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Hal O. Carroll, Journal Editor ■ www.HalOCarrollEsq.com ■ (734) 645-1404

From the Chair

Augustine O. Igwe, Kaufman, Payton & Chapa

Greetings to All!

We added eight new members since our last report, raising our membership count to 897. Our growth is steady and sustained. We continue to seek opportunities for growth and to broaden the resources available to all members. The following are some of the activities the Council has undertaken or planning to undertake in the coming months.

Journal – Special No-Fault Issue

Our quarterly *Journal of Insurance and Indemnity Law*, now in its twelfth year, features articles, case updates, analyses and opinions of interest pertaining to insurance and indemnity law. We encourage all our readers to be a part of the *Journal* by submitting an article or opinion piece to our editor for publication. You do not need to be a member of our section to submit an article.

This issue is devoted to the recent changes to Michigan's No-Fault Law, which has caused much controversy, praise and criticism from all participants in No-Fault practice. You will find a full expression of those views in the four articles in this issue of the *Journal*.

Student Scholarship

We have released and publicized our Section's 2019 Annual $5,000 Scholarship program. Any student currently enrolled in one of the Michigan's five law schools is eligible to participate by submitting an article. This year's topic is "Michigan's Automobile No-Fault Insurance System."

We received an offer of assistance from the Director of the Michigan Department of Financial and Insurance Services, Anita G. Fox, to have her Department assist with the review of submissions received from the students. We accepted the offer and look forward to working with the Department on this project.

Bar Leadership Forum

As we indicated previously, our Section participated in the 2019 Bar Leadership Forum held June 13th to 15th in Mackinac Island. I attended the event with Lauretta Pominville, Treasurer. We will be circulating summary and key observations from the summit.

Young Lawyers Section

Our Section sponsored at Gold-Level the Young Lawyers Section 2019 Summit, held in Detroit on May 17-19, 2019. We received inquiries and interests from many of the participating young lawyers, which we hope to leverage into increased membership. My special thank you to Milea Vislosky, Lauretta Pominville and Rabih Hamawi, who volunteered and covered the shifts at the Summit.

Council Meeting

Our next Council Meeting is scheduled for July 11, 2019, in which we will discuss, among other things, the next annual meeting of the members of our Section.

Welcome New Members

Finally, we extend a warm welcome to all new members and thank you for joining our Section. To all our new members and existing members, please plan to participate actively by writing an article, joining a committee or the Council, or simply providing us with your thoughts or opinions on any matter of interest to our Section. ■

Mission Statement of the Insurance and Indemnity Law Section

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

Editor's Notes

By Hal O. Carroll
www.HalOCarrollEsq.com

Introduction to the No-Fault Special Issue

Perhaps nothing in the realm of insurance has created as much interest and caused as much controversy as the recent changes to Michigan's No-Fault law. Some see the changes as necessary reform, while others see it as a poorly thought out degradation of coverage.

As with all issues involving insurance coverage, the *Journal*, like the section itself, takes no position as between insured and insurers.

In this issue, we have commentary by three authors, in four articles, in which each author offers analysis, commentary and criticism (occasionally harsh) of the changes.

For anyone who is looking for insight into the details and potential effects of the changes, this issue of the *Journal* will be a valuable resource. ■

No-Fault Reform 2019: Shame

Wayne J. Miller, *Miller & Tischler, PC*

"Don't let it be forgot
That once there was a spot
For one brief shining moment ...".

Lyrics from Camelot, by Lerner & Loewe

Introduction

Effective June 11, 2019 (with later effective dates for certain key provisions), we have a new no-fault auto insurance law. With much pomp and ceremony, and odes to bipartisanship, Governor Whitmer signed a piece of legislation that is a wonder to behold. The legislation: (a) will not meet its stated goal of reducing premiums; (b) will wreak havoc on the medical and rehabilitation industries; and (c) is so poorly drafted that years of litigation are guaranteed. That's quite an accomplishment, though a rather dubious one at that.

Historical Perspective

Our original no-fault law became effective on October 1, 1973. It was a daring social experiment to deal with the problems created by the fault system. As described in *Shavers v Attorney General*, 402 Mich 554; 267 NW2d 72 (1978):

> The Michigan No-Fault Insurance Act, which became law on October 1, 1973, was offered as an innovative social and legal response to the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or "fault") liability system. The goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses. The Legislature believed this goal could be most effectively achieved through a system of compulsory insurance, whereby every Michigan motorist would be required to purchase no-fault insurance or be unable to operate a motor vehicle legally in this state. Under this system, victims of motor vehicle accidents would receive insurance benefits for their injuries as a substitute for their common-law remedy in tort.
>
> The act's personal injury protection insurance scheme, with its comprehensive and expeditious benefit system, reasonably relates to the evidence advanced at trial that under the tort liability system the doctrine of contributory negligence denied benefits to a high percentage of motor vehicle accident victims, minor injuries were overcompensated, serious injuries were undercompensated, long payment delays were commonplace, the court system was

overburdened, and those with low income and little education suffered discrimination.

For many years our no-fault law worked very well. In its October 1988 issue, *Consumer Reports* declared Michigan's law to the "the most successful" in the nation. In April 1997, *Consumer Reports* advised that "...consumers should look to a state like Michigan, where the existing no-fault insurance system works quite effectively. Rates are at or below the national average, even though the state mandates a high level of coverage."

This started to change in recent years. There can be no question that premiums in the City of Detroit have become extremely high. Explanations however have been elusive. Insurers blamed fraudulent and excessive medical costs. Consumer and other groups blamed insurers for predatory rate making practices, particularly within our urban areas.

However, rather than making a serious effort to determine and then address the causes of high premiums, the solution was simply to slash benefits (under the much heralded mantra of "choice"). The original no-fault law was a majestic experiment in progressive legislation. The recent reform is petty, mean-spirited, punitive, and ultimately will be ineffective in achieving the goal of containing systemic costs. Worst of all, the new law largely destroys the most majestic accomplishment of the old law: full protection from financial jeopardy caused by catastrophic injury, both for the victims and perpetrators. The legislature attempted to address the costs of the system, while ignoring the benefits thereof.

The Act's Main Mechanisms for Achieving Insurance Premium Reductions

The legislation aims to achieves premium reductions through two main mechanisms:

1) *Eliminating the requirement to purchase lifetime/catastrophic coverage.*

Effective July 1, 2020, the requirement to purchase lifetime/catastrophic coverage is replaced by a system of choice. Policy holders may continue to purchase lifetime/catastrophic coverage, but may also purchase options of $500,000 or $250,000. Medicaid eligible claimants may choose coverage down to $50,000. Those with coverage through qualified health plans (e.g., Medicare) may opt out entirely. See MCL 500.3107c.

2) *Fee schedules.*

Effective July 1, 2021, the previous charge limitation of a "reasonable" charge is replaced by a fee schedule. There are two main fee schedule components. For those who render services which would otherwise be compensable under Medicare, the basic permissible charge is 200% of the amount payable by Medicare. MCL 500.3157(2).[1] If Medicare does not provide an amount payable for a service, the fee schedule is 55% of the amount charged by the provider as of January 1, 2019. MCL 500.3157(7).[2] It is this non-Medicare fee schedule that is perhaps the worst of many bad elements of the new law, as discussed below.

The Cost and Benefit of Coverage for Catastrophic Injuries

It will surprise no one to declare that I am a "CONF", a Creature of the No-Fault law. I have worked in the system for many years. My practice focuses on representing catastrophic injury survivors, families and service providers. Up until now, it has been extremely gratifying to be able to say to families of those with catastrophic injuries: "I can't heal your loved one, but I can give you one great reassurance: under our no-fault law, you will not have to pay out of pocket for lifetime medical, rehabilitative and custodial care." This reassurance has meant so much to families of the catastrophically injured, and so much to me as their "shepherd" through the lifetime process that they have just begun. Save for the probable few who will now select the lifetime/catastrophic option, that reassurance is no longer possible.

Catastrophic no-fault coverage of course includes strictly medical expenses such as hospital, doctor, prescription, nursing and therapies. However, no-fault is not unique in covering these benefits. Many commercially available policies, ERISA Plans, and Medicare may also cover these benefits. What makes no-fault unique is that it covers what these other payors typically do *not* cover: long term custodial care and rehabilitation. For those injured under the previous system, these benefits are available for the injured person's lifetime. For those who will be injured under the new system, we anticipate that few will opt for the catastrophic coverage. Many will choose the cheapest possible coverage. Advocates of the new law revel in the "choice" now available to our citizens. That choice is a false one that many will rue.

Think of the *new* choice available to those who will suffer catastrophic loss under the new system, and who have chosen low limits: they will have the choice to stay in a relative's basement if one is available, or go to a Medicaid nursing home. It will not be a pretty picture.

What savings are obtained by removing the requirement to purchase lifetime/catastrophic coverage? $220 per car per year. That's the assessment for the Michigan Catastrophic Claims Association (MCCA) for the period of July 1, 2019 to June 30, 2020.[3] The MCCA reimburses insurers for all claims expenses above $580,000 for injuries covered by policies is-

sued or renewed from July 1, 2019 to June 30, 2021. MCL 500.3104(2)(o).

Stating it another way, those who will buy the next tier of coverage below lifetime/catastrophic coverage at $500,000 will save approximately $220/year. Lifetime/catastrophic coverage is really cheap. Eliminating it does little to achieve the savings sought by advocates of choice. To save more than the $220/car for lifetime/catastrophic coverage, customers will have to buy ever smaller coverage options. Stating it another way, larger savings require the purchase of even more worthless policies. Eliminating the requirement for lifetime/catastrophic coverage ensures that many will buy policies that will save little money, but will cost them the ability to access essential services for catastrophic loss.

The Reformed No-Fault Law Will Not Result in Systemic Savings:

As a general proposition, it makes some sense that reducing the requirements for mandatory auto insurance will result in lower premiums to those who opt for lower coverage. Indeed, the new law requires premium reductions that are concomitant with the lower coverage choices. MCL 500.2111f. However, the legislation fails to provide effective enforcement mechanisms; indeed, the legislation provides escape clauses for the insurers. Moreover, the legislation completely fails to deal with the entirely foreseeable consequences that this legislation will have on *other* systems.

> The original no-fault law was a majestic experiment in progressive legislation. The recent reform is petty, mean-spirited, punitive, and ultimately will be ineffective in achieving the goal of containing systemic costs.

Increased Costs to Medicaid and Other Payors

Let's start with Medicaid. The new law permits those who are Medicaid eligible to purchase no-fault coverage as low as $50,000. MCL 500.3107c(a)(i). When the $50,000 is exhausted, the Medicaid eligible patient will return to Medicaid for primary medical coverage. In addition, most uninsured persons who are not disqualified from no-fault benefits, will henceforth be limited to $250,000 available from the Michigan Assigned Claims Plan (MACP), as opposed to the lifetime coverage previously available to uninsured but not disqualified persons. MCL 500.3114(4), and 3115. When the $250,000 is exhausted, Medicaid will become primary. According to the Senate Fiscal Agency, Medicaid costs will increase over a ten year period by $70 million.[4]

This does *not* suggest that the cost shift to Medicaid will equal the cost savings from no-fault. It is simply to suggest that a portion of any savings from the new no-fault law will be eaten up by increased taxes to cover the increased Medicaid obligations.

In addition to Medicaid, we can expect that there will be pressure on employers to add coverages that are lost with the new no-fault law. It is too early to tell what the systemic impact will be of this pressure on other payors.

Increased Tort Liability Exposure

The fundamental policy concept of the no-fault law was this quid pro quo: in return for lifetime/catastrophic coverage for medical expenses tortfeasors would obtain tort immunity for the medical expenses covered by the no-fault law. Since all medical expenses were covered by the no-fault law, tortfeasors had complete immunity from liability for any medical expenses. MCL 500.3135(3).

Under the new law, those who purchase coverages of less than the lifetime catastrophic level, will potentially have medical expenses in excess of their no-fault PIP policy limits. Under the new law, the driver who negligently hits and injures such a person will no longer have tort immunity. That negligent driver will now be exposed to all medical expense damages beyond the no-fault PIP limit chosen by the injured insured person. MCL 500.3135(3)(c).

The old law required insureds to purchase a minimum of $20,000 for residual tort liability. MCL 500.3009. The requirement was unchanged from 1967. Effective July 1 2020, the new law requires insureds to purchase a minimum of $250,000. MCL 500.3009(a).[5] Such coverage might be adequate under the old law. But with exposure for millions of dollars of excess medical loss in catastrophic cases, all Michigan citizens are now well advised to purchase much higher tort liability coverage. To be clear, even those who exercise the option for lifetime/catastrophic coverage *for themselves* are now exposed to substantial damage awards for economic loss that is not covered by their victims. The increased costs of purchasing higher tort limits (or the uncovered exposure for excess verdicts) has not been included in the estimated "savings" from the new legislation.

Insurer Escape Clauses – Will the Rate Reductions Really Happen?

The law mandates substantial premium reductions for the lower no-fault options chosen. MCL 500.2111f. However, notwithstanding the required premium reductions, the law does little to permit regulation of insurer rating practices. Moreover, the law has several clauses that permit insurers to avoid the premium reduction requirements. For example, the law permits insurers to increase individual insurance policy

premiums "if the increase results from applying rating factors as approved under this chapter...". MCL 500.2111f(9). This section is an escape clause permitting insurers to avoid the premium reductions altogether, merely by rating policies as they would anyhow. Some might answer that the premium reduction requirement of §2111 is an *average* requirement that allows for individual variations. But §2111f(9) is not limited to individual variations. That section permits an insurer to evade the limits for "*any* individual insurance policy premium." So we might well end up with a situation like that of Garrison Keillor's Lake Wobegon, where "all the children are above average."

What makes no-fault unique is that it covers what these other payors typically do *not* cover: long term custodial care and rehabilitation. For those injured under the previous system, these benefits are available for the injured person's lifetime. For those who will be injured under the new system, we anticipate that few will opt for the catastrophic coverage.

No-Fault Is a Small Portion of the Total Auto Insurance Bill

While the premium reductions promised by the new law seem impressive, some perspective is warranted. The new act and its savings apply only to the allowable expense portion of no-fault PIP benefits. MCL 500.3107(1)(a). The law does not limit work loss or replacement service no-fault PIP benefits. MCL 500.3107(1)(b) and (c).

Moreover, no-fault PIP coverage is seldom the biggest portion of one's auto insurance premium bill.Often the most significant portion of one's premium are the collision/comprehensive coverages. These coverages are typically one-half to two-thirds of the auto insurance premium.[6] The law does nothing to limit this most significant portion of the auto insurance bill. Although collision and comprehensive coverages are already optional per the law, they are often required by lease or loan agreements.

So let us make the charitable assumption that no-fault PIP and collision/comprehensive coverages are about equal. Let us further assume that the required average reduction of 35% will be achieved. That 35% reduction is for the no-fault PIP coverages. The reduction is *not* for the entire policy. As discussed above, the 35% reduction is for about half of the policy. In other words, the savings for the policy as a whole now becomes only about 17.5%.

Poor Conception and Poor Draftsmanship: Destruction of the Custodial Care and Rehabilitation Industry for the Catastrophically Injured

Whether or not one agrees with the policy choices made in this legislation, lawyers on both sides of the "v" are lamenting the poor draftsmanship of the law. Many sections are ambiguous; lengthy and costly appellate litigation is certain. A few examples will suffice.

For one, let us examine §3157(12). This section requires "neurological rehabilitation clinics" to be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). "Neurological rehabilitation clinic" is defined in §3157(15)(g) as "a person that provides post-acute brain and spinal rehabilitation care." This definition includes large brain injury rehabilitation facilities that often are already CARF accredited. However, this definition also clearly includes individual physicians, therapists, nurses, and even family attendant care providers. Obtaining CARF accreditation is often a laborious, lengthy and expensive process. Did the legislature really mean to impose this burdensome process on individual care providers? For what purpose? Has there been a previously unknown quality crisis in the rendering of care by individual providers? If so, it has not been made public.

