INSURANCE LAW

JAMES T. MELLON[†]

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I. INTRODUCTION

The growing trend in Michigan cases published during the *Survey* period is a continued movement toward plain language interpretation of contracts and statutes, the abrogation of judicial tolling and the ever-extending reach of *Devillers v. Auto Owners Insurance Co.*[1] While most Michigan Court of Appeals decisions regarding insurance law continue to be unpublished[2] and not precedential, several published decisions of the Michigan Court of Appeals and the Michigan Supreme Court during the *Survey* period continue to shape insurance law and the rights and obligations of insureds, insurers, and third-parties.

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† Principal, Mellon, McCarthy & Pries, P.C. B.A., 1967, University of Detroit; M.A., 1970, University of Detroit; J.D., 1973, University of Detroit; L.L.M., 2003, Wayne State University School of Law. Adjunct Professor, University of Detroit Mercy School of Law, teaching insurance law. Mr. Mellon has been conferred the designation Charter Property Casualty Underwriter (CPCU) from the American Institute for Property & Liability Underwriters and the designation Associate in Risk Management (ARM) from the Insurance Institute of America. He acknowledges the invaluable assistance of David R. Dyki, B.A. 2000, Michigan State University; J.D., 2003 Wayne State University School of Law.

1. 473 Mich. 562, 702 N.W.2d 539 (2005) (holding that judicial tolling could not apply to extend the "one year back" limitations period for no fault benefits).

2. Unpublished decisions are beyond the scope of this review.

II. DECISIONS OF THE MICHIGAN COURT OF APPEALS

A. The Patient's Right to Independent Review Act

The Patient's Right to Independent Review Act (PRIRA)[3] is in its infancy in terms of appellate review. One of the few cases to review the statute is *Ross v. Blue Case Network of Michigan.*[4] This is one of those sad cases where the insured is fighting for his life and also fighting with his health insurer, in this case, Blue Care Network.[5] Mr. Ross suffered from multiple conditions, including multiple myeloma, spinal stenosis, and fractured lumbar vertebrae.[6] His condition did not respond favorably to treatment at the University of Michigan Hospital, and a physician there suggested that he pursue treatment in Arkansas.[7]

Mr. Ross contacted the Myeloma Institute for Research and Therapy at the University of Arkansas for Medical Sciences (UAMS).[8] When he was first evaluated there, the doctor opined that Mr. Ross "was one week away from death."[9] A different type of therapy at the Myeloma Institute helped somewhat.[10] He was hospitalized at UAMS on two occasions.[11] BCN denied coverage for Ross's treatment in Arkansas as out-of-network treatment and because he was self-referred to UAMS.[12]

Mr. Ross "requested an external review by the Commissioner of the Office of Financial and Insurance Services" (OFIS) and the Commissioner assigned an independent review organization (IRO).[13] The IRO, through a board-certified medical oncologist and hematologist, concluded that Ross's care constituted emergency treatment and rejected BCN's assertion that the treatment was experimental or investigational.[14] Subsequent IRO reviews reached the same conclusion.[15] The Commissioner accepted part of the IRO recommendation, but questioned whether Mr. Ross's condition met the definition of emergency.[16] The Commissioner felt that Mr. Ross should have gone to the closest Michigan hospi-

3. MICH. COMP. LAWS ANN. § 500.1901 (West Supp. 2007).
4. 271 Mich. App. 358, 722 N.W.2d 223 (2006).
5. *Id.*
6. *Id.* at 360, 722 N.W.2d at 226.
7. *Id.* at 360-61, 722 N.W.2d at 226.
8. *Id.* at 361, 722 N.W.2d at 226.
9. *Id.* at 361, 722 N.W.2d at 227.
10. *Ross,* 271 Mich. App. at 361, 722 N.W.2d at 227.
11. *Id.* at 361-62, 722 N.W.2d at 227.
12. *Id.* at 362-63, 722 N.W.2d at 227.
13. *Id.* at 363, 722 N.W.2d at 228.
14. *Id.* at 363-64, 722 N.W.2d at 228.
15. *Id.* at 364-66, 722 N.W.2d at 228-29.
16. *Ross,* 271 Mich. App. at 366-67, 722 N.W.2d at 229-30.

tal, rather than to a hospital in Arkansas.[17] The Commissioner thus found that only part of Mr. Ross's treatment should have been covered.[18]

Mr. Ross appealed the Commissioner's decision to the Wayne County Circuit Court[19] pursuant to PRIRA.[20] At the August 26, 2005 hearing, Circuit Judge Michael Callahan held that "the Commissioner, [in] ruling that only part of [Mr.] Ross's treatment was an emergency, was 'splitting the baby,'"[21] and reversed the Commissioner's findings.[22] The Michigan Court of Appeals subsequently granted BCN's application for leave to appeal.[23]

The Court of Appeals noted that its review of the Commissioner's decision is prescribed by Article VI., Section 28 of the Michigan Constitution, which provides, in relevant part:

> All final decisions, findings, rulings and orders of any administrative officer or agency existing under the constitution or by law, which are judicial or quasi-judicial and affect private rights or licenses, shall be subject to direct review by the courts as provided by law. This review shall include, as a minimum, the determination whether such final decisions, findings, rulings and orders are authorized by law; and, in cases in which a hearing is required, whether the same are supported by competent, material and substantial evidence on the whole record.[24]

Because PRIRA does not require or provide for a hearing, the Court found that the proper standard of review was whether the Commissioner's "decision was authorized by law."[25] Interestingly, the Constitutional provision relied upon proscribes a "minimum" standard of review of "authorized by law."[26] This "minimum" language seems to suggest that the Court is permitted to employ a higher standard of review; however, the Court chose to interpret such language to mean that the minimum standard must be applied.[27]

BCN argued that the Commissioner was free to disregard the IRO recommendation and reach her own decision regarding the medical issues.[28] In support of this position, BCN relied on *English v. Blue Cross*

17. *Id.* at 366-67, 722 N.W.2d at 229.
18. *Id.* at 366-67, 722 N.W.2d at 229-30.
19. *Id.* at 367, 722 N.W.2d at 230.
20. MICH. COMP. LAWS ANN. § 550.1915(1) (West 2002).
21. *Ross*, 271 Mich. App. at 367, 722 N.W.2d at 230.
22. *Id.*
23. *Id.* at 230.
24. MICH. CONST. art. VI, § 28.
25. *Ross*, 271 Mich. App. at 368-69, 722 N.W.2d at 230.
26. MICH. CONST. art. VI, § 28.
27. *Ross*, 271 Mich. App. at 368-69, 722 N.W.2d at 231.
28. *Id.* at 374, 722 N.W.2d at 233.

Blue Shield of Michigan.[29] In *English*, Blue Cross Blue Shield of Michigan (BCBSM) argued that the provisions of PRIRA violate the health insurer's right to due process.[30] One of the arguments raised by BCBSM in *English* was that the health insurer had no knowledge of the identity of the IRO and was not afforded the opportunity to challenge the IRO's recommendations.[31] The Court of Appeals rejected BCBSM's contention, and in so doing, stated that the IRO's recommendation "is not binding."[32]

The *Ross* panel examined the *English* panel's holding, and found that it was not bound to follow it.[33] The court noted that "it is well settled that 'statements concerning a principle of law not essential to determination of the case are obiter dictum [sic] and lack the force of an adjudication.'"[34] Addressing the *English* decision, the court stated:

The *English* panel's statement that "the [IRO's] recommendation is not binding on the commissioner" is not a "rule of law." Rather, it is merely a statement "concerning some . . . legal proposition not necessarily involved nor essential to determination of the case in hand." The *English* panel was never actually presented with the question whether an IRO's recommendation is binding on the OFIS Commissioner.[35]

Accordingly, the court found that it was not bound by the statement in *English* that the IRO's recommendation "is not binding."[36]

The court then turned its attention to whether the OFIS Commissioner was in fact bound to follow the IRO's recommendation.[37] The relevant language of PRIRA provides: "Upon receipt of the assigned independent review organization's recommendation under subsection (14), the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier."[38]

The court, relying on the doctrine of "'*expressio unius est exclusio alterius*,' which means that the express mention in a statute of one thing implies the exclusion of other similar things,"[39] the court noted that the only requirement specified in the statute is that the Commissioner must "ensur[e] that [the recommendation] is not contrary to the terms of coverage under the covered person's health benefit plan."[40] The court stated that "while the Legislature intended that the OFIS Commissioner would

29. 263 Mich. App. 449, 688 N.W.2d 523 (2004).
30. *Id.* at 459, 688 N.W.2d at 530.
31. *Id.* at 463, 688 N.W.2d at 523.
32. *Ross*, 271 Mich. App. at 372, 722 N.W.2d at 232.
33. *Id.* at 373, 722 N.W.2d at 233.
34. *Id.* at 374, 722 N.W.2d at 233 (citation omitted).
35. *Id.* (citation omitted).
36. *Id.* at 375, 722 N.W.2d at 234.
37. *Id.* at 374, 722 N.W.2d at 234.
38. MICH. COMP. LAWS ANN. § 550.1911(15) (West Supp. 2002).
39. *Ross*, 271 Mich. App. at 377, 722 N.W.2d at 235.
40. *Id.* at 376, 722 N.W.2d at 234.

review the IRO's recommendation for consistency and compliance with the health plan itself, the Legislature did not intend that the OFIS Commissioner would review or reevaluate the IRO reviewer's specific medical or clinical findings."[41] Thus, the court held that, to the extent the Commissioner disregarded the IRO's medical determinations, her actions were not authorized by law.[42]

B. Agency

The Michigan Court of Appeals had a chance to examine the common law duties of insurance agents in *Pressey Enterprises, Inc. v. Barnett-France Insurance Agency*.[43] At issue was whether the facts of the case gave rise to an exception to the general rule that insurance agents owe no affirmative duty to advise or counsel an insured about the adequacy or availability of coverage.[44] The court adhered to the plain language of the test, and found that no exception applied.[45]

The plaintiffs alleged that Barnett-France, the insurance agency, acted negligently when it "failed to obtain adequate or appropriate insurance coverage for them, which resulted in plaintiffs' insurance coverage falling short when a fire 'almost completely' destroyed their hotel."[46] The court noted that the general rule is "that there is no affirmative duty for a licensed insurance agent to advise or counsel an insured about the adequacy or availability of coverage . . . ."[47] The issue presented in the case was whether one of the four recognized exceptions to this general rule applied.[48]

