In this Issue

Section News

From the Chair .................................................................2
Elaine M. Pohl

Editor’s Note .................................................................2
Hal O. Carroll

Congratulations .............................................................2

Announcement: Searchable Directory of Section Members .........................................................5

Annual Meeting Announcement .................................................................7

2013-2014 Officers and Council .................................................................23

Columns

Indemnity Law Case Note: “Natatorium Law” .................................................................7
Noreen L. Slank

Insurance and Indemnity 101: The Certificate of Insurance and Senate Bill 715 ..................12
Hal O. Carroll

Significant Insurance Decisions .................................................................14
Deborah A. Hebert

ERISA Decisions of Interest .................................................................16
Michael R. Shpiece

No-Fault Corner .................................................................18
Ronald M. Sanger Jr.

Feature Articles

Ambiguity in the Insurance Contract: The Doctrine of Contra Proferentem and the Use of Extrinsic Evidence to Resolve Ambiguity .................................................................3
Kate Barnaby and Sandra Lake

The Rise and Fall of the Reasonable Expectations Doctrine in Michigan ......................................8
Moheeb H. Murray and William E. McDonald III
From the Chair

Believe it or not, this column marks my final message to you in the Journal as Chair. I have been honored to serve in this position and I want to thank all of you for your support and dedication to the Section over the last two years. I especially wish to thank my fellow council members and I look forward to continuing to work with many of you in the future. I will take this opportunity to wish the best to my successor, Kathleen Lopilato, who will make a dedicated and hard-working Chair for our Section going forward.

In this issue you will see a notice regarding our upcoming annual meeting, which will be held on September 18, 2014 at 9:30 a.m. at DeVos Place in Grand Rapids, in conjunction with the State Bar’s annual meeting. After a short business meeting to elect officers and council members, we will present a panel discussion on the latest developments in cyber liability claims and insurance coverage for such claims. The program is entitled: Cyber Liability: Will your client – or your firm – be the next Target?

Cyber liability issues affect the clients of many of us, and our own practices as well. It promises to be another lively discussion and a signature event for our Section. We hope to see many of you there.

In addition to the regular reports on case law developments, you will also find several interesting articles in this issue, including [“title”] by [author] and [“title”] by [author]. As always, if you are interested in contributing to future issues of the Journal, please contact our editor, Hal Carroll.

By now, you should have received an e-mail from our new listserv. Messages from the listserv will be delivered from “ii-announce-request@groups.michbar.org.” The listserv is for announcements only; you may not reply to the group. Our council decided to create the listserv in order to more conveniently and efficiently communicate with all of you.

I also wanted to take a moment to mention the Supreme Court Task Force’s recent report on the ongoing issues relating to the State Bar of Michigan, including whether the organization should be a voluntary bar association. The Task Force’s report included certain issues relevant to sections like ours. There have been discussions among section leaders regarding how and whether to respond formally to the Task Force Report. I am monitoring those discussions and issues very closely and will keep you apprised of any important developments in that area. If you have any concerns or wish to discuss this matter further with me, please feel free to contact me.

Once again, it has been my honor to serve as Chair of this Section and I know with your continued support, we will continue to see our Section grow and thrive.

—Elaine M. Pohl, Plunkett Cooney

Congratulations

The Insurance and Indemnity Law Section congratulates council member Catherine Heise on her appointment as Circuit Judge in Wayne County.

Cathy served on the Section Council from the beginning, when we first created the Section in 2007. We will miss her wise counsel, and we know she will apply that same wisdom in her new position.
Ambiguity in the Insurance Contract: The Doctrine of Contra Proferentem and the Use of Extrinsic Evidence to Resolve Ambiguity

By Kate Barnaby, Farm Bureau Insurance of Michigan
Sandra Lake, Hackney, Grover, Hoover & Bean, PLC

How often have you heard counsel for the insured argue that if a provision in an insurance contract is ambiguous, then the ambiguity must be construed against the insurance company as the drafter? More often than not, it seems that the doctrine of contra proferentem is applied automatically, without any consideration as to when, and if, extrinsic evidence may be offered to resolve the ambiguity. Contra proferentem is a Latin phrase (“against the one who brings it forth”) which is used as a standard in contract law. It specifically provides that where a clause in a contract is ambiguous, the clause should be interpreted against the interests of the drafter.

However, this rule is only applied in very limited circumstances. It is often a rule of last resort, not a rule of construction, especially when extrinsic evidence may be offered to resolve the ambiguity. This article will examine the historical and modern day application of the doctrine of contra proferentem and will address how, and when, extrinsic evidence may be utilized before the doctrine of contra proferentem is applied.

The Law as it Stands Today

The rules of interpretation that apply to contracts generally also apply to insurance policies. In order to properly interpret an insurance contract, the intent of the parties must be ascertained. The law presumes that the intent of the parties is embodied within the actual words and language used in the insurance contract itself.

Where the words and language of the insurance contract are clear, the court will enforce the contract as written. Ambiguity will not be read into the insurance contract by a court when none actually exists and courts will not ignore the plain meaning of contractual language in favor of an otherwise strained interpretation. A determination that contractual language in an insurance policy is unambiguous will end the court’s inquiry without any further consideration of extrinsic evidence.

In contrast, where a court deems contractual language in an insurance policy to be ambiguous, the court’s inquiry has just begun. The language in an insurance policy is ambiguous when the language in question could reasonably be understood in different ways or when two provisions irreconcilably conflict. In making the determination as to whether contractual language in an insurance policy is ambiguous, courts will consider all portions of the contract. Effect will be given to every word or phrase contained within the agreement. Thus, the initial question of whether a contract term or provision is ambiguous is a question of law for the court to decide.

An ambiguity is defined as an uncertainty of meaning or intention in a contractual term. There are two types of ambiguity that can be found in the insurance contract: patent and latent. A patent ambiguity is an ambiguity that clearly appears on the face of the document, arising from the language itself. In contrast, a latent ambiguity is an ambiguity that does not readily appear in the language of a document, but instead arises from a collateral matter when the document’s terms are applied or executed.

Historically, the distinction between patent and latent ambiguities was important because patent ambiguities could not be explained away or resolved through the use of extrinsic evidence. However, over time, this distinction has become somewhat less significant across the United States and a significant number of courts have started to recognize that the language or words used in the contract itself are not the sole means of interpretation. Arguably, Michigan courts still seem to prohibit the introduction of extrinsic evidence to resolve patent ambiguities. This appears to be true, even though some Michigan cases have failed to identify the type of ambiguity at issue suggesting that the distinction between patent and latent ambiguities may not always be considered.

If the court determines that the language of an insurance contract creates a latent ambiguity, then extrinsic evidence is admissible to clarify the meaning of the contract. In other words, where a latent ambiguity is determined to exist in an insurance contract, extrinsic evidence is admissible to aid in the determination of the actual intent of the parties. If the actual intent of the parties cannot be resolved through the use of extrinsic evidence, only then should the court apply the doctrine of contra proferentem as means of determining a winner and a loser.


In Klapp v United Ins Group Agency, Inc, the Supreme Court clarified the doctrine of contra proferentem and when it should be applied. Before to Klapp, the doctrine was ap-
plied inconsistently by the Michigan appellate courts. Most often, the doctrine was applied as a rule of construction, that is to say, if the insurance contract was deemed ambiguous, it was construed against the insurance company and in favor of the insured as a matter of law.21 Thus, the court would consider the insurance policy language at issue, determine as a matter of law that the language was ambiguous, and then hold as a matter of law that the insured was entitled to a favorable ruling.

The initial question of whether a contract term or provision is ambiguous is a question of law for the court to decide

In ACIA v De La Garza,22 for example, the Supreme Court held that the spouse of the decedent was entitled to claim uninsured motorist benefits under her own no-fault insurance policy to the extent that she would be entitled to a tort recovery for the death of her spouse. ACIA argued that it only intended uninsured motorist coverage under circumstances where the named insured was injured, not where the injury occurred to the named insured’s spouse. Holding that the contract language as to this issue was ambiguous, the Supreme Court found as a matter of law that the contract must be construed against the drafter, the insurance company, and in favor of coverage.23 The court did not discuss, however, whether the ambiguity created a question of fact for the jury to decide or whether the parties should be permitted to present extrinsic evidence in support of their respective positions.

At other times prior to Klapp, the appellate courts have held that if the policy language at issue is ambiguous, then the intent of the parties is a question of fact for the jury to decide. In Arrigo’s Fleet Service, Inc v Aetna Life & Cas Co24, for example, the Court of Appeals first stated that the ambiguous policy exclusion at issue must be construed against the insurance company and in favor of coverage. The court ultimately held, however, that since the disputed policy exclusion was ambiguous, the issue was one of fact for the jury to decide, and therefore, the trial court erred in ruling on the issue as a matter of law.25 This seeming contradiction in authority was addressed by the Supreme Court in Klapp.

Klapp v United Ins Group

Although the Klapp case did not involve the interpretation of an insurance policy, its holding has since been held to apply to insurance contract disputes and has significantly altered and clarified the doctrine of contra proferentem in terms of how it is applied today. Klapp involved an employment contract dispute between an insurance company and the commissions owing to a retired insurance agent. Justice Markman, writing for the majority, very clearly laid out the rules of contract interpretation.

If a contract is ambiguous, then its interpretation is a question of fact to be decided by the jury. In resolving this question of fact, the jury is to consider relevant extrinsic evidence. If, after review of the extrinsic evidence, the jury still cannot discern the intent of the parties, then the jury is to revert to the rule of last resort—that the contract is to be construed against the drafter of the contract. In other words, the doctrine of contra proferentem is not a rule of contract construction and does nothing to further the quest to determine the intent of the parties. Instead, the doctrine is only applied as a matter of last resort—as a “tie-breaker.”

Klapp further notes that the doctrine of contra proferentem may not be applied to a nondrafter’s unreasonable interpretation of the contract. In other words, the nondrafter cannot offer an irrational, contradictory interpretation of the policy merely to create an air of ambiguity such that the policy must be interpreted in the nondrafter’s favor. Rather, it is only when there is true ambiguity (i.e., the choice between two or more reasonable interpretations) which cannot be resolved through application of the rules of construction that the rule of last resort is applied.

Justices Cavanagh, Weaver, and Kelly concurred in the ultimate result in Klapp, but authored a separate opinion to express their views regarding the application of the doctrine of contra proferentem. The concurring justices would have held that where the at-issue contract was drafted without the input of the other contracting party, such as is often the case with respect to insurance contracts, then the doctrine of contra proferentem should be applied as the primary rule of construction, without reference to extrinsic evidence. The concurring justices were concerned that in the absence of bilateral negotiations amongst the parties, there would be no extrinsic evidence to reflect the intent of all parties to the contract. The concurrence further opined that its proffered application of the doctrine of contra proferentem provides strong incentive to the drafting party to draft clear and unambiguous policy language.

