INSURANCE LAW

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I. INTRODUCTION

2012 was an election year, with Bridgett McCormick winning the seat vacated by retiring Justice Marilyn Kelly.[1] In the midst of a mortgage scandal, former Justice Diane Hathaway announced her resignation effective in January 2013, and the Michigan Supreme Court found itself in a term with another change in its membership.[2] Justice Hathaway's sudden resignation cleared the way for Michigan Governor Rick Snyder to appoint a replacement, Macomb County Circuit Judge David Viviano, in February 2013.[3] Therefore, Justices Viviano and McCormick did not take part in several early-2013 term cases, and insurance cases were no exception.[4] However, what is widely viewed as the majority ideology of the Michigan Supreme Court did not change during this period, as what is viewed as a conservative majority is believed to have increased with Governor Snyder's appointment.[5]

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1. Peter Shahin, *McCormack, Markman to Assume Seats on State Supreme Court*, MICHIGAN DAILY (Nov. 7, 2012), https://www.michigandaily.com/news/11supreme-court-results-still-undecided7.

2. *Michigan Supreme Court Justice Charged with Bank Fraud in Real Estate Deal: Diane Hathaway Resigns Monday*, BLADE (Jan. 21, 2013), http:www.toledoblade.com/Courts/2013/01/19/Michigan-Supreme-Court-justice-Diane-Hathaway-charged-with-banj-fraud-in-real-estate-deal-she-resigns-Monday.html.

3. Kathleen Gray, *Macomb County Circuit Judge Vivian to Replace Hathaway on Supreme Court*, DETROIT FREE PRESS (Feb. 27, 2013), http:www.freep.com/article/20130227/NEWS06/130227038/David-Viviano-Rick-Synder-Diane-Hathaway-Michigan-Supreme-Court-justice.

4. *See generally* Michigan Ins. Co. v. Nat'l Liability & Fire Ins. Co., 493 Mich. 924; 824 N.W.2d 563 (2013); Whitman v. City of Burton, 824 N.W.2d 568 (Mich. 2013).

5. *See How Michigan Supreme Court Opening Will Be Filled in Wake of Diane Hathaway Departure*, MLIVE (Jan. 8, 2013), https://www.mlive.com/politics/index.ssf/2013/01/michigan_supreme_court_snyder.com.

While most people likely do not converse with their insurance companies on a daily basis, people do interact daily with the subjects of insurance coverage: in operating automobiles, in inhabiting homes and apartments, in operating businesses, and even in patronizing the businesses of others.[6] Regardless of the day, it is virtually certain that the average person will have multiple interactions with someone or something covered by insurance. If nothing else, most people are certainly cognizant of the cost of insurance. Michigan is presently home to the second highest average automobile insurance premium in the nation, with the average automobile insurance premium at $2,520.[7] Decisions that have an effect on the insurance industry, therefore, have more than just an esoteric impact on people in Michigan.

II. DECISIONS OF THE MICHIGAN SUPREME COURT

A. The No Fault Act, MCLA Section 500.3101-500.3179

Automobiles are a part of everyday life, and it is little wonder that No-Fault Act cases frequently find themselves before the appellate courts of this state.

1. MCLA Section 500.3105—"Accidental Bodily Injury Arising Out of the Ownership, Operation, Maintenance or Use of a Motor Vehicle as a Motor Vehicle"

As a result of a motor vehicle accident in 2007, Ian McPherson developed a neurological disorder and received no-fault benefits.[8] In 2008, Mr. McPherson was operating a motorcycle when he experienced a seizure consistent with his neurological disorder and lost control of his motorcycle, hitting a parked car and leaving him a quadriplegic.[9] Mr. McPherson claimed that he was entitled to no-fault benefits as a result of the 2007 accident, in that the 2008 injury was one "arising out of" the

6. *See About Us*, ERIE INS., http://www.erieinsurance.com/about/Default.aspx (last visited Jan. 24, 2014) (stating that the company "[o]ffers auto, home, business, and life insurance"). *Cf.* Larry Copeland, *One in Seven Drivers Have No Insurance*, USA TODAY (Sept. 12, 2011), http://usatoday30.usatoday.com/news/nation/story/2011-09-11/uninsured-drivers/50363390/1 (stating that approximately fourteen percent of motorists are estimated to be uninsured, meaning that approximately eighty-six percent are insured and should have some idea of the cost of insurance).

7. Barbara Marquand, *The Most and Least Expensive States for Car Insurance*, INSURE.COM, http://www.insure.com/car-insurance/car-insurance-rates.html (last visited Feb. 25, 2014).

8. McPherson v. McPherson, 493 Mich. 294, 295; 831 N.W.2d 219 (2013).

9. *Id.*

operation of the motor vehicle in 2007.[10] The causation required to trigger no-fault liability for benefits must be more than "incidental, fortuitous, or 'but for.'"[11] The Michigan Supreme Court found the causal connection on these facts to be insufficient, as the spinal cord injury at issue was the result of the 2008 motorcycle crash, not the 2007 motor vehicle accident.[12] The first injury may have caused the second accident, which, in turn, caused the second injury, but that causal chain was too attenuated from the first accident to trigger no-fault benefits.[13]

2. MCLA Section 500.3107—"Allowable Expenses"

The Michigan Supreme Court considered what types of services are included within the term "allowable expenses," as used in MCLA section 500.3107.[14] James Douglas sustained a closed-head injury in 1996 when a hit-and-run motorist struck him; the Michigan Assigned Claims Facility assigned Allstate to be the provider of no-fault benefits.[15] In 1999, more than three years after the accident, Douglas was still unable to hold a job, and a psychiatrist concluded that further treatment was required due to the closed-head injury.[16] Mr. Douglas filed suit in 2005, "seeking compensation for unspecified" no-fault benefits that Allstate allegedly refused to pay.[17] Allstate filed several motions for summary disposition, asserting that any "attendant care was not reasonably necessary" because it had not been prescribed prior to November 7, 2006; Mr. Douglas responded with an affidavit from his psychiatrist that stated he was in need of attendant care during "all waking hours," and the trial court denied the motions.[18] During a bench trial, Mr. Douglas's wife, Katherine, testified that "her entire time was spent 'babysitting'" Mr. Douglas, even while she was engaged in performing other household tasks.[19] Forms completed by Mrs. Douglas in 2007

10. *Id.* at 296 (emphasis omitted).

11. *Id.* at 297 (quoting Thornton v. Allstate Ins. Co., 425 Mich. 643, 659; 391 N.W.2d 320 (1986)).

12. *Id.* at 297-98.

13. *Id.* at 298. The claimant relied upon a Michigan Court of Appeals decision, *Scott v. State Farm Mut. Auto. Ins. Co.*, 278 Mich. App. 578, 586; 751 N.W.2d 51 (2008), in which the court stated, "Almost any causal connection will do." The Michigan Supreme Court stated that it was "troubled" by the Court of Appeals usage "of a causal connection standard this Court has never recognized." *McPherson,* 493 Mich. at 299.

14. Douglas v. Allstate Ins. Co., 492 Mich. 241; 821 N.W.2d 472 (2012).

15. *Id.* at 249-50.

16. *Id.* at 250.

17. *Id.* at 250-51.

18. *Id.* at 251.

19. *Id.* at 252.

> outlined the various tasks that she performed, including organizing her family's day-to-day life, cooking meals, undertaking daily chores, maintaining the family's house and yard, ordering and monitoring plaintiff's medications, communicating with health care providers and Social Security Administration officials, calling plaintiff from work to ensure plaintiff's safety, monitoring plaintiff's safety, and cueing or prompting various tasks for plaintiff to undertake.[20]

Mr. Douglas' psychiatrist testified that his company provided the attendant care and employed Mrs. Douglas to perform those services.[21]

The trial court determined that Mr. Douglas needed "care for all his waking hours" and entered a judgment for services dating back to May 31, 2004, in the amount of $1,163,395.40, inclusive of attorney fees, no-fault costs, and interest.[22] The Michigan Court of Appeals affirmed the denial of the motions for summary disposition, concluding that a question of fact did exist as to whether the "services were 'reasonably necessary'" prior to November 7, 2006.[23] It also affirmed the conclusion that the benefits were intended to compensate for Mrs. Douglas' supervision, not just her presence in the home; the forms related to the services were found to be vague, so the court of appeals remanded for further proceedings regarding the amount of incurred expenses and to determine if Mrs. Douglas expected compensation.[24]

The Michigan Supreme Court began by providing the legal background of the No-Fault Act.[25] The Act permits unlimited lifetime benefits for "allowable expenses," but limits "ordinary and necessary services," e.g., replacement services, to $20 per day for the three-year period immediately following the injury.[26] The court needed to decide whether there was a "distinction between 'allowable expenses' and 'replacement services.'"[27] "Allowable expenses" are "all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."[28] To recover such expenses, a claimant must demonstrate

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20. *Douglas*, 492 Mich. at 252.
21. *Id.* at 253.
22. *Id.* at 253-54.
23. *Id.* at 254-55.
24. *Id.*
25. *Id.* at 257.
26. *Douglas*, 492 Mich. at 257 (quoting MICH. COMP. LAWS ANN. § 500.3107(1) (West 2013)).
27. *Id.* at 258.
28. MICH. COMP. LAWS ANN. § 500.3107(1)(a).

the following: "(1) the expense must be for an injured person's care, recovery, or rehabilitation, (2) the expense must be reasonably necessary, (3) the expense must be incurred, and (4) the charge must be reasonable."[29] The court reaffirmed a prior decision defining "care" as including those things related to the person's injuries sustained in the accident, but which may not actually "restore a person to his preinjury" condition.[30] However, "allowable expenses" do not include amounts for "ordinary and necessary services[,]" which every person, regardless of injury, must undertake, because such services are unrelated to the "injured person's care, recovery, or rehabilitation."[31] "While replacement services for the household might be necessitated by the injury if the injured person otherwise would have performed them himself, they are not *for* his care and therefore do not fall within the definition of allowable expenses."[32] Such amounts are more properly "replacement services."[33] Also, unlike "allowable expenses," "replacement services" are capped at a three-year time period, and there is no recovery for such expenses from anyone after that period has expired.[34]

The reasonable necessity of an "allowable expense" is analyzed under an objective standard.[35] Further, a person must become liable for, or subject to, an expense for it to be "incurred."[36] There must be an expectation of compensation on the part of the caregiver for the charge to be "incurred."[37] There are various means for demonstrating that a charge has been incurred, including a contract or a paid bill, and it behooves the caregiver to promptly submit requests for payment, as the one-year back-rule may operate to preclude a tardy invoice.[38] When it comes to care by family members, the importance of providing proof necessary to demonstrate that a service or product was actually provided cannot be over-emphasized.[39]

Finally, a charge must be reasonable, and when it comes to care provided by family members, the rates that are charged for such services by commercial agencies are too attenuated to be adopted as the

29. *Douglas*, 492 Mich. at 259.
30. *Id.* at 260 (quoting Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521, 535; 697 N.W.2d 895 (2005)).
31. *Id.* at 262.
32. *Id.* at 263.
33. *Id.*
34. *Id.* at 262.
35. *Douglas*, 492 Mich. at 265.
36. *Id.* at 267.
37. *Id.*
38. *Id.* at 269-70.
39. *Id.* at 272.

reasonable charge for family-provided services.[40] The commercial rate would include costs, such as overhead, that simply do not apply to family members.[41] The rate actually received by the family member for providing such services is highly probative of a reasonable rate for the services.[42]

In another decision, the Michigan Supreme Court considered whether the entire cost of a wheelchair accessible van was reimbursable as an "allowable expense."[43] The injury at issue dated to a catastrophic 1987 accident, which required Kenneth Admire to use wheelchair-accessible transportation.[44] Three times prior, Mr. Admire and his no-fault provider agreed that the insurer would pay the full purchase price for a van as well as the cost of modifications to make the vehicle wheelchair accessible.[45] When Mr. Admire sought a van for the fourth time, the insurer informed him that "it was not obligated to pay the base" price for the van; rather, the obligation only extended to paying for any necessary medical modifications and medical mileage.[46] In a prior decision, the Michigan Supreme Court had concluded that expenses that would have been necessary before an accident, e.g., the cost of ordinary food, were not compensable under the No-Fault Act.[47] The decisions of the Michigan Court of Appeals in attempting to apply *Griffith* have been inconsistent.[48]

The Michigan Supreme Court proceeded to parse the statutory language to consider whether the expense was "for" an injured person's "care, recovery, or rehabilitation."[49] Use of "for" in MCLA section 500.3107(1)(a) implies a causal connection, such that a charge can be recovered if the product, service, or accommodation "has the object or purpose of effectuating the injured person's care, recovery, or rehabilitation," a requirement that excludes products, services, and accommodations that an uninjured person would use over the course of his everyday life.[50] "[T]he new expense must be of a wholly different

40. *Id.* at 274-76.

41. *Douglas*, 492 Mich. at 275.

