INSURANCE LAW

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I. INTRODUCTION

Cases during the *Survey* period dealing with insurance law continue to be dominated by decisions under the No Fault Act and highlight the philosophical split between Justices of the Michigan Supreme Court.[1] While most Michigan Court of Appeals decisions regarding insurance law continue to be unpublished and not precedential, several published decisions of the Michigan Court of Appeals and the Michigan Supreme Court during the *Survey* period continue to shape Michigan insurance law and the rights and obligations of insureds, insurers, and third-parties.

II. MICHIGAN NO FAULT ACT

Decisions of the Michigan courts concerning insurance law continue to be dominated by opinions stemming from the No Fault Act[2] and continue to shape how coverage providers, insureds, and medical service

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1. Unpublished decisions are beyond the scope of this review. They are, however, often persuasive to trial courts and should not be overlooked.

2. MICH. COMP. LAWS ANN. §§ 500.3101-.3179 (West 2008).

providers interact on a daily basis. Also, these cases tend to highlight the philosophical differences between the current majority and minority of Justices of the Michigan Supreme Court. *Muci v. State Farm Automobile Insurance Co.*[3] is such a case. That case presented a situation of a stubborn insurance company, an overreaching plaintiff's attorney, and a trial court that gave plaintiff's counsel nearly all that he requested. The issue presented in *Muci* was whether provisions of the No Fault Act and insurance policy establish the "extent of allowable conditions on a medical examination of the claimant, or whether the allowable conditions are within a circuit court's discretion pursuant to MCR 2.311."[4] Factually, Alina Muci was injured in an automobile accident in 2002.[5] A claim for personal protection insurance (PIP) benefits was submitted to State Farm, which did not initially demand that Muci submit to an independent or defense medical examination.[6] State Farm failed to pay the submitted claim and a lawsuit ensued.[7]

During the lawsuit, State Farm demanded that its insured undergo an unconditional medical examination pursuant to Section 3151 of the No Fault Act,[8] which 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. A personal protection insurer may include reasonable provisions in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits.[9]

When Muci refused, State Farm filed a motion to compel Muci to submit to a medical examination.[10] The trial court issued an order allowing a medical examination, but imposing many of the onerous conditions that were proposed by Muci's counsel.[11] The court of appeals

3. 478 Mich. 178, 732 N.W.2d 88 (2007).

4. *Id.* at 180, 732 N.W.2d at 90.

5. *Id.* at 181, 732 N.W.2d at 90.

6. *Id.* Initially, Chief Justice Taylor refers to such examination as a "defense medical examination or DME" but later as an "independent medical examination." *Id.*

7. *Id.*

8. *Id.*

9. MICH. COMP. LAWS ANN. § 500.3151 (West 2008).

10. *Muci*, 478 Mich. at 181, 732 N.W.2d at 90.

11. *Id.* at 182-83, 732 N.W.2d at 91. The order included the following conditions:

> 1. That included with Plaintiff's notice of the medical examiner's deposition, Plaintiff's counsel shall be entitled to subpoena copies of all IRS form 1099's for the years 2000, 2001, and 2002, inclusive, for payments issued to said

examiner, individually, and to any entity which received compensation for Independent and/or Insurance and/or defense medical examinations and related forensic services performed by said examiner, including but not limited to:
a. Independent and/or Insurance and/or Defense medical examination;
b. Independent and/or Insurance and/or Defense medical examination reports;
c. Depositions;
d. Medical records reviews; and
e. Forensic activity for which payments were made.
In the event said examiner refuses to provide the subpoenaed documents at his deposition, Defendant will be barred from introducing said examiner's testimony at trial.
2. That the Plaintiff may be accompanied by her attorney or other representative as allowed by MCR 2.311(A) to observe the examination and/or be permitted to record the examination by means of simultaneous audio and visual recording.
3. No other persons other than Plaintiff, her representative, the videographer, and designated medical examiner and his or her staff are allowed to be present during the examination.
4. That the examination must be limited to Plaintiff's conditions, which are in controversy in this action, as provided by the Michigan Court Rules of 1985.
5. Any persons assisting the defense medical examiner must be fully identified by full name and title to Plaintiff, Plaintiff's representative, and on the video.
6. Defendant shall provide transportation or pay transportation to the Plaintiff for the evaluation/examination. If the Plaintiff chooses to drive or be driven by someone else she knows, the Defendant will reimburse the Plaintiff for reasonable transportation costs to and from each examination, at the rate of .35 cents [sic] a mile.
7. That the total time for examination and testing, if applicable, shall not be limited by Plaintiff or Plaintiff's counsel.
8. That a copy of this order shall be provided to the physician by the defense attorney prior to the exam.
9. That the Plaintiff's counsel will be provided a current copy of the curriculum vitae of the defense medical examiner no more than thirty (30) days after the scheduled appointment. [sic] As well as:
a. Within 21 days of the entry of this order Defendant will provide a statement of the reasonable charge for the Plaintiff's counsel taking of 1 hour deposition of the defense medical examiner at the medical examiner's office.
b. The full and correct name of the defense medical examiner (or separate billing entity, i.e. payee), with the tax identification number so that Plaintiff can comply with tax code and regulation requirements for any payment made in taking the examiner's deposition.
10. That no diagnostic test or procedure that is painful, protracted, or intrusive will be allowed as set forth in the Michigan Court Rules of 1985. X-rays will be allowed.
11. That the Plaintiff may be held responsible for cancellation fees charged the Defendant, unless the Plaintiff gives notification to the office of the Defense counsel 48 hours before canceling the appointment.
12. That the Plaintiff's attorney will be permitted to intercept communications between the Plaintiff and the defense medical examiner, in the same manner as if the Plaintiff's deposition were being taken and if the communications are in

granted State Farm's application for leave to appeal and, in a divided panel, affirmed the trial court's ruling.[12] The supreme court heard oral argument on whether to grant State Farm's Application for Leave to Appeal, and the opinion was issued in lieu of granting leave.[13]

Chief Justice Taylor authored the majority opinion.[14] He began by noting that, since the very first supreme court opinion dealing with the No Fault Act,[15] "we have, without exception, emphasized the act's comprehensive nature."[16] "What is unmistakable about this first-party payment scheme is that it was designed to cover contingencies that could arise, including, as relevant here, the process for making a claim, the

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violation of this order. Otherwise the attorney will not involve himself in the examination proceedings.

13. Defendant's attorney shall provide all pertinent information to the defense medical examiner.

14. That Plaintiff will not be required to give any oral history of the accident.

15. That Plaintiff will not be required to give any oral medical history not related to the areas of injuries claimed in this lawsuit.

16. That information that may be required by the Defense medical examiner may be obtained through the normal course of discovery.

17. That Plaintiff will not be required to sign any paperwork or fill out any paperwork at the defense medical examiner's office, including "patient information forms" or "consent forms" or the like, since the Plaintiff is not a patient of the defense medical examiner's office and is submitting to this examination only pursuant to Court Order and the requirements of the Michigan Court Rules of 1985.

18. That Plaintiff's counsel will be provided a copy of any and all reports and writings generated by the defense medical examiners in this matter pursuant to the Michigan Court Rules of 1985, including, but not limited to, a copy of a detailed written report, setting out any history obtained, examination, findings, (including the results of all tests made, diagnoses, prognoses, and conclusions of the examiner, all record review reports, a copy of all reports of earlier examinations of the same condition of the examinee made by that of [sic] any other examiner).

19. Throughout the litigation, the evaluation and examiner will be called and referred to as a defense medical evaluation and defense medical examiner respectively; and the term "independent medical evaluation" and/or "independent medical examiner" will not be used in the report, orally in a deposition, or at trial.

Id.

12. *Id.* at 183-85, 732 N.W.2d at 91-93. For a discussion of the court of appeals opinion, *see* James T. Mellon, *Insurance Law, 2007 Ann. Survey of Michigan Law: June 1, 2006 - May 31, 2007*, 53 WAYNE L. REV. 481 (2008).