If the actual intent of the parties cannot be resolved through the use of extrinsic evidence, only then should the court apply the doctrine of contra proferentem as means of determining a winner and a loser.

The Use of Extrinsic Evidence to Resolve Ambiguity

Once a policy provision has been deemed to be latently ambiguous, the parties may then present extrinsic evidence to aid in proving the intent of the parties. Extrinsic evidence is defined as evidence relating to a contract but not appearing
on the face of the contract because it comes from other sources, such as statements between the parties or the circumstances surrounding the agreement. While judges ordinarily interpret the language of contracts as a matter of law, if a contract contains a latent ambiguity, it generally becomes the task of the jury to use extrinsic evidence to determine the intent of the parties, subject to proper instruction from the court and based upon evidence of surrounding circumstances and the practical construction of the parties.

In resolving the question as to the meaning of ambiguous contract language, the jury is permitted to consider all relevant and otherwise admissible extrinsic evidence. This is true regardless of whether the insurance contract is drafted with or without bilateral negotiations.

At first glance, it appears that a jury’s consideration of such evidence would violate the parol evidence rule, but this is not the case. The parol evidence rule does not prevent the admission of extrinsic evidence to aid a jury in the interpretation or construction of ambiguous language in an insurance contract when the insurance contract itself does not clearly express the intention of the parties. Michigan case law makes a clear distinction that such evidence is not being admitted for the purpose of adding to, expanding, or detracting from the four corners of the insurance contract. In other words, no violation of the parol evidence rule will occur when extrinsic evidence is introduced to assist a jury in resolving the intended meaning of ambiguous language in an insurance contract because such evidence is not intended to alter the agreement previously reached between the parties, but rather, to explain it as it was originally intended.

A close examination of Michigan case law reveals that many different types of extrinsic evidence can be introduced to help resolve an ambiguity in the insurance contract. For example, conversations between the agent and insured, expert testimony regarding custom and usage, as well as the drafting history behind certain form policy language have been allowed to be introduced for consideration by the jury in resolving an ambiguity. However, certain other types of extrinsic evidence have been held to be inadmissible, including insurance policy language used by the same insurer but in another state and a self-serving affidavit of an insurance company employee (but only because the employee was not involved in drafting the insurance policy language in question). If the ambiguity cannot be resolved through the use of extrinsic evidence, only then should the court apply the doctrine of contra proferentem as a tie-breaker or means of determining a winner and a loser.

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**Announcement**

The Insurance and Indemnity Law Section’s

**Searchable Directory of Members**

Is Now Operational!

All Section members are invited and encouraged to register in the directory and indicate their areas of expertise and the services they can provide.

The directory will be a resource for attorneys and court personnel in Michigan to assist them in finding Section members to assist in the handling and/or resolution of litigation.

When you register you can include the following information, in addition to information on how to contact you.

**Areas of Practice:**
- Indemnity Issues, Contract Drafting, Insurance In-House, Insurance Policy Drafting,
- Insurance Coverage (Liability, First Party Auto, Third Party Auto, Life, Health, Disability)
- ERISA
- Regulatory Matters
- Corporate/Transactional

**Services:**
- Consultation
- Litigation and Appeals
- Contract Review
- ADR (Neutral Evaluation, Facilitation, Mediation)

**Client Base** (Percentage of work for insurers and insureds)

**To JOIN the Searchable Directory**, go to [http://mistatebar.com/add-me](http://mistatebar.com/add-me) check the appropriate boxes, enter your personal data, and click on “enter.”

**To SEARCH in the Directory**, go to [http://mistatebar.com](http://mistatebar.com), click on “find a lawyer,” check as many of the boxes as apply. You can select by one or more of these:
- Areas of Practice, Client Base (percentage of clients who are insurers, and insureds), Services Provided (e.g., ADR, Contract Analysis, Litigation), Location (by county).
- Then Click on “Apply”
Conclusion

A finding of contractual ambiguity is not a death knell to the insurance company’s position in a contractual dispute with the insured. An argument by the insured that a contract ambiguity must be construed as a matter of law against the insurance company should be strongly refuted.

As a practical matter, the issue is generally going to be addressed by the court for the first time through a motion for summary disposition (or cross-motions for summary disposition). More often than not, both parties will argue that the contractual language at issue is unambiguous and should be construed in their respective favor. Insurers may be wise, however, to preserve the alternative argument that if the policy provision is deemed ambiguous, then the insurance company should be permitted to present extrinsic evidence in support of its interpretation of the contract.

Determining what evidence constitutes “relevant” extrinsic evidence is somewhat amorphous, particularly considering the fact that the insured mostly likely had no participation in the drafting of the insurance agreement. But under current case law, any evidence that would assist the trier of fact in determining the contemporaneous understanding of the parties or the common usage and custom of a policy provision is admissible.

About the Authors

Kate F. Barnaby is a compliance and regulatory attorney at Farm Bureau Insurance of Michigan. Kate has experience handling complex litigation, transactional, and regulatory matters in the insurance and oil and gas industries. Kate is a graduate of Thomas M. Cooley Law School and was named an Up & Coming Lawyer by Michigan Lawyer’s Weekly in 2012.

Sandra J. Lake is an attorney at Hackney, Grover, Hoover & Bean, PLC and has over 15 years of experience concentrating in the areas of insurance defense and insurance coverage in both the trial courts and appellate courts. She has represented many insurance carriers in both the prosecution and defense of declaratory judgment actions concerning policy interpretation.

Endnotes

2 McIntosh v Groomes, 227 Mich 215, 218; 198 NW2d 954 (1924).
3 City of Grosse Pointe Park v Michigan Municipal Liability and Property Pool at 218-219.
4 Id. at 215.
8 Hunter v Pearl Assurance Co, Ltd, 292 Mich 543, 545; 291 NW 58 (1940).
10 Black’s Law Dictionary (3rd ed.).
13 Black’s Law Dictionary (7th ed).
16 Shay, supra, at 668.
18 City of Grosse Pointe Park v Michigan Municipal Liability and Property Pool at 198.
23 Id. at 214.
25 Id. at 492.
27 Parrett v Am Ship Bldg Co, 990 F2d 854, 858 (CA 6, 1993); Scott v Anchor Motor Freight, Inc, 496 F2d 276, 280 (CA 6, 1974).
29 Klapp at 471.
30 Edoff v Hecht, 270 Mich 689, 695-696; 260 NW 93 (1935).
31 Id.
32 Klapp, supra, at 470.
33 Id.
35 Cole v Auto-Owners Ins Co, supra; Wilcox v Munger, unpublished opinion per curiam of the Court of Appeals, issued December 20, 2007 (Docket No. 275329).
INSURANCE AND INDEMNITY LAW SECTION

Annual Meeting
DeVos Place, Grand Rapids, Michigan
September 18, 2014, 9:30-11:30am

Election of Council and Officers
Followed by our program

Cyber Liability: Will your client – or your firm – be the next Target?

Target Stores’ recent data breach is an example of the kind of business risk that many businesses face in today’s business climate. The risk isn’t limited to clients – law firms also face risks of unintended disclosure of confidential information.

Come learn about the types of coverages that may help your clients and your firm manage Cyber Risk exposures.

Third Party Risks include:
• Liability for data losses (unauthorized disclosure of corporate or personal information of customer or client).
• losses due to the inability of authorized persons to access the network due to a cyber attack
• transmission of virus or malware

First Party Risks include:
• expense of responding to and remediating a network breach
• expense of correcting credit and other records
• expense of notifying victims of data loss
• expense of recovering stolen personal identity
• business income loss from suspension of operations due to data breach

This event is FREE, but please register (http://www.michbar.org/annualmeeting.cfm) to allow for proper planning. Thank you.

Indemnity Law Case Note

“Natatorium Law”

By Noreen L. Slank
Collins, Einhorn, Farrell & Ulanaoff; noreen.slank@ceflawyers.com

Well, not exactly natatorium law. But the indoor swimming pool at the Sherman Lake YMCA completed in 1999 now has four published contractual indemnity appellate opinions to its credit and threatens to become a legal sub-specialty.

In 2009, the Court of Appeals held the lawsuit was time-barred based on application of the statute of repose that applies to architects, engineers and contractors. See MCL 600.5839 and 285 Mich App 289 (2009). Don’t linger too long on that because later the Supreme Court reversed. See 489 Mich 355 (2011). It is the general six-year contract limitation period that applies to indemnity cases. The six years runs from when the claim first accrues.

The case went back to the Court of Appeals partly to figure out when the indemnity claim accrued. Focusing here only on indemnity, the Court of Appeals again decided in favor of Ahrens Construction, the potential stuckee under the contract. It ruled that there’d been no claim or demand made under the indemnity contract and, if there had been, Miller-Davis hadn’t presented sufficient proof to show that the natatorium moisture problem was caused by Ahrens’s failures. See 296 Mich App 56 (2012). Wrong again.

On April 15, 2014, a unanimous Supreme Court held that the YMCA had indeed made a claim or demand on Miller-Davis. See 495 Mich 161 (2014). And its indemnity case was not barred by the 6-year statute of limitations (unlike Miller-Davis’s breach of contract case). That’s because Ahrens’s failure to indemnify Miller-Davis was “distinct” from its breach of contract for failure to install the roof properly. To my way of thinking, that all makes sense.

But the Supreme Court did not tell us how to know when an indemnity claim accrues. The Court says that breach of the indemnity agreement “necessarily occurred after Ahrens’s breach of the underlying promise to conform its work to the subcontract specifications.” True, of course. But when limitation periods start running in indemnity cases is very tricky and our case law leaves lots of unfortunate wiggle room for argument.

Miller-Davis offered three possible indemnity claim accrual dates. All three dates are in 2003, long before Miller-Davis’s 2005 indemnity complaint was in danger of missing its six-year limitation period. Those three alternatives were February 2003 when Miller-Davis did a partial roof tear-off
and discovered Ahern's non-conforming work, August 2003 when Miller-Davis entered into an agreement with the YMCA to fix the roof, and December 2003 when an engineering firm certified that Miller-Davis had corrected Ahern's defective work. The Supreme Court felt it didn't have to decide what the accrual date was for the indemnity claim "because we agree the claim did not accrue before February, 2003…".

Finally, this new Miller-Davis opinion gives the parties the answer they need. But in terms of the development of the law, it sheds more heat than light on the issue of when indemnity claims accrue. Clearly discovery dates don't set limitation periods in motion unless a statute says otherwise, see Eby v Trettadue, 479 Mich 378 (2007). And no statute says otherwise for indemnity cases. So the state of Miller-Davis's knowledge of the claim (in February, 2003 or otherwise) wouldn't be the long pole in any accrual tent. The Supreme Court is inattentive to the potential role of tender and rejection of tender un-der the indemnity agreement as setting an accrual date.

