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Most Michigan Court of Appeals decisions regarding insurance law continue to be unpublished and therefore, do not constitute binding precedent.[1] As such, unpublished opinions are excluded from this

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review. A number of the Michigan Court of Appeals cases decided issues of first impression. Further, the changing makeup of the Michigan Supreme Court has apparently played a role in case outcomes, as a case was reversed on rehearing shortly after Justice Hathaway replaced former Chief Justice Taylor.[2]

Insurance is pervasive in modern society. It is difficult to imagine a functional economy without insurance. The importance of insurance is hard to underestimate. The cost of private and social insurance in the United States is approximately $2.5 trillion per annum.[3] Insurance law decisions, whether interpreting a policy of insurance or a statute mandating or regulating insurance, set the parameters for resolution of insurance disputes between insurers, insureds and third parties.

II. DECISIONS OF THE MICHIGAN COURT OF APPEALS

A. Commercial Insurance

The pollution exclusion is one of the most litigated provisions in an insurance policy.[4] The court of appeals tried to make sense out of a pollution exclusion in *Hastings Mutual Insurance Co. v. Safety King, Inc.*[5] Safety King was sued for damages alleged to have resulted from the "use of a sanitizing agent" while cleaning out air ducts in a home.[6] Triclosan, the active ingredient in the sanitizer, is a pesticide which Hastings claimed was a "pollutant" as that term is used in its policy.[7] The

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1. Mich. Ct. R. 7.215(C) (West 2010).

2. *United States Fid. Ins. & Guar. Co. v. Mich. Catastrophic Claims Ass'n.*, 484 Mich 1, 27 (Young, J., dissenting) ("The facts have not changed. The text of the statute at issue has not changed. The parties' arguments have not changed. And the rationale advanced in the opinions of this Court has not changed. Yet, within a matter of months, a decision of this Court, thoughtfully briefed, argued, and considered by seven justices, is no longer worth the paper it was written on. Even the casual observer, however, does not really need to ask why. The reason is obvious: On January 1, 2009, the composition of this Court changed.").

3. KENNETH A. ABRAHAM, INSURANCE LAW AND REGULATION 2 (5th ed. 2010).

4. *Upjohn Co. v. New Hampshire Ins. Co.*, 438 Mich. 197, 227 (1991) (Levin, J., dissenting) ("In short, the scope of the pollution-exclusion clause . . . has been the subject of intense and frequent litigation since adoption by the insurance industry in the early 1970s.").

5. 286 Mich. App. 287 (2009).

6. *Id.* at 289.

7. *Id.* at 289-90.

policy defines "'pollutants' as 'any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste.'"[8]

The court applied the same principles of construction to this insurance agreement that it would to any other contract.[9] Triclosan is a compound used to combat "bacteria and dental plaque and is used in" a variety of everyday household products.[10] Simply because a substance is a "pesticide," does not mean it is a "pollutant" pursuant to the policy; rather, the policy requires that the substance be an "irritant or contaminant."[11] The court resorted to a dictionary to define irritant and contaminant.[12] Using these dictionary definitions, the court concluded:

> Considered in this context, [defining pollutant,] an 'irritant' is a substance that, because of its nature and under the particular circumstances, is generally expected to cause injurious or harmful effects to people, property, or the environment. And, considered in context, a 'contaminant' is a substance that, because of its nature and under the particular circumstances, is not generally supposed to be where it is located and causes injurious or harmful effects to people, property, or the environment.[13]

Hastings failed to prove that triclosan was an irritant or contaminant, but instead, mistakenly relied on *Protective National Insurance Co. of Omaha v. City of Woodhaven*,[14] which held that a pesticide was a pollutant.[15] In that case, the pesticide at issue was already shown to be an "irritant, contaminant or pollutant," where as in this case, there was no such proof.[16] Because at least a question of fact existed as to whether triclosan is a pollutant, Hastings has a duty to defend Safety King, as the claims arguably come within the policy's coverage.[17]

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8. *Id.* at 291.
9. *Id.* at 291-92.
10. *Id.* at 293.
11. *Hastings Mut. Ins. Co.*, 286 Mich. App. at 293.
12. *Id.* at 294.
13. *Id.* at 294-95.
14. 438 Mich. 154; 476 N.W.2d 374 (1991).
15. *Hastings Mut. Ins. Co.*, 286 Mich. App. at 295. *Cf. Protective Nat'l*, 438 Mich. at 165 (interpreting the old sudden and accidental pollution exclusion). However, the definition of pollutant was essentially the same. The court of appeals analysis is actually closer to then-Chief Justice Cavanagh's solitary dissent in *Protective National* than the *Protective National* majority opinion.
16. *Id.* at 295-96.
17. *Id.* at 299.

B. Insurance Regulation

The court of appeals issued a fractured opinion in *Progressive Michigan Insurance Co. v. Smith*,[18] a case of first impression. The facts of the case are uncomplicated. Plaintiff Smith purchased a car, but because he had no driver's license due to points on his driving record, he added a "friend, defendant Sheri Harris, to the title."[19] Ms. Harris signed a form listing Mr. "Smith as an excluded driver," and the declaration page of the insurance policy and certificate of insurance also list Mr. Smith as excluded.[20] Mr. Smith, nonetheless, drove the vehicle, and after crossing a centerline, struck a vehicle driven by the Mihelsics.[21] Progressive brought "a declaratory action to determine its liability to indemnify [Mr.] Smith," and the Mihelsics argued that since Progressive failed to use the statutory language to exclude a named driver on some insurance documents, that the exclusion was ineffective.[22]

Pursuant to statute, an exclusion 'shall not be valid' unless it states:

> [O]n the face of the policy *or* the declaration page *or* certificate of the policy *and* on the certificate of insurance: Warning—when a named excluded person operates a vehicle all liability coverage is void—no one is insured. Owners of the vehicle and others legally responsible for the acts of the named excluded person remain fully personally liable.[23]

Progressive used language which was in conformity with the statute, except that "on the face of the policy and" certificate of insurance the final word was changed from "liable" to "responsible."[24] Progressive argued that because the language it used on the declaration page was identical to the statutory language, statutory compliance was achieved.[25]

Judge Bandstra, writing for the majority, disagreed with Progressive, finding the sentence contained two clauses—one with three alternatives separated from each other by "or" and a second clause, separated from the first by "and."[26] To achieve compliance, therefore, the warning need appear on "one of the three alternatives" from "the first clause *and* on the

18. 287 Mich. App. 537 (2010).
19. *Id.* at 539.
20. *Id.*
21. *Id.*
22. *Id.* at 539-40.
23. MICH. COMP. LAWS ANN. § 500.3009(2) (West 2002) (emphasis added).
24. *Progressive Mich. Ins. Co.*, 287 Mich. App. at 540-41.
25. *Id.* at 541.
26. *Id.*

certificate of insurance."[27] The Legislature made clear that if the verbatim notice was not recited in the appropriate places, the exclusion "shall not be valid."[28] Though the statute did not expressly say "strict compliance" would be required, the language makes clear that substantial compliance is not enough. Judge Murray concurred in "both the reasoning and result of the majority opinion."[29]

In dissent, Judge Markey professed her belief that it was not the job of the judiciary to read into statutes that which is not present, but "[n]onetheless, on rare occasion, there may arise a situation where following this philosophy with myopic rigidity effects not only a complete thwarting of the Legislature's intent but also a profoundly unfair and inequitable result."[30] Judge Markey would find the verbatim recitation of the warning on the declaration page, coupled with the substitution of "responsible" for "liable" on the face of the policy and the certificate of insurance would suffice, because "the words 'liable' and 'responsible' are completely and totally synonymous."[31]

The dissent also noted that it was fair to assume the commissioner of insurance had approved the policy, because he is given authority to disapprove a policy for violating any provisions of the Insurance Code of 1956,[32] but did not do so here.[33] Thus, the dissent would shy away from a hyper-technical, strict constructionist interpretation, toward one of substantial compliance. In essence, because Progressive had changed one word, coverage which none of the involved parties intended was created and the result was, in Judge Murray's opinion, "no doubt unfortunate."[34]

In *Ulrich v. Farm Bureau Insurance*, [35] the court of appeals considered which policies under Order No. 05-060-M ("Order"), promulgated by the Office of Financial and Insurance Services on December 16, 2005, would apply. The Order "disapproved no-fault automobile insurance forms that provided a contractual limitations period of less than three years for claims for uninsured motorist coverage."[36]

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27. *Id.*

28. *Id.* at 543.

29. *Id.* at 544.

30. *Progressive Mich. Ins. Co.*, 286 Mich. App. at 546 (Markey, J., dissenting).

31. *Id.* at 548.

32. MICH. COMP. LAW ANN. § 500.2236 (West 2002).

33. *Progressive Mich. Ins. Co.*, 286 Mich. App. at 550 (Markey, J., dissenting).

34. *Id.* at 544. To Judge Markey, "unfortunate" was not strong enough language, as she labeled the outcome "a profoundly unfair and inequitable result." *Id.* at 446.

35. 288 Mich. App. 310 (2010).

36. *Id.* at 312. It is not clear whether the court of appeals considered each renewal as a separate policy, or if the multiple renewals over multiple years were, in effect, a single policy. If each renewal is a separate policy, then the policy ceased to be in effect at its expiration, and the premise of this decision is false.

The policy at issue had a contractual one-year period in which to bring a claim; the policy was issued before the Order, but was renewed after the Order was issued.[37]

The Order did not apply to contracts which were already in effect, "so long as such policy or rider is not revised in any respect."[38] The plaintiff had brought a no-fault claim within one year of the accident, but did not make a claim for uninsured motorist benefits for more than a year after the accident.[39] The question was whether a policy subject to automatic renewal becomes subject to the Order if renewed after the Order's issuance. The court determined that "[t]he order contains no sunset provision or expiration date for forms currently in use, nor does it prescribe any prohibition on renewal."[40] The court refused to read into the Order that which was not in the language. The court also rejected an attempt to apply the relation-back doctrine of MCR 2.118(D) to the one-year contractual limitation period, finding no authority for applying the doctrine used in statute of limitations periods to a contractual period.[41]

C. Uninsured Motorists

A court of appeals panel made fine distinctions to right an inequity in *Smith v. MEEMIC Insurance Co.*[42] Ms. Smith was "injured in an automobile accident" with an uninsured motorist, Mr. Victoriano Gonzales.[43] Smith notified MEEMIC, claimed uninsured motorist benefits, proceeded to file suit against Mr. Gonzales, and informed MEEMIC that she was in the process of obtaining a default judgment against Gonzales.[44] MEEMIC never responded, and Ms. Smith obtained her default judgment and proceeded to file suit against MEEMIC, which moved for summary disposition due to a "no settlement/no judgment" clause in its policy, as the default judgment was obtained without MEEMIC's consent.[45] After the motion was filed, but before it was heard, the default judgment was set aside.[46] The court of appeals

37. *Id.* at 315-16.
38. *Id.* at 318.
39. *Id.* at 313.
40. *Id.* at 321.
41. *Ulrich*, 288 Mich. App. at 322-23.
42. 285 Mich. App. 529, 530 (2009).
43. *Id.* at 530.
44. *Id.*
45. *Id.* at 530-31. The court could have concluded that MEEMIC had impliedly given consent when it did not respond to its insured's letter informing it that the insured was going to secure a default judgment against Gonzales.
46. *Id.* at 531.

concluded "that once the default judgment was set aside, [MEEMIC] was not entitled to summary disposition."[47] A judgment set aside is a nullity, and is the equivalent to the judgment never having been entered.[48] If judgment was never entered, then the policy exclusion would no longer apply. Further, the policy language is in the present tense,[49] and does not speak to a judgment which "was once" or "has been at some point" entered.[50] Additionally, the public policy behind such an exclusion is to protect the insurer's subrogation rights which have been restored with the setting aside of the default judgment, thus leaving the insurer unharmed.[51]

In *Dancey v. Travelers Property Casualty Co. of America*,[52] the court of appeals considered whether uninsured motorist benefits were payable in a situation where the vehicle which may have caused the accident could not be identified. Plaintiff Luann Dancey was driving a vehicle belonging to Maryland Electric—which employed her then-husband—insured by Travelers.[53] Maryland Electric indirectly provided vehicles for certain employees via a monthly car allowance; the vehicle was leased by the employee, then leased to Maryland Electric to bring the vehicle within the company's insurance coverage, with Ms. Dancey listed on the certificate of insurance along with the company.[54] Ms. Dancey was driving the interchange between I-696 and I-75 in Royal Oak, an area inaccessible to pedestrians, when she noticed a steel ladder blocking one of the left lanes.[55] Though Ms. Dancey swerved, she was unable to avoid the ladder completely, and lost control of her vehicle,

47. *Id.* at 532.

48. *Smith*, 285 Mich. App. at 532-33 (citing Jones v. O'Donnell, 292 Mich. 189, 193 (1940); People ex rel. Gilman v. Wayne Cir. Ct., 21 Mich. 372, 373 (1870)).

49. *Id.* at 533 ("coverage is precluded if the case '*is* settled or prosecuted to a judgment'" (emphasis in original)).

50. *Id.*

51. *Id.* at 533-34. The public policy appears to have been satisfied when the insured secured a $50,000 default judgment against the tortfeasor. If MEEMIC paid its insured under the uninsured motorist provision, it would be equitably, and, no doubt, contractually, subrogated to the insured's judgment, at least up to $50,000. It seems inequitable to allow an insurer to fail to respond to the insured's inquiries and then turn around and use the insured's actions on the exact matters into which the inquiry was directed to defeat the insured's purchased uninsured motorist coverage. No doubt the default judgment was not worth much against the uninsured tortfeasor.

52. 288 Mich. App. 1 (2010).

53. *Id.* at 4-5.

