

The Journal of Insurance & Indemnity Law

A quarterly publication of the State Bar of Michigan's Insurance and Indemnity Law Section

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Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.

From the Chair



Larry Bennett
Siekaly, Stewart &
Bennett PC

This is the last time I will be writing the “From the Chair” column for our Journal, as my term expires before the next issue is published. With a great deal of work and input from the other officers and members of the council as well as our new administrator, Madelyne Lawry, the last year has seen a significant growth in our membership as well as our presence in the State Bar of Michigan community. We have also focused on developing a strategy to increase the Section’s relevance to you, the members. We have also worked on expanding our connections with other sections, especially in the form of joint programs. On August 9, at the Grand Traverse Resort and Spa, we will have a joint program with the Women Lawyers Association of Michigan and the Negligence Law Section. This will be a casual and fun networking event in a terrific setting. I hope you will be able to join us and participate in this outreach event.

I am confident that in the capable hands of next year’s leadership, the Section will continue to grow and find more new ways to give you value in return for choosing to be one of our members.

Next year also promises to be another dynamic year for the insurance industry in Michigan.

Will We Cure Faults in Our No Fault System?

Our No Fault system continues to evoke strident positions on both sides. Those of us who represent injured victims decry problematic denials of benefits by insurers and cherish the ability to obtain for our clients the medical care they need and the economic support they have lost due to their injuries. Others among us who represent insurers point to the cost of insurance, particularly in Detroit, as well as instances of provider and patient abuse as showing a need for reform. Because our Section has members on both sides of this issue, the Section must remain neutral. Personally, I fall on the side of helping victims and their families get through a difficult time by providing them medical and economic support. It is my hope that as we continue to analyze and debate our No Fault system, we don’t throw the baby out with the bath water and instead, focus on improving it through appropriate safeguards against abuse, by either side.

If you have a view on this – from either side of the “v,” the *Journal* is available as a forum for your opinion.

A “Budding” Marijuana Insurance Marketplace in Michigan?

Legalization of recreational use of marijuana in Michigan

will be on this November’s ballot. If approved, there will be a new industry that will require commercial, and perhaps personal, lines of insurance. One would think that would ordinarily excite insurers. However, the issues associated with insurance for marijuana related businesses are made a bit hazy by Attorney General Jeff Sessions’ announcements on enforcement of federal law prohibiting use or possession of marijuana. In January 2018, the Trump administration lifted the Obama era policy that had eased enforcement of federal marijuana laws in states where recreational use had been legalized. In March, that pronouncement was somewhat modified when Mr. Sessions announced that federal prosecutors would not pursue “small” or “routine” cases. Time will tell on how this new field develops but one can certainly anticipate coverage issues arising.

Again, if you have expertise in this area and an opinion on what is being done in the insurance area, - or what should be done – the *Journal* would like to hear from you. Or if you have an idea for a program presentation on this, please let us know.

Insurance and Technology-How Will They Coexist?

As in many fields, technology will continue to have a significant impact within the insurance industry. Providers of homes or rooms through Airbnb or VRBO need some aspects of commercial coverage but certainly don’t need a typical comprehensive policy. Ride sharing continues to mature with many existing and proposed iterations, including driverless vehicles, and not all versions need the same types of insurance. There also is some movement towards customizing insurance through apps that receive information on activities, how safely one drives or to accommodate a new generation of drivers who drive less than previous generations. There even is a name for this new area: Insurtech. And, cyber insurance will continue to be a very evolving market.

If you have information to share in this area, we want to hear from you.

I am sure other issues in areas I am less familiar with (international insurance issues for one) will have dynamic times ahead. I eagerly anticipate reading about these issues in future Insurance and Indemnity Section *Journals* as a member.

Join Our Council!

We will be holding elections at our annual meeting in September. If you want to be on our Council, or start the officer track as Treasurer, just contact me or any council member and we will add you to the ballot.

I have very much enjoyed the interaction I have had with other State Bar leaders over the last year. I am thankful for the opportunity to have served as the Chair of this Section and I look forward to its continued growth. ■

Summer Reception

Featuring the WLAM, Negligence Section and Insurance and Indemnity Section

**Thursday, August 9, 2018 ■ Grand Traverse Resort and Spa
100 Grand Traverse Village Blvd, Acme, Michigan 48610**

The Insurance & Indemnity Law Section and Women Lawyers Association of Michigan are joining the Negligence Law Section's summer reception.

This free event will welcome members and non-members of all three groups to meet face to face in Northern Michigan.

The Negligence Law Section will also be presenting the Annual Outstanding Achievement Award to Michael Hayes Dettmer.

The reception will be casual and fun. Please plan to join us.

Reception—5:30 p.m. - 7:30 p.m., Hors d'oeuvres and Beverages

If you would like to stay overnight, please call 1-800-748-0303. Ask for the Negligence Law Section Group Rate. Hotel Guestroom \$189 or Tower Guestroom \$229.

Register Today! (<http://files.constantcontact.com/f4e9dba3201/c33bae96-6519-4ac3-99ce-7c991967011f.pdf>)



2018 Outstanding Achievement Award Recipient

Michael Hayes Dettmer
Email -- mike@envlaw.com



2018 Trial Judge of the Year Award Recipient

Judge Matthew F. Leitman

Because of a trial conflict, Judge Leitman will not be able to attend this Grand Traverse event. He was instead be presented with the award at the Council's April 25, 2018 regular meeting.

Email--
Matthew_Leitman@mied.uscourts.gov

Outstanding Achievement Award Prior Recipients

2008 - Justice Elizabeth Weaver
2009 - Attorney, Dean Robb
2010 - Judge Elizabeth Gleicher, Court of Appeals
2011 - Justice Michael Cavanagh
2012 - Willam D. Booth
2013 - William F. Mills
2014 - Peter L. Dunlap
2015 - Robert P. Siemion
2016 - Frederick D. Dilley
2017 - Donald G. Rockwell

Trial Judge of the Year Prior Recipients

2015 - Honorable Shalina D. Kumar
2016 - Honorable Paul J. Sullivan
2017 - Honorable Joseph J. Farah

About Grand Traverse Resort and Spa

Within a day's drive or commuter flight from most major Midwest cities, guests arrive at our premier Michigan resort to discover the destination's gifts - time, relaxation, and adventure. Rising in the midst of northern Michigan's freshwater bounty, winding wooded trails, and sugar-sand beaches, you'll find Grand Traverse Resort and Spa. Regarded as a premier Michigan vacation destination, we've been ranked among the nation's finest resorts with accolades from Golf Digest, USA Today, Family Circle, Conde Nast, Travel + Leisure, and others. Our 900-acre property always honored to receive such recognitions!

From the sandy shores of Lake Michigan's Grand Traverse Bay to the top of our 17-story glass Tower, our team's focus is on presenting a grand experience. Whether you've arrived for business, a vacation, or a more permanent stay, you'll find accommodations, amenities, and activities that suit your needs and lifestyle, paired with service that exceeds expectations.

You'll also find that our own love for Northern Michigan's unique natural attributes and commitment to our community instills a level of environmental stewardship that surpasses hospitality standards nationwide. Through the implementation of our Environmental Management System and the relentless effort from every Resort employee, Grand Traverse Resort and Spa practices ongoing stewardship of the environment.

Editor's Notes



By Hal O. Carroll
www.HalOCarrollEsq.com

The *Journal* – now in its eleventh year – is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The *Journal* – like the Section itself – takes no position on any dispute between insurers and insureds. All opinions expressed in contributions to the *Journal* are those of the author. But we welcome all articles of analysis, opinion, or advocacy for any position.

Copies of the *Journal* are mailed to all state circuit court and appellate court judges, all federal district court judges, and the judges of the Sixth Circuit who are from Michigan. Copies are also sent to those legislators who are attorneys.

The *Journal* is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at HOC@HalOCarrollEsq.com. ■

Report of the Lawson Program



Judge Lawson and Larry Bennett

We held a meeting and program at Mario's Italian Restaurant on May 21. The speaker was Judge David M. Lawson of the Eastern District of Michigan.

He discussed various points of interesting disputes arising out of insurance disputes.

- In ERISA claims, once administrators added language that applied an “arbitrary and capricious” standard to disputes over entitlement to benefits, the effect was to displace the general rule of *contra proferentem* when a plan document is vague. Under an arbitrary and capricious standard, ambiguity actually favors the drafter.
 - To reach the \$75,000 jurisdictional limit in coverage disputes, the test is whether the threshold will be reached at the time of trial. Therefore, in no-fault cases, the pleadings should be as detailed as possible to demonstrate that the threshold will be reached.
 - An attorney who is removing a case to federal court should treat the notice of removal much like a pleading, with all of the detail required in a pleading.
 - But multiple claims (such as when one accident leads to multiple injured claimants) cannot be aggregated to reach the limit.
 - In a declaratory action, Michigan case law provides that a tort plaintiff may be bound by the result of a declaratory action as long as it has notice of the action, even when it is not a party to the action.
- [Editor's Note: The reference may be to *Wilcox and Pioneer Mutual v Sealy*, 132 Mich App 38, 48; 346 NW2d 889 (1984), which states:
- A different view is expressed in *Allstate Ins Co v Hayes*, 442 Mich 56, 67, N 12; 499 NW2d 743 (1993): “Thus, if the insurer wishes to obtain a judgment that would bind the alleged tort victim, the insurer must make the victim a party to the action for declaratory judgment.”]
- The factors set forth in *Scottsdale Insurance Co v Flowers*, 513 F3d 546 (6th Cir. 2008) guides the court in determining whether to retain jurisdiction of a declaratory action filed in federal court when there is a concurrent state court action pending. The 6th Circuit favors letting the underlying state court case decide coverage issues when the coverage issue is dependent on the resolution of questions of fact in the underlying case. ■



Listening to Judge Lawson



Consider Removing Your Next PIP Case to Federal Court

By Matthew S. LaBeau, *Collins Einhorn Farrell PC*

Introduction

On May 21, 2018, the Insurance and Indemnity Law Section held its 2018 Spring Meeting & Program. Our section was fortunate to have Judge David Lawson of the United States District Court, Eastern District of Michigan present at the event and discuss, among other things, issues related to diversity jurisdiction and claims under the Michigan No-Fault Act. While Judge Lawson discussed the legal standard and best practices when removing a No-Fault case to federal court, there are also strategic considerations when determining whether to remove a claim. In the right circumstances, removal of a claim to federal court can be beneficial to an insurance carrier defending against a claim for first-party no-fault benefits.

Why Consider Removal?

Removal of a claim to federal court may be an opportunity for an insurance carrier to even the playing field. When a matter is filed in state court, it is important to assess the venue where the case is pending. If the jurisdiction or judge is favorable, then removal of the matter may not be the best course of action. However, in an instance where the state court jury pool is considered to be adverse, a federal jury pool will pull from a wider geographical region and may provide a better opportunity to select a more favorable jury. In addition, the judge presiding over the state court action may, either by experience or reputation, be more likely to give the benefit of the doubt to the opposing side. Removal of the matter to federal court may provide an opportunity to draw a jurist who will be more favorable to your position.

The complexity of the issues involved in the case should also be considered. There are state court venues that have more knowledge of no-fault cases. If the case involves a matter of complex statutory interpretation, or a complicated coverage issue that is germane to cases under the No-Fault Act, a state court judge with experience in such matters may be beneficial to the defense. On the other hand, there are also state court venues where, regardless how experienced, the judges have congested dockets with limited time and resources to devote to each case. In that instance, a complex matter may be more appropriate in federal court, where more time and resources can be utilized to bring the matter to a favorable conclusion.

Another consideration is your opposing counsel. There are aggressive attorneys that masterfully utilize the broad discovery rules in the state of Michigan to their advantage. The Fed-

eral Rules of Civil Procedure are narrower and can be utilized to shield the insurance carrier from extensive and far reaching discovery. In addition, motion hearings in federal court are frequently only permitted by leave of the court, and are not on a weekly scheduled docket. Once again, this can potentially limit the outlay of defense costs as well as limiting discovery disputes since there could be a delay in the court's addressing of the issue.¹ Lastly, there are certain attorneys who are better known to judges and juries in a certain jurisdiction by way of routinely practicing in the venue and being otherwise well known in the community. Removal of a claim can neutralize the advantage opposing counsel may have by selecting a jurisdiction with a larger jury pool and appointed judge.

