INSURANCE**LEGAL**NEWS

AUTISM COVERAGE MANDATED IN MICHIGAN

by Cynthia A. Moore, Member

The State of Michigan has approved new laws requiring health insurance companies to cover the diagnosis and treatment of autism spectrum disorders (Public Acts 99 and 100 of 2012, enacted on April 18, 2012). The law will apply to any group or individual policy or certificate delivered, issued for delivery, or renewed in Michigan on or after October 15, 2012 (180 days after the date of enactment).

Insurers must generally cover the diagnosis and treatment of autism spectrum disorders on the same basis that physical illness is covered, except that coverage may be limited to children through age 18 and may be subject to the following maximum annual benefit limitations:

- $50,000 for a child through age 6;
- $40,000 for a child age 7 through 12; and
- $30,000 for a child age 13 through 18.

The types of treatments of autism spectrum disorders that must be covered include the following evidence-based treatments:

- Behavioral health treatment;
- Pharmacy care;
- Psychiatric care;
- Psychological care; and
- Therapeutic care.

An insurer is permitted to apply generally applicable exclusions and limitations of the policy, such as coordination of benefits, participating provider requirements, utilization review, including review of medical necessity and case management, and other managed care provisions.

A companion law, Public Act 101 of 2012, establishes the Autism Coverage Reimbursement Program, which will reimburse insurers and self-funded plans for the cost of paid claims for the diagnosis and treatment of autism spectrum disorders (up to the annual cap on benefits). The Program is intended to mitigate the cost of covering autism spectrum disorders; however, no funds were appropriated for the Program, so the amount of assistance that will be available is currently unknown.

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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

MICHIGAN JOINS METLIFE SETTLEMENT REGARDING UNCLAIMED LIFE INSURANCE BENEFITS

by Ryan M. Shannon, Associate

Michigan is one of forty states that have to date joined in a $40 million settlement agreement with Metropolitan Life Insurance Company ("MetLife") over allegations that MetLife asymmetrically used the Social Security Administration's Death Master File ("DMF"), avoiding the discovery of names of its deceased life insurance policyholders.

The DMF is a database created and updated on a quarterly basis by the Social Security Administration. It contains upwards of 60 million death notices for individuals enrolled in the Social Security Program over the last 80 years, with information culled from government agencies as well as funeral directors and financial professionals.

Regulators from a number of states initiated an investigation into MetLife's practices based on allegations that MetLife was using the DMF to identify deceased annuitants so that MetLife could cease making annuity payments, but failed to similarly use the database to identify deceased life insurance policyholders. The National Association of Insurance Commissioners coordinated the investigation and created a multi-state task force in 2011 to oversee state efforts.

In addition to MetLife's agreement to provide $40 million to participating states to cover the costs of the investigation, MetLife agreed to make additional payments to unpaid beneficiaries in an amount which could exceed $400 million. MetLife is required by the terms of the settlement to use the DMF or a similar records database to identify deceased policyholders and to pay interest on unpaid claims dating back to 1995. The settlement also requires MetLife to attempt to locate beneficiaries of individuals identified in its review of the DMF and to report any unpaid funds as unclaimed property to state insurance agencies if no beneficiary is identified.

Additional states have until June 29 to participate in the settlement with MetLife, but a sufficient number of jurisdictions have already joined the agreement to trigger MetLife's payment obligations.

JAMES M. BURNS JOINS DICKINSON WRIGHT'S ANTITRUST PRACTICE

Dickinson Wright PLLC is pleased to announce that James M. Burns has joined the firm as a member and co-leader of the firm's antitrust practice. Mr. Burns practices out of our Washington, D.C., office.

We are also pleased to announce that he will regularly report on antitrust developments relating to insurers and health care companies in this newsletter or through other firm publications.

Mr. Burns brings over 25 years of antitrust law experience to the firm. He has litigated antitrust and related claims in trial and appellate courts across the country and also has an active merger compliance and antitrust counseling practice. Mr. Burns has particularly extensive experience in the representation of health care and insurance industry clients and has represented hospitals, providers, and health insurers in a wide variety of antitrust matters.

