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# I. SIGNIFICANT MICHIGAN COURT DECISIONS

## *A. SUPREME COURT DECISIONS*

### 1. No-Fault/PIP Decision

*Meemic Ins. Co. v. Fortson*, No. 158302
https://courts.michigan.gov/Courts/MichiganSupremeCourt/Clerks/Recent%20Opinions/19-20-Term-Opinions/158302.pdf

Insurer's Fraud Defense Not Upheld Because Grounded on Neither Either No Fault Act Nor Common Law.

The insurer sought to void its policy with the insured and stop paying no-fault benefits to their son. Although the benefits are mandated by statute, the insurer sought to avoid its statutory obligations by enforcing the antifraud provision in the policy. The issue before the Michigan Supreme Court was the extent to which a contractual defense like the one at issue was valid and enforceable when applied to coverage mandated by the No-Fault Act, MCL 500.3101.

The underlying facts showed that at the time of the accident, the insurer had provided no-fault coverage to a minor and his parents. The parents were the named insureds in the policy. But the son was also an "insured person" under the policy's "resident relatives" provision and under MCL 500.3114(1). Following an accident whereby the son was seriously injured, the insurer agreed to pay the parents $11 an hour to provide attendant-care services to the son and requested that the parents send the insurer monthly bills documenting actual hours spent providing care. From October 2009 to October 2014, the parents submitted bills for attendant care, and the insurer paid them. In May 2013, however, the insurance company began a formal investigation. The investigation revealed that between September 2012 and July 2014, the son had been in jail for 233 days and in drug rehabilitation for another 78 days. During this period, the son's parents had continued to bill the insurer for attendant care services allegedly rendered.

The insurer terminated the son's no-fault benefits and filed suit, asserting claims of breach of contract, fraud, common-law statutory conversion, and unjust enrichment. The insurer alleged that the parents had fraudulently represented the attendant-care services they claimed to have provided and sought to void the policy under its contractual antifraud provision, to terminate any future liability for benefits, and to require the parents to reimburse the insurer for the fraudulent attendant-care statements.

The Michigan Supreme Court held that such contractual provisions are valid when based on a defense to mandatory coverage provided in the no-fault act itself or on a common-law defense that has not been abrogated by the act. However, because here the insurer's fraud defense was grounded on neither the no-fault act nor the common law, it was invalid and unenforceable.

## 2. Appellate Court Decisions

### a) Insurance Coverage Decisions

*Cardinal Fabricating v. Cincinnati Ins. Co.*, No. 348339
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20200618_C348339_31_348339.OPN.PDF

Insurer Required to Defend Under CGL Policy; Must Plead Coverage Defenses Specifically as Affirmative Defenses or Waived.

A joint venture of contractors subcontracted with another company to manufacture support beams for a "visual screen" being constructed at the end of a runway owned by the Wayne County Airport Authority. This company purchased and used steel material fabricated by the insured. Defects in the insureds steel material compromised the integrity of the structure. The steel support columns cracked, causing panels to fall off the screen and damaging the structure's concrete base - each element constructed by other subcontractors.

In an underlying lawsuit, the joint venture was held liable to the WCAA. A court ordered the company that purchased the steel to indemnify the joint venture. That company, in turn, sought indemnification from the insured, alleging that any damage, or liability, was the result of defective materials supplied by the insured.

The insured then contacted its insurer, invoking its duty to defend and indemnify under its GCL and umbrella policies. The insurer responded that the alleged property damage was not the result of an "occurrence" as defined by the insurance policies, and therefore it had no duty to defend. The insured ultimately retained counsel and paid for its own defense of the underlying action. The insured then filed the current action, alleging the insurer breached its duties under the terms of the insurance policies. The insurer responded by denying coverage based on the absence of a covered occurrence.

The trial court and Michigan Court of Appeals both determined the insurer had a duty to defend. The terms of the CGL policy state in relevant part: "We will pay those sums that the insured becomes legally obligated to pay as damages because of […] 'property damage' to which this insurance applies. We will have the right and duty to defend the insured against any suit seeking those damages." The CGL policy further states that the policy only applies to property damage "that is caused by an 'occurrence,'" which is defined as "physical injury to tangible property, including all resulting use of that property […] or […] loss of use of tangible property that is not physically injured," and also as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Similar provisions are found under the umbrella policy as well. Reading these provisions together, the insurer had a duty under the policies to defend the insured in suits alleging physical injury to or the loss of use of tangible property caused by an accident.

In its letter denying coverage to the insured, the insurer quoted the impaired property clause as one of several exclusionary clauses contained within the insurance policies. However, the insurer stated that it had no duty to defend the insured because "the allegations do not meet the definition

of […] property damage […] or occurrence" under the terms of the insurance policies. When asserting its affirmative defenses in its answer to the insured's complaint, the insurer stated in general terms that the insured's claims might be excluded under the terms of the insurance policies. However, it did not expressly cite specific policy provisions under which coverage was excluded.