A second example is one of poor drafting compounded by incredibly poor policy. This is the 55% fee schedule for those who do not provide Medicare compensable services (effective July 1, 2020, declining over two years to 52.5%). The percentage reduction is based on the amount the provider charged as of January 1, 2019.[7]

One of the biggest victims of this law and particularly this provision will be the long term brain injury rehabilitation industry. Once the hospitals save the lives of those with severe brain injuries, they are referred to facilities for long term (and maybe permanent) custodial care and rehabilitation. Such facilities provide therapies that may be covered by Medicare, and therefore subject to the 200% base fee schedule. However, long term custodial care is not covered by Medicare. The long term custodial care is the core of the business of these brain injury rehabilitation facilities. The simple fact is that these facilities will go out of business if forced to render services at the 55% level. That is because such facilities (like most businesses on this planet) do not operate on a 45% margin.

I represent a number of such long term brain injury rehabilitation facilities. They employ thousands of skilled persons with good jobs (therapists, nurses, and aides). Their margins are generally 8-10%. The reasonableness of their charges is evidenced by the fact that insurers rarely challenge them (unlike providers of most other services). These facilities will not be able to stay in business. A conservative estimate is that 10,000 good jobs will be lost due to this single provision.[8] Worse yet, these facilities care for thousands of the most severely disabled brain

and spinal cord injury patients. Where will they go when the facilities shut down?

When we ponder the carnage that will soon happen to this vital industry and its patients, one has to ask what was the legislature thinking when they approved a 55% fee schedule? Were they thinking? And if so, who thought that it would be a good idea to ruin this industry of reputable and essential service providers?

Conclusion

This poorly conceived and drafted legislation is a testimony to the failure of the political process. Less severe yet effective alternatives were not considered, such as PIP *deductibles*. Mayor Duggan's Pinnacle Study ("D-Insurance: City of Detroit Insurance Company Feasibility Study, by Roosevelt Mosley, June 8, 2015) concluded that a $5,000 PIP deductible would have saved Detroit residents as much as 13%. This makes sense since, as discussed above, reducing caps does not save much money. Rather, the most expensive dollars in any medical insurance product are the *first* dollars. More moderate fee schedules would also save money without ruining health care providers. How about some (any?) investigation into how insurers set their rates and whether fee schedules on *insurers* would be a viable approach.

Even though high premiums were the product of insurance rate making, no serious/significant insurance reform/regulation occurred. The legislature instead protected the insurance industry through this new law (e.g., see the above discussion of §2111f(9)). The legislature extended no protection to the medical and rehabilitation care industries. In particular, the long term rehabilitation industry was left exposed to devastation. And for what? Small savings in the cost of a portion of the auto insurance premium. Significant increases in Medicaid expenses and liability premiums, as well as removal of tort immunity and exposure to significant tort verdicts; destruction of a significant sector of Michigan's economy. The system could have been saved with prudent revision, instead of wholesale destruction. It's a sad development for what was once a model for the nation.

Shame. ■

Abbout the Author

Wayne Miller is the co-author of the textbook on Michigan's no-fault law that is in use in 3 law schools in Michigan, and has taught the no-fault law as an Adjunct Professor of Law at Wayne Law School since 1998.. Licensed to practice law in Michigan since 1980, Mr. Miller represents survivors of those injured in catastrophic motor vehicle crashes, as well as their families and service providers.

Mr. Miller will be spending a lot of time in the coming months revising the textbook.

Endnotes

1 This amount declines to 190% of the Medicare rate after July 1, 2023. There are other charge limitations for certain providers as outlined in MCL 500.3157(3) and (6).

2 This amount declines to 52.5% after July 1, 2023.

3 See MCCA press release of March 27, 2019: http://www.michigancatastrophic.com/Portals/71/MCCA%20Assessment%20Press%20Release%20March%202019.pdf

4 https://www.legislature.mi.gov/documents/2019-2020/billanalysis/Senate/pdf/2019-SFA-0001-A.pdf

5 Insureds may purchase lower liability limits down to $50,000, with the signature of a special form confirming the choice of the lower option. MCL 500.3009(5).

Editor's introduction: *Ron Sangster prepared this article when the bill leading to no-fault changes was near the end of its progress through the Legislature and still in bill form. Part II analyses the content and effect of the Act as adopted.*

No-Fault Reform—The End of an Era – Part I

Analysis and Commentary

Ronald M. Sangster, *Law Offices of Ronald M. Sangster PLLC*

For over 45 years, Michigan's unique NoFault Insurance Act has been an important part of this state's legal landscape. As originally designed, one of the goals of the NoFault Act was to decrease the amount of tort litigation arising out of motor vehicle accidents. This was accomplished by ensuring that accident victims would receive all of their medical expenses, plus three years of work loss benefits and household service expenses, directly from their own insurer, and reserving tort lawsuits for non-economic damages for "serious" injury cases and excess work loss benefits.

By all accounts, just the opposite is true. Currently, there is a proliferation of first party nofault suits being filed by injured persons and their providers. With the loosened threshold requirements, brought about as a result of the Supreme Court's decision in *McCormick v Carrier*, 487 Mich 180; 795 NW2d 517 (2010), it is easier than ever to recover on tort claims as well. With the ever-increasing insurance premiums and the ever-larger payouts being made by insurance companies, it was just a matter of time before our representatives in Lansing would "do something" to "reform" the system.

In light of the NoFault Reform Bill, SB 1, as passed by both Houses of the Legislature during a rare Friday afternoon session on May 24, 2019, it appears that our experiment with the nofault insurance system, as we knew it, is coming to an end. While there are certainly some laudable measures in the bill, particularly with regard to cost controls on medical providers and utilization review provisions, there are other areas of the bill that are certainly problematic. One thing for certain is that there will definitely be higher payouts on the tort side of the equation, given the fact that damages that are no longer payable under PIP will be shifted over as an element of damages for the injured person's tort claim. With the significant increase in insurance policy liability limits as well, it is more likely that we will see more tort lawsuits going to trial, given the prospect of "future allowable expenses" being included as part of the damages black boarded in the Plaintiff's tort lawsuit, and the higher liability policy limits to shoot at!

Whether these changes will be good or bad for the system remains to be seen. Personally, I cannot help but wonder whether the Legislature "threw the baby out with the bathwater" by doing away with Michigan's provision for lifetime, unlimited medical expenses while, at the same time, opening up the tortfeasor's tort exposure. To put it another way, I cannot help but wonder if the savings realized on the PIP side of the equation won't be offset by the increase in the premium dollars paid for the increased tort liability policy limits. I also cannot help but wonder whether SB 1 assumes a level of sophistication, on the part of insurance consumers, when it comes to realizing exactly what their employer-provided health coverage actually provides, when it comes to the choice of opting out of the No-fault Act altogether.

What follows is this author's analysis of the pertinent provisions of the NoFault Reform Measure. This analysis is no substitute for actually reading the Senate Concurred Bill itself, which runs 120 pages (and tracks the changes to the existing statutes) or the Enrolled Bill, which runs 35 pages. It is intended to be a guide and perhaps a starting point for further discussions for possible legislative "tweaking." Despite this, the author is confident in noting that almost 50 years after NoFault took effect, we are now seeing . . . the end of an era.

Underwriting Changes

The new bill makes a number of changes that impact on the Michigan Department of Insurance and Financial Services (DIFS) and underwriters. The new legislation almost certainly ensures further involvement by the Insurance Director in both the underwriting process and in the claims process. For example, new section 261 of the Insurance Code requires that the Department of Insurance and Financial Services must maintain a website which, among other things:

> "Advises that the department may be able to assist a person who believes that an automobile insurer is not paying benefits, not making timely payments,

> or otherwise not performing as it is obligated to do under an insurance policy."

Although DIFS would occasionally notify the insurer that one of its claimants had filed a complaint, the insurer's reply would usually close out the department's involvement in the claim. Under this new statute, though, it certainly appears that the department will take a more active role.

> While there are certainly some laudable measures in the bill, particularly with regard to cost controls on medical providers and utilization review provisions, there are other areas of the bill that are certainly problematic.

For policies renewed or issued on or after July 1, 2020, the amendments to Chapter 21 of the Insurance Code will take effect. Previously, an insurer could not provide rating classifications based upon sex or marital status. Now, in addition to these factors, insurers can no longer establish rating classifications for home ownership, educational level attained, occupation, postal zones, or credit scores. However, insurers can still utilize "statistical reporting territories."

Furthermore, insurers must submit rate filings by July 1, 2020, for insurance policies issued or renewed after July 1, 2020, which provides for the following premium reductions for persons opting for the following coverages:

- 45% PIP premium reduction for those opting for the $50,000 PIP coverage under §3107c (1)(A);
- 35% PIP premium reduction for those opting for $250,000 in PIP coverage under §3107c (1)(B);
- 20% PIP premium reduction for those opting for $500,000 in PIP coverage pursuant to §3107c (1)(C);
- 10% PIP premium reduction for those opting for lifetime, unlimited allowable expense coverage under §3107c (1)(D);
- No PIP premium charge for those electing to be excluded from the NoFault Act under §3107d or those excluded from coverage under §3109a(2).

The significance of these elections and exclusions will be discussed below. *The important point here is that only the PIP portion of your premium payments will be reduced by the level of coverage selected.*

Section 2116b provides that between the effective of the Act and January 1, 2022, an insurer can no longer refuse to insure, refuse to continue to insure, limit coverage available to, charge a reinstatement fee for, or increase auto insurance premiums for a person otherwise eligible for auto insurance "solely because the person previously failed to maintain insurance required by §3101 for a vehicle owned by the person." Many insurers have an underwriting requirement which states that the person who operates their own, uninsured motor vehicle on the highways of this state without insurance during the preceding six months is simply ineligible for insurance. Those persons must obtain insurance through the non-standard market, where insurers typically charge higher premiums. However, for the next 2½ years, an insurer is prohibited from utilizing this underwriting criterion.

Finally, new section 2162 expressly states that an insurer cannot use an applicant's credit score to establish a rating classification, or to establish premiums for auto insurance.

One final note. The statute provides that the premium rate reductions for PIP coverages are based on the PIP premiums that were in effect as of May 1, 2019. The statute further provides that the premium reductions are to remain in effect for any policies that take effect before July 1, 2028 – a period of eight years. The statute further provides that the Insurance Director must review the filings to verify compliance with the premium reductions, and provides that "the Director shall disapprove a filing if after review the Director determines that the filing does not result in the premium reductions required by subsections (2) and (3)."

However, the insurer can apply for a lower premium reduction, or an exemption altogether from the percentage premium reductions, and the Director "shall approve the application" if compliance with the premium reductions would result in "the insurer reaching a company action level risk based capital" which translated means the insurer might be headed towards insolvency. Alternatively, these applications for an exemption from the premium reduction requirements "shall be approved by the Director" if the company can show a violation of the 14th Amendment to the U.S. Constitution, or a violation of Article I, Section 17 of the State of Michigan of 1963, regarding deprivation of property without due process of law. However, these constitutional provisions do not apply to any applications for an exemption filed after July 1, 2023. I cannot help but wonder why an action taken by the Director or the Department might be unconstitutional on June 30, 2023, but constitutional on July 2, 2023!

Residual Bodily Injury Liability Limits

At the present time, MCL 500.3009 sets forth minimum residual bodily injury liability limits of $20,000 per person, $40,000 per occurrence, and $10,000 in property damage not otherwise covered by Property Protection Insurance (such as property damage occurring outside the State of Michigan). Had these limits been indexed to the rate of inflation, the current liability limits would have been just under $120,000 per person or $225,000 per occurrence. However, the Act requires that the residual bodily injury liability limits be approximately doubled from these inflation-adjusted figures to $250,000 per person and $500,000 per occurrence. However, the Legisla-

tion also provides that a person can opt out of these higher limits, and obtain lower policy limits of not less than $50,000 per person or $100,000 per occurrence if the applicant signs a form which explains the various liability policy limit choices, the costs of each option and an explanation of the risks of accepting lower liability policy limits. If no election is made, the default provision is $250,000/$500,000.

Unlike the PIP election provisions, which take effect for policies issued or renewed after July 1, 2020, there is apparently no set effective date for the increase in the residual bodily injury liability limits. It can be inferred that the Legislature intended for the increased limits to take effect for all policies obtained or renewed after July 1, 2020, since the same form to be utilized in selecting the applicant's PIP coverage level options also applies to the selection of the applicant's liability policy limit options. The author anticipates that this oversight will be corrected in the very near future. Otherwise, the default provision will take place immediately and an individual's liability limits could "automatically" increase to $250,000/$500,000 effective on the date that the Governor signs the bill and it is filed with the Secretary of State's Office.

NoFault Changes – Coverage Options

The cornerstone for this nofault measure is the PIP choice sections. Presently, Michigan is the only state that provides for lifetime, unlimited "allowable expense" coverage under MCL 500.3107(1)(a), which includes medical expenses, attendant care expenses, pharmaceutical expenses, vocational rehabilitation expenses, and long-term institutional care expenses. All of this comes to an end for policies issued or renewed after July 1, 2020. At that time, the applicant will need to select allowable expense coverage at the following levels:

- $50,000 per individual per loss occurrence for "allowable expense" coverage , **if** (1) the applicant or named insured is enrolled in Medicaid, and (2) the applicant or named insured's spouse and relatives residing [but not domiciled?] in the same household have "qualified health coverage," Medicaid or nofault coverage on other vehicles – see MCL 500.3107c(1)(a);
- $250,000 per individual per loss occurrence for "allowable expense" payments under MCL 500.3107(1)(a) – see MCL 500.3107c(1)(b);
- $500,000 per individual per loss occurrence for "allowable expense" coverage – see MCL 500.3107c(1)(c);
- Unlimited "allowable expense" coverage – see MCL 500.3107c(1)(d).

Note that these limits apply only to "allowable expense" payments as defined in MCL 500.3107(1)(a). Work loss benefits, currently payable up to approximately $65,000 per year over the course of three years, are not included as part of this cap. Nor are household replacement service expenses. This may be subject to further legislative amendment to clarify precisely to what benefits these caps apply.

The Bill also provides that, if there is no election as to the benefit level chosen, the premium corresponds to the reduced premium levels set forth in subsections c(1)(a), c(1)(b) or c(1)(c), and a "rebuttable presumption" is created that the amount of the premium charged accurately reflects the coverage level chosen by the insured. This is a rebuttable presumption, not a conclusive presumption, and there is always a possibility that the injured person can claim that he or she did not understand what they were electing when they "told" the agent that they wanted a certain level of coverage.

The PIP coverage election applies to the named insured, the spouse or relative domiciled in the same household. However, it also applies to "any other person with a right to claim PIP benefits under the policy." This provision is rather curious, since in *Shelton v Auto-Owners Ins Co,* 318 Mich App 648, 899 NW2d 744 (2017), the Michigan Court of Appeals held that, for purposes of a fraud exclusion contained in an insurance policy, it was only binding on the named insured, spouse of the named insured or relatives domiciled in the same household. Absent a possible argument concerning third party beneficiaries, strangers to the insurance contract are not bound by such fraud exclusions. In certain situations, involving motorcyclists, it could be potentially unfair for the reasons discussed below.

There is also a provision requiring operators of Uber or Lyft vehicles to obtain allowable expense coverages of $250,000, $500,000 or unlimited, as noted above. There is also an unusual provision which provides that for insureds who opt for the capped "allowable expense" coverages, excerpted above, the insurer must offer "a rider that will provide coverage for attendant care in excess of the applicable limit."

Somewhat surprisingly, there is also a provision that allows certain individuals to opt out of the nofault system altogether. Section 3107d is a lengthy statutory provision that allows an individual to opt out of purchasing "allowable expense" coverage under MCL 500.3017(1)(a) if a person is a "qualified person." In addition to being a "qualified person," the applicant or the named insured's spouse and relatives residing [not domiciled?] in the household must have either "qualified health coverage" or have nofault benefits from other sources. A "qualified person" is defined as a person covered by Medicare. "Qualified health coverage" is defined as including Medicare coverages, or health and accident coverage that "does not exclude or limit coverage for injuries related to motor vehicle accidents" and for which the individual deductible is $6,000.00 or less per individual.

