretation.[117]

The Michigan Court of Appeals also considered the continued viability of *Koski v. Allstate Insurance Company* in its traditional notice context.[118] In *Defrain v. State Farm Mutual Insurance Company*, the decedent, a pedestrian, was struck in a hit-and-run accident involving a motor vehicle.[119] The decedent had uninsured motorist coverage with State Farm.[120] The policy in question required that State Farm be notified of hit-and-run accidents within thirty days of the accident, and State

110. *Id.* at 161.

111. *Id.* at 160-61 (citing Koski v. Allstate Ins. Co., 456 Mich. 439, 444; 572 N.W.2d 636 (1998)).

112. *Id.* at 161. The court determined that *Koski* created a narrow exception, which has not been overruled, to the general rule of *Rory v. Continental Insurance Co.*, that insurance contracts are to be enforced as written. Rory v. Cont'l Ins. Co., 473 Mich. 457, 461, 703 N.W.2d 23 (2005).

113. *Bradley*, 290 Mich. App. at 162. The court acknowledged that the collectability of the uninsured motorist is not a factor, as that issue would remain whether the motorist had been joined or not. *Id.*

114. *Id.* at 163.

115. *Id.*

116. *Id.*

117. *Id.* at 165-66 (Hoekstra, J., dissenting).

118. Defrain v. State Farm Mut. Ins. Co., 291 Mich. App. 713, 809 N.W.2d 601 (2011).

119. *Id.* at 715.

120. *Id.* at 714.

Farm was not timely notified.[121] The policy also stated that State Farm was to be given the details of an accident "as soon as reasonably possible" after the insured is examined or treated, and the trial court found that this language created ambiguity with the thirty-day notice provision.[122]

The court of appeals did not even address the issue of ambiguity because State Farm "ma[de] no argument that it suffered any prejudice as a result of the delay."[123] The court of appeals did not simply apply the prejudice requirement of *Koski* blindly. Rather, the court noted that the Michigan Supreme Court adopted the dissent in *Jackson v. State Farm Mutual Automobile Insurance Company*, which rejected the argument that prejudice be demonstrated regarding failure to comply with a notice provision of an insurance policy.[124] The court of appeals acknowledged that *Jackson* and *Koski* are in direct conflict, as both involve notice as a condition precedent to liability and coverage that was not mandated by statute.[125] Because *Jackson* did not address *Koski*, which is binding precedent, the court of appeals discarded *Jackson* as "of questionable and limited value."[126] The court also noted the recent application of *Koski* in *Bradley v. State Farm Mutual Automobile Insurance Company*.[127] Since *Koski* was controlling, it was incumbent upon the insurer to prove prejudice in attempting to deny coverage based on violation of a notice provision.[128]

### C. *Criminal and Intentional Act Exclusions*

In a single case involving teenagers and a brawl during a YMCA basketball game, the Michigan Court of Appeals interpreted two common insurance exclusions; one for criminal acts and one for intentional acts.[129] A pair of thirteen-year-olds got into a fight at a basketball game resulting in one of the children sustaining, among other things, an acute head injury.[130] The uninjured child was charged as a

121. *Id.* at 715.

122. *Id.*

123. *Id.* at 716.

124. *Defrain*, 291 Mich. App. at 716 (citing Jackson v. State Farm Mut. Auto. Ins. Co., 472 Mich. 942, 698 N.W.2d 400 (2005)).

125. *Id.* at 717.

126. *Id.* at 718. The court found it significant that *Koski* was a complete opinion on the topic, whereas *Jackson* was "merely a cursory order." *Id.*

127. *Id.* at 718-19.

128. *Id.* at 719.

129. Auto Club Group Ins. Ass'n v. Andrzejewski, 292 Mich. App. 565, 808 N.W.2d 537 (2011).

130. *Id.* at 567.

juvenile with aggravated assault in violation of MCL section 750.81a(1)[131] and pled no contest.[132] The policy issued by Auto Club excluded coverage for:

> 5. bodily injury or property damage resulting from an act or omission by an insured person which is intended or could reasonably be expected to cause bodily injury or property damage. This exclusion applies even if the bodily injury or property damage is different from, or greater than, that which is expected or intended.
>
> . . . .
>
> 10. bodily injury or property damage resulting from:
> a. a criminal act or omission committed by anyone; or
> b. an act or omission, criminal in nature, committed by an insured person even if the insured person lacked the mental capacity to:
> (1) appreciate the criminal nature or wrongfulness of the act or omission; or
> (2) conform his or her conduct to the requirements of the law; or
> (3) form the necessary intent under the law.
>
> This exclusion will apply whether or not anyone, including the insured person:
> a. is charged with a crime;
> b. is convicted of a crime whether by a court, jury or plea of nolo contendere; or
> c. enters a plea of guilty whether or not accepted by the court[.][133]

The court of appeals determined that the criminal act exclusion applied to these facts.[134]

The court of appeals distinguished the case from that presented in *Allstate Insurance Company v. McCarn*.[135] The exclusion at issue in

131. MICH. COMP. LAWS ANN. § 750.81a(1) (West 2004).
132. *Andrzejewski*, 292 Mich. App. at 568.
133. *Id.* at 571 (alterations in original).
134. *Id.*
135. *Id.* at 571-72 (citing Allstate Ins. Co. v. McCarn, 471 Mich. 283, 683 N.W.2d 656 (2004)).

*McCarn* combined intentional and criminal acts into one exclusion.[136] In this case, the criminal act exclusion was completely distinct from the intentional act exclusion, and did not require that the injuries resulting from the criminal act be the reasonably expected result of the criminal act.[137] As such, the court determined that the exclusion did not take into account the person's intent or expectation.[138] The court also found it inconsequential that the determination at issue was a juvenile delinquency proceeding because delinquency requires a finding that a municipal ordinance or other law has been violated and that the act, if committed by an adult, would constitute the crime of aggravated assault.[139]

The court also heard a second case involving a criminal act exclusion in *Auto Club Group Insurance Company v. Booth*.[140] Mr. Booth, who was intoxicated, was having a discussion with Michael Bordo about the amount of pain that he could endure.[141] Mr. Booth retrieved a handgun, and after inadvertently chambering a round, placed the barrel of what he thought was an unloaded gun against Mr. Bordo's wrist and pulled the trigger.[142] Serious and permanent damage to Mr. Bordo's wrist and hand resulted from Mr. Booth firing the gun.[143] Mr. Booth pled no contest to a misdemeanor of careless, reckless, or negligent discharge of a firearm resulting in injury, in violation of MCL section 752.861.[144] The trial court granted summary disposition to Mr. Booth and Mr. Bordo after determining that the two-prong test of *McCarn* was not satisfied.[145]

The court of appeals determined it was undisputed that Mr. Booth's conduct was a criminal act.[146] The court found that *McCarn* did not apply because the exclusion considered in that case was very different

136. *Id.* "'[W]e do not cover any bodily injury or property damage intended by, or which may reasonably be expected to result from the intentional or criminal acts or omissions of, any insured person.'" *Id.* (quoting *McCarn*, 471 Mich. at 289). That language required application of a two-prong test, excluding coverage where "the insured acted either intentionally or criminally, and . . . the resulting injuries were the reasonably expected result of an insured's intentional or criminal act." *McCarn*, 471 Mich. at 289-90.

137. *Andrzejewski*, 292 Mich. App. at 573.

138. *Id.*

139. *Id.* at 572-73 (citing MICH. COMP. LAWS ANN. § 712A.2(a)(1) (West 2002)).

140. 289 Mich. App. 606, 797 N.W.2d 695 (2010).

141. *Id.* at 608.

142. *Id.*

143. *Id.*

144. *Id.* The trial court concluded that while the act was intentional, the injury could not have been reasonably expected since Mr. Booth thought the gun was not loaded. *Id.*

145. *Id.* at 609.

146. *Booth*, 289 Mich. App. at 612.

from the exclusion at issue in the present case.[147] Unlike the clause considered in *McCarn*, the clause at bar did not contain language of injury reasonably expected to result from the criminal act.[148] Thus, there was no need to apply the two-prong test of *McCarn* because under the instant clause, the inquiry concludes when it is determined the injury resulted from a criminal act.[149] The court also refused to invalidate the clause on public policy grounds, noting that such clauses deter crime, and are thus favored by public policy.[150]

### *D. Insurance Regulation*

In *Michigan Basic Property Insurance Association v. Office of Financial and Insurance Regulation*, the court of appeals considered the authority of the insurance commissioner to disapprove changes to the Association's plan of operation.[151] The Association, a legislative creation that provided property insurance to individuals unable to obtain insurance in the regular market, sought to increase its rates.[152] In documentation to support the increase, the Association noted that the increase was premised on the actuarial method, which was a method different from that traditionally used, and that use of any other method would have resulted in a rate *decrease*.[153] The commissioner disapproved the rate increase for three reasons, concluding (1) that the increase was consistent with the "weighted average" language used in MCL section 500.2930a(1) because the method, with its base rate starting point, was not reflective of the premium which would actually be charged; (2) that the rate advocated by the association did not conform to MCL section 500.2109(1)(c), requiring that rates not be unfairly discriminatory in relation to another rate for the same coverage; and (3) that the rate advocated did not conform to MCL section 500.2920(2) requiring a plan of operation to be "fair, reasonable, equitable and nondiscriminatory" in

147. *Id.* at 613. Notably, the exclusion at issue was not a hybrid criminal/intentional act exclusion such as that considered in *McCarn*, but rather was a "pure" criminal act exclusion. *Id.* at 614.

148. *Id.* at 614.

149. *Id.*

150. *Id.* at 614-15 (quoting Auto Club Group Ins. Co. v. Daniel, 254 Mich. App. 1, 4-5, 658 N.W.2d 193 (2002)).

