STATE OF MICHIGAN

IN THE SUPREME COURT

RALPH KROCHMAL,

Plaintiff-Appellee,

-vs-

THE PAUL REVERE LIFE INSURANCE COMPANY,

Defendant-Appellant.

_____/

Supreme Court No. 126997

Court of Appeals No. 242776

Lower Court No. 00-004378-CK

PLAINTIFF-APPELLEE'S SUPPLEMENTAL BRIEF SUBMITTED PURSUANT TO THE COURT'S JUNE 17, 2005 ORDER

PROOF OF SERVICE

126997

MARK GRANZOTTO, P.C.

MARK GRANZOTTO (P31492)
Attorney for Plaintiff-Appellee
414 West Fifth Street
Royal Oak, Michigan 48067
(248) 546-4649

GRANT, BUSCH & KIRSCHNER

DAVID B. GRANT (P14269)
Attorney for Plaintiff-Appellee
26555 Evergreen, Suite 860
Southfield, Michigan 48076
(248) 353-2860

FILED

AUG 8 2005

CORBIN R. DAVIS
CLERK
MICHIGAN SUPREME COURT

TABLE OF CONTENTS

Page

INDEX OF AUTHORITIES iii

STATEMENT OF FACTS 1

ARGUMENT 2

I. THE POLICY INVOLVED IN THIS CASE IS NOT GOVERNED BY ERISA 2

II. THIS COURT SHOULD DECLINE DEFENDANT'S INVITATION TO REVIEW THE QUESTION OF WHETHER THIS BREACH OF CONTRACT ACTION IS TO BE GOVERNED BY AN "ARBITRARY AND CAPRICIOUS" STANDARD OF JUDICIAL REVIEW 3

A. The Implications Of Issue I, *supra:* This Case Is Not Governed By ERISA 3

B. The Parties' Agreement Does Not Limit Judicial Review To Abuse Of Discretion 8

C. The Contract Did Not Vest Paul Revere With Discretion 12

D. Even If The Policy Involved Herein Were Construed As An ERISA Policy, The Standard Of Judicial Review Would Not Be Arbitrary And Capricious 16

E. Does *Guiles v University of Michigan Board of Regents*, 193 Mich App 39; 483 NW2d 637 (1992), Accurately State The Law? 19

F. The Court Should Give Some Consideration To The Established Statutory Role Of The Insurance Commissioner 21

G. The Court Should Give Some Consideration To The Effect Of Its Decision On Other Areas Of Contract Law 24

RELIEF REQUESTED 26

INDEX OF AUTHORITIES

Cases

American Federation of State County and Municipal Employees v City of Detroit, 468 Mich 388; 662 NW2d 695 (2003) 4

Anderson v Great West Life Assurance Co, 942 F2d 392 (6th Cir 1991) 20

Archambo v Lawyers Title Ins Co, 466 Mich 402; 646 NW2d 170 (2002) 11

Auto-Owners Ins Co v Churchman, 440 Mich 560; 489 NW2d 431 (1992) 25

Bandit Industries Inc v Hobbs International, Inc., 463 Mich 504; 620 NW2d 531 (2001) 12

Bogue v Ampex Corp, 976 F2d 1319 (9th Cir 1992) 16

Bounds v Bell Atlantic Enterprises Flexible Long-Term Disability Plan, 32 F3d 337 (8th Cir 1994) 18

Cacavas v Zack, 43 Mich App 222, 227; 203 NW2d 913 (1973) 26

Cohen v Auto Club Ins Co, 463 Mich 525; 620 NW2d 840 (2001) 12

Crossley v Allstate Insurance Company, 155 Mich App 694; 400 NW2d 625 (1987) 10

Cruz v State Farm Mutual Automobile Insurance Co., 466 Mich 588; 648 NW2d 591(2002) 8

Drouillard v Metropolitan Life Insurance Co, 107 Mich App 608; 310 NW2d 15 (1981) 10

Firestone Tire and Rubber Company v Bruch, 489 US 101(1989) 3

Guiles v University of Michigan, 193 Mich App 39; 483 NW2d 637 (1993) 19

Henderson v State Farm Fire & Casualty Co, 460 Mich 348; 596 NW2d 190 (1999) 12

Hertzberger v Standard Insurance Co., 205 F3d 327 (7th Cir 2000) 16

Hoover v Provident Life and Accident Insurance Co., 290 F3d 801 (6th Cir 2002) 16

Kearny v Standard Insurance Co, 175 F3d 1084 (9th Cir 1999) (*en banc*) 15

Kinstler v First Reliance Standard Life Ins Co, 181 F3d 243 (2nd Cir 1999) 16

Kinstler v First Reliance Standard Life Insurance Co., 181 F3d 243 (2nd Cir 1999) 13

Klapp v United Ins Group Agency, 468 Mich 459; 663 NW2d 447 (2003) 11

Krochmal v Paul Revere Life Insurance Co, 472 Mich 928; 697 NW2d 526 (2005) 1

Krochmal v Paul Revere Insurance, 262 Mich App 115; 684 NW2d 375 (2004) 2

Lesner v Liquid Disposal, Inc., 466 Mich 95; 643 NW2d 553 (2002) 4

Nance v Sun Life Assurance Co of Canada, 294 F2d 1263 (10th Cir 2002) 18

Newcombe v Standard Ins Co, 187 F3d 1004 (9th Cir 1999) 17

Omne Financial, Inc. v Shacks, Inc., 460 Mich 305; 596 NW2d 591 (1999) 4

Original Great American Chocolate Chip Cookie Co v River Valley Cookies, Ltd,
970 F2d 273 (7th Cir. 1992) 10

Perry v Seid, 461 Mich 680; 611 NW2d 516 (2000) 12

Quality Products and Concepts Company v Nagel Precision, Inc.,
469 Mich 362; 666 NW2d 251 (2003) 8

Ramsey v Hercules, Inc., 77 F3d 199 (7th Cir 1996) 14

Rednour v Hastings Mutual Ins Co, 469 Mich 241; 661 NW2d 562 (2003) 11

Rory v Continental Insurance Co, ___ Mich ___; ___ NW2d ___ (2005) 4

Sands Appliance Service, Inc. v Wilson, 463 Mich 231; 615 NW2d 241 (2000) 12

Struble v New Jersey Brewery Employers Welfare Trust, 732 F2d 325 (3rd Cir 1984) 3