Although "the person that provides the qualified health coverage" is required to provide a list of individuals covered to the insurer, there is apparently no type of certification re-

quired from such "persons" regarding the lack of exclusions or limitations of coverage for auto accident-related injuries. Having reviewed countless self-funded ERISA Plans over the years, and even some insured ERISA Plans, there are a fair number of Plans out there that exclude coverage for auto accident injuries altogether. Are applicants or agents expected to become experts in ERISA Plan analysis?

> Although DIFS would occasionally notify the insurer that one of its claimants had filed a complaint, the insurer's reply would usually close out the department's involvement in the claim. Under this new statute, though, it certainly appears that the department will take a more active role.

So what happens if a "qualified person" somehow loses their "qualified health coverage?" Section 3107d(3)(e) provides that the person has thirty days after "the effective date of the termination of qualified health coverage" to obtain first party nofault insurance coverage, or they will be excluded from all "allowable expense" coverage "during the period in which coverage under this section was not maintained." However, there is another section, 3107d (6) (c) which provides that a person who allows their "qualified health coverage" to lapse and fails to obtain nofault coverage, "the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1) (a) for the injury but is entitled to claim benefits under the assigned claims plan," unless the injured person is entitled to benefits under some other No-fault policy. So a person does not recover "allowable expenses" but recovers other benefits, like work loss and household service expenses from the assigned claims plan? Furthermore, that person gets a $2,000,000.00 cap on benefits (yes, you read that right- Two Million Dollars), even though they are not entitled to any "allowable expense" coverage? This writer respectfully submits that this purported exclusion and the assigned claims plan cap, simply makes no sense.

Another "opt out" provision is found in §3019a (2), which applies only to those individuals who obtain the $250,000 "allowable expense coverage limit in section 3107d(1)(b). This provision allows a person to opt out of purchasing "allowable expense" coverage under MCL 500.3107(1) (a) altogether if the named insured, his or her spouse and all relatives domiciled [note the use of the term "domiciled", not "residing"] in the same household "have accident and health coverage that will cover injuries that occur as the result of a motor vehicle accident." If a member, but not all members, of a household have "health or accident coverage that will cover injuries that occur as the result of a motor vehicle accident," an insurer must offer a reduced premium that reflects "reasonably anticipated reductions in losses, expenses, or both." If all household members have such insurance, the insurer cannot charge a premium for the "allowable expense" coverage under the policy. *Section 3109a(2)(c) then provides that a person subject to exclusion under this subsection is not eligible for personal protection insurance benefits at all – not even work loss or household replacement service benefits!*

Like a "qualified person" who loses his or her "qualified health coverage," under section 3107d, section 3109a (2)(d)(i) provides that if a person loses their health coverage, they must apply for nofault "allowable expense" coverage in thirty days. If they suffer an injury within that thirty-day period, they are entitled to claim benefits through the Assigned Claims Plan, but with a $2,000,000 cap. If they fail to do secure that coverage, they are excluded from recovering "allowable expense" coverage under MCL 500.3107(1)(a). Presumably, they can still obtain other nofault benefits, but unlike section 3107d (6) (c), there is no indication of where the injured person would go to obtain those benefits.

So to re-cap how this provision works:

- A person who has "health and accident coverage" and therefore qualifies for this exclusion is not entitled to recover any No-fault benefits at all if they are involved in a motor vehicle accident;
- If they lose their "health and accident coverage," they have 30 days to obtain No-fault allowable expense and other benefits coverage, and if they are injured in an auto accident during this period of time, they receive benefits from the assigned claims plan, subject to a $2,000,000.00 cap (not $250,000.00 as in all other claims);
- If they fail to obtain No-fault coverage within that 30 day period, and they are injured in an automobile accident, they are excluded from recovering "allowable expenses" under section 3107(1)(a), (unless they are eligible for benefits under some other policy), but could conceivably obtain benefits elsewhere.

Out-Of-State Accidents

At the present time, accidents occurring outside the State of Michigan are compensable under the Michigan NoFault Act only if the injured person was the named insured on a Michigan nofault policy, the spouse of a named insured, or a relative or either domiciled in the same household. There is also a provision for payment of benefits to occupants of a motor vehicle insured under a Michigan nofault policy. When teaching this topic, I refer my students to the case of "Grandma in Oklahoma," who has never stepped foot inside the State of Michigan in her life. You are out to visit Grandma in Oklahoma, and you are driving her to a grocery store. On the way to the store, you are involved in an ac-

cident and Grandma is injured. Under the old version of MCL 500.3111, Grandma is entitled to recover Michigan nofault insurance benefits under your Michigan policy, simply because she was an occupant of your vehicle.

As indicated below, the Legislature clearly intends to exclude non-residents from recovering Michigan nofault benefits, and the Legislature attempted to do so in the amendment to MCL 500.3111. The statute now provides that an occupant of a Michigan-registered and insured vehicle can obtain benefits "if the occupant was a resident of this state." So far, so good. *However, the amendment also provides that Michigan PIP benefits are payable to "an occupant of a vehicle involved in the accident, if the occupant was a resident of this state or if the owner or registrant of the vehicle was insured under a personal protection insurance policy . . ."* By definition, in order to be entitled to benefits at all, arising out of an out-of-state accident, the non-resident must be occupying a Michigan-registered and Michigan-insured vehicle! *In other words, it appears that what the Legislature intended to take away, it gave right back.*

> The cornerstone for this no fault measure is the PIP choice sections. Presently, Michigan is the only state that provides for lifetime, unlimited "allowable expense" coverage under MCL 500.3107(1)(a), which includes medical expenses, attendant care expenses, pharmaceutical expenses, vocational rehabilitation expenses, and long-term institutional care expenses. All of this comes to an end for policies issued or renewed after July 1, 2020.

Simply put, the question to be determined by the Legislature is whether or not it wants to grant Michigan nofault benefits, arising out of out-of-state accidents, to non-residents. If it does, this section needs to be redrafted.

One final note. The legislative amendment does not change the difference in treatment between married persons and boyfriends-girlfriends. For example, imagine a situation where a married couple travel to Florida and are involved in an accident in Florida while walking across the street. Assume that the husband is the named insured on a nofault policy. Under this scenario, both spouses will be able to obtain nofault benefits. However, if that same scenario involves a boyfriend-girlfriend, the boyfriend will recover benefits because he is the named insured on his policy. Assuming that the girlfriend is living with the boyfriend, the girlfriend will not be able to recover benefits at all, unless she has her own policy of insurance on which she is the named insured.

Covenant Fix

The Legislature has amended MCL 500.3112 to legislatively overrule the Michigan Supreme Court's decision in *Covenant Med Ctr v State Farm*, 500 Mich 191; 895 NW2d 490 (2017). The amendment adds the following language to section 3112:

"A healthcare provider listed in section 3157 may make a claim and assert a direct cause of action against an insurer, or under the Assigned Claims Plan under sections 3171 to 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person."

This amendatory section applies to all products, services, and accommodations rendered on or after the effective date of the Act. In other words, assume that the Act is signed into law on June 1, 2019. A physician providing services on May 28, 2019, will still need to obtain an assignment of benefits from the patient. That same physician rendering treatment on June 3, 2019, need not do so.

However, this amendment arguably does not solve the problem that we encountered in the aftermath of the Court of Appeals' decision in *Covenant Med Ctr v State Farm*, 313 Mich App 50; 880 NW2d 294 (2015), regarding who had a right to receive those funds. Will we see "Motions to Approve Settlement" or "Motions to Apportion Settlement Proceeds" being filed in circuit court when we attempt to settle claims for nofault benefits? Again, there is no protection built into the amendatory act to protect the insurer when it issues a payment to, say, a medical provider which bypasses a purported attorney charging lien. In fact, the Legislature left unchanged the provision that the insurer "may apply to the circuit court for an appropriate order" regarding payment where the payees are disputed. Oh, how soon we forgot those days!

Section 3113 Exclusions

SB1 amends the "out-of-state" resident exclusion in MCL 500.3113(c) to exclude benefits where "the person was not a resident of this state." However there is an exception for those out-of-state residents where "the person owned a motor vehicle that was registered and insured in this state." This is arguably in conflict with MCL 500.3111, discussed above, which provides that Michigan nofault benefits are payable to "an occupant of a vehicle involved in the accident . . . if the owner or registrant of the vehicle was insured under a personal protection insurance policy." *In other words, section 3111 grants coverage to those individuals who occupy a Michigan-registered and insured vehicle, while amended section 3113(c) takes it away.* Again, if it is the intent of the Legislature to preclude out-of-state residents from recovering Michigan nofault benefits, unless they own a Michigan-registered and insured motor vehicle, it needs to reconcile the conflict between MCL 500.3111 and MCL 500.3113(c).

Changes in Priority

MCL 500.3114(1), which provides the "general rule" for payment of nofault benefits, has been amended to indicate that if a person is the named insured on his or her own policy, and could potentially be entitled to benefits from another household member's policy, he or she recovers benefits up to the limit prescribed in their own policy, without recoupment from the other household policies.

The "super priority" provision set forth in MCL 500.3114(2) has likewise been amended to exclude coverage for passengers in a motor vehicle, operated in the business of transporting passengers, who have elected not to maintain coverage under section 3017d (pertaining to Medicare recipients) or as to which the exclusion under section 3109a(2) applies. This begs the question as to why the Legislature chose to allow owners of motor vehicles "operated in the business of transporting passengers" to opt of the nofault system altogether?

MCL 500.3114(4) is also amended. No longer will occupants of motor vehicles, who have no insurance of their own in their households, go to the insurer of the owner, registrant or operator of the motor vehicle they are occupying for payment of their nofault benefits. Rather, they will turn to the Michigan Assigned Claims Plan, and, as shown below, their benefits will be capped at $250,000. However, if the injured person is an insured under a policy for which he or she has elected not to maintain coverage under section 3107d, or has elected the exclusion under section 3109a(2), this subsection does not apply.

Changes in Priority- motorcycles and non-occupants

The basic priority structure remains unchanged. The injured motorcyclist will first turn to the insurer of the owner or registrant of the motor vehicle involved in the accident for payment of their PIP benefits. If the owner or registrant of the motor vehicle has no insurance, the motorcyclist then turns to the insurer of the operator of the motor vehicle. Next in line is the motor vehicle insurer of the operator of the motorcycle, followed by the motor vehicle insurer of the owner or registrant of the motorcycle involved in the accident.

What if the owner, registrant or operator of the motor vehicle involved in the accident has opted not to maintain PIP coverage under section 3107d, or for which an exclusion under section 3109a(2) applies? The amendment seems to indicate that the motorcyclist goes down the chain of priority to find the next available policy coverage. However, under MCL 500.3107c, the motorcyclist may very well be bound by the coverage option chosen by the insurer of the owner, registrant or operator of the motor vehicle involved in the accident! *Motorcyclists across the state should be very concerned about this provision!*

I, as a responsible motor vehicle owner and motorcyclist, will opt to procure lifetime, unlimited nofault benefits, which I would hope will apply whether I am operating my own motor vehicle, operating my motorcycle, or walking across the street. Assume that one day, I am riding my motorcycle and I am struck by a motor vehicle whose owner or registrant purchases $250,000 in personal protection insurance benefit coverage under section 3107c(1)(b) or, worse yet, $50,000 in coverage under section 3107c(1)(a). As drafted, it certainly appears that I am bound by whatever level of coverage the operator of the motor vehicle involved in the accident chose. In other words, no matter how hard I, as a responsible motor vehicle owner and motorcyclist, try to protect myself, it seems that I am at the mercy of the owner of the other motor vehicle involved in the accident.

A suggested fix – maintain the same order of priority, but indicate that, after the exhaustion of nofault benefits payable from the insurer of the owner, registrant or operator of the motor vehicle involved in the accident, the motorcyclist's motor vehicle insurer will pick up the remaining nofault benefits, up to the limits of insurance chosen by the injured motorcyclist for his motor vehicle.

As for non-occupants of motor vehicles, who have no insurance of their own in the household, these individuals, too, will no longer claim benefits from the insurer of the owner, registrant or operator of the motor vehicle that struck them. Rather, they will turn to the Michigan Assigned Claims Plan, and their benefits will be capped at $250,000.

Changes in Tort Liability

As present written, the NoFault Insurance Act is quite clear. An insured owner/operator of a motor vehicle is immune from tort liability except for above-threshold non-economic losses, and excess wage loss. Now, with the imposition of allowable expense coverage caps, discussed above, the tortfeasor, and by implication his or her insurer, remains responsible for payment of those "allowable expenses" that are not covered under the injured person's PIP coverage.

To use a concrete example, let us assume that you are involved in an accident with a Medicaid recipient, who has chosen to obtain the $50,000 PIP coverage option. The PIP coverage option is quickly exhausted. At that point, responsibility for payment of the injured person's medical expenses now becomes an element of damages in a tort suit against the tortfeasor. This, in turn, will drive up the insured's exposure on the tort side of the equation. In other words, the Legislature has shifted the "pot of money" from the PIP pot to the tort pot!

The tortfeasor also remains liable for damages for economic loss to a non-resident. However, in order for the non-resident to recover his economic losses, he or she must show that their injury crosses one of the three thresholds set forth in MCL 500.3135 – death, permanent serious disfigurement, or serious impairment of body function.

Finally, the Legislature has codified the holding of the Michigan Supreme Court in *McCormick v Carrier*, 487 Mich 180, 795 NW2d 517 (2010). Again, this appears to confirm the intent of the Legislature to return to a tort-based compensation system, as opposed to the system that we have been operating under for almost fifty years.

PIP Processing Changes

At the present time, benefits are deemed to be "overdue" if not paid by the insurer within 30 days after the insurer receives "reasonable proof of the fact and of the amount of loss sustained." However, the legislative amendment provides that, if a provider of "allowable expenses" under MCL 500.3107(1)(a) fails to submit a bill to the insurer within 90 days after the service has been provided, the insurer has an additional 60 days, along with the existing 30 day provision, to make payment before the benefits are "overdue" and interest is owing. This provision is designed to give the insurer additional time to evaluate claims for, say, nine months of chiropractic or physical therapy treatments that are submitted at the same time by the provider, in order to prevent the insurer from obtaining an independent medical evaluation that would question the need for such excessive physical therapy or chiropractic treatments.

The amendment also legislatively overrules the Michigan Supreme Court's decision in *Devillers v ACIA*, 473 Mich 562, 702 NW2d 539 (2005) and reinstates the claim-tolling provision from *Lewis v DAIIE*, 426 Mich 93, 393 NW2d 167 (1986). MCL 500.3145(3) specifically provides:

> "A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence."

This language is fraught with all of the problems identified by the Michigan Supreme Court in *Devillers*. Imagine a scenario where a person requires a two-week hospitalization, and the facility proceeds to submit hospital charges, physician charges and radiology charges. One of the radiology bills "slips through the cracks" and is not paid by the insurer. The injured Claimant subsequently makes a claim for attendant care services, going back 3 years. Does the insurer's failure to pay that old radiology bill allow the injured Claimant to recover benefits beyond one year back from the date the complaint was filed?

Attorney Fee Changes

The attorney fee provisions have likewise been changed in MCL 500.3148(1). At the present time, there are some attorneys who are claiming attorney charging liens on undisputed medical expense payments, in addition to work loss benefits, household replacement service expenses and attendant care service benefits paid to the injured claimant. MCL 500.3148(1) has been amended to make it clear that an attorney "shall not claim, file or serve a lien for payment of a fee or fees" until (1) a payment for the claim is authorized, and (2) the payment is "overdue." In other words, an insurer is now apparently free to ignore an attorney lien for payment of medical expenses and can pay the medical provider directly. The same holds true for the payment of work loss benefits and household replacement service expenses. Insurers will need to process claims in a timely manner in order to avoid facing the issue of a potential attorney charging lien.

> A "qualified person" is defined as a person covered by Medicare. "Qualified health coverage" is defined as including Medicare coverages, or health and accident coverage that "does not exclude or limit coverage for injuries related to motor vehicle accidents" ...