The plaintiffs argued that the first exception applied because an employee of the defendant "said that she would switch the policy from a builder's risk policy to a full business/commercial policy once plaintiffs began putting furniture into the hotel and knew their opening date."[49] The court rejected this argument, finding that there was no evidence that defendant would automatically switch the policy, and plaintiffs failed to contact defendant to confirm the opening date of the hotel.[50] Therefore,

41. *Id.* at 377, 722 N.W.2d at 235.
42. *Id.* at 379-80, 722 N.W.2d at 236.
43. 271 Mich. App. 685, 724 N.W.2d 503 (2006).
44. *Id.* at 690, 724 N.W.2d at 507.
45. *Id.* at 690-91, 724 N.W.2d at 507.
46. *Id.*, 724 N.W.2d at 505.
47. *Id.* at 687, 724 N.W.2d at 505.
48. The four exceptions are: (1) the agent misrepresents the nature or extent of the coverage offered or provided, (2) an ambiguous request is made that requires a clarification, (3) an inquiry is made that may require advice and the agent, though he need not, gives advice that is inaccurate, or (4) the agent assumes an additional duty by either express agreement with or promise to the insured. *Id.*
49. *Pressey*, 271 Mich. App. at 687, 724 N.W.2d at 505.
50. *Id.* at 688, 724 N.W.2d at 505.

the court found that there was no genuine issue of material fact as to whether the nature or extent of coverage was misrepresented.[51]

The plaintiffs argued that the second exception applied because their request for "contents coverage" was an ambiguous request that required clarification.[52] The court rejected this argument, as well, finding that the "plaintiffs' request for contents coverage was not a request for an inexact or nonexistent type of coverage. It was a request for a specific and available additional policy."[53] Accordingly, "plaintiffs' request to add contents coverage did not implicitly require a change from a builder's risk policy to a business/commercial policy, nor did it require further clarification."[54]

The plaintiffs also argued that the third exception applied because the defendant's employee "gave them inaccurate advice regarding" contents coverage and telling plaintiffs that "they needed an occupancy permit" before the policy could be switched to a business/commercial policy.[55] The agent explained to the plaintiffs that "insureds, customarily, wait until the occupancy permit has been obtained, a package written and then the contents brought in."[56] The court noted that while the evidence demonstrated than an "occupancy permit was not explicitly required before the policy could be changed . . . as a practical matter, the applicable business/commercial policy could only be written if the premises were occupied for their intended purpose and, to be so occupied, an occupancy permit was required."[57] The court therefore rejected plaintiffs' argument that inaccurate information was given "in response to an inquiry."[58]

Finally, the plaintiffs argued that the fourth exception applied because the defendant assumed a duty to switch the policy form a builder's risk policy to a business/commercial policy once the plaintiffs started putting furniture in the hotel.[59] However, as was the case with the first exception, the court rejected the plaintiffs' argument, finding that no such promise was made.[60] The court, therefore, affirmed the grant of summary disposition in favor of the agency.[61]

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51. *Id.* at 688, 724 N.W.2d at 506.
52. *Id.*
53. *Id.* at 689, 724 N.W.2d at 506.
54. *Id.*
55. *Pressey*, 271 Mich. App. at 689, 724 N.W.2d at 506.
56. *Id.* at 690, 724 N.W.2d at 506.
57. *Id.* at 690, 724 N.W.2d at 506-07.
58. *Id.* at 690, 724 N.W.2d at 507.
59. *Id.*
60. *Id.*
61. *Pressey*, 271 Mich. App. at 690-91, 724 N.W.2d at 507.

C. Foreign Insurer Taxation

Another issue of statutory interpretation was presented in *Prudential Property & Casualty Insurance Co. v. Department of Treasury*.[62] Again, the Michigan Court of Appeals adhered to the plain language of the statute. The case involved interpretation of various provisions of Michigan's single business tax (SBT).[63] Pursuant to MCL sections 500.476a and 500.476b, Prudential was required to "calculate its tax under the SBT and then create a hypothetical company, mimetic in all things except its state of origin, and send it back to New Jersey to be taxed."[64] Under the statute, "[i]f [Prudential's] imaginary Michigan twin would theoretically pay more to New Jersey than [Prudential] was required to pay under Michigan's SBT, then [Prudential] must pay the amount its twin would have paid in New Jersey."[65]

The case arose because Prudential offset its "twin's" New Jersey tax obligations with SBT credits.[66] The credits in question were "credits for mandatory payments to Michigan insurance associations and facilities."[67] The court, applying the language of the statute, found that "neither credit is permitted because the credit is an SBT credit that should never factor into the calculation of the home state's financial burden on Michigan insurers."[68]

However, Prudential raised what the court termed a "compelling corollary argument."[69] Prudential argued that the defendant's analysis of the tax credits was incorrect because it failed to account for the fact that New Jersey provided Michigan insurers with a tax credit for association payments.[70] The court, after a lengthy discussion, ultimately concluded:

In this case, however, plaintiffs did not claim the association-fee tax credits that their home states allowed, but instead took SBT credits on the basis of the fees they paid to Michigan associations. This was neither an application of their home states' laws, nor a permissible action under Michigan law. It did not achieve similarity between them and their hypothetical twins, but skewed the analysis in their favor. . . . To correctly apply the law, it must be assumed that the hypothetical company completed the same transactions in the foreign state that the insurer completed in Michigan.[71]

62. 272 Mich. App. 269, 725 N.W.2d 477 (2006).
63. *Id.* at 271, 725 N.W.2d 477.
64. *Id.*
65. *Id.*
66. *Id.* at 271-72, 725 N.W.2d at 478.
67. *Id.* at 272, 725 N.W.2d 477.
68. *Prudential*, 272 Mich. App. at 272, 725 N.W.2d at 478.
69. *Id.* at 273, 725 N.W.2d at 479.
70. *Id.*
71. *Id.* at 281, 725 N.W.2d at 483-84.

D. Homeowners Insurance

One of the growing trends in insurance coverage cases, and contract interpretation in general, is the use of dictionary definitions to interpret undefined words or phrases in policies. This was the case in *Brown v. Farm Bureau General Insurance Co. of Michigan*.[72] The plaintiff insured rented a forklift to move materials on her property.[73] The plaintiff's son was operating the forklift with the assistance of Joseph Burlingame III until it got stuck in the mud.[74] While trying to free the forklift, the plaintiff's son lowered the forklift boom onto Burlingame, who was severely injured.[75] Burlingame filed suit against the plaintiff and her son, among others.[76] Farm Bureau refused to defend and indemnify the plaintiff under her home owners' policy, and the plaintiff filed a declaratory judgment action.[77] The trial court ruled that Farm Bureau did not owe any coverage based upon an exclusion for "motorized land conveyances."[78] The issue before the court, therefore, was whether the trial court properly determined that the forklift was a "motorized land conveyance" within the meaning of the policy.[79]

The court noted the general rule that "[e]xclusionary clauses in insurance policies are strictly construed in favor of the insured. Coverage under a policy is lost if any exclusion in the policy applies to an insured's particular claims."[80] The Farm Bureau policy did not define the term "conveyance."[81] Therefore, the court sought to give the word its "commonly understood meaning."[82] To accomplish this, the court turned to a dictionary, which defined "conveyance" as "1. the act of conveying. 2. a means of transporting, [especially] a vehicle. 3. a. the transfer of property from one person to another. b. the document accomplishing this."[83] The court also looked to cases from other jurisdictions which had interpreted the phrase "motorized land conveyances," including from South Dakota, New Jersey, Wisconsin, and Iowa for guidance.[84]

Taking into account the dictionary definition as well as case law from other jurisdictions, the court held that:

72. 273 Mich. App. 658, 662, 730 N.W.2d 518, 521 (2007).
73. *Id.* at 659, 730 N.W.2d at 520.
74. *Id.* at 659-60, 730 N.W.2d at 520.
75. *Id.* at 660, 730 N.W.2d at 520.
76. *Id.*
77. *Id.*
78. *Brown*, 273 Mich. App. at 661, 730 N.W.2d at 520.
79. *Id.*
80. *Id.* at 661, 730 N.W.2d at 521.
81. *Id.* at 662, 730 N.W.2d at 521.
82. *Id.*
83. *Id.*
84. *Brown*, 273 Mich. App. at 662, 730 N.W.2d at 521.

> [T]he disputed forklift, a "Gradall Motorized Sky Tracker," is a motorized land conveyance. It is designed to move materials from one point to another. It operates with a diesel engine and is equipped with a seat belt. It operates in both forward and reverse directions, and it can reach a speed of up to 19.5 miles an hour. It has multiple steering functions, brakes, and two mirrors. The forklift also has four-wheel drive, making it capable of traversing construction sites. It is equipped with a horn and roll-over protection, and can hold 38 gallons of fuel. It is also designed to carry the operator. Clearly, under the commonly understood meaning of the phrase, a forklift is a motorized land conveyance.[85]

In affirming the trial court's decision to grant summary disposition, the court also rejected the argument that the exclusion could not apply because "coverage for a forklift is generally not available under an automobile policy and the intent behind the exclusion is to eliminate coverage when coverage would be available under another policy."[86] Applying the court's definition, would the plaintiff have been able to secure insurance for operation of the forklift under any circumstances?

The *Survey* period also found the court determining issues related to home owners' policies such as an insured's duty to inquire about change in coverage,[87] and whether a home owners' insurer could recover from its insured's no fault insurer for a fire in the insured's home auto repair garage.[88]

E. Life Insurance

In *Book v. Monumental Life Insurance Co.*,[89] the court considered whether death by autoerotic asphyxiation constituted "self-inflicted injury" under a life insurance policy exclusion.[90] The opinion was remarkable in that it was rather brief, even though the court noted that "jurisdictions are split over the injury issue."[91] Normally, when deciding an issue over which jurisdictions are split, the court notes the competing positions

85. *Id.* at 663-64, 730 N.W.2d at 522.

86. *Id.* at 664 n.1, 730 N.W.2d at 522 n.1.

87. *See* Casey v. Auto Owners Ins. Co., 273 Mich. App. 388, 396, 729 N.W.2d 277, 284 (2007) (finding that "insured knowingly abrogated his duty to inquire about the change in his coverage, thereby implicitly accepted the new coverage limits).

