INSURANCE**LEGAL**NEWS

GOVERNOR APPOINTS NEW INSURANCE COMMISSIONER

On April 16, 2011, Michigan Governor Rick Snyder appointed Kevin Clinton as the new Commissioner of the Office of Financial and Insurance Regulation ("OFIR"). The appointment comes after former Commissioner Ken Ross announced his resignation on April 12. Mr. Ross had served as commissioner for just over three years of a four-year term.

Prior to his appointment, Mr. Clinton served as the president and CEO of American Physicians Capital, Inc., an East Lansing-based medical professional liability insurer. Mr. Clinton had also served as a special advisor to OFIR, and earlier in his career had worked for the Michigan Insurance Bureau, which is now part of OFIR.

In a press release,[1] the Governor stated that "[a]s the new insurance and banking commissioner, Kevin Clinton's first priority is to make sure consumers are protected by making sure financial institutions are sound. He will also lead our effort to eliminate burdensome regulations that are preventing the industry from growing."

[1]The press release, including more information on Mr. Clinton's background, is available at http://www.michigan.gov/snyder/0,1607,7-277-57577_57657-254365--,00.html.

HHS FINALIZES RULES ON HEALTH INSURANCE RATE REVIEW PROCESS

by Cynthia A. Moore

On May 19, 2011, the United States Department of Health and Human Services ("HHS") released its final rule regarding the disclosure and review of unreasonable premium increases for health insurance issuers under Section 2794 of the Public Health Service Act ("PHS Act"), one of the changes made by the Patient Protection and Affordable Care Act. The final rule largely follows the proposed rule published on December 23, 2010.

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INSURANCE WEB SITES OF INTEREST

National Association of Insurance Commissioners
http://www.naic.org/

Michigan Office of Financial and Insurance Regulation
http://www.michigan.gov/dleg/0,1607,7-154-10555---00.html

Under the final rule,[2] any rate increase of 10% or more in the individual or small group health insurance market is subject to review. "Individual market" and "small group market" are each defined by reference to state law. If state law does not define these markets, then the PHS Act definitions will apply, except that a small group means an employer with 50 or fewer employees. The rate review process does not apply to grandfathered health plans or to "excepted benefits," such as limited scope dental or vision plans. HHS is requesting comments on whether individual and small group coverage sold through an association plan should be subject to the rate review process.

The Department of Health and Human Services is expected to release lengthy regulations related to the operation of the state health insurance exchanges in June. In addition to addressing IT systems and infrastructure requirements, it is anticipated that the regulations will clarify administrative obligations of states as they make preparations in advance of implementation of the exchanges in 2014.

The state will conduct the rate review if the state is determined by the Centers for Medicare & Medicaid Services ("CMS") to have an effective rate review process. If CMS determines that a state does not have an effective rate review process, then CMS will conduct the rate review process. CMS will decide whether each state has an effective rate review process by July 1, 2011.

The initial threshold amount for triggering a rate review is an increase of 10% or more for the 12-month period beginning September 1, 2011, and applies to rate increases filed in a state on or after September 1, 2011, or effective on or after September 1, 2011, in a state that does not require a rate increase to be filed. In future years, CMS will determine a state-specific threshold which will be announced on June 1 and apply for the 12-month period beginning on the following September 1.

If a health insurance rate increase exceeds the 10% threshold, the insurer must file a Preliminary Justification with CMS and the state prior to implementing the rate increase. CMS will post portions of the Preliminary Justification on its website. The website will contain a disclaimer explaining the purpose and role of the Preliminary Justification and a process for accepting comments from the public on rates that CMS will review.

If CMS conducts the rate review, it will determine if the rate increase is unreasonable because the rate is excessive, unjustified, or unfairly discriminatory. If CMS determines that a rate increase is unreasonable, CMS will notify the insurer and, if the insurer implements the rate increase, the insurer must provide a Final Justification to CMS and prominently post information on its website relating to the rate increase, including the Final Justification. The Final Justification will also be posted on the CMS website.

If the state conducts the rate review, the insurer must follow state guidelines on when the proposed rate increase must be filed with the state. The state will determine whether the rate increase is unreasonable under its statutory and regulatory rules, and CMS will accept the state's determination. If the state determines that the rate increase is unreasonable, the insurer may implement the rate increase if allowed by applicable state law.