151. *Mich. Basic Prop. Ins. Ass'n v. Office of Fin. and Ins. Regulation*, 288 Mich. App. 552, 553-54, 808 N.W.2d 456 (2010).

152. *Id.* at 554.

153. *Id.* The Association used a calculation based "on the weighted base rate average of the top 10 insurer groups," instead of a calculation based on "the 'weighted average of actual charged premium.'" *Id.*

its administration.[154] The trial court reversed the disapproval, concluding that MCL section 500.2930a(1) was ambiguous and the commissioner lacked the ability to change a longstanding interpretation based on an alleged change in circumstances in how the insurance industry operates regarding premiums.[155]

The court of appeals noted that "the Legislature gave the insurance commissioner very large powers and assumed that the commissioner had the qualifications to assess issues affecting the industry."[156] The dispute surrounds what "weighted average" in MCL section 500.3109a(1) dictates. Traditionally, the calculation used "base rates," which are the starting point for a premium, prior to the application of any factors that would result in an increase or decrease.[157] The commissioner contended that the statute does not require the use of "base rates" and the commissioner is empowered to interpret the statute to carry out the legislative intent to provide affordable insurance to those who otherwise could not afford it.[158] The court agreed that the statute is ambiguous in that it does not state which "weighted average" is to be used.[159] Given the authority of the commissioner to examine issues affecting the insurance industry (with the goal of protecting the public), the court found that the commissioner was empowered to review the proposed rate increase and to determine whether it conformed to the statute.[160] Once the commissioner requested a different method of calculation, the court placed the burden on the Association to show "that its preferred method of calculation was fair, reasonable, equitable, and nondiscriminatory."[161] The Association's calculation method, on its face, did not appear fair and equitable, as it used the "base rate" which was inflated compared to the amount actually charged.[162] The court stated that "[i]nsurance laws are to be liberally construed in favor of the public," and that the insurance commissioner utilized his knowledge and expertise to recognize a disparity between the "base rate" traditionally used in the calculation,

154. *Id.* at 555-56.

155. *Id.* at 556-57. MCL § 500.2930a(1) states, in pertinent part: "Except as otherwise provided in subsection (4)(c), rates charged in each territory by the pool for home insurance shall be equal to the weighted average of the 10 voluntary market insurer groups with the largest premium volume in this state." MICH. COMP. LAWS ANN. § 500.2930a(1) (West 2002).

156. *Mich. Basic Prop. Ins. Ass'n*, 288 Mich. App. at 561-62.

157. *Id.* at 565.

158. *Id.* at 565-66.

159. *Id.* at 566.

160. *Id.* at 567-68.

161. *Id.* at 568.

162. *Mich. Basic Prop. Ins. Ass'n*, 288 Mich. App. at 568.

and the actual cost to obtain insurance.[163] The fact that "base rate" had been deemed acceptable did not mean that the commissioner did not have authority to take present insurance practices into account in determining the proper rate to use.[164] The commissioner acted within his authority in disallowing the calculation used in favor of one that more accurately reflected modern insurance practices.[165]

The court of appeals considered regulation of two unique entities, Blue Cross Blue Shield of Michigan ("BCBSM") and the Accident Fund Insurance Company of America, in *Attorney General v. Blue Cross Blue Shield of Michigan*.[166] BCBSM is a statutory, non-profit creation, which was permitted to purchase Accident Fund, a for-profit state workers' compensation insurer.[167] At issue was the acquisition by Accident Fund of three foreign insurance companies, as well as a $125 million transfer to the Fund from BCBSM, with no repayment obligation.[168] The Attorney General contended that, by statute, BCBSM was prohibited from acquiring any "domestic, foreign, or alien insurers," and that the contribution, without obligation for repayment, violated the statutory prohibition on BCBSM from using its funds to "operate or subsidize" Accident Fund in any way.[169] When it came to the acquisition of the insurers, the Attorney General argued that BCBSM could not do indirectly through Accident Fund that which it was prohibited from doing directly.[170]

The court of appeals agreed that the statutory prohibition on acquiring insurers applied to BCBSM, and not to Accident Fund, its wholly owned subsidiary.[171] MCL section 550.1207(1)(o) plainly applies to a "health care corporation," a term that includes BCBSM but not Accident Fund.[172] While BCBSM was previously prohibited from engaging in any investment activity indirectly that it could not engage in directly, that prohibition was removed effective July 23, 2003.[173] The court of appeals then went on to discuss the issue of primary jurisdiction,

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163. *Id.* at 569-70 (citing Att'y Gen. *ex rel.* Comm'r of Ins. v. Mich. Sur. Co., 364 Mich. 299, 110 N.W.2d 677 (1961); Tevis v. Amex Assurance Co., 283 Mich. App. 76, 770 N.W.2d 16 (2009)).

164. *Id.* at 571.

165. *Id.* at 573-74.

166. 291 Mich. App. 64, 810 N.W.2d 603 (2010).

167. *Id.* at 69.

168. *Id.* at 69-70.

169. *Id.* at 72-73 (citing MICH. COMP. LAWS ANN. § 550.1207(1)(o), (x)(vi) (West 2002)).

170. *Id.* at 74.

171. *Id.* at 79-80.

172. *Blue Cross*, 291 Mich. App. at 83-84.

173. *Id.* at 82-83.

which is not really an insurance issue; however the court noted that state agencies such as OFIR cannot issue decisions that are binding upon the courts or which can be used to overcome the plain meaning of a statute.[174]

*E. Formal Denial*

In a case involving fire insurance, the court of appeals addressed when a communication from an insurer constitutes a denial.[175] Following a 2003 fire that destroyed a farmhouse, Farm Bureau determined that the loss was not covered because the building had not been used as a domicile for about sixteen months, a time period greater than that permitted by the policy, though the insured disputed this conclusion.[176] The insured submitted a letter with a sworn proof of loss, to which Farm Bureau issued a response on May 22, 2003, noting the incompleteness of the statement but stating that the investigation was ongoing, and that "[t]his is not a denial of your claim but rather a rejection of the Proof of Loss . . . ."[177] After submission of a complete proof of loss, Farm Bureau issued a letter on June 26, 2003, stating that upon review, the company felt "justified in [its] denial of the . . . claim," due to the farmhouse being unoccupied for many months.[178] An agent contacted a claims supervisor on June 27, 2003 on behalf of the insured to attempt to correct the allegedly wrongful denial and to provide documents regarding the meaning of "vacancy" and "unoccupancy."[179] Farm Bureau responded on June 30, 2003, again denying the claim.[180] On July 21, 2003, the agent for the insured and the claims supervisor for Farm Bureau exchanged correspondence acknowledging the claim had been denied.[181] On September 24, 2003, the agent of the insured again wrote to the claims supervisor and requested a meeting with him.[182] The meeting took place on October 10, 2003 and, according to the insured's agent, the claims supervisor had been willing to give the matter further consideration upon provision of utility bills for the property.[183] The insured's agent sent the

174. *Id.* at 91-92.
175. McNeel v. Farm Bureau Gen. Ins. Co., 289 Mich. App. 76, 795 N.W.2d 205 (2010).
176. *Id.* at 80.
177. *Id.* at 81.
178. *Id.*
179. *Id.* at 81-82.
180. *Id.* at 82.
181. *McNeel*, 289 Mich. App. at 82.
182. *Id.* at 83.
183. *Id.*

utility bills to the claims supervisor on October 14, 2003 and the claims supervisor responded that his "findings still indicate[d] that the house was both vacant and unoccupied . . . ."[184] The insured commenced suit on October 5, 2004, and Farm Bureau moved to dismiss "for failure to file within one year of the date the claim was formally denied."[185] The trial court concluded that the question was one of fact and allowed the case to proceed to a jury trial; the jury returned a verdict for the insured.[186]

The court of appeals found that Farm Bureau waived its defense of timely filing as it pertained to the verdict by not presenting any evidence on the matter at trial.[187] However, the waiver did not affect Farm Bureau's ability to appeal the denial of its motion for summary disposition.[188] The court concluded that Farm Bureau withdrew its April 2003 denial in its May 22, 2003 letter, but later issued a second denial on June 26, 2003.[189] However, the subsequent correspondence and meeting between the insured's agent and the claims supervisor created a question of fact as to whether that second denial was withdrawn.[190] Therefore, the court had not erred in denying Farm Bureau's motion for summary disposition.[191]

Farm Bureau also raised an issue with the trial court's jury instruction with regard to occupancy.[192] However, Farm Bureau never suggested an instruction, thus the trial court did not err in failing to give an instruction when one was never requested.[193] Farm Bureau failed to precisely state the grounds for the objection made at trial and, therefore, the court of appeals reviewed the matter for "plain error affecting defendant's substantial rights."[194] The insurance policy at issue defined neither "unoccupied" nor "vacant," so the court turned to dictionary definitions and found that "vacant" meant "'[h]olding nothing: empty,'"[195] while "'unoccupied' mean[t] 'not lived in.'"[196] Since the trial

184. *Id.*
185. *Id.* at 83-84 (citing MICH. COMP. LAWS ANN. § 500.2833(1)(q) (West 2002)).
186. *Id.* at 84. Farm Bureau presented no evidence at trial as to when the formal denial occurred. *Id.*
187. *McNeel*, 289 Mich. App. at 86.
188. *Id.*
189. *Id.*
190. *Id.* at 87-88.
191. *Id.*
192. *Id.* at 89.
193. *McNeel*, 289 Mich. App. at 89.
194. *Id.*
195. *Id.* (quoting WEBSTER'S NEW BASIC DICTIONARY (Office ed. 2007)).
196. *Id.* at 91.

court found that "unoccupied" meant "'not [being] lived in'" the instruction properly informed the jury.[197]

Farm Bureau argued that the case of *Vushaj v. Farm Bureau General Insurance Company of Michigan*[198] was controlling.[199] The court flatly rejected the argument for two reasons: one, the present appeal had been filed before *Vushaj* was decided, and two, the policy language in *Vushaj* combined the terms "vacant" and "unoccupied" in the same clause, while the instant policy language placed the terms "vacant" and "unoccupied" in two separate clauses.[200] The definition of "unoccupied" used in *Vushaj* was "not routinely characterized by the presence of human beings,"[201] but the policy at issue required that the building be unoccupied for six consecutive months.[202] The six month period would restart if the building became occupied for even a single day.[203] Using the *Vushaj* definition, the word "consecutive" would be rendered nugatory, a result that would conflict with the rules of contract construction.[204]

The last issue addressed by the court was the retroactivity of the *Griswold Properties, L.L.C. v. Lexington Insurance Company*[205] decision that "'a first-party insured is entitled to twelve percent penalty interest if a claim is not timely paid, irrespective of whether the claim is reasonably in dispute, applied retroactively.'"[206] The court gave *Griswold* full retroactive effect and, therefore, the assessment of penalty interest against Farm Bureau was proper.[207] Judge Kirsten Frank Kelly dissented and would have found the claims time-barred by MCL section 500.2833(1)(q).[208] In Judge Kelly's opinion, when Farm Bureau denied the claim on June 26, 2003, time began to run and every subsequent

197. *Id.*

198. 284 Mich. App. 513, 773 N.W.2d 758 (2009).