The Legislature also amended the provision for defense attorney fees under MCL 500.3148(2) to allow an award of defense attorney fees "for defending against a claim for which the client was solicited by the attorney in violation of the laws of this state or the Michigan Rules of Professional Conduct." This provision, though, is meaningless because most attorneys are not directly soliciting clients. Rather, many clients are being solicited by shadowy third parties who set up the unsuspecting claimant with medical transportation services, physical therapy and/or chiropractic services, a treating physician, and even an attorney – one stop shopping!

The Legislature added a provision providing that attorney fees "must not be awarded in relation to future payments ordered more than three years after the trial court judgment for order is entered" in cases involving a dispute over payment of attendant care services. Obviously, the Legislature meant to preclude an injured claimant's attorney from taking a fee on attendant care service benefits for decades after the initial determination of entitlement is made. It remains to be seen how well this provision will work. *It bears repeating that if the attendant care service benefits are being voluntarily paid, in a timely manner, an attorney is precluded from taking a fee on those payments under MCL 500.3148(1).*

There is also a provision that precludes an award of nofault penalty attorney fees if the Plaintiff's attorney, or a related person of the attorney, has a direct or indirect financial interest in the person or entities that provided the treatment, product, service, rehabilitative occupational training, or accommodations to the injured person. This seems to be a rather weak

provision, since most PIP cases are settled before trial, without an award of nofault penalty attorney fees. Nonetheless, this provision does allow an insurer and its counsel to delve into the medical provider's financial interest holders during discovery, so that the insurer can evaluate a potential attorney fee claim by Plaintiff's counsel should the matter proceed to trial.

IMEs

The Legislature has now brought the IME provision in MCL 500.3151 in line with the expert witness requirement from the medical malpractice arena. As amended, section 3151 requires that the person performing the IME must be of the same specialty and, if appropriate, board certified as the treating physician. The IME physician must also spend the majority of his or her professional time in either the active clinical practice of medicine, or instructing students in an accredited medical school or in an accredited residency or clinical research program.

Fee Schedules

Along with the PIP choice provisions, the medical fee schedules are another key component of the NoFault Legislative Reform Measure. However, these fee schedules do not take effect until July 1, 2021 – more than two years after the bill is expected to be signed into law. The bill does nothing to curb the multiple provider suits that are filed in the various district court of the state. There are no procedural reforms that were enacted, either, which would at least drive down the cost of litigation that insurers confront. Simply put, for the next two years, insurers and their defense counsel will need to deal with the prospect of defending six or seven lawsuits, in various courts of the state (usually in jurisdictions having nothing to do with either the locale of the injured person or where the services were performed) and we will still be defending "balance bill" suits based upon the "reasonable and customary" analysis performed by databases, such as the Fair Health Database in New York.

Beginning on July 1, 2021, most providers will be capped at 200% of the Medicare Fee Schedule. This amount will drop down to 195%of Medicare rates as of July 1, 2022. One year later, the cap drops to 190%of the Medicare Fee Schedule, which will apparently remain in effect into the future.

However, there are exceptions to the fee schedule. For example, a facility that "renders treatment or rehabilitative occupational training" is initially capped at 230% of the Medicare rate. Beginning on July 1, 2022, the rate drops to 225% of the Medicare Fee Schedule. Thereafter, the amount drops to 220 %. There are certain criteria that must be met in order to qualify for these higher reimbursement rates. What is also interesting is the fact that only two freestanding rehabilitation facilities, chosen by the Director of Insurance, are entitled to recover these higher rates of reimbursement! Furthermore, a facility that provides thirty percent or more of its services to indigent individuals can obtain an even higher rate of reimbursement – 250% of Medicare.

There is also a different level of reimbursement for Level I or Level II Trauma Care Centers. These facilities are entitled to be compensated at the rate of 240% of the Medicare Fee Schedule for treatment rendered from July 1, 2021, through July 2, 2022. From there, the reimbursement rate drops to 235%. Beginning July 1, 2023, the reimbursement rate is 230%.

The Act also provides that if there is no Medicare Fee Schedule in place for a particular service, the rate of reimbursement will be 55% of the rate charged by that facility as of January 1, 2019. That percentage drops to 54% and eventually ends up at 52.5%. There are similar arrangements made for section 3157(3) facilities as well. Finally, if a Level I or Level II Trauma Center renders a service that is not contained within the Medicare Fee Schedule, compensation is paid at 75% of the rate that was in effect for that particular service, by that particular facility, as of January 1, 2019. The percentage then drops to 73% and eventually ends up at 71%, effective July 1, 2023.

Section 3157 also contains an hourly cap for attendant care services – 56 hours per week. An insurer can contract to provide for a greater number of hours. However, there is no hourly rate cap for attendant care payments!

Subsection 12 provides that a neurological rehabilitation clinic must be accredited in order to receive payment for its services. The accreditation must be performed by the "Commission on Accreditation of Rehabilitation Facilities or a similar organization recognized by the Director for purposes of accreditation under this subsection."

Finally, emergency medical services rendered by an ambulance operation are exempt from these fee schedules.

Utilization Review

Section 3157a requires the Department to establish a Utilization Review Department, in order to:

> "Establish criteria or standards for utilization review that identify utilization of treatment, products, services or accommodations under this chapter above the usual ranges of utilization for the treatment, products, services or accommodations based on medically accepted standards."

Medical providers are required to submit "necessary records and other information" and to comply with any decision of the Department of Insurance regarding utilization reviews. If it is determined that a provider provides treatment, products, services, or accommodations that "are longer in duration than, are more frequent than, or extend over a greater number of days than the treatment, products, services or accommoda-

tions usually require for the diagnosis or condition for which the patient is being treated," the insurer can ask the provider to explain why such treatment is necessary. If the provider is not satisfied with the decision by the insurance company to deny the claim based on the Department's utilization review, the provider "may appeal the determination to the Department" under the procedures to be promulgated by the Department. For those of us who have been out of law school for some time, it may be time to dust off years of cobwebs and re-familiarize ourselves with administrative law practice!

Out-of-State Residents

As currently written, MCL 500.3163 requires insurers doing business in this state to certify that any accidents in the State of Michigan, involving out-of-state residents insured under their auto liability policies, will become quasi-Michigan nofault insurance claims. This Bill effectively repeals section 3163, and provides that insurance companies are no longer required to provide Michigan nofault insurance benefits to out-of-state residents unless the out-of-state resident is the owner of a motor vehicle that is registered and insured in the State of Michigan. This effectively eliminates the "black hole" of the Michigan nofault insurance system, whereby insurers of out-of-state residents traveling in the State of Michigan, were required to provide lifetime, unlimited nofault benefits to certain Michigan residents (motorcyclists or occupants and non-occupants without insurance of their own) injured in auto accidents involving these out-of-state residents, without reimbursement from the MCCA.

Michigan Assigned Claims Plan

The legislation amends certain provisions of the NoFault Insurance Act pertaining to the operation of the Michigan Assigned Claims Plan. Of interest is the fact that neither the MAIPF, which operates the Michigan Assigned Claims Plan, nor a servicing insurer is required to pay interest "in connection with a claim for any period of time during which the claim is reasonably in dispute." This provision could impact on the payment of nofault penalty attorney fees, because if there is no interest owing because the payment is not "overdue" there can be no award of nofault penalty attorney fees. See *Beach v State Farm,* 550 NW2d 580, 216 Mich App 612 (1996).

Benefits paid by the MACP are now capped at $250,000. However, a 2,000,000 cap applies under the following circumstances:

- If a person opts out of the nofault system because he or she is a Medicare recipient, as allowed under section 3107d, and if that coverage somehow ends, and that person fails to obtain nofault insurance as otherwise required under the Act, the person "is entitled to claim benefits under the Assigned Claims Plan" but, as noted above, "the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a).

Again, this provision makes no sense, because if the person cannot recover "allowable expenses" under 3107(1)(a), how can they be entitled to recover $2,000,000 from the MACP?

This same $2,000,000 cap likewise applies to those individuals who exempt themselves from the NoFault Act under section 3109a(2), but lose their insurance coverage and fail to obtain nofault coverage as otherwise required. It seems to the author that we are rewarding individuals who fail to comply with the NoFault Insurance Act and obtain nofault coverage when they lose coverage through either Medicare or their health insurance.

The amendment also imposes a duty on the part of the injured person to cooperate with the MAIPF or its assigned insurer, and includes a requirement to attend Examinations Under Oath and IMEs, as required by the servicing insurer. The amendment also makes it clear that an assignment by the MAIPF to a servicing insurer is not an admission that coverage is owed. Rather, the servicing insurer can deny the claim at a later date if the servicing insurer determines that "the claim is not eligible under this chapter or the Assigned Claims Plan." This amendment legislatively overrules the Court of Appeals' decision in *Bronson Health Care Group v Titan Ins Co,* 314 Mich App 577, 887 NW2d 205 (2016), which held that once a claim was assigned to the servicing insurer, it could not conduct its own investigation into the Claimant's eligibility for benefits. This amendment, at least, is welcome relief to the MACP and its servicing insurers.

Managed Care Options

SB 1 amends the Insurance Code to allow nofault insurers to offer a managed care option, which will apply to all medical care except for "emergency care." Insurers offering this managed care option must also provide for "allowable expense" coverage that would not be subject to this managed care option.

Anti-Fraud Unit

In the negotiations leading up to the passage of SB1, there was a dispute between the Attorney General's Office, which had established its own Insurance Fraud Unit, and the Legislature, which wanted to have the unit located in the Department of State Police. Ultimately, the Legislature decided to house the Anti-Fraud Unit "as a criminal justice agency in the Department of Insurance! The Legislature provides that the Anti-Fraud Unit has the power to investigate "persons subject to the person's regulatory authority, consumers, insureds, and any other persons allegedly engaged in criminal and fraudulent activities in the insurance market." It can conduct background

checks on applicants for licenses and current licensees, collect and maintain claims of criminal and fraudulent activities in the insurance industry and share records with other criminal justice agencies. However, the Anti-Fraud Unit cannot share information with insurers or their defense counsel, who are on the front lines of combatting insurance fraud! Specifically, section 6302 provides that documents, materials or information related to an investigation by the Anti-Fraud Unit "is confidential by law and privileged, is not subject to the Freedom of Information Act, . . . is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. The amendment further provides that the Director "or any other person that received documents, materials, or information while acting on behalf of the Anti-Fraud Unit" is not allowed to testify in any private civil action. Furthermore, as far as prosecution of insurance fraud activities are concerned, the Anti-Fraud Unit has no authority to initiate prosecutions on its own. Rather, it only has the authority to:

> "Conduct outreach and coordination efforts with local, state and federal law enforcement and regulatory agencies to promote investigation and prosecution of criminal and fraudulent activities in the insurance market."

It is well known that insurance fraud cases are rarely, if ever, prosecuted, especially in southeast Michigan. As far as the federal government is concerned, so long as Medicare is not involved, it certainly has no interest in getting involved in these types of claims. It certainly will not become involved in cases involving medical necessity. *In this writer's humble opinion, the Anti-Fraud Unit, as established in the Act, is a "toothless tiger."*

Conclusion

While there are some good points about the Bill, particularly with regard to the medical fee schedules and utilization reviews it is far too complicated in many respects. The opt-out provisions for Medicare recipients under section 3107d, and for those individuals having health and accident coverage under section 3109a(2) are particularly problematic, for the reasons discussed above. There are issues regarding the effective dates of many of these provisions, as discussed above as well.

Hindsight, as they say, is always 20/20. What should have happened is that this bill should have been rolled out as the "working draft," with various refinements being made to alleviate many of the problems referenced above. As it is, though, it appears that this matter was rushed out of the Legislature in order to give both sides something to brag about at the Mackinac Conference, held during the week after Memorial Day. Perhaps there is still time to enact some measures to fix the flaws in the bill, identified above. If not, it appears that we will have a two to three-year period of time to see how all of this works out. However, all sides can agree on the fact that it is truly "the end of an era." ■

About the Author

Ron Sangster has practiced extensively in the area of no-fault law, and is a regular contributor to the Journal. This article is adapted from a newsletter he provided to his clients regarding the changes. His office is available to provide in-house presentations explaining the effects of the changes to no fault. He can be contacted at (248) 269-7040 or by email at rsangster@sangster-law.com if you have any further questions. An in-house presentation can be arranged by contacting Mr. Sangster's secretary, Melissa Francis at mfrancis@sangster-law.com or Mr. Sangster's Administrative Assistant, Kelly Curry at kcurry@sangster-law.com.

Editor's introduction: *Ron Sangster's "Part I" article discussed the No-Fault reform act when it was still in Bill form. The analysis and commentary continues here in a discussion of the Act as adopted.*

No-Fault Reform—The End of an Era – Part II

Analysis and Commentary

Ronald M. Sangster, *Law Offices of Ronald M. Sangster PLLC*

On May 30, 2019, Governor Whitmer signed SB 1, the no-fault reform amendments, into law during a public signing ceremony that took place on Mackinac Island. Surrounded by Legislators and media from around the state, she indicated that the changes that were being enacted were "historic." However, due to a number of flaws that were identified in SB 1, as noted in Part I, Governor Whitmer agreed not to submit SP 1 to the Secretary of State, while she waited for the Legislature to return from the Mackinac Island conference. On June 4, 2019, the Legislature passed HB 4397, the no-fault "amendments to the amendments," which clarified the effective date for the increase in the residual bodily injury liability limits. HB 4397 also clarified when the "mini-tort" damage limit increased from $1000.00 to $3000.00.

Governor Whitmer signed HB 4397 on Tuesday, June 11, 2019. Both SB 1 and HB 4397 were then transmitted to the Secretary of State, where the Great Seal of the State of Michigan was affixed to the Bills and they were assigned Public Act numbers – PA21 (for SB 1) and PA 22 (for HB 4397). Accordingly, unless otherwise stated in the texts of these two Acts, these Bills became Law on Tuesday, June 11, 2019.

In what could best be described as a chaotic situation, there was a great deal of confusion as to when these various provisions took effect. Many commentators were taking the position that the provisions of SB 1 took effect immediately when Governor Whitmer signed the bill on Mackinac Island – May 30, 2019. However, Article 4, §33 of the Michigan Constitution specifically provides:

> "If he [the Governor] approves, he shall within that time [14 days] sign the bill and file it with the Secretary of State and it shall become law."

In a 1984 Attorney General Opinion, number 6201, former Attorney General Frank Kelley advised then- Secretary of State Richard H. Austin that:

> "It is my opinion therefore, that a bill passed by the Legislature, given immediate effect and signed by the Governor, becomes law upon its filing with the Secretary of State."

As stated above, both SB 1 and HB 4397 were filed with the Secretary of State on June 11, 2019. As a result, these provisions will undoubtedly apply to auto accidents occurring on or after June 11, 2019. However, there are a few provisions that will apply to pending claims arising out of accidents that occurred before June 11, 2019, but it would appear that those changes will not affect the claimant's substantive rights. These provisions are discussed more fully in Section VI below.

Changes in Policy Coverages

As noted in Part I, the PIP choice provisions applies to insurance policies issued or renewed after July 1, 2020. However, with regard to the residual bodily injury liability limits, SB 1 did not provide for a similar effective date, even though the statute indicated that the residual bodily injury liability limit election was to be made on the same form as the PIP coverage elections. HB 4397 clarified this omission, and now provides that after July 1, 2020, the residual bodily injury policy limits must be $250,000 per person, or $500,000 per occurrence, unless the insured opts to obtain lower policy limits, on the same form used to make their PIP coverage choices, but no lower than $50,000 per person and $100,000 per accident.

Mini Tort Changes

As originally drafted, SB 1 apparently provided for an immediate increase in the mini tort damage limit from $1,000.00 to $3,000.00. HB 4397 clarifies the effective date of this important change. HB 4397 makes it clear that the tortfeasor remains liable for damage to motor vehicles, up to $3,000.00, for accidents that occur after July 1, 2020.