13. *Muci*, 478 Mich. at 187, 732 N.W.2d at 93.

14. *Id.* at 179, 732 N.W.2d at 90. Justice Corrigan, Justice Young, and Justice Markman concurred. *Id.* at 194, 732 N.W.2d at 97.

15. Advisory Opinion re Constitutionality of 1972 PA 294, 389 Mich. 441, 208 N.W.2d 469 (1973).

16. *Muci*, 478 Mich. at 187, 732 N.W.2d at 94.

procedures for investigation by the insurer, and the range of available enforcement tools."[17] It was important to the majority that the provisions of the No Fault Act and the insurance policy cover situations in which a lawsuit has not been filed, while the Michigan Court Rules only come into play after a lawsuit is commenced.[18] However, where the court rules and the No Fault Act conflict, the No Fault Act controls:[19]

> While the court rules control matters on which the No Fault Act is silent, they do not control matters specifically addressed by the act. Here, where the act covers independent medical examinations, it is entirely antithetical to the Legislature's desired approach to argue that § 3151 does not give the insurer the right to include a policy provision allowing it to choose the examiner or even insist on the examination itself.[20]

Having found that the provisions of the No Fault Act prevail over a conflicting court rule, the majority turned to the "remaining question:" "whether the various conditions imposed by the trial court on the independent medical examination were appropriate to protect against annoyance, embarrassment, or oppression."[21] Because the trial court had based its order on MCR 2.311 rather than the No Fault Act, the case was remanded.[22]

Turning to the conditions imposed by the trial court, the majority noted that the "plaintiff has produced demonstrable evidence that, on a previous occasion, defendant's medical examiner asked inappropriate questions of another examinee during an independent medical examination, including questions regarding settlement issues and inquiring into areas unquestionably protected by the attorney-client privilege."[23] Instructing the trial court on remand, the majority stated: "in the event that the defendant insists on using the medical examiner who asked the improper questions, the trial court shall reconsider plaintiff's proposed examination conditions, and determine which conditions, if any, ought to be imposed in light of the evidence proffered by plaintiff."[24]

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17. *Id.* at 188, 732 N.W.2d at 94.
18. *Id.* at 189 n.4, 732 N.W.2d at 94 n.4.
19. *Id.* at 190, 732 N.W.2d at 95.
20. *Id.*
21. *Id.* at 193, 732 N.W.2d at 96.
22. *Muci*, 478 Mich. at 193, 732 N.W.2d at 96.
23. *Id.* at 192-93, 732 N.W.2d at 96.
24. *Id.* at 194, 732 N.W.2d at 97.

Justice Marilyn Kelly authored the dissenting opinion,[25] concluding that M.C.L. Section 500.3151 and MCR Section 2.311 do not conflict, could be read together,[26] and noting:

> The majority concludes that the statute and the court rule conflict because the court rule allows court-imposed conditions while the statute is silent on the subject. I find this argument unpersuasive. Although MCL 500.3151 requires a claimant to undergo a medical examination to receive personal protection benefits, it does not state that the examinations must be without limits. Nothing in the statute prohibits a court from imposing conditions on the examination once litigation has commenced. Their imposition, if reasonable, would not interfere with the insurer's substantive right to force a claimant to submit to an examination.[27]

It is interesting to note that the *Muci* opinion, though it shares the common divide of majority versus minority, lacks the rancor seen in past insurance law cases. In fact, one of the focuses of last year's *Survey* was the often bitter divide on the current supreme court. Opinions from the court contained seemingly personal attacks by one justice against another, and terse language used by one side when attacking the other's position. The cases from the supreme court during this *Survey* period do not contain such intense language.[28]

The Michigan Court of Appeals also routinely considers no fault cases which have a profound impact on the day-to-day interactions between coverage providers, claimants, and counsel. Insurers, like individuals, do not want to pay any more than they have to and often look for ways to save money. On way is to argue technicalities as occurred in *Healing Place at North Oakland Medical Center v. Allstate Insurance Co.*[29] The Michigan Court of Appeals considered whether a improperly licensed medical service provider was entitled to payment for services rendered to a patient injured in an automobile accident.[30] In 1995, Edgar Naylor was struck by an automobile while riding a bicycle,

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25. *Id.* Justice Cavanagh and Justice Weaver concurred in the dissenting opinion. *Id.* at 202, 732 N.W.2d at 101.

26. *Id.* at 194-95, 732 N.W.2d at 97.

27. *Id.* at 198, 732 N.W.2d at 99.

28. It should be noted that, in 2009, Chief Justice Taylor was not re-elected to the Michigan Supreme Court. This undoubtedly will have a profound impact on future cases.

29. 277 Mich. App. 51, 744 N.W.2d 174 (2007).

30. *Id.*

and sustained a closed head injury.[31] Naylor had a substance abuse problem that predated the accident.[32] He received treatment at the Healing Place, Ltd., and New Start, Inc., prior to serving a prison sentence.[33] In 2004 and 2005, Naylor received an "integrated treatment for brain injury, psychiatric disorders, and substance abuse."[34] Allstate denied the Healing Place and New Start's claims for first-party personal protection insurance benefits.[35]

In the lawsuit that followed, Allstate argued that the Healing Place and New Start were not properly licensed to render the treatment and, therefore, the services were not "lawfully render[ed]" as required by the No Fault Act.[36] Allstate moved for summary disposition, and the trial court granted the motion.[37] The appeal centered on an interpretation of Section 3157 of the No Fault Act, which states, in pertinent part: "A physician, hospital, clinic or other person or other institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance . . . may charge a reasonable amount for the products, services and accommodations rendered."[38] In support of its argument that the services were not "lawfully render[ed]," Allstate:

> [P]resented both documentary evidence and deposition testimony. Allstate's documentary evidence established that The Healing Place at North Oakland Medical Center ("THP at NOMC") held a license for residential substance abuse services and was not licensed as a psychiatric unit, that New Start was licensed as an outpatient substance-abuse program and not as an adult foster-care facility, and that a New Start representative sent a letter to Naylor's parole officer intimating, if not representing, that THP at NOMC and New Start held licenses that they did not in fact hold.[39]

By contrast, the plaintiffs presented "only a paucity of evidence to rebut Allstate's arguments."[40]

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31. *Id.* at 54, 744 N.W.2d at 175.
32. *Id.* at 54, 744 N.W.2d at 176.
33. *Id.*
34. *Id.*
35. *Healing Place*, 277 Mich. App. at 54, 744 N.W.2d at 176.
36. *Id.* (citing MICH. COMP. LAWS ANN. § 500.3157 (West 2008)).
37. *Id.* at 54-55, 744 N.W.2d at 176.
38. MICH. COMP. LAWS ANN. § 500.3157 (West 2008).
39. *Healing Place*, 277 Mich. App. at 57-58, 744 N.W.2d at 177-78.
40. *Id.* at 58, 744 N.W.2d at 178.

The majority,[41] after discussing the language of the statute and canons of statutory interpretation, reasoned:

> In our judgment, the plain language of MCL 500.3157 requires that before compensation for providing reasonable and necessary services can be obtained, the provider of treatment, whether a natural person or an institution, must be licensed in order to be "lawfully rendering treatment." If both the individual and the institution were each required to be licensed and either was not, the "lawfully render[ed]" requirement would be unsatisfied.[42]

After noting that the language of the statute leads to only one plausible conclusion, the majority cited to two other statutes not found in the No Fault Act.[43] First was M.C.L. Section 450.225, which provides a "legally authorized to render" requirement: "A corporation . . . shall not render professional services . . . except through . . . agents who are duly licensed or otherwise legally authorized to render the professional services."[44] The majority held that this statute supported its requirement of licensing for "lawfully render[ed]" treatment, and stated:

> Thus, MCL 450.225 has a requirement similar to the "lawfully render[ed]" requirement of MCL 500.3157 that specifically states or suggests that the agent who renders the service must be licensed in order to satisfy the requirement. In contrast, MCL 500.3157 does not expressly state or suggest that the agent must be licensed in order to satisfy the "lawfully render[ed]" requirement. Rather, MCL 500.315 focuses on either the agent or the institution "lawfully rendering" treatment. In short, under MCL 500.3157, if both the individual and the institution were each required to be licensed and either was not, the "lawfully render[ed]" requirement would be unsatisfied.[45]

The second statute was M.C.L. Section 550.1105(4), part of the Nonprofit Health Care Corporation Reform Act.[46] That section defined a "health care provider" as including a "person licensed." The majority, in

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41. *Id.* Judge Wilder authored the majority opinion. *Id.* at 52, 744 N.W.2d at 175. Judge Zahra concurred. *Id.* at 61, 744 N.W.2d at 179.