199. *McNeel*, 289 Mich. App. at 92.

200. *Id.* That the policy at issue intended different definitions for the two terms is confirmed by the different time requirements associated with the terms: to exclude coverage, the building had to be vacant for sixty days or unoccupied for six consecutive months. *Id.*

201. *Id.* at 93 (quoting Vushaj v. Farm Bureau Gen. Ins. Co. of Mich., 284 Mich. App. 513, 516, 773 N.W.2d 758 (2009)).

202. *Id.*

203. *Id.*

204. *Id.*

205. 276 Mich. App. 551, 741 N.W.2d 549 (2007).

206. *McNeel*, 289 Mich. App. at 94 (quoting *Griswold*, 276 Mich. App. at 554)) (internal quotation marks omitted).

207. *Id.* at 95. The court also addressed an issue of attorney fees, but that issue was related to case evaluation sanctions, not an insurance statute or provision granting such fees. *Id.* at 97-103.

208. *Id.* at 104 (Kelly, J., dissenting).

correspondence reiterated the denial.[209] Nothing in the record evidenced that the June 26, 2003 denial was ever rescinded.[210] Judge Kelly found that the majority improperly applied principles of judicial tolling and equitable estoppel to avoid a clear statutory limitations period.[211]

### *F. Residence Requirements*

The use of the premises was again at issue in *McGrath v. Allstate Insurance Company*[212] Decedent Mary McGrath owned a home in Gaylord, Michigan, insured by Allstate.[213] Due to health issues, Ms. McGrath moved to an apartment in Farmington Hills in 2003 to be closer to family who could care for her.[214] Ms. McGrath's daughter notified Allstate that insurance bills should be sent to an address in Farmington Hills and the Gaylord house ceased to be a full time residence, although family members would occasionally visit the house.[215] In May 2006, it was discovered that the Gaylord house sustained water damage due to a burst pipe that had frozen due to lack of heat.[216] The trial court denied Allstate's motion for summary disposition, and the case proceeded to trial, where the jury found in favor of Ms. McGrath's estate.[217]

Allstate based its motion for summary disposition on the fact that Ms. McGrath did not reside at the Gaylord House at the time of loss, and did not notify it of any change in title, occupancy, or use regarding the house.[218] The court of appeals agreed with Allstate and held that there was no coverage since the policy only provided coverage for a "dwelling," defined as "a one, two, three, or four family *building structure*, identified as the insured property on the Policy Declarations, where *you* reside and which is principally used as a private residence."[219] The policy also required notice of any change in the title, use, or occupancy of the premises.[220] The court found that the use of "dwelling"

209. *Id.* at 112.
210. *Id.* at 114.
211. *Id.* at 117-18.
212. 290 Mich. App. 434, 802 N.W.2d 619 (2010).
213. *Id.* at 436.
214. *Id.*
215. *Id.* at 437.
216. *Id.* at 436-37. Though the Gaylord house was subject to an agreement with a propane provider to keep the heating fuel tank full, that agreement was cancelled in December 2005 when the driveway to the house became impassable. *Id.* The driveway remained snowed in and no further propane was delivered. *Id.* at 438.
217. *Id.* at 438.
218. *McGrath*, 290 Mich. App. at 439-40.
219. *Id.* (emphasis added).
220. *Id.*

did not merely warrant that the insured lived in the house at the time the insurance contract was signed, but required the insured to reside at the premises at the time of loss.[221] The court of appeals rejected the use of a more technical definition of "reside" that would include living at the location, or an intent to live at the location sometime in the future.[222] Unoccupied or vacant homes are a larger risk than occupied homes, and so there was no dispute that Ms. McGrath lived in Farmington Hills full time for over two years before the loss at issue.[223] The notification in the change of billing address was insufficient to put Allstate on notice that the occupancy of the Gaylord house had changed, as there may have been any number of reasons for the change in billing address that would not have implicated a change in occupancy, such as children taking over responsibility for paying an elder parent's bills.[224] Nor, the court held, would a change in billing address obligate Allstate to make further inquiry regarding whether the home was occupied.[225]

### *G. Reformation*

The court of appeals considered the equitable remedy of reformation where the insured makes a misrepresentation in procuring the insurance.[226] The facts of the case are not complicated. McKinley Hyten's driver's license was suspended on January 6, 2007 and her privileges were not to be restored until August 24, 2007.[227] On August 22, 2007, in preparation for the reinstatement of her daughter's license, Ms. Hyten's mother contacted an insurance agent, filled out an application on behalf of Ms. Hyten, and informed the agent that Ms. Hyten's license was presently suspended.[228] Since she needed to complete a driver's assessment, Ms. Hyten's license was not actually restored until September 20, 2007, but Allstate was never notified that

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221. *Id.* at 440-41.

222. *Id.* at 442 (rejecting any discussion in *Heniser v. Frankenmuth Ins.*, 449 Mich. 155, 534 N.W.2d 502 (1995), regarding the failure to satisfy either the popular or technical meaning of "reside" as *obiter dictum*).

223. *Id.* at 444-45.

224. *McGrath*, 290 Mich. App. at 446-47. The court agreed with the Seventh Circuit, which found that a change of billing address for an elderly insured, without more, would not give the insurance company notice that the elderly individual had moved out of the house. *Id.* at 447-48 (citing Estate of Luster v. Allstate Ins. Co., 598 F.3d 903, 906 (7th Cir. 2010)).

225. *Id.* at 448.

226. Titan Ins. Co. v. Hyten, 291 Mich. App. 445, 805 N.W.2d 503 (2011).

227. *Id.* at 447.

228. *Id.* The insurance agent post-dated the application to August 24, 2007, when the licensure was to be reinstated. *Id.*

the license was not actually restored on August 24, 2007.[229] On February 10, 2008, Ms. Hyten was involved in a motor vehicle accident, injuring Howard and Martha Holmes.[230] Titan Insurance Company sought to reform its policy to the statutory minimum for liability coverage—$20,000 per person and $40,000 per event—based on its assertion that it would never have issued the policy had it known Ms. Hyten's license had been suspended.[231] The trial court found against Titan on motions for summary disposition.[232]

The court of appeals noted that any ability to completely rescind a policy ceases when there has been injury to an innocent third party, at which time the insurer will be obligated to provide the insurance required by the No-Fault Insurance Act.[233] The question then became whether an insurer may reform the policy to the statutory minimum for liability coverage where there has been a misrepresentation by the insured.[234] The case of *Ohio Farmers Insurance Company v. Michigan Mutual Insurance Company*,[235] which stands for the proposition that public policy estops an insurer from reforming its policy to the statutory minimums, was in conflict with *Farmers Insurance Exchange v. Anderson*,[236] which declined to follow *Ohio Farmers* based on a failure to consider two aspects of the Financial Responsibility Act ("FRA"),[237] which permits an insurer to reform a policy of excess coverage on the basis of fraud.[238] However, *Anderson* limited its holding by denying an insurer that has collected a premium the ability to reform due to fraud, where the fraud could have been easily ascertained at the time of the contract.[239] No authority was previously cited for this limitation.[240]

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229. *Id.* at 448.

230. *Id.* at 447.

231. *Id.*

232. *Titan Ins. Co.*, 291 Mich. App. at 447.

233. *Id.* at 452 (quoting Farmers Ins. Exch. v. Anderson, 206 Mich. App. 214, 218, 520 N.W.2d 686 (1994)).

234. *Id.* at 453.

235. 179 Mich. App. 355, 363, 445 N.W.2d 228 (1989).

236. 206 Mich. App. 214, 520 N.W.2d 686 (1994).

237. *Titan Ins. Co.*, 291 Mich. App. at 453.

238. *Id.* at 454-55. MICH. COMP. LAWS ANN. § 257.520(f)(1) (West 2006) "prohibits an insurer from using fraud as a basis to void completely coverage under an insurance policy once an innocent third party has been injured" but only as to the statutory minimum coverage of $20,000/$40,000. *Anderson*, 206 Mich. App. at 218. In contrast, MICH. COMP. LAWS ANN. § 257.520(g) deals with excess coverage, and is not limited by the statutory minimums, evidencing "that the Legislature did not intend to preclude an insurer from using fraud as a defense to void optional insurance coverage." *Id.* at 219.

239. *Id.* at 455.

240. *Id.* at 457.