The Basics of Federal Jurisdiction

A case can be removed from state court to federal court if the case could originally have been filed in federal court.² As most of us recall from our civil procedure course in law school, there are two primary bases for federal court jurisdiction over a civil action: federal question and diversity. The Michigan No-Fault Insurance Act³ controls claims for personal injury protection benefits. Therefore, claims for such benefits do not involve a federal question. Accordingly, the primary basis to seek federal jurisdiction over a claim for no-fault benefits is by way of diversity.

In the instance of diversity jurisdiction, federal courts have original jurisdiction over all civil actions between citizens of different states if the amount in controversy exceeds \$75,000.⁴ The general rule is that a corporation is deemed a citizen of the state in which it is incorporated and the state here it has its principal place of business.⁵

Diversity jurisdiction is broader for "any direct action against the insurer of a policy or contract of liability insurance, whether incorporated or unincorporated, to which the action the insured is not joined as a party-defendant." In that instance, an insurer is also a citizen of "every State and foreign state of which is the insured is a citizen."⁶ In *Ljulj djuraj v State Farm Mut Auto Ins Co*, 774 F3d 908 (6th Cir 2014), the Sixth Circuit held that this exception does not apply to a claim for first party no-fault benefits.⁷

It should also be noted that, even in instances where diversity requirements are otherwise met, a case is not removable on the basis of diversity when any defendant is a resident of the state in which the suit is brought.⁸ For example, if a plaintiff

who resides in Florida files an action in state court in Michigan, and the defendant is a citizen of Michigan, the claim cannot be removed to federal court.

Therefore, for a no-fault carrier to remove a state court action filed in Michigan, the carrier must be incorporated and have a principal place of business outside of the state of Michigan. From time to time, a Michigan based carrier is sued for No-Fault benefits in another state. Such an action would be removable as long as all other requirements are met.

For a no-fault carrier to remove a state court action filed in Michigan, the carrier must be incorporated and have a principal place of business outside of the state of Michigan.

The Timing for Removal

If a defendant wishes to remove the case to federal district court, it must file a notice of removal within 30 days after being served with the complaint.⁹ However, it is important to note that this is not the only opportunity to remove a case to federal court. If it is not evident based upon the initial pleadings that a case is removable, a case may also be removed to federal court *within 30 days after receipt* “by the defendant, through service or otherwise, of a copy of an amended pleadings, motion, order, or other paper from which it may first be ascertained that the case is one which is or has become removable.”¹⁰

The Sixth Circuit has never fully expounded the meaning of “other paper” for purposes of removal. The court has indicated that, as a general matter, documents such as deposition transcripts, answers to interrogatories and request for admissions, amendments to ad damnum clauses of complaints, and correspondence between the parties and their attorneys or between attorneys may constitute “other papers” for the purposes of removal.¹¹ If the initial pleading lacks solid and unambiguous information that the case is removable, the defendant must file a notice of removal within 30 days of receipt an amended pleadings, motion, order, or other paper that contains solid and unambiguous information that the case is removable.¹² Several courts have interpreted that “other paper” for the purposes of removal to apply to papers and documents involved in the case being removed.¹³

At the initial pleadings stage, it is not unusual for a carrier to be unaware of the total amount of benefits claimed by a plaintiff in a lawsuit for no-fault benefits. It may not be until the plaintiff responds to written discovery requests that it is first learned that the plaintiff is seeking an amount that exceeds \$75,000. Therefore, an attorney representing a diverse insurance carrier should be vigilant in reviewing the plaintiff's discovery responses, and should timely file a notice of removal if appropriate.

A question may arise as to whether documentation submitted within the claim file, prior to the filing of a lawsuit, constitutes information sufficient to give notice that a claim is removable. Case law in the Sixth Circuit would suggest that information compiled before the filing of the lawsuit would not necessarily be considered an “other paper” for the purposes of removal.¹⁴ Therefore, just because documentation was submitted to a carrier prior to the filing of a lawsuit does not necessarily mean that a case is removable.

Ideally, counsel obtains a copy of the claim prior to the filing of responsive pleadings, but that is not always the case. If the claim file materials suggest that the amount in controversy would exceed \$75,000 at the time of filing responsive pleadings, then counsel should strongly consider filing a notice of removal at that time. However, if the amount in controversy is not clear from the claim file materials, a failure to remove the matter at the time responsive pleadings were due may not be fatal to a successful removal of the matter to federal court at a later date, upon receipt of additional documents. An argument can be made that, regardless of what was contained in the claim file, it does not constitute “other paper” for purposes of the removal statute, and that the claims and/or damages Plaintiff is claiming entitlement to in a lawsuit is not discernible until assertions are made through required disclosures in the discovery process.

The Amount in Controversy Requirement

As referenced above, the minimum jurisdictional amount for a civil action based on diversity jurisdiction in federal court is \$75,000. As a general rule, the court considers whether it had jurisdiction at the time of removal, not whether it has jurisdiction based on post-removal events.¹⁵ Therefore, because no-fault benefits are not payable until they are incurred under MCL 500.3107, any expenses incurred after removal for which the plaintiff may seek reimbursement are not considered in determining whether the \$75,000 diversity jurisdictional requirement is met.¹⁶

There are circumstances where federal courts have departed from the general rule. In *Herring v State Farm Mut Auto Ins Co*,¹⁷ the plaintiff sought \$30,096 in attendant care benefits already incurred, ongoing benefits without any end date, and a declaratory action seeking future damages. In that circumstance, the court found that the amount in controversy was met. But in other cases with similar facts, this argument was rejected.¹⁸

The Michigan No-Fault Act provides for statutory interest and attorney fees pursuant to MCL 500.3142 and MCL 500.3148. A plaintiff's claim for interest and attorney fees can be considered as part of the amount in controversy for purposes of the amount in controversy requirement¹⁹. A defendant must prove that the amount of interest and attorney fees more likely than not makes up any difference between the claimed benefits and the jurisdictional requirement of \$75,000.²⁰

At our recent section meeting, Judge Lawson recommended that the notice of removal be detailed as possible to avoid an order from the court requesting that the defendant show cause as to why the matter should not be remanded. In the instance of diversity jurisdiction, that includes identifying the citizenship of the parties, and every basis on which removal is sought.

An interesting wrinkle involves the assignment of claims to providers in the wake of the Michigan Supreme Court's opinion in *Covenant v State Farm Mut Auto Ins Co.*²¹ In that case, the court found that there is only one cause of action for no-fault benefits and it belongs to the injured claimant. While carriers continue to challenge whether a claim for no-fault benefits can be lawfully assigned to a medical provider, the *Covenant* decision suggested and subsequent Court of Appeals decisions have operated as though such a right exists. The question then becomes whether an expense that is assigned prior to or subsequent to removal can be considered as part of the amount in controversy requirement. At this point, there is no clear direction on this issue and room to argue for or against jurisdiction.

Another consideration relevant to the \$75,000 threshold is whether an action by a claimant and a provider, or multiple providers can be aggregated together to meet the amount in controversy requirement. Current case law would suggest that the claims can be aggregated to meet the requirement. Two or more claims asserted by a single plaintiff against a single defendant may be aggregated for the purposes of determining whether the amount in controversy requirement is met.²² Considering that the *Covenant* decision found that there is one claim for benefits, there is an argument that medical providers are merely assigned a portion of a claimant's overall claim as a whole.

Notice of Removal

A defendant seeking to remove a claim must file a notice of removal in the federal district court "containing a short and plain statement of the grounds for removal."²³ In Michigan, a plaintiff need only state that a claim seeks damages in excess of \$25,000 to be within the jurisdiction of the circuit court. Therefore, in such circumstances, the amount stated in the initial pleadings is not deemed to be the amount in controversy.²⁴ In that case, the notice of removal may assert the amount in controversy and removal is appropriate on that basis if the district court finds, by the preponderance of the evidence, that the amount in controversy exceeds \$75,000.²⁵

At our recent section meeting, Judge Lawson recommended that the notice of removal be detailed as possible to avoid

an order from the court requesting that the defendant show cause as to why the matter should not be remanded. In the instance of diversity jurisdiction, that includes identifying the citizenship of the parties, and every basis on which removal is sought. That also includes referencing all information that supports the defendant's assertion that the amount in controversy exceeds \$75,000. A defendant's notice of removal, though, need include only a plausible allegation that the amount in controversy exceeds the jurisdictional threshold. Evidence establishing the amount is required by 1446(c)(2) (B) only when the plaintiff contests, or the court questions, the defendant's allegation.²⁶

Challenging Removal

There are circumstances where a plaintiff may approve of removing the matter to federal court. If that is not the case, though, a plaintiff can challenge the removal by way of a motion to remand. A motion to remand based on a defect other than lack of subject-matter jurisdiction must be made within 30 days after filing of the notice of removal²⁷.

A common basis for challenging the removal of an action is that the notice was not timely filed. As referenced above, a defendant must remove a case within 30 days after service of the complaint, or within 30 days of receipt of certain information which allows the party to ascertain that the case is or has become removable. The argument in this instance is that the defendant had sufficient information at the time of initial responsive pleadings and should have removed the case at that time based on allegations in the complaint. In the instance of where case subsequently becomes removable, the argument is that the defendant did not act timely when sufficient information was received.

Another common basis for challenging the removal is that the amount in controversy does not exceed the minimum jurisdictional limit, i.e. \$75,000. A plaintiff can argue that, at the time of removal, the outstanding claim does not exceed \$75,000, and argue that the court cannot consider ongoing incurred benefits. A plaintiff can also argue that, while there may be a large amount of benefits anticipated, such as future home modifications, van modifications, or attendant care, the claim is not incurred and should not be considered as part of the amount in controversy. It should be noted, though, that the court can always remand a case if it discovers at any time before the final judgment that it lacks subject matter jurisdiction.²⁸ Therefore, a plaintiff can argue that if certain benefits are no longer being claimed, or cannot be claimed, the case can be remanded²⁹.

Generally, with exceptions that do not apply to no-fault cases, a remand order cannot be appealed.³⁰ Therefore, the district court has sole authority as it relates to whether the remand a claim for no-fault benefits to state court.

Conclusion

In certain circumstances, removal of a no-fault claim to federal court can be a favorable maneuver that ultimately proves beneficial to the defense of the claim. There are certain strategic considerations to take into account. There are also strict procedural requirements that require diligence and fore-thought. A plaintiff, though, is not without recourse if state court is the desired venue. The removal of a no-fault case to federal court can completely alter the course of the litigation, and even the playing field for the insurance carrier. Therefore, defense attorneys, consider removing your next no-fault case to federal court. ■

About the Author

Matthew S. LaBeau is a partner at Collins Einhorn Farrell PC. He focuses his practice on defense litigation in first party No-Fault claims, uninsured and underinsured motorist claims, automobile negligence, premises liability, general negligence, and contractual disputes. Matthew has extensive experience in defending catastrophic No-Fault claims, as well consulting insurers re-garding catastrophic claims prior to litigation. His email address is matthew.labeau@cflawyers.com.