88. *See* Allied Prop. & Cas. Ins. Co. v. Pioneer State Mutual Ins. Co., 272 Mich. App. 444, 450, 726 N.W.2d 83, 86 (2006) (finding that home auto repair constituted "course of a business of repairing, servicing, or otherwise maintaining motor vehicles," such that no fault insurer would not be liable for damages to home).

89. 271 Mich. App. 564, 723 N.W.2d 208 (2006).

90. *Id.* at 565, 723 N.W.2d at 209.

91. *Id.*

and offers a detailed rationale for its choice of one view over the other.[92] That did not occur in this case.

The decedent hung himself from his basement ceiling with a padlocked chain.[93] The court noted that "[h]e knew the risk of death, because a friend had died in a similar fashion."[94] The "[d]ecedent was apparently standing on his tiptoes on a board atop a stool when the stool broke, leaving him to hang to death."[95] The plaintiff argued that the broken stool was the cause of death, but the court tersely stated "it was decedent's own effort to deprive his brain of oxygen that ultimately led to his death."[96]

The court, after noting that "jurisdictions are split over the injury issue,"[97] relied on the rationale of *MAMSI Life & Health Insurance Company*,[98] a Maryland case. The court stated:

> [H]ere, decedent sought the sensations created by his self-induced hypoxia, and he used the chain as a noose for this purpose. His death resulted from his inability to extricate himself from the noose when his support gave way, so the death resulted from (and, more accurately, was an overextension of) his self-inflicted injury.[99]

In so holding, the court drew a distinction between autoerotic asphyxiation and dangerous activities such as "holding one's breath under water, bungee jumping, smoking tobacco, and drinking alcohol."[100] The court stated that, with autoerotic asphyxiation, "[t]he individual is not seeking to change the brain's perception through an external or internal intoxicant, but trying to suffocate it in a controlled, measured manner."[101]

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92. Indeed, whether autoerotic asphyxiation is a self-inflicted injury is an issue which continues to divide the courts. *See, e.g.*, Padfield v. AIG Life Ins. Co., 290 F.3d 1121, 1127 (9th Cir. 2002) (finding auto-erotic asphyxiation not suicide); Critchlow v. First UNUM Life Ins. Co. of Am., 378 F.3d 246, 262 (2nd Cir. 2003) ("That decedent had engaged in this very activity on prior occasions without apparently serious or permanent adverse consequences does not mean that the activity did not injure him, nor does the fact that he did not intend to die make the injury any less intentional."); MAMSI Life & Health Ins. Co. v. Callaway, 825 A.2d 997, 1007 (Md. 2003) (finding autoerotic asphyxiation to be self-inflicted injury). *See also* Sam Erman, Note, *Word Games: Raising and Resolving the Shortcomings in Accident-Insurance Doctrine that Autoerotic-Asphyxiation Cases Reveal*, 103 MICH. L. REV. 2172 (2005).

93. *Book*, 271 Mich. App. at 565, 723 N.W.2d at 209.

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. 825 A.2d 997 (Md. 2003).

99. *Book*, 271 Mich. App. at 566, 723 N.W.2d at 210.

100. *Id.* at 565 n.1, 723 N.W.2d at 210 n.1.

101. *Id.*

It would seem that the court's holding in *Book* might raise several issues in subsequent cases when the facts differ slightly. For example, what would the court make of a case where a skydiver's parachute malfunctioned (as the stool malfunctioned here), leading to the skydiver's death? Would the court find the malfunctioning parachute to be the cause, or the skydiver's own effort to simulate the sensation of falling to one's death in a controlled, measured manner? What if a friend's same brand parachute had malfunctioned or the skydiver had received a recall notice from the parachute manufacturer and had ignored it?

F. Uninsured Motorist

The *Survey* period saw two court of appeals cases addressing the applicability of *Rory v. Continental Insurance Co.*,[102] which reached differing results. The cases of *West v. Farm Bureau General Insurance Co.*[103] and *McGraw v. Farm Bureau General Insurance Co.*,[104] underscore the court's difficulty in construing and applying Supreme Court precedent which may overrule existing precedent or establish a new rule of law.

In *West,* the court was faced with the issue of whether to apply the holding of *Rory* retroactively.[105] The "plaintiff Jane West was injured in an automobile accident on June 20, 1999."[106] She had insurance through Farm Bureau, which contained a clause stating that "[n]o claimant may bring a legal action against the company more than one year after the date of the accident."[107] The action was not commenced until September 5, 2002.[108] The trial court denied Farm Bureau's motion for summary disposition based upon the one-year limitations period, finding that the provision was tolled because Farm Bureau had never formally denied plaintiff's claim.[109]

The court of appeals initially affirmed the trial court's decision basing its rationale on the concept of judicial tolling expressed in *Tom Thomas Organization, Inc. v. Reliance Insurance Co.*[110] [111] Farm Bureau filed an application to the Supreme Court, and the Supreme Court held the application "in abeyance pending its decision in *Rory*."[112] After *Rory* was decided, the Supreme Court remanded the case to the court of ap-

102. 473 Mich. 457, 703 N.W.2d 23 (2005).
103. 272 Mich. App. 58, 723 N.W.2d 589 (2006).
104. 274 Mich. App. 298, 731 N.W.2d 805 (2007).
105. *West*, 272 Mich. App. at 59-60, 723 N.W.2d at 590.
106. *Id.* at 60, 723 N.W.2d at 590-01.
107. *Id.* at 60, 723 N.W.2d at 591.
108. *Id.*
109. *Id.* at 61, 723 N.W.2d at 591.
110. 396 Mich. 588, 242 N.W.2d 396 (1976) (overruled by *Rory*, 473 Mich. 457, 703 N.W.2d 23 (2005)).
111. *West*, 272 Mich. App. at 61, 723 N.W.2d at 591.
112. *Id.* at 61, 723 N.W.2d at 591.

peals for consideration in light of *Rory*.[113] On remand, the court addressed two principal issues.[114] The first issue was whether *Devillers* applied to case;[115] the second was whether *Rory* should be applied retroactively.[116]

Although the Supreme Court in *Devillers v. Auto Club Ins. A'ssn*[117] expressly noted that its decision was to be applied retroactively, the court found that *Devillers* was limited to an interpretation of the No Fault Act, while the present case concerned interpretation of a contractual limitations period.[118] Therefore, the court found that *Devillers* did not apply, and then turned its attention to *Rory*.[119]

The court recognized that if it concluded that *Rory* applied retroactively, then it was constrained to rule in favor of Farm Bureau.[120] The court noted that if a decision:

> [C]learly establish[es] a new principle of law, then a court must weigh three factors to decide whether a judicial decision warrants prospective application: (1) the purpose to be served by the new rule, (2) the extent of reliance on the old rule, and (3) the effect of retroactive application on the administration of justice.[121]

The court, examining the first factor, noted "the purpose of the new rule is to put all insureds, including claimants, on notice regarding how insurers will handle insurance claims without penalizing those who have relied on past practices."[122] Turning to the second factor, the court stated that the "*Tom Thomas* tolling doctrine had shaped the insurance practice for nearly [thirty] years."[123] Finally, turning to the third factor, the court found that:

[T]he effect of retroactively applying *Rory* in this context offends the administration of justice because it creates a windfall for the insurers to the detriment of the insureds. Under *Tom Thomas*, the usual insurance practice included a notification of a claim by an insured followed by the passage of time insurers used to gather information in order to make informed decisions resulting in either settling claims or denying claims. By retroactively applying *Rory*, insurers unfairly benefit from the delay they

113. *Id.*
114. *Id.* at 62, 723 N.W.2d at 591-92.
115. *Id.* at 64, 723 N.W.2d at 592.
116. *Id.* at 65, 723 N.W.2d at 593.
117. 473 Mich. 457, 703 N.W.2d 23 (2005).
118. *West*, 272 Mich. App. at 65, 723 N.W.2d at 593.
119. *Id.*
120. *Id.* at 65-66, 723 N.W.2d at 593.
121. *Id.* at 66, 723 N.W.2d at 594.
122. *Id.* at 67, 723 N.W.2d at 594.
123. *Id.*

participated in creating during the adjustment process while, concomitantly, claimants suffer without recourse.[124]

Accordingly, the court found that *Rory* could not be applied retroactively and again affirmed the trial court decision.[125]

The court was faced with another challenge to *Rory* in *McGraw*.[126] *McGraw* involved a challenge to a one-year contractual limitation for underinsured benefits against the backdrop of the OFIS Commissioner's Order prohibiting the use of such contractual provisions.[127] The plaintiff was injured in an automobile accident on January 6, 2003.[128] Plaintiff had underinsured coverage through Farm Bureau, with a provision which stated:

> Any person seeking Family Protection Coverage must:
>
> > (a) present the claim for compensatory damages according to the terms and conditions of this coverage and policy; and
> >
> > (b) present to us a written notice of the claim for Family Protection Coverage within one year after the accident occurs.
>
> A suit against us for Family Protection Coverage may not be commenced later than one year after the accident that caused the injuries being claimed, unless there has been full compliance with the provisions of paragraphs (a) and (b), above.[129]

The plaintiff submitted a written application for no fault benefits on February 3, 2003, but never notified Farm Bureau of her claim for underinsured benefits.[130] Plaintiff commenced suit against Farm Bureau on June 21, 2005.[131]

On December 16, 2005, the OFIS Commissioner issued Notice and order of Prohibition 05-060-M regarding uninsured motorist coverage (the "Notice and Order").[132] The Notice and Order specifically noted that it agreed with the court of appeals in *Rory*, rather than the Supreme Court.[133] The Notice and Order found "that a one-year limitation period

124. *West*, 272 Mich. App. at 67-68, 723 N.W.2d at 594-95.
125. *Id.* at 68, 723 N.W.2d at 595.
126. *See McGraw*, 274 Mich. App. at 303, 731 N.W.2d at 808.
127. *See id.* at 303-04, 731 N.W.2d at 808.
128. *Id.* at 299, 731 N.W.2d at 806.
129. *Id.* at 300-01, 731 N.W.2d at 806.
130. *Id.* at 300, 731 N.W.2d at 806.
131. *Id.* at 301, 731 N.W.2d at 807.
132. *McGraw*, 274 Mich. App. at 301, 731 N.W.2d at 807.
133. *Id.* at 304, 731 N.W.2d at 808.