Titan alleged that two more recent opinions, *Hammoud v. Metropolitan Property & Casualty Insurance Company*[241] and *Manier v. MIC General Insurance Company*,[242] signaled a retreat from the "easily ascertained" exception.[243] The former case states that an insurer owes the *insured* no duty to investigate statements on an application, but says nothing of third parties, while the latter is a case where the court concluded that the misrepresentation could not have been "easily ascertained."[244] In the present case, the Holmeses were determined to be innocent third parties and Hyten's misrepresentation was "easily ascertainable."[245] The "easily ascertainable" standard derives from both the No-Fault Insurance Act[246] and common law fraud, where courts have held that "[t]here can be no fraud where a person has the means to determine that a representation is not true."[247] Titan failed to show that its reliance on Ms. Hyten's statements was reasonable in light of its choice not to investigate and the "easily ascertainable" nature of the misrepresentation.[248] Further, Ms. Hyten's acquisition of a license months before the accident, cured any innocent misrepresentation.[249] Even Titan did not claim that it would have refused to issue insurance as of September 20, 2007 due to a changed risk.[250] The court also cursorily found that the Holmes' insurer had a real interest in the outcome of this litigation and, therefore, had standing to participate in this case.[251]

## III. DECISIONS OF THE MICHIGAN SUPREME COURT

### *A. No-Fault Cases*

The Michigan Supreme Court considered the application of the one-year-back rule of MCL section 500.3145(1), which limits the damages

241. 222 Mich. App. 485, 563 N.W.2d 716 (1997).
242. 281 Mich. App. 485, 760 N.W.2d 293 (2008).
243. *Titan Ins. Co.*, 291 Mich. App. at 457.
244. *Id.* at 457-58.
245. *Id.* at 458.
246. MICH. COMP. LAWS ANN. § 500.3220 (West 2002). Though the statute does not require an insurer to undertake an investigation of the insured's representation, it does prevent an insurer from using later-acquired knowledge to cancel a policy, except in limited circumstances, after the policy has been in effect for fifty-five days. *Titan Ins. Co.*, 291 Mich. App. at 460-61.
247. *Titan Ins. Co.*, 291 Mich. App. at 462 (quoting Nieves v. Bell Indus., Inc., 204 Mich. App. 459, 464, 517 N.W.2d 235 (1994)).
248. *Id.* at 462.
249. *Id.*
250. *Id.* at 465.
251. *Id.* at 467.

recoverable in a No-Fault claim, in light of MCL section 600.5821(4), which permits:

> Actions brought in the name of the state of Michigan, the people of the state of Michigan, or any political subdivision of the state of Michigan, or in the name of any officer or otherwise for the benefit of the state of Michigan or any political subdivision of the state of Michigan for the recovery of the cost of maintenance, care, and treatment of persons in hospitals, homes, schools, and other state institutions are not subject to the statute of limitations and may be brought at any time without limitation, the provisions of any statute notwithstanding.[252]

In 2000, the University of Michigan Health System ("UMHS") treated a person injured in a motor vehicle accident who sought No-Fault insurance benefits from the Michigan Assigned Claims Facility, which designated Titan Insurance Company as the servicing insurer.[253] Nearly six years after having provided treatment to the injured party, UMHS filed suit against Titan seeking reimbursement for the full cost of the hospitalization.[254] The trial court dismissed the case based upon the one-year-back rule, which limits recovery in a No-Fault action to amounts incurred within one year of filing suit.[255] The court of appeals affirmed in a divided opinion.[256]

From 1982 to 2006, the decisions of the Michigan courts held that MCL section 600.5851(1) "preserves a claim by a minor or incompetent person for personal protection insurance benefits even though it would otherwise be barred by the one-year-back rule."[257] However, in 2006, the Michigan Supreme Court reversed that holding and found that the minority/insanity tolling provision did not apply to the one-year-back rule because the one-year-back rule is a damage limitation, not a statute of limitation.[258] Relying solely on *Cameron v. Auto Club Insurance Association*, in *Liptow v. State Farm Mutual Auto Insurance*

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252. Regents of the Univ. of Mich. v. Titan Ins. Co., 487 Mich. 289, 293-94 n.4, 791 N.W.2d 897 (2010), *reh'g denied*, 488 Mich. 893, 794 N.W.2d 570 (2010) (quoting MICH. COMP. LAWS ANN. § 600.5821(4) (West 2000)).

253. *Id.* at 293.

254. *Id.*

255. *Id.* at 294 n.3.

256. *Id.* at 294.

257. *Regents of the Univ. of Mich.*, 487 Mich. at 295 (citing Geiger v. Detroit Auto. Inter-Ins. Exch., 114 Mich. App. 283, 318 N.W.2d 833 (1982)).

258. *Id.* at 295-96 (citing Cameron v. Auto Club Ins. Ass'n, 476 Mich. 55, 62, 718 N.W.2d 784 (2006)).

*Company*,[259] the court of appeals found the provisions of MCL section 600.5821(4) to be inapplicable to the one-year-back rule because the former dealt with statutes of limitations, not damage limitations.[260]

The supreme court reversed the court of appeals and explicitly overruled *Liptow* and *Cameron*.[261] The analysis in *Cameron* was flawed because the court read the statutory language in isolation, which is impermissible because MCL section 600.5851(1) does not create a cause of action and, therefore, it must be read in conjunction with the statute creating the cause of action.[262] The court found that "[a]lthough the right to bring an action would be a hollow one indeed if a plaintiff could not recover damages, *Cameron* and *Liptow* limited a plaintiff to just that hollow right."[263] The supreme court proceeded to "restore the proper understanding of the interaction between MCL 600.5851(1) and the one-year-back rule," and held that the action/claim preserved includes a right to collect damages.[264] The statute at bar, MCL section 600.5821(4), also speaks of "actions" and therefore, the reasoning adopted as to MCL section 600.5851(1) applies with equal force.[265] The preservation enacted by such statutes includes more than the right to file papers in court; it protects the right to obtain damages if successful.[266] Therefore, the court succinctly concluded:

> *Cameron* erroneously held that MCL 600.5851(1) does not protect a plaintiff's claim from the one-year-back rule. We also hold that this understanding of the interaction between the statutes is equally applicable to the interaction between MCL 600.5821(4) and MCL 500.3145(1). Therefore, the provisions of MCL 600.5821(4) preserving a plaintiff's right to bring an action also preserve the plaintiff's right to recover damages incurred more than one year before suit is filed. The one-year-back rule in MCL 500.3145(1) is inapplicable to such claims.[267]

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259. 272 Mich. App. 544, 555-56, 726 N.W.2d 443 (2006).
260. *Regents of the Univ. of Mich.*, 487 Mich. at 297-98.
261. *Id.*
262. *Id.* at 298.
263. *Id.* at 299.
264. *Id.* The court then went on to quote from Justice Cavanagh's dissent in *Cameron*. *Id.*
265. *Id.* at 300.
266. *Regents of the Univ. of Mich.*, 487 Mich. at 300.
267. *Id.* at 302.

The court concluded with a discussion of stare decisis, which has become a common feature when the court acts to overrule precedent.[268]

The Michigan Supreme Court continued to overrule precedent in *McCormick v. Carrier*,[269] which dealt with the threshold injury sufficient to retain a tort cause of action in light of the No-Fault Insurance Act.[270] Mincing no words, the court held that *Kreiner v. Fischer*,[271] its most recent pronouncement regarding a "serious impairment of body function" under MCL section 500.3135, "was wrongly decided because it departed from the plain language of MCL 500.3135, and is therefore overruled."[272] Unsurprisingly, the majority opinion in *McCormick* was written by Justice Cavanagh, the same justice who authored the dissent in *Kreiner*.[273]

The court acknowledged that "tort liability for non-economic loss arising out of the ownership, maintenance, or use of a qualifying motor vehicle is limited to a list of enumerated circumstances. The act creates threshold requirements in MCL 500.3135(1), which has remained unchanged in all key aspects since the act was adopted."[274] The threshold is "serious impairment of body function," which though originally undefined in the No-Fault Insurance Act, was given legislative meaning in 1995 as "'an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life.'"[275]

> Under the plain language of the statute, the threshold question whether the person has suffered a serious impairment of body function should be determined by the court as a matter of law as long as there is no factual dispute regarding "the nature and extent of the person's injuries" that is material to determining whether the threshold standards are met . . . . [T]he disputed fact does not need to be outcome determinative in order to be

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268. *Id.* at 303-04.

269. 487 Mich. 180, 214, 795 N.W.2d 517 (2010).

270. *Id.* at 188-89.

271. 471 Mich. 109, 683 N.W.2d 611 (2004).

272. *McCormick*, 487 Mich. at 184.

273. *Id.* at 209.

274. *Id.* at 189 (citing MICH. COMP. LAWS ANN. § 500.3135(3) (West 2002)).