We will have to wait longer to understand some very key points about the operation of limitation periods in indemnity cases. The limitation period is six years. But when the six year clock starts running is still open to debate.

Stay tuned for yet another chapter in natatorium law. The Supreme Court remanded the case to the Circuit Court for entry of judgment in favor of Miller-Davis "and to determine whether Miller-Davis is entitled to attorney's fees under the relevant indemnification clause."

About the Author

Noreen Slank, shareholder and head of the appellate practice group at Collins, Einhorn, Farrell & Ulanoff, concentrates her practice on civil appeals and insurance coverage. Her email address is noreen.slank@ceflawyers.com.

The Rise and Fall of the Reasonable Expectations Doctrine in Michigan

By Moheeb H. Murray and William E. McDonald III, Bush Seyferth & Paige PLLC

Michigan is now clearly among the small minority of states that completely reject the "reasonable expectations doctrine," which came to jurisprudential prominence after it was articulated in a Harvard Law Review article written by Professor (later U.S. District Court Judge) Robert E. Keeton in 1970. In his article, Professor Keeton stated a doctrine that he believed explained case outcomes where courts interpreting insurance policies reached conclusions in conflict with the express terms of the contract. After reviewing the cases, Professor Keeton stated the reasonable expectations doctrine as follows: "The objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of the insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." The doctrine turns on the idea that, if the meaning of a policy term can be ascertained only after "painstaking study," and that meaning is "inconsistent with the reasonable expectations of a policyholder having an ordinary degree of familiarity with the type of coverage involved," courts should rule in accordance with the policyholder's reasonable expectations.

After Professor Keeton's article was published, courts across the country quickly began applying the doctrine in insurance cases where they believed that the actual contract language could not or should not be applied for various reasons. Depending on how one characterizes the scope of the reasonable expectations doctrine, approximately 39 states have adopted it in at least some form. For approximately three decades, it was unclear if Michigan courts recognized the doctrine, and if so, in what form. But in 2003, the Michigan Supreme Court decided Wilkie v Auto-Owners Ins Co, firmly staking its tent in the camp with the ten other states that have explicitly rejected the doctrine outright.

The Three Versions of the Reasonable Expectations Doctrine

Commentators and courts that have examined the doctrine's application in various courts have generally identified three different versions of the doctrine. One version is the "ambiguity version" in which a court will rely on the insured's reasonable expectations to resolve interpretation issues only if a pertinent contract term is first deemed to be ambiguous. A second version is a "fine print" or "prominence" version under which courts need not find an ambiguity before applying the doctrine; they can refuse to enforce clear and unambiguous terms if they find the disputed terms to be "buried" or "hidden" in the contract and such terms are in conflict with the insured's reasonable expectations, even if the terms are clear and unambiguous.
A third version has been referred to as “the whole transaction” or “unqualified” version. Courts applying this version enforce the insured’s expectations by looking beyond the policy to other factors such as the insurers’ “marketing patterns and general practices,” even if the policy language is unambiguous and obvious.

Michigan Rejects the Doctrine

As noted above, over a span of more than 30 years from 1970 through 2003, it was unclear whether and to what extent Michigan courts recognized the reasonable expectations doctrine. But the Michigan Supreme Court ended the uncertainty in its 2003 decision in Wilkie, declaring “we hold that the rule of reasonable expectations has no application in Michigan, and those cases that recognized this doctrine are to that extent overruled.”

In reaching its decision, the court first examined Michigan’s “puzzling history with the doctrine.” The doctrine first appeared in Michigan jurisprudence in the 1970 decision of Zurich Ins Co v Rombough, in which the court “held, exceptionally, that ambiguous policy provisions in an insurance contract had to be construed against the insurance company and in favor of the insured.” The Wilkie court noted that, in the Rombough decision, the court had merely cited a California Supreme Court case in which that court had “fleetingly referenced the rule of reasonable expectations.” But the Wilkie court concluded that the fleeting reference “was only to fully outline” the California court’s position, because Rombough was decided based on construing an ambiguous provision against the drafter; the reference to the doctrine was therefore merely “obiter dicta.”

The Michigan Supreme Court ended the uncertainty in its 2003 decision in Wilkie, declaring “we hold that the rule of reasonable expectations has no application in Michigan, and those cases that recognized this doctrine are to that extent overruled.”

The Wilkie court then noted that the doctrine was next referenced in the 1980 Michigan Supreme Court decision of Bradley v Mid-Century Ins Co, which included a discussion of a setoff provision in an insurance contract and a statement by the court that “[t]he set-off clause, whether regarded as ambiguous or inconsistent with the rule of reasonable expectations of the insured, cannot be enforced as written.” But the Wilkie court characterized that discussion as merely “an equivocal passage of the opinion,” and not an adoption of the doctrine. Id.

Two years later, the Michigan Supreme Court decided Raska v Farm Bureau Ins Co. The Wilkie court observed that in Raska, “a majority of the Court took pains to reject the rule of reasonable expectations,” and the Raska court did not mention the Bradley case decided just two years earlier. That omission, the Wilkie court concluded, “was not an oversight,” because Bradley was decided on grounds other than the reasonable expectations doctrine, and “it was probable that the majority considered any discussion of the rule of reasonable expectations in Bradley dicta, not requiring analysis.”

But then in 1986, the Michigan Supreme Court issued a plurality opinion in Powers v DAIIE in which the plurality cited Raska for the proposition that an insured’s reasonable expectation based on his or her reading of the policy was enforceable, and it further stated that it was unnecessary to even find an ambiguity before applying the doctrine. The Wilkie court found this “a curious source of authority” since Raska did not mention such a proposition. It therefore concluded that the Powers decision “apparently misconceived” prior case law regarding the doctrine and that the case was, in any event, not binding because it was a plurality decision.

Although Powers was not binding, in 1991, the Michigan Supreme Court decided Vanguard Insurance Co v Clark, agreeing with the plurality in Powers and holding the reasonable expectations rule was applicable to insurance-contract construction. This conclusion was puzzling, the Wilkie court held, because the Vanguard court “characterized the ‘sole issue’ in the case as whether to adopt the theory of dual or concurrent casualty in insurance,” and that issue “was resolved without any need to delve into the doctrine of reasonable expectations.” Thus, according to Wilkie, the “discussion of reasonable expectations was merely dicta.”

Several Michigan Supreme Court cases decided in the years after Vanguard “applied, but did not address the provenance of, the rule of reasonable expectations, apparently assuming it to be the law.” But as the Wilkie court observed, none of those cases cited the Raska decision in which the court had previously rejected the reasonable expectations doctrine. Then came the 1999 decision of Farm Bureau Mut Ins Co v Nikkel where the Michigan Supreme Court expressly “abandoned the Powers approach,” holding that “while the rule of reasonable expectations was, at most, an adjunct to the rules of construction, there was no occasion to invoke it because, under Vanguard, it could only be utilized where there was an ambiguity in the contract, which was not present in Nikkel.” The Nikkel case did not, however, expressly reject the reasonable expectations doctrine.

After summarizing the doctrine’s history in Michigan, the Wilkie court stated that it was “confronted with a confused jumble of ignored precedent, silently acquiesced to plurality opinions, and dicta, all of which, with little scrutiny, have been piled on each other to establish authority.” As noted above, the court addressed the issue by unequivocally rejecting the reasonable expectations doctrine.
The Court’s Rationale for Rejecting the Doctrine

Aside from the lack of authority for the proposition that Michigan courts had actually ever adopted the reasonable expectations doctrine, the Wilkie court also rejected the doctrine on policy grounds. Fundamental to the court’s decision was long-standing precedent favoring the freedom of contract and enforcing unambiguous contract terms as written, and the court decided that “the rule of reasonable expectations markedly fails in this respect.”31

Specifically, regarding the doctrine, the court observed that “[t]heir approach, where judges divine the parties’ reasonable expectations and then rewrite the contract accordingly, is contrary to the bedrock principle of American contract law that parties are free to contract as they see fit, and the courts are to enforce the agreement as written absent some highly unusual circumstance, such as a contract in violation of law or public policy.”32 The court further described the freedom to contract without government interference as “ancient and irrefutable” and “an unmistakable and ineradicable part of the legal fabric of our society.”33

Accordingly, the court held that “[t]he rule of reasonable expectations clearly has no application to unambiguous contracts” because “one’s alleged ‘reasonable expectations’ cannot supersede the clear language of a contract.”34 The court further observed that, to the extent the doctrine is applied to interpret an ambiguous contract provision, it is no different from the long-standing rule of contra proferentem, which states that “if a contract is ambiguous and the parties’ intent cannot be discerned from extrinsic evidence, the contract should be interpreted against the insurer.”35 “In other words, when its application is limited to ambiguous contracts, the rule of reasonable expectations is just a surrogate for the rule of construing against the drafter.”36

The Wilkie court therefore concluded that “because a policyholder cannot be said to have reasonably expected something different from the clear language of the contract,” the doctrine cannot apply to unambiguous contracts.37 Further, because it is already well settled that ambiguous language should be construed against the drafter, the doctrine “adds nothing to the way in which Michigan courts construe contracts and thus the rule of reasonable expectations should be abolished.”38 In sum, since Michigan law already provided an established doctrine for dealing with contractual ambiguities, there was no reason to adopt the reasonable expectations rule.

Other Policy Arguments Support Rejection

As just mentioned, the Michigan Supreme Court has clearly jettisoned the application of reasonable expectations doctrine from Michigan jurisprudence because contracts should be construed according to their clear language and Michigan law already follows the doctrine of contra proferentem to deal with ambiguous contract language. Although the Wilkie court did not specifically address them, there are also other policy reasons, which are consistent with the court’s freedom-of-contract rationale, that support rejecting the doctrine.