Twichel v MIC General Insurance Company, 469 Mich 524; 676 NW2d 616 (2004) 4

Universal Underwriters Insurance Company v Kneeland,
464 Mich 491; 628 NW2d 491 (2001) 8

Walke v Group Long Term Disability Ins, 256 F3d 835 (8th Cir 2001) 18

Wilkie v Auto Owners Insurance Co., 469 Mich 41; 664 NW2d 706 (2003) 8

Yates v Hendon, 541 US 1 (2004) 2

Statutes

MCL 117.4q(19)(e) 4

MCL 24.201 4

MCL 24.306(1)(e) 4

MCL 257.323(4)(e) 4

MCL 324.20117(8) 4

MCL 324.20119(5) 4

MCL 500.2236 21

MCL 500.2236(5) 9

MCL 500.4424(8) 4

Other Authorities

B. Duncan, *Judicial Review of Fiduciary Claims Under ERISA: An Alternative To The Arbitrary and Capricious Test*, Cornell L Rev 986(1986) 3

D. Richmond, *Trust Me: Insurers Are Not Fiduciaries To Their Insureds*, 88 Ky L J 1 (1999-2000) 11

Labor Management Relations Act of 1947, 29 USC §186(c) 3

Restatement, 2d, Contracts, §228 26

STATEMENT OF FACTS

Paul Revere Life Insurance Company has applied for leave to appeal from the Court of Appeals' May 20, 2004, decision, which affirmed the circuit court's determination that plaintiff Ralph Krochmal was entitled to benefits under the terms of a disability policy he purchased.

On June 17, 2005, the Court issued an Order indicating that it would entertain oral argument on the defendant's application. *Krochmal v Paul Revere Life Insurance Co*, 472 Mich 928; 697 NW2d 526 (2005). The parties were also invited to submit supplemental briefs which avoided "mere restatement of arguments made in application papers." Plaintiff submits this Supplemental Brief pursuant to the Court's direction.

ARGUMENT

I. THE POLICY INVOLVED IN THIS CASE IS NOT GOVERNED BY ERISA.

The first issue which the circuit court addressed in this case was whether the disability insurance policy which Ralph Krochmal purchased from Paul Revere was governed by ERISA. The first issue which the Court of Appeals addressed in its May 20, 2004 Opinion in this case was whether the policy in question was controlled by ERISA. *Krochmal v Paul Revere Insurance Co.*, 262 Mich App 115, 120-129; 684 NW2d 375 (2004). Both of these Courts were correct in recognizing that the beginning point in any analysis of the legal issues presented in this case must be the question of whether the policy at issue is governed by ERISA.

In its opinion in this case, the Court of Appeals concluded that the disability policy which Mr. Krochmal purchased was not an ERISA policy for two different reasons. First, the Court of Appeals ruled that the policy fell within the Department of Labor's "safe harbor" regulation, 29 CFR §2510.3-1(j). *Krochmal*, 262 Mich App at 122-128. Second, the Court of Appeals recognized that Mr. Krochmal "wholly owed" Manimark Corporation. *Id.* at 128-129. Since Mr. Krochmal wholly owned that entity and he was the only person to whom the disability policy applied, the policy could not be governed by ERISA. *Yates v Hendon*, 541 US 1, 22, n. 6 (2004). Both of these rationales support the conclusion that this case is not controlled by federal law.

Plaintiff has previously addressed in his response to the defendant's Application why, under either of the grounds discussed by the Court of Appeals, there is no basis for disturbing the determination that this policy is not within the coverage of ERISA. Plaintiff's Response, pp. 23-28. There is no reason to restate or reargue these points. This policy is not governed by ERISA.

II. THIS COURT SHOULD DECLINE DEFENDANT'S INVITATION TO REVIEW THE QUESTION OF WHETHER THIS BREACH OF CONTRACT ACTION IS TO BE GOVERNED BY AN "ARBITRARY AND CAPRICIOUS" STANDARD OF JUDICIAL REVIEW.

The issue which Paul Revere would have this Court review is whether the scope of judicial review with respect to its determination to stop paying disability benefits to Mr. Krochmal should be limited to a determination of whether the defendant's denial of those benefits was arbitrary and capricious. In addressing the issue which Paul Revere raises there are a number of points which this Court should consider, each of which should lead to the denial of defendant's application for leave.

A. The Implications Of Issue I, *supra:* This Case Is Not Governed By ERISA.

The arbitrary and capricious standard of judicial review which Paul Revere urges before this Court is a creature of federal law. That standard first gained prominence in federal law in actions brought under §302(c) of the Labor Management Relations Act of 1947, 29 USC §186(c); *See Firestone Tire and Rubber Company v Bruch*, 489 US 101, 109 (1989). That standard was later incorporated by federal courts construing a later passed federal statute, ERISA. *See e.g. Struble v New Jersey Brewery Employers Welfare Trust*, 732 F2d 325 (3rd Cir 1984), *see generally* B. Duncan, *Judicial Review of Fiduciary Claims Under ERISA: An Alternative To The Arbitrary and Capricious Test*, 71 Cornell L Rev 986, 992-998 (1986). The United States Supreme Court later ruled in *Firestone* that the arbitrary and capricious standard would apply to *some* decisions made by the fiduciaries of ERISA governed plans.

In its Application Paul Revere cites numerous cases in which a benefit decision was subject to judicial review under the arbitrary and capricious standard. In point of fact, the defendant could have presented this Court with thousands of such cases. But, each of the cases which Paul Revere

cites to this Court in support of the arbitrary and capricious standard of review has one thing in common - each involved benefits which were covered by ERISA. What the defendant so obviously ignores in presenting these cases is the basic point which is discussed in Issue I, *supra*. ***The insurance policy at issue in this case is not a policy which is governed by ERISA.***

ERISA does not apply to this case. Since it does not, it would be completely inappropriate for this Court to "amend" that statute to apply it herein. *Omne Financial, Inc. v Shacks, Inc.*, 460 Mich 305, 311; 596 NW2d 591 (1999) ("nothing may be read into a statute that is not within the manifest intent of the Legislature as derived from the act itself."); *Lesner v Liquid Disposal, Inc.*, 466 Mich 95, 101; 643 NW2d 553 (2002) (the Court is to apply the statute "as enacted without addition, subtraction or modification."); *American Federation of State, County and Municipal Employees v City of Detroit,* 468 Mich 388, 400;662 NW2d 695 (2003).