275. *Id.* (quoting MICH. COMP. LAWS ANN. § 500.3135(7) (West 2002)). The legislature further provided that the issue was a question of law, unless "[t]here is no factual dispute concerning the nature and extent of the person's injuries" or if there is a factual dispute as to the injuries, "the dispute is not material to the determination as to whether the person has suffered a serious impairment of body function or permanent serious disfigurement." MICH. COMP. LAWS ANN. § 500.3135(2)(a)(i)-(ii) (West 2002).

material, but it should be "significant or essential to the issue . . . ."[276]

The statute provides for a three part test in order to determine whether there has been "serious impairment of body function:" "(1) an objectively manifested impairment (2) of an important body function that (3) affects the person's general ability to lead his or her normal life."[277] The court proceeded to consider each prong of the test:

> [T]he common meaning of "objectively manifested" in MCL 500.3135(7) is an impairment that is evidenced by actual symptoms or conditions that someone other than the injured person would observe or perceive as impairing a body function. In other words, an "objectively manifested" impairment is commonly understood as one observable or perceivable from actual symptoms or conditions.[278]

The statute looks to the impairment, not the injury.[279] The court noted that this conclusion was consistent with case law as it existed before *Kreiner*.[280] To the extent that *Kreiner* required medical documentation to establish an objectively manifested impairment, it was wrongly decided.[281] The second prong, whether the body function was "important," "is an inherently subjective inquiry that must be decided on a case-by-case basis, because what may seem to be a trivial body function for most people may be subjectively important to some . . . ."[282] An "important" body function is not any body function, but it also does not refer to the *entire* body function.[283] Regarding the final prong, the court concluded:

> [T]he plain text of the statute and these definitions demonstrate that the common understanding of to "affect the person's ability to lead his or her normal life" is to have an influence on some of the person's capacity to live in his or her normal manner of

276. *McCormick*, 487 Mich. at 193-94 (citations omitted).
277. *Id.* at 195.
278. *Id.* at 196.
279. *Id.* at 197.
280. *Id.* (citing Cassidy v. McGovern, 415 Mich. 483, 505, 330 N.W.2d 22 (1982); DiFranco v. Pickard, 427 Mich. 32, 74, 398 N.W.2d 896 (1986)).
281. *Id.* at 198; *see also Kreiner*, 471 Mich. at 133.
282. *McCormick*, 487 Mich. at 199 (citing *Cassidy*, 415 Mich. at 504).
283. *Id.* The court noted that *Kreiner* appeared to be consistent with this interpretation. *Id.*

> living. By modifying "normal life" with "his or her," the Legislature indicated that this requires a subjective, person- and fact-specific inquiry that must be decided on a case-by-case basis.[284]

This general ability to lead one's life need only be affected, not destroyed, so the courts are to look at more than total cessation of a pre-accident "lifestyle element."[285] Further, "the plain language of the statute only requires that some of the person's *ability* to live in his or her normal manner of living has been affected, not that some of the person's normal manner of living has itself been affected."[286] Finally, the statute did not create any temporal requirement as to how long the impairment must last.[287] Regarding this prong, the *Kreiner* majority departed from the statutory text.[288] The non-exhaustive list of factors to be used to examine pre- and post-accident life were explicitly rejected.[289]

In place of *Kreiner*, the majority adopted a new test.[290] At the outset, "the court should determine whether there is a factual dispute regarding the nature and the extent of the person's injuries, and, if so, whether the dispute is material to determining whether the serious impairment of body function threshold is met."[291] If there is no material dispute, the court is to decide the issue of "serious impairment of body function" as a

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284. *Id.* at 202.

285. *Id.*

286. *Id.*

287. *Id.* at 203.

288. *McCormick*, 487 Mich. at 203-04. In particular, the court in *Kreiner* took a definition of "general"—meaning "the whole; the total; that which comprehends or relates to all, or the chief part; a general proposition, fact, principle, etc.;—opposed to particular; that is, opposed to special"—that best fit its conclusions. *Id.* at 204 (quoting *Kreiner*, 471 Mich. at 130). The decision was chastised for not choosing one of the other ten definitions of "general" and for selecting the most restrictive one. *Id.* Further, the *Kreiner* decision could be used out of context to focus the inquiry on how the impairment affects a person's life, not on how it affects his ability to live his life. *Id.* The *Kreiner* majority was said to have given an interpretation of the statute which was "inconsistent with common meanings and common sense" by holding that the impairment must affect the course/trajectory of a person's entire normal life. *Id.* at 205. The *Kreiner* majority, in essence, grafted the two words, "trajectory" and "entire," into the statute, even though those words do not appear in the actual text. *Id.* at 206-07.

289. *Id.* at 208. The factors were "(a) the nature and extent of the impairment, (b) the type and length of treatment required, (c) the duration of the impairment, (d) the extent of any residual impairment, and (e) the prognosis for eventual recovery." *Id.* (quoting *Kreiner*, 471 Mich. at 133).

290. *Id.* at 215.

291. *Id.* (citing MICH. COMP. LAWS ANN. § 500.3135(2)(a)(i), (ii) (West 2002).

matter of law.[292] If the matter is one of law, the court should then apply the three-part test dictated by the statute.[293] The test is inherently fact-specific, and therefore calls for fact conclusions, calling into question how the matter could ever be a question of law.[294] Applying the fact specific inquiry, the court determined that there had been a serious impairment of body function.[295] The majority then went on to address the dissent, including criticisms that Justice Cavanagh was resurrecting his own opinion in *DiFranco*, which the *Kreiner* court rejected.[296]

Justices Weaver and Hathaway concurred in the decision to overrule *Kreiner*, but wrote separately to address their opinions regarding stare decisis.[297] Justice Markman wrote a spirited dissent, criticizing the decision to overrule *Kreiner*, and accusing the court's short-lived majority of systematically overruling prior decisions of the supreme court with which it did not agree. The court aired its disputes in a quite public, and personal, fashion:

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292. *Id.*

293. *Id.* (identifying the three parts of the test as "(1) an objectively manifested impairment (observable or perceivable from actual symptoms or conditions) (2) of an important body function (a body function of value, significance, or consequence to the injured person) that (3) affects the person's general ability to lead his or her normal life (influences some of the plaintiff's capacity to live in his or her normal manner of living)").

294. *McCormick*, 487 Mich. at 215-16.

295. *Id.* at 216-17. Given the case-by-case nature of the inquiry, the facts themselves become rather unimportant since there is no rule that can be derived from the facts to be applied in all cases. *Id.* at 216. However, in the interest of completeness, the court found that plaintiff had a broken ankle, on which he could not place weight for one month, as well as two surgeries and months of physical therapy. *Id.* at 217. The court stated:

> Before the incident, plaintiff's 'normal life' consisted primarily of working 60 hours a week as a medium truck loader. Plaintiff also frequently fished in the spring and summer and was a weekend golfer. After the incident, plaintiff was unable to return to work for at least 14 months and did not return for 19 months. He never returned to his original job as a medium truck loader, but he suffered no loss in pay because of the change in job. He was able to fish at pre-incident levels by the spring of 2006 and is able to take care of his personal needs at the same level as before the incident. There is no allegation that the impairment of body function has affected his relationship with his significant other or other qualitative aspects of his life.

*Id.* at 217. The broken ankle was objectively manifested, plaintiff testified that he was unable to walk or perform work functions for some time, and the impairment "influenced some of his capacity to live in his normal, pre-incident manner of living." *Id.* at 218. Therefore, this plaintiff sustained a "serious impairment of body function." *Id.* at 219.

296. *Id.* at 220. Though this discussion is a fascinating insight into the inner-workings of the court, its relation to the subject of this article is not terribly significant.

297. *Id.* at 223-26.

> It is appropriate that Justice CAVANAGH, the authoring justice of the majority opinion in *DiFranco*, which was rejected by the Legislature, and also the authoring justice of the dissent in *Kreiner*, which was rejected by this Court, is now the authoring justice of the majority opinion, in which *Kreiner* is overruled. While to some, there may be a sense of justice, or at least a sense of irony, in this sequence of events, to others, including those of us in dissent in this case, such sequence embodies all that is wrong when a judiciary confuses its own preferences with those of the people's representatives in the Legislature. While it is intriguing that Justice CAVANAGH now is able to transform his dissent in *Kreiner* into a majority opinion, and thereby resuscitate his earlier opinion in *DiFranco*, this has been achieved only after the people of this state, through their Legislature, have made clear that *DiFranco* did *not* reflect what ought to be the policy of this state. Therefore, just as he did in his dissent in *Kreiner*, Justice CAVANAGH, now with majority support, rejects *Kreiner's* analysis of the language "that affects the person's general ability to lead his or her normal life." The worm has turned, and never mind what the people and their Legislature have sought to accomplish in establishing as the law.[298]

Of course, the "worm has turned" again, as Justice Markman now finds himself on the side of a new majority following the election of Justice Mary Beth Kelly and appointment of Justice Zahra.[299] Time will tell if the court's new majority will undo that which was done by the majority during this *Survey* period.

### *B. Insurance Regulation*

The court considered "the validity of rules promulgated by defendant Commissioner of Financial & Insurance Services (the OFIS rules) banning the practice of 'insurance scoring' under Chapters 21, 24, and 26 of the Insurance Code," in *Insurance Institute of Michigan v. Commissioner*.[300] A report of the then-insurance commissioner stated that "insurance scoring" was the practice of using "select credit

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298. *Id.* at 239-40 (Markman, J., dissenting).

299. *See Biographies of the Justices*, MICH. COURTS, http://courts.michigan.gov/supremecourt/aboutcourt/biography.htm (last visited May 13, 2012).

300. 486 Mich. 370, 374, 785 N.W.2d 67 (2010).

information to help insurance companies establish automobile and homeowners premiums."[301] Those individuals who have good "scores" are given discounts on premiums.[302] The practice was introduced in Michigan with the 1997 enactment of MCL section 500.2110a, "which allows insurers to establish and maintain a premium discount plan without prior approval by the Legislature or the insurance commissioner."[303]

The insurance commissioner issued bulletins that were aimed at protecting Michigan consumers by: (1) requiring insurers using scoring to file with the Office of Financial and insurance Services ("OFIS") "'the formula used to apply the discount,' 'the specific credit classification factors used to calculate the insurance credit score,' and an annual 'actuarial certification justifying the discount levels and discount tiers offered by the company[;]'"[304] (2) directing insurance companies to "'recalculate and then apply an insured's insurance credit score at least once annually' and to 'annually inform . . . policyholders or applicants of the credit score used to apply an insurance credit scoring discount . . . [;]'"[305] (3) noting the "problematic at best" nature of insurance scoring;[306] and (4) ultimately developing and enacting "administrative rules prohibiting the use of insurance scoring."[307] Several insurers brought this suit seeking a declaration of rights challenging the banning of insurance scoring.[308] The trial court agreed with the insurers, finding the OFIS rules "'illegal, invalid, and unenforceable,' and permanently enjoined the Commissioner from enforcing them."[309] On appeal, *three* separate opinions were issued by the three-judge panel for different reasons, with the majority voting to vacate the trial court's order.[310]

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301. *Id.* at 375 (quoting FRANK M. FITZGERALD, THE USE OF INS. CREDIT SCORING IN AUTO AND HOMEOWNERS INS. 5 (2002)) (internal quotation marks omitted).