42. *Id.* at 277. In other words, the amount the family-member caregiver was paid reflects a reasonable rate, as opposed to the amount a company might bill out for the family member's services.

43. Admire v. Auto-Owners Ins. Co., 494 Mich. 10; 831 N.W.2d 849 (2013).

44. *Id.* at 15.

45. *Id.*

46. *Id.* at 15-16.

47. *Id.* at 20-22 (citing Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521, 533-35; 697 N.W.2d 895 (2005)).

48. *Id.* at 23.

49. *Admire*, 494 Mich. at 26.

50. *Id.*

essential character than expenses borne by the person before the accident to show that it is *for* the injured person's care, recovery, or rehabilitation."[51] Modifications to items that would have been used without an injury are a combined expense, which are difficult to categorize and distinct from a blended expense, which cannot be easily separated into its constituent parts.[52] In this case, the base price of the van could be readily separated from the modifications required due to Mr. Admire's injury, and the base price, therefore, was not compensable.[53] "The base price of the van is an ordinary transportation expense," the essential character of which was the same as before the injury, even though the particular choice of a van, as opposed to some other vehicle, may have changed.[54] In other words, "the van is just a van; and while a van may not have been plaintiff's transportation preference, it remains an ordinary means of transportation used by the injured and uninjured alike."[55]

3. MCLA Section 500.3113(a)—Taken Unlawfully

Those who use a motor vehicle that had been "taken unlawfully" are barred from no-fault benefits, "unless the person reasonably believed that he or she was entitled to take and use the vehicle."[56] Prior decisions had permitted certain individuals, e.g., family members engaged in "joyriding" and secondary users who had obtained a vehicle from a permitted user, to be entitled to no-fault benefits.[57] In two consolidated cases, the Michigan Supreme Court took up the issues and examined both the "family joyriding exception" and the "chain of permissive use" theory, both of which permitted avoidance of the "taken unlawfully" exclusion.[58] The family joyriding exception arises when a family member takes a motor vehicle without permission but has no intent to steal the vehicle, while the chain of permissive use "theory arises when a vehicle owner authorizes the vehicle's use by another person (the

51. *Id.* at 27.
52. *Id.* at 28.
53. *Id.* at 31-32.
54. *Id.*
55. *Admire*, 494 Mich. at 33.
56. MICH. COMP. LAWS ANN. § 500.3113(a) (West 2013).
57. *E.g.*, Butterworth Hosp. v. Farm Bureau Ins. Co., 225 Mich. App. 244; 570 N.W.2d 304 (1997) (joyriding exception); Bronson Methodist Hosp. v. Forshee, 198 Mich. App. 617; 499 N.W.2d 423 (1993) (chain of permissive use exception).
58. Spectrum Health Hosps. v. Farm Bureau Mut. Ins. Co., 492 Mich. 503, 509-11; 821 N.W.2d 117 (2012).

intermediate user), who in turn authorizes a third person (the end user) to use the vehicle."[59]

In the first case, Craig Smith, Jr., while drunkenly driving his father's vehicle, was injured in a one-car accident; Mr. Smith's father had prohibited him from using his vehicle, as Mr. Smith did not have a valid driver's license.[60] Mr. Smith's father gave possession of the vehicle to Mr. Smith's girlfriend, who was instructed not to let Mr. Smith drive the vehicle, but she did so anyway.[61] The lower courts concluded that Mr. Smith was not barred from receiving no-fault benefits, as he was in the chain of permissive use.[62] In the second case, Ryan DeYoung lost his driver's license following three drunk-driving convictions.[63] Mr. DeYoung's wife owned and insured four family vehicles; Mr. DeYoung was expressly forbidden from driving those vehicles and listed as a named excluded driver on the insurance policy.[64] Mr. DeYoung, while intoxicated, took one of his wife's vehicles, without permission, and was injured in a one-car accident.[65] The trial court determined that cases applying the joyriding exception had not considered the case where the driver was a named excluded driver on the policy, and, therefore, the joyriding exception did not apply; the court of appeals reversed, holding that it was constrained by precedent to apply the exception and permit benefits for Mr. DeYoung.[66]

The phrase "taken unlawfully" means "a situation in which an individual gains possession of a vehicle contrary to Michigan law."[67] Michigan law prohibits "taking" a vehicle without authorization, and the "taking does not have to be larcenous."[68] The Michigan Supreme Court concluded that the "chain of permissive use" theory was not consistent with the No-Fault Act.[69] The court of appeals had considered a provision of the owner's liability statute, which does not use the phrase "taken unlawfully" and analogized interpretation of that statute to the No-Fault section at issue.[70] The owner's liability statute considers both an owner's consent and knowledge, which is a much broader focus than the "taken

59. *Id.* at 509-10.
60. *Id.* at 511-12.
61. *Id.* at 512.
62. *Id.*
63. *Id.* at 513.
64. *Spectrum*, 492 Mich. at 513.
65. *Id.*
66. *Id.* at 514.
67. *Id.* at 517.
68. *Id.* at 517-18.
69. *Id.* at 521.
70. *Spectrum*, 492 Mich. at 521-22.

unlawfully" language of MCLA section 500.3113(a), which focuses on whether the taking was lawful and looks not to the owner's perspective, but the driver's.[71] Therefore, Mr. Smith took his father's vehicle without authority and, in fact, in direct violation of his father's explicit prohibition on Mr. Smith's use of the vehicle. Thus, Mr. Smith took the vehicle unlawfully[72] and was not entitled to no-fault benefits.

The family joyriding exception was founded on an earlier plurality opinion of the Michigan Supreme Court that considered the Uniform Motor Vehicle Accident Reparations Act more than the text of MCLA section 500.3113(a).[73] The Michigan Supreme Court disapproves of using "model acts to interpret existing statutes rather than" the text of the statute as enacted.[74] Looking to the text of the statute, the family joyriding exception is unsupported.[75] *Stare decisis* need not be considered in this case, as the precedential case was a plurality opinion, not a majority opinion of the Michigan Supreme Court.[76]

4. MCLA Section 500.3135—Tort Recovery of Replacement Services

In July 2004, while a pedestrian, the plaintiff was struck by a motor vehicle driven by the defendant; the plaintiff filed an action against the tortfeasor, seeking to recover for replacement services incurred after the three-year period permitted by MCLA Section 500.3107.[77] The trial court concluded that the amounts could not be recovered pursuant to MCLA section 500.3135(3)(c); the Michigan Court of Appeals reversed.[78]

Replacement services are statutorily defined:

> Expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.[79]

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71. *Id.*
72. *Id.* at 524.
73. *Id.* at 529. *See* Priesman v. Meridian Mut. Ins. Co., 441 Mich. 60; 490 N.W.2d 314 (1992), *overruled by Spectrum*, 492 Mich. 503.
74. *Spectrum*, 492 Mich. at 530.
75. *Id.* at 533-34.
76. *Id.* at 535.
77. Johnson v. Recca, 492 Mich. 169, 172; 821 N.W.2d 520 (2012).
78. *Id.*
79. MICH. COMP. LAWS ANN. § 500.3107(1)(c) (West 2013).

The No-Fault Act generally abolished tort liability related to injuries involving motor vehicles, but exceptions exist, including "'[d]amages for allowable expenses, work loss, and survivor's loss as defined in [MCLA section 500.3107 to MCLA section 500.3110] in excess of the daily, monthly, and 3–year limitations contained in those sections.'"[80] Thus, the statute limits the categories of damages that can be recovered. "Replacement services" are distinct from "allowable expenses," as evidenced by their descriptions in different sections of MCLA section 500.3107(1).[81] The Michigan Court of Appeals read too much into the decision in *Griffith* to conclude that replacement services were part of the "care" permitted as an allowable expense pursuant to MCLA section 500.3107(1)(a).[82] That which is a "replacement service" cannot also be a form of "care" so as to be an allowable expense.[83] "Replacement services" are those things that an uninjured person would perform for himself; they are not necessitated by the injury, only the need for someone else to temporarily perform them is so necessitated.[84]

In 1992, the legislature rewrote MCLA section 500.3107, placing "replacement services" into its own section instead of in the section regarding "work loss."[85] This move suggests that the legislature never considered "replacement services" to be an "allowable expense."[86] The reasons for the legislative decision not to include "replacement services" in MCLA section 500.3135(3)(c) are not easy to understand and may, in fact, be the result of an oversight; but even if that is the case, it is for the legislature, not the courts, to address the issue.[87] The opinion also responded to the dissent at length, claiming that the dissenters had not truly considered the statutory language.[88] In short, since "replacement services" are not included in the categories listed in MCLA section 500.3135(3)(c), they are not part of the exception to the abolition of tort liability.[89]

The dissent, authored by former Justice Diane Hathaway, criticized the majority for ignoring the "obvious intent" of the legislature and

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80. *Johnson*, 492 Mich. at 175 (quoting MICH. COMP. LAWS ANN. § 500.3135(3)(c)).

81. *Id.* at 176.

82. *Id.* at 178-79 (citing Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521; 697 N.W.2d 895 (2005)).

83. *Id.* at 180-81.

84. *See id.* at 179-80.

85. *Id.* at 185-86.

86. *Johnson*, 492 Mich. at 186.

87. *Id.* at 187-88.

88. *Id.* at 188-97.

89. *Id.* at 197.

creating "conflicting and illogical" rules regarding no-fault benefits.[90] The dissent looked to the structure of the No-Fault Act as a whole to conclude that the legislature intended to include "replacement services" in tort actions.[91]

B. Material Misrepresentations in the Application for Insurance

The courts of this state "will not hold an insurance company liable for a risk it did not assume."[92] Therefore, when an insurance applicant makes a material misrepresentation on the application, the insurer may rescind the policy and declare it void *ab initio*, subject to certain caveats:

> Once an innocent third party is injured in an accident in which coverage was in effect with respect to the relevant vehicle, the insurer is estopped from asserting fraud to rescind the insurance contract. MCL 257.520(f)(1); MSA 9.2220(f)(1); *Auto-Owners Ins. Co. v. Johnson*, 209 Mich. App. 61, 64, 530 N.W.2d 485 (1995). However, an insurer is not precluded from rescinding the policy to void any "optional" insurance coverage, M.C.L. § 257.520(g); MSA 9.2220(g), unless the fraud or misrepresentation could have been "ascertained easily" by the insurer. *Farmers Ins. Exchange v. Anderson*, 206 Mich. App. 214, 219, 520 N.W.2d 686 (1994).[93]

The Michigan Supreme Court addressed these caveats in *Titan Insurance Co. v. Hyten*.[94]

In 2007, while McKinley Hyten's driver's license was suspended, her mother inherited a vehicle that she "earmarked" for Hyten, in anticipation of the restoration of her license.[95] Hyten's mother sought insurance for the vehicle and told the insurance agent about the license suspension; the application was post-dated to a time when Hyten's license was expected to be restored.[96] In response to a question that asked

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90. *Id.* at 198 (Hathaway, J., dissenting).

91. *Id.* at 198-201 (Hathaway, J., dissenting).

92. Frankenmuth Mut. Ins. Co. v Masters, 460 Mich. 105, 111; 595 N.W.2d 832 (1999) (citing Arco Indus. Corp. v. Am. Motorist Ins. Co., 448 Mich. 395; 531 N.W.2d 168 (1995), and Auto-Owners Ins. Co. v. Churchman, 440 Mich. 560, 567; 489 N.W.2d 431 (1992)).

93. Lake States Ins. Co. v. Wilson, 231 Mich. App. 327, 331-32; 586 N.W.2d 113 (1998).

94. 491 Mich. 547; 817 N.W.2d 562 (2012).

95. *Id.* at 551.

96. *Id.* at 551-52.

if anyone in the household had a suspended license, "no" was checked.[97] Hyten's license was eventually restored, but not until nearly a month after the policy became effective.[98] Subsequent to the restoration, Hyten was driving the insured vehicle and was involved in a motor vehicle accident, causing injury; the insurer instituted a declaratory action seeking to limit any of its liability to the limits required by the Financial Responsibility Act.[99] The lower courts determined that the insurer could not reform the policy because when an innocent third party has already sustained injury, reformation is not possible if the alleged fraud was easily ascertainable.[100]

The Michigan Supreme Court noted that insurance policies, in the absence of a statute, are interpreted as any other contract, with the terms of the contract governing the relationship; when a statute applies, such as No-Fault, then the statute governs issues related to that coverage.[101] Michigan common law has recognized a group of doctrines that can be generally designated "fraud," which permit a party to legal or equitable relief in the event fraud is used to procure a contract.[102] However, none of these doctrines (actionable fraud, innocent misrepresentation, or silent fraud) requires the party allegedly defrauded to prove that the fraud could not have been discovered through reasonable diligence.[103]

Pursuant to MCLA section 257.520(f),

> Every motor vehicle liability policy shall be subject to the following provisions which need not be contained therein:
>
> > (1) The liability of the insurance carrier with respect to the insurance required by this chapter shall become absolute whenever injury or damage covered by said motor vehicle liability policy occurs; said policy may not be cancelled or annulled as to such liability by any agreement between the insurance carrier and the insured

97. *Id.*

98. *Id.* at 552.