There is no federal statute which provides for an arbitrary and capricious standard in this case. There is, moreover, no Michigan statute which provides for such a standard of review.[1] The situation presented here is, therefore, entirely analogous to an issue which this Court has twice addressed within the last seventeen months. In both *Twichel v MIC General Insurance Company*, 469 Mich 524; 676 NW2d 616 (2004) and in the Court's July 28, 2005 decision in *Rory v*

---

[1]The Michigan Legislature has in a limited number of instances passed statutes which limit the scope of judicial review to a determination of whether a particular decision was arbitrary and capricious. Perhaps the most familiar of these statutes is the Administrative Procedures Act, MCL 24.201, *et seq*, which allows for the judicial revocation of an agency decision or order under that standard. MCL 24.306(1)(e). There are special other statutes providing for this level of judicial review. *See* MCL 117.4q(19)(e); MCL 257.323(4)(e); MCL 324.20117(8); MCL 324.20119(5). There is even one provision in Michigan's Insurance Code which limits judicial review to a determination of whether the Insurance Commissioner's decision on a particular issue was arbitrary and capricious. *See* MCL 500.4424(8). Obviously, neither MCL 500.4424(8) nor any other Michigan statute providing for such a limited scope of judicial review applies to this case.

Continental Insurance Co, ___ Mich ___; ___ NW2d ___ (2005), the Court considered provisions in an uninsured motorist insurance policy. In both *Twichel* and *Rory*, before embarking on a discussion of the legal issues presented, the Court made a point of noting that this type of insurance is not covered by a somewhat related statute, Michigan's no fault act. As expressed by the Court in *Rory*:

> Uninsured motorist coverage is optional-it is not compulsory coverage mandated by the no-fault act. *Accordingly, the rights and limitations of such coverage are purely contractual and are construed without reference to the no-fault act.*
>
> *Id.* at ___ (emphasis added); *see also Twichel*, 469 Mich at 533.

The same analysis must be applied to this case. The policy at issue in this case is not an ERISA policy. That statute does not control herein. Since neither ERISA nor any other statute controls the rights and obligations of the parties, those rights and obligations are, as *Rory* and *Twichel* clearly establish, "purely contractual" in character, to be construed *without reference* to these Acts.

It is the *contract* which the parties entered into, not ERISA or the thousands of state and federal cases applying that Act, which must govern the question of whether Paul Revere's decision terminating Mr. Krochmal's benefits is to be reviewed on an abuse of discretion standard. Since it is the contract which the parties entered into which controls this case, the entire premise of the defendants argument in support of its Application collapses. The defendant cites numerous federal court precedents applying an ERISA abuse of discretion standard. After noting that the review standard may be outcome determinative, Paul Revere advises this Court that, "it is critically important that Michigan jurisprudence be made consistent with federal law so that insurers doing

business in the State of Michigan are not subject to two different rules of law." Application Brief, p. 12.

What the defendant is telling this Court is that there are reasons presumably grounded in public policy why this Court should "harmonize" Michigan law with the law which applies in the ERISA setting. But, there is a fundamental fallacy to the entire argument which Paul Revere offers this Court. The defendant asks this Court to *make* Michigan law consistent with ERISA. But, the fundamental point which the defendant's argument overlooks is that *this Court does not make the law in this breach of contract case.*

It is simply not the function of this Court to create the Michigan law necessary to make this State's jurisprudence consistent with that which exists under federal law. This is particularly true in light of the fact that this case is ultimately grounded on contract law. Since there is neither federal nor state statutory law which applies to this case, the only "law" which controls here is the contract which the parties entered into. And, as this Court stated within the last few weeks, "a court may not revise or void the unambiguous language of the agreement to achieve a result that it views as fairer or more reasonable." *Rory*, ___ Mich at ___. Thus, even if the defendant could convince this Court that the law which it asks it to make would be "fairer and more reasonable," it is not the function of this Court to do so.

The argument which Paul Revere presents to the Court in this case is precisely the same sort of argument that this Court condemned in *Rory*. Paul Revere suggests that it would be "fairer" or "more reasonable" to harmonize Michigan contract law with ERISA. While plaintiff would vigorously dispute these assertions, the fact remains that it is not the function of this Court to rewrite the parties' contract to achieve these results.

There is another fundamental error in the defendant's request to "harmonize" this state's contract law to the standards applicable under ERISA. ERISA is a comprehensive statute which is designed to govern benefits which flow to individuals *in the employment setting*. As such, ERISA has absolutely no application, *inter alia*, to insurance policies which are not purchased through an employer. Thus, if Mr. Krochmal had been unemployed at the time he purchased this disability policy and he simply purchased that policy with his own money, there would be no question that ERISA would have no application whatsoever to this policy. ERISA was never meant to touch such insurance policies.

What defendant seeks in this case is to have the disability insurance policies which it sells directly to customers in the State of Michigan governed by the standards which have been developed under ERISA. If the defendant were successful in this argument, these policies, which everyone would agree are not governed by ERISA, would suddenly become subject to the special rules of judicial review which have been developed under ERISA. Contrary to what the defendant argues in this case, construing these privately purchased policies, which never came under ERISA's coverage, to be controlled by ERISA's review standards *does not in any way "harmonize" these policies to that federal statute*. To the contrary, if this Court were to adopt the argument which Paul Revere raises in this case, it would be going far beyond the coverage of ERISA. It would be extending the ERISA standard to countless insurance policies which the United States Congress never intended to impact when it enacted ERISA. The adoption of Paul Revere's argument in this case would in no way "harmonize" this states' contract law to ERISA, it would be extending ERISA

far, far beyond the coverage of that statute.[2]

B. The Parties' Agreement Does Not Limit Judicial Review To Abuse Of Discretion.

The essence of the defendant's argument is that the scope of judicial review applicable to its decision to cut off Mr. Krochmal's disability payments should be limited to a determination of whether that decision was arbitrary and capricious. For reasons discussed in the prior section of this brief, the answer to that question must be found in the language of the contract which the parties entered into, not in inapplicable provisions of federal law. It is absolutely clear that there is no language of any kind in the contract at issue herein which establishes that once Paul Revere makes a determination with respect to an insured's entitlement to disability benefits, judicial review of that decision is limited to a determination of whether Paul Revere acted arbitrarily and capriciously in arriving at this decision.