302. *Id.*

303. *Id.*

304. *Id.* at 376 (quoting DEP'T OF LICENSING AND REG. AFF., BULL NO. 2003-01-INS, IN THE MATTER OF CONFORMING INSURANCE CREDIT SCORING PRACTICES WITH INSURANCE CODE REQUIREMENTS (2003), *available at* http://www.michigan.gov/lara/0,4601,7-154-10555_12900_13376-61601--,00.html (last visited May 13, 2012)).

305. *Id.* at 376-77.

306. *Ins. Inst. Of Mich.*, 486 Mich. at 377 (quoting DEP'T OF LICENSING AND REG. AFF., BULL. NO. 2003-02-INS, IN THE MATTER OF INSURANCE CREDIT SCORING PRACTICES – UPDATE TO BULL. 2003-01-INS (2003), *available at* http://www.michigan.gov/lara/0,4601,7-154-35299_10555_12900_13376-75302--,00.html (last visited May 13, 2012)).

307. *Id.* at 378.

308. *Id.* at 379-80.

309. *Id.* at 381.

310. *Id.* at 382.

In reviewing the validity of agency rules, the court applied a three-part test: "(1) whether the rule is within the matter covered by the enabling statute; (2) if so, whether it complies with the underlying legislative intent; and (3) if it meets the first two requirements, when [sic] it is neither arbitrary nor capricious."[311] Applying this test, the court concluded "the Commissioner exceeded her authority in promulgating the OFIS rules. The rules purport to prohibit a practice—insurance scoring—that is permissible under the Insurance Code."[312] Since the OFIS rules apply to "personal insurance," three chapters of the insurance code are relevant: Chapter 21 (automobile and home insurance), Chapter 24 (group automobile and home insurance and personal lines covering home, rental property, RVs, motorcycles, and boats), and Chapter 26 (group home insurance and other personal property lines).[313] Pursuant to each of these chapters, the insurers, not the commissioner, formulate the plans to be used to establish insurance rates.[314] The commissioner is given rule-making authority by MCL section 500.210, MCL section 500.2484 and MCL section 500.2674 to effectuate the purposes of the various insurance laws.[315] Here, the insurers have demonstrated that the rules are not covered by the statutory rule-making authority because insurance scoring is permissible under the insurance code.[316] Since the code does not prohibit the practice, and the commissioner failed to demonstrate that the rates produced by insurance scoring unfairly discriminate, the rules exceeded the commissioner's authority.[317]

Pursuant to MCL section 500.2110a, insurers are permitted to establish and maintain a premium discount plan based on a variety of factors that correlate to the insurer's expected reductions, losses, or expenses.[318] The evidence shows that plans utilizing insurance scoring "may reflect reasonably anticipated reductions in losses or expenses on the part of the insurer employing the plan[,]" and thus evidences a correlation.[319]

> MCL 500.2110a allows "an insurer" to establish "*a plan*" "if *the plan* . . . reflects reasonably anticipated reductions in losses or

311. *Id.* at 385 (alteration in original) (quoting Chesapeake & Ohio Ry. Co. v. Mich. Pub. Serv. Comm'n, 59 Mich. App. 88, 98-99, 228 N.W.2d 843 (1975)).
312. *Ins. Inst. of Mich.*, 486 Mich. at 385.
313. *Id.* at 386.
314. *Id.*
315. *Id.* at 387.
316. *Id.* at 389.
317. *Id.*
318. *Ins. Inst. of Mich.*, 486 Mich. at 390.
319. *Id.*

> expenses." The plain meaning of this provision is that an insurer may establish a plan that it reasonably anticipates will reduce *its own* losses or expenses. It is unclear how an insurer would "reasonably anticipate[]" the effect of its premium discount plan on *industry-wide* losses or expenses. Individual insurers *do*, of course, anticipate reductions in their own losses or expenses to result from the use of premium discount plans using insurance scoring. Specifically, they anticipate that insurance score discounts will enable them to attract and retain more low-risk customers by offering these customers lower rates. Plaintiffs have demonstrated a clear correlation between insurance scores and risk of loss, as already discussed. Therefore, they have established that a discount plan that enables an insurer to attract and retain more lower risk insureds "reflects reasonably anticipated reductions in losses or expenses for that insurer."[320]

In fact, there is evidence that banning the use of insurance scoring would lead to *increases* in premiums paid, thus undercutting the commissioner's argument that prohibiting the practice would effectuate the goal of making insurance available and affordable to everyone.[321]

The commissioner argued that insurance scoring produces rates which are "unfairly discriminatory" in violation of MCL section 500.2109(1)(a), MCL section 500.2403(1)(d), and MCL section 500.2603(1)(d).[322] The court found it significant that the commissioner, who also has authority to regulate banking and finance, had taken no action to limit the use of credit reports by these industries.[323] The evidence demonstrates that most "errors" in credit reports are minor ones

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320. *Id.* at 395 (alteration in original).

321. *Id.* at 398.

322. *Id.* at 400. "Unfairly discriminatory" is defined nearly identically by all the statutes. *Id.* at 401. The court explained:

> A rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss, for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience. A rate is not unfairly discriminatory because it reflects differences in expenses for individuals or risks with similar anticipated losses, or because it reflects differences in losses for individuals or risks with similar expenses.

*Id.* (quoting MICH. COMP. LAWS ANN. § 500.2109(1)(c) (West 2003)).

323. *Id.* at 402.

that do not affect the actual score, such as misspelled addresses.[324] Insurance scoring can be used to establish a reasonable classification system for differences in rates charged, and therefore, such scoring is not unfairly discriminatory.[325]

## IV. DECISIONS OF THE FEDERAL COURTS

It is true that "a federal construction of state law is not binding" on the Michigan courts.[326] However, such cases can be persuasive authority.[327] The cases in which the federal courts are called upon to interpret state law, as persuasive authority, are worth review.

### *A. Decisions of the United States Court of Appeals for the Sixth Circuit*

The U.S. Court of Appeals for the Sixth Circuit used Michigan insurance law to resolve a dispute regarding insurance coverage regarding construction defects in *TMW Enterprises, Inc. v. Federal Insurance Company*.[328] A building sustained water damage, which the evidence demonstrated was due to poor construction, but when the building owner sought insurance coverage for the repairs, the insurer relied on exclusions in its policy for "construction defects" and "wear and tear."[329] However, the policy also stated that these exclusions do "not apply to ensuing loss or damage caused by or resulting from a peril not otherwise excluded."[330] The building owner contended that the exclusion did not apply due to the introduction of water, which is a "peril not otherwise excluded," as a contributing factor to the loss.[331]

The court began by posing hypotheticals as to covered events, including the collapse of a poorly constructed ceiling beam damaging the floor below due, in part, to gravity, which is not specifically excluded.[332] Citing to a U.S. Supreme Court case, the court found that where an insurance contract can be read two ways, but one way avoids surplus language and creates ambiguity, then it is usually inappropriate to apply

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324. *Ins. Inst. of Mich.*, 486 Mich. at 404.
325. *Id.* at 405.
326. State Bd. of Educ. v. Houghton Lake Cmty. Schs., 430 Mich. 658, 675, 425 N.W.2d 80 (1988).
327. People v. Bullock, 440 Mich. 15, 28, 485 N.W.2d 866 (1992).
328. 619 F.3d 574 (6th Cir. 2010).
329. *Id.* at 575.
330. *Id.*
331. *Id.* at 576.
332. *Id.* at 577.

the rule of construction disfavoring surplusage.[333] The court then turned to Michigan law and found that surplus language alone does not create ambiguity and, where the language is clear, it will not be construed to provide coverage simply to avoid finding that the contract contains surplus language.[334] The court found that:

> [I]f, on the one hand, the damage came "natural[ly] and continuous[ly]" from the faulty workmanship, "unbroken by any new, independent cause," . . . the exclusion applies and the ensuing loss provision does not . . . . But if, on the other hand, the later-in-time loss flows from a non-foreseeable and non-excluded cause, it is covered. In this instance, because defective wall construction naturally and foreseeably leads to water infiltration, the language of the exclusion, not the exception to the exclusion, ought to apply.[335]

The dissent concluded that the contract was ambiguous, and therefore, "should be construed against the insurer-drafter."[336]

Though not directly involving Michigan law, the Sixth Circuit also considered the duties of a Michigan statutory entity, Blue Cross Blue Shield of Michigan ("BCBSM"), regarding ERISA health care plans.[337] For certain purposes, the parties agreed that BCBSM was acting as a fiduciary for an ERISA plan self-funded by Flagstar Bank.[338] The question was whether that fiduciary capacity prevented BCBSM from negotiating with various hospitals that would raise the prices paid by plan participants, should they require hospitalization.[339]

BCBSM engages in contract negotiations with health care providers regarding the rates for treating BCBSM insureds.[340] BCBSM entered into

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333. *Id.* at 578 (quoting Lamie v. U.S. Trustee, 540 U.S. 526, 536 (2004)).

334. *TMW Enter., Inc.*, 614 F.3d at 575 (citing Mich. Twp. Participating Plan v. Pavolich, 232 Mich. App. 378, 388, 591 N.W.2d 325 (1998)).

335. *Id.* at 579 (quoting Mich. Sugar Co. v. Emp'rs Mut. Liab. Ins. Co. of Wisc., 107 Mich. App. 9, 14, 308 N.W.2d 684 (1981); citing Berger v. Travelers Ins. Co., 379 Mich. 51, 54, 149 N.W.2d 441 (1967)).