99. *Id.* Note, the insurer did *not* seek to completely rescind the policy, and no-fault benefits were not at issue, as the insurer "sought a declaration that it was not obligated to indemnify Hyten for any amounts above the minimum liability coverage limits required by the financial responsibility act ($20,000 per person/$40,000 per occurrence), MCL 257.501 et seq., for which [the insurer] acknowledged responsibility." *Hyten*, 491 Mich. at 552 n.2.

100. *Id.* at 553.

101. *Id.* at 554.

102. *Id.* at 555-57.

103. *Id.* at 557.

> after the occurrence of the injury or damage; no statement made by the insured or on his behalf and no violation of said policy shall defeat or void said policy, and except as hereinafter provided, no fraud, misrepresentation, assumption of liability or other act of the insured in obtaining or retaining such policy, or in adjusting a claim under such policy, and no failure of the insured to give any notice, forward any paper or otherwise cooperate with the insurance carrier, shall constitute a defense as against such judgment creditor.[104]

The Michigan Supreme Court determined that this statute "does not *in every case* limit the ability of an automobile insurer to avoid liability on the ground of fraud."[105] The statute applies only to policies certified pursuant to MCLA section 257.518 or MCLA section 257.519.[106]

In 1959, *Keys v. Pace* answered the precise question at issue—whether an insurer can avail itself of traditional legal and equitable remedies when there was fraud in the application for insurance that was easily ascertainable and the claimant is a third party.[107] *Keys* held "that an insurer may avail itself of traditional legal and equitable remedies to avoid liability under an insurance policy on the ground of fraud, notwithstanding that the fraud may have been easily ascertainable, and notwithstanding that the claimant is a third party."[108] The Michigan Court of Appeals ignored this rule in deciding *State Farm Mutual Automobile Insurance Co. v. Kurylowicz*, concluding that an insurer cannot rescind a policy on the ground of fraud when there has been an injured third party and the fraud was easily ascertainable.[109] *Kurylowicz* was wrongly decided in that it ignored *Keys* and departed from the common law based on its understanding of "public policy."[110] In so doing, the court in *Kurylowicz* looked to the No-Fault Act, but it ignored the explicit policies embodied by that Act and, instead, substituted a judicial construction of an overall goal of that Act as "public policy."[111] While it is true that MCLA section 500.3220(a) limits the ability to cancel a policy, it does not preclude an insurer who later uncovers fraud

104. MICH. COMP. LAWS ANN. § 257.520(f) (West 2013).
105. *Hyten*, 491 Mich. at 559.
106. *Id.* at 560.
107. *Id.* (citing Keys v. Pace, 358 Mich. 74; 99 N.W.2d 547 (1959)).
108. *Id.* at 562.
109. *Id.* at 562-63 (citing State Farm Mut. Auto. Ins. Co. v. Kurylowicz, 67 Mich. App. 568; 242 N.W.2d 530 (1976)).
110. *Id.* at 564.
111. *Hyten*, 491 Mich. at 565.

from looking to traditional legal and equitable remedies for that fraud.[112] *Hyten* overruled *Kurylowicz* and its progeny and reaffirmed the rule stated in *Keys*.[113] There is no basis to treat an insurer differently from anyone else in applying the fraud doctrines to contractual endeavors.[114] The Michigan Supreme Court did caution that if the insurer were to prevail in asserting fraud and may avail itself of a legal or equitable remedy in avoiding liability, "the remedies available to [the insurer] may be limited by statute."[115] The dissent, authored by former Justice Hathaway, would have affirmed the lower court decisions and retained the easily ascertainable rule based on "36 years of thoughtfully analyzed and legally sound case law interpreting the no-fault act."[116]

III. DECISIONS OF THE MICHIGAN COURT OF APPEALS

The vast majority of cases decided by the Michigan Court of Appeals are unpublished decisions; cases involving insurance law are no exception. Unpublished decisions are not binding on the Michigan Court of Appeals or circuit courts under the principles of *stare decisis*, and, therefore, such decisions are beyond the scope of this *Survey*.[117]

A. The No Fault Act, MCLA Sections 500.3101-.3179

1. MCLA Section 500.3107—Allowable Expenses, Work Loss, and Replacement Services

Arnold Grinblatt sustained injury in an automobile accident; at the time of that accident, he was unable to walk, needed the use of a personal mobility scooter, and was able to drive a van fitted with a lift and hand controls.[118] After the accident, Mr. Grinblatt could no longer transition from the driver seat of the van to his scooter or vice versa and, therefore, hired a transportation company to provide services both for medical appointments and personal trips. The trips had minimum charges of ten

112. *Id.* at 566-67. Further, the statute addresses only "cancellation" of a policy, not "rescission" of a policy. *Id.* at 566-68. The two terms have distinct meanings in the law, with the former applying to void coverage from the date of cancellation onward, and the latter applying to void coverage from the start of the policy. *See id.*

113. *Id.* at 570.

114. *Id.* at 571.

115. *Hyten*, 491 Mich. at 572.

116. *Id.* at 573-74 (Hathaway, J., dissenting).

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

118. ZCD Transp., Inc. v. State Farm Mut. Auto. Ins. Co., 299 Mich. App. 336, 338-39; 830 N.W.2d 428 (2012).

miles each way or twenty miles round trip, distances that exceeded the actual travel distance.[119] The insurer moved for, and the court granted, summary disposition as to any costs for personal trips and for medical trips to the extent that Mr. Grinblatt was not actually in the vehicle being transported.[120]

A no-fault insurer must provide benefits for injury "arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle," including allowable expenses and up to $20 per day in replacement services.[121] As to the allowable expenses, there must be a causal connection to the accidental bodily injury arising out of an automobile accident.[122] The expense must bear relation to the injured person's care, recovery, or rehabilitation.[123] Allowable expenses are distinct from replacement services.[124] Transportation services unrelated to medical treatment are not recoverable, as they would be replacement services, not allowable expenses.[125] Transportation to medical appointments is an allowable expense.[126] A transportation service will have pick-up and wait times, and such times are for services rendered and fees that were incurred. However, in this case, neither party addressed whether the fees for such times were reasonable, requiring remand.[127] As to the minimum mileage charges, those services were not actually rendered, and there is no coverage for charges above the mileage actually traveled.[128]

Another case considered the calculation of work loss benefits.[129] Barry Brown, a lawyer, slipped on the ice while exiting his vehicle, sustaining injury.[130] Mr. Brown was an employee of an S corporation specializing in arbitrations, which Mr. Brown wholly owned.[131] The insurer paid work loss benefits based on Mr. Brown's earnings as an employee of the corporation, but not the profit that the corporation would have generated during the period of disability, which Mr. Brown

119. *Id.* at 339.
120. *Id.*
121. *Id.* at 340 (quoting MICH. COMP. LAWS ANN. §§ 500.3105(1), .3107(1)).
122. *Id.* (citing Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521, 531; 697 N.W.2d 895 (2005)).
123. *Id.* at 341 (citing Douglas v. Allstate Ins. Co., 492 Mich. 241, 259; 821 N.W.2d 472 (2012)).
124. *ZCD Transp.*, 299 Mich. App. at 341.
125. *Id.* at 342-43.
126. *Id.* at 343.
127. *Id.* at 343-44.
128. *Id.* at 344.
129. Brown v. Home-Owners Ins. Co., 298 Mich. App. 678; 828 N.W.2d 400 (2012).
130. *Id.* at 681.
131. *Id.*

contended was pass-through income.[132] The parties filed competing motions for summary disposition, and the trial court found in favor of Mr. Brown, concluding that the lost profit was owed as part of the work loss benefits.[133] The trial court also awarded twelve percent penalty interest pursuant to MCLA section 500.3142 and attorney fees pursuant to MCLA section 500.3148.[134]

The No-Fault Act provides benefits for up to three years for "the loss of income from work" an injured person would have performed had he or she not been injured.[135] No case law directly addresses S corporations. However, a prior Michigan Supreme Court case determined that when the injured party is the sole employee and shareholder of an S corporation that is operating at a loss, the measure of work loss benefits is the injured person's W-2 wages.[136] That prior case held that "'the business expenses of the corporation [were] irrelevant in calculating [the] plaintiff's wage loss.'"[137] The court of appeals found *Ross v. Auto Club Group* distinguishable, as in that case, the corporation had no flow-through profit but was still paying wages to the injured party, and there was no indication that *Ross* extended beyond its specific factual situation.[138] *Ross* did not say that loss of income is limited to W-2 wages when the S corporation is profitable.[139] Here, Mr. Brown presented evidence that justified setting aside the separate corporate existence because his business was operating at a profit and paying flow-through income to him.[140] Thus, permitting Mr. Brown those profits would place him in the same position as, and not in a better position than, the position he would have been in prior to the accident.[141]

Edward Carroll suffered permanent disability as a result of a closed-head injury in an automobile accident, and a probate court named a conservator to manage Mr. Carroll's finances.[142] The probate court determined that only $99 of the $6,816.70 that the conservator sought related to the care, recovery, or rehabilitation of Mr. Carroll.[143] On

132. *Id.* at 681-82.
133. *Id.* at 683-84.
134. *Id.* at 684.
135. *Brown*, 298 Mich. App. at 685 (citing MICH. COMP. LAWS ANN. § 500.3107(1)(b) (West 2013)).
136. *Id.* at 687 (citing Ross v. Auto Club Grp., 481 Mich. 1; 748 N.W.2d 552 (2008)).
137. *Id.* (quoting *Ross*, 481 Mich. at 8).
138. *Id.* at 688.
139. *Id.* at 689.
140. *Id.*
141. *Brown*, 298 Mich. App. at 688.
142. *In re* Carroll, 300 Mich. App. 152, 156-57; 832 N.W.2d 276 (2013).
143. *Id.* at 157 (citing *In re* Carroll, 299 Mich. App. 395, 398-99; 807 N.W.2d 70 (2011), *vacated*, 493 Mich. 899; 822 N.W.2d 790 (2012)).

appeal, the court of appeals determined that if the conservator was a necessity due to the motor vehicle accident, all his services were compensable as "allowable expenses."[144] The Michigan Supreme Court remanded for consideration in light of *Johnson v. Recca*[145] and *Douglas v. Allstate Insurance Co.*,[146] which discussed "allowable expenses" and "replacement services."[147]

On remand, the court of appeals determined that "allowable expenses" were those "reasonably necessary for the 'injured person's care, recovery, or rehabilitation.'"[148] "Replacement services" include "all manner of ordinary or mundane household services that the injured person might have performed[, but for the accident]."[149] An "allowable expense" requires "a causal connection; that is, the insurer's liability to pay benefits under the No-Fault Act is only triggered 'to the extent that the claimed benefits are causally connected to the accidental bodily injury arising out of an automobile accident.'"[150] *Griffith* determined that ordinary food expenses were not "allowable expenses" because they were not required by the accident, as the claimant did not establish that his food requirements changed as a result of the accident.[151] "Allowable expenses" are distinct from "replacement services."[152] Even if after the accident a third-party must provide a service, if the service is one that was necessary before and after the accident, then it is a "replacement service," not an "allowable expense."[153]

There was no dispute that the motor vehicle accident necessitated the conservator's appointment, but the question was whether the services provided were for the person's care, recovery, or rehabilitation, or for ordinary services that Mr. Carroll would have performed himself.[154] To the extent that the services were to manage the day-to-day events of Mr. Carroll's household, the services were "replacement services."[155] To the extent that the services were extraordinary, beyond those which

144. *Id.*

145. 492 Mich. 169; 821 N.W.2d 520 (2012).

146. 492 Mich. 241; 821 N.W.2d 472 (2012).

147. *In re* Carroll, 493 Mich. 899. *See In re* Carroll, 300 Mich. App. at 159.

148. *In re* Carroll, 300 Mich. App. at 160 (quoting MICH. COMP. LAWS ANN. § 500.3107(1)(a) (West 2013)).

149. *Id.* at 161 (citing Fortier v. Aetna Cas. & Sur. Co., 131 Mich. App. 784, 793; 346 N.W.2d 874 (1984)).

150. *Id.* at 162 (quoting Griffith v. State Farm Mut. Auto. Ins. Co., 472 Mich. 521, 531; 697 N.W.2d 895 (2005)).

151. *Id.* at 163-64.

152. *Id.* at 165-66 (citing Johnson v. Recca, 492 Mich. 169; 821 N.W.2d 520 (2012)).

153. *Id.* at 167.

154. *In re* Carroll, 300 Mich. App. at 172.