According to a fact sheet issued by HHS simultaneously with the final rule, the rate review process under PHS Act Section 2794 and the final rule is intended to bring greater scrutiny and transparency to the health insurance rate review process. Consumers will be able to review the factors driving increases in health care costs, which will allow them to understand why they are paying the rates that they are, and thus ultimately may help bring down costs for consumers.

[2] 45 CFR Part 154.

RECENT CASE LAW SUMMARIES

CONSERVATOR'S FEES ARE COMPENSABLE AS "ALLOWABLE EXPENSES" UNDER THE MICHIGAN NO FAULT ACT

by Ryan M. Shannon

In *May v Auto Club Ins Ass'n*, 2011 Mich App LEXIS 746 (April 26, 2011), the Michigan Court of Appeals held that a conservator's fees were compensable as "allowable expenses" under the Michigan No Fault Act. MCL 500.3107(1)(a).

Alan May was appointed as conservator for Edward Carroll in December of 2008. Mr. Carroll had suffered a closed head injury in a 1982 automobile accident which left him debilitated and unable to care for himself. For the next two and a half decades, Carroll's insurer, Auto Club Insurance Association ("Auto Club"), compensated Carroll's wife for his care. After the death of his wife in late 2008, Carroll's daughter placed him in an adult foster care home and sought a formal guardianship. May was appointed as Carroll's conservator in subsequent proceedings.

When May filed a petition seeking fees in March of 2009, Auto Club refused to pay his conservator fee, which approached $7,000, and argued that conservator fees were not "allowable expenses" under the Michigan No Fault Act, MCL 500.3107(1)(a), because the fees "did not relate to Carroll's care and recovery arising out of the accident." *Id.* at *2. Auto Club argued that the fees related instead to May's services in seeking to rent or sell Carroll's property, and as such were compensable at a lower rate only as expenses for "replacement services."

The probate court sided with Auto Club, determining that May's claims involved administrative expenses rather than being "expenses related to a person's care, recovery, or rehabilitation," as required by the statute. *See id.* at *3. As such, the probate court found that Auto Club's liability for May's services was only $99.

On appeal, the court turned to its earlier decision in *Heinz v Auto Club Ins Ass'n*, 214 Mich App 195 (1995), in which it held that a guardian of a person injured in an automobile accident was entitled to fees under MCL 500.3107(1)(a). In *Heinz*, the court noted that MCL 500.3107(1)(a) "provides for the payment of expenses incurred for the reasonably

necessary services for an injured person's care." *Id*. at 198. The *Heinz* Court also stated that if a person was so seriously injured as to require a guardian, the services provided by that guardian are "reasonably necessary to provide for the person's care." *Id*. The *May* Court found little reason to distinguish between conservators and guardians, and found a conservator's fees were compensable as "allowable expenses" under the statute. 2011 Mich App LEXIS 746 at *8.

Auto Club argued that the conservatorship did not constitute care such that it could be differentiated from other replacement services. Under the Michigan No Fault Act, replacement services include "ordinary and necessary services in lieu of those that … an injured person would have performed during the first three years after the date of the accident." MCL 500.3107(1)(c). In rejecting Auto Club's argument, the court focused on the meaning of the word "ordinary," stating "Carroll is so incapacitated … that he cannot manage his own affairs …. Under these circumstances, the services provided transcend 'ordinary' services akin to cooking, cleaning or doing yard work and thus are not replacement services." *Id*. at *12.

Auto Club next argued that the conservatorship no longer constituted an "allowable expense" under Michigan law, as the Michigan Supreme Court had recently held that whether an expense was allowable depended on whether it was causally connected to an accidental bodily injury arising out of an automobile accident. *See Griffith v State Farm Mut Auto Ins Co*, 472 Mich 521, 531 (2005). The court of appeals also rejected this second argument, concluding that the conservator's actions were necessitated by the injury. May, the court noted, was not seeking recovery for expenses which Carroll would have paid regardless of the injury, but rather for services rendered by a conservator in managing those expenses. The court further stated that "[t]he conservator's services here are more akin to attendant care provided by a nursing assistant who handles an injured person's intimate hygiene needs." 2011 Mich App LEXIS 746 at *16.

The court of appeals therefore reversed the probate court's determination of Auto Club's liability at only $99, and remanded, holding that the probate court erred when it concluded Auto Club was not liable for the full amount of the conservator's fee.