336. *Id.* at 580 (Cole, J., dissenting) (citing Wilkie v. Auto-Owners Ins. Co., 469 Mich. 41, 61, 664 N.W.2d 776 (2003)). Judge Cole's position ignores Michigan case law holding that *contra proferentem* is a rule of last resort, to be used only after consideration of extrinsic evidence as to intent. Klapp v. United Ins. Group Agency, Inc., 468 Mich. 459, 470-71, 663 N.W.2d 447 (2004).

337. Deluca v. Blue Cross Blue Shield of Mich., 628 F.3d 743 (6th Cir. 2010).

338. *Id.* at 744.

339. *Id.*

340. *Id.* at 745. BCBSM offers a traditional open-access plan, a PPO, or HMO options to its insureds. *Id.*

an agreement with Flagstar Bank in which it would provide claims processing and other administrative services for the Flagstar ERISA plan.[341] In an effort to increase the competitiveness among its insurance options, BCBSM began entering into letters of understanding with health care providers regarding rates where BCBSM agreed to higher rates for its traditional and PPO options in exchange for lower rates for its HMO options.[342] The trial court granted BCBSM summary judgment, concluding that it was not acting as a fiduciary for the Flagstar plan when it negotiated the rate changes.[343]

Under ERISA, "fiduciaries shall discharge their duties with respect to a plan 'solely in the interest of the participants and beneficiaries,' that is, 'for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan.'"[344] The Sixth Circuit noted that while there are strict standards regarding fiduciary duties, they apply only when the entity is acting as a fiduciary, meaning "(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan."[345] BCBSM acted in two different capacities regarding the Flagstar plan: as an "administrator and claims-processing agent" and as a distributor of health-care services.[346] BCBSM was not acting as a fiduciary when it negotiated the rate changes because those efforts were "not directly associated with the benefits plan at issue here but were generally applicable to a broad range of health-care consumers."[347] If the conduct relates to a general business decision that has an effect on an ERISA plan, but does not constitute management/administration of the plan itself, fiduciary duties are not implicated.[348] BCBSM was not negotiating Flagstar plan-specific rates, therefore the trial court was affirmed.[349] The dissent would have found a fact question and remanded for trial.[350]

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341. *Id.*
342. *Id.* at 746.
343. *Deluca*, 628 F.3d at 746.
344. *Id.* (citations omitted) (quoting Pegram v Herdrich, 530 U.S. 211, 223-24 (2000)).
345. *Id.* (quoting 29 U.S.C. § 1002(21)(A)) (2008)).
346. *Id.* at 746-47.
347. *Id.* at 747.
348. *Id.* (citing Hunter v. Caliber Sys., Inc., 220 F.3d 702, 718 (6th Cir. 2000)).
349. *Deluca*, 628 F.3d at 748.
350. *Id.* at 751 (Kethledge, J., dissenting) ("Thus, to summarize: The record here would allow a jury to find that Blue Cross agreed to provide services rather than a product. Those services—'[e]stablishing, arranging, and maintaining provider networks

Under-/un-insured motorist ("UIM") coverage was at issue in *Anton v. National Union Fire Insurance Company.*[351] National Union issued a commercial policy to General Motors ("GM"), providing nationwide coverage for vehicles owned by GM.[352] Though the policy contained sixteen endorsements regarding UIM coverage for various states, there was no endorsement for the State of Michigan.[353] Mr. Anton was a GM executive who was provided with a GM-owned car.[354] While riding in the passenger seat of the car, Mr. Anton's wife was injured when another vehicle struck his GM car.[355]

The Sixth Circuit acknowledged Michigan law regarding contract interpretation insofar as all provisions of a contract should be given effect and the contract should be examined as a whole to give effect to the parties' intent.[356] UIM coverage is optional in Michigan, therefore the terms of the policy control.[357] The court found the Antons' interpretation of the policy to be "nonsensical."[358] The Antons' argued that UIM coverage was included:

> [B]ecause there is no geographical limitation in the Policy's UIM coverage, the word "Included" in the Declarations means that such coverage is implicit in every state except Ohio, and that their car was a "Covered Auto" under the Policy.
>
> . . . .
>
> [But the court found that] the word "Included" in the "Premium" column simply means that the premium for any UIM coverage, as "Separately Stated in Each UIM Endorsement" is included in the "Estimated Total Premium" listed on the first page of the

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. . . through contractual arrangements' with hospitals and other health-care providers—are highly discretionary and have a direct impact on the Plan's bottom line. Thus, if Blue Cross indeed provided those services, it was an ERISA fiduciary when it did so. And a jury could surely find that Blue Cross breached its fiduciary duties when it made the letter deals. Summary judgment should not have been granted as to DeLuca's claim under § 1104 of the statute.").

351. 634 F.3d 364 (6th Cir. 2011).

352. *Id.* at 366.

353. *Id.* at 366-67.

354. *Id.* at 367.

355. *Id.*

356. *Id.*

357. *Anton*, 634 F.3d at 368 (citing McDonald v. Farm Bureau Ins. Co., 480 Mich. 191, 193-94, 747 N.W.2d 811 (2008)).

358. *Id.*

> Declarations. This is explained on the first page of the Policy, which states: "Premium for Endorsements: Included."[359]

In this case, the endorsements, not the form policy, contained both the limits of the UIM coverage and the language of obligation to provide UIM coverage for a particular state.[360] There was no UIM endorsement for the State of Michigan.[361] National Union also offered its insurance binders as extrinsic evidence, which memorialized the agreement between the parties and provided coverage between the time of the agreement and the issuance of the policy.[362] The binders explicitly stated, "*Please note we do not offer UM/UIM in IN, MI or OH.*"[363] The court found the evidence reinforced its decision, but that it need not be considered because the policy was not ambiguous.[364]

### *B. Decisions of the Federal District Courts*

#### *1. Eastern District of Michigan*

An injured motorist sued his insurance carrier for first party benefits in *Durmishi v. National Casualty Company*.[365] The motorist moved for partial summary judgment seeking benefits for twenty-four-hour attendant care at the rate of $26.43 per hour, plus penalty interest and attorney fees.[366] The insurer moved for partial summary judgment contending it could "set off payment for the attendant care" for eight hours per day because the motorist was injured on the job and was therefore covered by workers' compensation.[367] There was no dispute that, while engaged in the course of his employment, Mr. Durmishi was injured when the semi-truck he was driving rolled over; however, Mr. Durmishi was involved in a dispute regarding workers' compensation benefits as well.[368] Upon discharge from the hospital, plaintiff's case manager noted that Mr. Durmishi would require twenty-four-hour care for the foreseeable future and Mr. Durmishi's wife quit both part-time

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359. *Id.*
360. *Id.* at 369.
361. *Id.*
362. *Id.* at 371.
363. *Anton*, 634 F.3d at 371.
364. *Id.*
365. 720 F. Supp. 2d 862 (E.D. Mich. 2010).
366. *Id.* at 863.
367. *Id.*
368. *Id.* at 864.

jobs she held to provide this care.[369] The insurer did not seek any medical examination of Mr. Durmishi until after commencement of the suit.[370] The examinations eventually conducted showed that Mr. Durmishi did not need twenty-four-hour attendant care, if he needed it at all.[371] The insurer did not dispute a portion of the attendant care alleged to be owed.[372]

The district court rejected the insurer's argument that it may withhold No-Fault benefits where an injured person is "theoretically" entitled to workers compensation benefits, whether the worker actually receives those benefits or not.[373] The court agreed with Mr. Durmishi that the No-Fault insurer cannot withhold payment while awaiting the outcome of the workers' compensation case.[374] While the insurer can set-off workers' compensation benefits actually received, the record did not indicate that any such benefits had been received to date, and therefore, there could be no set-off.[375]

Regarding the attorney fees sought by Mr. Durmishi, the insurer argued that any delay in payment was due to Mr. Durmishi's insistence on compliance with Federal Rule of Civil Procedure 35 as a condition to submitting to medical examinations.[376] The insurer insisted that it had an unconditional right to examine Mr. Durmishi pursuant to MCL section 500.3151.[377] Whether a delay is reasonable is a mixed question of law and fact.[378] An initial refusal or delay in payment of benefits creates a presumption of unreasonableness, which can then be rebutted by demonstrating the delay was due to a legitimate question of statutory construction, constitutional law, or factual uncertainty.[379] The district court determined that MCL section 500.3151 does not create an unconditional right to a medical examination.[380] In fact, MCL section 500.3159 provides for the issuance of an order compelling discovery

369. *Id.* at 865.

370. *Id.* at 867.

371. *Durmishi*, 720 F. Supp. 2d at 867.

372. *Id.* at 868.

373. *Id.* at 871.

374. *Id.* at 872 (citing Specht v. Citizens Ins. Co. of Am., 234 Mich. App. 292, 296, 593 N.W.2d 670 (1999)). *Specht* held that "the no-fault carrier is not entitled to delay payments in order to wait for the [workers' compensation] bureau's determination." *Specht*, 234 Mich. App. at 296.

375. *Durmishi*, 720 F. Supp. 2d at 872.

376. *Id.*

377. *Id.*

378. *Id.* at 873.

379. *Id.* (citing Univ. Rehab. Alliance, Inc. v. Farm Bureau Gen. Ins. Co. of Mich., 483 Mich. 955, 956, 763 N.W.2d 908 (2009)).