The Court of Appeals explained that general language reserving rights or defenses contained in letters denying coverage does not comply with an insurer's obligation to provide notice to an insured party and constitutes a waiver of more specific defenses. Here, the insurer failed to assert that a particular exclusion clause of the insurance policy applied to this case in its denial of coverage and in its affirmative defenses. The insurer therefore waived reliance on the impaired property exclusion and the trial should not have considered its applicability.

*Rozenberg v. Auto Club Group Ins. Co*, No. 348773
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20201229_C348773_38_348773.OPN.PDF

No Physical Contact Results in No UM Coverage When Item Fell from Lead Vehicle and Two Vehicles Never Made Physical Contact.

A car was driving behind a truck when an item dislodged or fell from the truck causing an accident where the driver was injured. The issue on appeal was whether the injured driver was entitled to uninsured motorist (UM) benefits when there was no "direct physical contact" between his vehicle and the uninsured motor vehicle, the truck, as required by the language of the applicable insurance policy.

The policy defined an "uninsured motor vehicle," in relevant part, as: "a hit-and-run motor vehicle of which the operator and owner are unknown and which makes direct physical contact with (1) you or a resident relative, or (2) a motor vehicle which an insured person is occupying."

The Michigan Court of Appeals found the policy at issue defines a "motor vehicle," in relevant part, as "a land motor vehicle or trailer, requiring vehicle registration," which implicitly refers to a whole, or at least mostly-whole, machine. The Court of Appeals continued to explain that unmodified, "physical contact" may be direct or indirect. However, "direct physical contact" has been established as requiring two vehicles—as vehicles, rather than in pieces—to touch each other. Thus, the Court of Appeals explained it was constrained to conclude that no "direct physical contact" occurred, as that term has been defined by binding precedent.

*Pontiac Sch. Dist. v. Travelers Indem. Co.*, No.347614
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20200903_C347614_55_347614.OPN.PDF

Two-Year Policy Limitations Period Upheld in Commercial Excess Insurance Policy.

An insurer provided an excess insurance policy to a self-insured property and casualty pool. Coverage issues arose following a water loss. The insurer denied coverage and litigation ensued. The Court of Appeals ruled in favor of the insurer when it invoked the policy's two-suit suit limitations provision. The Court of Appeals rejected an argument that the period of time to file

suit was tolled until the insurer had formally denied the claim. The Court of Appeals found that while this argument may apply in the context of fire insurance, it did not apply in the subject claim. It also found that even if the tolling rule did apply to the subject claim, the insurer had written a letter asserting the policy did not cover the loss and cited the reasons why. The letter would have operated as a denial letter and the subsequent lawsuit would have still been filed beyond the policy's limitations period.

*Estate of Wells v. State Farm Fire & Cas. Co.*, No. 348135
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20200716_C348135_50_348135D.OPN.PDF

Furnishing Minor's Alcohol Leading to Deadly Accident Not "Occurrence" or "Accident" Under Michigan Law.

Following a motor vehicle accident, the decedents estate obtained a policy limits settlement against a no-fault policy and then contained a consent judgment against the tortfeasor. It then turned to the tortfeasor's homeowner's insurer to satisfy portions of the judgment. However, the Court of Appeals determined the underlying event was not an "occurrence" under the subject homeowner's policy. The plaintiff's pleadings regarding social host liability embodied in the consent judgment showed that defendant's insured knowingly furnished alcohol to minors directly creating the risk of alcohol-impaired operation of a motor vehicle that was a proximate cause of plaintiff's damages. Consequently, plaintiff's pleadings show that the automobile crash was the reasonably foreseeable direct result of the insured's intentional act of furnishing alcohol to minors. It was, therefore, not an "occurrence" or an "accident" under Michigan law.

### b) No-Fault/PIP Decisions

*Settler v. Auto-Owners Ins. Co.*, No. 350925
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20201222_C350925_56_350925.OPN.PDF

Trial Courts Must Examine Whether Application for Benefit Forms Contain Fraudulent Statements, as Opposed to Attendant Care Forms.

The plaintiff was injured while driving a vehicle rented by his cousin, who allowed him to drive the vehicle while he was out-of-town. The plaintiff was then involved in an accident. He initially said he was not injured, was thereafter taken to a police precinct, and once returned home reported fainting. He was later diagnosed with a traumatic head injury and spent time in a medically induced coma. Plaintiff thereafter sought benefits, including attendant care services, through an insurance policy between the defendant-insurer and a repair shop that rented the vehicle.