155. *Id.* at 172-73.

ordinarily would be performed by an uninjured person, the services are "allowable expenses."[156] As no one challenged the probate court's determination as to the separation of services, the court of appeals affirmed that decision.[157]

2. MCLA Section 500.3112—Discharge from Liability

In exchange for a payment of $35,000, an insured resolved ongoing litigation with her no-fault provider and executed a release as part of that settlement.[158] Six months after the release, the insured began treatment with a medical provider as a result of the injuries from the automobile accident; the medical provider sought payment from the No-Fault insurer.[159] The trial court determined that the provider had an independent cause of action against the no-fault provider and entered judgment in its favor.[160]

MCLA section 500.3112 provides,

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.[161]

The court of appeals found it "well established" that an insured may waive payment and release an insurer from payment of further benefits.[162] The law of contracts applies to a release, and the parties' intent, as discerned from the plain meaning of unambiguous contract language, controls.[163] In this case, the language of the release unquestionably released liability for further payments and, therefore, barred the medical provider's claim.[164] However, the provider is not

156. *Id.* at 174.
157. *Id.*
158. Mich. Head & Spine Inst., P.C. v. State Farm Mut. Auto. Ins. Co., 299 Mich. App. 442, 444-45; 830 N.W.2d 781 (2013).
159. *Id.* at 445-46.
160. *Id.* at 446.
161. MICH. COMP. LAWS ANN. § 500.3112 (West 2013).
162. *Mich. Head & Spine Inst.*, 299 Mich. App. at 447 (citing Lewis v. Aetna Cas. & Sur. Co., 109 Mich. App. 136, 140; 311 N.W.2d 317 (1981)).
163. *Id.* at 448.
164. *Id.* at 448-49.

without remedy, as the insured executed an intake form agreeing to pay for services that may not be covered by insurance.[165]

3. MCLA Section 500.3113(a)—Exclusion of Person Using a Motor Vehicle "Taken Unlawfully"

Scott Hertzog owned a motorcycle that Andre Smith stole on August 9, 2009.[166] Andre Smith informed Lejuan Rambin that he had an extra motorcycle that Mr. Rambin could use for an event; Mr. Smith told Mr. Rambin that he owned the motorcycle, but the motorcycle was actually Mr. Hertzog's stolen motorcycle.[167] While on his way to return the motorcycle to Mr. Smith, Mr. Rambin sustained injury when the motorcycle struck a car.[168] The trial court determined that MCLA section 500.3113(a) barred Mr. Rambin's recovery.[169] Application of MCLA section 500.3113(a) requires a two-part analysis: (1) inquiry into whether the taking of the vehicle was unlawful and (2) whether the person reasonably believed that he was entitled to take and use the vehicle.[170] The court of appeals determined that "the law in this area has been hopelessly muddled," but that the court was attempting to apply the relevant case law, including the recent Michigan Supreme Court decision in *Spectrum Health Hospitals v. Farm Bureau Mutual Insurance Co. of Michigan*.[171] For a vehicle to have been "taken unlawfully," the vehicle must have been "taken," the taking must have been "unlawful," the injured claimant must have taken the vehicle, and the injured person must have both "taken" the vehicle and been "unlawful" in doing so.[172] The legislature has not defined "taken unlawfully," but prior case law makes clear that when the taking violates the Michigan Penal Code, it is "unlawful."[173] The court of appeals determined that the term "taken unlawfully" requires the "end user" to have taken action contrary to the Michigan Penal Code.[174]

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165. *Id.* at 449-50.
166. Rambin v. Allstate Ins. Co., 297 Mich. App. 679, 681; 825 N.W.2d 95 (2012).
167. *Id.*
168. *Id.*
169. *Id.* at 682.
170. *Id.* at 683.
171. *Id.* at 683-84 (citing Spectrum Health Hosps. v. Farm Bureau Mut. Ins. Co., 492 Mich. 503; 821 N.W.2d 117 (2012)). *See also supra* Part II.A.3.
172. *Rambin*, 297 Mich. App. at 685.
173. *Id.* at 685-86 (citing *Spectrum Health Hosps.*, 492 Mich. at 509).
174. *Id.* at 686.

Mr. Rambin, the "end user," did not take the motorcycle unlawfully.[175] Mr. Rambin had reason to believe that he obtained the motorcycle from its rightful owner.[176] The determination must focus on the conduct of the injured person, some unlawfulness about that conduct, and some element of intent on the part of the person.[177] As Mr. Rambin was not the person who had taken the vehicle unlawfully, there was no genuine issue of material fact that the first prong of the analysis of MCLA section 500.3113(a) was not satisfied.[178] The court of appeals, therefore, did not reach the second prong of the test, but it did go on, at some length, as to how the law in this area was uncertain and would benefit from further clarity regarding the second prong.[179]

4. MCLA Section 500.3113(b)—Exclusion of Owner or Registrant Who Fails to Maintain the Mandatory No-Fault Coverage

Progressive issued a policy of no-fault insurance to Nicholas Owsiany, insuring a vehicle owned by Mr. Owsiany's fiancée, who the policy listed as an excluded driver.[180] The fiancée was injured in an accident while driving the vehicle.[181] By statute, the owner or registrant of a motor vehicle is required to maintain the security required by the No-Fault Act.[182] The medical provider treating the fiancée brought suit against Progressive, which, in turn, impleaded Mr. Owsiany, his fiancée, and the Michigan Assigned Claims Facility (MACF).[183] The medical provider filed a new action against the MACF, contending that it was liable or, in the alternative, that it should assign a no-fault provider in the event that Progressive's excluded driver provision was upheld.[184] The trial court found in favor of Progressive and the MACF.[185]

The court of appeals determined that under the policy language and MCLA section 500.3009(2), all coverage was void at the time of the accident because the excluded driver was operating the vehicle.[186] The fiancée was not entitled to no-fault benefits because the coverage was

175. *Id.* at 687.
176. *Id.* at 699.
177. *Id.* at 701.
178. *Rambin*, 297 Mich. App. at 702.
179. *Id.* at 703-05.
180. Bronson Methodist Hosp. v. Mich. Assigned Claims Facility, 298 Mich. App. 192, 194; 826 N.W.2d 197 (2012).
181. *Id.*
182. *Id.* at 195 (citing MICH. COMP. LAWS ANN. § 500.3101(1)).
183. *Id.* at 195-96.
184. *Id.*
185. *Id.* at 196.
186. *Bronson Methodist Hosp.*, 298 Mich. App. at 198.

void; at the time of the accident, she was the owner of the vehicle involved in the accident and the required no-fault security was not in effect due to her operation of the vehicle as an excluded driver.[187] The court of appeals, therefore, affirmed the trial court.[188]

5. MCLA Section 500.3135—Abolition of Tort Liability

Though not in the context of insurance coverage, the Michigan Court of Appeals did address the No-Fault Act's abolition of tort liability.[189] The injured party claimed that the injury was intentionally caused in a fit of road rage, thus entitling her to non-economic damages pursuant to MCLA section 500.3135(3)(a); however, she also admitted that her own vehicle was not insured at the time of the incident.[190] The defendant argued that because the injured party failed to maintain the required no-fault insurance, she was precluded from recovering non-economic damages by MCLA section 500.3135(2)(c), which provides, "Damages shall not be assessed in favor of a party who was operating his or her own vehicle at the time the injury occurred *and did not have in effect for that motor vehicle the security required* by section 3101 at the time the injury occurred."[191] The trial court determined that the failure to maintain the insurance required by the No-Fault Act precluded recovery of non-economic damages.[192]

The court of appeals determined that the language of MCLA section 500.3135(2)(c) is limited to the threshold exception to tort liability under MCLA section 500.3135(1) and not to claims of intentional injury under MCLA section 500.3135(3).[193] By its terms, MCLA section 500.3135(2) addresses only "cause[s] of action for damages pursuant to subsection (1)."[194] Also, subsection three specifically states that it applies "[n]otwithstanding any other provision of law."[195] Therefore, the trial court erred in concluding that economic damages alleged to be intentionally caused were barred.[196]

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187. *Id.*
188. *Id.* at 199.
189. Gray v. Chrostowski, 298 Mich. App. 769; 828 N.W.2d 435 (2012).
190. *Id.* at 771-73.
191. *Id.* at 773 (quoting MICH. COMP. LAWS ANN. § 500.3135(2)(c) (West 2013)).
192. *Id.* at 774.
193. *Id.* at 776-77 (citing Robertson v. DaimlerChrysler Corp., 465 Mich. 732, 748; 641 N.W.2d 567 (2002)).
194. *Id.* at 777 (emphasis omitted) (quoting MICH. COMP. LAWS ANN. § 500.3135(2)).
195. *Gray*, 298 Mich. App. at 778 (alteration in original) (emphasis omitted) (quoting MICH. COMP. LAWS ANN. § 500.3135(3)).
196. *Id.* at 779.

In another case, the court of appeals also determined that amounts recoverable pursuant to MCLA section 500.3135(3)(c), amounts in excess of the daily, monthly, and three-year limitations, permit recovery of economic damages in excess of those time limitations from even a government entity.[197] The court again cited the "[n]otwithstanding any other provision of law" language.[198]

6. MCLA Section 500.3148—Attorney Fees

The Michigan Court of Appeals considered the propriety of no-fault attorney fees following a five-day jury trial that ended in a finding of no cause of action, in favor of the no-fault insurer.[199] The dispute centered around amounts for attendant care provided to an injured party by his mother, stepfather, and other family members that State Farm alleged were based on misrepresentations in the paperwork.[200] State Farm sought attorney fees pursuant to MCLA section 500.3148(2), which permits an insurer to recover attorney fees "for the insurer's attorney in defense against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation."[201] The trial court denied the request for attorney fees, finding that there was no dispute that a compensable injury requiring attendant care services took place, and the only questions involved whether the caregivers actually performed the services and the hourly rate.[202]

State Farm's request for attorney fees was based on the family member providers seeking benefits for hours when the injured party was not actually with them, failing to adequately supervise the injured party, and submitting documentation contrary to the facts.[203] An award of fees under MCLA section 500.3148(2) is discretionary.[204] The court of appeals vacated the trial court's denial of attorney fees to State Farm and remanded for further proceedings, as the decision below "was based on a problematic and faulty legal premise."[205] Simply because a compensable

197. Hannay v. Dep't of Transp., 299 Mich. App. 261, 267; 829 N.W.2d 883 (2013).

198. *Id.*

199. Gentris v. State Farm Mut. Auto. Ins. Co., 297 Mich. App. 354, 356; 824 N.W.2d 609 (2012). Although the court initially decided this case outside the *Survey* period, it was later approved for publication.

200. *Id.*

201. *Id.* at 357-58 (quoting MICH. COMP. LAWS ANN. § 500.3148(2) (West 2013)).

202. *Id.* at 358. A further dispute involved taxable costs pursuant to MCR 2.625(A), which lies outside the scope of this *Survey*. *See id.* at 364-68.

203. *Id.* at 359-60.

204. *Gentris*, 297 Mich. App. at 361.

205. *Id.* at 363.

injury has taken place and certain services were required does not mean that MCLA section 500.3148(2) is inapplicable.[206] Issues of fraud, excessiveness, and unreasonableness can permeate the issue of whether the services were performed, regardless of the fact that a compensable injury necessitating attendant care has occurred.[207]

The court of appeals considered MCLA section 500.3148(1) in *Brown v. Home-Owners Insurance Co.*[208] To award attorney fees under that provision, there must be a finding that the benefits were overdue and that that insurer unreasonably refused to pay, or delayed in paying, the claim.[209] Proof of the benefits being overdue creates a rebuttable presumption that the delay or refusal was unreasonable.[210] In *Brown*, the trial court made no findings as to whether the delay was unreasonable, but it implicitly found that a legitimate dispute regarding the statutory requirements did not exist.[211] As the terms "lack of income" and "income," in particular, are not defined by the Act and in light of previous case law, which determined that business expenses of an S corporation were not included, there did exist a legitimate question of statutory interpretation such that attorney fees were not properly awardable.[212]

7. MCLA Section 500.3163—Residency of a Claimant

"[Salvador] Lorenzo, an itinerant agricultural worker, did not have a 'permanent' residence in any state, but lived, worked, and resided in three different states where he picked fruit on a seasonal basis."[213] Mr. Lorenzo was a passenger in a motor vehicle that was involved in an accident in Michigan, causing injury to Mr. Lorenzo.[214] Mr. Lorenzo worked in Florida from October 2008 to May 2009 and in North Carolina from May 2009 to early July 2009. In July 2009, he came to Michigan,

206. *Id.* ("The court was of the opinion that simply because there was no dispute that John had injuries and was in need of attendant-care services, there could be no finding that plaintiff's claim for benefits was in some respect fraudulent or so excessive as to have no reasonable foundation.").

207. *Id.*

208. Brown v. Home-Owners Ins. Co., 298 Mich. App. 678, 690; 828 N.W.2d 400 (2012). See *supra* Part III.A.1 for discussion of the factual background of the case.

209. *Id.* (quoting Moore v. Secura Ins., 482 Mich. 507, 517; 759 N.W.2d 833 (2008)).