54. *Id.*

55. *Id.* at 6.

which rolled over.[56] There was no evidence as to who was responsible for the ladder being in a traffic lane.[57]

The court noted the rule of interpretation for insurance policies, requiring that the policy, the policy application and declarations page be viewed together as the contract.[58] The uninsured motorist endorsement required Travelers to pay amounts which an "insured" was entitled to recover from the driver of an uninsured vehicle.[59] Travelers argued, and the court seemed to accept, that an "insured" is "anyone occupying a vehicle owned by Maryland Electric;" the vehicle in question was leased, and therefore, still owned by the dealership from which it was leased.[60] However, the insurance agent added both Ms. Dancey and the vehicle to the Maryland Electric policy.[61] The court determined a question of fact existed as to whether Ms. Dancey was an "insured."[62]

An uninsured motor vehicle is one which hits or causes an object to hit an insured, a covered auto or a vehicle occupied by an insured.[63] In this instance, it was unknown how the ladder came to be in the roadway. The court proceeded to consider prior cases where accidents occurred due to objects in a roadway alleged to have come from unidentified vehicles, which had come to seemingly conflicting conclusions.[64] The

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56. *Id.*

57. *Id.*

58. *Darcey*, 288 Mich. App. at 8 (quoting Royal Prop. Group, L.L.C. v. Prime Ins. Syndicate, Inc., 267 Mich. App. 708, 715 (2005)).

59. *Id.* at 9.

60. *Id.* at 7. Even though Maryland Electric was leasing the vehicle for the term that the employee had leased it from the dealership, it would be an owner as it was a person "renting a motor vehicle or having the use thereof, under a lease or otherwise, for a period that is greater than 30 days." MICH. COMP. LAWS ANN. § 500.3101(2)(h)(i) (West 2002).

61. *Dancey*, 288 Mich. App. at 5.

62. *Id.* at 3.

63. *Id.* at 11-12.

64. *Id.* at 13-21. The Court considered four cases. In *Kersten v. Detroit Auto. Inter-Ins. Exch.*, 82 Mich. App. 459, 467-68 (1978), plaintiff struck a truck tire, still spinning, in front of her in the passing lane of a highway, and the court determined it was not "clear error" to conclude the tire had recently fallen off a vehicle. However, there was no uninsured motorist coverage because "[n]othing links the tire and rim with the hit-and-run vehicle except an inference drawn from the presence of a spinning tire and rim on the road." *Id.* at 472. Objective, not inferential evidence is required. *Id.* In *Adams v. Zajac*, 110 Mich. App. 522, 525 (1981), a truck tire and rim lying in the roadway was either struck by plaintiff's decedent, or the decedent swerved to avoid it and crashed. Disagreeing with *Kersten*, the court determined that inferential evidence would suffice to link the hit-and-run vehicle to the plaintiff's vehicle. *Id.* at 529. In *Hill v. Citizens Ins. Co. of Am.*, 157 Mich. App. 383, 384-85 (1987), a rock went through the windshield of Plaintiff's vehicle right as it was being passed by a large camper. There was testimony that the camper caused the rock to be in flight. *Id.* The court determined that there need

court found that there was no "objective and convincing evidence" that another vehicle was the source of the object striking Ms. Dancey's vehicle, rather only circumstantial evidence existed.[65] Ms. Dancey provided evidence of the location of the accident to support the inference that the ladder must have fallen off a vehicle, as that particular highway interchange "is inaccessible to pedestrians and non-vehicular traffic."[66] "A reasonable juror could conclude" that falling off a vehicle is the only reasonable explanation for the ladder's presence in the road, and therefore that there was a "substantial physical nexus" between the unidentified vehicle and Ms. Dancey's vehicle.[67] In other words the evidence would allow one to eliminate all other sources for the ladder except for having fallen off another vehicle.[68] Based on "the unique set of facts in this case, such speculation is not impermissible."[69] Therefore, the insurer was properly denied summary disposition.

D. No-Fault

1. An Insurable Interest

The court of appeals considered what "insurable interest" was necessary to support the existence of a valid no-fault policy in *Morrison v. Secura Insurance*.[70] On April 14, 2006, Sarah Jo Warfield drove a vehicle which struck a motorcycle upon which Kevin and Candice

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be "a substantial physical nexus between the disappearing vehicle and the object cast off or struck[,]" and that such a nexus existed on these facts. *Id.* at 394. In *Berry v. State Farm Mut. Auto. Ins. Co.*, 219 Mich. App. 340, 343; 556 N.W.2d 207 (1996), plaintiff drove over an object in the road which caused her to lose control of her vehicle. Minutes prior to the accident, a witness saw a truck which was hauling scrap metal stopped on the side of the road, with the driver inspecting the load; the witness observed metal in the road, which had not been there some 10-15 minutes prior. *Id.* at 343-44. The Court found that the facts established "a substantial physical nexus between the hit-and-run vehicle and the object struck by plaintiff[.]" *Id.* at 350. A "'continuous and contemporaneously transmitted force' is a significant, but not dispositive, factor to be considered in indirect contact cases in determining whether the requisite substantial physical nexus has been established." *Id.* at 351. Though such a force was not present, the witness testimony was enough to demonstrate "a continuous sequence of events with a clearly definable beginning and ending, resulting into plaintiff's coming into contact with the piece of metal." *Id.* at 351. The Court noted that only *Berry* was binding on it. *Dancey*, 288 Mich. App. at 21.

65. *Dancey*, 288 Mich. App. at 17.
66. *Id.* at 20.
67. *Id.* at 20-21.
68. *Id.*
69. *Id.*
70. 286 Mich. App. 569 (2009).

Morrison [plaintiffs] were riding.[71] The policy on the Warfield vehicle "was purchased by Warfield's mother," and listed the mother "as the named insured, but both" the mother and Ms. Warfield as drivers.[72] Only Ms. Warfield drove the vehicle, and in March 2006, the mother transferred title to Ms. Warfield, "who applied for a new title and registered" the vehicle in her name.[73] Secura therefore claimed that the mother "did not have an insurable interest" in the vehicle, and that the policy was void.[74]

The court of appeals majority concluded that Michigan law requires an "insurable interest" in order "to support the existence of a valid automobile liability insurance policy[,] ... However, an 'insurable interest' need not be in the nature of ownership, but rather can be any kind of benefit from the thing so insured or any kind of loss that would be suffered by its damage or destruction."[75] The court declined to consider whether a parent's interest in protecting a child from financial ruin is sufficient to constitute an "insurable interest," because other facts present in the case resolved the issue.[76]

It was not disputed that the mother had an insurable interest when she purchased the insurance and paid the premium, and the case law found by the court "shows that public policy forbids the *issuance* of an insurance policy where the insured lacks an insurable interest. Public policy does not appear to require an otherwise valid insurance policy to become void automatically."[77] As Ms. Warfield was always listed as a driver, the risk to the insurer did not change.[78] The "insurable interest" requirement arose as a means to safeguard against the insured transferring ownership "to commit any illegal or unethical act in order to collect the proceeds from the insurance policy at issue[,]" and such concern "is not present here."[79]

Finally, the transfer in this case was intra-family, and such a transfer "is not treated the same as it is between strangers."[80] Public policy does not support terminating a transfer of what was, in effect, "a family insurance policy."[81] The court summed up its reasoning for finding

71. *Id.* at 571.
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.* at 572-73.
76. *Morrison*, 286 Mich. App. at 573.
77. *Id.* at 573-74 (emphasis in original).
78. *Id.* at 574.
79. *Id.*
80. *Id.* at 574-75.
81. *Id.* at 575.

coverage applied to the accident: the mother had an "'insurable interest' . . . at the time the insurance policy was bought and paid for, the insured-against risk did not change, the basis for the 'insurable interest' requirement is weak, and the public policy favoring family units is strong."[82] On the other hand, Judge Talbot, in dissent, concluded that Fisher had no insurable interest in the vehicle, the title for which she had transferred to her daughter.[83]

2. MICH. COMP. LAWS ANN. Section 3107(1)(a)—Allowable Expenses

In *Begin v. Michigan Bell Telephone Co.*,[84] the Michigan Court of Appeals addressed an alleged conflict between the Michigan Supreme Court's decisions in *Griffith v. State Farm Mutual Automobile Insurance Co.*, and *Davis v. Citizens Insurance Co. of America*, regarding what constitutes an allowable expense pursuant to M.C.L.A. section 500.3107(1)(a).[85] *Davis* applied a three prong test to determine an "'allowable expense' under [section] 3107(1)(a) ... '(1) the charge must be reasonable; (2) the expense must be reasonably necessary; and (3) the expense must be incurred.'"[86] In *Griffith*, the Michigan Supreme Court noted that the statute required "'that an "allowable expense" must be "for" one of the following: (1) an injured person's care, (2) his recovery,

82. *Morrison*, 286 Mich. App. at 575.

83. *Id.* at 577. Presumably, underlying the declaratory judgment action was a lawsuit by the Morrisons (motorcycle operator and passenger) against the mother and daughter. Secura was presumably exposed to different risks such as payment of no-fault benefits to the Morrisons under M.C.L.A. section 500.3114(5) (West 2002), payment of damages for the apparent negligence of Warfield, and possible payment of the damage to Warfield's vehicle. If the Morrisons sued the mother as owner of the motor vehicle, perhaps the mother could present a valid defense that she had no ownership liability under M.C.L.A. section 257.401 (West 2006) because she was not the owner of the motor vehicle at the time of the accident. If it was a valid defense that the mother had no legal liability to the Morrisons because she did not own the vehicle, then the outcome of this case—that an insurable interest existed—is called into doubt. Perhaps the majority saw this inconsistency and dodged the issue.

84. 284 Mich. App. 581 (2009).

85. *Id.* (*comparing* Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521 (2005), *with* Davis v. Citizens Ins. Co. of Am., 195 Mich. App. 323 (1992)). As a preliminary matter, the court noted that the case involved a consent judgment, which normally waives a right to object to appellate review. *Id.* at 585. However, an appeal of right is available where a party preserves its right to appeal, and that preservation must be done as to specific issues. *Id.* The court refused to address several issues raised by Michigan Bell, which self insures for No-Fault and Workers' Compensation, on the grounds that the preservation was limited to issues related only to the *Griffith* and *Davis* cases, and all other issues were waived. *Id.* at 588.

86. *Id.* at 591 (quoting *Davis*, 195 Mich. App. at 326).

or (3) his rehabilitation.'"[87] The court of appeals described *Griffith* as having "clarified judicial construction of . . . MCL 500.3107(1)(a)" without overruling *Davis*.[88] The court noted that whether a product, service or accommodation used both before and after an accident was an "allowable expense" depended on the facts and circumstances of the individual case, and that *Griffith* announced no "bright-line rule."[89] Furthermore, the entire cost—as opposed to the marginal increase—of a product, service and accommodation used both before and after an accident "is an allowable expense if it satisfies the statutory criteria of being sufficiently related to injuries sustained in a motor vehicle accident and if it is a reasonable charge and reasonably necessary for the injured person's care, recovery or rehabilitation."[90]

In *In re Geror*,[91] the court of appeals addressed whether attorney fees could be "allowable expenses" pursuant to M.C.L.A. section 500.3107(1)(a).[92] The father of an individual injured in an automobile accident petitioned the court claiming that the individual's health had been negatively impacted by the actions of her guardian.[93] In order to address the claims, the injured individual's attorney visited her home, and determined that an assessment by a medical professional would be beneficial; that assessment was reviewed by the attorney to make recommendations; and other actions were taken to prepare for the guardianship hearing.[94] The court found the attorney's services to be directly related to the injured individual's care, and thus, the attorney fees were an "allowable expense."[95]

3. MICH. COMP. LAWS ANN. Section 3107(1)(b)—Work Loss

The Michigan Court of Appeals considered the proof necessary to be entitled to benefits for work loss pursuant to M.C.L.A. section

87. *Id.* at 593-94 (quoting *Griffith*, 472 Mich. at 532 n.8).

88. *Id.* at 594.

89. *Id.* at 594-95.

90. 284 Mich. App. at 596-97. For example, a person who suffers an injured leg in an accident requiring the use of special shoes after the accident surely used shoes before the accident. *Id.* at 596. Yet the entire cost of the special shoes might still be recoverable, depending on the facts of the case.

91. 286 Mich. App. 132 (2009).

92. *Id.* at 134.

93. *Id.* at 136.

94. *Id.*

95. *Id.*

500.3107(1)(b) in *Ward v. Titan Insurance. Co.*[96] Mr. Ward testified he was regularly employed as a night club bouncer, which testimony "was corroborated by two fellow employees."[97] Mr. Ward also had an affidavit from his claimed employer, Teion Crews; however that affidavit was refuted by sworn testimony from Mr. Crews that Mr. Ward was actually an independent contractor, not an employee.[98] The nightclub owner denied having ever employed Mr. Ward.[99] Though Mr. Ward testified he was "regularly employed" by the nightclub, Mr. Crews testified that Mr. Ward "did not work as often as he claimed"—this testimony contradicted Mr. Crews' previous averments—and that Mr. Ward's drug use made it unlikely he would continue to work at the club.[100] The majority summed up the dispute: "Suffice it to say that this case was replete with factual questions surrounding plaintiff's employment at the time of the accident and thus his entitlement to wage loss benefits resulting from the accident."[101]

The insurer claimed that Mr. Ward's "inability to produce documentation of his employment should be dispositive."[102] The court disagreed. While M.C.L.A. section 500.3158(1) "does require an employer to furnish a sworn statement regarding the earnings of an injured person," the statute does not say that the injured individual will lose work loss benefits if the statement is not provided.[103] To impose such a sanction would be to punish the individual for his employer's failure, and "imposing such a penalty would be a public policy decision for the Legislature, not the Court."[104] In dissent, Judge Markey disagreed with the majority's reasoning, concluding that the sworn statement of M.C.L.A. section 500.3158(1) provides the only method of providing work loss benefits.[105]

The majority reached its conclusion even though Mr. Ward was paid "under the table" and he failed to properly pay taxes on those earnings.[106] While Michigan does recognize a "wrongful conduct rule," that rule only

96. 287 Mich. App. 552 (2010). Both the majority and dissent accused each other of invading the Legislature's public policy role while both impliedly believed they were literally interpreting the No-Fault Act.

97. *Id.* at 554.

98. *Id.* at 555.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Ward*, 287 Mich. App. at 556.