Changes to Priorities

For accidents occurring before June 11, 2019, claimants who were injured while an occupant of another person's vehicle, and who did not have insurance of their own in their household, would turn to the insurer of the owner, registrant or operator of the motor vehicle they were occupying for their no-fault benefits, under the former version of MCL 500.3114(4). Similarly, non-occupants of motor vehicles,

such as pedestrians, bicyclists, and moped riders, who did not have insurance of their own in the household, would likewise turn to the insurer of the owner, registrant or operator of the motor vehicle involved in the accident for payment of their no-fault benefits, pursuant to MCL 500.3115(1).

For accidents occurring on or after June 11, 2019, these same individuals will now submit their claims to the Michigan Automobile Insurance Placement Facility, which operates the Michigan Assigned Claims Plan. These individuals will be capped at $250,000.00 for "allowable expense" benefits under MCL 500.3107(1)(a), plus work loss benefits under MCL 500.3107(1)(b), household replacement service benefits under MCL 500.3107(1)(c) or survivor's loss benefits under MCL 500.3108. Work loss, replacement service and survivor's loss benefits do not count against the $250,000.00 cap.

Again, the $250,000.00 cap only applies to "allowable expense" benefits under MCL 500.3107(1)(a), such as hospital and physician expenses, prescription expenses, medical mileage expenses, attendant care expenses, home modification expenses, van modification expenses and the like.

As for motorcyclists, the basic priority scheme remains unchanged, and until July 1, 2020, they will continue to receive lifetime, unlimited no-fault benefits under the priority scheme set forth in MCL 500.3114(5). However, after July 1, 2020, a motorcyclist may have no control over the coverage level of no-fault benefits that might be available to them. Instead, they are at the mercy of whatever coverage limits the owner of the motor vehicle involved in the accident has opted for!

As noted in Part I, I am an avid motorcyclist and, if I opted to purchase the lifetime, unlimited no-fault coverage, I would expect that coverage to apply whether I am operating my automobile, walking across the street, or riding my motorcycle, so long as I am involved in an accident with a motor vehicle. Before July 1, 2020, I will still be able to receive lifetime, unlimited no-fault benefits so long as my motor vehicle is insured, since even if I am struck by an uninsured motor vehicle, my motor vehicle insurer occupies the third order of priority under MCL 500.3114(5)(c) – "the motor vehicle insurer of the operator of the motorcycle."

However, for accident occurring after July 1, 2020, unless I am involved in an accident with an individual who has elected to exclude PIP coverage under Section 3107d or Section 3109a(2), my entitlement to no-fault benefits will be capped at whatever PIP coverage level was chosen by the owner of the motor vehicle involved in the accident. The absurdity of this provision becomes apparent when one considers the following:

- I am driving my automobile and am catastrophically injured – I still get lifetime, unlimited no-fault benefits if that is the option I chose;
- I am walking across the street when I am struck by a motor vehicle – I still get lifetime, unlimited benefits if that is the option I chose;
- I am riding my motorcycle when I am catastrophically injured in a motor vehicle accident with a motor vehicle whose owner has opted for $250,000.00 "allowable expense" coverage – I am capped at this amount (plus any work loss, household service or survivor's loss benefits), despite the fact that I chose lifetime, unlimited no- fault coverage for my motor vehicle.

In this writer's humble opinion, this is an oversight that needs to be corrected by the Legislature before these PIP choice amendments take effect on July 1, 2020.

Of course, if the motorcyclist does not own a motor vehicle, and does not otherwise have no-fault coverage available through a spouse or domiciled relative, and there is no other source of PIP coverage that can be identified within the standard order of priority for motorcyclists under MCL 500.3114(5), the motorcyclist would then turn to the Michigan Assigned Claims Plan, where his "allowable expense" benefits would be capped at $250,000 (plus work loss, household service or survivor's loss benefits).

Out-Of-State Residents

Prior to June 11, 2019, out-of-state residents would still be entitled to recover no-fault benefits under their out-of-state insurance policies if their insurer was a certified insurer under MCL 500.3163. With one weird exception discussed below, for accidents occurring on or after June 11, 2019, out-of- state residents are no longer eligible to recover Michigan no-fault insurance benefits unless they insure and register a motor vehicle in the State of Michigan. See MCL 500.3113(c). Those out-of-state residents will need to turn to the tort system to obtain compensation, but in order to recover any damages, whether economic or non-economic, the out-of-state resident must prove a threshold injury.

This writer foresees some problems with both handling and defending claims involving out-of-state residents. Since those out-of-state residents are essentially now operating under a tort system, their damages are, for the most part, going to be capped as whatever insurance policy limits are available to the tortfeasor. Let us assume, for example, that the out- of-state resident is seriously injured in a motor vehicle accident, through no fault of his own, on June 30, 2019. Having been shut out of the Michigan no-fault insurance system by these amendments, the out-of-state resident turns to the tort system for compensation, but until July 1, 2020 – a year down the road at the earliest, depending on the renewal date – the tortfeasor will still have the minimal policy limits of $20,000/$40,000, or even $50,000/$100,000 or $100,000/$300,000. The out-of-state resident may not be willing to settle for those limits, but may very well be inclined to pursue the tort claim to trial and secure a verdict in excess of the applicable policy limits. This will almost certainly result in higher tort payouts, higher personal exposure

for the tortfeasor and perhaps more protracted tort litigation than what we have seen in recent years.

The exception is found in MCL 500.3111, which governs accidents occurring outside the State of Michigan. Prior to the amendment, an out-of-state resident occupying a Michigan registered and insured motor vehicle would be entitled to lifetime, unlimited no-fault benefits, even if the out-of-state resident never set foot inside the State of Michigan in his or her lifetime. Now, MCL 500.3111 provides that PIP benefits are payable if "the occupant was a resident of this state *or* if the owner or registrant of the vehicle was insured under a personal protection insurance policy." Consider the following:

- Aunt Sally drives her vehicle from her residence in Kentucky to Michigan to visit you. Her vehicle is insured under a Kentucky policy issued by State Farm. She is excluded under MCL 500.3113(c) and MCL 500.3111 would not apply because the accident occurred in Michigan;
- Aunt Sally flies into Michigan from her residence in Kentucky and you pick her up in your car. You are subsequently involved in an accident in Michigan. Aunt Sally does not get Michigan no-fault benefits because she is an out-of-state resident, excluded under MCL 500.3113(c) and MCL 500.3111 does not apply to accidents occurring Michigan;
- Aunt Sally flies into Michigan from her residence in Kentucky and you pick her up in your car. You are subsequently involved in an accident in Ohio, on your way to visit the Toledo Zoo. Because the accident occurred out of state, and because Aunt Sally was an occupant of a vehicle whose "owner or registrant of the vehicle was insured under a personal protection insurance policy," she is entitled to benefits under MCL 500.3111, but is arguably excluded from recovering benefits under MCL 500.3113(c).
- So let's assume that MCL 500.3111 applies and Aunt Sally is entitled to Michigan no-fault benefits as a result of the accident occurring in Ohio while occupying a Michigan registered and insured motor vehicle. She used to go to your policy, as the insurer of the owner of the motor vehicle occupied, under the former version of MCL 500.3114(4)(a). No more – she now goes to the MACP, but the statutory provisions governing the operation of the MACP, MCL 500.3171 et. seq., clearly provide that its provisions apply only to "accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle in this state." See MCL 500.3172(1). So where does she go – she was, after all, injured in Ohio?

This makes no sense at all – what one section completely grants, the other completely takes away! Why should entitlement depend upon whether the out-of-state resident has crossed the Michigan-Ohio border? In other words, why is coverage excluded in Michigan and allowed in Ohio? And who picks up her claim? Either the out-of-state resident should be all in or all out. Another legislative "fix" is clearly needed!

Covenant Fix

SB 1 legislatively overrules the Michigan Supreme Court's decision in *Covenant Med Ctr v State Farm*, 500 Mich 191; 895 NW2d 490 (2017).

Instead, it specifically provides that a healthcare provider "may make a claim and assert a direct cause of action against an insurer, or under the Assigned Claims Plan . . . to recover

overdue benefits payable for charges for products, services, or accommodations provided to an injured person." As pointed out in Part I, this change applies to products, services and accommodations rendered on or after June 11, 2019.

For example, a chiropractor who treats an injured Claimant on June 1, 2019, will still need to obtain an assignment from the patient, if the chiropractor wishes to pursue payment of those expenses. If that same chiropractor renders treatment on June 14, 2019, no assignment is required, and the provider can institute a direct cause of action against the no-fault insurer, or the MACP, to obtain payment of those expenses.

Claims Handling – Procedural Changes

Unlike the changes referenced above, which affect the substantive rights of no-fault Claimants, the following changes are, in the author's opinion, procedural in nature. As such, they became effective on June 11, 2019, and are applicable to claims arising out of motor vehicle accidents occurring prior to that date.

Independent Medical Evaluations

SB 1 provided that an IME physician had to spend the majority of his or her professional time in either the active clinical practice of medicine or instructing students in an accredited medical school or in an accredited residency or clinical research program. As originally introduced, SB 1 also added the requirement that the physician performing the IME must be of the same specialty and, if the treating physician is board certified, the IME physician must carry the same board certification as the treating. This latter provision somehow did not make it to the Enrolled Bill that was signed into law by Governor Whitmer on May 30, 2019. However, the requirement that the IME physician have the same specialty and, if applicable, the same board certification as the treating physician was put back in by HB 4397. Accordingly, both of these provisions apply to examinations which take place on or after June 11, 2019.

So what is the practical effect of these amendments? In many cases, I have seen insurance companies utilize doctors specializing in physical medicine and rehabilitation to combat claims for chiropractic expenses. Now, if we have a chiropractor as a treating physician, the insurer will need to secure the services of a chiropractor to perform the IME. If the injured claimant is utilizing the services of, say, a chiropractor, a physiatrist and a neurologist, then the no-fault insurer will need to secure three IMEs of its own – one with a chiropractor, one with a physiatrist, and one with a neurologist. Obviously, this will require claim representatives to take a much more active role in the selection of IME physicians, instead of relying upon the IME facility to line up an IME with the first available physician.

Statute of Limitations

Prior to June 11, 2019, the One-Year-Back Rule was strictly applied. However, SB 1 now incorporates a tolling provision, which stops the running of the One-Year-Back Rule "from the date a specific claim for payment of the benefits is made until the date the insurer formally denies the claim." However, this provision does not apply if the Claimant "fails to pursue the claim with reasonable diligence." Therefore, as we see more and more litigation being filed over services rendered after June 11, 2019, motions for partial summary disposition based upon the One-Year-Back Rule, will soon become a thing of the past.

Attorney Fees

Effective June 11, 2019, a Claimant's attorney can no longer claim a lien on payment of an undisputed medical expense or, for that matter, any other undisputed claim that may be paid by the no-fault insurer. Obviously, this provision should put an end to the claims being filed by Plaintiff attorneys who demand that they be named as a payee on undisputed medical expense payments. In those cases, the insurer needs to make it clear that, because the benefits being paid are not "overdue," Plaintiff's counsel has no right to assert a lien against payment of those medical expenses.

However, this provision also poses a problem for many Plaintiff attorneys, who routinely take a one-third attorney fee on claims for work loss benefits, attendant care service benefits and household replacement service benefits that are voluntarily paid by the insurer. This provision arguably renders those attorney liens invalid, insofar as they pertain to payments issued by the insurer on or after June 11, 2019. It remains to be seen how the State Bar of Michigan will respond if and when an insurer notifies the State Bar of Michigan that a Plaintiff's attorney may be improperly claiming a lien on payment of undisputed no-fault benefits – not just medical expenses! As for my colleagues on the opposite side of the aisle, they should seriously consider the ramifications of continuing to claim a lien on payment of voluntarily paid no-fault benefits of any sort- not just medical expense payments.

PIP Claims Processing

The basic requirement, that an insurer has 30 days to pay a claim after receiving "reasonable proof of the fact and of the amount of loss sustained" remains in effect. However, if a medical provider, or even an attendant care service provider, fails to submit a bill within 90 days after a product, service, accommodation or training was provided, the insurer has a total of 90 days (the initial 30 day period plus a 60 day additional investigatory period) to issue payment before it is deemed to be "overdue."

Attorney Fees for Solicited Clients

Effective June 11, 2019, a no-fault insurer can obtain "a reasonable amount against a claimant's attorney as an attorney fee for defending against a claim for which the client was solicited by the attorney in violation of the laws of this state or the Michigan Rules of Professional Conduct." In this regard, plaintiffs will now be subject to cross examination as to whether or not they were solicited by an attorney, and it would appear that the Plaintiff's attorney will not be able to interpose an attorney- client privilege.

However, what if the client was solicited by Attorney A who, in turn, refers the client to Attorney B, who is wholly ignorant of the solicitation by Attorney A until the client is deposed. Is Attorney B liable for the attorney fee sanction under this provision? Probably not – Attorney B is not the one who did the soliciting. However, could Attorney A – the one who did the initial soliciting – be the target of this provision? If so, how will we get Attorney A lined up for sanctions? It will be interesting to see how this plays out down the road.

Conclusion

Obviously, HB 4397 goes a long way toward clarifying some of the issues that became apparent in the rush to pass SB 1, prior to the Mackinac Island Conference. However, evidence of sloppy draftsmanship still remains. Fortunately, there is still time for the Legislature to correct some of the issues that we have identified, and which may become apparent as we acclimate ourselves to the new world of No-Fault. One can only hope that the Legislature will be paying attention as these significant changes are rolled out, and that they will not simply turn a "blind eye" to the problems that crop up, on both side of the aisle, when it comes to implementing these provisions.

The fact remains, however, that as of June 11, 2019, we can now officially proclaim that it is . . . the End of an Era. ■

About the Author

Ron Sangster *has practiced extensively in the area of no-fault law, and is a regular contributor to the Journal. This article is adapted from a newsletter he provided to his clients regarding the changes. His office is available to provide in-house presentations explaining the effects of the changes to no fault. He can be contacted at (248) 269-7040 or by email at* rsangster@sangster-law.com *if you have any further questions. An in-house presentation can be arranged by contacting Mr. Sangster's secretary, Melissa Francis at* mfrancis@sangster-law.com *or Mr. Sangster's Administrative Assistant, Kelly Curry at* kcurry@sangster-law.com.

Looking Down the Road at Changes to the Michigan No-Fault Act

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

Executive Summary

It will likely take several years before the impact on premiums, claims, and litigation is fully determined. Certain provisions take effect immediately, while others, including regulatory changes, will take effect later. There are a few predictions that can be made at this time, however.

Providers will be able to bring their own cause of action against insurers. Once the fee schedule is implemented, however, insurers will no longer be litigating with claimants or providers as to the reasonableness of charges.

Lawsuits filed merely to prevent benefits from being barred by the one year back rule will no longer be necessary. It is now the obligation of the insurer to make a decision on a claim before it can be barred by the one year back rule. Insurers will now have more time to evaluate claims that are not submitted timely. Insurers and the state also have more tools in addressing potentially fraudulent claims.

It remains unclear whether this legislation will reduce the number of no-fault claims. If premiums are actually reduced, there may be more insured individuals on the roadways. It is also unknown how many people will opt out of allowable expenses coverage. Given that a large majority of no-fault claims fall below $250,000 or $500,000, it may not largely impact the value of most claims. Catastrophically injured claimants without lifetime allowable expenses will certainly be limited. As a result, one would expect that the MCCA would be pared down in both its assets and liabilities, as well as overall claims subject to involvement with the MCCA. As a result of the revamped order of priority, more claimants will now be required to seek coverage through the Michigan Automobile Insurance Placement Facility (MAIPF) and not from insurers of the motor vehicle involved.

Lastly, it is also entirely possible that claims for third party automobile negligence and uninsured/underinsured motorist benefits will increase. The minimum bodily injury policy limits are increasing substantially. Claimants can seek damages in the form of excess allowable expenses, including medical expenses and attendant care, in addition to seeking excess wage

loss benefits. One would suspect that claimants will need to file these claims to get their bills paid, and may need to be creative in order to establish a liability argument. Also, with the prospect of economic damages in third party cases, one could also envision cases becoming more difficult to settle, resulting in more cases going to trial.