210. *Id.* at 690-91 (citing Attard v. Citizens Ins. Co. of Am., 237 Mich. App. 311, 317; 602 N.W.2d 633 (1999)).

211. *Id.* at 691.

212. *Id.* at 691-92.

213. Tienda v. Integon Nat'l Ins. Co., 300 Mich. App. 605, 607; 834 N.W.2d 908 (2013).

214. *Id.* at 608.

where he rented an apartment.[215] Prior to the accident, Mr. Lorenzo obtained an automobile insurance policy issued in North Carolina using a Michigan driver's license, but he listed a North Carolina address on his application for insurance.[216] The insurer, Integon, eventually denied coverage for the reason that Mr. Lorenzo was a Michigan resident at the time of the accident and, pursuant to MCLA section 500.3163, it was only obligated to provide no-fault coverage if Mr. Lorenzo resided in a different state.[217] Mr. Lorenzo also submitted his claim to the MACF, which assigned the claim to Titan; Titan was impleaded into the action, and cross-claims ensued.[218] The trial court found that Integon was liable for benefits and that residency was irrelevant, but if it was at issue, Mr. Lorenzo was not a Michigan resident, but a resident of Florida.[219]

The court of appeals began by noting that residency was relevant for purposes of determining Integon's liability.[220] Though Integon issued Mr. Lorenzo's policy in North Carolina, Integon did issue policies in Michigan, and it filed a certificate pursuant to MCLA section 500.3163(1), which requires an insurer to provide no-fault benefits to an out-of-state resident injured within Michigan; as the statute only applies to out-of-state residents, Mr. Lorenzo's residence was at issue.[221] No Michigan case addressed migrant workers in the context of No-Fault.[222] In this case, when he came to Michigan, Mr. Lorenzo maintained no other residence and brought all of his belongings with him.[223] Every person needs a domicile, so the court noted that it could not conclude that none existed.[224] The duration of Mr. Lorenzo's stay in each state is of little import, as he always intended to stay for a limited amount of time and leave once the particular season was over.[225] The court of appeals concluded,

> It may appear that, given the nature of Lorenzo's itinerant lifestyle, his ties to Michigan appear as strong or as tenuous as

215. *Id.* at 608-09.
216. *Id.* at 609.
217. *Id.* at 609-10.
218. *Id.* at 610.
219. *Tienda*, 300 Mich. App. at 610-11.
220. *Id.* at 612.
221. *Id.* at 613.
222. *Id.* at 618 ("There are few published cases in Michigan that address residency of migrant . . . workers like Lorenzo and, as noted, none that addresses the issue for purposes of [Mich. Comp. Laws] 500.3163.").
223. *Id.* at 619.
224. *Id.* at 621 (citing People v. Dowdy, 489 Mich. 373, 385; 802 N.W.2d 239 (2011)).
225. *Tienda*, 300 Mich. App. at 622.

> his ties to North Carolina or Florida. However, under these unique facts, and for the reasons stated, we hold that, when the accident occurred on July 29, 2009, Lorenzo was a resident of Michigan as a matter of law.[226]

Thus, because Mr. Lorenzo was a Michigan resident, it was inappropriate to look to MCLA section 500.3163 and *Titan*, as the assigned insurer was liable for benefits.[227] In short, it appears that for transient workers, residency changes as they move from location to location for purposes of the No-Fault Act.[228]

B. Denial of Claims

On February 27, 2008, Geraldine Smitham's personal property was stolen from her apartment during a robbery, and Ms. Smitham made a claim with her insurer the very next day.[229] On August 7, 2008, the insurer, State Farm, denied the claim for the reason that Ms. Smitham did not submit the "Sworn Statement in Proof of Loss" and "Personal Property Inventory" forms.[230] On June 26, 2009, the claim was reopened, and on July 21, 2009, State Farm sent copies of past letters concerning the claim to Ms. Smitham.[231] On June 4, 2010, State Farm, in a letter to Ms. Smitham's daughter, formally denied liability on the basis of misrepresentations and fraud.[232] However, despite this denial, on August 3, 2010, State Farm sent a settlement draft for $4,700, which Ms. Smitham returned, resulting in the issuance of a second check on October 12, 2010, which Ms. Smitham cashed on October 22, 2010.[233] Ms. Smitham commenced an action seeking the remaining amounts she alleged were due under the policy, and State Farm asserted that it had paid all amounts due and that the suit was barred by the one-year period of limitations contained in the policy.[234] The trial court determined that the action was untimely, as it was not commenced within one year following the loss.[235]

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226. *Id.* at 623-24.
227. *Id.* at 624.
228. *Id.*
229. Smitham v. State Farm Fire & Cas. Co., 297 Mich. App. 537, 540; 824 N.W.2d 601 (2012).
230. *Id.*
231. *Id.*
232. *Id.*
233. *Id.* at 540-41.
234. *Id.*
235. *Smitham*, 297 Mich. App. at 542.

> A fire insurance policy must contain a provision
>
> > [t]hat an action under the policy may be commenced only after compliance with the policy requirements. An action must be commenced within 1 year after the loss or within the time period specified in the policy, whichever is longer. The time for commencing an action is tolled from the time the insured notifies the insurer of the loss until the insurer formally denies liability.[236]

The policy at issue provided that

> > [i]n the event a claim is formally denied, in whole or in part, the period of time in which a suit or action may be commenced against the company is extended by the number of days between the date the notice of the loss is provided to the company and the date the claim is formally denied.[237]

State Farm took the position that, pursuant to the policy, tolling is only applicable in the event of a formal denial, which did not occur on these facts, as State Farm paid the claim.[238]

Relying on federal case law, which it found to be "highly persuasive," the court of appeals concluded that the policy language was not compatible with MCLA section 500.2833(1)(q).[239] The policy language conditions tolling on a formal denial of liability while the statute is not conditional, as it simply provides that an action is tolled from the time of notice until formal denial.[240] As the policy language was contrary to the statute, it was absolutely void pursuant to MCLA section

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236. *Id.* at 542 (alteration in original) (quoting MICH. COMP. LAWS ANN. § 500.2833(1)(q) (West 2013)).

237. *Id.* at 543 (quoting a provision from the defendant's insurance policy).

238. *Id.* at 543-44.

239. *Id.* at 549 (citing Rory v. Cont'l Ins. Co., 473 Mich. 457, 470; 703 N.W.2d 23 (2005)).

240. *Id.* MICH. COMP. LAWS ANN. § 500.2833(1)(q) provides,

> Each fire insurance policy issued or delivered in this state shall contain the following provisions: . . . That an action under the policy may be commenced only after compliance with the policy requirements. An action must be commenced within 1 year after the loss or within the time period specified in the policy, whichever is longer. The time for commencing an action is tolled from the time the insured notifies the insurer of the loss until the insurer formally denies liability.

500.2860.[241] Violation of the law is an exception to the normal rule of construction that unambiguous contractual language is to be enforced as written.[242] Further, a re-opening of a claim effectively withdraws a previous denial.[243] Thus, the court found that State Farm's utilization of its August 7, 2008 denial as the starting period for the running of the one-year period was questionable.[244] Additionally, payment of an amount less than that sought by the insured is not sufficient to establish a formal denial of a claim, as a formal denial must be clear and explicit—the insurer states it is denying all liability in excess of the amount paid.[245] Therefore, State Farm's partial payment did not act as a denial.[246]

C. Commercial Insurance

The Michigan Court of Appeals considered whether a company's controller issuing herself second checks in the same amount as her actual paycheck from the payroll account constituted "employee dishonesty."[247] The employee was convicted of embezzlement for this unauthorized check scheme.[248] The "employee dishonesty" coverage defined "employee dishonesty" as

> only dishonest acts committed by an "employee", whether identified or not, acting alone or in collusion with other persons, except you or a partner, with the manifest intent to:
>
> (1) Cause you to sustain loss; and also
>
> (2) Obtain financial benefit (other than employee benefits earned in the normal course of employment, including: salaries, commissions, fees, bonuses, promotions, awards, profit sharing or pensions) for:
>
> (a) The "employee"; or

241. *Smitham*, 297 Mich. App. at 549 (citing MICH. COMP. LAWS ANN. § 500.2860 (West 2013)).
242. *Id.* at 549-50.
243. *Id.* at 551.
244. *Id.*
245. *Id.*
246. *Id.* at 551-52.
247. Amerisure Ins. Co. v. DeBruyn Produce Co., 298 Mich. App. 137, 138-39; 825 N.W.2d 666 (2012).
248. *Id.* at 139.

> (b) Any person or organization intended by the "employee" to receive that benefit.[249]

An exclusion provided that there was no coverage if the financial benefit consisted of "'employee benefits earned in the normal course of employment.'"[250] Both parties relied upon foreign case law.[251]

The court of appeals determined that the embezzlement at issue was closer to an improper "loan" from the company than to inducing the employee to erroneously issue a check greater than the person's actual salary.[252] Federal courts have noted that courts commonly have found that "employee dishonesty" coverage applies to improper loans.[253] The court described the situation at issue as "a classic act of embezzlement, and it was very similar to forging checks."[254] Knowledge on the part of the employer that the payments were made to the dishonest employee for the exclusion to apply "is implied by a natural reading of the types of compensation encompassed by the exclusion."[255] Here, there was no intent to write multiple checks to the employee, and the employee merely "helped herself to money under her control."[256] The mere fact that the money came from the payroll account does not make it salary for purposes of the exclusion.[257]

D. Automobile Insurance

Corey Drielick was operating a semi tractor without a trailer when he was involved in an accident with an automobile.[258] Empire issued a non-trucking use or bobtail policy to the trucking company, which covered damages only when the semi was not engaged in the business of hauling a trailer, or leased to a carrier, and excluded Mr. Drielick as a driver.[259] Empire denied coverage, asserting that Great Lakes Carriers Corporation used the vehicle for its business and an excluded driver operated the

249. *Id.* at 140.
250. *Id.*
251. *Id.* at 140-42.
252. *Id.* at 142.
253. *Amerisure Ins. Co.*, 298 Mich. App. at 142 (quoting Hartford Accident & Indem. Ins. Co. v. Wash. Nat'l Ins. Co., 638 F. Supp. 78, 84 (N.D. Ill. 1986)).
254. *Id.* at 144.
255. *Id.* at 144-45.
256. *Id.* at 146.
257. *Id.* at 147.
258. Hunt v. Drielick, 298 Mich. App. 548, 551; 828 N.W.2d 441 (2012).
259. *Id.*

vehicle at the time of the accident.[260] Mr. Drielick entered into consent judgments, assigning any right to collect on an insurance claim with Empire to the injured parties.[261] Writs of garnishment were filed against Empire, which moved to quash the writs in part based on the policy exclusions; the trial court denied the motion.[262] The court of appeals previously determined that the named driver exclusion was invalid, but it remanded for further development of the business use exclusion, which the court determined to be unambiguous.[263] At the time of the accident, Mr. Drielick was driving to the Great Lakes yard because he had been dispatched to haul a load to Cheboygan.[264]

The court of appeals began with the familiar statement that insurance policies, like other contracts, must be enforced as written if unambiguous.[265] No prior Michigan case has considered the exclusion at issue, which precludes coverage for injury occurring "'while a covered auto is used to carry property in any business.'"[266] The fact that the vehicle was not carrying cargo at the time of the incident is not dispositive.[267] There is no dispute that a carrier dispatched Mr. Drielick to the yard and that Mr. Drielick drove to the yard to pick up a loaded trailer.[268] Therefore, "the accident occurred during an interval of time when the truck was employed for the purpose of carrying property in the trucking business," and, consequently, the exclusion applies.[269] If the parties intended the exclusion to apply only while cargo was being physically carried on the truck, they could have drafted the exclusion in such a manner, but they did not do so.[270]

260. *Id.* (citing Hunt v. Drielick, Nos. 246367, 246367, 246368, 2004 WL 2238628, at *3-4 (Mich. Ct. App. Oct. 5, 2004)).

261. *Id.* at 551-52.

262. *Id.* at 552.

263. *Id.* at 552-53 (citing *Hunt*, 2004 WL 2238628, at *5).

264. *Hunt*, 298 Mich. App. at 553.

265. *Id.* at 554-55 (citing Westfield Ins. Co. v. Ken's Serv., 295 Mich. App. 610, 615; 815 N.W.2d 786 (2012), and Besic v. Citizens Ins. Co., 290 Mich. App. 19, 24; 300 N.W.2d 93 (2010)).

266. *Id.* at 555.

267. *Id.* at 555-56 (citing Carriers Ins. Co. v. Griffie, 357 F. Supp. 441, 442 (W.D. Pa. 1973)).

268. *Id.* at 556.

269. *Id.* at 556-57.

270. *Hunt*, 298 Mich. App. at 557.