42. *Id.* at 59, 744 N.W.2d at 178.

43. *Id.* at 59-60, 744 N.W.2d at 179.

44. *Id.*

45. *Healing Place*, 277 Mich. App. at 60, 744 N.W.2d at 179.

46. *Id.*

"reasoning by analogy,"[47] stated that "the no-fault act must be read to provide that if both the individual who provided services and the institution to which the individual belonged were each required to be licensed, and either was not, the 'lawfully render[ed]' requirement is not met."[48] Summary disposition in Allstate's favor was affirmed.[49]

Judge Smolenski dissented, opining that, even though the plaintiffs had the ultimate burden of proving that their claims were compensable, Allstate had the initial burden of supporting its motion for summary disposition.[50] To meet that burden, Allstate "had to present evidence that the entities at issue provided services to Naylor under circumstances that required those entities to possess a specific type of license and that the entities did not possess the required license."[51] Judge Smolenski found that the evidence presented by Allstate was insufficient to establish that services were provided without a license.[52] Judge Smolenski also cited *Miller v. Allstate Insurance Co.*[53] to support his dissenting opinion. In *Miller*, the court of appeals examined whether a defect in the corporate form of an entity that provided services to an injured person rendered the provision of services unlawful.[54] Finding the holding of *Miller* applied, Judge Smolenski stated:

> I conclude that the lack of a license to operate as a psychiatric unit does not necessarily render the services actually provided by THP at NOMC unlawful. Instead, as in *Miller*, I would hold that the relevant inquiry in determining whether a particular service was lawfully rendered for the purposes of MCL 500.3157 depends on whether the individual performing the actual service is properly licensed.[55]

The *Healing Place* decision would appear to have a significant effect on the provision of services to patients injured in automobile accidents. The *Miller* decision was recently affirmed by the Michigan Supreme Court, but the Michigan Supreme Court vacated the rationale of the court

47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.* at 62-63, 744 N.W.2d at 180.
51. *Healing Place*, 277 Mich. App. at 63, 744 N.W.2d at 180.
52. *Id.* at 64, 744 N.W.2d 181.
53. 275 Mich. App. 649, 739 N.W.2d 675 (2007). For discussion of *Miller*, *see* Mellon, *supra* note 12, at 481.
54. *Healing Place*, 277 Mich. App. at 66, 744 N.W.2d at 182.
55. *Id.* at 68, 744 N.W.2d at 183.

of appeals.[56] Practitioners for a time were able to rely upon the rationale of *Miller*, but *Healing Place* now controls. This turn of events is noteworthy and highlights the need for practitioners to stay abreast of current appellate developments.

To further illustrate this point, two cases that dealt with property insurance benefits[57] were actually decided and reversed by the supreme court during the *Survey* period.[58] Both cases stemmed from similar fact patterns. In both cases, a semi-tractor driving on an overpass struck a guard rail, and its cargo trailer carrying flammable liquid fell onto the roadway below, exploded, and caused severe property damage to the overpass.[59] In *Initial Transport*, the Michigan Department of Transportation spent approximately $3.5 million to repair the overpass.[60] In *North Central*, the repair costs were approximately $2 million.[61] The issue in both cases was whether the Department of Transportation was entitled to recover the full amount of its damages under the Motor Carrier Safety Act (MCSA), or if the $1 million liability limit for property damage in the No Fault Act controlled.[62] Both cases were decided by divided panels.[63] Because *Initial Transport* was decided first, and the *North Central* panel necessarily based its decision on *Initial Transport*,[64] *Initial Transport* will be primarily addressed.

Initial Transport was insured by Employers Mutual Casualty Company.[65] The policy included general liability coverage for the semi-tractor with a $1 million property protection limit.[66] Initial Transport also

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56. 481 Mich. 601, 751 N.W.2d 463 (2008). This case falls outside of the *Survey* period and will be discussed in detail in next year's *Survey*.

57. Under the No Fault Act, PIP benefits are unlimited, but property insurance benefits are limited.

58. Dep't of Transp. v. Initial Transp., Inc., 276 Mich. App. 318, 740 N.W.2d 720 (2007), *rev'd* 481 Mich. 862, 748 N.W.2d 239 (2008); Dep't of Transp. v. N. Cent. Coop., LLC, 277 Mich. App. 633, 750 N.W.2d 234 (2008), *rev'd* 481 Mich. 862, 748 N.W.2d 239 (2008).

59. *Initial Transp.*, 276 Mich. App. at 321, 740 N.W.2d at 723; *N. Cent. Coop.*, 277 Mich. App. at 635, 750 N.W.2d at 237.

60. *Initial Transp.*, 276 Mich. App. at 321, 740 N.W.2d at 723.

61. *N. Cent. Coop.*, 277 Mich. App. at 634, 750 N.W.2d at 236.

62. *Initial Transp.*, 276 Mich. App. at 321, 740 N.W.2d at 723; *N. Cent. Coop.*, 277 Mich. App. at 637, 750 N.W.2d at 238.

63. *Initial Transp.*, 276 Mich. App. at 334, 740 N.W.2d at 730; *N. Cent. Coop.*, 277 Mich. App. at 648, 750 N.W.2d at 243.

64. *See* MCR 7.215(J) (providing that "a panel of the Court of Appeals must follow the rule of law established by a prior published decision of the Court of Appeals issued on or after November 1, 1990, that has not been reversed or modified by the Supreme Court, or by a special panel of the Court of Appeals as provided in this rule").

65. *Initial Transp.*, 276 Mich. App. at 321, 740 N.W.2d at 722.

66. *Id.* at 321, 740 N.W.2d at 723.

had a separate excess policy with Employers with a $4 million limit.[67] Employers refused to pay more than $1 million, arguing that it was not required to pay more because, under the No Fault Act, Initial Transport's liability for property protection damages could not exceed $1 million.[68]

The Department of Transportation argued that "the adoption in the Motor Carrier Safety Act of federal regulations for transportation of hazardous materials, MCL 480.11, created an exception to the damages limitation in the no-fault act."[69] The majority of the court of appeals[70] agreed with the Department of Transportation, and, after a detailed analysis, held as follows:

> A goal of the no-fault act is to ensure that automobile accident victims receive without regard to fault compensation for their injuries in the form of property protection insurance benefits. [Citation omitted]. The goal of the MCSA, in part, is "to assure that motor carriers maintain an appropriate level of financial responsibility for motor vehicles operated on public highways." [Citation omitted]. These goals are not mutually exclusive; both provide the means for recompensing injury in the event of a motor vehicle accident. The MCSA is both more specific and more recent, and we hold that it creates an exception to the $1 million cap on damages established by the no-fault act.[71]

Chief Judge Whitbeck dissented from the majority's conclusion regarding the MCSA.[72] Judge Whitbeck began his dissenting opinion by noting:

> I believe that the MCSA is a regulatory act that simply (1) sets forth minimum amounts of financial responsibility for certain motor carriers and (2) imposes a civil penalty for the failure to comply with those minimum requirements. I disagree with the majority's conclusion that the MCSA creates a private remedy for a third party against an insured or an insurer. Indeed, the majority concedes that no such remedy is provided anywhere in the statutory scheme. I would hold that the no-fault act is the

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67. *Id.*
68. *Id.*
69. *Id.*
70. Judge Cooper authored the majority opinion. *Id.* at 319, 740 N.W.2d at 723. Judge Murphy concurred. *Id.* at 334, 740 N.W.2d at 730.
71. *Initial Transp.*, 276 Mich. App. at 329, 740 N.W.2d at 727.
72. *Id.* at 334, 740 N.W.2d at 730.