for making claims or filing suit for uninsured motorist benefits is unreasonable."[134] It further stated that insurance companies:

> "[S]hall not issue, advertise, or deliver to any person in this state a policy or rider that limits the time to file a claim or commence suit for uninsured motorist benefits to less than three years unless [the insurance company] was legally using that policy or rider form in Michigan prior to the date of this notice . . . ."[135]

The trial court, relying on the Notice and Order, denied Farm Bureau's motion for summary disposition, holding that "the one-year limitation in the insurance contract at issue in this case may be unenforceable on grounds of public policy . . . ."[136] The court rejected this argument, noting that the Notice and Order expressly states that it did not apply retroactively, and, consequently, could not apply to the policy at issue.[137] The court then turned to whether it was bound by the *West* panel's conclusion that *Rory* was not to apply retroactively.[138] The court distinguished *West*, stating that:

> *West*'s narrow holding – that *Rory* does not apply retroactively – applies only to those situations involving failure to file a lawsuit within the one-year contractual limitation period, as opposed to the situation in this case where there was a failure to give notice of a claim to the insurance company."[139]

Thus, the court reversed the trial court's denial of Farm Bureau's motion.[140]

An interesting development stemming from the *Rory* decision is the impact the Notice and Order may have on future disputes concerning the contractual limitations period. Of note is the Commissioner's disagreement with the Supreme Court regarding the reasonableness of the one-year limitations period. One of the foundations of the Supreme Court's holding in *Rory* is the fact that the Commissioner "approved" the use of the one-year limitations period, due to the Commissioner's failure to act within the requisite time period. How would *Rory* have been decided if the Commissioner had issued her directive before the decision? Does the Commissioner or anyone in her office actually read the policies that insurers file and use? Is the conclusion that the Commissioner has "approved" a policy that an insurer files and uses reasonable?

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134. *Id.*
135. *Id.* at 301, 731 N.W.2d at 807.
136. *Id.* at 302, 731 N.W.2d at 807.
137. *Id.* at 304-05, 731 N.W.2d at 809.
138. *McGraw*, 274 Mich. App. at 305, 731 N.W.2d at 809.
139. *Id.* at 305, 731 N.W.2d at 809.
140. *Id.* at 306, 731 N.W.2d at 809.

Another uninsured motorist case which evidenced the court's interpretation trends was *Cole v. Auto-Owners Insurance Co.*[141] In *Cole*, the court was faced with an issue of first impression, to wit: whether a bicyclist was a "pedestrian" for purposes of an uninsured motorist policy.[142] The term "pedestrian" was not defined in the policy, so once again the court turned to the dictionary definition of the term.[143] The court cautioned that "a word is not ambiguous simply because dictionary definitions differ."[144] The court stated that:

> [T]he plain and ordinary meaning of the term pedestrian, as defined in *Random House Webster's College Dictionary* (1997), is a person who goes or travels on foot. The term pedestrian is not ambiguous, and, under its common meaning, plaintiff was not a pedestrian under the policy because he was riding a bicycle at the time of the accident.[145]

Because uninsured and underinsured motorist coverage is not regulated, how far will insurers go in creating limitations and exclusions to these coverages? For example, what is the value of underinsured motorist coverage of $20,000, currently offered by one insurer, when the financial responsibility minimum is $20,000? Could the insurer ever owe any insurance coverage?

G. No-Fault Insurance

The long reach of *Devillers* was evident in the case of *Liptow v. State Farm Mutual Auto Insurance Co.*[146] In *Liptow*, the court considered the interplay between the statute providing that actions brought on behalf of the State of Michigan are not subject to the statute of limitations, and the one year statute of limitations and one-year-back provision of Michigan's No Fault Act.[147] On February 1, 1994, five-year-old pedestrian Jelinda Burnette-Liptow was severely injured in an accident with an automobile in North Carolina.[148] After the accident, she was transferred to Michigan, where she received treatment from the Michigan Department of Community Health (MDCH) until her death in 2002.[149]

141. 272 Mich. App. 50, 723 N.W.2d 922 (2006).
142. *Id.* at 51, 723 N.W.2d at 923.
143. *Id.* at 53-54, 723 N.W.2d at 923-24.
144. *Id.* at 54, 723 N.W.2d at 924.
145. *Id.* at 54, 723 N.W.2d at 924-25.
146. 272 Mich. App. 544, 726 N.W.2d 442 (2006).
147. *Id.* at 548, 726 N.W.2d 445.
148. *Id.* at 546, 726 N.W.2d 442.
149. *Id.*

On January 16, 2003, Liptow's mother commenced an action against State Farm, seeking recovery of no fault benefits.[150] MDCH intervened, seeking recovery of Medicaid payments that it made on Liptow's behalf.[151] State Farm filed a motion for summary disposition, arguing that the action was barred by both the one-year statute of limitations and the one-year back rules of MCL section 500.3145(1).[152] The trial court denied State Farm's motion.[153]

On appeal, the court noted that the one-year statute of limitations could not apply to MDCH pursuant to the clear language of the statute.[154] The court then examined the impact of *Devillers* and the one-year back provision on MCL section 600.5821(4).[155] The court held that MCL section 600.5821(4) could not be used to toll the one-year back provision, stating:

> MCL 600.5821(4) provides that actions brought by the state or its subdivisions to recover the cost of maintenance, care, and treatment of persons in state institutions "are not subject to the statute of limitations and may be brought at any time without limitation, the provisions of any statute notwithstanding." We conclude that, by the plain import of this language, the Legislature intended to exempt the state from statutes of limitations when bringing an action to recover public funds. The language refers to statutes of limitations and provides that an action may be brought at any time. But the statute does not address damage limitation provisions or any other limiting provisions. In other words, like the minority tolling provision, MCL 600.5821(4) concerns the *time* during which the state may bring an action; it "does not pertain to the damages recoverable once an action has been brought."[156]

Accordingly, the court held that MDCH can only recover funds which State Farm paid in the year immediately preceding the filing of the lawsuit pursuant to MCL section 500.3145(1).[157]

Still another question of statutory interpretation was presented to the court in *Miller v. Allstate Insurance Co.*[158] The court noted that the "sole

150. *Id.*
151. *Id.* at 547, 726 N.W.2d at 444.
152. *Liptow*, 272 Mich. App. at 547, 726 N.W.2d at 444.
153. *Id.* at 548, 726 N.W.2d at 445.
154. *Id.* at 554, 726 N.W.2d at 448.
155. *See id.* at 555-56, 726 N.W.2d at 449.
156. *Id.* at 555-556, 726 N.W.2d at 449 (citing Cameron v. Auto Club Ins. Ass'n, 476 Mich. 55, 718 N.W.2d 784 (2006)).
157. *Id.* at 556, 726 N.W.2d at 449.
158. 272 Mich. App. 284, 726 N.W.2d 54 (2006), *vacated*, 477 Mich. 1062, 728 N.W.2d 458 (2007), *appeal granted*, 480 Mich. 938, 741 N.W.2d 19 (2007).

issue" in the appeal was "whether the trial court erred in finding that PT Works was entitled to receive insurance benefits from Allstate under the no-fault act, MCL sections 500.3101 et seq., for physical therapy services provided by PT Works to plaintiff William Miller, who was insured by Allstate and injured in a motor vehicle accident."[159] The statute at the epicenter of this case, MCL section 500.3157, provides:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.[160]

Allstate argued that PT Works did not "lawfully render" services because its shareholders were not licensed physical therapists and the corporation was formed under the Business Corporation Act, instead of the Professional Service Corporation Act.[161] There was no dispute, however, that the treatment received by Miller was performed by licensed physical therapists.[162]

Focusing its analysis once again on the plain language of the statute, the court rejected Allstate's argument.[163] The court stated that the statute required only that the "treatment itself be lawfully rendered."[164] The court found that "[r]eference to the terms 'rendering' and 'treatment' clearly places the focus on the act of actually engaging in the performance of services, here conducting physical therapy sessions, rather than on some underlying corporate formation issues that have nothing to do with the rendering of treatment."[165] Put another way, the court stated that "[t]he connection between the rendering of treatment and the manner in which PT Works was incorporated and the nature of the incorporation is too attenuated to make the physical therapy provided to Miller an unlawfully rendered service."[166] The court, therefore, affirmed the grant of summary disposition to PT Works.

An important issue regarding appearance at an Independent Medical Examination (IME) was presented in *Roberts v. Farmers Insurance Ex-*

159. *Id.* at 285, 726 N.W.2d at 56.
160. MICH. COMP. LAWS ANN. § 500.3157 (West Supp. 2002).
161. *Miller*, 272 Mich. App. at 286, 726 N.W.2d at 56.
162. *Id.*
163. *Id.*
164. *Id.* at 287, 726 N.W.2d at 56-57.
165. *Id.* at 287, 726 N.W.2d at 57.
166. *Id.* at 288, 726 N.W.2d at 57.

change.[167] On December 11, 2002, 12-year-old Brittany Underwood and her mother, the plaintiff, were involved in an automobile accident.[168] The plaintiff alleged that Brittany sustained a closed head injury and "other physically debilitating injuries."[169] In April 2003, Brittany was examined by Dr. Jacobus Donders, who noted that Brittany reported "[r]ight frontal headaches that radiate to the neck and shoulders; apparently pressure-tension type."[170] In December, 2003, Brittany failed to appear at the Hospital twice for counseling.[171]

In 2004, Brittany repeatedly failed to attend IMEs scheduled by Farmers. The court noted the following history:

> On January 8, 2004, a physical IME of [Brittany] was scheduled for January 26, 2004. On January 19, 2004, Farmers scheduled a neuropsychological IME, for January 28, 2004, in Grand Rapids. According to Farmers, Roberts cancelled the neuropsychological IME on January 22, 2004.
>
> On January 22, 2004, the psychological IME was rescheduled for February 27, 2004, with Dr. Robert Fabiano, Ph.D., in Grand Rapids.
>
> On January 26, 2004, Roberts both called to cancel [Brittany's] physical IME and rescheduled it for February 9, 2004. Roberts then cancelled the February 9, 2004 appointment.
>
> On February 9, 2004, the psychological exam was rescheduled for March 17, 2004. Also on February 9, 2004, the physical IME was rescheduled for February 19, 2004, with Dr. Olejniczak in Grand Rapids. Roberts and [Brittany] attended the February 19, 2004, physical IME.
>
> [Brittany] failed to appear for either the February 27, 2004, neuropsychological examination or the March 17, 2004, neuropsychological examination. On March 25, 2004, the neuropsychological examination was rescheduled for April 23, 2004, with Dr. Fabiano. On April 22, 2004, the day before the neuropsychological examination, Roberts cancelled the appointment. Farmers was assessed a $250 late cancellation fee.
>
> On April 27, 2004, Farmers rescheduled Dr. Fabiano's examination for May 21, 2004. Dr. Fabiano indicated that if the patient again failed to appear or cancelled after May 14, 2004, he would assess a no-show/cancellation charge of $1,000. Accordingly, Farmers sent [Brittany] a letter in care of Roberts indicating: "If you fail to attend this appointment, or you cancel this appointment after 5/14/04, you will be responsible for any and all no-show/cancellation fees incurred by you at a