103. *Id.*

104. *Id.*

105. *Id.* at 556.

106. *Id.* at 557.

serves to bar a claim by one "who founded his cause of action on his own illegal conduct."[107] As Mr. Ward's claim has nothing to do with his failure to file income tax returns, but upon "allegations of an automobile accident," the "wrongful conduct rule does not apply."[108] Finally, the court turned to the issue on cross appeal, and adopted the housing costs dicta from *Griffith v. State Farm Mutual Automobile Insurance Co.*,[109] determining that "housing costs are only compensable to the extent" the costs have increased due to the accident—for example, if it was more expensive to rent a handicapped-accessible house than a non-handicapped-accessible house, that difference would be recoverable.[110]

4. MICH. COMP. LAWS ANN. Section 3135—Serious Impairment of Body Function[111]

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107. *Id.*

108. *Ward*, 287 Mich. App. at 557.

109. 472 Mich. 521 (2005).

110. *Ward*, 287 Mich. App. at 557-58.

111. The *Survey* period ended May 31, 2010. The cases during the *Survey* period relied upon *Kreiner v. Fischer*, 417 Mich. 109 (2004), in deciding what constituted a serious impairment of a bodily function. On July 31, 2010, the Michigan Supreme Court issued its opinion in *McCormick v. Carrier*, 487 Mich. 180 (2010). The opening paragraph of that case leaves no question as to the fate of *Kreiner*: "We hold that *Kreiner v Fischer*, 471 Mich 109; 683 NW2d 611 (2004), was wrongly decided because it departed from the plain language of MCL 500.3135, and is therefore overruled." *McCormick*, 487 Mich. at 184. Though the cases in this section are included as published decisions of the survey period, to the extent they rely on *Kreiner*, they have been supplanted by *McCormick* and are no longer good law.

Pursuant to M.C.L.A. section 500.3135(7), "a serious impairment of a bodily function" is established by a three-prong test: "(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." *McCormick*, 487 Mich. at 195. The statute is clear and unambiguous, and therefore needs no judicial construction. *Id.* "[A]n 'objectively manifested' impairment is commonly understood as one observable or perceivable from actual symptoms or conditions." *Id.* at 196. One need look to the impairment as objectively manifested, not the injury or its symptoms. *Id.* The focus, therefore is not on the injury, but on "how the injuries affected a particular body function." *Id.* at 197 (quoting DiFranco v. Pickard, 427 Mich. 32, 67 (1986)). The "'objectively manifested' requirement signifies that plaintiffs must 'introduce evidence establishing that there is a physical basis for their subjective complaints of pain and suffering' and that showing an impairment generally requires medical testimony." *Id.* at 198. (quoting *DiFranco*, 427 Mich. at 74). *Kreiner*, to the extent it required medical testimony in all cases, was explicitly rejected. *Id.* The second prong (important bodily function) "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, depending on the relationship of that function to the person's life." *Id.* at 199. Though the Court did not think *Kreiner* itself was inconsistent with this interpretation, the Court did note that *Kreiner* had been

In *Caiger v. Oakley*,[112] the plaintiff suffered a knee injury which he alleged was related to a motor vehicle accident, and which required two surgeries.[113] In reversing the trial court's grant of summary disposition in favor of the plaintiff, the court of appeals applied the objective test of *Kreiner* to determine if any change in the plaintiff's lifestyle "'has actually affected the plaintiff's "general ability" to conduct the course of his life.'"[114] The plaintiff offered a physician's letter that the pain leading to the surgery was "more likely than not" caused by the accident.[115] The court applied the nonexclusive list of objective factors contained in *Kreiner* to determine if the threshold was met: "'(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.'"[116] The court noted plaintiff "continues to suffer from chronic pain in his knee that will prevent him from returning to work in his previous occupation and prevents him from enjoying his woodworking hobby."[117] Therefore, he met the threshold requirement for impairment of an important body function.[118]

In another serious impairment case, *Fisher v. Blankenship*,[119] the majority favorably compared the instant facts to those of the recent *Caiger* decision. Mr. Fisher, who acknowledged he had prior dental problems, was involved in an automobile collision which damaged one of his front teeth, which had to be removed.[120] Mr. Fisher's dentist had

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construed as inconsistent, and those constructions are now rejected. *Id.* As to the final prong, the Court concluded 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 living[, which requires] a subjective, person- and fact-specific inquiry that must be decided on a case-by-case basis.

Id. at 202. The Court noted that the ability need only be "*affected*, not destroyed." *Id.* (emphasis in original). Next, as "general" modifies only "ability" and not "affect" or "normal life," it is required "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." *Id.* Finally, the injury need not be permanent, as "the statute does not create an express temporal requirement as to how long an impairment must last in order to have an effect on 'the person's general ability to live his or her normal life.'" *Id.* at 203. *Kreiner* significantly misinterpreted this prong. *Id.* at 203-04.

112. 285 Mich. App. 389 (2009).
113. *Id.* at 390.
114. *Id.* at 392 (quoting *Kreiner*, 471 Mich. at 133).
115. *Id.* at 393-94.
116. *Id.* at 392, 394 (quoting *Kreiner*, 471 Mich. at 133).
117. *Id.* at 395.
118. *Craiger*, 285 Mich. App. at 395.
119. 286 Mich. App. 54 (2009).
120. *Id.* at 57.

told him prior to the accident "that he would eventually need dentures to replace his top front teeth," possibly around the age of fifty to fifty-five; Mr. Fisher was forty-one at the time of the accident.[121] Apparently, the accident accelerated the need for dentures, and Mr. Fisher's dentist decided it was best "to extract all of Fisher's top front teeth—fourteen in total—and replace them with a partial upper denture."[122] Several years following the accident, Mr. Fisher chose to have all of his "upper teeth removed and to use an upper dental implant for his top teeth;" the insurer admitted, in its brief, that Mr. Fisher's injury included the loss of all the teeth removed in order to enable better use of the dentures.[123]

The majority concluded that aggravation of an existing condition can amount to a compensable injury, and accelerated loss of teeth could constitute a serious impairment.[124] Mr. Fisher cannot eat without the use of his dental implant, and experiences pain and difficulty using it; his speech has been altered and he occasionally drools because of the device.[125] The "tooth 'loss will affect every aspect of [his] life to some degree and will affect certain specific activities ... even more.'"[126] He cannot speak or eat without use of the dental device.[127]

Mr. Fisher's claim of permanent disfigurement was also addressed by the majority. The disfigurement must be both permanent and serious, and it "has [been] held that the determination depends on the physical characteristics of the injury rather than the effect of the injury on the plaintiff's ability to lead a normal life."[128] The court concluded Mr. Fisher was permanently disfigured, finding the "loss of teeth mars or deforms his overall appearance," and that "[i]t is also abundantly clear that the disfigurement will last for the remainder of his life."[129] While it is true that the dentures worn by Mr. Fisher may improve Mr. Fisher's overall appearance, compared to that pre-accident, "the statute does not limit recovery for disfigurement to those disfigurements that are always visible, and we will not read such a limitation into the statute."[130] The dissent disagreed with the majority's conclusion that Mr. Fisher had

121. *Id.*
122. *Id.* at 58.
123. *Id.* at 60, 61.
124. *Id.* at 63.
125. *Fisher*, 286 Mich. App. at 64.
126. *Id.* (quoting Moore v. Cregeur, 266 Mich. App. 515, 521 (2005)).
127. *Id.* at 65.
128. *Id.* at 66 (citing Kosack v. Moore, 144 Mich. App. 485, 491 (1985)).
129. *Id.* at 67.
130. *Id.* at 68. The court commented that such an argument was akin to saying a victim of severe burns on his back has no serious disfigurement because he could cover the scarring from public view.

"suffered a serious impairment of body function or a permanent serious disfigurement" as a matter of law, concluding that the plaintiffs failed to show either a threshold injury or any permanent serious disfigurement.[131] While the majority likened the case to *Caiger*, the dissent disagreed, stating, "[c]omparatively, the effect of plaintiff's injuries in this case is minuscule."[132]

5. *MICH. COMP. LAWS ANN. Section 3145—One Year Back Rule*

The distinction between the statute of limitations and the no-fault one year back rule was highlighted by the Michigan Court of Appeals in *Bronson Methodist Hospital v. Allstate Insurance Co.*[133] The timeline of events, as expected in a one-year-back case, was crucial. Lemuel Brown was injured on December 29, 2006, and treated at Bronson Methodist from December 30, 2006 through January 5, 2007.[134] At some later point, it was determined that the vehicle in which Mr. Brown was driving was uninsured, and that neither Mr. Brown nor any relatives residing with him had no-fault insurance.[135] Bronson Methodist "submitted an application to the Michigan Assigned Claims Facility" on December 14, 2007, and the claim was assigned to Allstate on January 7, 2008.[136] Bronson Methodist was notified of the assignment on January 15, 2008, and submitted its claim, but Allstate refused to pay, citing the one-year-back rule, M.C.L.A. section 500.3145(1); Bronson Methodist commenced suit on February 6, 2008.[137] Bronson Methodist claimed "that [M.C.L.A. section] 500.3174, the assigned claims plan notice and commencement section of the no-fault insurance act, extended the recovery limitation provision of MCL 500.3145(1) with respect to assigned claims."[138]

M.C.L.A. section 500.3145(1) states that no "action for recovery of personal protection insurance" benefits "may be commenced later than 1 year after the date of the accident . . . unless written notice of the injury . . . has been given to the insurer within that 1 year;" in the event notice is given, however, there will still be no recovery "for any portion of the loss incurred more than 1 year" prior to the institution of the action.[139]

131. *Fisher*, 286 Mich. App. at 70-71.
132. *Id.* at 73 n.4.
133. 286 Mich. App. 219 (2009).
134. *Id.* at 221.
135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
139. MICH. COMP. LAWS ANN. § 500.3145(1) (West 2002).

The courts will strictly enforce the recovery limitation, the one-year back rule, as written.[140] M.C.L.A. section 500.3174 states that a person making a claim through the assigned claims plan shall commence an action not "more than 30 days after receipt of notice of the assignment or the last date on which the action could have been commenced against an insurer of identifiable coverage applicable to the claim, whichever is later."[141]

Reading the statutes together, the court of appeals found M.C.L.A. section 500.3145(1) did not preclude Bronson Methodist's action, pursuant to M.C.L.A. section 500.3174, as thirty days after the assigned claims notice is later than one year following Mr. Brown's January 5, 2007 release.[142] The first two clauses of M.C.L.A. section 500.3145(1) and M.C.L.A. section 500.3174 all use phrases including "language limiting when *an action* can be *commenced*."[143] As the language is the same, the Legislature intended the phrases to be treated in the same manner.[144] As the two phrases of M.C.L.A. section 500.3145(1) have already been interpreted as statutes of limitations, so too should the same terms in M.C.L.A. section 500.3174 be interpreted as relating to a statute of limitations.[145] However, M.C.L.A. section 500.3174 addresses only the statute of limitations, and lacks any language which can operate to extend the recovery limitation of M.C.L.A. section 500.3145(1).[146] While M.C.L.A. section 500.3174 can extend the time to commence an action, it does nothing to alter the one-year back rule limiting recovery.[147] Bronson Methodist could not recover because "[t]he one year-back rule draws a strict line, which must be followed even with unfair results."[148]

6. MICH. COMP. LAWS ANN. Section 3148—Attorney Fees

In *Tinnin v. Farmers Insurance Exchange*,[149] the court of appeals considered an award of attorney fees in a case where the insurer originally provided benefits, but ceased paying after receiving results from two independent medical evaluations ("IMEs").[150] One IME

140. *Bronson Methodist Hosp.*, 286 Mich. App. at 224.
141. MICH. COMP. LAWS ANN. § 500.3174 (West 2002).
142. *Bronson Methodist Hosp.*, 286 Mich. App. at 225-26.
143. *Id.* at 227 (emphasis in original).
144. *Id.*
145. *Id.*
146. *Id.* at 228.
147. *Id.* at 229.
148. *Bronson Methodist Hosp.*, 286 Mich. App. at 229.
149. 287 Mich. App. 511 (2010).
150. *Id.* at 513.

revealed that ongoing physical medicine and rehabilitation ("PM&R") treatment was not necessary, but that treatment on an "as needed" basis would be reasonable; a different evaluation concluded that the need for attendant care resulted from "pre-existing borderline intelligence and not from" the accident.[151] At trial, the insurer's claims adjuster admitted discontinuation of the PM&R benefits was not proper in light of the "as needed" evaluation.[152] A jury found entitlement to PM&R benefits, in the amount of $1,235, and that the benefits were overdue; however, the jury awarded nothing on the claimed $90,000 in attendant care.[153] The trial court found the failure to pay for the PM&R treatment to be unreasonable, and awarded the full request of attorney fees of $57,680 and $9,651.67 in taxable costs.[154]

The court of appeals found that the insurer acted unreasonably in its failure to pay PM&R benefits. While it is true an insurer may rely on the opinion of its physicians and IMEs, the insurer failed to clarify the "as needed" results of the evaluation.[155] In light of this failure, the refusal to pay was unreasonable. Though the insurer argued that the bulk of the suit revolved around the attendant care services, and that claim could be completely separated from the PM&R claim, the court of appeals found that the insurer had failed to provide factual support for its attempt to separate the two claims.[156] Further, the insurer cited no authority for its proposition that attorney fees must be apportioned where its refusal to pay was unreasonable as to certain benefits but not unreasonable as to others.[157] The statutory language, M.C.L.A. section 500.3148(1), "does not unambiguously require the apportionment [insurer] advocates[,]" and the refusal to apportion is not an abuse of discretion; the trial court found the attorney fees were sufficiently related to his securing the overdue benefits.[158] The same reasoning holds true for the taxable costs pursuant to MCR 2.625(A)(1).[159]

There are different ways to skin a cat. The plaintiff's attorney secured attorney's fees, not from the no-fault insurer, but from the health care providers in *Miller v. Citizens Insurance Co.*,[160] which dealt with the question of whether an award of attorney's fees could reduce the amount