Mr. Burns is an American Bar Association Fellow and has served in the leadership of the American Bar Association's Antitrust Section for many years. He is currently the Vice Chair of the ABA Antitrust Section's Legislative Committee, and he previously served as the Chair of the Antitrust Section's Insurance Industry Committee. Mr. Burns is also the Chair of the Commercial Litigation Antitrust Practice Group at DRI and serves on the Editorial Board of Bloomberg BNA's *Pharmaceutical Law & Industry Reporter*. Mr. Burns writes extensively on antitrust issues in the trade press and is also a co-author of the ABA's *Insurance Antitrust Handbook* (first and second editions) and a contributing author to the ABA's antitrust treatise, *Antitrust Law Developments* (sixth and seventh editions).

RECENT CASE LAW SUMMARIES

SIXTH CIRCUIT HOLDS EXCESS INSURER IS PRECLUDED FROM SEEKING EQUITABLE CONTRIBUTION FROM SETTLING PRIMARY INSURER

by Ryan M. Shannon, Associate

In *OneBeacon Am Ins Co v Am Motorist Ins Co*, 2012 US App LEXIS 9881 (6th Cir May 17, 2012), the United States Sixth Circuit Court of Appeals held that a primary insurer's settlement with the insured can exhaust its obligations such that a non-settling excess insurer is precluded from seeking equitable contribution.

OneBeacon America Insurance Company ("OneBeacon") provided excess coverage on a primary $55 million policy issued by American Motorists Insurance Company ("AMICO") to B.F. Goodrich Corporation ("Goodrich"). OneBeacon's excess coverage obligations attached once AMICO's liability exceeded $20 million. After the federal government brought claims against Goodrich for soil and groundwater contamination cleanup, Goodrich entered into a settlement agreement as to AMICO's liability with respect to the government's claims.

Several years after the settlement, in 1999, Goodrich brought suit against OneBeacon and other insurers in state court on the grounds that the insurers were contractually obligated to indemnify Goodrich. OneBeacon's predecessor refused to settle, and a jury determined OneBeacon to be jointly and severally liable for $42 million in damages, as well as an additional $34.8 million in fees and interest. At the trial court, OneBeacon sought settlement credits for payments made by AMICO and other settling insurers to Goodrich. The trial court ultimately determined that the prior settlements encompassed other liabilities beyond Goodrich's past costs, including claims for future costs and costs of future litigation. Rather than grant settlement credits, the trial court suggested that OneBeacon seek declaratory relief for equitable contribution against AMICO.

When OneBeacon sought declaratory relief as to settlement credits, however, the federal district court dismissed the action, holding that OneBeacon's complaint "serves as nothing more than an effort to evade the original trial court's determination that settlement credits were inappropriate." *Id.* at *5.

The Sixth Circuit affirmed the district court, finding that both Ohio and federal courts had a policy of favoring settlements and that this policy provided sufficient guidance to conclude "that a settled policy is exhausted for purposes of equitable contribution." *Id.* at *21. If equitable contribution were permitted, the court noted, "an insurer

would have no incentive to settle with a policyholder," as it would potentially be "liable to another insurer down the road." *Id.* at *20. The court did not reach AMICO's additional argument that Ohio law did not permit interclass contribution actions or that the state court jury's finding of bad faith on the part of OneBeacon barred equitable relief in the later action.

UNAMBIGUOUS 30-DAY NOTICE PROVISION ENFORCEABLE WITHOUT SHOWING OF PREJUDICE TO THE INSURER

by Ryan M. Shannon, Associate

In *DeFrain v State Farm Auto Ins Co*, 2012 Mich LEXIS 764 (May 30, 2012), the Michigan Supreme Court held that an unambiguous 30-day notice-of-claim provision in a policy for uninsured-motorist (UM) coverage was enforceable without a showing that the failure to comply with the provision prejudiced the insurer. In doing so, the Supreme Court overturned the Court of Appeals' March 10, 2011 decision, which was reported in the March/April 2011 edition of *Insurance Legal News*.

The insured, William DeFrain, sustained severe head injuries as the result of a hit-and-run collision. DeFrain maintained UM coverage with State Farm, but the policy required that DeFrain provide notice to State Farm "as soon as reasonably possible" after the injury, and in the event of a hit-and-run, within 30 days' time. DeFrain, who was injured in May of 2008, did not notify State Farm until August, and ultimately succumbed to his injuries in November of 2008.

State Farm moved for dismissal of the subsequent suit, maintained by DeFrain's representative, on the basis that DeFrain had failed to comply with the 30-day notice provision. State Farm cited and relied upon *Jackson v State Farm Mut Auto Ins Co*, 472 Mich 942 (2005), in which the Michigan Supreme Court issued an order adopting an earlier Court of Appeals' dissent. That dissent, regarding a virtually identical notice-of-claim provision to that involved in *DeFrain*, concluded that the notice-of-claim provision was enforceable without a showing of prejudice to the insurer.