167. 275 Mich. App. 58, 737 N.W.2d 332 (2007).
168. *Id.* at 59, 737 N.W.2d at 335.
169. *Id.*
170. *Id.* at 60, 737 N.W.2d at 335.
171. *Id.*

rate of $1,000.00." [Brittany] broke the May 21, 2004, appointment, so Dr. Fabiano charged Farmers the $1,000 fee.[172]

Due to the repeated failures to attend the IMEs, Farmers cancelled Brittany's no fault benefits effective May 21, 2004.[173] On July 13, 2004, the plaintiff's attorney wrote to Farmers requesting reinstatement of the benefits.[174] Farmers responded that it would reschedule the IME if it received the $1,000 no-show/cancellation fee.[175] On August 20, 2004, the plaintiff filed a complaint, asserting that Farmers "has refused or is expected to refuse to pay Plaintiff all personal protection benefits in accordance with the applicable no-fault and contract provisions."[176] On October 19, 2004, Farmers filed a third-party complaint against Roberts individually, claiming that, as a result of Roberts's failure to produce Brittany for an IME, Farmers "has incurred $1,000 in no show fees."[177]

After the parties filed motions for summary disposition, the trial court entered an order granting plaintiff's motion for declaratory judgment, summary disposition and sanctions, providing that:

> (1) Farmers' refusal to reinstate benefits absent payment of $1,000 was unreasonable; (2) plaintiff's counsel shall submit his bill for fees to Farmers; (3) Farmers shall reinstate [Brittany's] no-fault benefits; (4) [Brittany] shall submit to an IME; and (5) the issue of compensability of Brittany Underwood's past, present and/or future medical expenses remains for future determination by this Court.[178]

The trial court also ruled that the plaintiff was responsible to pay the $1,000 fee.[179]

Farmers argued to the court of appeals that the trial court erred in awarding attorney fees.[180] The court noted that "[t]he purpose behind the no-fault act's attorney-fee penalty provision is to ensure that the insurer promptly makes payment to the insured."[181] The refusal or delay must be unreasonable.[182] However, "[a] refusal or delay in payment by an insurer will not be found unreasonable within the meaning of § 3148(1) where the refusal or delay is the product of a legitimate question of statutory

172. *Id.* at 60-61, 737 N.W.2d at 335-36.
173. *Roberts*, 275 Mich. App. at 61, 737 N.W.2d at 336.
174. *Id.*
175. *Id.*
176. *Id.* at 61-62, 737 N.W.2d at 336.
177. *Id.* at 63, 737 N.W.2d at 337.
178. *Id.* at 65, 737 N.W.2d at 338.
179. *Roberts*, 275 Mich. App. at 65, 737 N.W.2d at 338.
180. *Id.* at 67, 737 N.W.2d at 339.
181. *Id.*
182. *Id.*

construction, constitutional law, or a bona fide factual uncertainty."[183] The court stated:

Farmers had a statutory right to require that [Brittany] undergo physical and psychological IMEs. MCL 500.3151 provides: "*When the mental or physical condition of a person is material to a claim* that has been or may be made for past or future personal protection insurance benefits, *the person shall submit to mental or physical examination by physicians*." (Emphases added). "Shall" is mandatory . . . . The statute provides no penalty for a claimant's breach of her duty to submit to IMEs; therefore, Farmers raises a legitimate statutory question regarding the appropriate consequences of [Brittany's] breach of her statutory duty. Because Farmers had a legitimate question of statutory construction, its suspension of benefits to [Brittany] was reasonable.[184]

Therefore, the court held that "where a claimant repeatedly breaches her statutory duty to submit to IMEs, an insurer may properly suspend benefits pending completion of any requisite IME. Otherwise, an insured could breach with impunity his or her duty to submit to IMEs, and the insurer would have no way of investigating whether the injury claims were legitimate."[185] The court reversed the trial court's award of attorney fees.[186]

The court also considered an issue of the priority of no fault insurers in a van-motorcycle accident in *Farmers Insurance Exchange v. Farm Bureau General Insurance Company of Michigan*.[187] Rory Ostentowski was on a motorcycle when he was struck by a van driven by Lynn Smith, which was owned by Smith and John Petiprin.[188] The van was uninsured at the time of the accident due to failure to pay premium.[189] Apparently, Petiprin had a valid no-fault policy, but it did not list Smith as an insured and it did not list the van involved in the accident.[190] Ostentowski applied for no faulty benefits through the Assigned Claims Facility, who assigned the claim to Farmers.[191] Farmers sought reimbursement from Farm Bureau, who it argued had a higher priority for paying benefits.[192]

The principal issue presented to the court was "whether MCL section 500.3114(5)(a) requires an insurer to pay an injured motorcyclist no-fault benefits when the insurer did not issue a policy covering the vehicle in-

183. *Id.*
184. *Id.* at 68-69, 737 N.W.2d at 339-40.
185. *Roberts*, 275 Mich. App. at 69, 737 N.W.2d at 340.
186. *Id.* at 75, 737 N.W.2d at 343.
187. 272 Mich. App. 106, 724 N.W.2d 485 (2006).
188. *Id.* at 108, 724 N.W.2d at 487.
189. *Id.*
190. *Id.*
191. *Id.*
192. *Id.*

volved in the accident."[193] To resolve this question, the court had to examine the language of MCL section 500.3114(5), which provides that:

> A person suffering accidental bodily injury arising from a motor vehicle accident which shows evidence of the involvement of a motor vehicle while an operator or passenger of a motorcycle shall claim personal protection insurance benefits from insurers in the following order of priority: (a) The insurer of the owner or registrant of the motor vehicle involved in the accident.[194]

The court examined the language of the statute, and even turned to a dictionary for a definition of the word "of."[195] The court ultimately determined that Farm Bureau was the highest priority insurer because it insured the owner of the van.[196] The court stated:

> Here, because defendant insured Petiprin, who owned the van involved in the accident, defendant is first in priority to provide benefits under MCL 500.3114(5)(a). Had the Legislature intended MCL 500.3114(5)(a) only to require an insurer to provide no-fault benefits if the insurer actually insured the motor vehicle involved in the accident, it could have chosen the following language for MCL 500.3114(5)(a): "The insurer of the motor vehicle involved in the accident," deleting the first prepositional phrase, "of the owner or registrant." Clearly, the Legislature did not choose that language, and for us to adopt defendant's position would be to render the phrase "of the owner or registrant" in the statute nugatory.[197]

The court once again evidenced its reluctance to interpret a statute in a manner at odds with its plain language, even given compelling policy rationale.

Other Michigan No Fault Act cases also evidence the court's trend of construing statutes pursuant to their plain language, and refusing to legislate from the bench. For example, the court has refused to incorporate into the no fault act "a provision that a relative who is domiciled in the same household as the insured-and is thus entitled to PIP benefits under MCL 500.3114(1)-should nonetheless be denied those benefits if the person is an illegal alien."[198] Also, in yet another case involving statutory interpretation, the court found that the no fault act did not apply to every

193. *Farmers*, 272 Mich. App. at 110, 724 N.W.2d at 488.
194. *Id.* at 111-12, 724 N.W.2d at 489.
195. *Id.* at 113, 724 N.W.2d at 489-90.
196. *Id.* at 113-14, 724 N.W.2d at 489-90.
197. *Id.* at 113-14, 724 N.W.2d at 490.
198. Cervantes v. Farm Bureau Gen. Ins. Co. of Michigan, 272 Mich. App. 410, 418, 726 N.W.2d 73, 77 (2006).

instance of "accidental damage to tangible property arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle," rather, "an insurer's duty to pay benefits for accidental damage to tangible property arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle is subject to the provisions of 3123, 3125, and 3127."[199]

Most Michigan No Fault decisions involve questions of statutory interpretation, as No Fault is a creature of statute. The court was called on to interpret the Michigan Catastrophic Claims Association (MCCA) in *United States Fidelity Insurance & Guaranty Company v. Michigan Catastrophic Claims Association*.[200] Insurers belonging to the MCCA are entitled to indemnification for PIP payments incurred in excess of the statutory threshold.[201] Thus, in practice, the MCCA "acts as a kind of 'reinsurer' for its member insurers."[202] The relevant statute provides that the MCCA "shall provide and each member shall accept indemnification for 100% of the amount of ultimate loss sustained under personal protection insurance coverages in excess of" the statutory threshold.[203]

The issue presented to the court was whether the MCCA is bound to reimburse the member insurer for the full amount of the ultimate loss regardless of whether the amount paid was reasonable.[204] The MCCA argued that requiring 100% indemnification without a showing of reasonableness would drive up the costs of insurance, contrary to the intent of the No Fault Act, and lead to an absurd and unjust result.[205] The court disagreed, and held that the statute was to be applied as written, regardless of whether the court felt that the result was unjust.[206] The court stated:

> [O]ur Supreme Court repudiated the use of the "absurd result" rule of statutory construction in a case such as this where the language of the statute is unambiguous. *People v. McIntire*, 461 Mich. 147, 155-158; 599 N.W.2d 102 (1999). The Supreme Court's decision in *McIntire* precludes this Court from utilizing rules of statutory construction to impose policy choices different from those selected by the Legislature. *Id.* at 152, 599 N.W.2d 102. "'[I]n our democracy, a legislature is free to make inefficacious or even unwise policy choices. The correction of these policy choices is not a judicial function as long as the legislative

199. Auto Club Ins. Ass'n v. Novi Car Wash, 273 Mich. App. 315, 318, 732 N.W.2d 544, 546 (2007).

200. 274 Mich. App. 184, 731 N.W.2d 481 (2007).