Under the repeated and clear decisions of this Court, *the fact that there is no provision in the parties' contract specifying an arbitrary and capricious standard of review should be the end of the analysis*. This Court has emphatically indicated in a number of recent decisions that the fundamental right to freedom of contract demands that Courts enforce contracts as they are written, without additions, deletions or embellishment. *See Quality Products and Concepts Company v Nagel Precision, Inc.*, 469 Mich 362, 375; 666 NW2d 251 (2003); *Wilkie v Auto Owners Insurance Co.*,

---

[2]Thus, when the defendant speaks of "harmonizing" Michigan contract law and ERISA, the defendant is not asking the Court to harmonize these two bodies of law in general. What the defendant is really asking this Court to "harmonize" is one very limited aspect of this law, the standard of judicial review. However, by "harmonizing" this law in the limited respect which it requests, *i.e.* with respect to the standard of judicial review, the defendant is actually creating an extraordinarily broad and direct conflict between these two areas of law. Because, in doing so, it would be extending ERISA to whole areas which that statute was never intended to address.

469 Mich 41; 664 NW2d 706 (2003); *Cruz v State Farm Mutual Automobile Insurance Co.*, 466 Mich 588, 594; 648 NW2d 591(2002), *Universal Underwriters Insurance Company v Kneeland*, 464 Mich 491; 628 NW2d 491 (2001).

Where the parties' contract makes no provision for arbitrary and capricious review, it would be completely inappropriate for this Court to read such a limitation into the parties' agreement.[3] Since it is impossible for the defendant to cite to language in its policy which limits judicial review under an arbitrary and capricious standard, the very best that Paul Revere can come up with under the circumstances is the suggestion that the policy vests it with "discretion" to decide whether Mr. Krochmal was entitled to benefits. Paul Revere misreads its own policy in suggesting that such discretion exists.[4] However, even if the defendant could get beyond the lack of textual support in the contract for this claimed "discretion", the fact remains that this "discretion" does not provide the defendant with the narrow judicial review of its decision making embodied in the arbitrary and capricious standard.

The defendant's argument that the existence of discretion translate to judicial review on the arbitrary and capricious standard is based exclusively on the law as it has developed under ERISA. The United States Supreme Court held in *Firestone, supra,* that where an ERISA benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits, judicial

---

[3]Since the contract at issue in this case does not contain a provision which limits judicial review to the arbitrary and capricious standard, there is no reason to discuss in this brief whether under Michigan law Paul Revere *could* incorporate such a provision in one of its policy. It is, however, clear that if Paul Revere chose to include such a provision in one of its policies, it would first have to present such a provision to the Insurance Commissioner who would then have to assess the propriety of such a provision under MCL 500.2236(5). Plaintiff will address the relevancy of the role played by the Insurance Commissioner more fully in section II(F), *infra*.

[4]This error will be addressed in Section II (C) and II(D), *infra*.

review of that decision will be limited to whether the exercise of that discretion was arbitrary and capricious. 489 US at 115.

However, as plaintiff detailed in his original response to the defendant's Application, the Supreme Court arrived at this decision in the ERISA area based on principles of trust law. The Supreme Court concluded in *Firestone* that, because ERISA "abounds with the language and terminology of trust law," 489 US at 110, it was appropriate to incorporate into ERISA the judicial review concepts provided in trust law. Thus, in rendering the decision which it did in *Firestone*, the Supreme Court adopted the deferential standard of view embodied in Restatement (Second) of Torts, §187. 489 US at 111. That section of the Restatement provides: "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court, except to prevent an abuse by the trustee of his discretion." The Supreme Court's decision in *Firestone* makes it perfectly clear that the arbitrary and capricious standard of review is the product of the discretion which may be extended to decision makers in ERISA governed plans. Moreover, *Firestone* also makes it perfectly clear that the amount of discretion imparted is relevant to the determination of the standard of review precisely because of the trust law antecedents of ERISA.

Thus, in urging this Court to adopt an arbitrary and capricious standard of judicial review based on the existence of discretion, the defendant is clearly asking this Court to incorporate principles of trust law into this case. However, this is a cause of action for breach of contract governed by the language of the agreement the parties have entered into; it is not a case in which the implied powers which a fiduciary may enjoy under the law of trusts can overcome the agreement which the parties entered into.

Under Michigan law, insurers are not fiduciaries with respect to their insureds. *Crossley v Allstate Insurance Company*, 155 Mich App 694, 697; 400 NW2d 625 (1987); *Drouillard v Metropolitan Life Insurance Co*, 107 Mich App 608, 621; 310 NW2d 15 (1981); *cf Original Great American Chocolate Chip Cookie Co v River Valley Cookies, Ltd*, 970 F2d 273, 280 (7th Cir. 1992) (holding that parties to a contract are not each others fiduciaries since "contract law does not require parties to behalf altruistically toward each other."); *see* D. Richmond, *Trust Me: Insurers Are Not Fiduciaries To Their Insureds*, 88 Ky L J 1 (1999-2000).

Since an insurer such as Paul Revere neither is nor wants to be placed in the position of a fiduciary with respect to an insured, there is no merit to the suggestion that the standard of judicial review which is implied in the law of trusts has any application to this breach of contract claim. Instead, the standard of review that applies to this breach of contract claim is the *de novo* standard. The United States Supreme Court acknowledged this point in *Firestone* when it noted that the *de novo* standard of review applicable to some ERISA claims is consistent with the standard under the law which would have governed in this area prior to ERISA's enactment - contract law. The Court stated in *Firestone*:

> The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA. Actions challenging an employer's denial of benefits before the enactment of ERISA were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe undertain terms, the court reviewed the employee's claim as it would have any other contract claim by looking to the terms of the plan and other manifestations of the parties' intent.