The trial court refused to dismiss the action, and the Court of Appeals affirmed the trial court's order, rejecting *Jackson* in favor of the Supreme Court's earlier decision in *Koski v Allstate Ins Co*, 456 Mich 439 (1998). Though the opinion in *Jackson* was issued seven years after *Koski*, the Court of Appeals considered *Koski* a fully developed opinion which still governed the disposition of the case given that *Jackson* was "merely a cursory order." 2012 Mich LEXIS 764 at *6.

State Farm appealed to the Supreme Court, which reversed, holding *Jackson* to be indistinguishable and binding. Though *Jackson* was merely an order, the Supreme Court stated that the "order's reference to the Court of Appeals dissent was straightforward and clear, and the instant Court of Appeals panel had no difficulty understanding the order's directive." *Id.* at *12. The Supreme Court continued by holding that "[b]ecause this Court's order in *Jackson* contained a concise statement of the facts and reasons supporting its decision, and was a final disposition of an application, it constitutes binding precedent, and the Court of Appeals was not free to disregard the order …." *Id.*

Under *Jackson*, as well as *Rory v Continental Ins Co*, 473 Mich 457 (2005), the Supreme Court held, the Court of Appeals was required to enforce the 30-day notice provision as written unless doing so would violate the law or public policy. 2012 Mich LEXIS 764 at *17. The Supreme Court in turn rejected the plaintiff's argument that State Farm's 30-day notice provision conflicted with Michigan public policy, as well as the argument that plaintiff could not have reasonably given sooner notice. *See id.* at *18.

Finally, the Supreme Court held that *Koski*, which involved a contract provision requiring the insured to "immediately forward [to the insurer] any legal papers" relating to an accident, was distinguishable from *DeFrain*, as the 30-day notice requirement in the State Farm policy was clear and unambiguous. *Id.* at *20-21.

The Supreme Court remanded the matter to the trial court for an entry of summary disposition in favor of State Farm.

LESSORS HAVE NO INSURABLE INTEREST UNDER MICHIGAN NO-FAULT LAW

by Ryan M. Shannon, Associate

In *Corwin v DaimlerChrysler Ins Co*, 2012 Mich App LEXIS 693 (April 17, 2012), the Michigan Court of Appeals held in a published decision that a long-term lessor cannot be listed as a named insured on a policy conferring personal injury protection ("PIP") benefits under the Michigan No-Fault Act.

The plaintiffs were injured in a car accident while in a vehicle they had leased from Chrysler LLC. An insurance policy issued by the defendant, DaimlerChrysler Insurance Company ("Chrysler Insurance"), named Chrysler LLC and its subsidiaries as the insureds. The policy additionally provided that Chrysler Insurance was not responsible for PIP benefits to the plaintiffs in the event the plaintiffs were entitled to PIP benefits as the named insureds under another policy. The plaintiffs were entitled to PIP benefits under policies with two other insurance companies on their other vehicles.

The plaintiffs, together with one of their alternate insurers, brought suit against Chrysler Insurance seeking declaratory relief regarding their rights to reimbursement and recovery. The trial court granted Chrysler Insurance's motion for summary disposition, finding that the policy did not violate the Michigan No-Fault Act and that the plaintiffs' other insurers were required to provide first priority payments.

The Michigan Court of Appeals reversed. The court first noted that "under Michigan law, an insured must have an 'insurable interest' to support the existence of a valid automobile liability insurance policy" and that the "insurable interest must be that of a named insured." *Id.* at *16-17. While "owners and registrants have an insurable interest," the court noted that the Michigan No-Fault Act expressly excludes a long-term lessor from being either an owner or registrant. *Id.* at *19 (citing MCL 500.3101(2)(h)-(i)). The court also noted that Chrysler LLC lacked any insurable interest flowing from protection of a person's "health and well-being" as it could itself not suffer accidental bodily injury. *Id.*

As to whether Chrysler Insurance's policy could validly shift primary liability for no-fault coverage to the plaintiffs' other automobile insurers, the court held such a policy violated legislative intent that "an injured person's personal insurer stand *primarily* liable for PIP benefits." *Id*. at *25 (emphasis in original).

The court thus reformed Chrysler Insurance's policy to list the plaintiffs as the named insureds. The court also held that Chrysler Insurance would be equally liable for PIP benefits with the plaintiffs' other insurers. The court remanded for a determination of the amount of liability and to order appropriate reimbursement.