One thing is certain: this will be an interesting few years as courts throughout the state interpret these new statutory provisions. Stay tuned!

It remains unclear whether this legislation will reduce the number of no-fault claims.

Introduction

The Michigan No-Fault Act has remained largely unchanged from the time of its enactment in 1973. Over the years, rising insurance rates, especially in the City of Detroit, created a push for reforming the Act in order to provide relief to consumers. The Michigan legislature and the governor have agreed on bipartisan legislation that drastically alters the provisions of this statute. This article summarizes the major changes that will impact all aspects of claims under the No-Fault Act.

Coverage Choices For Allowable Expenses

The No-Fault Act provides for three primary categories of benefits: allowable expenses, work loss, and household replacement services. The category of allowable expenses includes a broad array of medical related benefits which were previously unlimited in amount and scope. This has now drastically changed. Insurers may now sell automobile insurance policies with coverage for allowable expenses in limited amounts.[1] These limits do not apply to wage loss or household replacement services benefits. Coverage for allowable expenses will be available in the following amounts:

- $50,000 (only if the applicant or named insured is enrolled in Medicaid and any spouse and all resident relatives have qualifying health insurance or a no-fault policy with coverage for allowable expenses).
- $250,000 per individual and per loss occurrence.
- $500,000 per individual and per loss occurrence.
- Unlimited per individual and per loss occurrence.
- Opt out of coverage (i.e. no coverage) for allowable expenses (only if the named insured or applicant has qualified health insurance, and the spouse, and any resident relative have qualified health coverage or a no-fault policy with coverage for allowable expenses).

An insurer must provide a prospective insured with a form that explains the benefits and burdens of each coverage option, allows them to choose their desired option, and acknowledges that they received and reviewed the form. The default option is unlimited coverage if the applicant or named insured does not make an effective selection. There is a presumption as to a given coverage level, however, if a policy is issued with a certain coverage level and the premium charged matches that coverage level.[2]

For coverage levels that have limits on allowable expenses, carriers are required to reduce premiums a certain percentage at each level.[3] Carriers can be exempt from the premium reduction requirements if they can show that the premium reduction will result in a financial hardship or a constitutional violation as applied to the insurer.[4] It should be noted that the regulatory changes for insurance carriers with regard to rates have changed so drastically that they should be reviewed for compliance.

In addition, automobile insurers may now offer a managed care option that provides for allowable expenses. This managed care option will operate like an HMO, with monitoring and adjudication of the injured person's care and the use of a preferred provider program. The option will include deductibles and co-pays in exchange for a reduced premium.[5]

Coordination of Benefits

Under MCL 500.3109a, an insurer may offer personal protection insurance benefits at reduced rates, deductibles, and exclusions reasonably related to other health and accident coverage. This was commonly referred to as a coordination of benefits provision, and created a scenario where health or disability insurance would be required to pay medical or wage loss benefits first, with the automobile insurer only having a potential exposure for excess benefits.

MCL 500.3109a was amended by the no-fault reform legislation to allow an insurer to offer an applicant or named insured, if they select allowable expenses coverage in the amount of $250,000, to be excluded from coverage for allowable expenses if the person has "qualified health coverage." This applies to policies issued or renewed after July 1, 2020.[6]

Both MCL 500.3107D and MCL 500.3109a, which both provide for an opt-out of allowable expenses, share the same definition of qualified health coverage. The term refers to other health or accident coverage where (a) the coverage does not exclude or limit coverage for injuries related to motor vehicle accidents and (b) any annual deductible for coverage is $6,000 or less per individual. It also includes coverage under parts A and B of the federal Medicare program.[7]

MCL 500.3109a provides that if the named insured has qualified health coverage, and the named insured's spouse and any resident relative residing in the same household also has qualified health coverage, the premium for allowable expenses on the policy must be reduced by 100%.[8] If a member, but not all members, of the household is covered by qualified health

coverage, then the policy is subject to a reduced premium, but only individuals with qualified health coverage receive a 100% reduction in the premium for allowable expenses.[9] If there are members of the household who are not covered by qualified health coverage, then they would be able to claim up to $250,000 in allowable expenses should they suffer accidental bodily injury arising out of a motor vehicle accident.

If a person excluded from allowable expenses due to having qualified health coverage loses their coverage, the named insured must notify the insurer that the person is no longer eligible.[10] The named insured then has 30 days to obtain coverage for allowable expenses under the policy applicable to that individual.[11] If the excluded individual suffers accidental bodily injury from a motor vehicle accident during that 30 day period, the individual must claim benefits under the Michigan Automobile Insurance Placement Facility (MAIPF).[12] If the coverage is not added by the end of the 30 day period, the injured person who was excluded is not entitled to coverage for allowable expenses.[13]

The category of allowable expenses includes a broad array of medical related benefits which were previously unlimited in amount and scope. This has now drastically changed. Insurers may now sell automobile insurance policies with coverage for allowable expenses in limited amounts.

Fee Schedule Applies to Medical Expenses

Previously, rates charged by medical providers were only required to be "reasonably necessary." MCL 500.3157 has now been expanded to include a fee schedule. The fee schedule applies depending on the nature of the medical care provided.

A provider that has 20-30% indigent volume or a free-standing rehabilitation facility (as defined by statute and selected by DIFS under MCL 500.3157(4)(B)) is subject to the following:

- After July 1, 2021 and before July 2, 2022, 230% of amount payable under Medicare (or 70% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 225% of amount payable under Medicare (or 68% of average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 220% of amount payable under Medicare (or 66.5% of average charge as of January 1, 2019 if Medicare does not provide an amount payable).

A hospital that is classified as a Level I or Level II trauma facility is subject to the following:

- After July 1, 2021 and before July 2, 2022, 240% of amount payable under Medicare (or 75% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 235% of amount payable under Medicare (or 73% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 230% of amount payable under Medicare (or 71% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).

All other providers providing care where Medicare provides an amount payable:

- After July 1, 2021 and before July 2, 2022, 200% of amount payable under Medicare (or 55% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 195% of amount payable under Medicare (or 54% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 190% of amount payable under Medicare (or 52.5% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).

A neurological rehabilitation clinic is not entitled to payment or reimbursement unless the clinic is accredited by an approved organization. This does not apply to a clinic that is in the process of obtaining accreditation as of July 1, 2023, unless three years have passed since the process began and the clinic is still not accredited.

Limits on Attendant Care

Along with a fee schedule, MCL 500.3157 also provides limits on family-provided attendant care. The statute refers to the provisions of the Michigan Workers' Compensation Act which limits family-provided attendant care to 56-hours per week. This limitation only applies if the attendant care is being provided directly or indirectly by an individual who is related to the injured person, an individual who is domiciled in the household of the injured person, or an individual with whom the injured person had a business or social relationship before the injury.[14] An insurer may contract with an injured person to pay benefits in excess of the 56 hour limitation.[15] In the instance of a policy that provides limited allowable expenses, an insurer will be required to offer a rider that provides coverage for attendant care in excess of the coverage limits.[16]

Provider Lawsuits

For decades it has been argued that providers were entitled to an independent cause of action. The *Covenant v. State Farm*[17] decision made it clear that providers did not have an independent cause of action, but provider suits continued if the provider was able to procure a valid assignment from the claimant. Under the new law, a health care provider listed in MCL 500.3157 is allowed to make a claim and assert a direct cause of action against an insurer to recover overdue benefits.[18] MCL 500.3157 sets forth multiple requirements for a health care provider to qualify for reimbursement under the No-Fault Act.

Statute of Limitations

MCL 500.3145 provides a one year back rule that limits benefits to those incurred one year prior to the commencement of a lawsuit. Since *Devillers v. ACIA*[19], this statute had been interpreted as having a firm one-year-back rule, meaning that there was no tolling, absent a showing of fraud. MCL 500.3145 has been amended to allow tolling with regards to submission of a claim. Now, the one-year-back rule is tolled from the date of a specific claim for payment of benefits until the date the insurer formally denies the claim. Tolling does not apply, however, if the person seeking payment does not act with "reasonable diligence, with that term being left undefined.[20]

Previously, if a claim was submitted, and the one-year deadline was coming up, a claimant would have to file a lawsuit to protect the right to seek payment for that claim. Now if a claim is submitted, the one-year-back rule is tolled until a decision is made on the claim.

Order of Priority

Under the Michigan No-Fault Act, with exceptions, if the claimant is the named insured on a policy, coverage under that policy is the highest in the order of priority. If the claimant is not a named insured, but has a spouse or resident relative with no-fault coverage, then that policy is first in the order of priority. Under the new legislation, this order remains the same, but there is a different order of priority with regards to the exceptions to the general rule.

When a claimant sustains injury while the operator or passenger of a vehicle in the business of transporting passengers, the insurer of the vehicle is responsible for the payment of benefits. When the claimant in this scenario is a passenger in certain buses, a taxicab, or a transportation network vehicle (such as Uber or Lyft), the insurer of the vehicle is only responsible if there is no other coverage available to the passenger. Now, if the passenger is in a vehicle that is insured under a policy that opted out of coverage for allowable expenses, he or she must look elsewhere first before seeking benefits from the insurer of the vehicle.[21]

Previously, if a person suffered accidental bodily injury as an occupant of a vehicle, and the person did not have coverage available through his or her own policy, or a spouse or resident relative, the person would seek coverage through the owner of the vehicle, and if none, then the operator of the vehicle. Now, a person who is an occupant of a vehicle in this circumstance will be required to seek coverage through the Michigan Automobile Insurance Placement Facility (MAIPF).[22]

With regard to motorcycles, the priority of responsible carriers remains the same: the insurer of the owner or registrant of the motor vehicle involved in the accident; the insurer of operator of the motor vehicle involved in the accident; the motor vehicle insurer of the operator of the motorcycle involved in the accident; and the motor vehicle insurer of the owner or registrant of the motorcycle involved in the accident. However, now, any policies that do not have allowable expenses coverage are excluded from the order of priority. If there are no policies that provide coverage for allowable expenses in the order of priority, then the claimant must seek benefits from the MAIPF.[23]

A person who sustains injury as a non-occupant, such as a pedestrian or bicyclist, must now seek benefits from the MAIPF, unless there is available coverage through his or her own policy or that of a spouse or resident relative.[24] Previously, a non-occupant would seek benefits from the insurer of the owner or registrant of the motor vehicles involved, and then the insurers of operators of motor vehicles involved in the accident.

Michigan Automobile Insurance Placement Facility (MAIPF)

The MAIPF is the insurer of last resort and is funded by the State of Michigan. The MAIPF provides benefits when no PIP coverage is applicable to the injury, no PIP coverage applicable to the injury can be identified, there is a dispute between two or more carriers concerning their obligation to provide benefits, or the identifiable coverage is inadequate due to financial inability to fulfill its obligations.[25] A significant revision to the statute, as referenced in the order of priority section, is that more claimants are eligible to receive benefits through the MAIPF.

A person seeking benefits through the MAIPF must submit an application, and the MAIPF or the carrier assigned to the claim must specify what materials constitute reasonable proof of loss within 60 days after receipt of the application.[26] The MAIPF or the carrier assigned to the claim are not responsible for interest for the period of time a claim is reasonably in dispute.[27]

A person seeking benefits must cooperate with the MAIPF, and the MAIPF may suspend benefits until it procures cooperation. Along with submitting the above-referenced application, cooperation includes the obligation to appear for an examination under oath (EUO).[28]

Previously, the statute required the assignment of a claim to a carrier for handling after an initial determination of eligibility. Now, the MAIPF may conduct its own investigation without referring the claim to a carrier, or can refer the matter to a carrier for further investigation.[29]

The default limit of coverage for a person seeking benefits under the MAIPF is $250,000. If a person is claiming benefits from the MAIPF as a result of a lapse in qualified health insurance coverage in the instance of a policy with no allowable expenses coverage, the coverage limit is $2,000,000.[30]

A claimant is required to notify the MAIPF of a claim within one year of the accident and is subject to the written notice and one-year-back limitation stated in MCL 500.3145. The MAIPF may bring an action for indemnity or reimbursement against a responsible insurer or third party. The action must be brought within two years after the assignment of the claim, one year after the date of the last payment made to the claimant, or one year after the date the responsible third party is identified.[31]

Previously, rates charged by medical providers were only required to be "reasonably necessary." MCL 500.3157 has now been expanded to include a fee schedule. The fee schedule applies depending on the nature of the medical care provided.

Out-Of-State Residents

Previously, out-of-state residents could seek no-fault benefits in certain scenarios. This has changed drastically. Now, a person who is not a resident of the state of Michigan is completely excluded from no-fault benefits unless the person owned a motor vehicle that was registered and insured in Michigan.[32] Based upon this revision, admitted insurers are no longer required to file a certification under MCL 500.3163.

Penalty Interest and Attorney Fees

It remains the law under MCL 500.3142 that no-fault benefits are payable within 30 days of the receipt of reasonable proof of the fact and of the amount of loss sustained, and overdue benefits are subject to penalty interest. However, the statute has been amended to add section 3142(3) which provides that, if a medical bill is submitted more than 90 days after the product, service, accommodation or training is provided, the insurer has an additional 60 days before benefits are overdue. This gives insurers additional time to evaluate claims that are not timely submitted before being subject to penalty interest.

It also remains the law under MCL 500.3148 that an attorney is entitled to a reasonable fee for advising and representing a claimant in an action for overdue benefits. That attorney fee can be charged against the insurer if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed making proper payment.

However, there are now several important requirements and exceptions to a claim for attorney fees. Specifically, an attorney cannot claim payment of an attorney fee until a payment for claimed benefits is *authorized* and *overdue*.[33] This would appear to preclude attorney fees asserted against claimants for voluntary and timely paid benefits. With regard to attorney fees for disputes involving attendant care or nursing services, attorney fees must not be awarded as to future payments ordered more than three years after the trial court judgment or order is entered.[34] This would likewise appear to be a limitation on an attorney's ability to charge a fee for payment of ongoing attendant care benefits resulting from a trial verdict or court ruling.

In addition, an attorney cannot be awarded an attorney fee where the attorney has a direct or indirect financial interest in the treatment, product, service, training, or accommodation provided to the claimant.[35]

An insurer continues to have a claim for attorney fees for defending a claim that was fraudulent or excessive. An insurer may now also seek attorney fees against a claimant's attorney for defending against a claim for which the client was solicited by the attorney in violation of Michigan law or the Michigan Rules of Professional Conduct.[36]

Claims Practices and Fraud Issues

The Michigan Department of Insurance Financial Services (DIFS) is taking on an expanded role in addressing claim practices for insurers. Under MCL 500.261(1), DIFS must maintain a website that advises that the department may assist a person who believes an insurer is not paying benefits, not paying timely, or otherwise not performing its obligations under the insurance policy. The website will also allow a person to submit complaints online with supporting documentation. DIFS must also maintain a page that allows a person to report fraud, unfair settlement practices, and unfair claims practices by an insurer.

MCL 500.6301 establishes an anti-fraud unit within DIFS that is a criminal justice agency dedicated to prevention and investigation of criminal and fraudulent activities. The agency may investigate all persons who have allegedly engaged in criminal or fraudulent activity. The agency may also conduct criminal background checks on individuals seeking licensure,

maintain records of fraudulent and criminal activity, and share information with other criminal agencies. The records within the agency are confidential and not subject to subpoena.

Pursuant to MCL 500.3157A, a new section under the statute, medical providers are required to submit to utilization reviews performed by an insurer. An insurer may require a provider to explain the necessity or indication for treatment in writing. If an insurer deems treatment to be overutilized or inappropriate, or the cost of a treatment to be inappropriate, the provider may appeal the decision to DIFS and will be bound by the decision. A provider who knowingly submits false or misleading documents or other information to an insurer, the MCCA, or DIFS, commits a fraudulent insurance act and is subject to criminal penalty.