489 US at 112-113 (emphasis added).

During the last six years alone, this Court has indicated in at least twelve cases that the

standard of review in a breach of contract case is *de novo*. *Rory*, ___ Mich at ___ ("questions involving the proper interpretation of a contract or the legal effect of a contractual clause are also reviewed *de novo*."); *Klapp v United Ins Group Agency*, 468 Mich 459; 663 NW2d 447 (2003); *Rednour v Hastings Mutual Ins Co*, 469 Mich 241; 661 NW2d 562 (2003); *Archambo v Lawyers Title Ins Co*, 466 Mich 402; 646 NW2d 170 (2002); *Cohen v Auto Club Ins Co*, 463 Mich 525; 620 NW2d 840 (2001); *Bandit Industries Inc v Hobbs International, Inc.*, 463 Mich 504; 620 NW2d 531 (2001); *Sands Appliance Service, Inc. v Wilson*, 463 Mich 231; 615 NW2d 241 (2000); *Perry v Seid*, 461 Mich 680; 611 NW2d 516 (2000); *Henderson v State Farm Fire & Casualty Co*, 460 Mich 348; 596 NW2d 190 (1999). It is this contract law standard of review which applies here, not the standard of review which might be implied if this were an action based on trust law.

C. <u>The Contract Did Not Vest Paul Revere With Discretion.</u>

As discussed in the previous section of this brief, the defendant's claim that its policy vested it with discretion is legally irrelevant to the determination of whether judicial review of its decision terminating benefits is limited by an arbitrary and capricious standard. But, what is also true is that the policy in question never extended to the defendant the discretion which it now claims. This point was addressed to some extent in plaintiff's initial response to the defendant's Application, *see* Response, pp. 18-22. Plaintiff will attempt to avoid repetition in the observations which follow.

The claim of discretion which Paul Revere advances in this case rests on a single provision of the parties' insurance contract. That provision is Part 9.6 of the policy, which states:

> **9.6 TIME OF PAYMENT OF CLAIMS**
>
> After We receive satisfactory written proof of loss:
>
> a. We will pay any benefits then due that are not payable

periodically; and

b. We will pay at the end of each 30 days any benefits due that are payable periodically - subject to continuing proof of loss.

In this appeal Paul Revere has done its best to rewrite this clause. According to the Application for Leave which it filed, the policy "unambiguously vested Paul Revere with discretion by conditioning the payment of benefits upon Krochmal providing *satisfactory proof of loss.* Application Brief, p. 13 (emphasis added). In making the argument that it does, Paul Revere contorts this language further, suggesting that the language "satisfactory proof of loss" actually means "proof of loss satisfactory *to us*."

The policy which the parties entered into does *not* state that the proof presented by Mr. Krochmal in support of his claim of disability had to be "satisfactory to Paul Revere."[5] Thus, the text of the policy did not vest discretion in the defendant to decide the legitimacy of Mr. Krochmal's

---

[5]Even if the policy contained language indicating that Mr. Krochmal had to submit evidence of his disability "satisfactory to Paul Revere", such language would not necessarily be sufficient to vest discretion with the defendant. The Second Circuit Court of Appeals in *Kinstler v First Reliance Standard Life Insurance Co.*, 181 F3d 243 (2nd Cir 1999), found in the context of an ERISA claim that such language would not operate to vest discretion in the decision maker for the following reason:

> But a more fundamental point than this fine distinction about wording is that the word "satisfactory," whether in the phrase "satisfactory proof" or the phrase "proof satisfactory to [the decision-maker]" is an inadequate way to convey the idea that a plan administrator has discretion. *Every plan that is administered required submission of proof that will "satisfy" the administrator. No plan provides benefits when the administrator thinks that benefits should not be paid! Thus, saying that proof must be satisfactory "to the administrator" merely states the obvious point that the administrator is the decision-maker, at least in the first instance.*

Id. at 252 (emphasis added).

request for disability benefits.[6] Nor does the policy use the language which defendant suggested was there in its Application, "satisfactory proof of loss." Application, p. 13.

In actuality, what the contract demands is "satisfactory written proof of loss." The policy, contrary to the claims of the defendant, does not demand satisfactory *evidence* of the insured's disability, it requires a satisfactory written proof of loss. The term "written proof of loss" is actually defined in part 9.4 of the policy:

> **9.4 WRITTEN PROOF OF LOSS**
>
> Written proof of loss must be sent to Us within 90 days after the end of a period for which You are claiming benefits. If that is not reasonably possible, Your claim will not be affected. But, unless You are legally incapacitated, written proof must be given within one year.

---

[6]It is noteworthy that the policy has the "subjective" component which the words "to us" might convey in at least two other places. Most notably, a Supplemental Social Insurance Benefit Rider to the policy (a section of the contract which has no application here), specifically provides: "You must give us written proof that you qualify for the added monthly benefit. Such written proof of loss must be ***satisfactory to us***."Policy Rider (Defendant's Application Exhibit A), p. 1 (emphasis added). Similarly, the policy requires the submission of a claimant's prior earnings as of the time of the disability being claimed. The portion of the policy applicable to proof of lost earnings specifies that such proof, "may include personal and business tax returns, financial statements, accountant to statements or other proof ***acceptable to Us***." Policy (Part 9.4), p. 16 (emphasis added).

Thus, there are other sections of the policy which use the term "to us", while the section of the policy at issue in this case does not. An ERISA case which discusses the significance of a similar omission is *Ramsey v Hercules, Inc.*, 77 F3d 199 (7th Cir 1996). In that case, the plaintiff was suing for long term disability benefits. The operative plan contained language with respect to short term disability payments which indicated that such benefits would cease being paid when the employee was no longer disabled and capable of returning to work, "as determined by the company." 77 F3d at 205. By contrast, the plan's coverage with respect to long term disability - the benefit being sought by the plaintiff in *Ramsey* - contained no comparable language indicating that qualification for that benefit was "as determined by the Company." The Seventh Circuit noted this "crucial" difference in concluding that a *de novo* standard of review was appropriate since the defendant had not clearly reserved discretion with respect to decisions pertaining to long term disability.

> We can also require reasonable proof from You of Your:
>
> a. Prior Earnings; and
> b. Monthly Earnings for the month for which Disability is claimed.
>
> This may include personal and business tax returns, financial statements, accountant's statements or other proof acceptable to Us. We can have an audit performed as often as is reasonably required while Your claim is continuing. Such an audit will be at Our expense.
>
> Policy, Part 9.4, p. 16.