151. *Id.*
152. *Id.*
153. *Id.* at 514.
154. *Id.*
155. *Tinnin*, 287 Mich. App. at 517.
156. *Id.* at 520.
157. *Id.* at 521 (quoting Cole v. DAIIE, 137 Mich. App. 603, 614 (1984)).
158. *Id.* at 522.
159. *Id.* at 523.
160. 288 Mich. App. 424 (2010).

of recovery from the treating hospital.[161] Ryan Miller, who had been injured in an automobile accident on September 5, 2007, instituted a suit through a guardian for benefits from Citizens Insurance.[162] Miller and Citizens agreed to settle, and entered into a stipulated order of dismissal on January 22, 2008, with the trial court retaining jurisdiction only to settle any attorney liens related to the benefits.[163] The Detroit Medical Center ("DMC") had treated Mr. Miller, and received notice of a hearing to take place on February 11, 2008, to settle the attorney liens; DMC asserted that it had received no notice of the litigation prior to settlement.[164] The trial court ordered Citizens to make payment to the health-care providers, but that the providers were subject to an attorney lien on one-third of their billings.[165] DMC objected to the lien, and unsuccessfully attempted to intervene in the settled case.[166]

On January 22, 2008, DMC was notified by Mr. Miller's attorney that insurance coverage had been secured and that the attorney was seeking a one-third lien on the outstanding balance as his fee.[167] DMC's witness admitted that DMC was aware by December 4, 2007, that Mr. Miller was represented by attorneys, as their names and phone numbers had been written on Mr. Miller's Medicaid application.[168] Further, a DMC representative admitted, "she first had contact with plaintiff's attorneys on November 29, 2007, a week before Ryan was admitted" to a DMC facility.[169] Documents in Mr. Miller's medical file identified attorneys, who requested billing information on December 13, 2007; DMC did not contact or advise Mr. Miller's attorneys "that it did not want them to pursue this matter on their behalf."[170]

The court of appeals agreed with the trial court that one-third of the amount claimed by DMC was subject to an attorney lien.[171] Before it admitted Mr. Miller, DMC knew that he had been denied no-fault benefits, and that attorneys were pursuing the matter on his behalf, yet DMC never advised Mr. Miller or his attorneys not to pursue coverage on its behalf.[172] The settlement was akin to a common fund which

161. *Id.* at 429.
162. *Id.* at 426.
163. *Id.* at 428.
164. *Id.*
165. *Id.*
166. *Miller*, 288 Mich. App. at 429.
167. *Id.* at 429.
168. *Id.* at 430.
169. *Id.*
170. *Id.* at 430-31.
171. *Id.* at 438.
172. *Miller*, 288 Mich. App. at 434.

benefits not only Mr. Miller, but his medical providers—who would receive payment from the fund—after having chosen not to pursue their own litigation.[173] Pursuant to the American Rule, each party pays its own attorney fees, but Michigan recognizes a common law exception for an attorney's charging lien on common funds.[174] It is simply "'unfair to allow others to benefit at the expense of the prevailing party without contribution to the costs incurred in seeking the common fund.'"[175] This case does not involve the no-fault penalty attorney fee statute, M.C.L.A. section 500.3148(1), as the issue is whether Mr. Miller's attorneys are entitled to their fees, not whether Citizens Insurance had to pay penalties.[176] In sum, where a party has notice that another is pursuing litigation which will benefit the notified party if successful, the notified party cannot ride on the other person's coattails and then refuse to contribute to the costs of obtaining the benefit.

E. Further Cases from the Michigan Court of Appeals

A majority of the court of appeals refused to create a new cause of action for spoliation of evidence that interferes with a prospective civil action against a third party in *Teel v. Meredith*.[177] Allstate, the landlord's insurer, sent a representative to investigate an apartment fire which resulted in one tenant's death, her spouse's injury and property damage.[178] Allstate's agent conducted an investigation without notice to or the presence of the tenant, and apparently altered the scene such that evidence regarding the fire's cause and origin was spoiled.[179] The majority declined the invitation to create a new cause of action for the alleged spoliation of evidence.[180] It determined that to allow the case to proceed would not only create a new duty on the part of the insurance industry, but would create a new cause of action which would need to be defined.[181]

As the Michigan Legislature has already created comprehensive regulation of the insurance industry, public policy counsels strongly against the creation of a new cause of action in this heavily regulated

173. *Id.* at 435.
174. *Id.* at 437.
175. *Id.* (quoting Nemeth v. Abonmarche Dev., Inc., 457 Mich. 16, 38 n.11 (1998)).
176. *Id.* at 440.
177. 284 Mich. App. 660 (2009).
178. *Id.* at 661.
179. *Id.*
180. *Id.* at 663.
181. *Id.* at 665.

arena.[182] Judge Alton Davis, prior to his brief stint on the Michigan Supreme Court, dissented, arguing *"ubi injura, ibi remedium."*[183] He did not feel that it was necessary to create a new cause of action, but instead to simply fashion a remedy for the right to have evidence preserved. He felt the facts were "particularly compelling"[184] and concluded "where an individual's ability to pursue or defend an action has been impaired by a third party's willful or negligent spoliation of evidence, that individual may pursue a tort action against the spoliator."[185]

The court of appeals addressed the questions of limitations on liability coverage and the duty to defend in *Auto-Owners Insurance Co. v. Martin.*[186] The facts of the case are relatively straightforward. A car dealership, Grand Greenville, allowed a potential purchaser, Victor Martin, to test-drive a car, and Mr. Martin became involved in an accident on the test-drive.[187] Auto-Owners insured Grand Greenville, while Mr. Martin had insurance for his personal vehicle through State Farm.[188] The Auto-Owners policy provided up to $1 million in liability coverage, to an "insured," which excluded Grand Greenville customers, in general, but provided:

> 1. Where other valid collectible insurance existed, with limits sufficient to pay damages up to the limit of the financial responsibility law, no damages were collectible under Auto-Owners policy;
> 2. Where other valid collectible insurance existed, with limits insufficient to pay damages up to the limit of the financial responsibility law, Auto-Owners policy would apply to the excess damages, up to the limit; and
> 3. Where other valid collectible insurance did not exist, Auto-Owners policy would apply, but only to the limit of the financial responsibility law.[189]

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182. *Id.*

183. *Teel*, 284 Mich. App. at 674 (Davis, J. , dissenting) (citing Williams v. Polgar, 391 Mich. 6, 11 (1974)). The translation provided was "[w]here there is a person negligently injured by another, normally there is recovery therefor." *Id.* However, the Latin simply means, "Where there is an injury, there is a remedy." This cliché, of course, proves nothing, because a remedy often does not exist. Consider, for example, all the circumstances where a defendant is granted immunity, or where the law imposes no duty.

184. *Id.* at 678.

185. *Id.* at 680.

186. 284 Mich. App. 427 (2009).

187. *Id.* at 429-30.

188. *Id.* at 430.

189. *Id.* at 431-32.

Except when explicitly stated, Auto-Owners was to be primary insurance.[190] State Farm's policy stated that coverage for non-owned cars, which was subject to other vehicle liability coverage, was to be in excess over that other insurance.[191]

The court of appeals wasted little time in finding that Auto-Owners' attempted limitation was void. The No-Fault Act prohibits an insurer from denying "'residual liability to an entire class of persons' who *used* the vehicles it insured, specifically 'customers' who used the vehicles with the owners' permission, unless the customer was uninsured or underinsured."[192] Auto-Owners conceded the invalidity to the extent required no-fault coverage was precluded, but argued that its primary liability was limited to the statutory minimums of residual liability coverage—$20,000 for injury to one person and $40,000 for injury to two or more[193]—at which time State Farm's coverage became primary, with the balance of Auto-Owner's coverage becoming excess to State Farm.[194]

Relying on *Farmers Insurance Exchange v. Kurzmann*,[195] the court concluded that if the insurer knows or should know that an exclusion in its policy is void, "the insurer is primarily liable up to the limits of its policy.[196] In this case, the No-Fault Act clearly states that a policy must provide residual liability coverage regarding the use of a vehicle, and the exclusion at issue had been invalidated some 8 years prior to the policy's issuance.[197] Where a knowingly invalid exclusion is used in the policy, the policy is ambiguous and must be construed against the insurer.[198] Even under basic principles of contract law, Auto-Owners was found to be primary up to its policy limits; as deleting the void exclusion would leave intact the policy language covering any person using the vehicle with permission, coverage under such a permissive use is $1 million per occurrence.[199] The position of Auto-Owners was found to be an impermissible shift of a portion of the residual liability away from the

190. *Id.*

191. *Id.* at 432.

192. *Auto-Owners Ins. Co.*, 284 Mich. App. at 435 (quoting Citizens Ins. Co. of Am. v. Federated Mut. Ins. Co., 448 Mich. 225, 230-31 (1995)) (emphasis in original).

193. MICH. COMP. LAWS ANN. § 500.3009(1) (West 2002).

194. *Auto Owners Ins. Co.*, 284 Mich. App. at 436-37.

195. 257 Mich. App. 412, 419-20 (2003).

196. *Id.* at 441.

197. *Id.* at 445 (citing Citizens Ins. Co. of Am. v. Federated Mut. Ins. Co., 448 Mich. 225 (1995)).

198. *Id.* at 446.

199. *Id.* at 448.

owner of the vehicle, and "'*any* such shifting provision is void.'"[200] Though *Kurzmann* did not decide issues related to defense costs, "it follows that Auto-Owners is obligated to defend Martin in the underlying action and that State Farm is entitled to reimbursement for those costs."[201]

The court of appeals also addressed the ability of an injured party to intervene in a declaratory action between an insurer and the alleged tortfeasor in *Auto-Owners Insurance Co. v. Keizer-Morris, Inc.*[202] Gary Howard was injured, allegedly as a result of an explosion of equipment manufactured by Keizer-Morris; Auto-Owners, the insurer for Keizer-Morris, denied coverage.[203] Mr. Howard sought to intervene in the declaratory action between Auto-Owners and Keizer-Morris, but the trial court denied the motion without explanation, and proceeded to grant Auto-Owners summary disposition, as Keizer-Morris failed to defend or even appear.[204]

The court of appeals first determined that failure to give explanation, alone, does not demonstrate an abuse of discretion.[205] Still, the court reversed the trial court and succinctly held that "'the injured party in an insurer's action for declaratory judgment is a proper party to that action[,]'" and has a substantial interest in the case.[206] That the injured party is not a third party beneficiary of the insurance agreement is not dispositive of the injured party's standing to participate in the action for declaration of rights, in which he is a real party in interest.[207] Thus, Auto-Owners was thwarted in its effort to obtain summary disposition against a defunct corporate insured under circumstances where Auto-Owners opposed the only party who had an interest in arguing for coverage, i.e., the injured party. Equity and the law were on the injured party's side, but, no doubt, were not brought to the attention of the trial court by Auto-Owners in its unopposed motion. While the court noted, "[a] trial judge is presumed to know the law,"[208] under these circumstances, the trial court probably did not know any more law than that cited to it by Auto-Owners.

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200. *Id.* at 449-50 (quoting State Farm Mut. Auto. Ins. Co. v. Enter. Leasing Co., 452 Mich. 25, 27-28 (1996)) (emphasis added by court of appeals).

201. *Auto-Owners Ins. Co.*, 284 Mich. App. at 452.

202. 284 Mich App. at 610.

203. *Id.* at 611.

204. *Id.*

205. *Id.* at 612-13.

206. *Id.* at 614 (quoting Allstate Ins. Co. v. Hayes, 442 Mich 56, 67 (1993)).

207. *Id.*

208. *Auto-Owners Ins. Co.*, 284 Mich. App. at 613. *See also* In re Costs & Attorney Fees, 250 Mich. App. 81, 101 (2002).

In *In re Genaw Estate*, the court of appeals considered what happens to life insurance proceeds when the policy holder dies prior to formally changing the beneficiary designation following a divorce.[209] The decedent policyholder and his wife divorced, and in the divorce decree each specifically waived any interest in any insurance policy on the other's life.[210] The policyholder's husband died prior to changing the beneficiary designation on an Unum life insurance policy.[211] After decedent's ex-wife submitted a claim for benefits, identifying her relationship with the decedent as "ex-spouse," Unum conducted an investigation, concluded benefits were payable, and paid the full amount ($111,000) to the ex-wife.[212] The personal representative of the estate thereafter attempted to claim the same policy benefits, but the claim was denied by Unum as the benefits had already been paid.[213] Not only did the trial court enter judgment against the ex-wife and Unum in the amount of $111,000, with a set-off for Unum for the amount of the funds still in the ex-wife's bank account, it also found the ex-wife had committed wrongful conversion or embezzlement.[214]

M.C.L.A. section 552.101(2) discharges the life insurer of all liability upon payment of the proceeds according to the policy terms, "unless before the payment the company receives written notice, by or on behalf of the insured or the estate of the insured, 1 of the heirs of the insured, or any other person having an interest in the policy, of a claim under the policy and the divorce."[215] The appellate court found that the stature required only "'notice of a claim ... and the divorce' ... which does not equate to a mandate that an actual copy of, or detailed information regarding, the content of a judgment for divorce be submitted in conjunction with the filing of a claim."[216] Therefore, notice of the existence of a divorce is sufficient to prevent the statutory discharge.[217] Because Unum was on notice of the divorce, it is not discharged from liability for payment to the designated beneficiary.[218]

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209. 285 Mich. App. 660 (2009). Though outside the *Survey* period, leave to appeal before the Michigan Supreme Court was sought. Instead of granting leave, the court reversed the court of appeals "for the reasons stated in the Court of Appeals dissenting opinion." *Genaw v. Genaw*, 486 Mich. 940, 940 (2010).

210. *In re Genaw Estate*, 285 Mich. App. at 662.

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.* at 663.

215. MICH. COMP. LAWS ANN. § 552.101(2) (West 2005).

216. *In re Genaw Estate*, 285 Mich. App. at 666.

217. *Id.*

218. *Id.* at 669.