201. *Id.* at 196, 731 N.W.2d at 488.

202. *Id.* at 196, 731 N.W.2d at 488.

203. *Id.*

204. *Id.* at 189-90, 731 N.W.2d at 484-85.

205. *Id.* at 200-01, 731 N.W.2d at 490.

206. *Fidelity Insurance*, 273 Mich. App. at 202, 732 N.W.2d at 491.

choices do not offend the constitution.'" *Id.* at 159, 599 N.W.2d 102.[207]

Accordingly, the court found that the MCCA is bound to indemnify the member insurer for 100% of the ultimate loss, regardless of its own determination of "reasonableness."[208] Such a requirement is not found in the statute, and the court, pursuant to its framework for interpreting statutes, would not read such a requirement into the statute.[209]

The court also decided cases during the *Survey* period involving the No Fault Act, such as priority of insurers under MCL section 500.3114,[210] an award of attorney fees under MCL section 500.3148,[211] the interplay between the Michigan Consumer Protection Act and the No Fault Act,[212] the erroneous submission of the issue of future no fault benefits to the jury,[213] and an award of penalty interest under MCL section 500.3142.[214]

III. DECISIONS OF THE MICHIGAN SUPREME COURT

One of the most important cases coming from the Supreme Court during the *Survey* period was *Cameron v. Auto Club Insurance Association*,[215] which further revealed the philosophical division between the Justices.[216] Daniel Cameron, a minor, suffered a closed head injury resulting in a cognitive disorder when an automobile struck his bicycle in 1996.[217] Daniel's parents maintained a no-fault automobile insurance policy with Auto Club.[218] In 2002, when Daniel was sixteen, his parents filed suit on his behalf seeking PIP benefits for attendant care rendered to Daniel from August 1996 to August 1999.[219] Auto Club moved for summary disposition, arguing that the claim was barred by the one-year back rule of MCL section 500.3145(1).[220] The trial court denied the motion,

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207. *Id.* at 202-03, 731 N.W.2d at 491.

208. *Id.* at 204, 731 N.W.2d at 492.

209. *Id.*

210. Amerisure Ins. Co. v. Coleman, 274 Mich. App. 432, 733 N.W.2d 93 (2007).

211. Ivezaj v. Auto Club Ins. Ass'n, 275 Mich. App. 349, 737 N.W.2d 807 (2007).

212. Grant v. AAA Michigan/Wisconsin, Inc., 272 Mich. App. 142, 724 N.W.2d 498 (2006).

213. Rose v. State Farm Mutual Automobile Insurance Company, 274 Mich. App. 291, 732 N.W.2d 160 (2006).

214. Borgess Med. Ctr. v. Resto, 273 Mich. App. 558, 730 N.W.2d 738 (2007).

215. 476 Mich. 55, 718 N.W.2d 784 (2006).

216. The *Cameron* case was discussed in detail in the previous year's *Survey*. However, because the decision actually took place during this year's *Survey* period, the discussion bears repeating.

217. *Cameron*, 476 Mich. at 59, 718 N.W.2d at 787.

218. *Id.*

219. *Id.*

220. *Id.*

but the Court of Appeals reversed.[221] The Court of Appeals held that tolling under MCL section 600.5851(1) does not affect the one-year back rule of MCL section 500.3145(1).[222]

The Court granted leave to appeal to consider whether the minority/insanity tolling provision contained in MCL section 600.5851(1) applies to toll the one-year-back rule of MCL section 500.3145(1) of the No Fault Automobile Insurance Act.[223] The Michigan Court of Appeals had previously found that such tolling did not apply, but also noted that:

> [O]ne aspect of the legislative amendments of MCL 600.5851 . . . was to change the wording of the minority/insanity tolling provision in subsection 1 from stating that it applies to a person entitled to 'bring *an action*' to stating that it applies to a person entitled to 'bring *an action under this act*.' (Emphasis added.)"[224]

A majority of the Court[225] found that "we must assume that the thing the Legislature wants is best understood by reading what it said."[226] Because the language of the two statutes "is clear, no less clear is the policy. Damages are only allowed for one year back from the date the lawsuit is filed. We are enforcing the statutes as written."[227] The majority, however, vacated the portion of the Court of Appeals decision which discussed "the broader question whether the legislative amendments in 1993 PA 78 limit the applicability of the minority/insanity tolling provision to causes of action for which the applicable statute of limitations is set forth in the RJA."[228]

The majority then issued a response to the dissenting Justices,[229] continuing what is commonplace in a philosophically-divided Court. The majority stated:

> What this all comes down to is that the proponents of the dissents' positions who have petitioned this Court for assistance are simply in the wrong place. They should go the Legislature . . . . [A]s judges, we have read the statutes at issue without a thumb on the scale. We are willing to enforce what the Legislature has enacted. It is just plain wrong to say or imply that we are indifferent or hostile to the rights of the disabled. We are not. We are

221. *Id.*
222. *Id.*
223. *Cameron*, 476 Mich. at 60, 718 N.W.2d at 787.
224. *Id.* at 60 n.4, 718 N.W.2d at 787 n.4.
225. Justices Taylor, Corrigan, Young and Markman formed the majority, although Justice Markman authored a concurring opinion.
226. *Cameron*, 476 Mich. at 63, 718 N.W.2d at 789.
227. *Id.*
228. *Id.* at 64, 718 N.W.2d at 789.
229. Justices Kelly, Cavanagh and Weaver dissented.

> recognizing the right that the lawgivers gave them, and no Court should do more or less.[230]

Justice Markman authored a concurring opinion, in which he expressed concern that:

> [A]s a consequence of this decision, the protections afforded by the tolling provision may become increasingly illusory . . . . [A]lthough the tolling provision was intended to protect minors and insane persons, as a consequence of this decision, when such persons are injured in an accident in which others are also injured, they are likely to be undercompensated for equivalent medical expenses compared to other persons . . . . [That] the larger purpose of the tolling provision will be undermined . . . . [and] it will border on legal malpractice for an attorney ever to recommend reliance on the minority/insanity tolling provision.[231]

Justice Cavanagh authored the first dissenting opinion, and stated:

> This case is essentially the second installment of defendant's attempt to further immunize itself and other insurers from having to pay benefits indisputably owed to their injured insured – people who have diligently paid policy premiums with the expectation that, should they be injured, their insurer will reimburse them for all allowable expenses. While in *Devillers*[232] defendant targeted people who had not filed suit because of insurer delay, in this case, defendant targets infants and the legally incompetent.[233]

The dissenting Justices chastised the majority for applying too strict a construction and ignoring the Legislature's intent.[234] Justice Kelly felt that the interpretation proffered by the majority led to an absurd result.[235]

The Supreme Court sometimes focuses on issues which the parties to the case may deem irrelevant and which may not even be raised in the pleadings below. In *Michigan Chiropractic Council v. Commissioner of the Office of Financial and Insurance Services*,[236] the Supreme Court considered a challenge to a "Preferred Provider Option" by the plaintiff Michigan Chiropractic Council (the "Council").[237] The appellant-

230. *Cameron*, 476 Mich. at 66-67, 718 N.W.2d at 791.
231. *Id.* at 73-75, 718 N.W.2d at 794-95.
232. *Devillers*, 473 Mich. 562, 702 N.W.2d 539 (2005).
233. *Cameron*, 476 Mich. at 87, 718 N.W.2d at 801-02.
234. *Id.* at 109, 718 N.W.2d at 813-14.
235. *Id.* at 110-11, 718 N.W.2d at 814.
236. 475 Mich. 363, 716 N.W.2d 561 (2006).
237. *Id.* at 366, 716 N.W.2d at 564.

insurers offered a "Preferred Provider Option" (PPO) to their no fault policyholders, allowing the policyholders to pay a reduced premium in exchange for agreeing to receive treatment from a network of medical providers.[238] The PPO was entirely voluntary.[239] The Council claimed that the PPO violated the rights of both insureds and chiropractic providers.[240] The Supreme Court granted leave to appeal, and directed the parties to brief the issue of whether the Council had standing to challenge the PPO, even though this issue was not presented to the lower courts.[241] The Supreme Court cautioned that "questions of justiciability concern the judiciary's constitutional jurisdiction to adjudicate cases containing a genuine controversy . . . and may not be waived by the parties."[242] The Court noted that "[w]here a lower court has erroneously exercised its judicial power, an appellate court has 'jurisdiction on appeal, not of the merits but merely for the purpose of correcting the error of the lower court in entertaining the suit.'"[243]

The Court examined whether the Council had standing to vindicate the rights of insureds and chiropractors, noting that the rule of *jus tertii* ("litigating the rights of a third party") is disfavored.[244] However, the Court noted that there are exceptions to the general rule, and adopted the "traditional federal test for third-party standing."[245] The Court stated:

> A party seeking to litigate the claims of another must, as an initial matter, establish standing under the test established in *Lee* . . . . Second, the party must have a "close relationship" with the party possessing the right in order to establish third-party standing. Last, the litigant must establish that there is a "hindrance" to the third party's ability to protect his or her own interests.[246]

Turning the application of the rule to the facts before it, the Court found that "there is absolutely no evidence that any obstacle or hindrance prevents appellants' insureds from protecting their own interests through litigation."[247] Accordingly, the Court found that the Council lacked third-party standing to assert the rights of the insureds.[248]

The remaining question was whether the Council could advocate the rights of its member chiropractors.[249] The Court noted that "[a]s a non-

238. *Id.* at 367, 716 N.W.2d at 565.
239. *Id.*
240. *Id.* at 368, 716 N.W.2d at 565.
241. *Id.* at 369, 716 N.W.2d at 565-66.
242. *Michigan Chiropractic Council*, 475 Mich. at 374, 716 N.W.2d at 568-69.
243. *Id.* at 374, 716 N.W.2d at 569.
244. *Id.*
245. *Id.* at 375-77, 716 N.W.2d at 570.
246. *Id.* at 377-78, 716 N.W.2d at 570.
247. *Id.* at 378, 716 N.W.2d at 571.
248. *Michigan Chiropractic Council*, 475 Mich. at 378, 716 N.W.2d at 571.
249. *Id.* at 379, 716 N.W.2d at 571.