The justification most often given for the “whole transaction” or the “fine print” versions of the reasonable expectations doctrine is that insurance contracts are somehow inherently different from other contracts.39 Proponents of the reasonable expectations doctrine point to various considerations for treating insurance policies differently, including that (1) there is a likelihood that the purchaser will not receive the policy until after paying the first premium; (2) there is an inequality of bargaining power between the insurer and insured; and (3) insurance policies are typically standard forms with technical terms and fine print.40 Thus, proponents contend that because consumers purportedly do not read their contracts and cannot negotiate terms, consumers do not meaningfully assent to the “boilerplate” terms.41

As an initial matter, the Michigan Supreme Court has already expressly ruled that regardless of whether one characterizes insurance policies as “adhesive” contracts, “insurance policies are subject to the same contract construction principles that apply to any other species of contract.”42 Consistent with that ruling, some commentators note that the existence of form insurance contracts results from market pressures to lower transaction costs, not unequal bargaining power. They argue that using form policies, rather than separately negotiated and supervised contracts, lowers transaction costs to the insurance-consuming population, resulting in lower premiums, and therefore makes insurance available for more consumers.43

Thus, as opponents of the reasonable expectations doctrine contend, because form insurance contracts are a market-driven reality, as opposed to an abuse of leverage by the insurer, there is no basis to treat insurance policies differently from other contracts. Moreover, even if unequal bargaining power were a basis for avoiding unambiguous contract terms, the reasonable expectations doctrine would be an economically inefficient way of addressing that issue, because it drives up the cost of insurance for the public as a whole, more than offsetting the benefit to a single policyholder in his or her individual case.44
Opponents of the “fine print” version of the doctrine also contend that, for at least two reasons, one cannot necessarily conclude that since the insurer writes the contract, the contract will include only terms favorable to the insurer and unfavorable to the insured.\(^4\) First, the terms and rates of insurance policies are regulated by respective state insurance commissions, which should prevent unduly harsh terms from entering insurance contracts at the outset.\(^4\) Second, insureds who fear that an insurer has “hidden” unduly harsh terms in the fine print will discount the amount they are willing to pay for insurance from such an insurer.\(^4\) Thus, as a whole, insurers have a disincentive to gain a reputation for using harsh terms against insureds.\(^4\) Instead, insurers are incentivized to develop good claims-adjustment reputation.\(^4\)

Another policy consideration against applying the “fine-print” version of the doctrine is that it actually creates an increasing spiral of complex policy terms. The doctrine’s opponents contend that applying the doctrine causes insurers to respond to uncertainty by drafting longer and more complex policies in attempts to capture legal words of art or other phrases that courts rely on to find coverage based on what courts conclude an insured “reasonably” expects.\(^5\) Therefore, the argument states, the additional judicial review of private contracts resulting from applying the reasonable expectations doctrine does not lessen the problems associated with the length and technicality of insurance contracts, but instead exacerbates them in the long run. This again, leads to increased costs and higher premiums.

In sum, the Wilkie court generally relied on overarching policy principles as the basis for its ruling that the reasonable expectations doctrine contravenes freedom-of-contract rights in a free society. And although the court did not delve into a detailed law-and-economics analysis, each of the policy considerations above discussed further illustrates why “government interference”\(^6\) in the form of applying the reasonable expectations rule can lead to economic inefficiencies.

Conclusion

Since Professor Keeton first articulated the reasonable expectations doctrine, it has morphed into various versions, and its application in and across various jurisdictions has often been inconsistent and results-based in favor of insureds, leading to uncertainty about whether and to what extent even unambiguous insurance policy terms will be enforced. By eschewing the reasonable expectations doctrine, the Michigan Supreme Court has chosen to stand with a minority of jurisdictions. But in doing so, it has remained consistent with Michigan’s long-standing precedent favoring the freedom to contract without undue government intervention by maintaining the position that unambiguous contract terms be enforced as written. Moreover, it has done so while preserving the doctrine of contra proferentem to protect insureds when policy terms are ambiguous. This stance provides parties in Michigan with more certainty which insurance policy provisions will actually be enforced, which in turn, serves the public interest by lowering transaction costs for insurance, avoiding economic inefficiencies, and making insurance available to more people.

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Endnotes

3. Keeton, supra, 967.
4. Id. at 968; Popkik & Quackenbos, supra, 428.
7. Ware, supra, 1467; Popkik & Quackenbos, supra, 430.
8. Ware, supra, 1472-1473; Popkik & Quackenbos, supra, 430.
9. Ware, supra, 1472.
10. Wilkie, 469 Mich at 63.
11. Id. at 55.
12. 384 Mich 228; 180 NW2d 775 (1970)
14. Id.
15. Id.
In the world of liability insurance, the most common policy is the “occurrence” policy. If the occurrence took place in the policy year and meets the policy’s other requirements, the policy applies and provides the coverage. ‘An ‘occurrence’ policy protects the policyholder from liability for any act done while the policy is in effect, whereas a “claims made policy” protects the holder only against claims made during the life of the policy.”1

Claims made policies are the relative newcomers in liability insurance. Claims made policies “are of relatively recent origin and were developed primarily to deal with situations in which the error, omission or negligent act is difficult to pinpoint and may have occurred over an extended period of time.”2 This illustrates why claims made policies are so often used to insure professional liability. For an occurrence policy, where the insured is alleged to have been negligent, the negligent occurrence and the injury are almost always contemporaneous. For professionals, the situation is different, because the alleged negligence will have occurred during the course of professionals services.

From the insurer’s perspective, the claims-made policy has another advantage over the occurrence policy. When the insurer’s occurrence policy covers policy year 2014, the insurer cannot close its books on its risk when 2014 ends, because the insured claimant will have as many years to sue as the statute of limitations permits. Claims-made policies allow the insurer to close its books when the policy year ends, because the policy only covers claims that are made in the policy year, whether the underlying event took place in that year or not.

Claims made coverage represents a compromise in which the insurer limits its risk in exchange for a premium that reflects the reduced risk.
Claims Made and Reported

The insurer can only close its books on the policy year when it knows there are no claims for that policy year. So every claims-made policy has a reporting requirement, requiring that the claim must be “made and reported” during the policy period. Because the reporting requirement is written as a precondition of coverage, the cases have held that the insurer need not show prejudice from late notice. “That principle developed in the context of ‘occurrence’ policies. We see no basis for applying that principle here.”

There is a statute that seems to compel a different result. MCL 500.3008 refers to liability policies generally and excuses late notice if the insured can show that it was not reasonably possible to give notice in a timely way:

Sec. 3008. In such liability policies there shall be . . . a provision that failure to give any notice required to be given by such policy within the time specified therein shall not invalidate any claim made by the insured if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible.

The Supreme Court has held that this applies only when the insured can show that it was not reasonably possible to give notice, but that the prejudice requirement does not apply. The failure to make a timely report of the claim is fatal to coverage.

Most policies allow a grace period, called an “extended reporting period,” so that if a claim comes in at the end of the year, the insured will have typically 60 days to report it.

Retroactive Date

The fact that the date of the claim and not the date of the incident is what determines coverage leads to one of the characteristics peculiar to claims-made policies, the retroactive date (in the jargon of the trade, “retro date”). Assume an attorney leaves her firm in 2014 and strikes out on her own. She buys her professional liability insurance policy for 2014, with an inception date of January 1. Will the policy cover her for any claim that is made in 2014, even if the underlying negligence took place in, say 2012? That’s a particularly unappealing deal from the perspective of the insurer. For one thing, it means that the insurer doesn’t know what its exposure is, because it doesn’t know what happened in prior years. And there’s always the concern that the attorney may have bought the insurance precisely because she knows of some potential liability.

So every claims-made policy has a retro date. Sometimes it will be negotiated, and in our hypothetical, the insurer and the insured might agree that, in exchange for an increased premium, the policy will apply to any claim made in 2014 if the underlying event took place after 2011. Often though, the policy will set the retro date equal to the inception date of the policy. That means the coverage for the first year is very small, since the underlying event and the claim both have to come in 2014. But in 2015 and future years, as long as the insured stays with the same insurer, the retro date will stay January 1, 2014, the inception date of the first policy with that insurer. The premium will also go up, because the insurer’s risk now extends to two years’ worth of conduct.

So every claims-made policy has a reporting requirement, requiring that the claim must be “made and reported” during the policy period. Because the reporting requirement is written as a precondition of coverage, the cases have held that the insurer need not show prejudice from late notice.

Tail Coverage

Now let’s look at the other end. In 2025, our hypothetical attorney, having reached the point where she can retire, decides to do so. If she decides to stop renewing the insurance, she will have exposure for any claims that are made in 2026 and after. For this, insurers offer an “Additional Extended Reporting Period” in exchange for an additional premium if the insured elects not to continue coverage. This is commonly called “tail coverage.” The policy will commit to providing that coverage, often for three years, and will cap the premium, such as not to exceed 200% of the last year’s premium. In our hypothetical, the retiring attorney will be able to buy coverage for any claim made in the three-year period after 2025 where the underlying event took place between January 1, 2014 and December 31, 2025.

About the Author

Hal Carroll is a co-founder and first chairperson of the Insurance and Indemnity Law Section. Mr. Carroll practices extensively in the area of insurance coverage and indemnity law, and was designated a “Super Lawyer®” again in 2013. He also consults with businesses and insurers on the drafting of contracts, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His website is www.HalOCarrollEsq.com and his email address is HOC@HalOCarrollEsq.com.

Endnotes

2 Stine at 98-99.
Significant Insurance Decisions

By Deborah A. Hebert, Collins, Einhorn, Farrell; Deborah.hebert@ceflawyers.com

6TH Circuit Court of Appeals

Death Benefits – Alcohol Exclusion

_Cultrona v Nationwide Life Ins Co_
748 F3d 698 (6th Cir 2014)

Death benefits were not arbitrarily or capriciously denied where the policy excluded benefits for covered persons deemed to be under the influence of alcohol at the time of injury or death and where the deceased was medically determined to have died from acute ethanol intoxication (.22) and prolonged and extreme hypertension of neck and torso while intoxicated and unconscious. The insurer conducted a full and fair review of the claim and the beneficiary failed to produce any evidence to rebut application of the exclusion. The court further affirmed the trial court’s award of $8,910 to the beneficiary, which amount represented a statutory penalty of $55 dollars a day for the insurer’s failure to timely provide a copy of the policy upon written request.

Michigan Supreme Court

Policy-Mandated Appraisal is a Verdict for Purposes of Sanctions

_Acorn Investment Co v Michigan Basic Property Ins Assc_
___ Mich ___ (2014)
(Docket No. 146452)

A property damage appraisal obtained under MCL 500.2833 (the provision in the Insurance Code requiring parties to a fire insurance contract to resolve valuation disputes by appraisal) is a “verdict” for purposes of case evaluation sanctions under MCR 2.403(O).

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waive its claim by failing to present evidence of that cost to the appraisers. The case was remanded for further proceedings.

Michigan Court of Appeals—Published
Catastrophic Claims Association Is Not Subject to FOIA
Coalition Protecting Auto No-Fault Brain
Injury Asse of Mi v MCCA
___ Mich App ___ (2014)
(Docket No. 314310)

The Michigan Catastrophic Claims Association (MCCA) is not subject to FOIA. Plaintiffs submitted a request for records of all claims serviced by MCCA, including information about numbers of claims handled, total amounts paid, dates and types of injuries, etc. The trial court determined that the MCCA was bound to respond because it is a public body created by statute. The Court of Appeals reversed, holding that even if the MCCA were a public body, a provision in FOIA, MCL 15.243(1), exempts such public bodies from disclosure where some other statute so provides. A section of the Insurance Code, MCL 500.134, expressly exempts the MCCA from FOIA obligations. MCL 500.134(4) and (6)(c). This exemption applies to any and all records.