> exclusive remedy available to MDOT for the property damage sustained in this case.[73]

The No Fault Act provides a $1 million cap on property protection benefits.[74] The MCSA does not create a private cause of action, and does not create an exception to the no-fault statutory scheme.[75] Judge Whitbeck stated:

> it is within the power of the Legislature, not this Court, to create an exception to the $1 million property-damage limit for motor carriers if such an exception is indeed deemed warranted. Absent express direction from the Legislature, the financial responsibility requirements must be read within the framework of the no-fault act.[76]

In the *North Central* case, the majority[77] reached a similar result, relying on *Initial Transport*.[78] Judge Zahra dissented, relying on the dissent authored by Judge Whitbeck.[79]

The Supreme Court, in lieu of granting leave to appeal, issued a unanimous order, that stated:

> In lieu of granting leave to appeal, we REVERSE in part the judgment of the Court of Appeals, for the reasons stated in the Court of Appeals dissenting opinion. The Motor Carrier Safety Act, in MCL Section 480.11a, did not create an exception to the $1 million cap on property damages established by the Michigan no-fault act in MCL Section 500.3121.[80]

Another no fault case dealing with an issue of statutory interpretation was *Iqbal v. Bristol West Insurance Group*.[81] *Iqbal* presented a question as to whether the driver of a motor vehicle involved in an accident

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73. *Id.* at 334-35, 740 N.W.2d at 730.

74. *Id.*

75. *Id.*

76. *Id.* at 341, 740 N.W.2d at 733.

77. Judge Servitto authored the majority opinion. *N. Central*, 277 Mich. App. at 633, 750 N.W.2d at 236. Judge Murphy concurred. *Id.* at 648, 750 N.W.2d at 243.

78. *Id.* at 640, 750 N.W.2d at 238.

79. *Id.* at 648, 750 N.W.2d at 243.

80. *N. Central*, 481 Mich. at 862, 748 N.W.2d at 239.

81. 278 Mich. App. 31, 32-33, 748 N.W.2d 574, 575-76 (2008).

qualified as an "owner."[82] The plaintiff was the driver of a car that was rear-ended at a stoplight.[83] He resided with his sister and was covered under a household no-fault insurance policy issued by Bristol.[84] The vehicle was titled and registered in the name of the plaintiff's brother, and was insured by Auto Club.[85] Bristol argued that the plaintiff should be considered the "owner" of the vehicle because he had use of the vehicle for a period greater than thirty days.[86] Therefore, according to Bristol's argument, the plaintiff would not be entitled to no fault benefits because he failed to maintain insurance on the vehicle.[87]

The court of appeals went through a brief analysis of the definition of "owner" under the No Fault Act, only to conclude that is was "unnecessary to determine whether plaintiff was an owner of the vehicle at the time of the accident . . . because our interpretation of MCL 500.3113(b) renders the question irrelevant."[88] M.C.L. Section 500.3113 provides, in pertinent part:

> A person is not entitled to be paid personal protection insurance benefits for accidental bodily injury if at the time of the accident any of the following circumstances existed: . . .
>
> (b) The person was the owner or registrant of a motor vehicle or motorcycle involved in the accident with respect to which the security required by section 3101 or 3103 was not in effect.[89]

This statute linked the required security or insurance solely to the vehicle.[90] In support of its analysis, the court stated:

> To construe MCL 500.3101(1) as requiring anything more in relation to the vehicle and in the context of its interrelationship with MCL 500.3113(b) would be problematic. The problem is that, assuming MCL 500.3113(b), as influenced by MCL 500.3101(1), was meant to demand that each and every owner maintain insurance on a particular vehicle or lose a right to

82. *Id.* at 38, 748 N.W.2d at 578. The parties disputed whether the plaintiff qualified as an "owner" under M.C.L. § 500.3101(2)(g)(i), but not M.C.L. § 500.3101(2)(g)(ii). *Id.*
83. *Id.*
84. *Id.* at 32, 748 N.W.2d at 576.
85. *Id.*
86. MICH. COMP. LAWS ANN. § 500.3101(2)(h)(i) (West 2008).
87. *Iqbal*, 278 Mich. App. at 38-39, 748 N.W.2d at 579.
88. *Id.*
89. MICH. COMP. LAWS ANN. § 500.3113(b) (West 2008).
90. *Iqbal*, 278 Mich. App. at 39, 748 N.W.2d at 579.

> receive PIP benefits, regardless of whether the vehicle is already covered by insurance, an owner who actually obtained insurance could be denied a right to recover PIP benefits. For example, if two persons qualified as owners of a particular vehicle under MCL 500.3101(2)(g), and only one of the owners maintained insurance, the owner who obtained insurance would be precluded from receiving PIP benefits under MCL 500.3113(b) because that person would be an owner of a vehicle with respect to which the insurance required by MCL 500.3101 was not in effect, as *all* the owners had not procured coverage for the vehicle.[91]

The court concluded that the requirement that the security be maintained is tied to the vehicle, rather than the driver.[92] Because the vehicle was insured by the plaintiff's brother, the court concluded that the plaintiff was entitled to receive no fault benefits.[93]

Often, lawsuits involving the No Fault Act center around whether a particular treatment or medication is causally connected to the automobile accident. The No Fault Act provides that an insurer is "liable to pay benefits for accidental bodily injury *arising out of* the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle."[94] One case during the *Survey* period shed some light on what proof is necessary for a claimant to establish that a given benefit was causally connected to the accident. In *Scott v. State Farm Mutual Automobile Insurance Co.*,[95] the court considered whether the cost of the injured plaintiff's cholesterol medication was compensable under the No Fault Act. Krohn, the injured party, was involved in a motor vehicle accident in 1981, just before her eighteenth birthday.[96] She sustained a brain injury, and Scott was the co-conservator of her estate.[97] Krohn received no fault benefits from State Farm.[98] In 1991, the plaintiffs became aware that Krohn has a high-cholesterol problem.[99] In 1997, Dr. Martin A. Jacobson informed State Farm that it was his opinion that Krohn's cholesterol problem was directly related to sequelae from her automobile

91. *Id.* at 40 n.2, 748 N.W.2d at 58 n.2.
92. *Id.* at 46, 748 N.W.2d at 583.
93. *Id.*
94. MICH. COMP. LAWS ANN. § 500.3105(1) (West 2008) (emphasis added).
95. 278 Mich. App. 578, 751 N.W.2d 51 (2008).
96. *Id.* at 579, 751 N.W.2d at 52.
97. *Id.*
98. *Id.*
99. *Id.* at 579, 751 N.W.2d at 53.

accident.[100] His reasoning was that "since the accident Krohn was not able to do as much exercise as she should, but mainly she had impairment of self-control from her head injury, which made it hard for her to eat a reasonable diet."[101] Over the next several years, attempts were made to help Krohn with her diet by sending her to a nutritionist[102] and prescribing her medication.[103] Eventually, Krohn was prescribed Vytorin, and a combination of Zocor and Zetia.[104] State Farm refused to pay for the Vytorin or Zetia, claiming that the need for it was insufficiently related to the automobile accident.[105] The trial court denied State Farm's motion for summary disposition, and the court considered the appeal on leave granted.[106]

The standard set forth by the Supreme Court was that "there should only be coverage where the causal connection between the injury and the use of the motor vehicle was more than incidental, fortuitous, or 'but for.'"[107] "[I]t is well settled that 'arising out of' requires more than an incidental, fortuitous, or but-for causal connection, but does not require direct or proximate causation."[108] The court found that the procedural status of the lawsuit was of great significance, and that the plaintiffs had carried their summary disposition burden of establishing a genuine issue of material fact that the medications were causally connected to the auto accident.[109] Therefore, the court affirmed the trial court's decision to deny summary disposition to State Farm.[110]