COURT OF APPEALS REVERSES DISMISSAL ON PRIMARY JURISDICTION GROUNDS; FINDS WCA LACKS JURISDICTION OVER GROUP SURPLUS CLASS ACTION

by Ryan M. Shannon, Associate

In *A&D Development v Michigan Commercial Ins Mut*, 2012 Mich App LEXIS 344 (February 28, 2012) (unpublished), the Michigan Court of Appeals held the Worker's Compensation Agency ("WCA") lacked concurrent original jurisdiction over the plaintiffs' class action suit challenging the use of surplus funds after the conversion of a worker's compensation self-insurance fund into a mutual insurance company.

On January 1, 2000, the Michigan Construction Industry Self-Insurance Fund converted into a mutual insurance company known as Michigan Commercial Insurance Mutual ("MCIM"). Pursuant to a trust agreement, surplus funds remaining after the conversion would be distributed to MCIM. After approving the conversion, the WCA approved numerous surplus transfers into the newly formed mutual insurer.

On July 23, 2010, the plaintiffs brought a class action suit against MCIM and its president with respect to the transfers, alleging, among other things, that the approval for the transfers had been secured through fraud, conversion, and breach of fiduciary duty.

MCIM and its president moved to dismiss for lack of jurisdiction. The trial court granted the defendants' motion on the basis that the issues raised by the plaintiffs "fell within the WCA's specialized and expert knowledge" such that the WCA had primary jurisdiction over the claims. *Id*. at *5.

The Michigan Court of Appeals reversed. The court first noted that in order for the WCA to properly exercise primary jurisdiction, it had to possess "concurrent original jurisdiction over the issues raised." *Id.* at *7. MCIM is a mutual insurance company, regulated by the Office of Financial and Insurance Regulation ("OFIR"), and its president was in no way affiliated with an existing self-insurance group fund; thus, according to the court, "even if the WCA held a hearing … it could not award plaintiffs any relief because it has no authority over defendants." *Id.* at *8. The court also found that the WCA lacked statutory authority to hear class actions or grant equitable relief as requested by the plaintiffs. Finally, the court found that the WCA lacked specialized knowledge with respect to the handling of surplus funds or claims for fraud, negligence, and misappropriation. *Id.* at *9.

The court remanded for further proceedings. On April 9, 2012, MCIM filed an application for leave to appeal the decision with the Michigan Supreme Court. That application remains pending.

For Further Information

Dickinson Wright PLLC's Insurance Task Force is directed by Joe Fink. Questions regarding the firm's insurance practice may be direct dialed to him using the contact information below:

Joseph A. Fink
Phone: 517-487-4711 (Lansing) or 313-223-3534 (Detroit)
E-mail: jfink@dickinsonwright.com

Dickinson Wright Offices

Detroit
500 Woodward Avenue, Suite 4000 • Detroit, MI 48226
Phone: 313.223.3500 • Fax: 313.223.3598

Lansing
215 South Washington Square, Suite 200 • Lansing, MI 48933
Phone: 517.371.1730 • Fax: 517.487.4700

Ann Arbor
301 East Liberty Street, Suite 500 • Ann Arbor, MI 48104
Phone: 734.623.7075 • Fax: 734.623.1625

Troy
2600 W. Big Beaver Road, Suite 300 • Troy, MI 48084
Phone: 248.433.7200 • Fax: 248.433.7274

Grand Rapids
200 Ottawa Avenue, NW, Suite 1000 • Grand Rapids, MI 49503
Phone: 616.458.1300 • Fax: 616.458.6753

Washington, D.C.
1875 Eye Street, NW, Suite 1200 • Washington, DC 20006
Phone: 202.457.0160 • Fax: 202.659.1559

Toronto
222 Bay Street, P.O. Box 124 • Toronto, ON, Canada M5K1H1
Phone: 416.777.0101 • Fax: 416.865.1398

Nashville
424 Church Street, Suite 1401 • Nashville, TN 37219
Phone: 615.244.6538 • Fax: 615.256.8386

Phoenix
5009 East Washington Street, Suite 125 • Phoenix, AZ 85034
Phone: 602.244.1400 • Fax: 602.244.1441

Las Vegas
7201 West Lake Mead Boulevard, Suite 503 • Las Vegas, NV 89128
Phone: 702.541.7888 • Fax: 702.541.7899