DENIAL OF INSURED'S CLAIM FOR FAILURE TO TIMELY FILE PROOF OF LOSS UPHELD DESPITE INSURED'S ASSERTED LACK OF AWARENESS

by Brian P. Vincent

In *Durall v Home-Owners Ins Co*, 2011 Mich App LEXIS 591 (March 29, 2011) (unpublished), the Michigan Court of Appeals held that an insurer's ("Insurer") denial of its insured's ("Insured") claim for benefits under a homeowner's insurance policy was proper based upon the Insured's failure to timely submit a sworn proof of loss statement ("POL") as required by the policy, regardless of whether or not the Insured was aware of this requirement.

This dispute arose following the Insured's procurement of a homeowner's insurance policy from the Insurer. After the real property covered under the policy was destroyed by fire, the Insured filed a claim with the Insurer for benefits under the policy. The Insurer, however, ultimately denied the Insured's benefits claim for failure to comply with certain of the policy's requirements.

Thereafter, the Insured filed a breach of contract action. The Insured alleged that the Insurer's denial constituted breach of the homeowner's insurance policy and sought the benefits initially claimed thereunder.

Following the close of discovery, the Insurer moved for summary disposition and argued that the Insured was barred from recovering the benefits sought because he failed to comply with the policy's express claims procedures and requirements. Specifically, the Insurer asserted that dismissal was proper because the Insured was aware that under the policy he was required to file a POL within 60 days of the fire, and the Insured's failure to do so barred his claim for benefits. The Insured, however, contended that he was entitled to the benefits sought because: (1) he was unaware of the policy's POL requirement; (2) the Insurer was estopped from claiming the POL was untimely due to its partial benefits payments before and after the 60-day POL deadline; (3) he filed the "functional equivalent" of a POL; and (4) in any event, the Insurer "was able to thoroughly investigate [his] claim." *Id*. at *2.

The trial court, however, agreed with the Insurer and granted its motion for summary disposition based upon the Insured's failure to timely file a POL. *Id*. at *3-4. On appeal, the court of appeals affirmed the trial court's grant of summary disposition in favor of the Insurer.

The court of appeals explained that the subject policy expressly required the Insured to send to the Insurer, "within 60 days after the loss, a proof of loss signed and sworn to by the insured[.]" *Id*. at *5. Further, the court noted that, on the day after the Insured reported the fire, the Insurer mailed to the Insured a letter with instructions on how to proceed with his claim for benefits. These instructions specifically stated that the Insured "must submit the proof of loss within 60 days of the fire" and "enclosed proof of loss forms for the Insured to submit."

The court concluded that, even if the Insured did not receive this instructional letter, and even if he was in fact unaware of the policy's 60-day POL filing requirement, it was undisputed that the Insured *did* receive a copy of the policy, which expressly articulated the 60-day POL filing requirement. And, even if the Insured had not read the policy, "he . . . [was] nevertheless charged with knowledge of the terms and conditions" therein. *Id*. at *11.

Moreover, the court of appeals concluded that the Insurer was not estopped from denying the Insured's claim due to its payment of partial benefits before and after the 60-day POL filing deadline. The Insured executed a non-waiver agreement, which stated that issuance

"of advance payments by the [Insurer was] not an admission of liability" and that the agreement was "not a PROOF OF LOSS as required by the policy." *Id*. This non-waiver agreement negated any claim of waiver or misrepresentation.

FEDERAL COURT HOLDS NEW YORK LIFE AGENTS ARE "OUTSIDE SALESMEN" DESPITE ADDITIONAL QUALIFICATIONS; WAGE DEDUCTION CLAIMS CONTINUE

by David J. Houston

The District Court for the Southern District of New York recently dismissed collective and putative class claims brought by commission-paid financial products sales agents who sought to challenge the New York Life Insurance Company's (the "Company") classification of those agents as "outside salesmen" exempt from the overtime requirements of the Fair Labor Standards Act. *Gold v New York Life Co*, 1:09-cv-03210-WHP (SDNY May 19, 2011). The *Gold* case involved a number of sales agents as putative class members who were required to be "registered representatives" permitted and trained to provide financial advice. Under the FLSA, outside salesmen are normally exempt from the statute's overtime pay provisions, but class members argued that, because of the Company's training and sales procedures requirements, Company agents were more akin to financial advisors and thus entitled to overtime compensation. The court rejected this argument on the basis that these agents were primarily responsible to make sales, and their additional qualifications did not change the nature of their duties to such an extent that the agents were exempt from treatment as "outside salesmen."