Michigan Court of Appeals—Unpublished
Failure to Read Policy Does Not Bar Claim Against Agent
Schumitsch v Pioneer State Mutual Ins Co
Unpublished Court of Appeals Opinion of March 20, 2014
(Docket No. 313046)

After plaintiffs’ pole barn was damaged by fire, they learned that their farm-owners policy did not cover the loss because they had not purchased property coverage for that building. Plaintiffs sued both the insurance company and the agency, claiming negligence and misrepresentation. The Court of Appeals upheld the order of summary disposition for defendants on the misrepresentation claim because plaintiffs admitted they never read the policy. But the case was remanded for further proceedings on the claim of negligence against the agency because one of the plaintiffs testified that she “inquired of the agency on two occasions whether the barns were covered and she was assured that they were.” Her failure to read the policy did not bar this claim.

Failure of Paint to Adhere Is Not an Occurrence
Dave Cole Decorators, Inc. v Westfield Ins Co
Unpublished Court of Appeals Opinion of March 25, 2014
(Docket No. 313641)

CGL policy does not cover the insured painting contractor for the cost of having to clean and repaint steel components of a building after the first coat of paint failed to properly adhere. Because there were no damages beyond the cost of remediating the insured’s own work, there was no “occurrence” and the CGL insuring agreement was not triggered.

Health Insurance – Failure to Disclose Relevant Information Bars Coverage
Tibble v American Community Mutual Ins Co
Unpublished Court of Appeals Opinion of May 1, 2014
(Docket No. 314271)

Defendant health insurer is not obligated to cover medical expenses incurred by the policyholder in a dirt bike accident that occurred one day before coverage commenced. The insurer had informed the policyholder in writing that the policy would not pay for treatment of pre-existing conditions. In addition, the insurer was permitted to cancel the policy after the accident due to the policyholder’s misrepresentations about his weight and participation in organized motocross racing. As to the claims against the agency for alleged negligence in failing to procure a policy with Blue Cross/Blue Shield, plaintiff failed to produce evidence that such a policy would have made any difference and thus failed to offer support for the causation element of his claim.

PIP Claim Resolution Is Not Res Judicata as to UM Claim
Miles v State Farm Mutual Automobile Ins Co
Unpublished Court of Appeals Opinion of May 6, 2014
(Docket No. 311699)

Plaintiff pedestrian was injured when he was struck by an uninsured vehicle. State Farm insured a vehicle owned by plaintiff’s mother, with whom plaintiff resided, but denied PIP benefits on the ground that plaintiff’s medical problems were unrelated to the accident. Plaintiff sued and the PIP claim was settled. A short time later, plaintiff filed a second lawsuit, claiming additional PIP benefits and seeking uninsured motorist benefits for the first time. After the parties again resolved the PIP claim, the trial court dismissed the UM claim on grounds of res judicata. The Court of Appeals reversed in a split decision, because PIP claims differ from UM claims, in that PIP benefits are immediately available without regard to fault and are subject to a short limitations period. A UM claim, in contrast, requires a showing of fault on the part of a third person and involves different elements of damage. The majority concluded that res judicata did not prevent a UM lawsuit after the conclusion of a lawsuit for PIP benefits. The dissenting judge would have applied res judicata because both claims arise out of the same transaction or accident.
Significant Insurance Decisions
Continued from page 15

Homeowner Policy Does Not Insure Relatives of Deceased Policyholder

*Auto-Owners Ins Co v Robert E. McGowan Trust*

Unpublished Court of Appeals Opinion of May 15, 2014 (Docket No. 314118)

Homeowners policy does not provide liability coverage for the trustee or relatives of a named insured after his death because they do not qualify as “insureds” under the policy and because there was no evidence to support coverage under theories of equitable estoppel or implied contract. Prior to his death in 2006, Robert McGowan owned seasonal property which he insured under a homeowners policy with Auto-Owners. After McGowan’s death, his trustee and children submitted a change of address form and continued paying premiums for the next five years. No one ever informed Auto-Owners of the insured’s death or sought to add others to the policy. In the course of investigating a claim in 2011, Auto-Owners discovered the fact of the insured’s death. It opted to defend the liability claim under a reservation of rights, while pursuing this declaratory judgment action on coverage. The Court of Appeals concluded that nothing in the policy or in any communication from Auto-Owners suggested that the Trust or the children were insureds and “no reasonable person could view Auto-Owners’ conduct as indicative of an intent to contract with defendants as named insureds.”

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ERISA Decisions of Interest

*Michael R. Shpiece, Michael R. Shpiece, PC*

**Sixth Circuit**

Blue Cross Blue Shield Breached Fiduciary Duty By Collecting “Transfer Fees” From Self-Funded Clients.

*Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Michigan, ___ F.3d ___, 2014 WL 1910554 (6th Circ. May 14, 2014).*

Until the mid-1970’s, BCBSM provided its coverage on essentially a fully underwritten basis; that is, it would charge its customers a premium, and out of that premium, BCBSM was obligated to provide all covered services and pay its costs of operations. These costs of operations included maintaining a level of “contingency reserves” and an implicit or explicit subsidy for its subscribers who did not obtain BCBSM coverage through an employer or some other group (“non-group subscribers”) and subscribers who were retirees.

However, in the 1970’s, many BCBSM customers – especially larger customers – moved to an arrangement with BCBSM whereby the group itself would be responsible for paying for the covered services received by its enrollees, although BCBSM would be responsible for processing the claims. In other words, BCBSM would process the claims, determine the amount payable to providers for those claims, prepare checks in that amount to the providers, and notify the group of that amount. The group would then provide BCBSM with that amount and BCBSM would release the checks to the providers. BCBSM would charge the group a fee for the administrative services it provided. In addition to its administrative fee, BCBSM began either implicitly or explicitly including a fee for the contingency reserves and the subsidy for retirees and non-group subscribers. Many groups objected to paying these additional charges and several actually refused to make these payments. This put BCBSM in a difficult position: the payments were required under both statute and by order of the Insurance Commissioner, but the customers refused to pay them. See MCL 550.1609(5) (authorizing cost transfers). BCBSM responded to this predicament by trying alternate ways of characterizing these additional charges.

One way was through a “Retention Reallocation” program that produced revenue in addition to the administrative fee. BCBSM has historically negotiated discounts with its participating providers, such as hospitals. These discounts result in BCBSM (and its self-funded customers) paying providers significantly less than what the providers charged other payors. Under the Retention Reallocation program, BCBSM added the additional charges to the amount of the discounted provider payments, in essence telling the self-funded group that the cost of that group’s claims were more than what was actually paid to the providers. The Retention Reallocation program began in 1993.

Several groups, including Hi-Lex Controls, eventually challenged this. Hi-Lex sued BCBSM in 2011, alleging that BCBSM breached its fiduciary duty under ERISA by collecting the additional charges under this program. The district court ruled in favor of Hi-Lex and awarded over $5.1 million in damages and over $900,000 in pre-judgment interest. BCBSM appealed.
The Sixth Circuit began by holding that BCBSM, at least with respect to the collection of these additional charges, was an ERISA fiduciary. Under ERISA, a person is a fiduciary if it has or exercises any discretionary control over a plan or if it exercises any authority or control over plan assets (i.e., even non-discretionary authority or control). This is determined by a party’s functional role and cannot be disclaimed by contract. BCBSM argued that “simple adherence to a contract’s term giving a party ‘the unilateral right to retain funds as compensation’ does not give rise to fiduciary status.” But the court held that this did not apply when the party exercises discretion with respect to that right, and the testimony indicated that BCBSM, on occasion, waived, delayed collection of, or reduced the amount of the additional charges.

BCBSM then argued that the additional charges were collected from money paid by Hi-Lex rather than any plan assets. The court rejected this argument, noting that employees made contribution to the cost of the plan, these contributions were never separated from employer contributions, and that the parties, including plan participants, at least reasonably understood that money BCBSM held were plan assets.

The court then turned to whether Hi-Lex’s claims were barred or limited by ERISA’s statute of limitations. While ERISA does not have a statute of limitations for benefit claims, it does for breaches of fiduciary duty. Generally, claims must be brought within 3 years of when the plaintiff first had “actual knowledge” of the breach. However, in the case of “fraud or concealment,” the statute is extended until 6 years after the discovery of the violation. In order for this extension to apply, the plaintiff’s failure to discover cannot be attributable to a lack of due diligence on the plaintiff’s part.

Although there was language in the parties’ contracts that referred to the additional charges, the court held that the language was “opaque and misleading” and thus did not provide Hi-Lex with actual knowledge of the additional charges. Moreover, the court determined that BCBSM “committed fraud by knowingly misrepresenting and omitting information about the [additional charges] in contract documents” and then “engaged in a course of conduct designed to conceal evidence of [its] alleged wrong-doing.” The court found that (1) Hi-Lex made reasonable inquiries about the existence of the additional charges, (2) the contract document did not “reference or explain the [additional charges] in a way that a reasonable reader would understand that those fees involved additional compensation for BCBSM, and (3) a BCBSM account manager “testified that she did not understand anything about the [additional charges], including their existence.” The court said, if “BCBSM’s account manager – who was tasked with explaining contract documents to customers – did not understand that the [additional charges] were being authorized by contract documents, then a ‘reasonably diligent’ CFO could not be expected to know about them.” Therefore, the court held that the 6 year extended statute of limitations applied and the case had been timely filed.

ERISA prohibits a fiduciary from dealing with plan assets in its own interest or for its own account. Not surprisingly given the above holdings and a prior Sixth Circuit decision involving the same contract, the court held that BCBSM had breached its fiduciary duties to the Hi-Lex plan. Although ERISA does include a provision allowing the payment of “reasonable compensation” for necessary services, that provision does not apply to this type of fiduciary breach.

This case is interesting in its own right, but becomes even more interesting when it is compared to decisions by Michigan state courts in similar cases. For example, in Calhoun County v Blue Cross Blue Shield Michigan, 297 Mich App 1 (2012), the Michigan Court of Appeals determined that a similar (if not identical) contract allowed BCBSM to collect and retain the additional charges, and provided sufficient notice to the plaintiff of this. Although the court expressed skepticism over whether BCBSM was a fiduciary, it held that even if it were, the contract authorized the collection of the additional and the “defendant’s charging a fee that it was contractually entitled to charge” could not be the basis of a fiduciary duty breach.

Thus, it appears that BCBSM will win cases brought in state court, but will probably lose cases brought in federal court. In fact, it appears that there are four other state court decisions following Calhoun, and at least five federal cases rejecting Calhoun.

Continued on the next page
U.S. District Court Decision

Catholic Health System Maintained “Church Plan” Exempt From ERISA


Plaintiff was employed by a hospital that was owned by Ascension Health, a Missouri non-profit corporation that operates many hospitals throughout the country. Ascension, in turn, is controlled by and associated with the Roman Catholic Church. Plaintiff, on behalf of herself and others, filed an extensive complaint alleging the Ascension mis-administered one of its pension plans, in violation of ERISA.