Judge Fitzgerald dissented, reasoning that the ex-wife, the contractual beneficiary of the policy, is not one of the persons qualified to provide the notice under the statute.[219] The statute allows for notice by the three persons—the estate of the insured, the heirs of the insured or "any *other* person having an interest in the policy"—which comprise a group of people "who *could* have an interest in the policy *if* the beneficiary designated in the policy no longer had a right to the benefits of the policy."[220] The "other person," therefore, refers to one other than the beneficiary already known to the insurer.[221] As no person authorized to give notice to the insurer did so prior to the payment, the insurer was discharged from liability pursuant to the statute.[222]

The court considered the effect of a "sexual molestation" exclusion in a homeowners insurance policy—where both the perpetrator and victim are minors—in *Mother of John Doe v. Citizens Insurance Co. of America*.[223] A thirteen-year-old was at a public beach with a five-year-old when, at the older child's request, the two engaged in acts of oral sex.[224] The insurance policy at issue had a specific exclusion for "sexual molestation," though it did not define that term.[225] The court had little trouble finding that the act clearly fit within the common meaning of "molest," defined in a dictionary as including "'to make indecent sexual advances to' and 'to assault sexually.'"[226] The court found that plaintiff's reliance on *Fire Insurance Exchange v. Diehl* was misplaced.[227] The *Diehl* case dealt with an intentional act exclusion, finding that when it comes to minors performing sexual acts on other minors, "intent cannot be inferred as a matter of law."[228] At issue here is a specific exclusion for "sexual molestation" which is distinct and separate from any intentional

219. *Id.* at 670 (Fitzgerald, J., dissenting).

220. *Id.* at 676 (emphasis in original).

221. *Id.*

222. In its peremptory reversal, the Michigan Supreme Court adopted Judge Fitzgerald's dissent and remanded for an Order for summary disposition in Unum's favor. *Genaw*, 486 Mich. at 940. Chief Justice Kelly dissented and in large measure adopted the reasoning of the court of appeals majority and would have granted leave to appeal; Justice Hathaway would also have granted leave. *Id.* at 940-43.

223. 287 Mich. App. 585 (2010).

224. *Id.* at 586.

225. *Id.* at 587.

226. *Id.* (quoting Random House Webster's College Dictionary (2d ed.)).

227. *Id.* at 587-88 (citing Fire Ins. Exch. v. Diehl, 450 Mich. 678 (1996), *overruled in part by* Wilkie v. Auto-Owners Ins. Co., 469 Mich 41 (2002).

228. *Id.* at 588.

act exclusion.[229] As the policy clearly excludes coverage for the acts alleged, there is no duty to defend or indemnify.[230]

Murphy's Law was at work in *Auto-Owners Insurance Co. v. Ferwerda Enterprises, Inc.*[231] The first court of appeals decision in this case was reviewed in last year's *Survey*,[232] however, the Michigan Supreme Court vacated that Opinion, reinstated the circuit court's grant of summary disposition against Auto-Owners and in favor of Auto-Owners' insured, Holiday Inn, and the underlying tort plaintiffs.[233] Whereas the majority of the court of appeals in the first case had determined that the Auto-Owners policy was ambiguous, the supreme court determined that, "[t]he subject policy unambiguously provided coverage for the defendants' claim."[234] On remand, the court of appeals was to address attorney fee and penalty interest issues.[235]

The second court of appeals opinion was written by Judge O'Connell, who had dissented in the first case. Previously, the same panel of the court of appeals vacated a judgment following a jury trial in *Bronkema v. Ferwerda Enterprises, Inc.* remanding that case to the trial court for a new trial.[236] While Auto-Owners had opposed the injured third-party claimant's intervention in the declaratory judgment action reviewed above in *Auto-Owners Insurance Co. v. Keizer-Morris, Inc.*,[237] in this declaratory judgment action, it was Auto-Owners which chose to sue the underlying plaintiffs—third parties to its insurance contract—in addition to its insured.[238] The trial court awarded substantial attorney fees to both Auto-Owners' insured and the underlying plaintiffs.[239] This time around, Judge O'Connell wrote the unanimous opinion addressing attorney fees and penalty interest. He acknowledged that the court's first opinion, "did not address these issues."[240] The court of appeals opinion erroneously noted that Auto-Owners had failed both to defend and

229. *Mother of Doe*, 287 Mich. App. at 588.

230. *Id.*

231. 287 Mich. App. 248 (2010).

232. James T. Mellon, et al., *Insurance Law, 2009 Ann. Survey of Mich. Law*, 56 WAYNE L. REV. 455 (2010).

233. *Auto-Owners Ins. Co. v. Ferwerda Enters. Inc.*, 485 Mich. 905 (2009).

234. 45 Mich. 905 (2009).

235. *Id.*

236. No. 275528, 2009 WL 1066110 (Mich. Ct. App. April 21, 2009).

237. 284 Mich. App. 610 (2009).

238. *Auto-Owners Ins. Co. v. Ferwerda Enters. Inc.*, 287 Mich. App. 248, 252 (2010).

239. *Id.* at 254. The award to Ferwerda Enterprises was $186,127.44 in attorney fees and costs and the award to the Bronkemas was $71,365.72 in attorney fees and costs. *Id.* Further, the trial court had ordered penalty interest. *Id.*

240. *Id.* at 256.

indemnify when, in fact, Auto-Owners had defended its insured in the underlying case.[241]

Unless expressly authorized by court rule or statute, an award of attorney fees is generally prohibited; in this case, Holiday Inn contended it was awarded fees pursuant to MCR 2.625(A)(2) because Auto-Owners' claim was frivolous.[242] The court of appeals reversed the award of attorney fees, finding the award improper in light of the trial court's own determination that "the suit was not frivolous and that there was law supporting [Auto-Owners'] position."[243] MCLA sections 500.2006(1) and (4) authorize penalty interest where an insurer fails to pay "on a timely basis" benefits to which an insured, or other individual is entitled under a policy, with an exception for cases where the claim is "reasonably in dispute."[244] The court concluded that it does not matter if the award stems from a breach-of-contract claim, where the contract claim is specifically tied to the underlying tort claim.[245] The claim in this case was "reasonably in dispute" and therefore, an award of penalty interest is not proper.[246]

Following the *Survey* period, the Michigan Supreme Court vacated the portion of the court of appeals' opinion regarding the erroneous statement that Auto-Owners failed to defend, noting that Auto-Owners had defended its insured while pursuing the declaratory judgment action.[247] Further, the supreme court bypassed the court of appeals, remanding the matter directly to the circuit court, ordering that the circuit court clarify the issue of whether or not it had found Auto-Owners' claim to be frivolous.[248]

III. DECISIONS OF THE MICHIGAN SUPREME COURT

The Michigan Supreme Court's opinion in *U.S. Fidelity Insurance & Guaranty Co. v. Michigan Catastrophic Claims Association*[249] was

241. *Id.* at 252. *See infra*, notes 247-48.

242. *Id.* (citing Windemere Commons I Ass'n v. O'Brien, 269 Mich. App. 681, 683 (2006)).

243. *Id.*

244. MICH. COMP. LAWS ANN. § 500.2006(1), (4) (West 2002).

245. *Auto-Owners Ins.*, 287 Mich. App. at 252.

246. *Id.*

247. *Auto-Owners Ins. Co. v. Ferwerda Enters.*, 488 Mich. 917 (2010).

248. *Id.* The Court of Appeals had found that the trial court made an "explicit statement" that the suit was not frivolous, and that therefore, attorney fees were not properly awarded. *Auto-Owners Ins. Co.*, 287 Mich. App. at 257. The Michigan Supreme Court did not address the Court of Appeals' reversal of the award of penalty interest, thus leaving that portion of the opinion intact.

249. 482 Mich. 414 (2008).

addressed during the previous *Survey* period.[250] However, when Chief Justice Clifford Taylor lost his re-election bid to Wayne County Circuit Court Judge Diane Hathaway, the court decided to rehear the case, and did an about-face. In its original reversal of the court of appeals, the court considered whether the MCCA had to indemnify an insurer for attendant care expenses for the amount actually paid or for the amount that the MCCA deemed reasonable, and determined that:

> [W]hen a member insurer's policy provides coverage only for 'reasonable charges,' the MCCA has authority to refuse to indemnify unreasonable charges. If the policy provides broader coverage, the MCCA must review for compliance with the broader coverage and indemnify claims within that coverage, but it may reject claims in excess of that coverage.[251]

With the court's make-up changed, the court ordered rehearing, without additional briefing.

A new majority of the supreme court reversed course, concluding that the MCCA, by statute, "'shall provide and each member shall accept indemnification for 100% of the amount of ultimate loss sustained under personal protection insurance coverages in excess of [specified amounts.]'"[252] The court determined that "ultimate loss specifically refers to coverage, which is broader than benefits and is not statutorily limited to reasonable payments."[253] The court completely reversed its decision delivered just seven months prior:

> [T]he indemnification obligation set forth in § 3104(2) does not incorporate the reasonableness standard that § 3107 requires between claimants and member insurers. Furthermore, the powers granted to the MCCA in § 3104(7) are limited to adjusting the "practices and procedures" of the member insurers and do not encompass adjustment to the payment amount agreed to between claimants and member insurers. Finally, we hold that the power granted to the MCCA under § 3104(8)(g) is limited to

250. Mellon, *supra* note 232, at 488.

251. *U.S. Fidelity Ins. & Guar. Co.*, 482 Mich. at 432 (2008).

252. U.S. Fidelity Ins. & Guar. Co. v. Mich. Catastrophic Claims Ass'n, 484 Mich. 1, 4 (2009) (quoting MICH. COMP. LAWS ANN. § 500.3104(2) (West 2002)).

253. *Id.* at 5.

> furthering the purposes of the MCCA, and that determining reasonableness is not one of its purposes.[254]

Thus, the MCCA was obligated to reimburse all amounts paid which exceed the statutory threshold, regardless of whether those amounts were reasonably paid or not.[255]

Justice Weaver, who had dissented the first time around, now wrote the majority opinion which re-decided two consolidated catastrophic loss cases that had been settled by the two involved insurers.[256] Both of the consolidated cases involved individuals who had sustained catastrophic injuries in motor vehicle accidents and needed 24 hour a day nursing care.[257] In both cases, the involved insurers entered into settlement agreements with the no-fault claimants which led, over the passage of time, to what the majority seems to implicitly acknowledge as unreasonable payments.[258]

Justice Young, in dissent, pointed out that in one of the cases the injured party's father had set up a corporation that allowed for $200,000 per-year profit after the corporation paid for the nursing care with benefits.[259] The majority felt that even though an insurer had to be reimbursed 100 percent of whatever agreement it entered into, there would be incentive on the part of insurers to only enter into reasonable settlements because otherwise insurance premiums would "increase greatly."[260]

On the other hand, Justice Young pointed out that an insurer, understandably, might be willing to enter into an unreasonable settlement to avoid the threat of paying no-fault attorney fees.[261] The majority concluded the fear of higher costs to insureds was unfounded,[262] dismissing out of hand the affidavit of MCCA's executive director attached to Justice Young's dissent. The affidavit was based upon an actuarial study after the supreme court had granted rehearing and which

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254. *Id.* at 25-26.

255. *Id.*

256. *Id.* at 1-2.

257. *Id.*

258. *U.S. Fidelity Ins. & Guar. Co. v. Mich. Catastrophic Claims Ass'n.*, 484 Mich. at 1-2.

259. *Id.* at 11, n.12 (Young, J., dissenting). The nurses were paid $32 per hour, which included benefits, yet the agreement provided for the payment of $54.84 per hour for nursing care. *Id.*

260. *Id.* at 5, n.19.

261. *Id.* at 13 (Young, J., dissenting). MCCA does not reimburse for any attorney fees that might be assessed against an insurer, which in a catastrophic case could well be substantial.

262. *Id.* at 6.

caused an MMCA assessment increase of more than 19 percent.[263] Justice Young repeatedly referred to "the new majority,"[264] perhaps foreshadowing future reversals of recent precedent.

In another peremptory reversal of a case reviewed in last year's *Survey*,[265] the supreme court reversed the court of appeals regarding the interpretation of an insurance policy in *Berkeypile v. Westfield Insurance Co.*[266] Ms. Berkeypile was injured in a multi-vehicle accident while in a vehicle insured by Westfield under a policy including an uninsured motorist endorsement.[267] As a result of settlements with three of the drivers, Ms. Berkeypile obtained $332,500, or $32,500 more than the policy limit for her uninsured motorist coverage.[268] Westfield claimed that because Ms. Berkeypile already received more than the policy limit for uninsured motorist coverage under its policy, she was not entitled to uninsured motorist benefits pursuant to the policy.[269] The court of appeals found the policy contained no language which:

> dictates that any offset pertains only to duplicate payments for the same noneconomic and excess economic losses. Westfield would be liable for [uninsured motorist] benefits equivalent to the difference by which any overall damages award exceeds the sum of the settlement proceeds, subject to the policy limit and any allocation of fault determined by the trier of fact.[270]

In other words, a fact question existed, so summary disposition was not proper.[271]

The supreme court reversed the court of appeals, concluding that it failed to consider a section of the policy which provided that

> [i]f there is other applicable insurance available under one or more policies or provisions of coverage . . . [t]he maximum recovery under all coverage forms or policies combined may equal but not exceed the highest applicable limit for any one

263. *Id.* at 16 (Young, J., dissenting).
264. *See, e.g., U.S. Fidelity Ins. & Guar. Co.*, 484 Mich. at 15 (Young, J., dissenting).
265. Berkeypile v. Westfield Ins. Co., 280 Mich. App. 172 (2008); Mellon, *supra* note 232, at 471.
266. 485 Mich. 1115 (2010).
267. *Berkeypile*, 280 Mich. App. at 174.
268. *Id.*
269. *Id.* at 175-76.
270. *Id.* at 202.
271. *Id.* at 174.