IV. DECISIONS OF THE FEDERAL COURTS

A. United States Supreme Court

In 2010, the United States Congress passed the Patient Protection and Affordable Care Act (ACA), colloquially known as "Obamacare."[271] Pursuant to the ACA, it was required that individuals maintain certain minimum health care coverage, the so-called "individual mandate," which penalizes those who do not maintain the minimum coverage.[272] The United States Supreme Court took up the constitutionality of the ACA in *National Federation of Individual Business v. Sebelius*.[273] Though the ACA will have a large impact on the insurance industry and those purchasing health care insurance, the case itself is addressed to the power of Congress to enact legislation such as the ACA.[274] Such matters are better covered in a survey of constitutional law as opposed to insurance law. However, the primary conclusions of the decision are worth mention. The "individual mandate" was found to exceed the power of Congress to regulate commercial activity pursuant to the Commerce Clause.[275] However, the "individual mandate" and the "penalty" provision were permissible pursuant to the powers granted to Congress to "tax."[276] Chief Justice John Roberts authored the opinion, and the decision may be a reflection of a change in the Chief Justice's vote. The dissent, authored by Justice Antonin Scalia, referenced "Justice Ginsburg's dissent on the issue of the Mandate."[277] In the opinion that was released, Justice Ginsburg voted with the majority and concurred in several sections of the opinion,[278] implying that a switch in votes occurred after Justice Scalia wrote his opinion.

B. United States Court of Appeals for the Sixth Circuit

1. The No Fault Act, MCLA Sections 500.3101-.3179

Interpretation of the No-Fault Act reached the United States Court of Appeals for the Sixth Circuit in *Armisted v. State Farm Mutual*

271. Patient Protection and Affordable Care Act, Pub. L. No. 11-148, 124 Stat. 119 (2010).
272. 26 U.S.C. § 5000A(b)(1) (2014).
273. 132 S. Ct. 2566 (2012).
274. *Id.* at 2587.
275. *Id.*
276. *Id.* at 2594.
277. *Id.* at 2648 (Scalia, J., dissenting).
278. *Id.* at 2566 (Ginsburg, J., concurring).

Automobile Insurance Co.[279] Six individuals, who sustained catastrophic injuries as a result of automobile accidents, sought payment of no-fault benefits relative to the cost of attendant care services.[280] Pursuant to settlement agreements, State Farm, the insurer, initially paid the benefits at the requested rates but later reduced the rates based on market surveys of the cost of such services. The injured parties refused to submit documentation regarding the nature and extent of the care provided, and, consequently, State Farm refused to restore the rates.[281] The jury returned a verdict in favor of State Farm.[282] The rate sought by the injured parties for $30 per hour for around the clock attendant care was based on the average rate of a "life skills trainer" or "behavioral technician," persons with formal training in behavior, which are more costly than home health aides.[283]

The Sixth Circuit noted that trained medical personnel need not provide care and that family members are entitled to reasonable compensation for care provided.[284] The burden is on the insured to prove entitlement to no-fault benefits, and the question at issue centers around whether the expenses were "incurred."[285] Family members do not need to submit formal bills to create an issue of fact as to whether an expense has been "incurred," but the burden remains with the insured to demonstrate that the expense was "incurred."[286] According to State Farm's theory, which the district court determined that the jury adopted, "plaintiffs could not prove that they incurred allowable expenses for attendant care services because they failed to produce documentation showing, among other things, who provided attendant care, what type of care was provided and for how long, and the qualifications of the providers."[287] Whether a person incurred an expense is a matter for the jury, and the jury's conclusion that the lack of documentation as to the care evidenced a failure to prove the expense was "incurred" was a reasonable one.[288]

279. 675 F.3d 989 (6th Cir. 2012).

280. *Id.* at 991.

281. *Id.* at 991-92.

282. *Id.* at 992.

283. *Id.*

284. *Id.* at 995 (citing Van Marter v. Am. Fid. Fire Ins. Co., 144 Mich. App. 171, 180; 318 N.W.2d 679 (1982), and Bonkowski v. Allstate Ins. Co., 281 Mich. App. 154, 163; 761 N.W.2d 784 (2008)).

285. *Armisted*, 675 F.3d at 995 (citing U.S. Fid. Ins. & Guar. Co. v. Mich. Catastrophic Claims Ass'n, 484 Mich. 1, 17; 795 N.W.2d 101 (2009), and Williams v. AAA Mich., 250 Mich. App. 249, 257; 646 N.W.2d 476 (2002)).

286. *Id.* at 995-96 (citing Booth v. Auto-Owners Ins. Co., 224 Mich. App. 724, 728; 569 N.W.2d 903 (1997)).

287. *Id.* at 996.

288. *Id.* (citing *Booth*, 244 Mich. App. at 729-30).

The court also determined that it was not fraudulent for a person to collect amounts for attendant care provided by another person, for which the other person was paid at a lower rate than that sought from State Farm; the person collecting provided room and board to the actual provider and was also "on call" to assist if necessary.[289] Therefore, the court could not grant State Farm attorney fees pursuant to MCLA section 500.3148(2) as to this individual.[290]

2. Umbrella Coverage

The Sixth Circuit issued a published opinion in *Stryker Corp. v. XL Insurance America*,[291] but that opinion was superseded and amended in another opinion issued one month later.[292] A medical device manufacturer brought suit against its umbrella carrier relative to claims stemming from the implantation of expired artificial knees, both direct from the end user and by Pfizer, Inc., under an obligation to reimburse.[293] As a byproduct of the sterilization procedure, artificial knee joints manufactured by a wholly owned subsidiary of Pfizer began to slowly degrade when exposed to air in the packaging, necessitating the inclusion of an expiration date on the joints.[294] Stryker acquired the subsidiary from Pfizer, and a provision in the acquisition agreement required Stryker to indemnify Pfizer for claims brought related to the subsidiary's products.[295] Though the expiration dates for the artificial knees were supposed to be entered into a database, some units were not included, and in late 1999, it became known that an expired knee had been implanted in a patient; though, it was not until 2000 that it was realized that the error was on Stryker's end, as opposed to the purchasers of the devices.[296]

The XL policy had an endorsement regarding medical devices

> [w]hich grouped all medical products with the "same known or suspected defect or deficiency which is identified by the same advisory memorandum" into one "batch" or occurrence for coverage purposes. The endorsement provided that the advisory memorandum set the date at which the batch "occurred" for

289. *Id.* at 998.
290. *Id.* at 999.
291. 681 F.3d 806 (6th Cir. 2012).
292. Stryker Corp. v. XL Ins. Am., 735 F.3d 349 (6th Cir. 2012).
293. *Id.* at 351.
294. *Id.* at 352.
295. *Id.*
296. *Id.*

> coverage purposes. However, the endorsement provided that "[b]atch coverage shall not apply to any loss which arises out of a defect or deficiency that is known or suspected prior to 1–1–[20]00."[297]

XL denied coverage on the ground that Stryker knew or suspected the defect prior to January 1, 2000.[298] The ensuing litigation lasted about ten years, and after a bench trial, the district court determined that XL was liable for both direct claims and the indemnity obligation to Pfizer and that the underlying settlement was reasonable.[299] It further determined that the products were defective if they were "in inventory" for over five years—meaning in Stryker's inventory—and an issue with Striker's own inventory was not discovered until April 2000.[300] The district court also determined that XL's breach of its duty to defend voided any limits of liability on the XL policy, and, therefore, the settlement with Pfizer did not exhaust the policy.[301]

The court of appeals recognized that Michigan law treats insurance policies just as any other contract, affording unambiguous language its plain meaning, but it noted that exclusions and ambiguities would be strictly construed against the insurer.[302] The district court's interpretation of "in inventory" as being limited to Stryker's inventory is more reasonable than XL's interpretation expanding the term to anyone's inventory, as XL's interpretation would result in a defective product even if it was completely out of the insured's hands, rendering any medical product with an expiration date uninsurable, as there is always a known possibility that someone will ignore the expiration date.[303] Further, at most, XL's interpretation creates ambiguity, which, in turn, must be construed against the insurer anyway.[304]

The policy is limited to $15 million above the self-insured retention of $2 million, but "when an insurer breaches the duty to defend or indemnify under the policy, the insurer is responsible for 'expectation interest' through awarding damages for the *economic loss* suffered by the

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297. *Id.* at 353 (alterations in original).
298. *Stryker*, 735 F.3d at 353.
299. *Id.*
300. *Id.* at 355.
301. *Id.* at 354.
302. *Id.* (citing Westfield Ins. Co. v. Ken's Serv., 295 Mich. App. 610; 815 N.W.2d 786 (2012), and Northland Ins. Co. v. Stewart Title Guar. Co., 327 F.3d 448, 455 (6th Cir. 2003)).
303. *Id.* at 355.
304. *Stryker*, 735 F.3d at 356.

promisee."[305] The district court relied upon a prior Sixth Circuit case, *Capitol Reproduction, Inc. v. Hartford Insurance Co.*,[306] in determining that policy limits do not apply when the insurer breaches the duty to defend; though that may have been Michigan law at the time of the previous Sixth Circuit decision, it is no longer so.[307]

> *Capitol Reproduction* holds that, in an insurance context only, all losses are assumed to be consequential losses, without the breached party's having to demonstrate the connection between the loss and the breach. This is an extra-contractual rule of the kind the Michigan Supreme Court rejected in *Frankenmuth* and *Wilkie* [*v. Auto-Owners Ins. Co.*].[308]

Therefore, the policy limits apply, and the court remanded the case for consideration of whether any amounts in excess of those limits are consequential damages under Michigan law.[309] Pfizer's defense costs in the tort suits, however, did not count toward the limits, as the XL policy committed it to defend actions covered by the policy, and expenses incurred in defense were in addition to the limits; however, Pfizer's defense costs in the indemnity action against Stryker did count toward the exhaustion of the limits, as that liability was part of the general grant of coverage, not in defense of an otherwise-covered injury under the policy.[310]

Finally, the Sixth Circuit noted that Michigan law provides for penalty interest of twelve percent for claims that are not timely paid in two instances: (1) when the claimant is an insured or directly entitled to benefits under the policy or (2) if the liability of the insurer for the claim is not reasonably disputed and the insurer has refused payment in bad faith, as determined by a court of law.[311] Michigan courts have recognized that a first party claimant need not show that the claim was not reasonably in dispute to recover the twelve percent penalty.[312] An

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305. *Id.* at 357 (internal quotation marks omitted) (quoting Frankenmuth Mut. Ins. Co. v. Keeley, 433 Mich. 525, 557; 447 N.W.2d 691 (1989) (Levin, J., dissenting), *dissent adopted on reh'g*, 436 Mich. 372; 461 N.W.2d 666 (1990)).

306. 800 F.2d 617, 624 (6th Cir. 1986).

307. *Stryker*, 735 F.3d at 358.

308. *Id.* (citing *Frankenmuth Mut. Ins. Co.*, 433 Mich. 525, and Wilkie v. Auto-Owners Ins. Co., 469 Mich. 41; 664 N.W.2d 776 (2003)).

309. *Id.*

310. *Id.* at 358-59.

311. *Id.* at 359-60 (quoting MICH. COMP. LAWS ANN. § 500.2006(4) (West 2012)).

312. *Id.* (quoting Griswold Props., LLC v. Lexington Ins. Co., 276 Mich. App. 551, 565-66; 741 N.W.2d 549 (2007)).

intervening Michigan Court of Appeals decision held that a breach of an insurance contract specifically tied to the underlying third-party tort claim was subject to the reasonable dispute language, but that case was subsequently vacated in part by the Michigan Supreme Court.[313] The Sixth Circuit determined that the subsequent vacation of the case was on other grounds and, at best, "turn[ed] the penalty interest analysis in *Ferwerda I* into dicta."[314] The Sixth Circuit concluded that the language of the statute focuses on the identity of the claimant, not the source of the claim, and, therefore, when the claimant is the insured, as Stryker was, the reasonable dispute language no longer applies.[315] Further, attorney fees resulting from an insurer's breach of the duty to defend are included for purposes of calculating penalty interest.[316]

3. Employee Fidelity Coverage

The Tooling, Manufacturing and Technologies Association (TMTA) purchased employee fidelity coverage from Hartford Fire Insurance Company to protect against certain employee theft.[317] TMTA arranged sales of insurance policies to its members but created TMTA Insurance Agency (Agency), a separate limited liability company, as a licensed producer to actually carry out the transactions because Michigan law prohibits TMTA from collecting commissions directly from insurance companies.[318] Almost all of TMTA's revenue came from the Agency in the form of commissions paid by insurance companies, and all of the Agency's income went to TMTA.[319] The Agency was not named as an "other insured" on the Hartford policy, which defined an employee of any insured to be an employee of every insured.[320] An employee of TMTA, using entities that he owned, redirected some $715,000 in commission payments due to the Agency for his own benefit, which

313. *Stryker*, 735 F.3d at 360 (citing Auto-Owners Ins. Co. v. Ferwerda Enters, Inc., 287 Mich. App. 248; 797 N.W.2d 168 (2010) (*Ferwerda I*), *vacated in part and appeal denied in part*, 784 N.W.2d 44 (Mich. 2010)). Note, the Sixth Circuit described the Michigan Supreme Court decision as a reversal on other grounds. *Id.*

314. *Id.*

315. *Id.* at 361.