Other published cases which involved interpretation and/or application of the No Fault Act included cases involving awards of attorney fees,[111] and a case involving the Act's residual liability requirement.[112]

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100. *Id.* at 580, 751 N.W.2d at 53.
101. *Scott*, 278 Mich. App. at 580, 751 N.W.2d at 53.
102. *Id.*
103. *Id.* at 581, 751 N.W.2d at 53.
104. *Id.*
105. *Id.*
106. *Id.*
107. *Scott*, 278 Mich. App. at 582, 751 N.W.2d at 54.
108. *Id.* at 586, 751 N.W.2d at 56.
109. *Id.*
110. *Id.* at 586-87, 752 N.W.2d at 56.
111. Hill v. L.F. Transp., Inc., 277 Mich. App. 500, 746 N.W.2d 118 (2008) (finding that insurer who had secured an award of costs by appellate court in prior action had a right to intervene in third-party action); Moore v. Secura Ins., 276 Mich. App. 195, 741 N.W.2d 38 (2007) (affirming award of penalty interest and attorney fees when insurer terminated benefits without attempting to reconcile the opinion of its independent medical examiner and the insured's treating physicians).
112. Farm Bureau Ins. Co. v. Abalos, 277 Mich. App. 41, 742 N.W.2d 624 (2007) (affirming the trial court's determination that the insured's failure to cooperate is not a

III. PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT

In the prior *Survey*,[113] the Michigan Court of Appeals decision in *Ross v. Blue Care Network*[114] was discussed in detail. During this *Survey* period, that decision was reversed by the Supreme Court.[115] The interplay between different justices on the Supreme Court often overshadows the dynamic between the court of appeals and the supreme court, though the dynamic between these courts should not be overlooked. It is necessary for practitioners to monitor the status of appellate decisions diligently, to stay abreast of a case's final resolution.

Such was the case with *Ross*. Chief Justice Taylor authored the majority opinion.[116] Mr. Ross suffered from multiple conditions, including multiple myeloma, spinal stenosis, and a fractured lumbar vertebrae.[117] 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.[118]

Mr. Ross contacted the Myeloma Institute for Research and Therapy at the University of Arkansas for Medical Sciences (UAMS).[119] Blue Cross Network (BCN) denied coverage for Ross's treatment in Arkansas as out-of-network treatment and because he was self-referred to UAMS.[120]

Mr. Ross requested an external review by the Commissioner of the Office of Financial and Insurance Services (OFIS),[121] and the Commissioner assigned an independent review organization (IRO).[122] 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.[123] The Commissioner accepted part of the IRO

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defense to the extent that residual liability insurance is compulsory and finding that Ohio law applied).

113. Mellon, *supra* note 12, at 481.

114. 271 Mich. App. 358, 722 N.W.2d 223 (2006).

115. Ross v. Blue Care Network, 480 Mich. 153, 747 N.W.2d 828 (2008).

116. *Id.* at 154, 747 N.W.2d at 830. Justice Corrigan, Justice Weaver, Justice Young, and Justice Markman concurred. *Id.* at 177, 747 N.W.2d at 841.

117. *Id.* at 157, 747 N.W.2d at 830.

118. *Id.* at 157, 747 N.W.2d at 831.

119. *Id.*

120. *Id.* at 158, 747 N.W.2d at 831.

121. On February 1, 2008, Governor Jennifer Granholm signed Executive Order 2008-02, which reorganized OFIS and changed the official name to the Office of Financial and Insurance Regulation (OFIR).

122. *Ross*, 480 Mich. at 158, 747 N.W.2d at 831.

123. *Id.* at 161-62, 747 N.W.2d at 833.

recommendation, but questioned whether Mr. Ross's condition met the definition of emergency,[124] finding that Mr. Ross should have gone to the closest Michigan hospital, rather than to a hospital in Arkansas.[125] Thus, the Commissioner concluded that only part of Mr. Ross's treatment should have been covered.[126]

Mr. Ross appealed the Commissioner's decision to the Wayne County Circuit Court[127] pursuant to PRIRA.[128] At the hearing, Circuit Judge Michael Callahan held that the Commissioner, in ruling that only part of Mr. Ross's treatment was an emergency, erred and reversed the Commissioner's findings.[129] The Michigan Court of Appeals subsequently granted BCN's application for leave to appeal,[130] and concluded that the Commissioner had failed to comply with the requirements of PRIRA and exceeded her authority when she discounted the IRO's medical recommendations and replaced them with her own independent determinations.[131] The Supreme Court ordered oral argument on BCN's application, and directed the parties to discuss whether the IRO's recommendations were binding on the Commissioner, or whether the Commissioner could render a decision contrary to the recommendations.[132]

The majority noted that "PRIRA is a relatively recent addition to our state's laws."[133] The statute is in its infancy in terms of substantive judicial review, and was described as an "across-the-board attempt to regulate HMOs and other insurance providers consistently,"[134] that "was intended to standardize the external review process designed to resolve disputes over covered benefits, establish IRO qualifications, and provide penalties in cases of wrongful denial of benefits."[135] After a lengthy discussion of the requirements of PRIRA, the majority noted that the court of appeals had failed to consider the use of the word "recommendation" in the statute.[136] As courts often do when defining a term in a statute, it turned to the dictionary definition of

124. *Id.* at 162, 747 N.W.2d at 833.
125. *Id.*
126. *Id.*
127. *Id.*
128. MICH. COMP. LAWS ANN. § 550.1915(1) (West 2008).
129. *Ross*, 480 Mich. at 162, 747 N.W.2d at 833.
130. *Id.* at 163, 747 N.W.2d at 833.
131. *Id.*
132. *Id.* at 163-64, 747 N.W.2d at 834.
133. *Id.* at 164, 747 N.W.2d at 835.
134. *Id.*
135. *Ross*, 480 Mich. at 164, 747 N.W.2d at 835.
136. *Id.* at 171, 747 N.W.2d at 838.

"recommendation."[137] Using this definition and the language of the statute, the majority noted that "nowhere in the statute does it say that the IRO's recommendation is binding in any way."[138] Therefore, the court of appeals erred in finding that the statement in the only other appellate case to address PRIRA[139] was dicta.[140] The decision of the court of appeals "essentially created a judicially defined bifurcated system of review in which the IRO would be the final authority on issues of medical or clinical-review criteria, while the commissioner would be the ultimate authority on purely contractual issues."[141] Ultimately, the Supreme Court majority held that "an IRO's recommendation concerning whether to uphold or reverse a health carrier's adverse determination is merely a recommendation and is not binding on the commissioner."[142]

Justice Kelly dissented,[143] and, examining the language of the statute, stated: "The commissioner is specifically authorized to review the IRO's recommendation to ensure that it is not contrary to the 'terms of coverage.' In this respect, the recommendation is not binding. But the commissioner is not allowed to substitute her lay opinion for the medical conclusions of the IRO."[144]

Justice Kelly then offered her response to the majority:

> The majority argues that my analysis using *expressio unis est exclusio alterius* leads to an interpretation that is contrary to the language of the statute. The majority claims that I fail to recognize that the commissioner is given the power to uphold or reverse an adverse determination whereas the IRO is not. What the majority overlooks is that the commissioner's power to review the IRO's recommendation is limited to "ensur[ing] that it is not contrary to the terms of coverage . . . ." Thus, the commissioner is authorized to reject the IRO's recommendation only if it is contrary to the terms of coverage. It necessarily follows that the commissioner must adopt the IRO's recommendation when it is not contrary to the terms of coverage. I recognize this point. The majority does not. Hence, it is the

137. *Id.*

138. *Id.*

139. English v. Blue Cross Blue Shield of Mich., 263 Mich. App. 449, 688 N.W.2d 523 (2004).

140. *Ross*, 480 Mich. at 173, 747 N.W.2d at 839.

141. *Id.* at 174, 747 N.W.2d at 840.

142. *Id.*

143. *Id.* at 177, 747 N.W.2d at 841. Justice Cavanagh would have denied leave to appeal. *Id.* at 190, 747 N.W.2d at 848.