Although ERISA generally governs employer-sponsored benefit plans, it exempts from its coverage “church plans” and “governmental plans.” The court held that the Ascension pension plan qualified as a “church plan.” This was the case even though it was sponsored by a civil law organization, rather than by the Church itself, because Ascension was “controlled by and associated with” the Catholic Church, and thus met the statutory language for the exemption. The court refused to consider plaintiff’s arguments that on some matters Ascension acted contrary to Catholic religious doctrine, explaining that the First Amendment prohibited the court’s intrusion into matters of religious doctrine.

The plaintiff also argued that if the church plan exemption applied, it was unconstitutional because it would “require religiously intrusive inquiries to determine association.” However, the court held that the Plaintiff lacked standing to raise this argument, because she did not allege that she had suffered any specific or concrete injury as a result of the application of the exemption.

About the Author

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Endnotes

1 The author was involved in the drafting of state legislation authorizing the charges involved in this case.

No-Fault Corner

By Ronald M. Sangster Jr.
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With the Michigan Supreme Court approaching the end of the 2013-2014 term, we have two rather interesting cases to report from the Supreme Court. First, the Court has clarified the reach of the “unlawful taking” exclusion, found at MCL 500.3113(a) and has clarified the types of proofs that insurers will need to present in order to trigger application of this exclusion. Second, the Supreme Court has reaffirmed the principle, most recently enunciated in its decision last year in Grange Ins Co v Lawrence, 494 Mich 475; 835 NW 2d 363 (2013), to the effect that a person can have one domicile, but multiple residences, in the context of migrant farm workers.

We also see two significant cases from the Michigan Court of Appeals discussing District Court jurisdictional limits and the relationship between an individual’s claim for no-fault benefits and the claims of his or her medical providers. The Court of Appeals has also released an interesting case involving interpretation of the terms of an insurance contract and its impact on PIP coverage. There have also been a number of unpublished decisions from the Court of Appeals that raise a variety of interesting issues, ranging from the effect of a mutual acceptance of a Case Evaluation award on a claim for declaratory relief to preclusion of UM claims when a PIP claim against the same insurer is dismissed with prejudice.

Supreme Court Action

Supreme Court Clarifies Reach of the “Unlawful Taking” Exclusion in MCL 500.3113(a)

Rambin v Allstate Ins Co, 2014 WL 2108969

In Rambin, plaintiff was riding a motorcycle which had been stolen approximately three weeks prior to plaintiff’s involvement in a motorcycle-motor vehicle accident. Three months before the loss, plaintiff had joined a motorcycle club, even though he did not own a motorcycle. Prior to going on a ride with the club, he was apparently given the motorcycle by another club member. Allstate Insurance Company was the motor vehicle insurer of the last registered owner of the motorcycle and, if plaintiff was found to be entitled to recover no-fault benefits, Allstate would have occupied the highest order of priority under MCL 500.3114(5)(d).

Allstate denied the claim on the basis that plaintiff had unlawfully taken the motorcycle from its rightful owner and, following discovery, the Circuit Court granted summary disposition in favor of Allstate.

In a published opinion, Rambin v Allstate Ins Co, 297 Mich App 679, 825 NW 2d 95 (2012), the Court of Appeals reversed the Circuit Court’s grant of summary disposition and
remanded the matter back to the trial court, holding that Plaintiff was entitled to recover benefits as a matter of law. In doing so, the Court of Appeals noted, “In this case, there is no dispute that Plaintiff did not take the [motorcycle] in violation of the Michigan Penal Code, and that, viewed from Plaintiff’s (the driver’s) perspective, there was no ‘unlawful taking.’”

Allstate then applied for leave to appeal to the Supreme Court. The court granted oral argument on the application for leave to appeal and asked the parties to brief the issue of whether MCL 500.3113(a) “requires the person . . . using [the] motor vehicle or motorcycle to know that such use has not been authorized by the vehicle or motorcycle owner . . . and, if so, whether the Court of Appeals erred in concluding that Plaintiff lacked such knowledge as a matter of law given the circumstantial evidence presented in this case.” Rambin v Allstate Ins Co, 493 Mich 973 (2013).

In reversing the Court of Appeals, the Supreme Court determined that MCL 750.414, commonly referred to as the “joyriding” statute, contains a mens rea requirement. That is, in order to avoid the exclusionary effect of the joyriding statute and MCL 500.3113(a), the individual must have some belief that the person who gave him the property had a right of control over that property. As stated by the Supreme Court:

“This Considering MCL 750.414 as a whole, we conclude that it properly requires a showing of knowingly taking without authority or knowingly using without authority. For a person to take personal property without the authority of the actual owner, there must be some evidence to support the proposition that the person from whom he or she received the property did not have the right to control or command the property.”

Rambin, slip opinion at page 15 (emphasis added).

Thus, while plaintiff would be permitted to submit evidence that he did not “unlawfully take” the motorcycle, Allstate would be permitted to introduce evidence to the contrary, which the court summarized as follows:

“Plaintiff was in possession of a stolen motorcycle only 18 days after it had been stolen. In the early morning hours of August 23, 2009, plaintiff was riding the stolen motorcycle and travelling on the Davison Freeway with another member of the motorcycle club when a car entered the freeway and instantaneously crossed several lanes to cut in front of plaintiff’s motorcycle. This action caused plaintiff to lay the motorcycle down and collide with the car. Plaintiff sustained serious and substantial injuries yet neither he nor the other member of his motorcycle club called the police or summoned emergency medical care. To the contrary, the two left the motorcycle on the side of the freeway, fled the scene of the accident and drove to the hospital. At the hospital, plaintiff was eventually confronted by police and he fabricated a story that denied his connection to the motorcycle. Specifically, plaintiff told police he was walking across the freeway on his way home from the bar when he was struck and dragged down the freeway by a car. Plaintiff later recanted his story, claiming that he lied to police only to avoid getting a ticket. When plaintiff finally confessed involvement in the accident involving the stolen motorcycle, he told police that it was an Andre “Smith I presume” who had loaned him the motorcycle. Yet, plaintiff had never met Andre before Andre loaned him the motorcycle, did not have Andre’s phone number, did not know where Andre lived, and did not try to contact Andre after the accident. Plaintiff maintains that it is his belief that the motorcycle remains in the police compound. ‘Possession of the fruits of a robbery plus certain other facts and circumstances permits the inference that the possessor is the thief.’ [Citing People v Gordon, 60 Mich App 412, 213 NW 2d 409 (1975)] This evidence is more than sufficient for a reasonable fact-finder to conclude plaintiff knew that the motorcycle had been stolen and violated MCL 750.414.”

Rambin, slip opinion at pages 17-18.

Accordingly, the matter was remanded back to the Circuit Court for trial on the issue of whether or not Plaintiff knew that he lacked authority to take the motorcycle from its rightful owner.


Tienda and Gomez were part of a group of migrant farm workers, who had been in the State of Michigan for approximately three weeks prior to their involvement in the motor vehicle accident occurred in July 2009. At the time of the occurrence, Plaintiffs were occupants of a motor vehicle insured under a North Carolina auto liability policy issued by Integon National Insurance Company. Integon initially paid benefits pursuant to MCL 500.3163(1), which imposes liability on an insurance company that issued an auto liability policy to an out-of-state resident to afford Michigan no-fault benefits if the claimants were injured as a result of the ownership, operation or use that automobile by an “out-of-state resident.” Although Integon initially paid benefits, Integon ceased paying benefits when it took the position that, in fact, the owner of the vehicle (who was a part of this group of migrant farm workers) was, in fact, a resident of the State of Michigan at the time of this occurrence. Plaintiffs subsequently filed a claim for no-fault
benefits with the Michigan Assigned Claims Facility which, in turn, assigned the matter to Titan Insurance Company.

Titan prevailed in the lower court, which held that Integon was responsible for payment of the applicable no-fault benefits. The lower court specifically found that the vehicle owner was a resident of the State of Florida, as that was where he spent the majority of his time. The Court of Appeals reversed in a published opinion, *Tienda v Integon Nat’l Ins Co*, 300 Mich App 605, 834 NW 2d 908 (2013). The Court of Appeals ruled, in a matter of first impression, that the owner of the vehicle occupied by the injured claimants was, in fact, a Michigan resident, thereby rendering MCL 500.3163(1) inapplicable. Essentially, the Court of Appeals noted that, because this group of migrant farm workers carried all of their worldly possessions with them as they travelled from state to state to work in the fields, they were residents of whatever state they happened to be in at any given time.

Titan subsequently filed an application for leave to appeal. The Supreme Court granted oral argument on the application and asked the parties to submit supplemental briefs as to what constitutes Michigan residency, in the context of migrant farm workers. After hearing oral argument, the Supreme Court denied Titan’s application for leave to appeal thereby allowing the Court of Appeals’ opinion to stand.

In her concurring opinion, Justice McCormick expressed concern over the fact that, while Integon had collected a premium with regard to its North Carolina auto liability policy, the burden of paying no-fault benefits was being shifted to the Michigan Assigned Claims Facility and its assigned insurer, Titan Insurance Company. However, she (and apparently her colleagues) were bound by the court’s earlier decision in *Grange Ins Co v Lawrence*, 494 Mich 475, 835 NW 2d 363 (2013), which drew a distinction between the concepts of “domicile” and “residence.” As noted by Justice McCormick:

“It is in determining domicile, and not residence, that an individual’s intent to reside is relevant. Furthermore, because a person can have more than one residence, it is possible for an individual to be resident of more than one state. In such a case, how the term ‘out-of-state’ resident in MCL 500.3163 would apply to an individual who is a resident of both Michigan and another state is not one we need decide today, as this case presents no such question. The insured maintained no other living space in any other state at the time of the accident; he carried all his worldly possessions with him as he followed agricultural seasonal work from state to state. The insured had only one residence at the time of the accident, and that residence was in Michigan.”

However, Justice McCormick suggested a legislative fix:

“Although I agree with the Court of Appeals that the insured was not an out-of-state resident at the time of the accident, I believe that the legislature might wish to review the language of MCL 500.3163 because the statute would seem to place liability on Michigan’s Assigned Claims Facility even when an out-of-state insurance company is collecting monthly premiums for an out-of-state insurance policy.”

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For a person to take personal property without the authority of the actual owner, there must be some evidence to support the proposition that the person from whom he or she received the property did not have the right to control or command the property.