Though the Company prevailed on the federal claims, putative class claims under a New York statute, which prohibited the Company from making "any deduction from the wages of an employee" without the employee's authorization or a regulatory justification, were allowed to continue. The court found that New York law prohibited the employer's "ledger" compensation practice of crediting commission payments and subsequently making deductions. This ruling is a reminder that the relative uniformity of the federal Fair Labor Standards Act concerning employee classification does not extend to areas of purely state law such as payment of and deductions from wages. Many states have statutes regulating those matters, which typically vary from state to state. *See, for example,* the *Michigan Payment of Wages and Fringe Benefits Act*. Accordingly, review of payroll practices should not be limited to federal law, but should extend to the law of each state in which the entity employs workers.

POLICY EXCLUSION FOR "CRIMINAL ACTS" INCLUDES ACTS COMMITTED BY JUVENILE FOUND DELINQUENT IN DELINQUENCY PROCEEDINGS

by Ryan M. Shannon

In *Auto Club Group Ins Ass'n v Andrzejewski*, 2011 Mich App LEXIS 888 (May 17, 2011), the Michigan Court of Appeals upheld summary disposition in favor of the plaintiff Auto Club Group Insurance Association ("Auto Club"), finding a policy exclusion for coverage for harms resulting from "criminal acts" prevented insurer liability for the acts of a juvenile even if the juvenile was subject to delinquency, rather than criminal, proceedings.

In 2008, during a basketball game, Nicholas Andrzejewski, then thirteen, put an opposing player in a headlock, causing the opposing player to have a seizure. As a result, Andrzejewski was charged with aggravated assault and pleaded nolo contendere. Meanwhile, the opposing player filed a civil suit against Andrzejewski and his parents, all of whom were insured under a homeowners insurance policy issued by Auto Club, which included liability insurance coverage.

While defending the underlying tort action, Auto Club issued a reservation of rights denying coverage and citing, among other reasons, the policy's exclusion of coverage for liability from "criminal acts." The trial court, finding Andrzejewski's acts to be criminal, granted summary disposition to Auto Club.

On appeal, Andrzejewski argued that his actions could not be considered "criminal in nature" because "the proceedings against [him] under the Juvenile Code were not criminal proceedings." *Id*. at *9. The court of appeals rejected this argument, noting that the court in the juvenile proceedings "must find that the juvenile committed an act which, if committed by an adult, would constitute the crime of aggravated assault." *Id*. at *9-10. As such, the court of appeals affirmed the grant of summary disposition to Auto Club.

MICHIGAN SUPREME COURT HOLDS MINIMUM EMPLOYER CONTRIBUTIONS ARE CONSISTENT WITH THE SMALL EMPLOYER GROUP HEALTH COVERAGE ACT

by Ryan M. Shannon

In *Priority Health v Commissioner*, 2011 Mich LEXIS 790 (May 17, 2011), the Supreme Court of Michigan held that a carrier's policy requiring minimum employer contributions from small employers was consistent with the Small Employer Group Health Coverage Act (the "act"). MCL 500.3701 *et seq*.

In 2006, Priority Health requested a declaratory ruling from the Office of Financial and Insurance Regulation ("OFIR") as to whether an HMO may require small employers to contribute a specific minimum in payment of premiums if that minimum is reasonable and is applied uniformly. The Commissioner issued a declaratory ruling in which she concluded that the mandated employer contribution in Priority Health's policies was inconsistent with the act. Both the circuit court as well as the Michigan Court of Appeals affirmed the decision of the Commissioner on the basis that an employer's failure to pay a minimum percentage of its employees' premiums was not listed among the reasons set forth in

the act for which a carrier may refuse to renew an insurance plan, and was thus inconsistent with the act's guaranteed-renewal provisions.