144. *Id.* at 185, 747 N.W.2d at 845.

> majority's interpretation that is contrary to the language of the statute, not mine.[145]

Justice Kelly then assailed the majority's frequent use of dictionary definitions in the interpretation of statutes:

> The interpretation of the statute advanced by the members of the majority is another example of their belief that the answer to all questions of statutory interpretation lies in a dictionary. As a result of this belief, they focus on the dictionary definition of the word "recommendation" to solve the case. But the majority ignores the fact that the commissioner's power of review is limited. Regardless of how the majority defines the word "recommendation," the commissioner exceeds the scope of her power when she performs an act that she is not empowered to do. As I have explained, PRIRA gives the commissioner the power to review the recommendation solely to ensure that it is not contrary to the terms of coverage.[146]

IV. INSURANCE CONTRACT AND STATUTORY INTERPRETATION

Chief Justice Taylor and Justice Kelly were at odds again in *McDonald v. Farm Bureau Insurance Co.*[147] *McDonald* presented another opinion regarding "judicial tolling," and served as yet another directive to practitioners that reliance on tolling is hazardous. The issue presented was "whether a contractual limitations period in an insurance policy is tolled from the time a claim is made until the insurance company denies the claim and, if it is not, whether the limitations period may be avoided under the doctrines of waiver or estoppel."[148]

The case involved underinsured motorist (UIM) coverage which is not mandated by statute; therefore, the terms of the policy control.[149] The plaintiff was injured in an automobile accident on November 29, 2001.[150] The UIM coverage contained an endorsement which stated: "No claimant may bring a legal action against the company more than one year after the accident."[151] On May 10, 2002, plaintiff's attorney notified

145. *Id.* at 185, 747 N.W.2d at 845 n.21.
146. *Ross*, 480 Mich. at 185, 747 N.W.2d at 845 n.21.
147. 480 Mich. 191, 747 N.W.2d 811 (2008).
148. *Id.* at 193, 747 N.W.2d at 814.
149. *Id.* at 194, 747 N.W.2d at 814.
150. *Id.*
151. *Id.*

Farm Bureau that plaintiff had a UIM claim.[152] Farm Bureau responded by stating that it needed to be sent answers to interrogatories before it could give permission to settle.[153] On August 2, 2002, plaintiff's attorney sent another letter seeking permission to settle with the tortfeasor.[154] Farm Bureau then sent written permission to settle.[155] No further action took place until December 10, 2002, when Farm Bureau sent a letter to plaintiff "indicating that the one-year limitations period had expired and that defendant would no longer consider the UIM claim."[156] Plaintiff commenced a lawsuit five months later.[157]

Both the trial court and the court of appeals held that the one year contractual limitations period was tolled by plaintiff's May 10, 2002 letter to Farm Bureau until Farm Bureau denied the claim on December 10, 2002.[158] The Supreme Court granted leave to appeal.[159] In another split decision, the majority[160] concluded that the Court had expressly abolished in *Rory v. Continental Insurance Co.*,[161] and *Devillers v. Auto Club Insurance Association*.[162] the doctrine of judicial tolling.[163] Therefore, the plaintiff was required to commence the lawsuit within one year of the date of the accident.[164] Though the equitable doctrines of waiver and estoppel may still apply, the facts of the case did not warrant their application.[165]

Justice Weaver authored a dissenting opinion, in which she referred to the "majority of four"[166] and the "unjust and unfair"[167] holdings in *Rory* and *Devillers*. She noted:

> The doctrine of judicial tolling in insurance contracts is one of the specialized rules of equity that acknowledge and account for the difference in bargaining power, or lack thereof, between an

152. *Id.*
153. *McDonald*, 480 Mich. at 194-95, 747 N.W.2d at 814.
154. *Id.* at 195, 747 N.W.2d at 814.
155. *Id.*
156. *Id.* at 195, 747 N.W.2d at 815.
157. *Id.*
158. *Id.* at 195-96, 747 N.W.2d at 815.
159. *McDonald*, 480 Mich. at 196, 747 N.W.2d at 815.
160. Justice Corrigan, Justice Young, and Justice Markman concurred. *Id.* at 206, 747 N.W.2d at 820.
161. 473 Mich. 457, 703 N.W.2d 23 (2005).
162. 473 Mich. 562, 702 N.W.2d 539 (2005).
163. *McDonald*, 480 Mich. at 197-201, 747 N.W.2d at 815-18.
164. *Id.* at 201, 747 N.W.2d at 818.
165. *Id.* at 204-05, 747 N.W.2d at 819-20.
166. *Id.* at 206-07, 747 N.W.2d at 820.
167. *Id.* at 207, 747 N.W.2d at 820-21.

> insured and an insurer. As Justice Kelly aptly states, "it is a pragmatic doctrine that is fair to both insurers and insureds." By extending its decision from *Devillers* . . . the majority of four does away with a doctrine that allowed for fairness in the insurance-claim negotiation process and leave nothing in its place to ensure that insurers promptly take action to afford their insureds reasonable time to make decisions regarding legal action or the settlement of claims.[168]

Justice Kelly authored a separate dissenting opinion.[169] After examining case law from other jurisdictions, Justice Kelly noted that, under the majority's decision, insureds may be caught in a procedural quagmire.[170] "If they bring a claim too soon, the court may dismiss it as unripe. If they wait for the insurer to decide the claim, they risk a technical forfeiture under a limitation-of-suit provision."[171] According to Justice Kelly, the abolishment of the judicial tolling doctrine would have practical implications as well:

> An insured should not be forced to choose between filing a premature lawsuit and trusting that the insurance company will consider the claim after the contractual limitations period has expired. Choosing the first option may unnecessarily poison the relationship between the parties. It may create unnecessary litigation that serves only to burden our overtaxed judicial system. Such a result has been accurately called both "anomalous and inefficient." Yet choosing the second option gives insurance companies the opportunity to avoid coverage on timeliness grounds.[172]

Another Farm Bureau contractual limitation clause was at issue in *Klida v. Braman*.[173] *Klida* also involved a contractual, one-year limitations period for a UIM claim.[174] However, this time Farm Bureau argued that the claim was time barred even though the insured was a minor and subject to the minority tolling provision of the Revised Judicature Act (RJA).[175] That provision provides:

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168. *Id.* at 208-09, 747 N.W.2d at 821-22 (internal citations omitted).
169. *McDonald*, 480 Mich. at 209, 747 N.W.2d at 822.
170. *Id.* at 211-12, 747 N.W.2d at 823.
171. *Id.* at 212, 747 N.W.2d at 823.
172. *Id.* (footnote omitted).
173. 278 Mich. App. 60, 748 N.W.2d 244 (2008).
174. *Id.* at 61, 748 N.W.2d at 246.
175. *Id.* at 62, 748 N.W.2d at 246.

> Except as otherwise provided in subsections (7) and (8), if the person first entitled to make an entry or bring an action under this act is under 18 years of age or insane at the time the claim accrues, the person or those claiming under the person shall have 1 year after the disability is removed through death or otherwise, to make the entry or bring the action although the period of limitations has run.[176]

The language of the statute at issue was "an action under this act."[177] Farm Bureau argued that the lawsuit was not "an action" under the RJA and, therefore, the minority tolling provision did not apply.[178]

The court of appeals found that the provision was subject to multiple plausible interpretations.[179] The "proposition that all civil actions are brought in accordance with the RJA; thus, all civil action are brought 'under' the RJA," was plausible.[180] The phrase could also be "construed to limit the application of the minority tolling provision . . . to causes of action arising from a purported violation of a specific statutory provision contained within the RJA."[181] Also, "[a] third possible construction is that the minority tolling provision may apply only to causes of action for which the applicable statute of limitations is set forth in the RJA."[182] Because the court found that the phrase was subject to multiple reasonable constructions, it was ambiguous and judicial construction was appropriate.[183]

The court considered the history of the provision as well as the intent of the legislature, and concluded that the minority tolling provision applied to all civil lawsuits,[184] and stated:

> We conclude that a reasonable construction of the phrase 'under this act' contained within the minority tolling provision, MCL 600.5851(1), that best accomplishes the statute's purpose is that all civil actions are brought 'under' the RJA, including plaintiff's breach of contract action. We discern no persuasive reason to ascribe a legislative intent to limit the application of MCL 600.5851(1) to causes of action arising from a purported

176. MICH. COMP. LAWS ANN. § 600.5851(1) (West 2008).
177. *Klida*, 278 Mich. App. at 62-64, 748 N.W.2d at 247.
178. *Id.* at 64, 748 N.W.2d at 247.
179. *Id.* at 65, 748 N.W.2d at 248.
180. *Id.* at 66, 748 N.W.2d at 248.
181. *Id.* at 67, 748 N.W.2d at 249.
182. *Id.* at 68, 748 N.W.2d at 249-50.
183. *Klida*, 278 Mich. App. at 70, 748 N.W.2d at 250-51.
184. *Id.* at 71, 748 N.W.2d at 251.