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**Court of Appeals**

**Court of Appeals Clarifies Jurisdictional Limit for District Court Actions in Cases Involving an Individual Claimant and Multiple Medical Provider Lawsuits**


In *Moody*, plaintiff filed a complaint for no-fault benefits in the 36th District Court for the City of Detroit. In his complaint, he alleged that his claim for damages did not exceed $25,000.00. Three of plaintiff’s medical providers – Get Well Medical Transport, Progressive Rehab Center and Caroline Reints Inc. – filed a separate lawsuit in the same court. The providers’ suit sought a combined total claim for damages of $21,982.14 – just below the $25,000.00 jurisdictional limit of the District Court. During the course of litigation, it became apparent that the individual plaintiff’s claim greatly exceeded the $25,000.00 jurisdictional limit. Specifically, plaintiff indicated that he was seeking payment of a medical bill from Henry Ford Hospital totaling over $32,000.00, plus $110,000.00 in lost wages and over $262,800.00 in attendant care service benefits. Nonetheless, the District Court refused to transfer the matter to the Wayne County Circuit Court and, instead, consolidated the individual plaintiff’s claim and the medical providers’ suits for purposes of trial.

At trial, the jury returned a verdict in favor of the individual plaintiff which was over the $25,000.00 jurisdictional limit of the District Court. The jury also returned verdicts in favor of the three medical providers in the amounts they originally sought, totaling over $21,000.00. The District Court reduced the individual plaintiff’s judgment to $25,000.00 – the jurisdictional limit – and Defendant appealed to the Circuit Court.

In a scathing opinion on appeal, the Circuit Court judge noted that plaintiff’s counsel had engaged in forum shopping...
“as a matter of strategy in hopes of having a better opportu-

nity to win on the issue of residence” and reversed judgment of the District Court, noting that the only alternative that the District Court had, under MCR 2.227, was either to dismiss the case for lack of jurisdiction or transfer it to the Wayne County Circuit Court.

On appeal, the Court of Appeals clarified the nature of the jurisdiction of the District Court. First, the court noted that, under MCL 600.8301(1), the “amount in controversy” is not limited to the allegations stated in the Complaint. Rather, the “amount in controversy” “is the dollar value of the amount that is disputed in the lawsuit, the amount parties argue about, debate, or, stated otherwise, the amount that the parties ‘controvert.’” In this case, the individual plaintiff’s pre-trial discovery responses showed that the “amount in controversy” far exceeded the $25,000.00 subject matter jurisdiction of the District Court. Therefore, under MCR 2.116(C)(4), the court should have either dismissed the action or transferred it to the Circuit Court under MCR 2.227(A)(1). Because the District Court, in this case, did not transfer the matter, the judgments that were entered against defendant insurer were void for want of subject matter jurisdiction.

Second, the Court of Appeals noted that, when an individual plaintiff and his or her medical providers both file suits, the value of all of the claims must be considered in determining whether or not the District Court still has jurisdiction. As stated by the Court:

“Here, there is a virtual identity between the providers’ and Moody’s claims and Moody could have brought all the claims in a single case in which a single judgment is entered. Indeed, it is Moody’s claim against Defendant Home-Owners that the providers are allowed to assert because the No-Fault Act provides that ‘benefits are payable to or for the benefit of an injured person’, MCL 500.3112. [Citation omitted.] But the providers’ PIP claims actually belong to Moody because ‘the right to bring an action for personal protection insurance benefits, including claims for attendant care services, belongs to the injured party.’ [Citation omitted.] . . .

Based on the foregoing, we conclude that there is such an identity between the providers’ and Moody’s claims that consolidation for trial resulting in merging the claims for purpose of determining the ‘amount in controversy’ under MCL 600.8301(1).

Because the providers’ claims are derivative of Moody’s claims, the consolidated claims are the equivalent of a single Plaintiff asserting multiple claims against a single Defendant.”

Since Moody was decided, many insurers have been filing what have been termed “Moody motions” in order to have medical provider lawsuits (which are typically filed in District Court) dismissed and/or transferred to the Circuit Court to be consolidated with actions filed by the individual plaintiffs. Pending further clarification from either the Michigan Supreme Court, whether by way of an actual court decision or by an amendment in the Michigan Court Rules, it appears that Moody may be the first step to getting a handle on the recent proliferation of medical provider lawsuits, which are typically filed in a few select District Courts.

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Essentially, the Court of Appeals noted that, because this group of migrant farm workers carried all of their worldly possessions with them as they travelled from state to state to state to work in the fields, they were residents of whatever state they happened to be in at any given time.

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Court of Appeals Applies Moody Rationale to Similar Fact Pattern Involving AAA

Madison v AAA Michigan,
Court of Appeals docket no. 312880
Unpublished decision rel’d 3/13/2014

Within three weeks after the release of Moody, the Court of Appeals again addressed the situation where plaintiff had filed suit in the 36th District Court, alleging that the amount in controversy did not exceed $25,000.00. During trial, though, plaintiffs presented proofs regarding attendant care services, valued at $144,480.00. The jury returned a verdict in excess of $40,000.00 – well beyond the $25,000.00 jurisdictional limit of the District Court. Defendant stipulated to the entry of a judgment on the verdict in the amount of $25,000.00, but then filed a Motion for JNOV or transfer on the ground that the actual proofs, presented at trial, showed that the District Court lacked subject matter jurisdiction. Again, relying on Moody, the Court of Appeals vacated
the judgment of the District Court and remanded the matter back to the District Court with instructions to either dismiss the case, or transfer it to the Circuit Court for further proceedings. In a footnote, the court noted that its decision was not altered by the fact that both parties stipulated to reduce the jury’s verdict to $25,000.00, noting that “A court’s subject matter jurisdiction may not be waived or conferred upon the court by consent of the parties.”

Fault Benefits

Debra and Richard, were not required to maintain security on the decedent’s vehicle. Rather, only the owner or registrant of a motor vehicle is required to maintain insurance under MCL 500.3101(1). Thus, even though Geico undoubtedly insured the vehicle occupied by the decedent at the time of the accident, because it did not insure the “owner” or “registrant” of the vehicle, and because coverage was not otherwise triggered by virtue of its insurance policy language, GEICO was entitled to summary disposition.

Court of Appeals Affirms Lower Court Determination that Manipulations under Anesthesia (MUA) Were “Reasonably Necessary” Under MCL 500.3107(1)

Szelesi v Allstate Ins Co, docket no. 311279
unpublished decision rel’d 4/10/2014

Plaintiff was involved in a motor vehicle accident in June 2004 and suffered injuries to her neck, shoulders and back. When the conditions did not improve, she began treating with Dr. Marvin Bleiberg at Michigan Spine and Pain. In addition to physical therapy, Dr. Bleiberg recommended that plaintiff undergo manipulations under anesthesia (MUA). The Court of Appeals noted, “It appears that MUA is a generally accepted procedure, and not experimental: Blue Cross/Blue Shield covers certain MUA procedures, and MUAs possess their own CPT codes for an insurance provider’s reference.” At trial, the court heard from various experts, on both sides, and concluded, in a bench trial, that the MUAs were reasonable and necessary for plaintiff’s care, recovery and rehabilitation.

On appeal, the Court of Appeals affirmed the finding of the Circuit Court in all respects.

Mutual Acceptance of a Case Evaluation Award Precludes Declaratory Judgment Action over Future No-Fault Benefits

Lafontsee v Home-Owners Ins Co, docket no. 313613
unpublished decision rel’d 3/27/2014

Plaintiff filed suit to recover no-fault insurance benefits. The matter proceeded to case evaluation under MCR 2.403 and resulted in an award of $85,000.00, for no-fault benefits incurred through that date. Both parties accepted the case evaluation award and, over plaintiff’s objections, the matter was dismissed in its entirety, including the portion of the complaint that sought declaratory relief with regard to future no-fault benefits.

In affirming the District Court, the Court of Appeals made note of the recent amendments to MCR 2.403(M)(1), which currently provides:

“If all the parties accept the panel’s evaluation, judgment will be entered in accordance with the evaluation, unless the amount of the award is paid within 28 days after notification of the acceptanc-
es, in which case the court shall dismiss the action with prejudice. The judgment or dismissal shall be deemed to dispose of all claims in the action and includes all fees, costs, and interest to the date it is entered, except for cases involving rights to personal protection insurance benefits under MCL 500.3101 et seq., for which judgment or dismissal shall not be deemed to dispose of claims that have not accrued as of the date of the case evaluation hearing.”

The Court of Appeals noted that, pursuant to the plain language of the amended court rule, the trial court was required to dismiss all of plaintiff’s claims pursuant to a mutual acceptance of a case evaluation award. Plaintiff was free to refile suit in the future, if the insurer denied any claims for future no-fault benefits that were incurred following the date of the Case Evaluation Hearing. However, plaintiff was precluded from litigating the declaratory judgment issue, in the case at hand, after the mutual acceptance of the case evaluation award.

Insurer Relieved of Responsibility for Paying Benefits for Conditions Previously Compensated Under the No-Fault Act in Light of New and Updated Medical Opinions

*Collier v Liberty Mutual*, docket no. 310633
unpublished decision rel’d 3/25/2014

Plaintiff was injured in a motor vehicle accident occurring in March 2001. As a result of this accident, she allegedly sustained an aggravation of a pre-existing Chiari malformation, a developmental anomaly at the base of the brain that results in the downward displacement of some of the brain’s structures into the spinal canal. Plaintiff subsequently underwent surgery for this condition in February 2004. Plaintiff’s neurosurgeon testified that, in fact, the Chiari malformation was aggravated as a result of the accident, thereby necessitating the surgery. Seven months after this surgery was performed, Plaintiff was diagnosed with transverse myelitis which resulted in permanent paralysis in her lower extremities. Her insurer paid no-fault benefits, associated with the transverse myelitis and subsequent paralysis until October 2009, when it obtained reports from both a neurosurgeon and a neurologist who opined that the March 2001 motor vehicle accident did not aggravate plaintiff’s Chiari malformation and that, even if it did, Plaintiff’s transverse myelitis (which caused the permanent paralysis) was not caused by the February 2004 surgery. The matter proceeded to trial and, when asked, “Did plaintiff’s claimed injuries arise out of the March 19, 2001, motor vehicle accident,” the jury responded “No.” Plaintiff subsequently appealed to the Court of Appeals.

On appeal, plaintiff challenged the trial court’s decision to admit the reports authored by defendant’s medical experts. The court concluded that, in fact, the reports should not have been admitted into evidence because they contained inadmissible hearsay under MRE 802. The Court rejected defendant’s reliance on MRE 803(6), the business records exception, because the IME reports were not “kept or made in the regular course of business activity.” Even though the trial court abused its discretion by admitting these reports, there was no argument, by the plaintiff, that admission of the reports affected the outcome at trial. Furthermore, the court concluded that admitting the reports as evidence was harmless “because the contents of the doctor’s reports were cumulative to the testimony offered by the doctors.” In other words, the court’s evidentiary ruling was harmless error and because admission of these reports was not “inconsistent with substantial justice” and did not affect “a substantial right of the [opposing] party,” there was no error requiring reversal.