As Part 9.4 of the contract indicates, a "Written Proof of Loss" is a tangible thing. It is, therefore, entirely plausible to read the critical language on which the defendant relies in part 9.6 of the policy - "satisfactory written proof of loss - as a purely "procedural" requirement. An insured must under the policy's language submit written proof of loss which comports with the technical requirements set out in the policy.[7]

Yet, even if the defendant were allowed to reformulate the language of its policy so that the word "satisfactory" could be read as "satisfactory *evidence*" of a disability, that language would still not convey the essential discretionary decision making which the defendant claims.

A disability policy could provide that an insured is required to present "satisfactory evidence" of disability without reserving for the insurer the right to decide what is or is not "satisfactory evidence." Such language standing alone does not impart the essential component of the discretion which the defendant argues for - *who* makes the decision as to whether "satisfactory evidence" has

---

[7]As will be discussed in the next section of this brief, under the standards governing ERISA cases, to claim the arbitrary and capricious standard of review, the fiduciary must rely on language which *clearly* establishes the requisite discretion. Ambiguity in the plain language, therefore, defeats a claim of discretion under ERISA and requires application of the *de novo* review standard. *See e.g. Kearny v Standard Insurance Co*, 175 F3d 1084, 1089-1090 (9th Cir 1999) (*en banc*).

been presented. A policy which calls upon an insured to present "satisfactory evidence" of a disability can easily be encompassed under the general contract law *de novo* review standard. Following the denial of benefits, a court would decide *de novo* the question of whether the insured did, in fact, present "satisfactory evidence" of a disability.

D. Even If The Policy Involved Herein Were Construed As An ERISA Policy, The Standard Of Judicial Review Would Not Be Arbitrary And Capricious.

Paul Revere has argued for the incorporation of ERISA review standards into this breach of contract action. For reasons discussed, *supra*, the defendant's attempt to incorporate ERISA into a case in which the policy in question is not governed by ERISA must fail. But, even if Paul Revere could somehow succeed in its quest for the wholesale incorporation of ERISA principles into Michigan contract law, such success would not result in the application of the arbitrary and capricious standard of review in this case. This is because, even if this were an ERISA cause of action, the *de novo* standard of review would apply.

As noted previously, the Supreme Court held in *Firestone*, that the scope of judicial review under ERISA is *de novo* unless the administrator or fiduciary is given the discretionary authority to determine eligibility for benefits. 489 US at 115. In applying the *Firestone* standard, federal courts have recognized that the discretion extended to fiduciaries which triggers the arbitrary and capricious review standard must be clearly expressed. *See Hoover v Provident Life and Accident Insurance Co.*, 290 F3d 801, 807 (6th Cir 2002); *Hertzberger v Standard Insurance Co.*, 205 F3d 327, 330-331 (7th Cir 2000); *Kinstler v First Reliance Standard Life Ins Co*, 181 F3d 243, 252 (2nd Cir 1999); *Bogue v Ampex Corp*, 976 F2d 1319, 1325 (9th Cir 1992).

Various federal courts have examined policy language either comparable or identical to that

employed by Paul revere herein and have concluded that the language used in this policy will not confer the discretion necessary to trigger the arbitrary and capricious standard of review. For example, in *Kearny v Standard Insurance Co*, 175 F3d 1084 (9th Cir 1999) (*en banc*), the Ninth Circuit considered an ERISA disability policy which indicated that benefits would be paid "upon receipt of satisfactory written proof that you have become disabled." *Id.* at 1089. The Court held in *Kearny* that this language was ambiguous with respect to the discretion being given the insurer and, therefore, did not give rise to arbitrary and capricious review.

Following the decision in *Kearny*, a panel of the Ninth Circuit in *Newcombe v Standard Ins Co*, 187 F3d 1004 (9th Cir 1999), considered a policy which had language identical to that involved herein: "satisfactory written proof of loss." 187 F3d at 1006. The *Newcombe* Court held on the basis of *Kearny* that this language did not contain a clear statement of the defendant's discretion to decide plaintiff's claim and, on that basis, denied the defendants request for judicial review only on th arbitrary and capricious standard.

Another case of significance in this area is the Seventh Circuit's decision in *Hertzberger, supra.* In that case Chief Judge Posner ruled that a plan which indicates that "benefits shall be paid when the plan administrator upon proof (or substantial proof) determines that the applicant is entitled to them," 205 F3d at 329, did *not* represent a sufficient reservation of discretion to trigger the arbitrary and capricious standard of review. The *Hertzberger* Court ruled:

> We hold that the mere fact that a plan requires a determination of eligibility or entitlement by the administrator, or requires proof or satisfactory proof of the applicant's claim, or requires both a determination and proof (or satisfactory proof), does not give the employee adequate notice that the plan administrator is to make a judgment largely insulated from judicial review by reason of being discretionary. Obviously a plan will not - could not, consistent with

> its fiduciary obligation to the other participants - pay benefits without first making a determination that the applicant was entitled to them. The statement of this truism in the plan document implied nothing one way or the other about the scope of judicial review of his determination, any more than our statement that a district court "determined" this or that telegraphs the scope of our judicial review of that determination. That the plan administrator will not pay benefits until he receives satisfactory proof of entitlement likewise states the obvious, echoing standard language in insurance contracts not thought to confer any discretionary powers on the insurer.
>
> *Id.* at 332.

In *Bounds v Bell Atlantic Enterprises Flexible Long-Term Disability Plan*, 32 F3d 337 (8th Cir 1994), the Eighth Circuit ruled that an ERISA plan's language with respect to payment of a long term disability claim was not sufficient to clearly vest discretion in the plan administrators. The plan in question provided that claims would be paid, "after Travelers receives adequate proof of loss." The Court ruled in *Bounds* that a *de novo* standard of review had to be applied for the following reasons:

> *Bruch* declared that the proper way to elect this deferential standard is to grant express discretionary authority to the plan administrator or fiduciary. Predictability in the law furthers the goal of efficient plan administration. Thus, we conclude that the deferential standard under *Bruch* is not triggered by an insurance policy's proof-of-loss provision unless it expresses an intent to confer discretion.
>
> *Id.* at 339; *see also Walke v Group Long Term Disability Ins*, 256 F3d 835, 839-840 (8th Cir 2001).