Medical Examinations

While an insurer remains entitled to have a claimant submit to a mental or physical examination by a physician under MCL 500.3151, there are now stricter criteria for the physician performing the examination.

The new requirements indicate that, if the claimant is being treated by a specialist, the examining physician must specialize in the same specialty as the treating physician. Also, if the treating physician is board certified in a specialty, the examining physician must also be board certified in that specialty. The examining physician is also required to have an active clinical practice or teaching position within the year prior to the examination. If the claimant is being treated by a specialist, the active clinical practice or teaching position must be in that specialty.

Michigan Catastrophic Claims Association (MCCA)

For decades the Michigan Catastrophic Claims Association (MCCA) was instrumental in limiting exposure for insurers because it was required to reimburse no-fault carriers for claims paid in excess of the ultimate loss threshold. With policyholders being permitted to select policies that provide for limited allowable expenses, the MCCA will not be required to reimburse on policies that provide less than unlimited, lifetime benefits. Accordingly, policyholders who opt out of coverage for allowable expenses or select an allowable expense cap of $50,000, $250,000 or $500,000, cannot be assessed a premium for the MCCA.[37] In addition, retention levels will be increased for policies that were issued after July 1, 2013.

Insurance carriers will still be assessed a premium by the MCCA for polices that provide lifetime allowable expenses. Insurers can pass that premium on to policy holders with lifetime policies, but the premium must be equal to the amount charged by the MCCA.[38]

The MCCA will be subject to an independent audit every three years, beginning on July 1, 2022. If the assets of the MCCA exceed 120% of the liabilities, policyholders who were assessed an MCCA premium will be refunded the excess beyond 120% of liabilities.[39] The MCCA must also issue a consumer statement regarding claims submitted to the MCCA and the financial condition of the MCCA.

Residual Bodily Injury Claims

For decades, the minimum bodily injury policy limits in Michigan were $20,000 per person and $40,000 per occurrence. After July 1, 2020, the default minimum policy limits will now be $250,000 per person and $500,000 per occurrence.[40] The minimum policy limits for property damage remain at $10,000. A person may be able to select a policy with limits as low as $50,000 per person and $100,000 per occurrence if they complete the required form and the insurer makes certain necessary disclosures.[41] If the person did not make the choice, or if the required actions were not taken, the default policy is $250,000 person and $500,000 per occurrence.[42]

With limits being permitted for no-fault claims, damages available for residual bodily injury against an at-fault driver are expanded. An injured person can now seek economic damages in excess of the limits for allowable expenses available to the person.[43] This is in addition to a person's ability to claim damages for wage loss in excess of the monthly and yearly limits prescribed under the no-fault act.

An out-of-state resident is able to claim economic damages against an at-fault driver. The non-resident must show death, serious impairment of body function, or permanent serious impairment in order to recover damages.[44] A resident is not required to make such a showing as to economic damages.

As for the tort threshold, an injured party must still demonstrate a serious impairment of body function in order to obtain non-economic damages. The statute has been amended to codify the standard for serious impairment of body function as stated in the Michigan Supreme Court's *McCormick v. Carrier*[45] decision. "Serious impairment of body function" now means:

- It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.
- It is an impairment of an important body function which is a body function of great value, significance, or consequence to the injured person.
- It affects the injured person's general ability to lead his or her normal life, meaning it has had an influence on some of the person's capacity to live in his or her normal manner of living. Although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last. This examination is inherently fact and circumstance specific to each injured person,

must be conducted on a case by case basis, and requires comparison of the injured person's life before and after the incident.[46]

A person suffering damage to their vehicle can now claim damages (aka a "mini-tort" claim) against the responsible party for up to $3,000 to the extent that the damages were not covered by insurance.[47] Previously, the amount was $1,000. This is meant to cover the person's deductible. This change applies to motor vehicle accidents that occur after July 1, 2020. ■

About the Author

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

Endnotes

1 MCL 500.3107C and MCL 500.3107D
2 MCL 500.3107C(3)
3 MCL 500.2111F
4 MCL 500.2111F(7)
5 MCL 500.3181-MCL 500.3189
6 MCL 500.3109a(2)
7 MCL 500.3107D(7)(B); MCL 500.3109a(5)
8 MCL 500.3109a(2)(A)
9 MCL 500.3109a(2)(B)
10 MCL 500.3109a(2)(D)
11 MCL 500.3109a(2)(D)(i)
12 MCL 500.3109a(2)(D)(ii)
13 MCL 500.3109a(2)(E)
14 MCL 500.3157(10)
15 MCL 500.3157(11)
16 MCL 500.3107C(9)
17 500 Mich 191 (2017)
18 MCL 500.3112
19 473 Mich 562 (2005)
20 MCL 500.3145(3)
21 MCL 500.3114(2)(H)
22 MCL 500.3114(4)
23 MCL 500.3114(5), (6), and (7)
24 MCL 500.3115
25 MCL 500.3172(1)
26 MCL 500.3172(3)
27 MCL 500.3172(4)
28 MCL 500.3172a(2) and (3)
29 MCL 500.3173a(1)
30 MCL 500.3172(7)
31 MCL 500.3175(3)
32 MCL 500.3113(c)
33 MCL 500.3148(1)(A) and (B)
34 MCL 500.3148(4)
35 MCL 500.3148(5)
36 MCL 500.3148(2)
37 MCL 500.3104(7)(d)
38 MCL 500.3104(20)
39 MCL 500.3104(21), (22), and (24)
40 MCL 500.3009(1)
41 MCL 500.3009(5)
42 MCL 500.3009(8)
43 MCL 500.3135(3)(c)
44 MCL 500.3135(d)
45 487 Mich 180 (2010)
46 MCL 500.3135(5)
47 MCL 500.3135(3)(e)


Selected Insurance Decisions

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

Michigan Court of Appeals – Unpublished Decisions

Remand to determine whether insured is entitled to full roof replacement under ordinance and law coverage

Murad Management, Inc. v
Hastings Mutual Insurance Company
Docket No. 339206
Released December 18, 2018

Insured discovered a roof leak in its building due to a broken water pipe and submitted a claim to insurer, who agreed to pay for the interior water damage. The insurer denied coverage for the roof damage based on several exclusions, including that the damage was due to "wear and tear"; "rust, or other corrosion, decay, deterioration, hidden or latent defect or any quality in property that causes it to damage or destroy itself;" or "continuous or repeated seepage or leakage of water, or the presence or condensation of humidity, moisture or vapor, that occurs over a period of 14 days or more." Despite the denial, the insured proceeded to replace the entire roof, all of the trusses, and the roof-top air conditioning unit, and then sued defendant for breach of contract and demanded an appraisal.

The trial court granted summary judgment to the insurer finding that the roof damage fell within the "exclusion for deterioration and continuous or repeated seepage or leakage of water." The trial court also found there was no evidence of a "collapse," which the insured argued in the alternative.

The Court of Appeals found the insured was entitled to appraisal in light of the insurer's admission of liability for interior water damage and that the trial court erred by granting summary disposition as to the roof damage because there were conflicting expert reports. The Court of Appeals also noted that the trial court failed to address whether replacement of the undamaged portion of the roof fell within the Ordinance or Law coverage in the policy and that on remand, the trial court should determine whether a genuine issue of material fact exists concerning whether the insured is entitled to coverage for the full roof replacement under the terms of that coverage.

Summary disposition for insurer because home was not "residence premises"

Kwan Yee, et al. v Memberselect Insurance Company, et al.
Docket No. 341218
Released January 24, 2019

Plaintiffs owned a home in Milford, but moved in with their daughter in Novi in May 2012. In April 2015, plaintiffs were notified about a possible leak at the Milford home, and discovered widespread flooding. The leaks were caused by frozen and burst pipes and/or fittings, possibly due to corrosion. Defendant denied plaintiffs' property damage claim because the home was not their "residence premises" as required under the policy. Plaintiffs never notified defendant of the change in occupancy, which substantially increased the potential for a loss. The trial court granted defendant's early motion for summary disposition because plaintiffs' failure to notify defendant of the change in occupancy violated a policy requirement and resulted in the loss of coverage. The Court of Appeals affirmed, concluding that further discovery would not likely to support a contrary ruling.

"Claims made and reported" coverage does not require report of earlier non-covered claims

Illinois National Insurance Co v AlixPartners, LLP
Docket No. 337564
Released February 26, 2019

After paying over $18,000,000 to satisfy an arbitration award against its insured, plaintiff insurer determined that the claim wasn't covered under any of the three professional policies issued and, pursuant to its reservation of rights, sued to recover the sum paid. This opinion focuses on the "claims first made and reported" language in these policies, limiting coverage to claims that were both made and reported during a policy period or an extended reporting period.

Both the trial court and the Court of Appeals agreed that the insurer was wrongly conflating earlier claims for an abatement of management fees (a non-covered claim) with the subsequent arbitration claim for damages caused by the insured's failure to exercise due diligence in recommending the purchase of a company that fell far short of meeting profitability projections (a covered claim). The insured had no obligation to report non-covered claims. When confronted

with a covered claim, the insured reported that claim within the policy period covering that claim.

UM policy limits applied to an accident involving two different collisions

Estate of Gomez v Farm Bureau General Insurance Company
Docket No. 341812
Released March 19, 2019
Motion for Rehearing pending

Plaintiffs were injured when the vehicle they were occupying was struck first by an uninsured vehicle and then by a second vehicle with liability coverage of $100/300,000. Those policy limits were tendered. Plaintiff's own vehicle was insured with Farm Bureau under a policy that included UM coverage in the same amount as the liability policy. Farm Bureau moved for summary disposition on the lack of any UM coverage under its policy because the limits of UM coverage were to be reduced "by any amounts paid or payable for the same bodily injury . . . by or on behalf of any person . . . who may be legally liable for the bodily injury." The Court of Appeals found a question of fact about whether the injuries attributable to each collision were divisible. If so, plaintiffs could have a claim for UM coverage for injuries caused by the first collision and not by the second. The case was remanded for further proceedings.

Claims of defective construction are not covered

Skanska USA Building v M.A.P. Mechanical Contractors and Amerisure
Docket No. 340871
Released March 19, 2019

Relying on *Hawkeye-Security Ins Co v Vector Construction Co*, 185 Mich App 369 (1990) and its progeny, the Court of Appeals concluded that Amerisure had no duty to defend or indemnify a property owner's claim against the additional insured construction manager and the named insured subcontractor for the cost of repairing damage caused by either insured's work. Amerisure produced evidence "that all of the repair and replacement work was within the scope of plaintiff's original project" and plaintiff failed to produce any contrary evidence.

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Unpublished Federal District Court Decisions

UM coverage for injuries caused by insured vehicle operated by non-permissive driver

Sylvester v FCCI Insurance Company
E.D. Case No. 18-cv-10464
Released January 24, 2019

Plaintiff was working on a construction site when he observed a thief stealing the work truck provided by his employer. Plaintiff attempted to stop the thief by jumping on the running board and reaching into the driver's side window to grab the keys. He fell off the running board and was injured when the truck ran over him. FCCI insured the truck. Because the truck was being operated by a non-permissive user, there was no owner liability for the accident and no coverage for the driver. Plaintiff therefore made a claim for UM benefits as on occupant of the covered vehicle. FCCI denied the claim because (1) the injuries did not arise out of an accident, (2) plaintiff was not an occupant of the covered vehicle, and (3) the vehicle that injured him was not an uninsured vehicle. The trial court rejected all three positions, finding instead that: (1) the incident was an accident from the standpoint of the insured because the injury was neither intended nor expected, (2) plaintiff was "occupying" the vehicle because that term is defined in the policy to include "getting in, out, or off" the insured vehicle, and (3) the vehicle was uninsured for this particular accident because of the exclusion of coverage for non-permissive drivers.

Genuine issues of material fact preclude summary judgment on claim for burst frozen pipes

Tamika Keathley v Grange Insurance Company of Michigan
E.D. Case No. 15-cv-11888
Released February 4, 2019
Appeal pending

Insured sustained damage to her home as a result of burst frozen pipes. While there was no dispute that the policy covered a loss caused by frozen/burst pipes, defendant insurer did dispute 1) the timeliness of the notice of loss, 2) the property allegedly damaged, and 3) coverage for the mold condition allegedly known at the time coverage was bound. The main dispute was whether the insurer suffered material prejudice as a result of the plaintiff's delay in providing notice. The loss occurred sometime between January 28 and February 4, 2014, but plaintiff did not file a claim until April 4, 2014, after significant remediation and repair work had been completed. She submitted a claim for $132,000 with no invoices, receipts or documented proof of payment. Defendant denied the claim after it was unable to determine the true date of loss, the true extent of damage, and the actual repairs made. The court found that the insurer did suffer significant prejudice as a result of the delayed notice and was entitled to summary judgment. ■


ERISA Decisions of Interest

K. Scott Hamilton, *Dickinson Wright PLLC, khamilton@dickinsonwright.com*
Kimberley J. Ruppel, *Dickinson Wright PLLC, kruppel@dickinsonwright.com*

Sixth Circuit Update

Denial of benefits not arbitrary and capricious where plaintiff's subjective pain complaints, although supported by some objective evidence, were contradicted by other medical evidence

Jackson v Blue Cross Blue Shield of Michigan LTD Program
(6th Cir, Jan 22, 2019) (unpub)
Case No. 18-1542, 2019 WL 291966

Plaintiff complained of debilitating back pain that caused him to quit in his sedentary job as a telephone customer service representative. MRI scans after an injury in 2006 showed several herniated discs, and worsening pain cause him to stop working at the end of 2014. The plan administrator denied the plaintiff's claim for disability benefits, which the district court held was not arbitrary or capricious, and the Sixth Circuit affirmed.

The court first noted that "[t]o be sure, [the plaintiff's] MRI scans reveal disc degeneration and his electromyogram points to calf atrophy and absent reflexes," and the plaintiff also complained of pain, prompting his treating physician to conclude he was disabled from even a sedentary role. The court stated that "[i]f this were the only evidence in the record, [the plaintiff] might have a valid claim that [the] denial was arbitrary and capricious." But "the record also contains contrary evidence – including objective medical evidence – showing that [the plaintiff] can fully perform sedentary work," including a functional capacity evaluation ("FCF") which revealed he could complete 88% of tasks needed for a sedentary job.

The claim administrator also relied on several physicians, including two who "reviewed all of [the plaintiff's] medical files and independently determined that the record lacked compelling objective evidence to support" the claim. Moreover, "the record reveals that [the administrator] took [plaintiff's treating physicians'] opinions seriously," noting that the administrator's consulting physician opined there "is no reliable, valid and reasonably compelling evidence that [the plaintiff] has impairments preventing him" from working in a sedentary capacity, and another treating physician's conclusion of disability was "not supported by objective findings." Although the consulting physicians disagreed with the plaintiff's treating physicians' ultimate conclusions, they did not ignore them.

Plaintiffs were independent contractors, not employees, and therefore not plan participants under ERISA

Jammal v American Family Ins Co
914 F.3d 449 (6th Cir 2019)

In an interlocutory appeal, the Sixth Circuit in a 2-1 decision reversed the district court and held that current and former insurance agents were independent contractors, not employees, and therefore not entitled to ERISA benefits.

Nationwide Mut Ins Co v Darden, 503 US 318 (1992), set out the test "for determining who qualifies as an 'employee' under ERISA," the crux of which is "the hiring party's right to control the manner and means by which the product [of the individual's work] is accomplished." *Id* at 323. Several factors go into that determination, such as location of the work, whether the hiring party can assign additional work to the hired party, the amount of discretion the hired party has, how they are paid, tax treatment of the hired party, and similar considerations. *Id*. Moreover, "an express agreement between the parties concerning employment status is also a relevant consideration."

The district court held the plaintiff insurance agents were employees under the *Darden* test and therefore entitled to rights under ERISA. The district court certified its decision for interlocutory appeal. The Sixth Circuit reversed, clarifying the proper standard of review for decisions under the *Darden* test.