The insurer sought to avoid extending coverage arguing the plaintiff committed fraud in the presentation of the claim, especially statements/representations he made on attendant care forms. The Court of Appeals noted the only source of statements that may form the basis of a viable fraud defense would be those made by plaintiff on his application for benefits. Defendant produced an application form, purportedly executed by plaintiff, in which he denied experiencing in the past the same or similar symptoms as those from the auto accident. The application form also stated

that the injury occurred while plaintiff was at work, and plaintiff admitted during the course of discovery that this was not true. Plaintiff also testified, however, that he did not recognize the application for benefits and did not recognize his purported signature on the application form.

The Court of Appeals explained the trial court did not address whether the application for benefits contained false statements, concluding only that the attendant-care forms were sufficient for defendant to deny coverage. Moreover, the trial court did not analyze the case through the framework set forth in *Meemic* and *Haydaw*, both issued after the trial court rendered its decision. The case was therefore remanded for further deliberations.

*Mich. Ambulatory Surgical Ctr. v. Farm Bureau Gen. Ins. Co.*, No. 349706
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20201119_C349706_57_349706D.OPN.PDF

Assignment of Benefit Restrictions in Settlement Agreements.

Defendant's insured was injured in a motor vehicle accident and filed suit against defendant to collect unpaid PIP benefits. Pursuant to a settlement agreement between the insured and the insurer, in exchange for $7,500, the insured released her rights to PIP benefits accrued through the date of the case evaluation. The settlement agreement was a separate contract with a merger clause - not an addendum to the no-fault policy and did it not in any way limit coverage under the policy or prohibit the insured from seeking additional PIP benefits in the future. Rather, the settlement agreement anticipated that the insured would accrue additional claims to PIP benefits in the future. The settlement agreement specifically provided that she would "not assign any of her rights to medical benefits to medical providers in the future without the express written consent of the insurer" with respect to any claim for benefits arising from the motor vehicle accident.

Thereafter, the insured sought and received plaintiff's medical services and thereby created a newly accrued claim for PIP benefits. Contrary to her agreement with the insurer, the insured then assigned to the medical provider her right to reimbursement for the medical provider's billings. The medical provider filed suit against the insurer to recover payment for the assigned, newly accrued PIP benefits. The insurer then filed a motion for summary disposition, arguing that the anti-assignment clause in the settlement agreement invalidated the insureds later assignment to plaintiff.

The medical provider responded that contractual provisions barring the post-loss assignment of an accrued claim to payment of insurance benefits are unenforceable as against public policy under *Jawad A Shah, MD, PC v State Farm Mut Auto Ins Co*, 324 Mich App 182. In turn, the insurer argued that *Shah* only applied to anti-assignment clauses in no-fault insurance policies but not to similar clauses in settlement agreements.

The Court of Appeals determined the trial court erred when it concluded that an anti-assignment provision in a settlement agreement was invalid pursuant to the Michigan Supreme Court's holding in *Shah*. The issues relating to the settlement agreement in this case were factually distinct from the facts presented in *Shah.* Although MCL 500.3143 prohibits the assignment of future benefits, it is silent regarding agreements not to assign benefits. The reasonable implication of the Michigan

Legislature's omission regarding agreements not to assign benefits is that parties are free to contract according to their wishes.

*Glasker-Davis v. Auvenshine*, No. 345238
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20200813_C345238_35_345238.OPN.PDF

Insurer Must Plead Fraud as Affirmative Defense or Waived.

Following an automobile accident, plaintiff alleged a claim for negligence against the driver of the other vehicle and asserted a claim for first-party benefits against the plaintiff's own no-fault insurance provider. Specifically, plaintiff claimed she was entitled to compensation for several months of replacement care services she received daily from her daughter. At her deposition, plaintiff testified that her daughter had performed services daily for a brief period and otherwise only came over two to three times a week. On the basis of that discrepancy, the insurer moved for summary disposition on the ground of fraud. However, the Court of Appeals found the insurer failed to plead fraud as an affirmative defense and it therefore waived asserting fraud as a defense in the litigation. Specifically, a defense premised on an alleged violation of an anti-fraud provision in an insurance policy constitutes an affirmative fraud defense.

### c) Premises Liability Decisions

*Drob v. SEK 15, Inc.*, No. 351198
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20201119_C351198_46_351198.OPN.PDF

Bartender, Paid Under-the-Table, was an Independent Contractor and When Injured Could Not Submit a Workers Compensation Claim, but Could Pursue Claim Under Bar's Liability Policy.

The plaintiff worked as a bartender for the bar under-the-table for cash. She injured her ankle while working and subsequently sought to obtain either Worker's Disability Compensation (WDC) benefits or benefits under the bar's liability insurance policy.