> violation of a specific statutory provision contained within the RJA or to causes of action for which the applicable statute of limitations is provided by the RJA.[185]

Practitioners should also be aware of decisions in which a panel of the court of appeals disagrees with a prior panel.[186] This can lead to a special panel to resolve the conflict. Such was the case in *Griswold Properties, L.L.C. v. Lexington Insurance Co.*,[187] where the special panel considered whether a first-party insured was entitled to penalty interest under M.C.L. Section 500.2006(4) when the insurer failed to pay the claim within the applicable statutory period, regardless of whether the amount of the claim was "reasonably in dispute."[188] M.C.L. Section 500.2006(4) is part of the Uniform Trade Practices Act, and provides:

> If benefits are not paid on a timely basis the benefits paid shall bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at a rate of 12% per annum, if the claimant is the insured or an individual or entity directly entitled to benefits under the insured's contract of insurance. If the claimant is a third party tort claimant, then the benefits paid shall bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at a rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith and the bad faith was determined by a court of law. The interest shall be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest shall be payable based upon the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid pursuant to this section shall be offset by any award of interest that is payable by the insurer pursuant to the award.[189]

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185. *Id.* at 74, 748 N.W.2d at 252-53.

186. *See* MCR § 7.215(J)(3) (governing the resolution of conflicts in court of appeals decisions).

187. 276 Mich. App. 551, 741 N.W.2d 549 (2007).

188. *Id.* at 554, 741 N.W.2d at 550.

189. MICH. COMP. LAWS ANN. § 500.2006(3) (West 2008).

The conflict was between the cases of *Griswold Properties, L.L.C. v. Lexington Insurance Co.*,[190] and *Arco Industries Corp. v. American Motorists Insurance Co.*[191] In *Arco*, the court of appeals had held that a portion of the Supreme Court opinion in *Yaldo v. North Pointe Insurance Co.*,[192] was dicta, and found that the "reasonably in dispute" language of § 500.2006(4) applied to "first party" claims as well as "third party" claims.[193] In *Yaldo*, the Supreme Court ruled that the plaintiff was entitled to interest under a different statute,[194] but went on to note that an alternative basis for affirmance was the application of M.C.L. Section 500.2006(4).[195] *Yaldo* rejected the argument that the penalty interest was only applicable if the claim was "reasonably in dispute": "With respect to the collection of twelve percent interest, reasonable dispute is applicable only when the claim is a third-party tort claimant."[196] In *Arco*, the court held that this analysis was dicta, and concluded that the reasonable dispute requirement applied to first-party claims as well.[197]

In *Griswold*, the court found that it was bound to apply *Arco*, even though it did not agree with its conclusion.[198] A special panel was convened. In a unanimous decision, the special panel ruled that *Arco* was wrongly decided.[199] The court found that the *Arco* panel erred in concluding that the *Yaldo* language was dicta, and stated: "an issue that is intentionally addressed and decided is not dictum if the issue is germane to the controversy in the case, even if the issue was not necessarily decisive of the controversy in the case."[200] Turning to the language of the statute, the special panel concluded that the "reasonably in dispute" language appears only in the second sentence, and, therefore, only applies to third-party tort claimants.[201]

Other cases involving statutory and/or contractual interpretation included *National Pride at Work, Inc. v. Governor of Michigan*,[202]

190. 275 Mich. App. 543, 740 N.W.2d 659 (2007).
191. 233 Mich. App. 143, 594 N.W.2d 74 (1998).
192. 457 Mich. 341, 578 N.W.2d 274 (1998).
193. *Id.*
194. MICH. COMP. LAWS ANN. § 600.6013 (West 2008).
195. *Yaldo*, 457 Mich. at 344-49, 578 N.W.2d at 275-77.
196. *Id.* at 349, 578 N.W.2d at 274.
197. *Arco*, 233 Mich. App. at 147-49, 594 N.W.2d at 75-76.
198. *Griswold*, 276 Mich. App. at 562, 741 N.W.2d at 555.
199. *Id.*
200. *Id.* at 563, 741 N.W.2d at 555.
201. *Id.* at 566, 741 N.W.2d at 557.
202. 481 Mich. 56, 748 N.W.2d 524 (2008) (involving constitutional law and holding that certain insurance benefits are prohibited by Michigan's "Marriage Amendment," MICH. CONST. of 1963, art. 1, § 25).

Citizens Insurance Company v. Secura Insurance,[203] *Shields v. Government Employees Hospital Association, Inc.*,[204] and *Comerica Inc. v. Zurich American Insurance Co.*[205] Decisions of the Michigan courts reveal that it is often difficult to interpret the "plain language" of statutes and contracts, which explains the varying decisions and reversals by the appellate courts.

V. EMPLOYEE RETIREMENT INCOME SECURITY ACT

While Michigan federal courts are sometimes called upon to decide insurance cases on the basis of diversity of citizenship, the majority of cases applicable to the *Survey* involve the Employee Retirement Income Security Act (ERISA). Often, the federal courts are called upon to review the benefits decision of an ERISA plan administrator. The standard of review for these cases typically is whether the lower court's decision was "arbitrary and capricious,"[206] and is usually the deciding factor in a court's decision to uphold or reverse the plan administrator's decision. The impact of the standard of review was on display in *Lennon v. Metropolitan Life Insurance Co.*[207] The plaintiff's son, David Lennon, was employed by General Motors Acceptance Corporation (GMAC) as an accountant from 1993 until 2003.[208] David purchased a personal accident insurance policy issued by MetLife, which provided benefits to the designated beneficiaries in case of "accidental" bodily injuries leading to death.[209] The policy also provided an exclusion for "self-inflicted" injuries.[210] 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.[211] MetLife declined to pay benefits under the policy, claiming that David's death was not the result of accidental injuries and,

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203. 279 Mich. App. 69, 755 N.W.2d 563 (2008) (holding the insurer's argument that the negligent party drove its insured's vehicle without consent did not defeat statutory presumption of consent, and thus insurer had duty to defend the negligent party).

204. 490 F.3d 511 (6th Cir. 2007) (applying Michigan law, the Sixth Circuit concluded that attorney fees are not recoverable under the no fault act for portions of case which sought to fight the imposition of lien).

205. 498 F. Supp. 2d 1019 (E.D. Mich. 2007) (applying language of policy, United States District Judge David M. Lawson concludes that insured's own payment of judgment amount was insufficient to satisfy excess policy requirement that underlying insurance be exhausted).

206. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 103 (1989).

207. 504 F.3d 617 (6th Cir. 2007).

208. *Id.* at 618.

209. *Id.* at 619.