More importantly, the Court of Appeals rejected plaintiff’s argument that the no-fault insurer’s payment of no-fault benefits for five years (from September 2004 – the onset of the paralysis – through October 2009) required the insurer to continue paying benefits into the future. Plaintiff attempted to argue that the insurer’s conduct constituted a judicial admission that plaintiff’s paralysis was caused by the injuries suffered in the March 2001 motor vehicle accident. In rejecting this argument, the Court of Appeals drew a distinction between a “judicial admission” and an “evidentiary admission”:

“Moreover, nothing in [the adjuster’s] testimony rose to the level of a formal judicial admission that relieved plaintiff of her burden to prove that her paralysis was caused by the March 19, 2001 automobile accident. [The adjuster] merely testified that defendant paid PIP benefits to plaintiff until approximately October of 2009 because defendant believed, based on opinions from medical experts, that plaintiff’s current condition was caused by the March 19, 2001 automobile accident. This does not rise to the level of an express statement by [the adjuster] that defendant wished to conclusively admit that plaintiff’s injuries were caused by the March 19, 2001 automobile accident. [Citation omitted.] At most, this was an evidentiary admission that, at one time, defendant believed plaintiff’s injuries were caused by the March 19, 2001 automobile accident. An evidentiary admission is distinct from a judicial admission in that it is not a formal decision to relieve a party from its obligation to prove a certain issue. [Citation omitted.] Indeed, an evidentiary admission does not conclusively establish a matter for trial. Rather, an evidentiary admission, which simply consists of a party’s prior statement, is always subject to contradiction or explanation. Here, [the adjuster] explained that defendant’s previous decision to pay no-fault benefits to plaintiff was based on then-existing medical evidence, and that the
decision to discontinue benefits came after it received new medical opinions. [The adjuster’s] explanation concerning defendant’s prior evidentiary admission that at one time it believed plaintiff’s injuries were caused by the accident, combined with the expert testimony noted above, demonstrates that the jury’s verdict was not against the great weight of the evidence.”

In other words, even though an insurer may pay benefits for years and years following the onset of a condition that it initially believed was related to an automobile accident, the insurer is free to obtain new medical evidence and re-examine the old records to determine if, in fact, the complained of condition arose out of the subject motor vehicle accident.

Delay in Insurer’s Investigation into Claim Results in Grant of Summary Disposition in Favor of Plaintiff and Award of Attorney Fees

Reese v Auto-Owners Ins Co, docket no. 314210
unpublished decision rel’d 3/18/2014

Plaintiff was involved in a motor vehicle accident in December 2010 and was diagnosed with left wrist and hand contusions, as well as an acute closed head injury. Five months post accident, plaintiff complained of concentration problems and was referred for a neuropsychological evaluation. The neuropsychologist opined that plaintiff was suffering from a pain disorder, related to the motor vehicle accident that increased her pre-existing depression, anxiety and obsessive compulsive disorder features. The neuropsychologist recommended a program to deal with both her physical pain and psychological issues and began attending counseling sessions which lasted from August 2011 through May 2012. During this time, defendant did not pay any no-fault benefits.

After suit was filed, plaintiff moved for summary disposition under MCR 2.116(C)(10) even before the close of discovery. The insurer argued that summary disposition was premature, as plaintiff’s pre-accident medical records might reveal that she had the same problems before the accident. The lower court granted summary disposition to plaintiff, arguing that the insurer was dilatory in its investigation of this claim.

On appeal, the Court of Appeals affirmed the lower court’s decision in most respects. The court concluded that plaintiff’s treatment for her left wrist and hand complaints were clearly compensable under the No-Fault Act, as the causal relationship between the injury and the complained of condition, as manifested in the emergency room records, was clear. The court also noted that the need for the initial neuropsychological testing was clear as well and should have been paid by the insurer in light of the documented head injury (noted in the emergency room records) and follow-up examination with her primary care physician. The Court of Appeals also affirmed the award of no-fault penalty attorney fees under MCL 500.3148(1) with regard to these conditions.

However, with regard to the counseling expenses, the Court of Appeals reversed that portion of the lower court’s findings and remanded the matter to the trial court for further proceedings. Because plaintiff had been receiving counseling treatment “on a wide array of problems,” when viewed in the light most favorable to the insurer, “it is debatable whether everything reportedly troubling plaintiff was related to the motor vehicle accident, and a remand for further proceedings is appropriate.” However, because defendant took so long to obtain plaintiff’s records, the Court of Appeals cautioned the trial court that, “should it be concluded after remand that therapy bills are covered, associated and apportioned attorney fees would be appropriate.”

In short, it is important for insurers to timely investigate claims for no-fault benefits and, when necessary, to obtain independent medical evaluations as soon as practicable.

Trial Court Must Apportion No-Fault Penalty Attorney Fee Award to Securing Only Those Benefits that Were Found to be Overdue

Esterhai v Farm Bureau, docket no. 313690
unpublished decision rel’d 3/13/2014

Plaintiff sustained injuries in a 1988 car accident. The underlying claims included medical expenses for neck pain, cervical spine surgery and podiatric care, because plaintiff could not trim her own toenails due to her lower back surgery. The jury found defendant liable for payment of the medical expenses, but determined that none of the expenses were overdue. The trial court granted plaintiff’s partial JNOV, finding that the payments were, in fact, overdue and granting plaintiff’s motion for no-fault attorney fees. In the initial Court of Appeals decision, the Court of Appeals affirmed the grant of JNOV and attorney fees on the issue of plaintiff’s podiatric care, but reversed the grant of JNOV and attorney fees on the issue of plaintiff’s cervical care. Esterhai v Farm Bureau, docket no. 295441, unpublished decision rel’d 5/24/2011.

On remand, the lower court again awarded plaintiff the full amount of attorney fees being sought. On appeal, the Court of Appeals again vacated the lower court’s award of attorney fees and remanded the matter back to the trial court with instructions to apportion the attorney time between the amount spent obtaining podiatric care benefits (for which an attorney fee award was appropriate) from the amount of time spent recovering benefits related to the cervical spine.

In doing so, the Court of Appeals rejected any notion that its earlier decision in Tinnin v Farmers Ins Exch, 287 Mich App 511, 791 NW 2d 747 (2010) required the lower court to disregard any apportionment of attorney fees. The court readily distinguished Tinnin because, in that case, the court found that apportionment was not necessary because all of the attorney fees were “sufficiently related to the recovery of the overdue benefits.” In fact, in support of its requirement that
the lower court apportion any award of attorney fees to the amount of time spent collecting overdue benefits, the Court of Appeals relied upon the Supreme Court's decision in *Moore v Secura Ins Co*, 482 Mich 507, 759 NW 2d 833 (2008) in which the Supreme Court held that, “Because [the] plaintiff did not attribute any of the $79,415.00 that the trial court awarded her in attorney fees and costs to collecting $822.52 in overdue work loss benefits, [the] plaintiff is not entitled to attorney fees.” *Moore*, 482 Mich at 524. In short, no-fault penalty attorney fees “may be awarded only for hours spent recovering benefits deemed overdue.”

Court of Appeals Affirms Denial of No-Fault Penalty Attorney Fees Where Insurer Terminated Benefits Based Upon a Single IME, With No Reconciliation Between the Opinions of the IME Physician and Plaintiff’s Treating Doctors

*McGhee v State Farm*, docket no. 311976
unpublished decision rel’d 3/13/2014

Plaintiff sought an award of no-fault penalty attorney fees where the jury found that plaintiff was entitled to wage loss benefits but not household replacement service expenses. The insurer’s decision to terminate benefits was based upon an independent medical evaluation performed by Dr. Ronald Taylor M.D. The lower court denied plaintiff’s request for an award of no-fault penalty attorney fees and awarded plaintiff $578.00 in taxable costs.

On appeal, the Court of Appeals noted that the refusal to pay benefits is not unreasonable if it is based upon a bona fide factual uncertainty, citing *Moore v Secura Ins Co*, 482 Mich 507, 759 NW 2d 833 (2008). The court also noted that the insurer does not have a duty to look beyond the medical opinion of its own physician, and there is nothing in the No-Fault Act that required the insurer to reconcile the competing opinions of an IME physician and the plaintiff’s treating physicians. In light of the IME physician’s credentials, and the results of his physical examination, the Court of Appeals confirmed that there was, in fact, a bona fide factual uncertainty, thereby precluding any award of no-fault penalty attorney fees.

Dismissal of PIP Claim with Prejudice Bars Later Claim for Uninsured Motorist Benefits

*Graham v State Farm*, docket no. 313214
unpublished decision rel’d 2/18/2014

In January 2009, plaintiff was involved in a motor vehicle accident. Plaintiff filed a PIP suit against his insurer, State Farm, and an automobile negligence action against the other driver. During the course of that litigation, plaintiff discovered that the other motorist was uninsured. Plaintiff did not move to amend his complaint to add a count for uninsured motorist coverage. Instead, he settled his first party PIP claim with State Farm and dismissed the action with prejudice. He subsequently dismissed the negligence action against the uninsured motorist without prejudice.

Plaintiff then filed a second lawsuit against State Farm, demanding payment of uninsured motorist benefits. State Farm moved for summary disposition and argued that the subsequent lawsuit was barred because the plaintiff could have brought the UM claim in the earlier litigation. The Circuit Court granted State Farm’s motion for summary disposition, premised on both *res judicata* and the compulsory joinder rule, MCR 2.203(A).

On appeal, the Court of Appeals affirmed the lower court’s grant of summary disposition pursuant to MCR 2.116(C)(7). In doing so, the Court of Appeals noted that in *Estes v Titus*, 481 Mich 573, 751 NW 2d 493 (2008), the Michigan Supreme Court held that *res judicata* will bar a second, subsequent action when all of the following are present:

1. The prior action was decided on the merits;
2. Both actions involved the same parties or their privies; and
3. The matter in the second case was, or could have been, resolved in the first action.

Applying the “broader transactional test” first enunciated by the Michigan Supreme Court in *Adair v Michigan*, 470 Mich 105, 680 NW 2d 386 (2004), the Court of Appeals held that, in fact, plaintiff’s uninsured motorist claim was barred because it could have been brought in the context of the PIP litigation, especially when plaintiff discovered, during that litigation, that the tort feasor was uninsured.

Although PIP claims are routinely dismissed with prejudice when there is a settlement, plaintiff’s counsel should be aware that if an uninsured motorist claim has or could be filed against that same insurer, the dismissal order should be tailored to dismiss only those claims for PIP benefits with prejudice.
Annual Meeting
in conjunction with SBM Annual Meeting
DeVos Place, Grand Rapids, Michigan
September 18, 2014, 9:30-11:30am

Election of Council and Officers
Followed by our program

Cyber Liability: Will your client – or your firm – be the next Target?

See page 7 for more details