profit organization, petitioners have standing to litigate on behalf of their members to the degree that their members would have standing as individual plaintiffs."[250] However, the Court stated that "[r]eview of the record in this case reveals no evidence that any of petitioners' members have experienced an actual injury as a result of appellants' policy endorsement. Because petitioners seek relief for a hypothetical injury, the ripeness of the claim comes into question."[251]

Examining the ripeness of the claim, the Court determined that "[n]othing in the record before us indicates that petitioners' members have in fact been reimbursed at less than a reasonable amount."[252] Accordingly, the Court found that the Council's claim was "not ripe for review at this juncture and is not justiciable."[253]

Justice Kelly authored an opinion in which she concurred in the result only, and Justice Weaver concurred in the result but dissented from the majority's analysis.[254] Both Justice Kelly and Justice Weaver opined that the test for third-party standing prior to the adoption of the federal rule in *Lee v. Macomb County Board of Commissioners*[255] was sufficient. Specifically, Justice Weaver noted that the majority erred by "transforming the prudential doctrines of mootness and ripeness into constitutionally based doctrines that affect the jurisdiction of the Court."[256] Justice Weaver pointed to the distinction between the application of the doctrines in the state and federal courts:

> When the mootness and ripeness doctrines are viewed as prudential limits, a state court has *discretion* in applying those doctrines. By contrast, the "case or controversy" clause in U.S. Const. art. III, § 2 *requires* federal courts to dismiss cases that are not moot or not ripe. By transforming the doctrines of mootness and ripeness into constitutional requirements, the majority requires these doctrines to be treated as jurisdictional issues by the Michigan state courts as well.[257]

Justice Markman authored a long partial concurrence. Justice Markman opined that additional briefing was necessary with regard to the applicability of the majority's ripeness analysis. Justice Markman noted that the OFIS Commissioner had issued a "final order" and therefore three questions arose:

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250. *Id.*
251. *Id.* at 380, 716 N.W.2d at 572.
252. *Id.* at 381, 716 N.W.2d at 573.
253. *Id.* at 382, 716 N.W.2d at 573.
254. *Michigan Chiropractic Council*, 475 Mich. at 382-83, 716 N.W.2d at 573-74.
255. 464 Mich. 726, 629 N.W.2d 900 (2001).
256. *Michigan Chiropractic Council*, 475 Mich. at 383, 716 N.W.2d at 574.
257. *Id.* at 384-85, 716 N.W.2d at 574.

> (1) Does the fact that we are dealing with a "final decision[ ] . . . of [an] administrative officer or agency," Const. 1963, art. 6, § 28, authorize judicial review of the commissioner's order independently of the justiciability inquiry required for cases traditionally heard pursuant to the "judicial power"? . . . .[258]
>
> (2) Notwithstanding Const. 1963, art. 6, § 28, to what extent, if any, is the commissioner's decision subject to judicial review? . . .[259]
>
> (3) Of what significance are the commissioner's legal conclusions apart from his decision not to hold a contested-hearing case?[260]

Without briefing on these issues raised by Justice Markman, he did not join in the majority opinion with respect to the ripeness analysis.[261]

The Court also considered a question of coverage in *Citizens Insurance Company v. Pro-Seal Service Group, Inc.*[262] The issue presented to the Court was "whether defendant Pro-Seal Service Group, Inc.'s act of shipping a product in a competitor's packaging with Pro-Seal's labeling affixed to it constitutes an "'advertisement' for purposes of an insurance policy."[263] Pro-Seal was a Michigan company that sells and repairs mechanical seals used in Alaskan oil production facilities.[264] Pro-Seal was insured by Citizens, and their major competitor in Alaska was Flowserve Corporation.[265] In June 2003, a Flowserve employee discovered that two Flowserve seals had been repaired by Pro-Seal and were being shipped to a customer in Flowserve's packing with the name "Pro-Seal" affixed to the outside of the container.[266] Flowserve brought suit, claiming that "Pro-Seal created confusion in the marketplace by imitating or infringing trademarks or product marks, and by using trade secrets, blueprints, engineering drawings, packaging materials, and sales practices that misrepresented Pro-Seal seals as being Flowserve seals."[267] Citizens refused to defend or indemnify Pro-Seal, leading to this declaratory judgment action.[268]

The issue in the declaratory judgment action was whether "the act of shipping a product in a competitor's packaging with one's own name

258. *Id.* at 393, 716 N.W.2d at 579.
259. *Id.* at 394, 716 N.W.2d at 579,
260. *Id.* at 399, 716 N.W.2d at 582.
261. *Id.* at 402, 716 N.W.2d at 583.
262. 477 Mich. 75, 730 N.W.2d 682 (2007).
263. *Id.* at 77, 730 N.W.2d at 683.
264. *Id.* at 78, 730 N.W.2d at 683.
265. *Id.*
266. *Id.*
267. *Id.*
268. *Citizens Ins. Co.*, 477 Mich. at 78, 730 N.W.2d at 683.

affixed to it" constitutes an "advertisement" as that term is used in the Citizen policy.[269] The policy did not define the term advertisement. However, under the policy, "an 'advertisement' takes place when there is: (1) a notice; (2) that is broadcast or published; (3) to the general public or specific market segments; (4) about [the company's] goods, products, or services; and (5) for the purpose of attracting customers."[270] The Court of Appeals had determined that the activity of Pro-Seal met these requirements, and, consequently, an "advertisement" had occurred.[271] The Supreme Court majority, after examining the language of the policy, disagreed, and stated:

> However, both the Court of Appeals and defendant overlook that, under the terms of the CGL policy, defendant must publicly disseminate information about its good and services for the purpose of attracting the patronage of potential customers. Here, defendant sent a seal to a *specific* customer in a Flowserve container for the purpose of completing a single transaction. At best, Pro-Seal's argument that it expected that other customers might view the package at the distribution center and, as a result, would be encouraged in doing business with defendant was an incidental and remote benefit that does not fundamentally alter the fact that this was a single transaction with a specific customer. We conclude that the purpose for placing a Pro-Seal label on the Flowserve container in this instance was to identify for *that specific customer* the source of the seal to allow that specific customer to contact defendant with any questions or complaints about that product. Accordingly, we conclude that the harm alleged to have been caused by Pro-Seal's act of shipping a seal in a Flowserve container did not "arise out of an advertisement" and, therefore, plaintiff was not obligated to tender a defense based on this allegation under the terms of the CGL policy.[272]

Justices Cavanagh, Weaver, and Kelly dissented. Justice Cavanagh noted the general rule that an insurer's duty to defend is broader than its duty to indemnify and, "[i]n a case of doubt as to whether or not the complaint against the insured alleges a liability of the insurer under the policy, the doubt must be raised in the insured's favor."[273] According to Justice Cavanagh, an opinion shared by Justices Weaver and Kelly, "Flowserve's allegations were sufficient to trigger a duty to defend. Flowserve alleged that Pro-Seal used Flowserve's trademarks to identify

269. *Id.* at 77, 730 N.W.2d at 683.
270. *Id.* at 82, 730 N.W.2d at 685.
271. *Id.* at 79, 730 N.W.2d at 684.
272. *Id.* at 85-87, 730 N.W.2d at 687-88.
273. *Id.* at 89, 730 N.W.2d at 689.

Pro-Seal products and through its actions caused customer confusion regarding the origin or manufacturer of the goods."[274]

With the decision in *Citizens Ins. Co.*, the status of the often-quoted statement that the duty to defend is broader than the duty to indemnify may be in jeopardy in Michigan. In fact, the majority did not even examine the applicability of this rule. Instead, the majority focused solely on whether there was a duty to indemnify under the policy. While the majority made no reference to abolishing the rule, it remains to be seen how the rule will apply in future cases.

IV. DECISIONS OF THE FEDERAL COURTS

A. United States Court of Appeals for the Sixth Circuit

Diversity jurisdiction and cases involving the Employee Retirement Income Security Act (ERISA) can present federal courts with insurance coverage issues. In *McLiechey v. Bristol West Insurance Company*, the insureds filed a class action lawsuit alleging that Bristol West violated Michigan law by using the insureds' economic circumstances and residence location in setting automobile insurance rates.[275] The case involved interpretation of Chapter 21 of the Michigan Insurance Code, also known as the Essential Insurance Act (the Act).[276] The Act regulates the setting of insurance rates, and lists the factors that insurance companies may consider in setting automobile insurance rates: "age of the driver, vehicle characteristics, commuting mileage . . . earned income, use of safety belts," as well as factors which may not be considered, i.e., "sex, marital status."[277] The Act permits insurance companies to maintain "statistical reporting territories" and, if the OFIS Commissioner agrees, "utilize factors in addition to those specified."[278] The Act also contains a remedial scheme, including review by the OFIS Commissioner.[279]

The Sixth Circuit Court found that the Act "does not create a private cause of action because its remedial scheme is not 'plainly inadequate.'"[280] Accordingly, the court affirmed the dismissal of the complaint.[281] Relying on Michigan law, the court noted that "[b]ecause Chapter 21 does not explicitly provide for a private cause of action, courts will interpret the statute as creating one only if the statutory remedial scheme is 'plainly inadequate.'"[282] The court examined the available

274. *Citizens Ins. Co.*, 477 Mich. at 90, 730 N.W.2d at 689-90.
275. 474 F.3d 897, 898 (6th Cir. 2007).
276. *Id.* at 899.
277. *Id.*
278. *Id.*
279. *Id.*
280. *Id.* at 900.
281. *McLiechey*, 474 F.3d at 900.
282. *Id.*

review by the OFIS Commissioner, and found it to be adequate under Michigan law.[283] The court noted that "[a] remedial scheme is not 'plainly inadequate' merely because it does not provide a plaintiff with the ideal result."[284] Because the statute provides an adequate remedial remedy, the Court found that the plaintiffs could not proceed with the lawsuit.[285]

During the *Survey* period, the Sixth Circuit also decided whether a federally-prescribed endorsement modified the attachment point of an umbrella policy,[286] as well as whether a federal workers' compensation insurer was entitled to reimbursement out of the insured's third-party tort recovery.[287]

B. United States District Courts

An interesting factual scenario was presented to the United States District Court for the Eastern District of Michigan in *Lennon v. Metropolitan Life Insurance Company*,[288] which demonstrated the difficulty in applying the "arbitrary and capricious" standard of review in an ERISA case. The plaintiff's son, David Lennon, was employed by General Motors Acceptance Corporation ("GMAC") as an accountant from 1993 until 2003.[289] David purchased a personal accident insurance policy issued by Metropolitan Life Insurance Company (Met Life), which provided benefits to the designated beneficiaries in case of "accidental" bodily injuries leading to death.[290] The policy also provided an exclusion for "self-inflicted" injuries.[291] David died in an automobile accident, and it was later determined that he was under the influence of alcohol at the time of the accident.[292] Met Life declined to pay benefits under the policy, claiming that David's death was not the result of accidental injuries and, further, was the result of a self-inflicted injury.[293]

The district court noted that, because the case was governed by ERISA, its review of Met Life's decision was limited to whether the de-

283. *Id.* at 900-01.