210. *Id.*

211. *Id.* at 618-19.

further, was the result of a self-inflicted injury.[212] The district court noted that, because the case was governed by ERISA, its review of MetLife's decision was limited to whether the decision was "arbitrary and capricious."[213] The court ultimately found that MetLife's decision was arbitrary and capricious.[214]

A divided Sixth Circuit reversed the district court,[215] noting that Lennon's behavior was "grossly negligent."[216] Citing to "a prominent tort law treatise,"[217] the lead opinion concluded that "[i]f tort law can treat such conduct the same way it treats intentional conduct, it is not arbitrary and capricious for an ERISA plan administrator to treat such conduct as not accidental under a policy that only covers accidents."[218] The majority opinion cited a Fourth Circuit case which stated that "federal courts have found with near universal accord that alcohol-related injuries and deaths are not 'accidental' under insurance contracts governed by ERISA."[219] Accordingly, the court found the plan administrator's decision was not "arbitrary and capricious," and reversed the district court.[220]

Circuit Judge Boggs authored a concurring opinion.[221] He concurred with the result reached by Judge Rogers in the lead opinion, but disagreed with the analysis.[222] Judge Boggs felt that the lead opinion should have focused solely on whether the plan administrator's decision was arbitrary and capricious, not whether the result was correct.[223]

Circuit Judge Clay authored a dissenting opinion.[224] Explaining the sometimes muddled review process for ERISA cases, Judge Clay stated:

> At the heart of this dispute lies a question that *should* admit of a simple and straightforward answer, and that *would* if the question were posed to any man on the street. The seemingly simple question is whether a motorist intoxicated beyond the legal limit who crashes his vehicle has been in an "accident," or

212. *Id.* at 619-20.
213. Lennon v. Metro. Life Ins. Co., 446 F. Supp. 2d 745, 749-50 (E.D. Mich. 2006).
214. *Id.* at 755-56.
215. *Lennon*, 504 F.3d at 624. Judge Rogers authored the lead opinion, Judge Boggs authored a separate concurrence, and Judge Clay dissented.
216. *Id.* at 620-21.
217. DAN R. DOBBS, THE LAW OF TORTS § 147 (2000).
218. *Lennon*, 504 F.3d at 621.
219. Eckelbery v Reliastar Life Ins. Co., 469 F.3d 340, 344 (4th Cir. 2006).
220. *Lennon*, 504 F.3d at 624.
221. *Id.*
222. *Id.*
223. *Id.*
224. *Id.* at 626.

> has been "accidentally" injured. A man on the street would answer "yes." But the question (or some form of it) was put to an ERISA plan administrator and then to a court. The matter quickly became over complicated by exclusions read into express contractual language, by standards of review, and something akin to Cardozo's great "Serbonian bog"—an unwieldy body of legal precedent laced with not-so-subtle moralistic judgments.[225]

Judge Clay cautioned that the interpretation adopted by the plan administrator and affirmed by the majority would have the effect of "eviscerat[ing] accidental injury coverage in many circumstances where the insured, on the basis of the policy language, would expect to be covered."[226] Judge Clay gave the following examples:

> A motorist driving cross-country attempts to make it another hour before stopping after an 18 hour day behind the wheel. The motorist is not speeding, drives in accordance with the laws, and encounters no other vehicles but, ultimately, fatigue overcomes him. He swerves off the road into a ditch and later dies from injuries sustained in the crash. Another motorist drives 89 miles per hour on a road with a designated speed limit of 70. Arriving at a turn in the road, that motorist spins out, unable to control his vehicle. He suffers injury when his vehicle hits a cement wall in the road's median and also dies. Finally, a man partakes in bungee jumping for sport. He has successfully completed several jumps before, but on his last jump, his safety harness fails and he plummets to his death. Under the PAI Policy language, an insured would expect to be covered in each of these hypothetical situations. Yet, on Defendant's reasoning, which the majority affirms today, Defendant could deny coverage by calling the injury or death a "reasonably forseeable" result of the insured's conduct.[227]

The analysis adopted by the majority opinion in *Lennon* seemingly would present many difficulties for future courts attempting to discern whether a given event was "accidental." In addition to Judge Clay's examples in the dissenting opinion, there would seem to be many more

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225. *Id.* at 626 (citing Landress v. Phoenix Mut. Life Ins. Co., 291 U.S. 491, 499 (1934) (Cardozo, J., dissenting).

226. *Lennon*, 504 F.3d at 630.

227. *Id.*

instances where conduct could arguably be deemed "grossly negligent" and potentially not covered.[228] It is sometimes difficult for federal courts to review a plan administrator's decision under the "arbitrary and capricious" standard of review, which was apparent in *Lennon*.

A case to which the "arbitrary and capricious" standard of review did not apply was *Papenfus v. Flagstar Bankcorp, Inc.*[229] Judge John Feikens of the United States District Court for the Eastern District of Michigan decided this case, which involved the question of whether the defendants were estopped from denying benefits to the plaintiff.[230] The plaintiff was an employee of Flagstar and participated in an employee welfare benefit plan which included spousal life insurance.[231] The employee elected $100,000 worth of coverage for his spouse.[232] The enrollment form for the policy stated that "[a]mounts elected over $50,000 will require proof of good health."[233] The plaintiff was never asked to provide evidence of his wife's good health, and the premium for the $100,000 policy was regularly deducted from his paycheck.[234] When the plaintiff's wife died, he made a claim for the $100,000.[235] Hartford, the plan administrator, denied the claim in part because the plaintiff had not provided evidence of his wife's good health.[236] Hartford tendered $50,000.[237]

The plaintiff filed suit, alleging that the defendants were estopped from denying his claim.[238] Judge Feikens noted that the Sixth Circuit "has recognized that promissory estoppel is a viable theory in ERISA welfare benefit actions."[239] Moreover, estoppel claims "are not claims for denial of benefits and are, therefore, addressed in the first instance in the district court, requiring no deference to any administrator's action or decision."[240] Judge Feikens went through the elements of estoppel as

228. *See* Mellon, *supra* note 12, at 481; *see also* Gaddy v. Hartford Life Ins. Co., 218 F. Supp. 2d 1123 (E.D. Mo. 2002) (holding insured's death in vehicle crash when insured's blood alcohol level was .21 was not accidental); Harrell v. Minn. Mut. Life Ins. Co., 937 S.W.2d 809 (Tenn. 1996) (holding insured's death in auto crash was accidental even though insured was intoxicated).

229. 517 F. Supp. 2d 969 (E.D. Mich. 2007).

230. *Id.* at 971.

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.*

235. *Papenfus*, 517 F. Supp. 2d at 972.

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.* (citing Moore v. LaFayette Life Ins. Co., 458 F.3d 416, 428 (6th Cir. 2006)).

applied to the specific facts of the case, and held that the plaintiff was entitled to summary judgment and payment of the $50,000.[241]

In another ERISA case, the district court rejected the defendants argument that they should not be bound to a collective bargaining agreement because they never read it.[242]

VI. CONCLUSION

"Perhaps no modern commercial enterprise directly affects so many persons in all walks of life as does the insurance business. Insurance touches the home, the family, and the occupation or the business of almost every person in the United States."[243]

The cases surveyed involved real people with real life problems. Insurance covers risks, generally risks of adverse consequences. Accordingly, not unexpectedly, insurance law cases, including those in this *Survey*, involve the push and pull as to what an insurer reasonably should or should not cover. The decisions during the *Survey* period evidence the continuing trend to plain language, contractual and statutory interpretation in Michigan and the ever-extending reach of *Devillers* and *Rory*. Perhaps some future Michigan Supreme Court will reconsider those decisions.

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, an insurer offering little or no meaningful UM or UIM coverage may, in the short term, be at an advantage in the marketplace where it provides little for a premium. This may cause other insurers to likewise further restrict the UM and UIM coverage offered. These coverages are obviously very important when an uninsured or underinsured motorist is legally liable for a bodily injury sustained by an insured. Perhaps statutory or regulatory action in this area will be needed. No doubt there will be further appellate decisions dealing with UM and UIM coverage, as well as what constitutes

241. *Papenfus*, 517 F. Supp. 2d at 973-75.

242. Mich. Elec. Employees Pension Fund v. Encompass Elec. & Data, Inc., 556 F. Supp. 2d 746 (W.D. Mich. 2008).

243. United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 540 (1944) (Black, J.).

accidental bodily injury or self-inflicted injury in disability, life and other areas of insurance.