316. *Id.* (citing Alticor, Inc. v. Nat'l Union Fire Ins. Co. of Pa., 345 F. App'x 995, 1001-02 (6th Cir. 2009)).

317. Tooling, Mfg. & Techs. Ass'n v. Hartford Fire Ins. Co. (*Tooling II*), 693 F.3d 665, 667 (6th Cir. 2012).

318. *Id.* at 668.

319. *Id.* (citing Tooling, Mfg. & Techs. Ass'n v. Hartford Fire Ins. Co. (*Tooling I*), No. 08-cv-11812, 2010 WL 3464329, at *2 (E.D. Mich. Aug. 30, 2010)).

320. *Id.*

amount would have eventually accrued to TMTA.[321] TMTA and the Agency sued the employee in Michigan state court and prevailed, but Hartford refused to make a determination of coverage, resulting in this declaratory action.[322] The policy provided that it would pay for loss "'which result[ed] *directly* from "theft" by an "employee", whether or not identifiable, while acting alone or in collusion with other persons.'"[323] The policy also excluded coverage for "[l]oss that [was] an *indirect* result of any act or 'occurrence' covered by [the] Policy."[324] Finally, the policy defined "theft" in terms of an unlawful taking "'to the deprivation of the insured.'"[325]

> The district court granted summary judgment to Hartford, holding that: (1) the TMTA cannot have a direct interest in the commissions due to the Agency because the Agency is a separate entity under Michigan law; (2) the Agency is not a named insured in the Policy; (3) the exclusion clause barring recovery for indirect losses applies to the commissions stolen by Tyler; and (4) Tyler only had a duty to turn the stolen commissions over to the Agency, not to the TMTA.[326]

The Sixth Circuit recognized long-standing principles of contract and insurance law: that the court is to construe an unambiguous policy according to its terms and that an insurer cannot be liable for a risk it did not assume.[327] Determining coverage requires an analysis which first asks if the policy extends to the loss at issue and second whether that coverage is negated by an exclusion.[328] TMTA admitted that it was separate, albeit closely related, to the Agency and the policy language clearly indicated that it was for the benefit of the insured alone; though the policy listed six other entities as the insured, the Agency was not.[329] Therefore, the policy did not cover the Agency or any of its losses due to employee theft.[330] Further, the employee's theft did not "directly" result

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321. *Id.* at 669.
322. *Id.*
323. *Tooling II*, 693 F.3d at 668.
324. *Id.* at 669 (quoting the Harford Policy that TMTA procured).
325. *Id.* (emphasis omitted) (quoting the Hartford Policy that TMTA procured).
326. *Id.* (citing *Tooling I*, 2010 WL 3464329, at *4-7).
327. *Id.* at 670 (citing Citizens Ins. Co. v. Pro-Seal Serv. Grp., Inc., 477 Mich. 75, 82; 730 N.W.2d 682 (2007)).
328. *Id.* at 670-71 (citing Heniser v. Frankenmuth Mut. Ins. Co., 449 Mich. 155, 172; 534 N.W.2d 502 (1995)).
329. *Tooling II*, 693 F.3d at 672.
330. *Id.* at 673.

in loss to TMTA, based on the plain meaning of "directly," which equates to "immediate."[331] The employee stole commissions intended for the Agency, and, therefore, there was no direct loss to TMTA, as there was an intermediate step to transfer the funds between the Agency and TMTA before TMTA would receive the funds.[332] Therefore, the district court was affirmed because coverage was unavailable.[333]

4. ERISA[334]

Thomas Judge required surgery to repair an aortic valve and dilated ascending aorta, for which he applied for coverage pursuant to a group insurance policy through Delta Airlines, which is administered by MetLife; MetLife denied coverage, determining that Mr. Judge was not totally and permanently disabled pursuant to the plan.[335] For a person to be regarded as having "total and permanent disability," the person must be "expected never again to be able to do: [y]our job; and [a]ny other job for which [y]ou are fit by education, training and experience."[336] Mr. Judge, who worked for Delta as a baggage handler, was required to submit proof of disability to MetLife, which was

> [w]ritten evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When any claim is made for any benefit described in this certificate, Proof must establish: the nature and extent of the

331. *Id.* The Sixth Circuit went on to collect cases regarding the two schools of thought on the "directly" language, which either hold that "direct is direct" or utilize a proximate cause approach in giving meaning to the term. *Id.* at 674-75. The Sixth Circuit applied the "direct is direct" approach, which it thought the Michigan Supreme Court would adopt if it were to consider the question. *Id.* at 676. An unpublished Michigan Court of Appeals decision, *Acorn Inv. Co. v. Mich. Basic Prop. Ins. Ass'n*, No. 284234, 2009 WL 2952677, at *2 (Mich. Ct. App. Sept. 15, 2009), adopted the proximate cause analysis in the context of a physical property damage insurance policy, but the Sixth Circuit remained convinced that the Michigan Supreme Court would not adopt such an approach, as the Michigan Court of Appeals acknowledged the plain meaning of "directly" as "immediate," but ignored that meaning in application. *Tooling II*, 693 F.3d at 676.

332. *Tooling II*, 693 F.3d at 676.

333. *Id.* at 667.

334. ERISA, the Employee Retirement Income Security Act of 1974, is primarily a creature of federal law. 29 U.S.C. § 1001 (West 2013). However, decisions involving ERISA that discuss or impact state insurance law are discussed in this *Survey*.

335. Judge v. Metro. Life Ins. Co., 710 F.3d 651, 654 (6th Cir. 2013).

336. *Id.*

> loss or condition; Our obligation to pay the claim; and the claimant's right to receive payment.[337]

Mr. Judge submitted several post-surgery reports from his physicians to support his claim, and MetLife considered each claim.[338] The reports began positively, noting that Mr. Judge was doing well and was "freely mobile" and able to increase his activities, but limiting his lifting ability to fifteen pounds.[339] However, six months after surgery, the reports began to limit Mr. Judge's activity (including standing, sitting, and walking) and disabled him from work for an indefinite period of time, sometimes without explanation.[340] Given the inconsistencies between the earlier and later reports, MetLife denied his claim, finding insufficient information to support the disability required by the plan.[341]

The standard of review for an ERISA denial is arbitrary and capricious and is based upon a review of the administrative record.[342] There was evidence tending to support the conclusion that Mr. Judge would never again be able to lift heavy objects, but improvement was expected in all areas of functional capacity other than lifting.[343] There was no evidence demonstrating that Mr. Judge was permanently unable to function "so as to prevent him from doing some other job for which he is fit by education, training, or experience," as required by the plan; no physician concluded that he was permanently disabled, and Mr. Judge never requested any further explanation from his physician regarding the inability to stand or walk when MetLife informed Mr. Judge that the material submitted was insufficient.[344] Further, MetLife was not required to consult a vocational expert to determine what other jobs Mr. Judge was capable of performing based on his education, training, and experience when the medical record provided support for a finding that the claimant was not totally and permanently disabled.[345] MetLife also did not have an independent medical examination undertaken, as the medical review was sufficient.[346] The medical review made no credibility determinations, nor did it second-guess the physicians, but, rather, the

337. *Id.* at 654-55.
338. *Id.* at 655.
339. *Id.*
340. *Id.* at 655-56.
341. *Judge*, 710 F.3d at 656.
342. *Id.* at 660 (citing Spangler v. Lockheed Martin Energy Sys., Inc., 313 F.3d 356, 362 (6th Cir. 2002)).
343. *Id.*
344. *Id.* at 660-61.
345. *Id.* at 661.
346. *Id.* at 663.

review echoed the physician's findings and noted the lack of objective medical evidence regarding some of the unexplained conclusions.[347]

C. U.S. District Courts for the Eastern and Western Districts of Michigan

1. The No Fault Act, MCLA Sections 500.3101-.3179

A no-fault insurer sought reimbursement from the Michigan Catastrophic Claims Association (MCCA).[348] The insurer paid over $1.2 million in benefits to an individual injured in a 2001 motor vehicle accident covered by its no-fault policy issued to Avis Rent-A-Car and was a member of the MCCA at the time of the accident; it sought reimbursement for amounts over $250,000, the MCCA threshold at the time of the accident.[349] The insurer discovered that it had not paid the MCCA premiums under the Avis policy for a five-year period, including the time of the accident, and belatedly tendered the premiums to the MCCA after the filing of the lawsuit.[350] The MCCA board of directors met, rejected the payment, and returned the funds to the insurer.[351]

The Michigan legislature created MCCA out of concern that the provision of no-fault personal injury protection (PIP) benefits "'placed too great a burden on insurers . . . in the event of "catastrophic" injury claims.'"[352] MCCA membership is mandatory, and members are permitted to withdraw only upon the insurer's ceasing to write insurance.[353] The MCCA's obligation to indemnify is mandatory, as by statute, it "shall accept indemnification" above the threshold amount, and the MCCA must also charge and accept premium payments.[354] "The MCCA would [not be able] to fulfill its statutory purpose if the membership and indemnification provisions were not mandatory."[355] The legislature did not grant MCCA authority to reject a tendered premium.[356] For four reasons, the MCCA does not have discretionary authority to reject tendered premiums, even if belatedly made:

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347. *Judge*, 710 F.3d at 663.

348. Cont'l Cas. Co. v. Mich. Catastrophic Claims Ass'n, 874 F. Supp. 2d 678 (E.D. Mich. 2012).

349. *Id.* at 679.

350. *Id.* at 680.

351. *Id.*

352. *Id.* at 681 (quoting *In re* Certified Questions: Preferred Risk Mut. Ins. Co., 433 Mich. 710, 713-14; 499 N.W.2d 660 (1989)).

353. *Id.* at 681 (quoting MICH. COMP. LAWS ANN. § 500.3104(1), (3) (West 2012)).

354. *Cont'l Cas. Co.*, 874 F. Supp. 2d at 681 (emphasis omitted) (quoting MICH. COMP. LAWS ANN. § 500.3104(2), (7)(d)-(e)).

355. *Id.*

356. *Id.* at 682.

> (1) the Michigan Legislature clearly intended the indemnification regime to be mandatory on all parties; (2) the Supreme Court of Michigan held in *United States Fidelity Ins. & Guaranty Co. v. MCCA*, 484 Mich. 1, 795 N.W.2d 101, 113 (2009) (Fidelity), that the "necessary and proper" clause of Section 3104(8)(g) must be interpreted narrowly; (3) the MCCA has other means available to recover delinquent premiums; and (4) membership in the MCCA is mandatory for insurance carriers doing business in Michigan and obligates the insurer to pay premiums.[357]

An implied power to reject cannot exist in the face of an express provision requiring an acceptance.[358] Further, the MCCA admitted that in the past, when no catastrophic claim was pending, the MCCA would accept the late payment and charge a late fee; thus, the MCCA cannot treat this insurer differently than other insurers from which it had accepted late payments in the past.[359]

2. Duty to Defend

Alticor, Inc. was sued in the Western District of Missouri and requested coverage for the suit pursuant to its commercial general liability policy, but the insurers, National Union Insurance Company and Illinois National Insurance Company, instead filed a declaratory action in the Western District of Michigan seeking declaration that they had no obligation to provide coverage.[360] The court determined that the allegations, arising under the Sherman Act, did not even arguably come within the coverage, but a year later, when an amended complaint was filed in the Missouri action, alleging injurious falsehood, coverage was again requested.[361] As a result of discovery in the underlying action, it was revealed that the false statements apparently dated from 1998 to 1999, and the insurer declined coverage, stating that (1) the complaint, not the discovery, determined a duty to defend; (2) the discovery did not "demonstrate that the injurious falsehood claim [was] based on events that occurred in 1998"; and (3) coverage was excluded because the

357. *Id.* at 683.

358. *Id.* at 686.

359. *Id.* at 689.