Endnotes

- 1 This, obviously, goes both ways. If the defense is seeking discovery, or otherwise has an objection, there will be a delay in resolution.
- 2 28 USC 1441(a)
- 3 MCL 500.3101, et seq.
- 4 28 USC 1332(a)(1)
- 5 28 USC 1332(c)(1)
- 6 *Id.*
- 7 The Court specifically found that the direct action provision “on its face does not apply where a suit is brought under an insurance policy provision that does not provide for liability insurance.” 774 F3d at 911. The provision for no-fault benefits in this case “provides benefits on the basis of plaintiff’s having been a passenger in the primary insured’s automobile, and not on the basis of the primary insured’s liability to the plaintiff.” *Id.*
- 8 28 USC 1441(b)(2)
- 9 28 USC 1446(b)
- 10 28 USC 1446(b)(3)
- 11 *Brerea v. Mesa Medical Group, PLLC*, 779F.3d 352, 365 (6th Cir 2015)
- 12 *Id.* at 364
- 13 *Dahl v. R.J. Reynolds Tobacco Co.*, 478 F.3d 965, 969 (8th Cir 2007), citing *Chaganti & Assocs., P.C. v. Nowotny*, 470 F.3d 1215, 1220–21 (8th Cir.2006) (motion response which states federal cause of action is “other paper”) and *Addo v. Globe Life & Accident Ins. Co.*, 230 F.3d 759, 761–62 (5th Cir.2000) (post complaint demand letter seeking an amount greater than \$75,000 is “other paper”).
- 14 See *Holston v. Carolina Freight Carriers Corp.*, No. 90-1358, 1991 WL 112809 (6th Cir 1991)(Even if a “defendant may have the papers in its possession as of the filing of the suit,” a defendant “does not receive notice of the facts contained therein until it reviews those papers in connection with the suit.”), as cited by *Berera, supra*
- 15 *Rogers v. Wal-Mart Stores, Inc.*, 230 F.3d 868, 872-873 (6th Cir 2000), *cert denied*, 532 US 953 (2001).
- 16 *JD v. ABM Amtech, Inc.*, No. 05-40393, 2006 US Dist LEXIS 7056 (ED Mich Jan 31, 2006).
- 17 No. 05-CV-73556, 2005 US Dist LEXIS 29648 (ED Mich Nov 16, 2005).
- 18 *Spawr v. Encompass Ins Co*, No 1:08-CV-614, 2008 US Dist LEXIS 77087 (WD Mich Oct 2, 2008)
- 19 *Haggard v. Allstate Prop and Case Ins Co*, No. 13-12779 (ED Mich Sept 12, 2013), citing *Williamson v. Aetna Life Ins Co*, 481 F3d 369, 376 (6th Cir 2007)
- 20 Michigan Head and Spine Institute, Inc. v Safeco Ins Co of Illinois, No. 18-10902 (ED Mich June 1, 2018), citing *Everett v. Verizon Wireless, Inc.*, 460 F3d 818, 822 (6th Cir 2006)
- 21 500 Mich 191 (2017)
- 22 *Everett v. Verizon Wireless, Inc.*, 460 F3d 818, 822 (6th Cir 2006)
- 23 28 USC 1446(a)
- 24 Under 28 USC 1446(c)(2), “the sum demanded in good faith in the initial pleading shall be deemed to be the amount in controversy, except that-- (A) the notice of removal may assert the amount in controversy if the initial pleading seeks-- (i) nonmonetary relief; or (ii) a money judgment, but the State practice either does not permit demand for a specific sum or permits recovery of damages in excess of the amount demanded;”
- 25 28 USC 1446(c)(2)(B)
- 26 *Dart Cherokee Basin Operating Co., LLC v. Owens*, 135 S. Ct. 547, 554 (2014); 28 USC 1446(c)(2)(B).
- 27 28 USC 1447(c)
- 28 *Anusbigian v. Trugreen/Chemlawn, Inc.*, 72 F3d 1253, 1254 (6th Cir 1996); 28 USC 1447(c)
- 29 See *Kibler v. Luiso*, No 06-13215, 2007 US Dist LEXIS 2018 (ED Mich Jan 11, 2007) (Because (1) Plaintiff never sought to bring this action in federal court, (2) Plaintiff never specifically sought damages exceeding \$75,000, and (3) Plaintiff has agreed to seek damages not greater than \$74,000, the case should be remanded to state court once plaintiff files an amended complaint).
- 30 28 USC 1447(d)

Cyberinsurance: Necessary, Expensive and Confusing

By Sharon D. Nelson, Esq. and John W. Simek
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Setting the stage

The title of this article was also the title of a session presented at ABA TECHSHOW this year. And each part of the title is true. It is absolutely necessary to have cyberinsurance in order to manage your risk. No amount of technology, policies or training can guarantee that you will not be breached. Expensive? Oh yes. Get ready for sticker shock when you purchase cyberinsurance. Because we teach CLEs on cyberinsurance, we can tell you with some assurance that lawyers are very confused about what specific insurance they need. Insurance companies are not very helpful—the various policies offered across the industry are not at all standardized – and of course they are written in complicated language which often obfuscates their meaning.

Where are we today?

Not in a great place. According to a 2017 survey by the data analytics firm FICO, half of U.S. business have no cyberinsurance, 27% have no plans to buy coverage and only 16% report having a policy that covers all cyber risks. There is a certain justified cynicism about cyberinsurance. The news is rife with companies who had cyberinsurance, but found – after being breached – that a substantial portion of their damages were not covered.

A 2017 report by Deloitte called “Demystifying Cyber Insurance Coverage” called the market “promising” but “problematic” for the insurance companies as well as customers. We don’t have a lot of data going back in time to help us construct reliable predictive models. With threats evolving daily and many different kinds of damages possibly occurring, perhaps over a broad swath of insurance company customers, insurers are “flying blind” – something you can see for yourself when you look at widely varying prices for widely varying coverage. As a result, many insurers are focused on PII (personally identifiable information) coverage which may or may not be the primary need of an organization. Chubb Group, a well-known and early entrant into the cybersecurity market, paid some of the losses for P.F. Chang’s point-of-sale data breach but it did not cover the required \$1.9 million Payment Card Industry Data Security Standard assessment. If you don’t even know what that means (and many lawyer do not), take a deep breath and do a search on PCI-DSS fines . . .

And after all this time, many law firms and other entities mistakenly believe that their general liability or business inter-

ruption policies fully cover data breaches. Some of them have learned the hard way how very wrong they were.

Given the fact that law firms are generally not models of strong cybersecurity practices, it would be prudent of law firms to up their game, especially since both clients – and potential insurers – are asking hard questions about firms’ security. In 2017, legal technology firm LogicForce gave the legal industry only a 42% rating on its cybersecurity health. The score was based on twelve factors, weighted differently, including information on information security executives, polices, multifactor authentication, cyber training (we have seen a big uptick there), cyberinsurance, penetration testing, vulnerability testing, third-party risk assessments, information governance, cyber investment, full disk encryption, and data loss prevention technology and software.

Apples to apples comparisons?

Fuggedaboutit. The best you can probably do is to consult a trusted insurance advisor who is accustomed to dealing with cybersecurity policies. Once you get over the aforementioned sticker shock for the costs of the policy and absorb the grim reality of the high deductibles, you’ve got to get into the nitty gritty of a subject that is very hard to understand if you are not in the insurance business with a keen understanding of cybersecurity.

In many cases when lawyers ask where to get impartial advice, we are apt to recommend that lawyers ask their colleagues for references – not so much here because, unless your colleagues have suffered damages from a cyber attack or breach, they really don’t know how good their policies are.

Most lawyers have professional liability insurance, which will undoubtedly get you some cyberinsurance coverage since you are holding data because you are rendering legal services. However, more than 50% of the cost of a data breach may come from digital forensics and the data breach lawyer you hire – which are not covered by the LPL (Lawyers’ Professional Liability) policy. Other costs which are likely not covered include public relations coverage, data breach law compliance/notification costs, regulatory investigations costs, including subsequent fines and penalties.

What will cyber insurers likely need to know before giving you a quote?

Clearly, the information sought will vary from insurer to insurer, but here is a likely list of questions they might ask and

things they will require:

1. Have you had an independent 3rd party cybersecurity audit? And yep, they'll want the results and an accounting of any remediation that was performed.
2. Do you have e-mail encryption available for use? Is it used?
3. Do you employ full disk encryption?
4. A description of how your backup is engineered – to make sure, if you contract ransomware, that you have a reliable backup that you can restore your data from.
5. Do you train your employees in cybersecurity and how often you train?
6. Your security-related policies.
7. What kind of enterprise level security software and hardware are deployed, including firewalls, data loss prevention, incident detection software, etc.?
8. Have you ever experienced a data breach or other major cybersecurity incident? Yes, they will want details, including how long it took to discover any breaches.
9. A description of the physical security of your premises.
10. Do you comply with any national/international cybersecurity standards?
11. Have you ever made an insurance claim involving cybersecurity? Details will be required.
12. Has any other insurer canceled your cybersecurity policy or refused to renew one?
13. Mobile device security in place, which can cover a lot, but they will certainly want to know if you can remotely wipe lost or stolen devices.
14. Details of vendor management for those who have any degree of network access or who hold your data by design – are audits of those vendors required?
15. When employees are processed out of your firm, what measures are taken to secure your data?
16. Do you do background checks on new employees? Are they trained in security policies?
17. Awareness of facts which might give rise to a possible claim at the time the application is filled out.
18. The amount of your annual cybersecurity budget (particularly true for larger firms).
19. Are you following general best practices regarding passwords, access control, patching and upgrading outdated software which is not receiving security patches?
20. A description of the kind of data you hold (health data, credit card data, banking records – any sort of protected data).

21. Financial data about your firm, including assets, revenues, number of employees and any proposed merger or acquisitions.
22. Is logging enabled? What is the retention period of log files?

The list of possible insurer questions can seem daunting, especially if you become aware that your truthful answers (and failure to be truthful may invalidate coverage) will not please the prospective insurer.

What should you be asking a prospective insurance company?

This can be a hard question, but we have found it useful to set forth specific scenarios with specific damages and ask the insurance agent to show us what language covers what damages. For instance, virtually all insurance policies cover actual loss or damage to your computers, but not the loss of the data. Can you sometimes negotiate the coverage itself? Absolutely. Of course, that may come with a price tag. Taken together, the premium, the deductible and the coverage should give you a fairly clear idea of how well you are managing the risks you cannot wholly protect against – and the price for doing so. And if you don't like one proposal, well, there are now more than 60 carriers offering cyberinsurance, so you certainly have alternatives.

If your data is in the cloud or otherwise held by third parties, you are certainly going to need third party coverage. If your firm is active with social media coverage, you may need media liability coverage. And when regulatory fines loom, and they often do these days, you certainly want coverage for regulatory fines.

Ask your insurer as many questions as you can think of, but here are a few starters.

1. Is the coverage retroactive? How far back, if so?
2. Does the insurer believe your limits of coverage are adequate for your needs, especially given the nature of the data you hold and the size of your firm?
3. Does the policy cover both the loss and the compromise of data (e.g., make sure data encrypted by ransomware is covered)
4. Is there a discount if you have a 3rd party independent audit and remediate any critical vulnerabilities found by the audit?
5. Are you covered if a vendor holding your data suffers a breach?
6. For an additional premium, does the insurer offer a subrogation waiver? We know some of you are asking "What's this?" Google it for the full explanation and why such a waiver may be desirable.

Final Thoughts Where is cyberinsurance going?

Fitch Ratings said the industry grew by 35% in 2016. Allied Market Research predicted that the global market may reach \$14 billion (now that's a big number) by 2022. But if you want a queasy stomach as you fork over huge premiums, consider this quote from Tim Francis, a vice president and enterprises lead for cyberinsurance at Travelers: "There's so much new coverage out there that hasn't been tested . . . One day there will be certain claims and we'll figure if the words we used to convey coverage actually say what we thought they meant, which is often up to a lot of lawyers." Not very reassuring, is it? The world of cyberinsurance is evolving – think

how little we have by way of precedents. Combine that with the rapid changes in attack surfaces, cyber weapons and tactics, etc. and it is a bit unsettling. As we have now reached the point where many firms have been breached – and will be breached again - the one thing we can tell you for sure is that cyberinsurance is essential risk management for law firms.