380. *Id.* at 874.

only on good cause shown, and permits the court to enter a protective order regarding an examination to prevent annoyance, embarrassment, or oppression.[381] However, by policy language, a No-Fault insurer can alter the conditions that may be placed on a medical examination.[382] However, that ability does not control the application of Rule 35, which is a procedural, not a substantive, law.[383] The district court found the attempt by the insurer to characterize its ability to seek a medical examination as a substantive right, being "based on the state supreme court's anemic definition of 'substantive right' found in *Muci*, as a rule or statute 'that has as its basis something other than court administration.'"[384] That definition conflicts with federal law defining "procedural."[385] Therefore, demanding compliance with Rule 35 does not, by itself, justify any failure to delay payment.[386]

Regarding the dispute over the necessity of the attendant care for Mr. Durmishi, questions as to whether an expense is reasonable and necessary are generally questions for the jury.[387] The reports as to necessity are conflicting, and result in a fact question as to any benefits that are contested.[388] Finally, the court refused to strike an expert offered by Mr. Durmishi who determined the rate at which attendant care should be paid to unlicensed care providers (i.e. family members) because the court found his methodology in line with both federal evidence law and the Michigan No-Fault Act.[389]

*2. Western District of Michigan*

The U.S. District Court for the Western District of Michigan considered a dispute regarding two separate policies insuring a boat in *Mid-Century Insurance Company v. Fish*.[390] During a time in which a boat was to be "laid up," Mr. Fish was instead preparing the boat for use and accidentally caused an explosion.[391] The insurer sought "declaration

381. *Durmishi*, 720 F. Supp. 2d at 874.

382. *Id.* (citing Muci v. State Farm Mut. Auto. Ins. Co., 478 Mich. 178, 194, 732 N.W.2d 88 (2007)).

383. *Id.* (citing FED. R. CIV. P. 35).

384. *Id.* at 876 (quoting *Muci*, 478 Mich. at 191) (internal quotation omitted).

385. *Id.*

386. *Durmishi*, 720 F. Supp. 2d at 877 (citing FED. R. CIV. P. 35).

387. *Id.* at 878 (quoting Kallabat v. State Farm Mut. Auto. Ins. Co., 256 Mich. App. 146, 151, 662 N.W.2d 97 (2003)).

388. *Id.*

389. *Id.* at 881-82.

390. 749 F. Supp. 2d 657 (W.D. Mich. 2010).

391. *Id.* at 663 (stating that the boat was to be "laid up" from October 1 through April 1 during the policy period).

that it owe[d] no duty to indemnify for damage" to the boat or personal injury and property damage as a result of the explosion, due to violation of the "lay-up" requirement.[392] Because the court was sitting in diversity, state law applied.[393]

The "lay-up" requirement mandated that the boat "be laid up and *out of commission ashore or in a safe berth afloat.*"[394] Mr. Fish admitted that it was not "out of commission," but argued that the boat was "in a safe berth afloat," and therefore in compliance with the "lay-up" requirement.[395] The policy did not define "safe berth afloat.[396] While the failure to define a term does not necessarily render that term ambiguous, because "safe" is dependent upon location and weather patterns, it cannot be defined with a commonly understood meaning beyond the four corners of the policy.[397] The insurer enhanced the ambiguity by contradicting the "lay-up" provision with a notation on the declarations page: "Lay-Up Type: Ashore."[398] There was no way to rectify the declarations page with the policy provision, and since the ambiguity could not be eliminated, the district court predicted the Michigan Supreme Court would construe the ambiguous provision against the drafter.[399]

Regarding excess coverage allegedly issued, Mr. Fish did not dispute that the underlying policy covering his boat was not listed as underlying insurance for the excess policy.[400] However, the court quoted from Mr. Fish's brief, noting "Michigan courts have recognized that in certain situations, estoppel or waiver may operate to hold a Defendant liable for coverage that may differ from the expressed terms of the contract."[401] In this case, the excess insurer provided a "deck sheet" listing coverage for two power boats; Mr. Fish only owned two power boats, one of which was the subject of the litigation.[402] The court held that

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392. *Id.*
393. *Id.* at 665.
394. *Id.* at 671.
395. *Id.*
396. *Mid-Century*, 749 F. Supp. 2d at 671.
397. *Id.* at 672 (concluding "Any definition which cannot render insignificant the vagaries and uncertainties of location and weather patterns cannot be said to dispel the ambiguity of the word.").
398. *Id.* at 673.
399. *Id.* at 674.
400. *Id.* at 675.
401. *Id.* at 676 (citing Parmet Homes, Inc. v. Republic Ins. Co., 111 Mich. App. 140, 314 N.W.2d 453 (1981)).
402. *Mid-Century*, 749 F. Supp. 2d at 676.

> [T]he party asserting estoppel must establish that (1) the insurer's actions or representations induced the insured to believe that an otherwise applicable exclusion clause would not be invoked and that coverage would be provided, (2) the insured justifiably relied on this belief, and (3) the insured was prejudiced by its reliance on this belief.[403]

While an insurer is generally estopped from raising defenses not contained in a denial stating other defenses, that is not the case where the effect of the estoppel would result in coverage of a loss the insurer never agreed to insure.[404] The district court could not reach the issue though, because the parties did not provide admissible evidence regarding the alleged estoppel, or lack thereof.[405]

In a case involving questions of the application of Michigan law to an ERISA plan, the district court considered the case of injury sustained in an automobile accident for which medical coverage existed in a Michigan No-Fault policy or through a self-funded ERISA plan.[406] Though the ERISA plan initially paid medical bills related to the accident, it began refusing to make payments and demanded and obtained reimbursement from the No-Fault insurer, claiming that the plan was secondary to the No-Fault insurance.[407] The No-Fault insurer brought the instant suit alleging that it was not primary.[408]

Because a self-funded ERISA plan was involved in the dispute, federal common law controlled the dispute between insurers, not Michigan law.[409] However, as ERISA does not contain an "applicable statute of limitations provision," the court looked to the "most analogous state law statute of limitations."[410] The No-Fault insurer argued for application of the general six-year contract limitations period of MCL section 600.5807(8).[411] The court held that "[u]nder Michigan law, when a no-fault auto insurer whose obligation to pay is secondary sues the primary insurance provider for reimbursement of medical expenses paid by the secondary insurer, the secondary insurer sues as a subrogee of the

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403. *Id.* at 677.

404. *Id.* (quoting Makki v. Farmers Ins. Exch., No. 249547, 2005 Mich. App. LEXIS 24 at *4 (2005)).

405. *Id.* at 678.

406. Auto-Owners Ins. Co. v. Edward D. Jones & Co. Emp. Health & Welfare Program, 759 F. Supp. 2d 895, 898 (W.D. Mich. 2010).

407. *Id.*

408. *Id.* at 899.

409. *Id.*

410. *Id.* at 900.

411. *Id.*

insured."[412] Where an insurance contract dictates a shorter limitations period, that contractual provision is binding in an action by a No-Fault insurer against a health plan insurer.[413] The contractual limitations period requires suit to be commenced within two years of the injury date or three years of the denial date.[414] There was no need to determine which period applied, as both had lapsed.[415] The court was not persuaded by Auto-Owners' argument that each payment made should carry its own limitations period because, under Michigan law, "[a] claim accrues as soon as suit may be brought, and later damages do not toll the running of the clock."[416] Even if the action was timely, the No-Fault insurer would still be primary, even though it is not explicitly subject to the coordination of benefits clause, because the language "evinces an intent on the part of the Plan to subordinate its coverage in many circumstances not directly or explicitly addressed in this section . . . . includ[ing] virtually all circumstances in which the covered party may receive payments from an alternate source."[417]

An employee theft provision was at issue in *Coopersville Motors, Inc. v. Federated Mutual Insurance Company*.[418] Coopersville Motors, Inc. (CMI) purchased a commercial insurance policy that included an endorsement providing commercial crime coverage.[419] This endorsement insured against employee theft, but only as to three named employees.[420] The policy covered an "occurrence" taking place during the policy period, which wass defined as:

> (1) An individual act;
> (2) The combined total of all separate acts whether or not related; or
> (3) A series of acts whether or not related; committed by an "employee" acting alone or in collusion with other persons, during the Policy Period shown in the Declarations, except as provided under Condition E.1.k or E.1.l.[421]

412. *Auto-Owners*, 759 F. Supp. 2d at 900.
413. *Id.*
414. *Id.* at 901.
415. *Id.*
416. *Id.* at 902.
417. *Id.* at 905.
418. 771 F. Supp. 2d 796, 799 (W.D. Mich. 2011).
419. *Id.*
420. *Id.*
421. *Id.* at 800.

All of the employee conduct alleged by CMI occurred prior to the beginning of the policy period and suggested bad business deals, not theft, defined as the "unlawful taking of property to the deprivation of the Insured."[422] The allegations, in effect, were that CMI employees used CMI funds to pay legitimate CMI debts.[423] Furthermore, even if the acts were covered, an officer of CMI knew of the acts prior to the start of the policy period, and the policy did not cover acts committed that were known to the insured prior to the start of the policy period.[424] Finally, because these known acts were not disclosed to the insurer before the policy was issued, there had been a misrepresentation of a material fact so as to void coverage.[425] Note that the court did not cite a single authority for any of its findings and based its entire decision on the policy language.[426]

## V. CONCLUSION

Insurance disputes continue to form a regular and significant portion of the dockets of the courts of Michigan. The recent changes in the court composition bring with them questions regarding some of the decisions released during the *Survey* period. With the present court majority unhappy with the previous majority's decision to overturn several precedential cases, the public is left to wonder about the stability of the decisions announced during the *Survey* period. There is the possibility that the new majority will simply undo the decisions it viewed as incorrect. Or, there is the possibility that the court, in the name of finality, will not revisit issues upon which it has recently opined. Time will tell whether these decisions will become foundations for future decisions, or aberrations of a chaotic time in the membership of the Michigan Supreme Court.

422. *Id.*
423. *Id.* at 801.
424. *Coopersville Motors*, 771 F. Supp. 2d at 801.
425. *Id.* at 802.
426. *See generally id.* at 801-02.