> vehicle under any coverage form or policy providing coverage on either a primary or excess basis.[272]

Thus, Ms. Berkeypile's recovery was capped at the highest limit of any one policy available, or, in this case, $300,000. Because Ms. Berkeypile already received an amount exceeding $300,000 in settlement, she was not entitled to any further recovery under Westfield's uninsured motorist endorsement.[273]

IV. DECISIONS OF THE U.S. DISTRICT COURTS

A. Cases Interpreting Michigan Law

Judge Murphy, of the Eastern District of Michigan, enforced an examination under oath (EUO) provision in a homeowner's policy in *Yaldo v. Allstate Property & Casualty Insurance Co.*[274] The insureds claimed that the insurer's demand for an EUO made more than thirty days after proof of loss was submitted was unenforceable pursuant to Michigan law requiring prompt payment of claims.[275] The district court was unpersuaded. The case cited by the insureds, *Griswold Properties, L.L.C. v. Lexington Insurance Co.*, stands for the proposition that an insurer is not protected from paying statutory penalty interest from the date of the proof of loss, and does not hold that the insured's claimed amount becomes payable—in the amount claimed—due to an insurer's failure to respond to a proof of loss.[276]

Likewise, the court found the context of another case relied upon by the plaintiff, *Cruz v. State Farm Mutual Insurance Co.*, to be distinguishable.[277] In *Cruz*, the Michigan Supreme Court found that EUO provisions would yield to the extent they "clash with the rules the Legislature has established for such mandatory insurance policies."[278] *Cruz* dealt with the No-Fault Act, which mandates insurance.[279] The

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272. *Berkeypile*, 485 Mich. at 1116.

273. *Id.*

274. 641 F. Supp.2d 644 (E.D. Mich. 2009).

275. *Id.* at 648. The insureds claimed that MCL sections 500.2833(1)(p), 500.2836(2) and 500.2006(3) act in concert to require the prompt payment of losses within 30 days after receipt of proof of loss. *Id.* at 649.

276. *Id.* at 650 (citing Griswold Props., L.L.C. v. Lexington Ins. Co., 275 Mich. App. 543 (2007), *vacated in part on other grounds*, 276 Mich. App. 551).

277. *Id.* at 652 (distinguishing Cruz v. State Farm Mut. Ins. Co., 466 Mich. 588 (2002)).

278. *Cruz*, 466 Mich. at 598.

279. *Id.* at 590.

district court noted that property and fire insurance are not mandatory and not subject to a comprehensive statutory scheme of regulation, unlike no-fault.[280] Insurance relationships are controlled by the policy, and the EUO provision "is a condition to payment of a claim and to the commencement of litigation."[281] Michigan courts favor such provisions and presume them to be valid and enforceable.[282] The policy prohibits an insured from suing the insurer unless there has been complete compliance with the policy terms.[283] The plaintiff's failure to submit to an EUO "is a material breach of a condition precedent to recovery on the policy or suing on the policy," and, therefore, the insurer is entitled to summary judgment.[284]

In *Bucciarelli v. Nationwide Mutual Insurance Co.*, a case primarily dealing with an alleged franchise agreement, the Eastern District of Michigan was called upon to determine whether the Michigan Franchise Investment Law (MFIL), M.C.L.A. section 445.1501 *et seq.*, applied to insurance agency contracts, in light of the comprehensive regulation by the Michigan Insurance Code.[285] The court found no Michigan cases which were on point and concluded, "absent clearer direction from the Michigan courts or the statute, this court will not hold as a matter of law that the MFIL does not apply to insurance contracts."[286] The court went on to deny the insurance company's motion to dismiss the plaintiff's claim based on the MFIL, finding further factual development was required.[287]

The insured's attempt to secure no-fault benefits in a suit filed some twenty-five years after a motor vehicle accident by alleging fraud to circumvent the one-year-back rule of M.C.L.A. section 500.3145 was unsuccessful in *Burger v. Allstate Insurance Co.*[288] Mr. Burger was struck by a motor vehicle on April 2, 1982, sustained serious injuries, and was given attendant care by his wife.[289] Mr. Burger claimed that on April 3, 1985, an Allstate representative informed him that all "service related benefits" expired on the third anniversary of the accident, a

280. *Yaldo*, 641 F. Supp.2d at 652.
281. *Id.* at 653.
282. *Id.*
283. *Id.* at 655.
284. *Id.* at 656.
285. 662 F. Supp.2d 809 (E.D. Mich. 2009).
286. *Id.* at 817.
287. *Id.* at 820.
288. 667 F. Supp.2d 738, 740 (E.D. Mich. 2009).
289. *Id.* at 741.

statement Mr. Burger took to mean that all of his benefits ended on that date.[290] Mr. Burger alleged fraud on the part of Allstate.[291]

To sustain a claim of silent fraud, it was incumbent upon Mr. Burger to demonstrate, as a precursor, that Allstate had a duty to disclose.[292] While the insurer has a duty to give a complete response where the insured makes a specific inquiry, in this case, Mr. Burger failed to demonstrate any inquiry he made which would trigger a duty on the part of Allstate to disclose the full benefits available pursuant to the policy.[293] Mr. Burger's reliance on the Uniform Trade Practices Act was misplaced, because, though the act creates a duty on the part of an insurer not to misrepresent benefits to insureds, it does not impose an affirmative duty to disclose.[294] With limited exceptions, none of which were present in this case, Michigan law generally holds there is no duty to disclose all benefits.[295]

Finally, Mr. Burger failed to state a cause of action for fraud, as he has failed to identify any false statement by Allstate.[296] Allstate's statements that service-related benefits were expiring conformed to the policy and did not reach the level of misrepresentation required to be actionable pursuant to Michigan law.[297] Furthermore, under Michigan law, fraud requires reasonable reliance by the person defrauded. Fraud is legally impossible where the would-be victim has full knowledge of a representation to the contrary; in this case, Mr. Burger is presumed to have read his policy, and an insured cannot have reasonably relied on any representation which would be contrary to the policy.[298] Because Mr. Burger has failed to state a claim for fraud, equity and fairness did not require Mr. Burger's case to be excepted from the one-year-back rule of

290. *Id.*

291. *Id.*

292. *Id.* at 742.

293. *Id.* at 742-43.

294. *Burger*, 667 F. Supp.2d at 743.

295. *Id.* at 744 (citing Harts v. Farmers Ins. Exch., 461 Mich. 1, 10-11 (1999)). The exceptions to the rule that there is no duty to disclose all benefits occur in situations where: 1) there has been misrepresentation by the insurer/agent, 2) "an ambiguous request is made [requiring further] clarification," 3) an agent responds to an inquiry with inaccurate advice, or 4) "the agent assumes an additional duty" via an express agreement or promise. *Id.*

296. *Id.* at 745.

297. *Id.* at 746 (citing Bromley v. Citizens Ins. Co. of Am., 113 Mich. App. 131, 135-36 (1982)).

298. *Id.* at 745-46. Mr. Burger's understanding that *all* his benefits would be terminated after three years is contrary to the policy language.

M.C.L.A. section 500.3145, and thus, any damages were limited to those sustained in the one year preceding the filing of the lawsuit.[299]

The Eastern District of Michigan addressed a situation where an individual was injured by a hit-and-run driver of a stolen vehicle in *K.G. v. State Farm Mutual Automobile Insurance Co.*[300] While on her front lawn, a minor was struck by a stolen vehicle, likely owned by John Dominick Romanowski.[301] Neither the minor nor her parents were named insureds on any no-fault policy, however, an insured vehicle borrowed by the minor's mother from a relative was present at the household.[302] Both Encompass, as insurer of Mr. Romanowski, and Farmers, as insurer of the owner of the borrowed vehicle, denied coverage.[303] State Farm was assigned the claim by the Michigan Assigned Claims Facility pursuant to M.C.L.A. section 500.3172, but refused to pay benefits because it determined the insurance dispute was not *bona fide*.[304] The minor was thus forced to bring suit.

Under M.C.L.A. section 500.3172, "an assigned claims insurer may be assigned . . . to pay no-fault personal injury benefits" in four situations, including cases such as this—where there is a dispute between two or more insurers regarding the provision of coverage.[305] M.C.L.A. section 500.3172(3) contains provisions laying out the mechanism for resolving disputes between insurers, but State Farm did not follow any of its provisions.[306] M.C.L.A. section 500.3172 imposes a duty on the assigned claims insurer to pay benefits once the claim is assigned, and grants no authority to the assigned insurer to determine the merits of the dispute between the other insurers.[307] The Legislature desired that the assigned insurer should pay the injured person and *then* "seek contribution from higher-priority insurers," to the extent they exist.[308] As State Farm failed to pay within 30 days, it is subject to penalty interest pursuant to M.C.L.A. section 500.3142(3).[309] As to attorney fees, the touchstone is whether the refusal to pay was reasonable, not whether an

299. *Id.* at 747.
300. 674 F. Supp.2d 862 (E.D. Mich. 2009).
301. *Id.* at 867.
302. *Id.* at 865, 867.
303. *Id.* at 865.
304. *Id.* at 869.
305. *Id.* at 868. An assigned claims insurer will also step in where 1) no personal protection insurance applies to the injury, 2) no personal protection insurance can be identified, and 3) the identifiable insurance cannot provide sufficient benefits due to financial inability of the insurers. MICH. COMP. LAWS ANN. § 500.3172(1) (West 2002).
306. *K.G.*, 674 F. Supp.2d at 868-69.
307. *Id.* at 869-70.
308. *Id.* at 872.
309. *Id.*

insurer is ultimately found responsible for paying benefits.[310] As State Farm received reasonable proof of the loss and its amount, the insurer had the burden of showing that its delay was reasonable, and State Farm did not meet that burden.[311] Having failed to carry the burden, attorney fees were proper.[312] The court declined to address State Farm's claim of indemnification against Encompass and/or Farmers, leaving State Farm to pursue that claim in state court if it desired.[313]

In *Pennsylvania Life Insurance Co. v. City of River Rouge*, the Eastern District of Michigan also considered the effect of an insured's failure to pay premiums because the funds had been embezzled by a middleman.[314] River Rouge, through a broker, Adam Korejsza, contracted with Penn Life to obtain prescription drug coverage for its employees.[315] Pursuant to the policy, premiums were due on the first of each month, with a forty-five day grace period before termination could occur.[316] River Rouge directed invoices be sent to Korejsza, who was to receive River Rouge's payments and then distribute the amount to the insurer.[317] From the start, River Rouge was delinquent in its payments, and Korejsza only submitted payments about once every two months, "but only in an amount sufficient to pay for one month of benefits."[318] River Rouge had been submitting the entire payment, on-time, to Korejsza, and later learned that Korejsza was embezzling the payments.[319] There is no question that Penn Life continued to provide benefits, despite having not received the full premiums for over one year.[320]

The policy provision requiring payment on the first of the month with a 45-day grace period did not operate to terminate the policy after expiration of the grace period without full payment.[321] The insurer can waive a provision, and the court concluded it did so here, as benefits continued to be provided.[322] In such a case, a claim for *quantum meruit* recovery arises.[323] Pursuant to Michigan law, "[a]n insurance producer

310. *Id.* at 872 (citing Ross v. Auto Club Group, 481 Mich. 1 (2008)).
311. *Id.* at 873.
312. *K.G.*, 674 F. Supp.2d at 873 (E.D. Mich. 2009).
313. *Id.*
314. 676 F. Supp.2d 575, 577 (E.D. Mich. 2009).
315. *Id.* at 577.
316. *Id.*
317. *Id.* at 578.
318. *Id.*
319. *Id.* at 578-79.
320. *Pa. Life Ins. Co.*, 676 F. Supp.2d at 582.
321. *Id.* at 580.
322. *Id.* (citing Glass v. Harvest Life Ins. Co., 168 Mich. App. 667, 670 (1988)).
323. *Id.*

shall not act as an agent *of an insurer* unless the insurance producer becomes an appointed agent *of that insurer*."[324] This statute does not render the policy unenforceable because nothing in the policy language requires that Korejsza act as Penn Life's agent.[325] Further, "[a]s a general rule, 'an independent insurance agent or broker is an agent of the insured, not the insurer.'"[326] In fact, witnesses testified time and again that Korejsza was an agent for River Rouge, and River Rouge identified him as its agent in a related suit.[327] Neither waiver nor laches barred recovery by Penn Life in this case. As instructed by River Rouge, Penn Life submitted monthly invoices, with notice of the delinquency, to Korejsza.[328] Korejsza's knowledge is imputed to River Rouge under principles of agency.[329] While any delay in contacting River Rouge directly may play a factor in the damage calculation, it will not defeat liability.[330] Judge Duggan felt that equitably, River Rouge, who installed Korejsza as the middleman, should bear the cost of Korejsza's embezzlement.[331]

The Eastern District also considered the rejection of an application for an insurance license under Michigan's insurance code due to an admitted felony conviction in *Heller v. Ross*.[332] Mr. Heller had a history of drug problems, but had turned his life around by the time he pled guilty to a felony criminal charge based on his prior activities; he received a sentence which was "an extreme downward departure" from the sentencing guidelines.[333] Mr. Heller obtained employment with an insurance service company, earned several promotions and applied for a Resident Producer License (RPL).[334] Michigan's Office of Financial Regulation (OFIR) denied the license solely due to the felony conviction.[335]

Pursuant to M.C.L.A. section 500.1205(1)(b), an application for an RPL "shall not be approved unless the commissioner finds that the individual" has not committed an enumerated act, including "[h]aving

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324. MICH. COMP. LAWS ANN. § 500.1208a(1) (West 2002) (emphasis added).

325. *Pa. Life Ins. Co.*, 676 F. Supp.2d at 581.

326. *Id.*

327. *Id.*

328. *Id.* at 582.

329. *Id.* (citing New Freedom Mortg. Corp. v. Globe Mortg. Corp., 281 Mich. App. 63, 79 (2008)).

330. *Id.*

331. *Pa. Life Ins. Co.*, 676 F. Supp.2d at 583.

332. 682 F. Supp.2d 797 (E.D. Mich. 2010).

333. *Id.* at 798-99.

334. *Id.* at 799. Pursuant to M.C.L.A. section 500.1205, an RPL is required to sell certain insurance products.