The weight of federal court authority on this issue was summarized by the Tenth Circuit in *Nance v Sun Life Assurance Co of Canada*, 294 F2d 1263 (10th Cir 2002):

> Because the issue before us is whether Sun Life properly refused to grant disability benefits based on Plaintiff's depression or back condition, the pertinent language is the requirement that "[p]roof [of long term disability] must be satisfactory to Sun Life." To begin our

> analysis, we distinguish this language - in particular, the words "satisfactory to Sun Life" - from language in other plans that requires only submission of satisfactory proof, without reference to who must be satisfied. *Most circuits that have considered the issue have concluded that the mere requirement to submit satisfactory or adequate proof of eligibility does not confer discretion upon an administrator.*

Id. at 1267 (emphasis added).

Paul Revere's policy requires only a satisfactory written proof of loss. It does not call for satisfactory *evidence* of Mr. Krochmal's disability. Yet, even if it did, it is clear under these federal precedents that this language would not be sufficient to give rise to the arbitrary and capricious review standard if this case were governed by ERISA.

E. Does *Guiles v University of Michigan Board of Regents*, 193 Mich App 39; 483 NW2d 637 (1992), Accurately State The Law?

In its June 17, 2005 Order, the Court has indicated that one of the issues which the parties should be prepared to discuss at oral argument is whether the Court of Appeals' decision in *Guiles v University of Michigan*, 193 Mich App 39; 483 NW2d 637 (1993), accurately states Michigan law.

Guiles involved a disability benefit which was extended to the plaintiff through his employment. However, because the plan involved was maintained by a governmental entity, the plan is excluded from ERISA coverage. *Guiles*, 193 Mich App at 44, n. 2. The circuit court in the *Guiles* employed an arbitrary and capricious standard of review in affirming the defendant's decision to deny the plaintiff's request for benefits. The Court of Appeals reversed that determination, concluding that *de novo* judicial review was appropriate. There is no question that *Guiles* reached the correct result in deciding that the *de novo* review standard applied. However, the method by which the Court of Appeals reached that conclusion was flawed.

Plaintiff does not question the *Guiles* Court construction of the law as it exists under ERISA. As in this case, the defendant in *Guiles* argued in favor of the arbitrary and capricious standard based on a "litany" of federal court cases decided under ERISA. 193 Mich App at 43. The Court of Appeals concluded that these ERISA cases were not dispositive of the issue before it because all of them predated the Supreme Court's decision in *Firestone*. 193 Mich App at 43. The *Guiles* Court proceeded to examine the *Firestone* opinion, correctly noting that the Supreme Court in that case had rejected the wholesale incorporation of the LMRA's arbitrary and capricious standard into ERISA. 193 Mich App at 44-45. The *Guiles* Court also correctly noted that the Supreme Court in *Firestone* had found the trust law antecedents of ERISA controlling and *Firestone* introduced into ERISA the trust law concept that a fiduciary's decision will be judicially reviewed on an arbitrary and capricious standard only when the fiduciary is vested with the discretion to make that decision. 193 Mich App at 45-46. The *Guiles* Court also correctly noted that under ERISA, discretion is not the norm and that, "absent a clear grant of discretion to the administrator, application of the highly deferential arbitrary and capricious standard of review" is not appropriate. 193 Mich App at 46, n. 3, *citing Anderson v Great West Life Assurance Co*, 942 F2d 392, 395 (6th Cir 1991).

Having reviewed the federal law discussed by the Supreme Court in *Firestone*, the *Guiles* Court arrived at the following conclusion:

> After reviewing the *Firestone* decision, we find it persuasive to the extent that it explicitly rejects the arbitrary and capricious standard of review relied on by defendant and the trial court.

193 Mich App at 46.

While perhaps somewhat open to interpretation, the Court of Appeals' decision in *Guiles* with respect to *de novo* review is premised exclusively on ERISA as interpreted by the Supreme

Court of the United States in *Firestone*. The Court of Appeals also apparently determined in *Guiles* that, because the policy at issue therein would be governed by the *de novo* standard of review under ERISA, the plaintiff's claim for benefits was subject to *de novo* review.

The obvious problem with the approach taken by the Court of Appeals in *Guiles* is the Court's over reliance on a federal law which, as acknowledged by the *Guiles* Court, did not even apply to the case before it. *Id.*, p. 44, n. 2. The Court of Appeals in *Guiles* appears to have held that by tying the standard of review applicable in that case exclusively to the law as it exists under ERISA, the Court of Appeals' decision in *Guiles* potentially opens the door to an interpretation that, under the trust law principles discussed in *Firestone*, a policy governed exclusively by Michigan law (not ERISA) might be subject to the arbitrary and capricious standard simply because, if it *were* an ERISA policy it would be governed by these standards. That analysis is wrong. ERISA's arbitrary and capricious standard did not apply in *Guiles* because *ERISA did not apply to the policy at issue in Guiles*.

There was no need for the Court of Appeals in *Guiles* to discuss at any length the status of the law under ERISA because the policy in question was governed by basic Michigan contract law, not ERISA. In failing to address the real source of the rights and liabilities of the parties involved in the *Guiles* case - the contract involved therein - the *Guiles* Court erred.

F. The Court Should Give Some Consideration To The Established Statutory Role Of The Insurance Commissioner.

In confronting the issue which the defendant raises in its Application, the Court should also take into consideration the statutorily assigned role of the Michigan Insurance Commissioner. That role was recently the subject of this Court's decision in *Rory*. The Court noted in that case that the

Michigan Legislature has provided a mechanism to ensure the reasonableness of insurance policies issued in this state. That mechanism consists of the statutory power vested in the Commissioner of Insurance to approve any insurance policy language before a policy may be issued in this state. The statute which extends that authority to the Commissioner is MCL 500.2236, which provides in relevant part:

> (4) After January 1, 1992, any change or addition to a policy or annuity contract form for personal, family, or household purposes, whether by indorsement, rider, or otherwise, or a change or addition to a rider or indorsement form to such policy or annuity contract form, which policy or annuity contract form has not been previously approved under subsection (3), shall be submitted for approval pursuant to subsection (3).
>
> (5) Upon written notice to the insurer, the commissioner may disapprove, withdraw approval or prohibit the issuance, advertising, or delivery of any form to any person in this state *if it violates any provisions of this act, or contains inconsistent, ambiguous, or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy*. The notice shall specify the objectionable provisions or conditions and state the reasons for the commissioner's decision. If the form is legally in use by the insurer in this state, the notice shall give the effective date of the commissioner's disapproval, which shall not be less than 30 days subsequent to the mailing or delivery of the notice to the insurer. If the form is not legally in use, then disapproval shall be effective immediately.
>
> MCL 500.2236(4), (5) (emphasis added).