On review, the Michigan Supreme Court reversed, holding that minimum contribution provisions were not inconsistent with the act and were valid if reasonable. In doing so, the court noted that "[t]he act does not expressly permit carriers of small-employer benefit plans to mandate a minimum employer contribution in their policies," but also stated that policy provisions not expressly prohibited are otherwise permissible so long as they are both reasonable and not otherwise inconsistent with the act's purposes. *Id*. at *9. "[C]hapter 37," the court stated, "does not require a proposed policy provision to be expressly authorized by chapter 37 before a small-employer carrier can include it in a policy." *Id*. The act's guaranteed renewal provision, the court additionally found, does not prevent a carrier from including a minimum employer contribution in its initial policy, but only from adding such a provision at the time of renewal. As such, the Commissioner was in error when she concluded that the guaranteed renewal provision prevented small-employer carriers from requiring minimum employer contributions.

The Supreme Court thus reversed the Court of Appeals, vacated the prior OFIR declaratory ruling, and remanded the case to OFIR for a determination of whether Priority Health's specific provisions were reasonable.

U.S. SUPREME COURT HOLDS CLASS MEMBERS MUST DEMONSTRATE ACTUAL HARM AND CAUSATION TO OBTAIN EQUITABLE RELIEF FOR EMPLOYER'S MISLEADING SUMMARY PLAN DESCRIPTION

by Brian P. Vincent

In *CIGNA Corp v Amara*, No. 09-804, 2011 U.S. LEXIS 3540 (May 16, 2011), the United States Supreme Court held that, although Section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA") did not authorize the district court to reform CIGNA's newly adopted pension plan, relief was authorized under ERISA Section 502(a)(3), which allows beneficiaries to "obtain other appropriate equitable relief" to redress violations of ERISA or a pension plan's terms.

This dispute arose following CIGNA's modification of its pension plan. CIGNA's old pension plan provided employee retirees with an annuity based upon pre-retirement salary and length of service. CIGNA's new pension plan replaced that annuity with a cash balance based upon a defined annual contribution, increased by compound interest. Under the new plan, already-earned benefits under the old plan were to be translated into an opening amount in beneficiaries' cash balance accounts. *Id*. at *12-18.

In its summary plan description ("SPD"), CIGNA represented that under the new plan, retirement benefits would increase, the initial cash deposit would represent the full value of benefits earned under the old plan, and the new plan would not result in any cost savings to CIGNA. *Id*. at *12-16. Following implementation of the new plan, the class action plaintiff beneficiaries brought an action challenging CIGNA's adoption of the new plan and alleging that the statements and disclosures contained in CIGNA's SPD violated ERISA.

The district court concluded, as a matter of law, that the representations (and omissions) contained in CIGNA's SPD violated: (1) ERISA Section 204(h), which prohibits an amendment that would significantly reduce future benefits without written notice; and (2) ERISA Sections 102(a) and 104(b), which require a plan administrator to provide beneficiaries with an SPD that is written in a manner calculated to be understood by the average participant, and calculated to reasonably apprise beneficiaries of their rights and obligations under the plan. *Id*. at *19-20. The district court found that only those class members whom CIGNA's ERISA violations had harmed could obtain relief. However, the district court nevertheless concluded that a presumption of "likely harm" had been raised and thus did not require each class member to demonstrate individual injury. *Id*. at *20-21. Next, the district court reformed certain terms of the new plan and ordered CIGNA to calculate benefits according to the terms of the reformed plan and to pay appropriate benefits to those class members who had already retired. *Id*. at *23.

The Court of Appeals for the Second Circuit affirmed the district court's judgment. Thereafter, the United States Supreme Court granted CIGNA's petition for writ of certiorari.

The Supreme Court concluded that ERISA Section 502(a)(1)(B) – which contemplates "enforcement" of a pension plan's terms "as written" and not revision of a plan's terms – did not authorize the district court's reformation. *Id*. at *26. Nevertheless, the Supreme Court found that ERISA Section 502(a)(3) authorized entry of relief because the district court's "affirmative and negative injunctions obviously [fell] within this category." *Id*. at *33. The Supreme Court concluded that, although it did not so state, the relief entered by the district court may be authorized under Section 502(a)(3) if such relief was entered for an equitable purpose, including any of the following exemplary equitable purposes: (1) reformation to remedy false or misleading information provided by CIGNA; (2) reformation to hold CIGNA to its promise that it would not take away already-accrued benefits; and (3) entry of an injunction to require payment of benefits owed to already-retired beneficiaries under the terms of the plan as reformed (a "surcharge"). To obtain equitable relief in the form of a surcharge, however, the Supreme Court stated that a class member must individually show that the alleged ERISA violations in an SPD "injured him or her." *Id*. at *40. In contrast to the district court's holding, the Supreme Court held that to demonstrate "injury," a class member must demonstrate actual harm and causation, but is not necessarily required to demonstrate detrimental reliance.