335. *Id.*

been convicted of a felony."[336] Judge Tarnow noted that the court was constrained by binding Sixth Circuit precedent,[337] which he "reluctantly conclude[d,]" recognized the constitutionality of the licensing scheme.[338] A rational basis was articulated by OFIR, and that minimal threshold is all that is required to satisfy the Constitution regarding this classification.[339]

Michigan law was used to analyze an insurance policy providing benefits where the decedent was involved in a fatal accident in a taxi cab in *Atifah v. Union Security Insurance Co.*[340] The policy at issue provided for a $100,000 benefit for death involving a motor vehicle, but $1,000,000 for death involving a licensed common carrier.[341] The policy defined a common carrier as "an air, land, water conveyance operated under a license for regularly scheduled fare paying passenger service."[342] "Regularly scheduled" was not defined in the policy.[343]

Plaintiff's attempted use of a dictionary definition of "common carrier" rather than the policy's definition was rebuffed, as contractually defined terms, even if different than common usage, must control.[344] While it is true that "regularly scheduled" is not defined in the policy, that failure to define alone does not render a term ambiguous.[345] The court cited to decisions of other federal courts which had concluded that on-demand transportation services, such as taxi cabs, are not "regularly scheduled."[346] As the plaintiff failed to demonstrate ambiguity, the court found that extrinsic evidence was not permitted, but noted that even if such evidence were to be considered,[347] the result would not change, as the policy contained an integration clause and notice agents could not alter the policy in any way.[348]

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336. *Id.* at 799 (quoting MICH. COMP. LAWS ANN. § 500.1205(1)(b) (West 2002) and MICH. COMP. LAWS ANN. § 500.1239(1)(f) (West 2002)).

337. *Id.* at 802 (citing Darks *v.* Cincinnati, 745 F.2d 1040, 1044 (6th Cir. 1984)).

338. *Heller*, 682 F. Supp.2d at 804.

339. *Id.* at 807.

340. 694 F. Supp.2d 668 (E.D. Mich. 2010).

341. *Id.* at 669.

342. *Id.* at 671.

343. *Id.*

344. *Id.* at 671-72 (citing Amerisure Mut. Ins. Co. v. Carey Transp., *Inc.*, 578 F. Supp.2d 888 (W.D. Mich. 2008)).

345. *Id.* at 672.

346. *Atifah*, 694 F. Supp.2d at 672 (E.D. Mich. 2010) (quoting Smith v. Family Life Assurance Co. of Columbus, 584 F.3d 212, 218-19 (5th Cir. 2009)).

347. Plaintiff wished to introduce evidence regarding a sale-pitch phone conversation with the telemarketer who sold her the policy. *Id.* at 672.

348. *Id.* at 673.

B. ERISA

In *Glover v. Nationwide Mutual Fire Insurance Co.*, the Western District of Michigan considered a dispute between a Michigan no-fault carrier and an ERISA health plan as to which coverage is primary.[349] Ms. Glover was injured in a motor vehicle accident, and was provided some $59,000 in benefits under her father's ERISA health plan; her parents' no-fault insurer, Nationwide, has not paid any benefits.[350] The insurer of the vehicle which injured Ms. Glover tendered its $50,000 policy limit in satisfaction of all claims arising from the accident.[351] In this declaratory action, the ERISA plan seeks reimbursement from the $50,000 settlement, pursuant to the plan's terms, and Ms. Glover, through her representative, seeks a determination that she be allowed to recover any amounts she is required to reimburse the plan.[352] Both the plan and the no-fault policy contain coordination of benefit clauses.[353]

The ERISA plan unambiguously creates a right to reimbursement from the settlement, and because ERISA preempts state law as it relates to the plan, Michigan law to the contrary must yield.[354] As to Ms. Glover's claim, the coordination of benefits clauses in the plan and the policy do not conflict, and therefore, there is no preemption issue.[355] The district court rejected on-point Michigan Court of Appeals case law, *Dunn v. Detroit Automobile Inter-Insurance Exchange*,[356] which held that a no-fault insurer was not required to reimburse an injured party for amounts he paid to reimburse an ERISA plan from a settlement.[357] Instead, the district court applied a Sixth Circuit decision which rejected *Dunn* as "not good law," as it conflicted with *Sibley v. Detroit Automobile Inter-Insurance Exchange*,[358] a Michigan Supreme Court decision which interpreted a provision of the no-fault act, not an insurance policy.[359] The relevant inquiry is whether the health benefits

349. 676 F. Supp.2d 602, 606 (W.D. Mich. 2009). The court noted the dispute "proves once again the truth of the adage that the only thing worse than having no insurance policy is having two." *Id.*

350. *Id.*

351. *Id.* at 608.

352. *Id.* at 606.

353. *Id.* at 607-08.

354. *Id.* at 613.

355. *Glover*, 676 F. Supp.2d at 614-15.

356. *Dunn v. DAIIE*, 254 Mich. App. 256 (2002).

357. *Glover*, 676 F. Supp.2d at 616-17 (citing *Dunn*, 254 Mich. App. at 271-72).

358. 431 Mich. 164 (1988)

359. *Id.* at 617-18 (citing Shields v. Gov't Emps. Hosp. Ass'n, 450 F.3d 643, 646 (6th Cir. 2006), *overruled in part by* Adkins v. Wolever, 554 F.3d 650 (6th Cir. 2009)). The Sixth Circuit reached its conclusion on the conflict between *Dunn* and *Sibley*, despite the

were "paid," as the no-fault insurer can reduce its obligation by amounts "paid" by a health insurer; benefits which the insured must subsequently reimburse the health carrier cannot be said to be "paid."[360] As these benefits must be paid back by the beneficiary, they have not been "paid," and the no-fault insurer must reimburse those amounts.[361]

In another ERISA case, *Isner v. Minnesota Life Insurance Co.*, the Eastern District addressed an issue regarding offsets due to Social Security benefits and ERISA long-term disability benefits.[362] Mr. Isner, who suffered from Parkinson's Disease, collected benefits pursuant to two separate ERISA plans providing him with long-term disability benefits.[363] When the Social Security Administration began paying disability benefits to Mr. Isner, both ERISA plan providers reduced their monthly payments by the amount paid by Social Security; that is to say, both plans offset by the full amount.[364] Both plans allowed for offsets due to other income benefits, including Social Security.[365]

The court concluded that the double offset was permissible, as ERISA authorizes integration of Social Security benefits.[366] As ERISA's non-forfeiture provision does not apply to long-term disability benefits, the plan administrator is left to determine whether the ERISA benefits are offset by Social Security benefits.[367] The policies at issue are clear, unambiguous, and provide for an offset for Social Security benefits.[368] As such, the clear policy language must be enforced. Plaintiff's appeals to equitable relief pursuant to 29 U.S.C. section 1132(a)(3) are unfounded. That section may not be used to recover money damages, because although a claimant is allowed to challenge a plan administrator's denial of benefits pursuant to 29 U.S.C. section 1132(a)(1)(B), section 1132(a)(3) does not create a right to a cause of action.[369]

In *Sundstrom v. Sun Life Assurance Co. of Canada*, the Western District concluded that where an ERISA claim involved the denial of

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Court in *Dunn* holding that *Sibley* was distinguishable, and therefore not controlling. *Dunn*, 254 Mich. App. at 270-71. The Sixth Circuit's condemnation of *Dunn* as "not good law" is therefore at least questionable, if not wholly incorrect.

360. *Glover*, 676 F. Supp.2d at 618.

361. *Id.*

362. 677 F. Supp.2d 950, 952 (E.D. Mich. 2009).

363. *Id.* at 952.

364. *Id.*

365. *Id.* at 952-54.

366. *Id.* at 957.

367. *Id.* at 956.

368. *Isner v. Minn. Life Ins. Co.*, 677 F. Supp.2d at 957-58.

369. *Id.* at 958-59 (quoting Wilkins v. Baptist Healthcare Sys., 150 F.3d 609, 615 (6th Cir. 1998)).

employee benefits, the court's review is limited solely to the administrative record.[370] Where the plan administrator has discretion, a court may review that decision using an arbitrary and capricious standard, the least demanding form of review.[371] This is not to say the review is a mere formality, though, as the court reviews both the decision and its basis.[372] The court considered the decision by a plan administrator, interpreting plan language dictating the time period to convert a group life insurance policy to an individual one.[373] That the claimant's estate offered an alternate interpretation of the language, did not render the administrator's decision arbitrary or capricious.[374]

A claimant did succeed in having a plan administrator's denial of benefits overturned under the arbitrary-and-capricious standard in *Lanier v. Metropolitan Life Insurance. Co.*,[375] proving that the standard of review is not a rubber stamp. In this case, Mr. Lanier had a history of back pain which continued to progress into a host of debilitating medical conditions requiring several surgeries.[376] Met Life at first provided benefits on a short-term basis, and then on a long-term basis.[377] Met Life informed Mr. Lanier that it would discontinue benefits upon completion of the three-year period following Mr. Lanier's last day of work, and Mr. Lanier appealed.[378] Met Life relied in part on a physical capacity evaluation from Mr. Lanier's treating physician, Dr. Seidel.[379] During the appeal, Dr. Seidel issued a new report to correct misstatements in his original evaluation regarding Mr. Lanier's ability to tolerate sitting, standing and walking; further diagnostic tests were also performed.[380] A report was submitted from a vocational expert who evaluated Mr. Lanier for Social Security disability and concluded that Mr. Lanier, if credible, was unable to perform any jobs available in significant numbers in the economy.[381] Mr. Lanier was also found to be disabled by the Social

370. 683 F. Supp.2d 594, 596 (W.D. Mich. 2010) (citing *Wilkins*, 150 F.3d at 618-19).
371. *Id.* at 596 (quoting McDonald v. W.-S. Life Ins. Co., 347 F.3d 161, 168 (6th Cir. 2003)).
372. *Id.* at 597 (citing Metro. Life Ins. Co. v. Conger, 474 F.3d 258, 264 (6th Cir. 2007)).
373. *Id.* at 598-599.
374. *Id.* at 599.
375. 692 F. Supp.2d 775 (E.D. Mich. 2010).
376. *Id.* at 779.
377. *Id.* at 779-80.
378. *Id.* at 780.
379. *Id.*
380. *Id.* at 780-81.
381. *Lanier*, 692 F. Supp.2d at 781.

Security Administration, and Met Life reversed its position on appeal based on the evidence.[382]

Just eight months later, Met Life again terminated benefits, this time based on the opinion of a vocational consultant who based her opinion on Dr. Seidel's initial report, which had since been repudiated; no new medical evidence formed the basis of this denial.[383] Met Life had Mr. Lanier's second appeal reviewed by two medical consultants, neither of whom interviewed or examined Mr. Lanier, and concluded that the medical record was insufficient to support a conclusion of disability.[384] The reviewing doctors criticized Dr. Seidel and noted the subjective nature of Mr. Lanier's complaints.[385]

The application of the arbitrary-and-capricious standard of review was unchallenged by the parties.[386] The court noted that the review is the "least demanding" form, but also that the decision must be supported by "substantial evidence"—that is to say supporting evidence which is "'rational in light of the plan's provisions.'"[387] In general, where the plan administrator bases a decision on the medical opinion of one doctor over another, the decision is not arbitrary or capricious.[388] However, a plan administrator is not allowed to base his decision on an interpretation of the plan which has no support in the text, nor can he "cherry-pick" evidence to get a favorable result.[389]

In this case, the court found the decision arbitrary and capricious for a multitude of reasons: 1) Mr. Lanier presented with multiple ailments to support his claimed pain;[390] 2) the conclusions of the Met Life consultants were inconsistent both internally and with the medical records;[391] 3) at least one consultant relied on an MRI which was nearly two years old, when a more recent test was available;[392] 4) the consultants made conclusions about the credibility of Mr. Lanier's complaints without adequately addressing the treating physician's diagnoses and examinations;[393] 5) Met Life did not address the Social

382. *Id.*
383. *Id.* at 781-82.
384. *Id.* at 782-83.
385. *Id.* at 783.
386. *Id.* at 785.
387. *Lanier*, 692 F. Supp.2d at 785-86 (quoting Smith v. Ameritech, 129 F.3d 857, 863 (6th Cir. 1997)).
388. *Id.* at 786 (citing *McDonald*, 347 F.3d at 169.
389. *Id.*
390. *Id.* at 788.
391. *Id.*
392. *Id.*
393. *Lanier*, 692 F. Supp.2d at 789. Although there is nothing *per se* improper with an administrator relying on a review by a physician who has only conducted a file review,

Security Administration's finding of disability;[394] 6) Met Life gave no weight to Mr. Lanier's treating physician, who actually conducted examinations;[395] and 7) the manner in which the denial determination was reached evidences influence by conflicting interests.[396] Given these factors, Judge Lawson concluded it was inescapable that the decision to terminate benefits was arbitrary and capricious.[397]

C. Further Cases of The United States District Courts

The Western District considered a request to change venue in a dispute between an insurance carrier and its insured in *Cincinnati Insurance Co. v. O'Leary Paint Co.*[398] The insured, a Michigan corporation, received a notice from the Indiana Department of Environmental Management regarding allegations of an unauthorized release of substances from a facility located in Indiana.[399] The insurer, an Ohio company, filed a declaratory action in federal district court in Michigan, while the insured filed a breach of contract action in federal

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such reliance is inadequate where the conclusions of that review "'include critical credibility determinations regarding a claimant's medical history and symptomology.'" *Id.* (quoting Calvert v. Firstar Fin., Inc., 409 F.3d 286, 297 n.6 (6th Cir. 2005)).

394. *Id.* at 789. While it is true that qualifying for Social Security Disability benefits does not automatically qualify one for ERISA disability benefits, as the two programs have critical differences, the Social Security decision "is 'far from meaningless.'" *Id.* at 789 (quoting *Calvert*, 409 F.3d at 294). Indeed, where the plan administrator encourages application for Social Security benefits and financially benefits from the receipt of those benefits, the administrator should explain why he disagrees with the position of the Social Security Administration in determining disability. *Id.* at 789-90.