This Court in *Rory* summarized the reach of MCL 500.2236 as follows:

> Clearly, the Legislature has assigned the responsibility of evaluating the "reasonableness" of an insurance contract to the person within the executive branch charged with reviewing and approving insurance policies: the Commissioner of Insurance. The statute permits, but does not require, the Commissioner to disapprove or withdraw an insurance contract if the Commissioner determines that a condition

> or exception is unreasonable or deceptive. The decision to approve, disapprove, or withdraw an insurance policy form is within the sound discretion of the Commissioner.
>
> *Rory* at p. __.

Plaintiff would suggest that there are several important implications to be derived from MCL 500.2236. First, while the Commissioner has approved the language contained in the policy in existence between Mr. Krochmal and Paul Revere, the Commissioner has *not* approved language in that policy which limits the scope of judicial review to the arbitrary and capricious standard. Since that language is not contained in the parties' policy, it is clear that the deferential standard of judicial review which the defendant urges this Court to read into the policy has not yet met with the approval of the Commissioner as MCL 500.2236 requires. The fact that the Commissioner has not approved language providing for such a judicial review standard provides another reason why the Court must reject the defendant's argument in this case.

Similarly, there is nothing in the policy which the parties entered into which provides that Paul Revere has reserved for itself the right to decide whether Mr. Krochmal is disabled under the terms of the policy. Again, there is no language in the contract which provides for such a unilateral decision and, in the absence of action on the part of the Commissioner, it would be inappropriate for the Court to impose such a provision on the parties.

These observations regarding the arbitrary and capricious standard of review and on an insurer's discretionary decision making authority are particularly important here in light of action which has been taken by the National Association of Insurance Commissioners (NAIC), the national organization comprised of the insurance commissioners of each state. The NAIC has approved a proposed uniform act, Model Act 42, which would prohibit the use of discretionary clauses in

insurance policies. A copy of the NAIC's Model Act 42 is attached hereto as Exhibit A. The purpose of this proposed Law "is to assure that health insurance benefits and disability income protection coverage are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide whether benefits are due." Model Act (Exhibit A), §2. To accomplish this goal, the NAIC's Model Act 42 proposes the following:

> No policy, contract, certificate or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

Id., §4(B).

While Model Act 42 has not been adopted by the Michigan Legislature, the consensus represented by the NAIC's promulgation of a strict prohibition of discretionary clauses in insurance contracts would have to be weighed by the Commissioner if and when such a policy provision is submitted for approval. Thus, in making the reasonableness determination discussed by the Court in *Rory*, the Commissioner might well consider the NAIC's Model Act if an insurer ever sought approval of such a discretionary clause.

Finally, plaintiff would note that the argument being advanced by the defendant herein, if embraced by this Court, would represent a dramatic alteration of existing insurance law. It would, if accepted, vest decision making authority in one party to a contract and it would afford that unilateral decision considerable weight by drastically limiting the scope of judicial review. Plaintiff would therefore suggest that if, following the oral argument which will be held on the defendant's Application, this Court is still entertaining the incorporation of ERISA standards into Michigan

contract law, the Court should grant leave to appeal in this case and invite the Commissioner's participation on this issue.

G. The Court Should Give Some Consideration To The Effect Of Its Decision On Other Areas Of Contract Law.

The Court's recent decision in *Rory* vigorously reinforced the fact that general principles of contract law must apply to contracts which arise in the insurance setting. The Court emphasized in *Rory* that, "insurance policies are subject to the same contract construction principles that apply to any other species of contract." *Rory* at ___; *Auto-Owners Ins Co v Churchman*, 440 Mich 560, 566; 489 NW2d 431 (1992). The converse of the Court's clear ruling in *Rory* must also be true. If this Court were to adopt the position advanced by the defendant herein, the contract law principles underlying such a decision cannot be confined to the insurance setting. Instead, the Court's adoption of the defendant's argument would necessarily affect the interpretation and application of *every* contract, in *every* setting.

Plaintiff would suggest that if this Court is considering the adoption of the arguments being advanced by the defendant, it must give significant thought to how these principles would impact on other contracts, particularly those in the commercial setting. The defendant's argument, if adopted, would result in an enormously one-sided arrangement in two critical respects. First, through use of such words as "satisfactory", "adequate" or "sufficient", the defendant claims that a contract may have the effect of giving one party the unilateral right to decide whether the contract's conditions have been satisfied. Second, the defendant proposes that this unilateral decision would be significantly immunized from judicial interference under the arbitrary and capricious standard of review.

If the Court were to adopt the defendant's arguments, the law as it presently exists in the commercial setting would be significantly affected. The general contract law rule applicable to contractual conditions that the obligor be "satisfied" is at present judged by an objective standard based on whether a reasonable person in the position of the obligor would be satisfied. *See generally* Restatement, 2d, Contracts, §228; *see also Cacavas v Zack*, 43 Mich App 222, 227; 203 NW2d 913 (1973).

If the defendants position in this appeal ultimately proves persuasive, the objective, reasonable person standard will be gone, displaced by a subjective standard of what constitutes "satisfied", largely walled in from judicial interference by a deferential standard of review. Plaintiff would further suggest that with the demise of an objective standard of conduct and *de novo* judicial review, the public interest in the stability and predictability of contractual relations would fall with it.

RELIEF REQUESTED

Based on the foregoing, plaintiff-appellee, Ralph Krochmal, respectfully requests that this Court deny the defendant's Application for Leave to Appeal in its entirety.

Respectfully submitted,

MARK GRANZOTTO, P.C.

MARK GRANZOTTO (P31492)
Attorney for Plaintiff-Appellee
414 West Fifth Street
Royal Oak, MI 48067
(248) 546-4649

GRANT, BUSCH & KIRSCHNER

DAVID B. GRANT (P14269)
Attorney for Plaintiff-Appellee
26555 Evergreen Road, Suite 860
Southfield, MI 48076
(248) 353-2860

Dated: August 5, 2005