The Supreme Court also discussed and disagreed with the Solicitor General's argument that the disclosures in the SPD constituted the terms of the plan and could be enforced by participants under ERISA Section 502(a)(1)(B). Importantly, the Supreme Court concluded that the SPD, which is intended to provide simple, clear communication to participants, is a disclosure *about* the plan, but does not itself constitute the *terms* of the plan for purposes of allowing a participant to enforce the terms of a plan under ERISA Section 502(a)(1)(B).

The Supreme Court vacated the district court's judgment and remanded this case for further proceedings consistent with its opinion to determine if any appropriate equitable remedy may be imposed under Section 502(a)(3).

SIXTH CIRCUIT ADDRESSES ISSUE OF FIRST IMPRESSION AND HOLDS THAT DISTRICT COURTS DID NOT ABUSE THEIR DISCRETION IN CONCLUDING THAT CLAIMS FILED BY TWO SIMILAR PUTATIVE CLASSES WERE NOT AMENABLE TO CLASS-WIDE RESOLUTION

by Brian P. Vincent

In *Randleman v Fidelity Nat'l Title Ins Co*, No. 09-4533, 2011 U.S. App. LEXIS 9915 (6th Cir., May 16, 2011), the United States Court of Appeals for the Sixth Circuit addressed an issue of first impression – the standard of review applicable to orders decertifying classes – and held that the district courts did not abuse their discretion in concluding that the claims presented by two similar "putative classes [were] not amenable to class-wide resolution" and affirmed the district courts' respective judgments.

These two similar actions involved disputes regarding the premium rates charged on title insurance policies issued to homeowners who had previously purchased title insurance for the same property from another insurer within ten years. *Id.* at *1-2. The defendant title insurer in each action – Fidelity National Title Insurance Company and First American Title Insurance Company (collectively, the "Insurers") – issued new title insurance policies to the homeowner plaintiffs but failed to offer or provide a discounted "refinance" rate as required under certain circumstances by the Ohio Title Insurance Rating Bureau's "Rate Manual."

Under this "Rate Manual," title insurers transacting business in Ohio are required to charge a discounted premium rate for policies issued in connection with refinancing transactions where a different insurer has issued a policy on the same property within the previous ten years. *Id*. at *3-4. The plaintiff homeowners were allegedly unaware of this premium rate discount and, consequently, they never requested the discount or submitted the necessary documentation to establish that they had recently purchased title insurance. *Id*. at *4-7.

The plaintiff homeowners in both actions alleged that by not providing the rate discount, the Insurers overcharged them in violation of their filed rates.

In the first action, membership in the proposed class turned upon each individual homeowner's "entitlement" to receive the rate discount. The district court initially certified the proposed class based upon its preliminary presumption that the existence of a prior mortgage invariably notified the Insurer of a prior policy and thus "eligibility" could be determined according to each individual homeowner's insurance application. *Id*. at *5. However, the district court in this action subsequently learned that mortgagees often rely on opinion letters or title guarantees in lieu of purchasing title insurance. *Id*. Thus, the district court found that liability could only be determined on an individual basis and thus the putative class failed to meet the commonality or typicality requirements of Federal Rule of Civil Procedure 23, and that common questions did not predominate. Thus, the district court decertified the class.

In the second action, the proposed class included all homeowners who had refinanced a mortgage within the ten-year look-back period. *Id*. at *7-8. In this action, the district court likewise concluded that the proposed putative class failed to meet the commonality or typicality requirements of FRCP 23, and that common questions did not predominate. Thus, the district court denied the plaintiff homeowners' motion for class certification.

On appeal, the Sixth Circuit stated preliminarily that it had not previously addressed the standard of review applicable to orders decertifying classes, and adopted the highly deferential, "abuse-of-discretion" standard, which other circuits have applied to certification orders. *Id*. at *9-10.

The Sixth Circuit concluded that the allegations of the respective putative classes implicated substantial individual inquiries and, therefore, the actions were not amenable to class-wide resolution. Thus, the Sixth Circuit held that the district courts did not abuse their discretion and affirmed the district courts' respective class certification decisions.

For Further Information

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