360. Alticor, Inc. v. Nat'l Union Fire Ins. Co., 916 F. Supp. 2d 813, 817 (W.D. Mich. 2013).

361. *Id.* Illinois National agreed to defend based on policies it issued from 2002 to 2004. *Id.* at 820. National Union denied coverage on the basis that the allegation did not occur prior to 2002, and its policy dated from 1998 to 1999. *Id.*

statements were allegedly made with "knowledge of their falsity or in reckless disregard [of] the truth."[362]

The court acknowledged that unambiguous policies are to be enforced as written and that the two-step process used in Michigan is to determine if coverage exists and then to determine if an exclusion negates coverage.[363] Neither party contended that the relevant portions of the insurance policy were ambiguous, but they disputed the appropriate interpretation of Michigan law regarding the duty to defend.[364] The duty to defend looks to the allegations of the complaint, but it is not limited to the specific language used therein, as the insurer is obligated to look behind the allegations in its analysis.[365] If any theory of recovery even arguably falls within the terms of coverage, the duty to defend is triggered.[366] Doubts on whether the claim is covered should be resolved in the favor of the insured.[367]

The court determined that the allegations of the amended complaint did not give rise to a duty to defend, as the claims for injurious falsehood were based on events occurring after 1999.[368] The duty was triggered by the answers produced during the discovery process, though, as the insurer stated that the date of the false statements occurred as far back as 1998 to 1999.[369] Based on these responses, coverage became arguable, and any doubt must be resolved in the insured's favor.[370] Under Michigan law, "other insurance" refers to two or more policies that insure the same risk and interest, and benefit the same person during the same period.[371] Though National Union did issue successive policies between 1991 to 2002, issuance of such policies did not implicate an "other insurance" provision of a policy.[372] The policies were not concurrent and did not insure the same risks, and, therefore, the "other

362. *Id.* at 821.

363. *Id.* at 822 (citing Rory v. Cont'l Ins. Co, 473 Mich. 457, 461; 703 N.W.2d 23 (2005), and Heniser v. Frankenmuth Mut. Ins. Co., 449 Mich. 155, 172; 534 N.W.2d 502 (1995)).

364. *Alticor*, 916 F. Supp. 2d at 825.

365. *Id.* at 825-26 (citing Protective Nat. Ins. Co. of Omaha v. City of Woodhaven, 438 Mich. 154, 159; 476 N.W.2d 374 (1991)).

366. *Id.* at 826 (citing Auto Club Grp. Ins. Co. v. Burchell, 249 Mich. App. 468, 480-81; 642 N.W.2d 406 (2001)).

367. *Id.* at 827 (citing Am. Bumpers Mfg. Co. v. Hartford Fire Ins. Co., 452 Mich. 440, 452; 550 N.W.2d 475 (1996)).

368. *Id.*

369. *Id.*

370. *Alticor*, 916 F. Supp. 2d at 828.

371. *Id.* (citing Douglas Richmond, *Issues and Problems in "Other Insurance," Multiple Insurance, and Self Insurance*, 22 PEPP. L. REV. 1373, 1376 (1995)).

372. *Id.*

insurance" provision was inapplicable.[373] When an insurer breaches its duty to defend, it becomes liable for the costs of the defense, but the damages awardable are limited to the economic loss sustained by the insured.[374] Therefore, Alticor could not recover the stated deductible, as Alticor would have been responsible for that amount, even if National Union had defended the action.[375] National Union failed to address the application of penalty interest allegedly owed pursuant to MCLA section 500.2006(4), and the court determined that Alticor was entitled to the interest as to amounts submitted to, but not paid by, National Union.[376] National Union also argued that the court should allocate any costs pro rata between it and Illinois National.[377]

> Michigan courts and the Sixth Circuit have applied the pro rata, or time-on-the-risk, method for allocating damages and costs for situations involving consecutively issued insurance policies. . . . In situations where the insured had multiple, consecutively issued policies, or included periods of self-insurance, courts have applied time-on-the-risk to allocation of defense costs when some of the defense costs were related to claims arising across the policy periods.[378]

However, no basis to allocate defense costs existed at that point because the allocation required a determination that a duty to defend or indemnify arose during another policy period, and no such determination had been made in this case.[379] National Union was the only insurer that was a party to this case, and only its policies were at issue.[380] Therefore, the court denied National Union summary judgment and granted in part Alticor's motion for summary judgment, finding that National Union breached its duty to defend.[381]

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373. *Id.* at 829.
374. *Id.* at 831 (citing N. Bank v. Cincinnati Ins. Cos., 125 F.3d 983, 986 (6th Cir. 1997), and Stryker Corp. v. XL Ins. Am., 681 F.3d 806, 814 (6th Cir. 2012)).
375. *Id.*
376. *Alticor*, 916 F. Supp. 2d at 832.
377. *Id.*
378. *Id.*
379. *Id.* at 833.
380. *Id.*
381. *Id.* at 834.

3. Proof of Loss Requirements

The Touchtons owned a home that was in a flood zone and for which they had obtained flood insurance with Fidelity National Property and Casualty Insurance Company.[382] They filed a claim for structural damage and personal property loss following a February 2009 flood caused by a combination of melting snow and several days of rain.[383] An itemized, detailed list of the contents that were damaged was provided, but the Touchtons did not swear, under oath, that list was true.[384] When the adjuster proffered a proof of loss, the Touchtons noticed several inaccuracies and refused to sign the proof.[385] A second proof of loss offered by the adjuster was also inaccurate and went unsigned. The Touchtons communicated the inaccuracies to Fidelity several times.[386] Fidelity accepted the adjuster's second proof of loss, which the Touchtons refused to sign, but the Touchtons never submitted their own proof of loss within sixty days of the flood, as required by the policy.[387] A second flood occurred in August 2009, which the Touchtons submitted to Fidelity in November 2009, but the Touchtons also did not submit a sworn proof of loss for this August flood.[388] Fidelity denied the claim for the second flood, stating that there was no "general condition of flooding" as defined in the policy and that a non-covered "ground-water intrusion" had caused certain damage.[389] Fidelity now based its denial of both claims on the failure to submit a sworn proof of loss.[390]

As the insurance at issue was federally subsidized through the National Flood Insurance Program ("NFIP"), the Code of Federal Regulations governed the terms of the insurance.[391] 44 C.F.R. § 61, App. A(2)(J)(4) requires a claimant to provide proof of loss, "signed and sworn to by you."[392] These proof requirements are to be "strictly enforced."[393] It was undisputed that the Touchtons did not provide a proof of loss, and no triable issue of fact had been raised on the matter.[394]

382. Touchton v. Fid. Nat'l Prop. & Cas. Ins. Co., 911 F. Supp. 2d 505, 506 (E.D. Mich. 2012).
383. *Id.*
384. *Id.* at 507.
385. *Id.*
386. *Id.*
387. *Id.*
388. *Touchton*, 911 F. Supp. 2d at 508.
389. *Id.*
390. *Id.*
391. *Id.* at 509.
392. *Id.* (quoting 44 C.F.R. § 61 App. A(2)(J)(4) (West 2012).
393. *Id.* (citing Neuser v. Hocker, 246 F.3d 508, 510 (6th Cir. 2001)).
394. *Touchton*, 911 F. Supp. 2d at 510.

Instead, the Touchtons claimed that they should be excused from the requirements because Fidelity did not send out a certified Federal Emergency Management Administration (FEMA) adjuster to inspect their property, or that Fidelity was estopped from requiring a proof of loss due to its own misconduct, or that Fidelity waived the proof of loss by accepting the adjuster's proof of loss.[395]

The court found no support for the proposition that Fidelity's failure to have a certified FEMA adjuster personally inspect the property would excuse the proof of loss requirement.[396] The NFIP Adjuster Claims Manual provided that the adjuster's assistance with the proof of loss was "only a courtesy" and that a proof of loss was required on every claim.[397] Regarding estoppel, NFIP is federally funded, and the government cannot be estopped when the claimant seeks public funds.[398] The Touchtons also failed to demonstrate waiver, as the evidence demonstrated that Fidelity required a signed sworn proof of loss.[399] Therefore, Fidelity was entitled to summary judgment based on the Touchtons' failure to submit a sworn proof of loss.[400]

4. ERISA

General Motors (GM) established an ERISA "welfare benefits" plan, which provided, among other coverage, for life insurance.[401] As part of the federal bailout of GM, in bankruptcy court, the court reduced the value of the life insurance benefits to $10,000.[402] The beneficiaries brought suit in state court, making claims under state law.[403]

The court determined that the claims, however they were labeled, were "for benefits and/or for clarification of plaintiffs' rights to benefits under the Plan," which clearly fell within ERISA's comprehensive civil enforcement scheme, 29 U.S.C. § 1132(a); ERISA's provision preempted the claims.[404] The beneficiaries' state law claims were also subject to the express preemption provision of ERISA, 29 U.S.C. § 1144(a), which provides that ERISA "shall supersede any and all State laws insofar as

395. *Id.*
396. *Id.* at 511.
397. *Id.*
398. *Id.* at 512 (citing Office of Pers. Mgmt. v. Richmond, 496 U.S. 414, 434 (1990)).
399. *Id.* at 513.
400. *Touchton*, 911 F. Supp. 2d at 513.
401. Haviland v. Metro. Life Ins. Co., 876 F. Supp. 2d 946, 951 (E.D. Mich. 2012).
402. *Id.* at 953.
403. *Id.* at 954.
404. *Id.* at 955.

they may now or hereafter relate to any employee benefit plan."[405] The court also determined that the state law claims for statutory conversion, unjust enrichment, breach of contract, negligent misrepresentation, and unfair trade practices failed to state claims on which relief can be granted.[406]

The Eastern District of Michigan also applied the "arbitrary and capricious" standard of review to a plan administrator's determination of entitlement to benefits.[407] Richard Barron, who had had purchased uncoordinated no-fault coverage and obtained health insurance through his employer via an ERISA plan, was involved in an automobile accident.[408] Mr. Barron demanded that his health insurer, Blue Cross, pay him an amount equal to the amount the no-fault insurer paid to his health care providers; in other words, Mr. Barron sought to "double-dip."[409] The ERISA plan provided that its coverage will be coordinated with, and secondary to, any individual automobile insurance, including no-fault.[410] As Blue Cross had discretionary authority to determine eligibility for benefits, its decision was reviewed on an arbitrary and capricious standard.[411]

Mr. Barron's claim ignored the language from the plan regarding coordination, which was fatal to his case.[412] The plan unambiguously stated that its coverage was coordinated and secondary to employee-purchased plans, such as no-fault.[413] A similar issue was considered by the Michigan Supreme Court previously, which concluded,

> Plaintiff contends that without a nullification of the coordination of benefits clause, he will not be allowed to receive the insurance coverage he contracted for. The flaw in that argument is that there was no contracting between the employee, the employer, and the health care provider for uncoordinated coverage. The contract was with the no-fault carrier for uncoordinated coverage, meaning the no-fault carrier agreed to be primary in the event of a claim. The contract between the no-fault carrier and the insured cannot be said to bind PHP and alter the terms of

405. *Id.*
406. *Id.* at 956-58.
407. Barron v. Blue Cross Blue Shield of Mich., 898 F. Supp. 2d 933, 938 (E.D. Mich. 2012).
408. *Id.* at 935.
409. *Id.* at 934.
410. *Id.* at 935.
411. *Id.* at 938.
412. *Id.* at 939.
413. *Barron*, 898 F. Supp. 2d at 940.

> the agreement it made with Meijer, Inc., to provide health insurance to its employees.[414]

Therefore, Mr. Barron was not entitled to duplicative benefits.[415] The court also rejected an estoppel argument, though that rejection was based on federal law, not Michigan law.[416]

The court also considered the issue of exhaustion of administrative remedies under ERISA.[417] While ERISA does not have an explicit exhaustion requirement, the overall scheme does require exhaustion prior to filing a lawsuit.[418] The court may excuse this exhaustion requirement if it would be futile to do so and when the suit is directed to the legality, not the interpretation, of the plan, or "when the defendant lacks authority to take the action" a plaintiff seeks to compel.[419] Strong doubts are not enough to demonstrate futility, as it must be certain that a claim would be denied on further administrative appeal, not just doubtful that a different result would occur.[420]

V. CONCLUSION

The importance of insurance and its impact on society cannot be underestimated. While the courts interpret unambiguous insurance contracts as written,[421] at least when the coverage is not statutorily mandated, insurance contracts are complex documents, with numerous provisions that may or may not apply depending on the facts involved in some subsequent dispute that may arise. Michigan courts, or federal courts applying Michigan law, are still frequently interpreting the Michigan No-Fault Act forty years after it was first enacted[422] The Michigan Supreme Court continues to reconsider and reverse prior insurance decisions, especially in the No-Fault arena.[423] The landscape of insurance law is anything but static.

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414. *Id.* at 941 (quoting Smith v. Physicians Health Plan, Inc., 444 Mich. 743, 754-55; 514 N.W.2d 150 (1994)).

415. *Id.*

416. *Id.* at 941-42.

417. Beamon v. Assurant Emp. Benefits, 917 F. Supp. 2d 662 (E.D. Mich. 2013).

418. *Id.* at 667 (citing Miller v. Metro. Life Ins. Co., 925 F.2d 979, 986 (6th Cir. 1991)).

419. *Id.* (quoting Dozier v. Sun Life Assurance Co., 466 F.3d 532, 535 (6th Cir. 2006)).

420. *Id.*

421. Alticor, Inc. v. Nat'l Union Fire Ins. Co. of Pa., 916 F. Supp. 2d 813, 822 (W.D. Mich. 2013) (citing Rory v. Cont'l Ins. Co., 473 Mich. 457, 470; 703 N.W.2d 23 (2005)).

422. *See supra* Parts II-IV.

423. *See supra* Part II.