395. *Id.* at 790. While an administrator need not defer to the treating physician, where that physician's opinion is reliable, it must be accorded due weight. *Id.* (citing Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003)). Certain common-sense guidelines are used when evaluating a non-treating physician's opinion: 1) "whether the reviewing physician has a conflict of interest," 2) whether the administrator determined that the reviewer should only conduct a file review, particularly when an examination can be required, and 3) whether the non-treating physician's conclusion makes credibility determinations as to a patient's history and symptoms without having observed the patient. *Id.* (quoting Houston v. Unum Life Ins. Co. of Am., 246 F. App'x. 293, 301-02 (6th Cir. 2007)).

396. *Id.* at 791. No evidence was presented showing any improvement in Mr. Lanier's condition, and, in fact, the evidence showed the condition to be getting worse. *Id.* Further, just 8 months prior, Met Life found a disability *did* exist, and "it is only reasonable that some new evidence calling into doubt the continuing disability of the claimant is necessary to justify the change of course." *Id.*

397. *Id.*

398. 676 F. Supp.2d 623 (W.D. Mich. 2009).

399. *Id.* at 625.

district court in Indiana.[400] The insured moved to change venue of the declaratory action to the federal district court in Indiana.[401] Though not particularly relevant to substantive insurance law, the decision bears on declaratory actions, which are frequently utilized in insurance disputes.

The court began by noting that while a plaintiff's choice of forum is normally accorded deference, it is given less weight in a declaratory action, especially where, as here, the "natural plaintiff" is not the party which initiated the suit.[402] The court went on to apply factors from *Steelcase, Inc. v. Smart Technologies*,[403] to conclude that changing venue in this instance was appropriate.[404]

V. DECISIONS OF THE U.S. COURT OF APPEALS FOR THE SIXTH CIRCUIT

A. Cases Interpreting Michigan Law

The Sixth Circuit addressed the interaction between the Federal Tort Claims Act[405] (FTCA) and Michigan's No-Fault Act[406] in *Premo v. United States*.[407] In this case, the plaintiff, who was 19 years old and did not own an automobile at the time, was struck by a U.S. Postal Service (USPS) vehicle.[408] When the plaintiff sought no-fault benefits, the USPS replied that it was self-insured, that it was exempt from the requirements of state motor vehicle insurance law and that plaintiff's only remedy was through the FTCA.[409] When plaintiff filed suit in federal district court, the USPS moved for summary judgment, contending that economic damages could not be recovered because the Michigan No-Fault Act applied, and that plaintiff failed to meet the threshold for non-economic damages pursuant to Michigan law.[410]

The Sixth Circuit determined that the intent of the FTCA was to allow the government to be "'liable in tort as a private individual would be under like circumstances,'" with certain exceptions.[411] A two-step analysis is required: first, local law applies to determine liability and

400. *Id.* at 629-30.
401. *Id.* at 630.
402. *Id.* at 631 (citing Hyatt Int'l Corp. v. Coco, 302 F.3d 707, 778 (7th Cir. 2002)).
403. Steelcase, Inc. v. Smart Techs., Inc., 336 F. Supp.2d 714, 719-20 (W.D. Mich. 2004).
404. *O'Leary*, 676 F. Supp.2d at 632-40.
405. 28 U.S.C § 2671, *et seq.* (2010).
406. MICH. COMP. LAWS ANN. § 500.3101, *et seq.* (West 2002).
407. 599 F.3d 540, 542 (6th Cir. 2010).
408. *Id.* at 542.
409. *Id.* at 542-43.
410. *Id.* at 543.
411. *Id.* at 544 (quoting Richards v. United States, 369 U.S. 1, 6 (1962).

damages, and second, federal law steps in to bar certain recoveries for which sovereign immunity has not been waived.[412] Under Michigan law, with limited exceptions, a private individual could only look to the No-Fault Act for compensation for automobile-related injuries.[413] The FTCA does not waive immunity for claims resting on strict liability,[414] and since the No-Fault Act awards benefits "without regard to fault," it is, in essence, a strict liability statute.[415] This imposition of liability without regard to fault must yield to the FTCA.[416] The No-Fault Act may not be used as a basis for a claim pursuant to the FTCA.[417] It does not matter that the government initially took a position that the No-Fault Act did not apply, because in the realm of estoppel, the government is not treated as any other litigant.[418] The plaintiff would need show some "affirmative misconduct"—meaning an act which intentionally or recklessly misleads—in addition to the standard elements of estoppel.[419] Plaintiff could not even show any misrepresentation; the government was not now contending that the No-Fault Act applies directly, but rather that the FTCA requires a determination of liability to be based on state law, which just so happens to be the No-Fault Act.[420] USPS always claimed the FTCA applied, and indeed it barred the claim.[421]

B. ERISA

In *Kramer v. Paul Revere Life Insurance Co.*, the Sixth Circuit considered the provision of long-term disability benefits to an insured who becomes "totally disabled."[422] Dr. Kramer was an obstetrician gynecologist (ob/gyn) with two ERISA life policies: one policy provided benefits if the insured was "not able to perform the substantial and material duties of *your occupation*," and the other provided benefits in the event that she was "unable to perform the important duties of *his own occupation* on a full-time or part-time basis."[423] Medical tests revealed

412. *Id.* at 545.
413. *Premo*, 599 F.3d at 545.
414. Chancellor v. United States, 1 F.3d 438, 440 (6th Cir. 1993).
415. *Premo*, 599 F.3d at 548.
416. *Id.*
417. *Id.* at 549.
418. *Id.* at 547.
419. *Id.*
420. *Id.*
421. *Premo*, 599 F.3d at 547.
422. 571 F.3d 499, 501 (6th Cir. 2009).
423. *Id.* at 501 (emphasis added). The companies issuing the two insurance policies merged, first with each other, and then with Unum Life Insurance Co. *Id. N.B.*: Though

several conditions which interfered with Dr. Kramer's ability to work, including disk herniation, spinal cord compression, and loss of the normal use of her left arm; even a review of records by the insurer's physicians supported the conclusion that Dr. Kramer was eligible for disability benefits.[424] Dr. Kramer's condition was periodically tested, revealing either no improvement or worsening of the conditions.[425] After having paid disability benefits for several years, the insurer requested another independent medical exam, which resulted in a change from the previous diagnoses.[426] Coupling this report with a second report concluding that the record did not support a finding of impairment which would preclude the physical demands of Dr. Kramer's profession, together with video surveillance showing Dr. Kramer working on a sailboat, the insurer terminated the benefits.[427] In response, Dr. Kramer submitted reports from her own doctors, her ob/gyn colleagues, and even her former supervisor that she was "unemployable" as an ob/gyn.[428]

The district court found that one policy did not give the plan administrator discretion, so termination of benefits was reviewed *de novo*; the second plan did vest discretion, so the arbitrary and capricious standard applied.[429] As to the policy it reviewed *de novo*, the district court found that the termination of benefits was improper as the evidence demonstrated that Dr. Kramer could not perform the duties of her own occupation.[430] The Sixth Circuit was baffled, however, that the district court reached the opposite conclusion as to the policy which it reviewed on an arbitrary and capricious standard.[431] In essence, the district court used the same evidence and arguments it rejected as to the *de novo* policy in sustaining the determination as to the arbitrary and capricious policy.[432] The Sixth Circuit could find no basis for the different outcomes, regardless of the standard of review.[433] Further, the insurer offered no explanation for the decision to terminate benefits it had paid for years due to a total disability, when there was no medical evidence

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this opinion technically dates from the previous *Survey* period, the decision to publish the opinion was not made until June 30, 2009.

424. *Id.* at 502.
425. *Id.*
426. *Id.*
427. *Id.* at 503.
428. *Kramer*, 571 F.3d at 503-04.
429. *Id.* at 501.
430. *Id.* at 506.
431. *Id.*
432. *Id.*
433. *Id.* at 507.

that Dr. Kramer's position had improved.[434] Though arbitrary and capricious is a high standard of review, it does not mean that the court will merely rubber stamp a plan administrator's decisions.[435] As the district court found the evidence established permanent disability pursuant to one policy, there was no reasoned basis to sustain the determination of non-disability based on an equivalently worded policy and the same discredited evidence.[436]

In *Helfman v. GE Group Life Assurance Co.*, the Sixth Circuit considered application of ERISA to a benefit plan where a beneficiary claimed to have reimbursed his employer for the premiums paid, but the company contributed to premiums on behalf of others in the plan.[437] The court considered the "safe harbor" provision which exempts certain plans from ERISA if four criteria are satisfied:

> (1) No contributions are made by an employer or employee organization;
>
> (2) Participation [in] the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.[438]

The court concluded that only the first criterion needed to be addressed in this case.[439] That criterion was not met because it would violate ERISA's goal of nationally uniform plan administration to subject the same plan to differing governing schemes based on whether the premiums were paid in full by a particular employee or whether the employer contributed to the premiums.[440] ERISA's goals require "that a single plan may not be variously governed by both ERISA and state law, depending on the particular employee in question."[441] If an employer

434. *Kramer*, 571 F.3d at 507.
435. *Id.* at 508.
436. *Id.*
437. 573 F.3d 383, 386-87 (6th Cir. 2009).
438. *Id.* at 388-89 (quoting 29 C.F.R. § 2510.3-1(j)(1) to .3-(4) (2010)).
439. *Id.* at 388-89.
440. *Id.* at 390.
441. *Id.*

pays part of any employee's premiums, ERISA applies to the entire plan, even if some employees pay their own premiums in full.[442]

Having concluded that ERISA applied to the plan, the court then went on to consider the termination of long term benefits by the insurer.[443] As the plan administrator had discretion in interpretation, an arbitrary and capricious standard was applied.[444] The court considered whether the decision was the culmination of a "deliberate, principled reasoning process" under this standard.[445] Where, as here, the insurer both determines eligibility for benefits and pays the benefits, a conflict of interest "should at least be considered."[446] In this instance, a file review was conducted to determine benefits, even though the plan allowed for examination by a physician.[447] Though there is nothing inherently wrong with utilizing a file review to determine benefits, doing so "raises questions about the thoroughness and accuracy" of the claim review, where the plan explicitly reserved the right to an examination.[448]

If a file review is to be used, then any letter from the treating physicians must be considered, but an interview with those physicians is not *per se* required.[449] An insurer's failure to explain the reasons behind its decision to terminate benefits supports a conclusion that the insurer did not engage in a deliberate, reasoned decision-making process.[450] Where a plan does not preclude prophylactic restrictions, the plan administrator cannot reject such suggested restrictions as a matter of course.[451] Stress, though highly subjective, may be a factor preventing individuals with heart conditions from working.[452] An administrator weighing credibility as to a subjective factor, such as stress, without a physical examination, supports a finding that the decision was arbitrary.[453] A decision is arbitrary and capricious where it is based on 1) a disregard of the treating physician's determination, 2) dismissal of claimed stress as subjective and irrelevant, and 3) failure to conduct a permitted physical examination.[454]

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442. *Id.* at 391.
443. *Helfman*, 573 F.3d at 392-95.
444. *Id.* at 392.
445. *Id.*
446. *Id.* at 392-93.
447. *Id.*
448. *Id.* at 393.
449. *Helfman*, 573 F.3d at 393.
450. *Id.* at 394.
451. *Id.* at 395.
452. *Id.*
453. *Id.* 395-96.
454. *Id.* at 396.

The Sixth Circuit, in *Cox v. Standard Insurance Co.*, considered the case of an individual with a history of migraine headaches, diagnosed by his treating physician as having had a stroke which prevented him from resuming his work as a family practice physician.[455] The court found nothing arbitrary or capricious about the decision to discontinue benefits where that determination was based on the opinions of two consulting physicians who disagreed with Dr. Cox, an independent medical evaluation, several days surveillance, evidence that the individual worked as a consultant and spoke at medical conferences during his disability period, evidence that the individual rarely sought emergency care for his condition, evidence that the individual did not receive ongoing rehabilitation, evidence the individual went for weeks without headaches, and lack of a physical examination by the individual's treating physician.[456]

In this case, the only factors that could weigh in favor of an arbitrary and capricious decision were that the Social Security Administration's determination of disability was not considered and that there may be a possible conflict of interest where the insurer both determines eligibility and pays benefits.[457] As to the former, plan administrators are not bound by the Social Security Administrator's determination, and the court did not have any information regarding that determination, which occurred two years prior.[458] As to the latter factor, the conflict was simply not enough where there was no evidence of an abuse of discretion on the insurer's part.[459]

VI. CONCLUSION

Insurance is a business affected with the public interest. Michigan courts addressed a number of statutorily mandated, judicially imposed public policy considerations during this *Survey* period. After there was a change of one justice, which changed the philosophical balance of the Supreme Court, the court promptly reversed itself.[460]

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455. 585 F.3d 295, 296-97 (6th Cir. 2009).

456. *Id.* at 303.

457. *Id.*

458. *Id.*

459. *Id.*

460. The outcome of the November 2011 election changed the composition of the Michigan Supreme Court again, with Alton Davis losing his retention bid, and Wayne County Circuit Court Judge Mary Beth Kelly being elected to the Court. Further, Justice Maura Corrigan resigned from the court in January 2011, and was replaced by court of appeals Judge Brian Zahra. The Court's majority has shifted twice in a very short period. In a case outside the *Survey* period, the ideological rift among the justices of the court

Insurance coverage and disputes continue to be topics of frequent litigation. With the apparent divisiveness on the Michigan Supreme Court, and the pre-January 2011 majority's willingness to overturn precedent over the objections of the current majority, the next *Survey* period could prove to be one of the most active in recent memory.

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was strikingly laid out in a candid dissent by Justice Young, who noted no less than 12 cases the "new majority" had explicitly overruled, eight precedential cases which the majority ignored or did not follow, and even one case implicitly overruled by a "contradictory court rule." *Regents of Univ. of Mich. v. Titan Ins. Co.*, 487 Mich. 289, 325 n.7, 8 (2010) (Young, J., dissenting). The dissent then went on to chastise "*un*civil criticism" by Chief Justice Kelly, as well as to note the chief justice's "hypocritical" calls for civility in light of her own comments. *Id.* at 328 (emphasis in original).