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Potential Issues With AIA's 2017 Construction Agreement Insurance Exhibit

By Michael S. Hale, *Clairmont Advisors, LLC* and *Hale & Hirn, PLC*

An Addendum is Likely Warranted in Almost Every Construction Agreement

Fast Facts

- AIA's 2017 changes have made it somewhat easier to extract the insurance requirements of owners and contractors by making them part of an Exhibit to the General Conditions of the Contract for Construction, now referred to as AIA Document A101 – 2017 Exhibit A – Insurance and Bonds.
- AIA Forms, including the most recent 2017, are not a panacea and need to be tailored to the needs of a client, whether it's the owner or contractor.
- Some of the sections of the AIA 2017 template may create unintended results such as the waiver of claims by the owner for loss of use of property for insured or uninsured losses, regardless of the cause.
- A major concern in the 2017 AIA template is the absence of a reference to subcontractor's coverages, conditions and requirements.
- Many lawyers would not know the intricacies of coverage endorsements or options when negotiating contracts for owners or contractors. It is often worthwhile to retain insurance counsel to assist in the process.

For many years, The American Institute for Architects ("AIA") has developed and published standardized contract

forms to achieve some consistency in construction agreements between owners and contractors. This has also included the ever-changing area of insurance coverage and bonds. These templates are used by many and usually are updated by AIA every ten years. In the 2017 update, the AIA uses an Exhibit format to address insurance and bonds.

The seven pages of the Insurance Exhibit are, overall, better designed and laid out than what you would find in nonstandard construction agreements, particularly as respects builder's risk coverage issues. Nonetheless, some exposures are not clearly addressed. Here are some comments which are particularly applicable to owners:

1. Exhibit A's insurance provisions are not to be read alone. There remain insurance requirements and conditions in Section 11 of the AIA General Terms and Conditions including reference to notices of cancellation, the waiver by the owner of loss of use claims, and settlement of losses.
2. Subcontractor coverages are not addressed. Notably missing from the AIA Exhibit is the obligation of the contractor to assure that its subcontractors maintain coverage at least as broad as that required of the contractor including additional insured requirements in favor of the owner.

Also not addressed are any conditions under the contractor's CGL policy that its subcontractors have certain limits and specific coverages. For example, some CGL policies will require that the subcontractor in-

- demnify the contractor and owner and include specific limits. If they do not, a claim could under the contractor's CGL could be excluded or a higher self-insured retention or deductible could apply. It is important to attempt to negotiate such endorsements away or to limit it to the higher self-insured retention condition.
3. There is no stated requirement that the contractor's workers' compensation policy include a waiver of subrogation. This leaves the owner exposed to a subrogation claim by the contractor's workers' compensation carrier. While the indemnity obligations of section 3.18 extend some protection to the contractor, the better risk management is to have a waiver of subrogation in the first place to block the claim.
 4. The Insurance Exhibit optional coverage requirement check-boxes are general in nature. There are specific issues under each of those optional policies that need to be considered if such exposures exist.
 5. It is required under this Exhibit that the owner obtain the builder's risk coverage and do so on an "all-risks" basis and that property coverage be maintained beyond the substantial completion of the job. It is also required that the owner insure existing structures, which most builder's risk policies do not automatically include, unless endorsed. In most cases, the owner should avoid electing to have the contractor provide the builder's risk policy.
 6. Deductibles of the owner under builder's risk and property insurance are stated as the responsibility of the owner. Thus, if there is a \$50,000 deductible on the builder's risk policy, this is arguably not recoverable against a negligent contractor who caused the fire or other covered loss.
 7. Coinsurance penalties under property insurance are the stated responsibility of the owner. These clauses should be negotiated from the policy(ies) where possible.
 8. There is no requirement that the contractor insure underground property or work under the builder's risk or property insurance. This should be kept in mind where such exposures exist such as on sewer projects.
 9. Flood and earthquake coverages are required of the owner. These are not automatic under most builder's risk or property insurance policies. Moreover, where coverage is secured in these areas and there are sublimits, they must be listed under the cause of loss section of the AIA form.
 10. In the Section 11 general terms and conditions the owner waives all "rights of action" against the contractor and architect for loss of use of the property including consequential damages. This is an issue in the event of any uninsured or underinsured loss. What if the owner's insurance for some reason does not pay?
 11. Cyber coverages are optional on the Exhibit. However, the description is very vague and does not reference whether the "loss" to be covered is first or third party, involves penalties, etc. If these exposures are apparent, they should be specifically addressed.
 12. Specific CGL exclusion prohibitions. There is no prohibition against the contractor's general policy excluding claims related to:
 - Scaffolding
 - Cranes
 - Structural wall modifications
 - Buildings more than a certain number of floors
 These exclusions should be carefully considered considering the work being done.
 13. There is no additional insured requirement in favor of the owner as to auto claims or pollution policies. This should be addressed on a project by project basis.

Mission Statement of the Insurance and Indemnity Law Section

Issues arising out of insurance contracts and indemnity agreements affect a broad range of practice areas. In addition, insurance is a regulated industry, and state and federal regulations present specialized questions. The membership of the Insurance and Indemnity Law Section of the State Bar of Michigan consists of those who have expertise in this area of practice, as well as those whose expertise lies in other practice areas that are affected by insurance and indemnity issues. The mission of the Section is to provide a forum for an exchange of information, views and expertise from all perspectives on both insurance coverage issues and indemnity issues, and to provide information and assistance to other persons or organizations on matters relating to insurance and indemnity. Membership is open to all members of the State Bar of Michigan.

14. Where pollution coverage is required, there should be an amendment to the insured versus insured provision so that only claims of “named insured” v. “named insured” are excluded. This would protect the owner in the event of a claim of pollution injury by a third party unrelated to the contractor.
15. There is no option to require that the contractor procure employment practices liability coverage. Consideration should be given to whether this is important. However, even if coverage is secured, it is unlikely that it would cover the owner as an insured.

Conclusion

AIA’s 2017 modifications to the insurance requirements of contractors address some key issues but leave other exposures open-ended. No template addresses all the issues for a specific project and that is precisely the point. The problem is that many lawyers negotiating these contracts do not have

the background to enable them to understand what coverages should be required. It is often worth the time and resources to obtain an insurance expert to assist in the negotiating process. ■

About the Author

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Cybercrime Liability and Insurance

By James A. Johnson ©2018

“Adapt or perish, now as ever, is nature’s inexorable imperative.”

—H. G Wells

Cybercrime is an emerging risk evidenced by a plethora of news stories of hacking involving Equifax, Yahoo, J. P. Morgan, Target, American Express, Kmart and many other companies. In 2014, there were 27% more data breaches than in 2013.¹ Equifax is experiencing a tidal wave of class action litigation for a data breach in exposing the sensitive personal information of 143 million customers in the United States and abroad. This should be notice enough as to the importance of cybersecurity.

A hacker is one who uses programming skills to gain illegal access to a computer network or file.² The purpose of this article is to highlight effective procedures to protect a company or law firm against the theft of its data. Law firms and companies should make a thorough review of their computer use policies including training to ensure that employees have no expectation of privacy in using company computer systems.

The internet is a part of our daily lives. Almost anything you do on the internet can be observed by other people. Advancement in computer technology creates new kinds of

insurance risks. Enter cybercrimes, that demand new and different insurance policy forms. When a new risk emerges, so too do new coverage issues. For example, how do intentional act exclusions apply to computer crimes?

Most commercial general liability (CGL) policies specifically exclude data. Cybercrime policies are specifically tailored policy provisions and claims involve intentional bad acts. But, my whom the hacker or the policyholder? In *Lambrecht & Assoc, Inc v State Farm Lloyds*, the court held that a hacker acted intentionally and not the policyholder. Thus, the injury was not intended by the policyholder and there was coverage.³

A question of coverage arises when criminals give bad information that is legally entered into the policyholder’s computer. In *Hudson United Bank v Progressive Cas Co*, the court held that hacking coverage did not apply because there was no actual breaking into the computer. Fraudulent data entry was not recoverable because data was not entered into the covered computer. This case demonstrates the difference between hacking a computer and using a computer.⁴

Limitations and exclusions for persons or actions

Computer-specific policies provide specific grants of coverage. For example, coverage is often limited to defined persons, acts and injuries. One common limitation is based on the type of person who used the computer and thereby caused the injury. Computer-specific policies often limit coverage to the bad acts of persons who are not authorized to use the computer, and therefore exclude acts by employees.⁵

Another limitation draws a distinction between fraudulent data and fraudulent entry of data. In *Universal American Corp v National Union Fire Insurance Co of Pittsburgh, PA*,⁶ a computer systems fraud policy covered “loss resulting directly from a fraudulent entry of electronic data.” The insured, a health insurer, lost \$18 million from fraudulent claims, submitted by providers. The providers entered fraudulent information. The pivotal question was the meaning of “fraudulent entry.” The court held for the insurer based on the word entry which is the act of entering data.

Property damage coverage

Another question facing cybercrime insurance is the issue whether the injury comes within the definition of property damage. Specifically, is data physical or tangible property? Some insureds have established physical damage by tying data to hardware.

Claims under computer policies involve a causation issue. Coverage in most cases is limited to losses directly related to some type of bad act on a computer. In *Retail Ventures, Inc. v National Union Fire Ins Co of Pittsburgh, PA*, criminals used computers to steal credit card information and then stole from the accounts. The losses resulted from a computer hacking scheme that compromised customer credit card and checking account information. The 6th Circuit held that the losses resulted directly from computers used by the criminals but the computers themselves were not used to carry out the crimes.⁷

Law firms as targets

Law firms are prime targets for cybercrimes. It is your data that cybercriminals and hackers want. A lawyer must act competently to safeguard information relating to the representation of a client against inadvertent or unauthorized disclosure by the lawyer. Special circumstances may warrant special precautions depending on the sensitivity of the information. Law firms should use encryption to protect confidential information. Encryption is increasingly required in areas such as banking and healthcare by virtue of reported hacking in these industries. The bad guys use encryption too; it's called ransomware. Ransomware encrypts your data and follows with a demand for payment to get your data back.

Training your employees not to click on suspicious E-Mail, attachments or links is your first defense. Have a strong pass-

word consisting of uppercase and lowercase letters, symbols and numbers. And change your passwords every 90 days.

Vigilance is especially important because hackers often do research on law firms and may know about your existing cases and the names of principal attorneys in your firm or on the other side. How many times have you seen in an E-Mail referencing a specific case and saying something like: “Please forward document attached,” or “The hearing set for the 16th has been rescheduled,” or “You do not have to appear at the summary judgment hearing set for the 12th because the court will decide on the pleadings before it.”

Protecting the data

Even non-malevolent events can cause data loss so you should also have a backup system in place to avoid any significant data loss. Moreover, employees should be required to strictly adhere to company policies on personal use of company computers with severe consequences. Some studies suggest employees are rogue by nature and steal your data and often bring their own devices which can infect your network.

Cybersecurity Training

If possible hire a third party consulting firm that does cybersecurity training. Large law firms can afford to hire a consulting firm. With a little digging, smaller firms can also find a cybersecurity firm within their budget. Make it mandatory for employees to attend training sessions. Trainers must explain to employees why security policies are needed and must be enforced. The importance of encryption should be emphasized on all devices and e-mails.

Also, training is needed to avoid negligent handling of documents by attorneys or employees that can compromise a case in disclosing confidential information. For example in *Harleysville Ins Co v Holding Funeral Home, Inc*, the defendant uploaded privileged documents into a cloud file sharing account that was not protected by a password. Opposing counsel found the hyperlink, accessed the account and downloaded and read the documents.⁸ Harleysville had failed to redact an e-mail and opposing counsel discovered the hyperlink. Harleysville filed a motion to disqualify opposing counsel that was denied. The court held that Harleysville waived both the attorney-client privilege and the work product doctrine.

Although the court found that Harleysville's disclosure was inadvertent under Virginia law, intent may not be determinative. Using the Supreme Court of Virginia's five factor test it concentrated on the reasonableness of the precautions to prevent inadvertent disclosure. The court opined that the investigator had taken no precautions to prevent the files disclosure.⁹ In addition, the court noted, the investigator left the files accessible in the account for six months and therefore waived the attorney-client privilege.¹⁰

Harleysville's work product privilege claim is governed by Federal Rule of Evidence 502(b). This rule states that an inadvertent disclosure does not operate as a waiver if...