284. *Id.* at 901.

285. *Id.*

286. Kline v. Gulf Ins. Co., 466 F.3d 450 (6th Cir. 2006) (finding that the insurer was not obligated to pay any more than what was required under the original umbrella contract).

287. Shields v. Government Employees Hospital Ass'n, Inc., 450 F.3d 643 (6th Cir. 2006) (finding that the insured was required to reimburse payments to cover medical expenses under federal law).

288. 446 F. Supp. 2d 745 (E.D. Mich. 2006), *rev'd*, 504 F.3d 517 (6th Cir. 2007). The Sixth Circuit decision was released after the *Survey* period.

289. *Id.* at 747.

290. *Id.*

291. *Id.*

292. *Id.* Lennon's blood alcohol level was .321, which was three times the legal limit in Michigan. *Id.*

293. *Id.* at 748.

cision was "arbitrary and capricious."[294] The Sixth Circuit "has recognized that for an insurer's decision on eligibility for benefits to be arbitrary and capricious, it must not have been 'rational in light of the plan's provisions.'"[295] The pertinent issues presented in the case were whether the death was accidental and whether the injuries leading to death were self-inflicted.[296] The court examined the accidental requirement, noting that "[t]here is a split of authority as to whether death occurring when the insured is driving while intoxicated is accidental."[297] The court examined the competing positions, and examined several statistics related to drunk driving fatalities.[298] The court found that "although driving while intoxicated may cause death or injury, this does not necessarily mean that death or injury is a highly likely consequence – or even a reasonably foreseeable result – of driving while intoxicated."[299] The court therefore found Met Life's decision to be arbitrary and capricious.[300]

Turning to whether the injury was self-inflicted, the court noted that "[i]nherently risky activities, however, do not necessarily fall within the self-inflicted injury exclusions under ERISA plans."[301] The court examined case law under ERISA which found that certain inherently risky activities did not fall within the self-inflicted injury exclusion.[302] The court found that the self-inflicted injury exclusion did not apply, stating:

However, unlike the Russian roulette player who pulls the trigger of a gun pressed to his or her head, tempting the chance that a bullet is in the firing chamber, the drunk driver does not necessarily expect to die. A person who holds a gun to his or her head and pulls the trigger intentionally chances death. While a driver who consumes alcohol may intentionally impair his or her faculties, one cannot assume that the individual also intends to cause his or her death. As discussed *supra*, statistical evidence does not even support the conclusion that death is an expected or highly likely outcome of such conduct.[303]

Thus, the court found that Met Life's decision was arbitrary and capricious.[304] It is interesting to note the seemingly differing conclusions

294. *Lennon*, 446 F. Supp. 2d at 748.
295. *Id.*
296. *Id.* at 749.
297. *Id.*
298. *Id.* at 750.
299. *Id.* at 751.
300. *Lennon*, 446 F. Supp. 2d at 752.
301. *Id.* at 753.
302. *See generally* Critchlow v. First UNUM Life Ins. Co. of America, 378 F.3d 246 (2nd Cir. 2004) (stating autoerotic asphyxiation is not a self inflicted injury); King v Hartford Life & Accidental Ins. Co., 414 F.3d 994 (8th Cir. 2005) (stating that driving while intoxicated is not a self inflicted injury); Holsinger v. New England Mutual Life Ins. Co., 765 F. Supp. 1279 (E.D. Mich. 1991) (stating that death due to overdose of codeine is not a self inflicted injury).
303. *Lennon*, 446 F. Supp. 2d at 754.
304. *Id.* at 755-56.

reached by the court of appeals in *Book*, and the district court in *Lennon*. Indeed, *Lennon* specifically relied on those cases from other jurisdictions which held that autoerotic asphyxiation was not a self-inflicted injury for purposes of an ERISA policy. Both courts endeavored to apply the plain language of the policies, yet reached different results.[305]

District courts are sometimes faced with issue of applying Michigan law to questions of insurance coverage due to diversity jurisdiction. Such was the case in *Western World Insurance Company v. Lula Belle Stewart Center, Inc.*[306] On March 23, 2002, Stephen Alston and his siblings were removed from their mother's care because of neglect.[307] Stephen was assigned to Lula Belle foster care for placement.[308] On March 24, 2002, Stephen was placed in the foster care home of Sutlana Sami, who also was caring for a twelve-year-old and a seven-year-old boy.[309] Between March 24, 2002 and May 14, 2002, Stephen was sexually assaulted by the twelve-year-old boy on a regular basis.[310] Stephen's mother allegedly told Stephen's case manager about the assaults, but the case manager did nothing.[311] Ultimately, when Sami became aware of the assaults, Stephen was removed from her care and placed with his grandmother.[312] Stephen's mother filed a lawsuit, naming Lula Belle as a defendant, along with others.[313] Western World insured Lula Belle under two CGL policies.[314] The first policy expired during the period of molestation (in April, 2002), but the second policy took effect immediately thereafter and the two policies were materially indistinguishable.[315] Western World filed this declaratory action, acknowledging that it was obligated to provide coverage up to its $100,000 per claim limit, but asserting there only was one claim.[316]

The CGL policies contained an exclusion which stated that "no coverage exists for claims or suits brought against any insured for damages arising from sexual action."[317] However, a "sexual molestation" endorsement gave back some of this coverage (sub-limit of $100,000), and provided that Western World was obligated to "pay those sums the insured becomes legally obligated to pay as damages because of any 'mo-

305. As noted *supra*, note 254, the Sixth Circuit reversed *Lennon* in a decision released outside the *Survey* period.
306. 473 F. Supp. 2d 776 (E.D. Mich. 2007).
307. *Id.* at 778.
308. *Id.*
309. *Id.*
310. *Id.*
311. *Id.*
312. *Western World Ins.*, 473 F. Supp. 2d at 778.
313. *Id.*
314. *Id.* at 779.
315. *Id.*
316. *Id.*
317. *Id.*

lestation' [] to which this insurance applies."[318] The endorsement further provided that it "applies to damages from 'molestation' only if: (1) The 'molestation' takes place in the 'coverage territory'; [and] (2) The 'molestation' fist occurs during the policy period."[319] The endorsement further provided that "[t]he Each Claim limit" - defined elsewhere in the endorsement as $100,000 - "is the most we will pay for each claim or suit for damages due to 'molestation,'" and "[t]he Aggregate Limit" - defined elsewhere in the endorsement as $300,000 - "is the most we will pay because of all damages due to 'molestation.'"[320]

The court first addressed whether only one of the CGL policies applied, or whether both applied because molestation occurred during both policy periods.[321] Western World argued that the molestation "first occurred" during the first CGL time period and, therefore, only that policy could apply.[322] The court, however, disagreed, and stated:

> [T]he policy's inelegant and confusing reference to the time at which a molestation "first occurs" cannot overcome the explicit definition of "molestation" as "any *action* with sexual connotation or purpose resulting in bodily or mental injury." And, even if this definition could be construed as embracing both discrete acts of sexual abuse and a series of related incidents of sexual molestation, the endorsement provides no clue as to how the requisite degree of "relatedness" is to be determined. At best, then, the policy's reference to the point at which "[t]he 'molestation' first occurs" is ambiguous, and this ambiguity must be resolved against the Plaintiff insurer as the drafter of the policy language at issue.[323]

The court found that, based upon its interpretation of the policy language, multiple "molestations" had occurred, giving rise to coverage under both CGL policies.[324] Accordingly, the $100,000 limit of both policies was applicable.[325]

The United States District Courts also considered issues during the *Survey* period such as applicability of the doctrines of waiver and estop-

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318. *Western World Ins.*, 473 F. Supp. 2d at 779-80.
319. *Id.* at 780.
320. *Id.*
321. *Id.*
322. *Id.* at 780-81.
323. *Id.* at 784 (emphasis added). Interestingly, the Michigan Supreme Court has recently clarified this rule, sometimes referred to as the rule of *contra proferentem.* Klapp v. United Ins. Group Agency, 468 Mich. 459, 663 N.W.2d 447 (2003) (noting that, if a policy provision is ambiguous, the proper interpretation sequence is to look to extrinsic evidence to determine the intent of the contracting parties. If extrinsic evidence proves unsuccessful, it is only then that the provision is construed against the drafter).
324. *Western World Ins.*, 473 F. Supp. 2d at 787.
325. *Id.* at 789.

pel in an ERISA case,[326] and an insured's duty to inform its insured of the extent of her benefits.[327]

V. CONCLUSION

It is interesting to note the difficulty encountered by courts in attempting to apply the clear and unambiguous language of insurance policies and statutes. Nevertheless, the decisions during the *Survey* period evidence the continuing trend of plain language contractual and statutory interpretation in Michigan, and the ever-extending reach of *Devillers* and *Rory*.

No Fault is state-mandated insurance governed by specific statutory provisions while uninsured (UM) and underinsured (UIM) motor insurance is not mandated and generally governed only by whatever provisions an auto insurer inserts into its policy. The essentially non-regulated UM and UIM coverage allows some insurers to insert harsh conditions, limitations, and exclusions into their policies, while other insurers decline to do so. However, the insurer who is offering little or no meaningful UM or UIM coverage is at an at least short-term advantage in the marketplace which may cause other insurers to also restrict UM and UIM coverage. These coverages are obviously very important when the insured sustains accidental bodily injury arising out of the ownership, operation, maintenance or use of an uninsured or underinsured motor vehicle. Further appellate decisions are forecasted in this area as well as cases dealing with what is an accidental bodily injury or self-inflicted injury in disability, life, and other areas of insurance.

326. O'Connor v. Provident Life and Accident Co., 455 F. Supp. 2d 670 (E.D. Mich. 2006).

327. Buntea v. State Farm Mutual Auto Ins. Co., 467 F. Supp. 2d 740 (E.D. Mich. 2006).