The plaintiff was denied WDC benefits given her employment relationship and thereafter filed a premises liability lawsuit wherein she escribed herself as a "business invitee" who was injured while employed by defendant. The plaintiff also alleged the defendant bar violated the Worker's Disability Compensation Act (WDCA), MCL 418.1 et seq., by failing to maintain required WDC insurance for all its employees.

The Michigan Court of Appeals determined plaintiff was not an employee, but rather was an independent contractor who could file a premises liability action against the bar. Although plaintiff served under a contract of hire, she held herself out to the public to perform the same services she performed for the tavern, excluding her from the definition of "employee" and the exclusive remedy provision of the WDCA.

### d) Governmental Immunity Decision

*Kellapoures v. Suburban Mobility Auth*., No. 351790
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20201015_C351790_28_351790.OPN.PDF

Analysis of Governmental Immunity in Context of MCL 691.1405 and Negligent Operation of Motor Vehicle.

The issue concerned whether the circumstances of the incident—where plaintiff alleged that he fell after a bus quickly accelerated from a stop and "jerked" back into traffic while plaintiff had been standing in the bus aisle on an area of floor that was wet and slippery - constituted the "negligent operation" of a motor vehicle for purposes of satisfying the motor-vehicle exception to governmental immunity. The Michigan Court of Appeals explained that under MCL 691.1405, the governmental entity can be liable "only if plaintiff's injuries resulted from 'the negligent operation' of a motor vehicle" and the governmental entity is protected by governmental immunity if there was no negligent operation of the motor vehicle. The bus in this case was being operated as a motor vehicle because it was being driven as it provided transportation services to the public, specifically driving away from the curb after picking up plaintiff and his wife, when plaintiff allegedly fell as the bus suddenly accelerated while plaintiff was standing on a wet and slippery portion of the bus floor.

### e) Other Significant Decisions

*Estate of Miller v. Angels' Place, Inc*., No. 348940
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20201022_C348940_36_348940.OPN.PDF

Adult Foster Care Facility Not a Medical Provider Under Facts of Case and Could Not be Sued for Medical Malpractice.

Following the decedent's death in an adult foster care facility, an estate attempted to pursue a medical malpractice claim. However, the Michigan Court of Appeals determined an adult foster care facility could not be a licensed health facility or agency, regardless of whether it also had certification as a provider of care for the developmentally disabled. Therefore, the facility and its employee could not be liable for medical malpractice in that capacity. The Court of Appeals focused on the fact the evidence did not show the facility was a hospital, long-term care unit, nursing home, county medical care facility, or other nursing care facility, or distinct part thereof. Because the facility was not licensed under article 17 of the Public Health Code, it was not a licensed health facility or agency under MCL 600.5838a, and the trial court therefore erred in finding that the facility was a health facility or agency.

*Estate of Homrich v. Selective Ins. Co. of Am.*, No. 346583
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20200924_C346583_50_346583.OPN.PDF

Witness Statement Provided to Insurance Company Protected as Work Product.
Following a motor vehicle accident in which a pedestrian was struck and killed, the Michigan Court of Appeals determined a recorded witness statement provided to an insurance company by

an insured was protected work-product and not subject to production in discovery. The Court of Appeals focused on the fact that the recorded statement was prepared by a representative of the insurance carrier and MCR 2.302(B)(3)(a) specifically provides that the work-product doctrine applies to materials prepared in anticipation of litigation by a party's insurer. Furthermore, at the time the statement was taken, the prospect of litigation was identifiable because the facts of the situation had already arisen, and a fatal motor vehicle accident generally gives rise to the prospect of litigation. Finally, the recorded statement contained more than objective facts because it also included the questions posed by a representative of the insurance company.

*Lost Lake Distillery v. Atain Ins. Co*., No. 346552
http://publicdocs.courts.mi.gov/OPINIONS/FINAL/COA/20200917_C346552_61_346552.OPN.PDF

No Duty of Insurance Agency to Warn Policy Nearing Expiration.

An insured utilized an insurance and subagent agency to obtain four policies of varying lengths. At the expiration of each of the first three policies, the agency reached out to the insured to inquire/remind about a renewal. The fourth policy expired without a reminder/inquiry about a renewal and a fire occurred shortly after the fourth policy expired. The agency then placed a new policy and backdated the policy to the expiration date of the third policy. Once the premium was paid on the 4th policy, the fire damage claim was submitted with an incorrect date of loss. The insurer later denied coverage and rescinded the policy on the basis of fraud

The Court of Appeals held for the insurer and agency. It first found the duty to ensure that a particular contract addresses an insured's needs is distinct from a purported duty to warn that a particular policy is about to expire. There is no such duty to warn about the policy's looming expiration, despite these warnings having been voluntarily provided in the past.

**These cases were pending at the time this summary was printed. To confirm whether the Supreme Court has issued a decision in this case, we invite you to visit our website at http://www.rolfeshenry.com.**