1. The disclosure is inadvertent;
2. The holder of the privilege or protection took reasonable steps to prevent disclosure; and
3. The holder promptly took reasonable steps to rectify the error, including (if applicable) following Federal Rule of Civil Procedure 26(b)(5)(B).

Rule 502 requires that the proponent bear the burden of proving that each of the rule's elements are met. The court held that Harleysville's information release did not qualify as inadvertent under federal law. The court reasoned that Harleysville did not argue that its investigator acted unintentionally. Moreover, Harleysville took no measures to prevent and remedy the disclosure.

Company Practices and Security Policies

Obviously the insured's own internal practices and policies are important as a preventive measure. A company or law firm can easily spell out what is forbidden through a compliance code, employee handbook or employee agreements. Whether an employee has an expectation of privacy on the company computers can be a critical issue when it is suspected that an employee may have stolen company data.

It is essential to clearly define the computer systems that are covered by the policy, including the technology used such as text messaging, removable flash drives and disks. Spell out precisely the scope of an employee's permissible authorization to the company computers. Make clear that all data created in furtherance of any personal use belongs to the company and will be monitored by the company and will not be confidential. Make certain by specific language that employees have no expectation of privacy in using the company computer systems and delineating the scope of the employee's permissible access to the company's computers.¹¹

Cybercrimes

As technology continues to advance with mobile devices, so do efforts to better protect content from unauthorized access. For example, in addition to its existing privacy features, WhatsApp also encrypts voice calls.¹² This accelerated development revolves around the dispute between Apple and the FBI regarding accessing encrypted data in the iPhone iOS. The Fifth Amendment of the U. S. Constitution guarantees that no person shall be compelled in any criminal case to be a witness against himself. So compelling a defendant to divulge a passcode on a mobile is protected, because that evidence is testimonial or communicative.¹³ The government cannot force an accused to reveal knowledge of facts or share his or her

thoughts or beliefs relating him to the offense that may incriminate him.¹⁴ But, what about using a fingerprint? A fingerprint is that a physical characteristic and not testimonial; is disclosure of the fingerprint protected by the Fifth Amendment? The answer to this question is a topic for another day.

The Fifth Circuit Court of Appeals in *Apache Corp v Great American Ins Co* held that losses from social engineering scams by business emails are not covered by computer fraud provisions of commercial crime insurance policies. Scammers pretended to be a vendor of Apache and called one of its employees with new bank wiring instructions and then followed up the call with an email on the purported vendor's letterhead. Apache sent \$7 million to the scammers.

Apache made a claim under the "Computer Fraud" provision of its commercial crime insurance policy based on the position that the email caused the transfer of funds. However, this provision covered losses resulting directly from the use of any computer to fraudulently cause a transfer of funds. In this case, it was the content of the email that caused the transfer.¹⁵

Effective September 1, 2017 the Texas Cybercrime Act amended the criminal version of the Texas *hacking law*, the Breach of Computer Security¹⁶ section of the Texas Penal Code to make certain that the methods of cyber-attacks criminals currently use are prohibited by statute. Thus, malware and ransomware attacks are specifically prohibited by Texas statute. Also these attacks are prohibited by the federal Computer Fraud and Abuse Act.¹⁷

Conclusion

Nowhere does the aphorism "adapt or perish" apply with greater force than in the practice of law.

The first line of defense in protecting company or law firm data is to create an effective computer policy that protects the company or firm against the theft of its data by its own employees.

Lawyers need to be especially aware of how little privacy there is on the Internet if you are not using encryption. Some type of encryption should be used when sending confidential information over the Internet. Encryption can also keep anyone from seeing where you browse on the Web.

Advancement in computer technology creates new kinds of insurance risks. Cybercrimes create new and different insurance policy forms because when a new risk emerges so too do new coverage issues, and eventually new policy forms and terms. An effective cybersecurity policy should be a primary policy.

Computer fraud occurs when someone hacks or obtains unauthorized access or entry to a computer in order to make an unauthorized transfer. In cybercrime insurance, it appears that computer fraud coverage requires more than a criminal using a computer. The criminal must use the computer to cause the fraud. A combination of computer-specific policies, encryption technology and employee training should be in

place to prevent cybercrimes and data loss.

The practice of law is always evolving and we as lawyers must adapt or perish.

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Insurance and Indemnity 101

The Misunderstood Certificate of Insurance

By Hal O. Carroll, *Law Office of Hal O. Carroll*

It's a common situation in construction contracts. The owner and the general contractor want to be "additional insureds" on the subcontractor's liability policy. The obligation to make the owner and general contractor additional insureds comes from the contract that the subcontractor has signed.

How is this accomplished? Often the subcontractor provides a certificate of insurance, using the standard "Accord" form. The certificate is provided by the insurance broker, and the broker writes in at the bottom something like "Owner and General Contractor are additional insureds." The subcontractor provides this form to the general contractor and owner, and everyone is happy.

The problem is that the certificate of insurance does not "add" anyone to the subcontractor's policy. The certificate itself says that it does not do that. At the top the certificate announces that it is provided only for information, i.e., to confirm that the subcontractor has insurance. It says:

This certificate is issued as a matter of information only and confers no rights upon the certificate holder [the general contractor and owner]. This certificate does not amend, extend or alter the coverage afforded by the policies below.

At the bottom is a box entitled "Certificate Holder." This is where the broker puts in the name of the general contractor and/or owner.

So far, so good.

The problem comes in the box that's right above the "Certificate Holder" box. This box is entitled "Description of Operations Locations Vehicles Special Items." In this box you would expect to find a reference to the construction project that the owner, contractor and subcontractor are involved in.

But what often happens is that the broker will insert into the certificate a phrase like "owner and general contractor are additional insureds." The subcontractor then feels like he or she has met the requirement to add the general contractor and owner to the sub's liability policy.

The problem comes when someone is injured and sues the general and/or owner, and they tender the claim to the subcontractor's insurer. The subcontractor's insurer declines the tender on the ground that the certificate was ineffective to add anyone to the policy.

The insurer is right for two related reasons. First, the certificate is not issued by the insurer. It is issued by the broker, and

the broker is not the agent for the insurer. The broker is the agent for the subcontractor-insured. When the subcontractor asks the broker for insurance the broker shops various insurers to look for the best deals. The broker is acting as agent for the subcontractor, not for the insurers.

"[T]he independent insurance agent or broker is considered an agent of the insured rather than an agent of the insurer."

West American Ins Co v Meridian Mutual Ins Co, 230 Mich App 305, 310; 583 NW2d 548 (1998).

Because the broker is not the agent for the insurer, the broker cannot bind the insurer by any act that the broker does.

This leads to the second reason why the certificate is ineffective. The insurer's contract is the policy of insurance, and the certificate is not a part of the policy.

"The certificate is no part of the insurance contract." *Chrysler Corp v Hardwick*, 299 Mich 696, 700; 1 NW2d 43 (1941).

"[T]he independent insurance agent or broker is considered an agent of the insured rather than an agent of the insurer."

"[T]he insurance certificate at issue did not purport to represent the terms, benefits, or privileges promised under the policy. Instead, the stated purpose was merely to certify that the listed insurance policies had been issued." *Id.* at 311.

West American Ins Co v Meridian Mutual Ins Co, 230 Mich App 305, 310; 583 NW2d 548 (1998)

All that the certificate does – all that it can do – is to certify that the subcontractor has an insurance policy. That's what the *West American* case says and that's what the certificate itself says at the top – "this certificate is issued as a matter of information only . . ."

All of this is pretty straightforward if you follow through the language of the certificate and the cases that interpret certificates. The certificate is like the proof of insurance that every driver is supposed to have. The proof of insurance shows the State of Michigan that you have an auto policy. It doesn't make the State an additional insured.

This doesn't mean that the certificate is worthless. There is real value to the general contractor and owner in knowing that

the subcontractor has a policy of insurance. For one thing, the contract that the sub signs may have an indemnity clause requiring the sub to indemnify the general or owner for any losses arising out of the sub's work. If so, the indemnity clause will probably be an "insured contract" under the sub's policy, so that the sub's insurer will be the source of money to pay the indemnity obligation.

Apart from that, just having an additional insurance company that might be in a position to contribute to a settlement is a tangible value for the general contractor and the owner.

But neither of these can create a direct relationship of insurance between the sub's insurer and the general contractor or owner. So when the sub presents a certificate to the general or the owner, the sub has failed to comply with its contractual promise to make the general and/or owner additional insureds.

Yet in a surprising number of cases, the certificate is all that the sub provides.

The basic rule is that only the policy can make anyone an insured. Every liability policy has a provision entitled something like "Who Is An Insured." It's possible that the general contractor or owner could be listed here, but not usually.

So what the sub needs to do is to get an endorsement from the insurer that makes the general and/or owner additional insureds. One way is to have a named insured endorsement that says something short and simple like "ABC general contractor is an additional insured."

But more likely, the insurer will issue a "Blanket Additional Insured Endorsement." There are many versions of this type of endorsement, tailored to different types of underlying arrangements. Typically, they extend coverage to "any organization you [the named insured subcontractor] are required to add as an additional insured under a written contract."

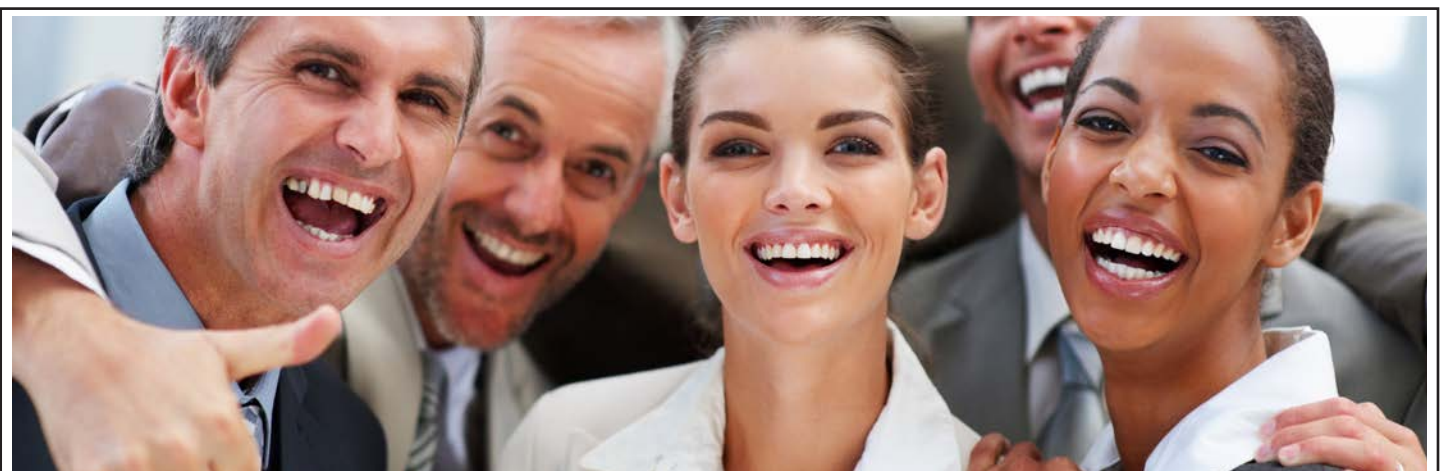
The coverage will come with limits, though. For one thing the coverage will apply when the general or owner is sued for "your acts or omissions," or the acts or omissions of the sub's own subcontractors. It may also contain an "other insurance" clause that says that the coverage it provides to the general or owner is secondary to ("excess" over) the general's own policy.

The sophisticated owner or general may specify in detail in its contract with the sub exactly what the additional insured endorsement should contain, so the sub (actually the sub's broker) can't just grab any old Blanket Additional Insured Endorsement. This is the point where the sub's attorney can get involved, and review the general's contract with the sub to determine what it requires and what kind of endorsement will meet the requirements.

At least that's how it should work. Many subcontractors are far less sophisticated in this area than the general contractor is, which is why the sub often just asks the broker for a certificate of insurance and believes that he or she has provided what the general and the owner want. The problem with coverage goes undetected until there is another problem – the injury and the lawsuit.

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 2017. He also consults with businesses and insurers on the drafting of contracts, represents insureds and insurers in declaratory actions, and is a frequent author of articles in the areas of insurance coverage and indemnity contracts. His email address is HOC@HalOCarrollEsq.com.



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Legislative Update: Summer Recess

By Patrick D. Crandell, Collins, Einhorn, Farrell PC

With the entire Legislature now on summer recess until September, there was a brief flurry of activity prior to members heading back to their home districts to campaign before the midterm elections. We can expect work to ramp back up in September, given that all pending bills expire when the Legislature recesses in December.

Members continue to introduce new bills (2145 in the House and 1060 in the Senate) and, since the last update, there has been activity on a number of bills previously referred to the House or Senate Insurance Committees:

- **Regulating medical service transportation** - HB 5217-5219 implements protocols for medical service transportation, including requirements to use motor vehicle transportation in most instances and to notify patients of the costs, and prescribing certain payments and requirements regarding air medical transportation. *Reported out of the House Insurance Committee on 11/30/17; Passed the House (96-14) on 12/6/17; Referred to the Senate Insurance Committee on 12/12/17; Reported out of the Senate Insurance Committee on 6/7/18*
- **Cancer medication cost sharing** - HB 5367 requires health insurers that provide coverage for orally, intravenously and/or injected administered anticancer medication to ensure that cost sharing requirements and treatment limitations are equal regardless of the method of administration. *House Insurance Committee voted to refer to House Committee on Health Policy on 6/7/18*
- **Electronic delivery of insurance notices and documents** - HB 5430 allows and creates requirements for electronic delivery of insurance notices and documents *Reported out of the House Insurance Committee on 3/1/18; Passed unanimously by the House on 3/14/18; Referred to the Senate Insurance Committee on 3/15/18; Senate Insurance Committee held a hearing on 5/23/18*
- **Cranial hair prosthetics** - SB 234-235 requires private health insurers and Medicaid to cover cranial hair prosthetics for individuals under 19 years old with hair loss due to a medical condition. ***Senate Insurance Committee held a hearing on 5/23/18***
- **Regulation of anticancer medication policies** - SB 492 sets financial restrictions on health insurance policies that cover anticancer medication, prohibits disparate treatment limitations on oral versus intravenous medications, and sets a process for reviewing the impact of these restrictions and prohibitions. *Reported out of the Senate Insurance Committee on 10/12/17; Passed the Senate (36-1) on 10/18/17; Referred to the House Insurance Committee on 10/18/17; House Insurance Committee voted to refer to the House Committee on Health Policy on 6/7/18*
- **Tort liability insurance for agents** - SB 638 clarifies the available tort liability for insurance agents *Reported out of the Senate Insurance Committee on 11/30/17; Passed unanimously in the Senate on 12/6/17; Reported out of the House Insurance Committee on 2/15/18; Passed by the House on 3/1/18 (108-1); Concurred in unanimously by the Senate on 3/6/18; Presented to the Governor for signature on 3/15/18; Signed by the Governor on 3/26/18 (PA 0091'18)*
- **PIP coverage options** – SB 787 allows people over 65 years old to select the maximum limit of personal protection benefits payable under their automobile policies. *Reported out of the Senate Insurance Committee on 6/7/18; Passed by the Senate (23-13) on 6/7/18; Referred to the House Insurance Committee on 6/7/18*
- **Electronic insurance verification** - SB 819-820, 1028 enact the real-time electronic insurance verification act. *Senate Insurance Committee held a hearing on 6/7/18*
- **Insurance company annual reports** - SB 898 modifies the date when captive insurance companies must provide their annual reports. *Reported out of the Senate Insurance Committee on 5/24/18; Passed by the Senate (32-0) on 5/30/18; Referred to the House Insurance Committee on 5/30/18*

The Legislature also referred a number of new bills to the House and Senate Insurance Committees since the last update:

- **90-day refills** - HB 5737 prohibits a prescription drug insurer from denying a 90-day refill request simply because it is at end of a calendar year

- **Renewal quotes – advance notice** – HB 5859 requires home and auto insurers to provide renewal quotes 30 days before policy expiration and to detail any premium change and the reasons for the change
- **MCCA premium calculation** - HB 5878 requires the Michigan Catastrophic Claims Association to disclose the basis for its premium calculation
- **Pothole loss and rate increase** - HB 5938 prohibits an auto insurer from raising the premium due to a claim for damage caused by a pothole
- **Coverage for spouse or resident relative** - HB 5981 prohibits an auto insurer from excluding coverage for the spouse or relative of the insured, as long as they reside with the insured
- **Coverage for prostheses** - HB 6009 and HB 6085 require health insurers to provide coverage for medically necessary prosthetic devices
- **Limit co-pay for primary care visits** - HB 6051 prohibits health insurers from charging more than a \$5 co-pay for primary care visits
- **PIP benefits for Medicare recipients** - HB 6100 requires auto insurers to provide certain deductibles and exclusions for PIP benefits received by Medicare recipients
- **Reporting requirements for life insurance policies** - HB 6115 eliminates certain reporting requirements in life insurance policies
- **MCCA actuarial calculations** - HB 6118 requires the Michigan Catastrophic Claims Association to base actuarial calculations on a 90-year life expectancy
- **Credit history and premiums** - HB 6128 prohibits auto insurers from considering credit history in determining premium
- **Privacy policies** - SB 950 modifies the requirements for providing privacy policies to customers
- **Certified mail notice of cancellation** - SB 953 requires insurers to send by certified mail a notice regarding cancellation of a life insurance policy
- **Waiver under Affordable Care Act** - SB 961 creates a task force to facilitate a waiver under the Affordable Care Act
- **Public Health Code** - SB 966 permits health insurers to refuse to pay covered claims submitted by a hospital that are in violation of Section 21517 of the Public Health Code
- **Auto Insurance – bases for raising rates** - SB 972 prohibits auto insurers from basing rates on certain non-driving factors
- **Auto Club contracts exemption** - SB 985 exempts an “automobile club contract” from the Michigan Insurance Code. *Reported out of the Senate Insurance Committee on 6/7/18*
- **Miscellaneous amendments to Insurance Code - SB 1014** – amends the Michigan Insurance Code in a number of ways, including: describing when an insurance rate is excessive, inadequate or discriminatory; dissolving the Michigan Catastrophic Claims Association; limiting payment of attendant care; limiting the amount of insurance payments to the average of what is paid for the services; creating the Michigan Automobile Fraud Authority. *Reported out of the Senate Insurance Committee on 6/7/18; Passed the Senate (23-13) on 6/7/18; Referred to the House Insurance Committee on 6/7/18*
- **Division of stock insurers** - SB 1029 permits a domestic stock insurer to divide into multiple insurers, describes the process for the division. *Reported out of the Senate Insurance Committee on 6/7/18*
- **Hospital master charge sheets – public availability** - SB 1033 requires hospitals to make their master charge sheets available to the public. ■

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Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*
Amy Felder, *Atain Insurance Companies*

Michigan Court of Appeals – Published Decisions

Contractual fraud provision is an affirmative defense that is waived if not pled

Baker v Marshall (Jansen, J. dissenting)

___ Mich App ___ (2018) (Docket No. 335931)

Released April 5, 2018 (Sup Ct app lv pending)

Plaintiff sued IDS Property Casualty Insurance Company for PIP and uninsured motorist benefits after IDS denied coverage under the fraud exclusion in its policy. The majority held that fraud in the submission of a claim is an affirmative defense, citing *Shelton v Auto-Owners Ins Co*, 318 Mich App 648 (2017) (fraud in the application for insurance is an affirmative defense). Because the insurer failed to assert the contractual exclusion in its pleadings, the insurer was foreclosed from asserting the exclusion as a defense. The dissent countered that the controlling authority is *Stanke v State Farm Mut Auto Ins Co*, 200 Mich App 307 (1993) (fraud in the submission of a claim prevents an insured from proving a valid claim for benefits and is therefore not an affirmative defense.)

Uninsured motorcyclist is not barred from residual tort liability claim under MCL 500.3135

Brickey v McCarver

___ Mich App ___ (2018) (Docket No. 337448)

Released April 17, 2018

Plaintiff was injured in a motor vehicle accident while driving his motorcycle, which was uninsured at the time, in violation of MCL 500.3103(1). The lack of insurance barred plaintiff from making a claim for PIP benefits under MCL 500.3113. It did not bar him from pursuing a tort action under MCL 500.3135. The statutory bar to residual liability claims is limited to the owner/operator of an uninsured motor vehicle, which does not include motorcycles.

Hurdles of proving fraud as a defense to insurance claims

Meemic Ins Co v Fortson (Cameron, J. dissenting)

___ Mich App ___ (2018) (Docket No. 337728)

Released May 29, 2018

This case involves fraud in the submission of a PIP claim but announces at least two principles of law that have broader

application. First, the majority decided that the abrogation of the innocent third party rule in *Bazzi v Sentinel Ins Co* applies only to policies that are rescinded for fraud in the procurement. If a policy is valid at inception, the insurer must provide the coverage described by statute and cannot rely on common law principles of equity applicable to the contracting party to deprive an innocent party of coverage. (*Note: the Supreme Court heard arguments in Bazzi on January 11, 2018*). Second, the majority decided that contractual fraud provisions become unenforceable once the policy expires because there is no longer a contract, and no longer an “insured” under the contract, against whom the provision can be applied. While the insurer remains liable for claims under an occurrence-based policy, contract provisions applicable to “insureds” can no longer be applied.

Michigan Court of Appeals – Unpublished Decisions

No ambiguity in UIM policy that limits both settlements and lawsuits

Strauss v Kantola

Docket No. 337812

Released April 10, 2018

Plaintiff’s UIM policy barred coverage if she settled her bodily injury with a tortfeasor without Farm Bureau’s consent. It also barred her from suing Farm Bureau for UIM benefits unless all other policies were exhausted. The trial court found that when these two provisions were read together, coverage was ambiguous and so the court allowed plaintiff to proceed with her suit against both the tortfeasor and Farm Bureau. The Court of Appeals reversed, holding that the lower court’s concern over the reasonableness of potential outcomes did not render the otherwise plain language of the insurance contract void or unenforceable.

No coverage where named insured was deceased prior to renewal of homeowners policy

Thompson v Floyd Jude Living Trust

Docket No. 337368

Released April 10, 2018

Named insured on a homeowners policy passed away. Policy was renewed by personal representative of named insured’s

estate. While going through personal belongings at the insured home, a family member fell and was injured. Family member filed suit, received a judgment, and garnished the homeowners policy. But the court denied coverage. An insurer has no duty to investigate or to verify representations made by a potential insured. To require an insurer to do so would be to hold an insurer to a different and higher standard than that of other contracting parties. Here, the insurer had no duty to inquire whether the insured was still living at the time of the renewal of the policy. Further, the doctrine of equitable estoppel will not be applied to broaden the coverage of a policy to protect the insured against risks that were not included in the policy or that were expressly excluded from the policy. Finally, reformation of an insurance policy can only happen when there is a mutual mistake or a mistake by one party and fraud by another.

Personal auto policy does not cover vehicle while it is being used for commercial deliveries

Cox III, LLC v Farmers Insurance Company
Docket No. 336777
Released April 12, 2018

Insured who was involved in car accident while delivering sandwiches for Jimmy John's was sued by injured parties. The court found that the exclusion in the insured's auto policy for "carrying a person or property for charge" is unambiguous and precludes insurance coverage for car accidents sustained while the insured was delivering sandwiches for his employer.

CGL coverage for contractual indemnity limited to insured's tort liability

Great West Cas Co v Merchants Metals, LLC
Docket No. 336709
Released April 19, 2018

This case addresses the scope of coverage created by the "insured contract" exception to the standard CGL exclusion for contractual liability. Based on the usual definition of "insured contract," coverage is extended to the insured's assumption of an indemnitee's tort liability only. This insured faced claims by two separate parties seeking indemnity for a bodily injury claim. One of the parties was alleged to have negligently caused the injury. The CGL policy covered the insured's assumption of that tort liability under the "insured contract" exception. The other party was not liable in tort but had contractually assumed liability for the injury. The CGL policy did not cover the insured's assumption of that purely contractual liability.

Failure to submit timely proof of loss precludes homeowners coverage

Aleksov v Auto Owners Insurance Company
Docket No. 338264
Released May 15, 2018

Based on the policy language, timely submission of a sworn proof of loss was a condition precedent to filing suit against the homeowner's insurer. The insureds did not, at any time after the loss or before filing suit, submit a sworn proof of loss to their insurer. They instead claimed 1) substantial compliance and 2) waiver or estoppel on the ground that the insurer did not advise of the need for a sworn proof of loss in its first letter. The court held the insurer did not waive nor was it estopped from asserting the lack of a sworn proof of loss as required by the plain language of the contract. As to substantial compliance, the court held that the insureds made no effort to comply at all.

Summary disposition premature where discovery is ongoing and questions of fact remain as to the residency of insured and injured passenger at time of accident

Hahn v Geico Indemnity Company and Automobile Club Insurance Association
Docket No. 336583
Released June 12, 2018

Plaintiff filed a claim with Geico, which insured the vehicle in which Plaintiff was injured in an accident. Geico determined that Plaintiff was entitled to up to \$500,000 in benefits pursuant to MCL 500.3163. Plaintiff filed a complaint seeking a declaration that either ACIA, which insured Plaintiff's father, or Geico, or both were responsible for paying full no-fault benefits. The Court of Appeals found a question of fact as to whether Geico knew the driver of the vehicle was a Michigan resident at the time of the accident, when it issued a North Carolina policy, noting that the parties had not even begun discovery on that issue. The court rejected, however, plaintiff's reliance on the "mend-the-hold" doctrine, which is an equitable theory of estoppel designed to prevent a party from changing positions after litigation has commenced.

UIM requirement of "actual" physical contact with another vehicle does not necessarily require direct physical contact

Paul v Farm Bureau Insurance Company of Michigan
Docket No. 339075
Released June 19, 2018

Plaintiff-insured was involved in a multi-vehicle pileup in the middle of a whiteout. While the plaintiff was standing outside his vehicle, another vehicle struck plaintiff's vehicle and

propelled it into plaintiff. The other driver left the scene and could not be identified. Plaintiff's policy with Farm Bureau provided UM coverage if the other auto "causes bodily injury by actual physical contact with the injured person or the auto the injured person is occupying." The court held that "actual" physical contact between injured person and the unidentified vehicle can be indirect as long as there is a substantial physical nexus between the vanishing vehicle and the object that strikes and injures the insured. Coverage applied.

Collapse coverage did not apply to unstable building

Community Garage, Inc v Auto-Owners Insurance Company

Docket No. 339300

Released June 19, 2018

Plaintiff truck repair business discovered that its building was unstable due to latent construction defects in the trusses supporting the roof. It submitted a claim to its commercial property insurer, but the policy excluded coverage unless the damage fit within a section of the policy adding coverage for "abrupt collapse." As defined in the policy, "collapse" did not include buildings that were sagging or were otherwise at risk of falling down and were still standing. The policy did not cover plaintiff's claim.

6th Circuit Court Of Appeals Decisions

Excess policy does not cover post-judgment interest

Key Safety Systems, Inc v AIG Specialty Insurance Company

___ Fed Appx ___ (2018)

Case No. 17-1934, Released April 20, 2018

Following an unsuccessful appeal from a \$3,700,000 product liability judgment, plaintiff looked to its excess insurer to cover all exposure beyond the \$2,000,000 self-insured retention, specifically including all post-judgment interest. But the policy with AIG only covered post-judgment interest on the excess portion of the judgment covered by AIG's policy. Post-judgment on the \$2,000,000 self-retention was not covered by the excess policy.

Federal District Court Decisions

Insurer's Motion to Dismiss based on two-year limitation to file lawsuit denied

ID Ventures v Chubb Custom Insurance Company

E.D. Michigan Case No. 17-14182

April 16, 2018

The insured alleged that insurer breached its Commercial Property Insurance Policy by failing to pay a claim for damage to the plumbing in an apartment building owned and operated by the insured and covered under the insurance policy.

The policy included a two-year limitations period for filing a lawsuit. The insurer argued that insured's lawsuit was barred because the contractual limitations period expired prior to filing the lawsuit. The insured claimed the limitations period was tolled while the claim was being adjusted and also because the damages were incurred over time. The court found that the insurer failed to support its early motion to dismiss with sufficient proof that the "direct physical loss or damage" all occurred on a date certain.

Summary judgment for insurer on claims that it overcharged premiums to insured

E.L. Hollingsworth & Company v Zurich American Insurance Company

E.D. Michigan Case No. 17-10989

Released April 16, 2018

Insured withheld adjusted premiums for 3 years, believing the insurer was overpaying on large claims and paying small claims that the insured had already settled on its own, causing the adjusted premiums to rise unfairly. But the insured couldn't point to any specific claim that shouldn't have been paid. The trial court ruled in favor of the insurer on the insured's single-count complaint for breach of contract and ordered the insured to pay past premiums due.

Genuine issues of material fact involving burst frozen pipes

Samuels v Allstate Property & Casualty Insurance Company

E.D. Michigan Case No. 16-cv-10890

April 20, 2018

Insured suffered water damage to her home as a result of burst frozen pipes. Insurer denied coverage under the policy's fraud provision. The court found genuine issues of material fact as to whether the insured willfully concealed and misrepresented facts; whether the insured willfully made false statements in her proof of loss; and whether the insured provided a satisfactory proof of loss. The court also concluded that insured did not leave her home unoccupied so as to trigger the policy's exclusion for failure to drain the pipes. ■



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No-Fault Corner

Fighting Fraudulent Claims . . . With One Hand Tied Behind Your Back

Court of Appeals Refuses to Enforce Fraud Exclusion in the Face of an Admittedly Fraudulent Claim for Attendant Care Service Benefits in a Controversial 2-1 Decision

By Ronald M. Sangster Jr.

In the April 2017 issue of this journal, we published an article extolling the virtues of the Court of Appeals' decision in *Babri v IDS Property Casualty Ins Co*, 308 Mich App 420, 864 NW2d 609 (2014) and how it was such a powerful tool in rooting out fraudulent nofault insurance claims.¹ In *Babri*, the Court of Appeals determined that where an injured Claimant submitted a claim for nofault benefits that was directly and specifically contradicted by other evidence, such as surveillance, the fraud exclusion contained within most insurance policies could conceivably be triggered. This, in turn, would result in voiding of all coverages under the nofault policy – not just the particular benefits for which the claim was filed. Simply put, an insured's fraudulent claim for, say, household replacement service expenses could void all coverages under the policy, including claims for medical expenses, even though the medical providers themselves were obviously not a party to the fraudulent conduct.

In that same article, though, this author analyzed the Court of Appeals' Valentine's Day gift to the Plaintiff's bar in *Shelton v Auto-Owners Ins Co*, 318 Mich App 648, 899 NW2d 744 (2017), which was released on February 14, 2017. In that case, the Court of Appeals ruled that the only parties bound by the fraud exclusion contained within an insurance policy are the named insured, his or her spouse or a relative of either domiciled in the same household – all of whom obtain their benefits through MCL 500.3114(1). All other claimants who are "strangers to the insurance contract," including motorcyclists, occupants of motor vehicles who do not have a policy of insurance available to them in their household or pedestrians who similarly do not have a policy of insurance available to them in their households, derive their benefits by statute . . . not by contract.² Therefore, as "strangers to the insurance contract," these claimants are not bound by the fraud exclusion contained within those policies. Although the Court of Appeals' decision in *Shelton* seems to open the door for fraudulent claims, at least those of us who practice extensively in this area believed that we had a "bright line rule" between fraudulent conducts perpetrated by the named insured, his or her spouse or a relative domiciled in the same household, and the proverbial "strangers to the insurance contract." Given

the fact that the Michigan Supreme Court denied the insurer's Application for Leave to Appeal,³ it seemed as if the Michigan Supreme Court had little interest in taking up the issue of fraudulent nofault insurance claims.

However, on May 29, 2018, the Court of Appeals issued a published, and therefore binding, decision, which effectively "kills the goose that laid the golden egg" in *Babri*, *supra*, once again! In a controversial 2-1 decision, which seems destined to find its way to the Michigan Supreme Court, the Court of Appeals in *MEEMIC Ins Co v Fortson, et al*, ___ Mich App ___, ___ NW2d ___ (Docket no. 337728, rel'd 5/29/2018), over a strongly worded dissent by Judge Cameron, issued a number of rulings that effectively gut the impact of *Babri* and its progeny, even where the fraud is being perpetrated by the named insured himself!

As noted above, *Babri* was a 2-1 decision. The majority opinion was authored by Judge Michael J. Kelly. Judge Kelly was joined by Judge Jane Markey. Judge Thomas Cameron dissented.

In *Fortson*, MEEMIC Insurance Company insured Richard and Louise Fortson. Their son, Justin Fortson, was a resident relative. In September 2009, Justin Fortson, then 19 years old, was riding on the hood of a vehicle when the driver suddenly accelerated and turned. Justin was thrown from the vehicle and struck his head on the ground. As a result, he suffered a fractured skull, a traumatic brain injury and bruising on his shoulder. After his initial hospitalization, he returned to live with his parents, who began submitting claims for 24-hour per day attendant care service benefits. MEEMIC paid the attendant care claims without question, as the claims representative testified that she knew that Justin had sustained a serious traumatic brain injury with significant residual effects requiring "24/7 supervision." In June 2010, MEEMIC notified the Fortson's that their policy would be cancelled effective July 29, 2010.

In 2014, MEEMIC conducted an investigation and determined that despite the attendant care submissions, the parents were not providing Justin with "daily direct supervision." Instead, MEEMIC uncovered the following information:

"Indeed, the investigation showed that Justin had been periodically jailed for traffic and drug offenses

and had spent time at an inpatient substance-abuse rehabilitation facility. Additionally, on social media, Justin had referenced spending time with his girlfriend and smoking marijuana. Based on its investigation, MEEMIC concluded that Louise and Richard had fraudulently represented the attendant care services they claim to have provided. MEEMIC terminated Justin's no-fault benefits and filed suit against Louise and Richard, alleging that they had fraudulently obtained payment for attendant care services that they had not provided. Louise and Richard filed a counter complaint, arguing that MEEMIC breached the insurance contract by terminating Justin's benefits and refusing to pay for attendant care services."

Fortson, slip opinion at pg 2.

Following the close of discovery, both sides filed Cross Motions for Summary Disposition. The Berrien County Circuit Court granted the insurer's Motion for Summary Disposition, and denied the Fortson's Cross Motion for Summary Disposition.

On appeal, the Court of Appeals reversed the decision of the lower court and remanded the matter back to the Circuit Court for further proceedings consistent with the majority opinion. In doing so, the Court of Appeals issued a number of key rulings.

First, the Court of Appeals recognized that that the parents had undoubtedly submitted a fraudulent claim for no-fault attendant care service benefits. Each of the necessary fraud elements, set forth in the Michigan Supreme Court's decision in *Titan Insurance Company v Hyten*, 491 Mich 547, 817 NW 2d 562 (2012) were satisfied. The parents admitted that they were aware that Justin was incarcerated and that he had spent time at an inpatient drug rehabilitation facility, during which time they continued to submit claims for attendant care services which were not being performed. Therefore, the Court of Appeals accepted as true the assertion that MEEMIC's named insureds (the parents) had committed fraud with regard to the claim for attendant care services.

However, the Fortson's argued that their son, Justin Fortson, was an "innocent third party" "because there were no allegations or evidence that Justin participated in or even benefited from his parents' fraud." The Court of Appeals then determined that the abrogation of the "innocent third party" rule only comes into play when there is fraud in the procurement of the policy, not fraud in a claim submitted under the policy. In this regard, the Court observed that in both *Hyten*, *supra*, and *Bazzi v Sentinel Ins Co*, 315 Mich App 763, 891 NW 2d 13 (2016) (which abrogated the "Innocent Third Party" Doctrine as applied to statutorily mandated benefits), the fraudulent acts were committed while procuring the sub-

ject policy of insurance. Therefore, the "innocent third party" rule still survived in this case because the policy was "properly procured." As stated by the Court of Appeals:

"This is because there is a meaningful distinction between fraud in the procurement of a no-fault policy and fraud arising *after* a claim was made under a properly procured policy. For instance, when a policy is rescinded on the basis of fraud in the procurement of the policy, it is as if no valid policy ever existed. As this Court explained in *Bazzi*, mandating no-fault benefits when an insurer can declare a policy void *ab initio* on the basis of fraud in the procurement would be akin to requiring the insurer to provide benefits in the case where the automobile insurer had never obtained an insurance policy in the first place.' [Citation omitted]. Thus, fraud in the procurement essentially taints the entire policy and all claims submitted under it. In contrast, 'if there is a valid policy in force, the statute controls the mandated coverages.' Here, when Justin submitted his claim that there *was* a valid policy in place, there were no allegations of fraud in the application tainting the validity of the policy. Therefore, under the NoFault Act Justin was required to seek no-fault benefits from his parents' no-fault policy. See MCL 500.3114(1). The mere fact that fraud arose in connection with attendant care services forms submitted *after* Justin made his claim simply has no bearing as to whether or not there was a valid policy in effect at the time he made his claim. Accordingly, we conclude that the trial court erred in finding *Bazzi* dispositive."

Fortson, slip opinion at pages 3-4.

In this regard, the Court of Appeals recognized that what MEEMIC was trying to do was to rescind coverage altogether. Noting that "rescission is generally viewed as an equitable remedy," the Court must weigh the equities and in doing so, the Court of Appeals noted:

"However, in this case, equity appears to lean in favor of protecting the innocent third party who was statutorily mandated to seek coverage under a validly procured policy and was, unlike the Claimant in *Babri*, wholly uninvolved in the fraud committed *after* the policy was procured."

Id., fn 1.

In this regard, Judge Cameron, in his dissent, squarely rejected this so-called "meaningful distinction" and noted that the fraud exclusion contained in the policy applied with equal

force to both a fraud in the insurance application, and fraud in the making of a claim – regardless of the identity of the person submitting the fraudulent claim.

Next, the Court addressed the validity of the Fraud Exclusion contained in the MEEMIC policy, which provides:

“This entire policy is void if any **insured person** has intentionally concealed or misrepresented any material fact or circumstance relating to:

- A. This insurance;
- B. the Application for it;
- C. or any claim made under it.”

The Court noted that pursuant to its earlier decision in *Shelton*, *supra*, if a person were not an “insured person” under an insurance contract, but rather were “strangers to the contract,” they would not be bound by any fraud exclusion contained in the policy. The court recognized that Justin Fortson was, in fact, an “insured person” under the insurance contract. However, the Court of Appeals ruled that, even as applied to an “insured person,” the fraud exclusion conflicted with the priority provisions in MCL 500.3114(1) and was therefore void. As noted by the Court of Appeals:

“Under MEEMIC’s logic, by duplicating statutory benefits in a no-fault policy, an insurer can avoid paying no-fault benefits to an injured Claimant if someone other than the Claimant commits fraud and triggers a fraud-exclusion clause that allows the policy to be voided. We do not agree that the statutory provisions can be so easily avoided. ‘An insurer who elects to provide automobile insurance is liable to pay no-fault benefits subject to the provisions of the No Fault Act.’ [Citation omitted]. Contractual provisions in an insurance policy that conflict with statutes are invalid. [Citation omitted]. Because MCL 500.3114(1) mandates coverage for a resident relative domiciled with a policy holder, the fraud-exclusion provision, as applied to Justin’s claim, is invalid because it conflicts with Justin’s statutory right to receive benefits under MCL 500.3114(1). And, as explained above, his statutory right to receive benefits under the NoFault Act was triggered because his parents had a validly procured no-fault policy in place at the time of the motor vehicle accident.”

As noted above, in *Shelton*, the Court of Appeals had ruled that “strangers to the contract” are not bound by the fraud exclusion in an insurance contract. In *Fortson*, the Court of Appeals took the analysis one step further and essentially ruled that the insurer’s incorporation of no-fault benefits into an insurance policy was simply a way of attempting to avoid the

court’s ruling in *Shelton*. As a result, if an “insured person” other than the injured person is submitting a fraudulent claim, the injured person’s entitlement to benefits is still preserved.

Next, the Court of Appeals determined that even if the fraud exclusion clause was valid, with regard to the claims presented by Richard and Louise Fortson on behalf of their son, the fraud exclusion was no longer applicable because the policy had been cancelled back in 2010! As a result, even though Justin’s claim for no-fault benefits was preserved or “locked in” as of the date of the accident, which is typically what happens with regard to “occurrence policies,” the same could not be said for the parents. Because they were no longer “insured persons” under the insurance contract (because the policy was no longer in force), they were no longer bound by the fraud exclusion contained in the policy! As stated by the Court of Appeals:

“Accordingly, once the policy was cancelled on July 29, 2010, Louise and Richard were no longer named insureds under the policy, which means that they were no longer ‘insured persons’ as defined in the policy. Further—and this is key—because the fraud was committed *after* the cancellation of the policy, when they were no longer insured persons, their actions were irrelevant for purposes of triggering the fraud-exclusion clause.”

Fortson, slip opinion at page 6.

What the court is essentially saying is that even though the injured person’s right to recover benefits continues under the policy, the other provisions of that policy, such as the fraud exclusion, no longer apply.

The Court of Appeals’ majority grudgingly noted that the insurer is not without a remedy. It can deny the attendant care claims based on fraud. It could also conceivably sue the parents to recover payment of the attendant care monies wrongfully paid. The majority simply ruled that the insurer could not utilize the General Fraud Exclusion to void all coverages available under the policy in the future.

As noted above, Judge Cameron issued a dissent. First, Judge Cameron opined that “the majority resurrects, albeit in a new form, the abolished innocent third party rule” which had been abrogated in the Court of Appeals’ decision in *Bazzzi*, *supra*. In this regard, Judge Cameron noted that whether a policy is void due to a fraud in the application, or void due to a fraudulent claim, the result should be the same—Justin “should not be allowed to continue to collect PIP benefits”⁴ because the policy no longer exists.

Second, Judge Cameron noted that with regard to the majority’s invalidation of the General Fraud Exclusion clause, “the majority’s holding carves out an unprecedented exception to the general rule that a fraud provision in an insurance policy

is valid.”⁵ In this regard, Judge Cameron noted that “there is no meaningful distinction for purposes of coverage between a policy holder and resident relative” under MCL 500.3114(1). According to Judge Cameron:

“Whether a policy holder or a resident relative, the policy’s provisions are applicable to the no-fault claim as long as they do not conflict with the No-Fault Act. [Citation omitted]. In this case, the policy, including the fraud provision, applies to Justin’s claim as a resident relative, and that fraud provision does not contravene the NoFault Act. [Citation omitted]. Contrary to what the majority claims, the policy is not ‘duplicating statutory benefits.’ Instead, it is providing the terms of coverage, which are subject to the NoFault Act.”

Fortson, slip opinion at page 3 (Cameron, J. dissenting).

Finally, Judge Cameron argued that under the policy, all of the provisions carry through, even after the policy is cancelled, because the basis for the “claim” — the automobile accident — occurred while the policy was still in effect. As noted by Judge Cameron:

“The claims for attendant care benefits — even if sought after the cancellation of the contract — still originate from the initial claim for no-fault benefits. Defendants cannot avoid the consequences of committing fraud simply because the policy is no longer in effect. Any such outcome contravenes the purpose of an occurrence-based policy.”

Based upon the strength of Judge Cameron’s dissenting opinion, it seems highly likely that MEEMIC will, in fact, file an Application for Leave to Appeal with the Michigan Supreme Court.

So Now What?

If the reader works for an insurance company that handles first-party no-fault claims, or represents insurers in first-party litigation, you should probably look at precisely who is submitting the potentially fraudulent attendant care service claim forms. In many cases, it is the attorney for the injured Claimant that is submitting the claims for attendant care services — not just the service providers individually. In those cases, the author questions whether the “Innocent Third Party” Doctrine really applies. After all, the claim is being submitted *by the injured person himself*, through his or her legal representative — his or her attorney! Certainly, when representing an injured Claimant, his or her attorney should be counseling both the injured Claimant and his or her care providers not to submit fraudulent claims, which could conceivably jeopardize the

injured person’s entire claim under the General Fraud Exclusion in the policy. Furthermore, if the attorney demands that the insurer issue a three-party check, payable to the injured claimant, the attendant care service provider, and the law firm, could it not be argued that, by negotiating such third-party checks, the injured claimant is complicit in the fraud being perpetrated by his or her service providers?

Second, the insurer should change its attendant care service claim forms and require that the injured person sign off, and thereby ratify, any claims for attendant care service benefits that are purportedly rendered on his or her behalf. If the insurer utilizes its own attendant care service claim forms, which does not contain a space for the injured Claimant to ratify the claim, the forms should immediately be altered to incorporate language to the effect of:

“I, [injured person] affirm that the above-described attendant care/nursing care/supervisory care services were, in fact, performed by the individual identified above, for the hours and on the dates identified above, and were performed for my benefit.”

In *Fortson*, it appears that the attendant care service claim forms were being submitted by the service providers, without any verification or ratification by the injured Claimant.⁶ If Justin Fortson had verified, and perhaps even ratified, the attendant care service claim forms that were being submitted on his behalf, the author doubts whether he would still be considered an “innocent third party” under those circumstances.

Third, perhaps the Legislature should step in and amend the NoFault Insurance Act to make the provisions of MCL 500.3173a(2), applicable to claims arising out of the Michigan Assigned Claims Plan (where there are no policies of insurance) applicable in all cases involving claims for nofault insurance benefits. In other words, our elected representatives should consider legislatively overruling both *Shelton* and *Fortson*, and finally provide insurers and defense counsel with valuable tools to combat fraudulent nofault insurance claims.

Finally, there is always hope that the Michigan Supreme Court might take up the insurer’s appeal, reverse the decision of the Court of Appeals and give the insurers some ammunition to combat the blatantly fraudulent claims for nofault insurance benefits that undoubtedly drive up the cost of nofault insurance benefits.⁷ In the meantime, insurers and their defense counsel will simply need to deal with this decision by making the changes referenced above. Stay tuned. ■

Endnotes

- 1 Don’t believe me? I invite the reader to spend two weeks in the medical fraud unit of any defense firm that specializes in the defense of first-party, no-fault insurance claims, and it becomes obvious that fraudulent nofault claims are rampant, particularly in southeast Michigan.

No Fault Corner Continued

- 2 Incidentally, many insurance policies specifically identify these “strangers to the insurance contract” as intended third party beneficiaries under the insurance contract, under the definition of the term “insured.” Should they not be likewise bound by the fraud exclusions contained within those policies under a third party beneficiary theory? That is a topic for another article.
- 3 *Shelton v Auto-Owners Ins Co*, 501 Mich 951, 904 NW2d 851 (2018)
- 4 *Fortson*, slip Opinion at pg 2 (Cameron, J. Dissenting)
- 5 *Id.*, slip Opinion at pg 2 (Cameron, J. Dissenting)
- 6 Again, refer to the statement in the majority opinion that the injured party, Justin Fortson, was “wholly uninvolved in the fraud committed *after* the policy was procured.” *Fortson*, slip opinion at pg. 4, fn 1.
- 7 For example, according to information available on the MCCA website, www.MichiganCatastrophic.org, reimbursement for attendant care service claims paid by the insurer constitute the single largest percentage of reimbursement moneys paid to nofault insurers.

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