It first stated that it is clear that "the district court's findings underlying its holding on each of the *Darden* factors are factual findings, and the court's ultimate conclusion as to whether the plaintiffs were employees is a question of law." But it noted "we have yet to clarify whether and to what extent a court's conclusions about the individual factors that make up the *Darden* standard are factual or legal in nature." Although "[o]ther circuits . . . have explicitly considered this question and have come down on the side of treating these as factual matters subject to review for clear error," the Sixth Circuit parted company with its sister circuits and held that "we do not agree that a district court's conclusion relating to the existence and degree of each *Darden* factor is entirely a question of fact." Thus, the court held it is "appropriate for us to review *de novo* those determinations to the extent that they involve the application of a legal standard to a set of facts," and "it is also appropriate for us to review *de novo* the district court's weight

assigned to each of the *Darden* factors, given the legal context in which the claim has been brought."

Applying a *de novo* standard of review, rather than reviewing for clear error, the Sixth Circuit held that the "district court incorrectly applied the legal standards in determining the existence of the *Darden* factors relating to" two elements, and incorrectly weighed other relevant factors. It therefore concluded that the insurance agent plaintiffs were independent contractors, not employees, and were therefore not entitled to ERISA benefits or remedies.

Plaintiff was entitled to attorneys' fees under erisa for arbitrary and capricious denial of benefits

Guest-Marcotte v Life Ins Co of N America
(6th Cir, April 1, 2019) (unpub)
Case No. 18-1948, 2019 WL 1470910

Under ERISA, a "court in its discretion" may award attorney fees to a party if it achieved "some degree of success on the merits." 29 USC §1132(g) and *Hardt v Reliance Standard Life Ins Co*, 560 US 242, 252 (2010). In the Sixth Circuit, whether to award attorneys' fees is based on the "*King* factors" (*Sec of Labor v King*, 775 F2d 666 (6th Cir 1985), which are "(1) the degree of the opposing party's culpability or bad faith; (2) the opposing party's ability to satisfy an award of attorneys' fees; (3) the deterrent effect of an award on other persons under similar circumstances; (4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA; and (5) the relative merits of the parties' positions."

In *Guest-Marcotte*, the Sixth Circuit reversed the district court's denial of attorneys' fees in a 2-1 decision, stating the "facts of this case represent a paradigm case for when attorneys' fees are called for under 29 USC §1132(g)." It was "one of the rare instances" in which "a district courts' denial of fees under this statute must be reversed."

The court noted the claim administrator "denied benefits based on repeated and material misreading of the plan requirements," denied benefits even though her employer "recognized her medical impairments supported her inability to perform her duties," and misapplied a "non-existent objective-evidence requirement" that, although maybe not amounting to bad faith, "is about as culpable as it could otherwise get."

Life insurance benefits properly denied under plan's aerial navigation exclusion

Briggs v National Union Fire Ins Co of Pittsburgh, PA
(6th Cir, May 23, 2019) (unpub)
Case No. 18-1828, 2019 WL 2234596

A participant in a life insurance plan designated his dependent as beneficiary, and his mother as contingency beneficiary. The plan participant and his dependent were killed in a small plane crash in which the plan participant was the pilot. The plan excluded accidental death and dismemberment ("AD&D") coverage for loss caused by "flight in . . . any vehicle used for aerial navigation, other than as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline whether as a passenger, pilot, operator or crew member."

The contingent beneficiary claimed the AD&D benefits, which the administrator denied under the exclusion. She administratively appealed unsuccessfully, then sued the plan participant's employer (IPG) and the insurer (NUFIC).

The Sixth Circuit affirmed dismissal of the claim against IPG (providing a misleading benefits guide which did not mention the exclusion; equitable reformation; and failing to providing a plan summary) because there was no allegation the plan participant read or misunderstood the benefits guide, or that IPG misled him in any way. Moreover, failing to provide a plan summary does not allow a substantive remedy of benefits.

As to the claims against NUFIC under §502(a)(3), there was no allegation "that NUFIC took any actions that could support a plausible breach of fiduciary [duty] claim" because there was no alleged misrepresentation by NUFIC, or facts to establish that the plan participant read the guide and decided not to obtain alternative coverage because of it.

The Court concluded the plaintiff was "not entitled to benefits under §502(a)(1)(B) or any form of equitable relief under §502(a)(3). ■

Legislative Update: No-Fault Changes…And Other Insurance Issues

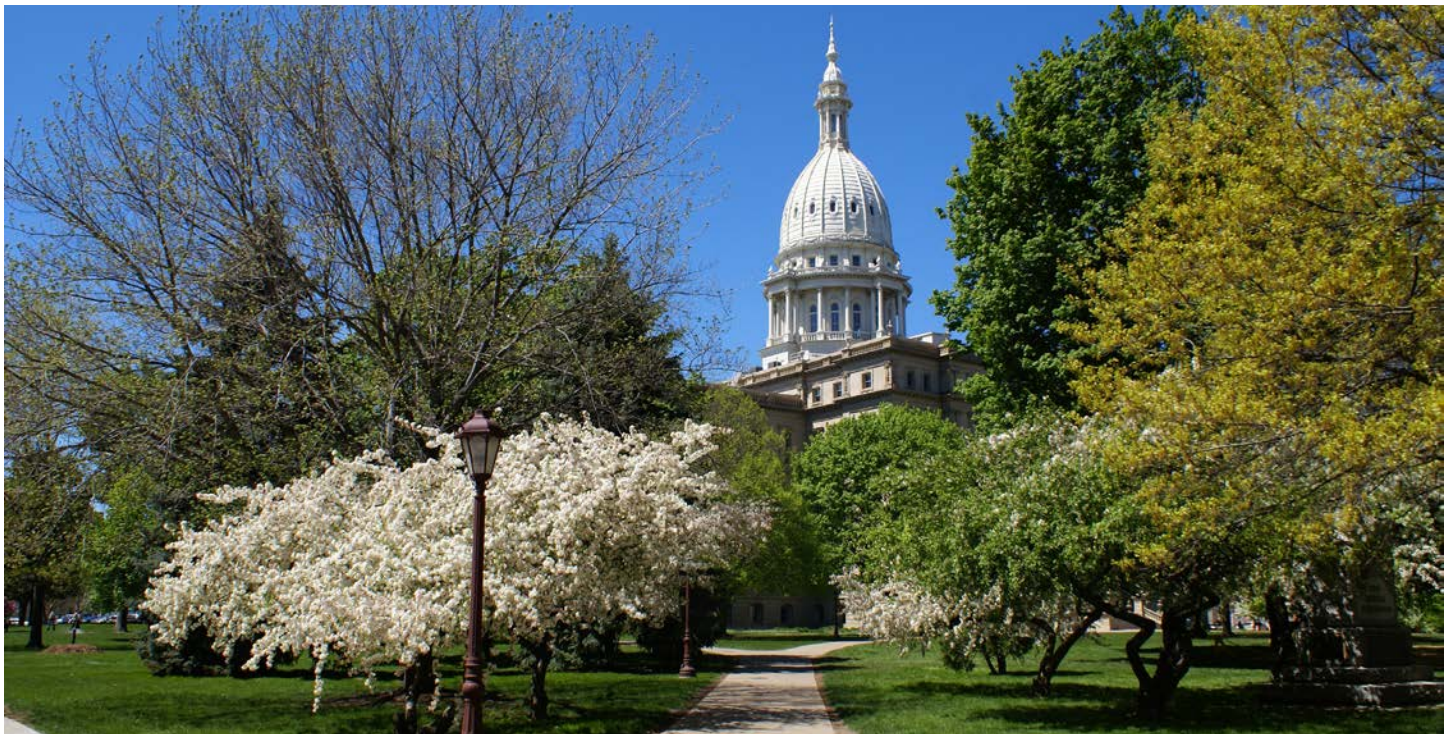
By Patrick D. Crandell, *Collins, Einhorn, Farrell PC*

On May 20, 2019, Governor Whitmer signed SB 1 into law, making sweeping changes to Michigan's no-fault automobile insurance system. The very-next week, the Legislature passed HB 4397, a follow-up bill addressing a number of additional issues related to those changes. There are a number of good articles in this Volume that walk through those changes and their potential impact.

Moving forward, the Legislature will meet through then end of June and then will take a two-month summer recess for members to spend time in their districts.

While the no-fault negotiations and debate sucked up most of the oxygen, members continue to introduce new bills (694 in the House and 364 in the Senate) and have referred a number of them to the House and Senate Insurance Committees:

- **HB 4398** – revises proof of insurance requirements to reflect elimination of no-fault
- **HB 4399** – revises insurance requirements under the limousine, taxicab and transportation network company act, to reflect elimination of no-fault
- **HB 4400** – revises bus insurance requirements to reflect elimination of no-fault
- **HB 4401** – revises requirements for municipal corporation group self-insurance pools to belong to the catastrophic claims association, due to the elimination of no-fault
- **HB 4402** – revises Albion College's vicarious liability for volunteers, to reflect elimination of no-fault
- **HB 4403** – revises nonprofit corporations' vicarious liability for volunteers, to reflect elimination of no-fault
- **HB 4404** – creates non-economic loss damages caps recoverable in personal injury actions involving the use of a motor vehicle: $280,000, unless the injury is part of the specified list, then the cap is $500,000
- **HB 4449** – removes certain chiropractic services from the list of non-reimbursable personal injury protection benefits ***Committee adopted H-1 Substitute on 4/18/19***
- **HB 4473** – requires workers compensation benefit cover-



age for post-traumatic stress disorder suffered by members of the police and fire departments, county sheriffs and deputies and conservation officers

- **HB 4479** – prohibits insurance premium increases for repair claims caused by damages due to certain road conditions
- **HB 4508** – amends the Insurance Code to change the definition of "travel insurance" and to add a new chapter to regulate the sale of that insurance
- **HB 4520** – creates the insurance agents standard of care act, which establishes a standard of care for liability
- **HB 4571** – eliminates reference to "colored" persons in the Insurance Code
- **HB 4651** – amends the Insurance Code to: (1) require the director to employ actuaries to review rate filings for compliance and excessiveness; (2) remove the excessive exception for reasonable competition; and (3) permit the director to commence a contested case regarding a rate filing
- **HB 4653** – prohibits automobile insurance rates based on certain factors
- **HB 4654** – requires the catastrophic claims association to disclose its actuarial computation used in setting rates
- **HB 4655** – prohibits automobile insurers from setting rates based on the insured's zip code
- **HB 4656** – allows persons over 62 to partially waive coverage for personal protection insurance benefits under an automobile insurance policy, for a reduced premium
- **HB 4657** – prohibits automobile policy cancellation or premium increase due to an accident for which the insured was not substantially at fault
- **HB 4660** – prohibits automobile insurance rates based on certain factors
- **HB 4685** – requires automobile insurers to offer coverage for a personal vehicle used for business pursuits, when used by a police officer, firefighter or emergency medical services personnel
- **SB 256** – creates a continuing education carry-over system for insurance producers who belong to a professional insurance association
- **SB 286** – requires the catastrophic claims association to disclose premium calculation information
- **SB 292** – requires the venue for all actions involving PIP benefits to be the county in which the injury occurred or in which the injured person resided ***Reported out of the Senate Insurance Committee on 5/7/19***
- **SB 295** – amends the Penal Code to add insurance fraud to the definition of "racketeering" ***Reported out of the Senate Insurance Committee on 5/7/19***
- **SB 301** – makes the catastrophic claims association subject to the open meetings act
- **SB 302** – makes a number of changes to the catastrophic claims association, including revising its membership, requiring an annual audit and making it subject to the open meetings act and the freedom of information act.
- **SB 305** – prohibits automobile insurance rates based on certain factors ***Reported out of the Senate Insurance Committee on 5/16/19***

Insurance & Indemnity Law Section 2018-2019 Officers and Council

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aoigwe@kaufmanlaw.com

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Nicole.Wilinski@ceflawyers.com

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Council Members

Nicholas S. Andrews,
NAndrews@fabiansklar.com
Term ends 2019

Patrick D. Crandell
Patrick.Crandell@ceflawyers.com
Term ends 2020

Ann-Marie E. Earls
annieearls@mdlmpc.com
Terms ends 2019

Amy L. Felder
alfelder@atainins.com
Term ends 2020

Rabih Hamawi
rh@hamawilaw.com
Term ends 2020

Steven M. Hickey
smh@hclawyers.com
Term ends 2020

Robert B. June
bobjune@junelaw.com
Term ends 2019

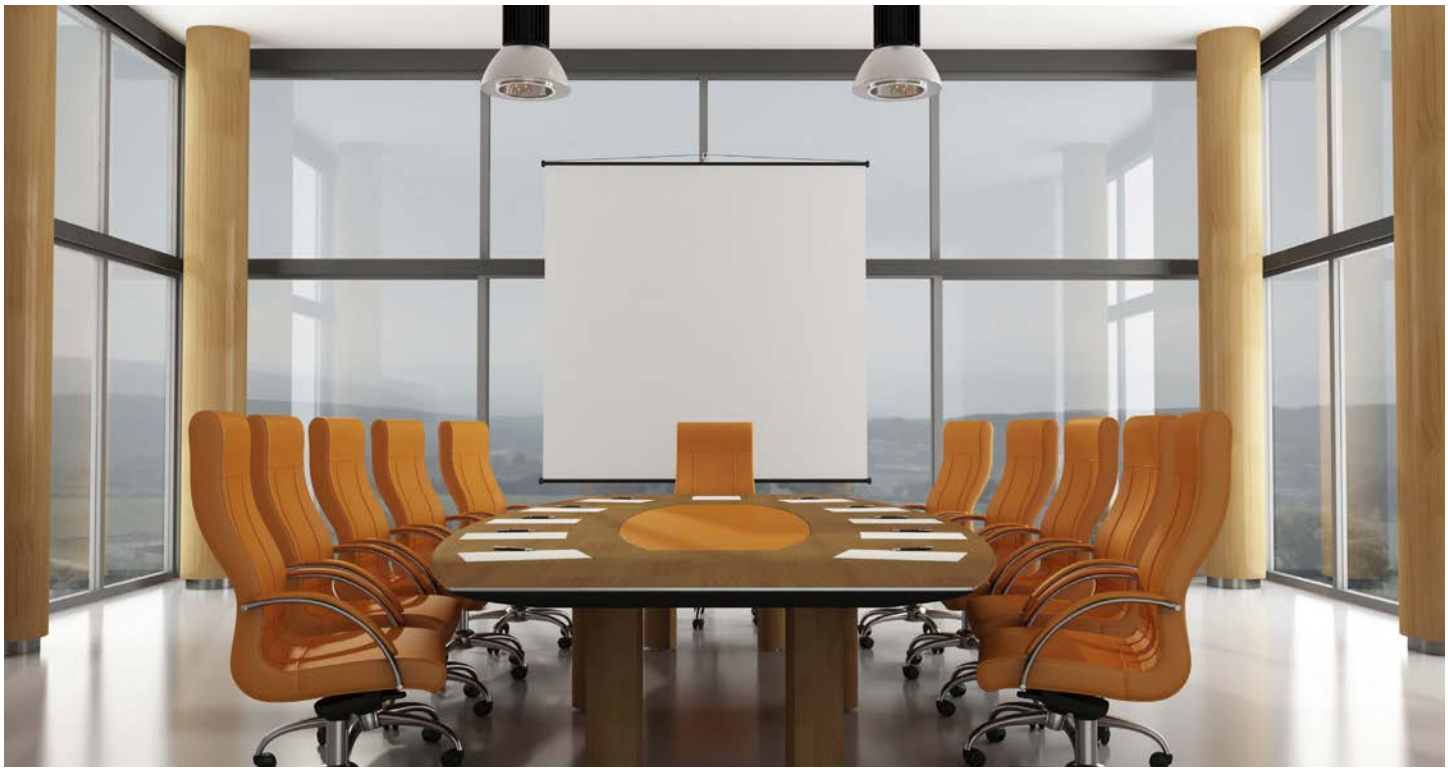
Gail L. Storck
StorckG1@nationwide.com
Term ends 2020

Renee T. Vander Hagen
Renee.vanderhagen@cfins.com
Term ends 2019

Milea M. Vislosky
mvislosky@msapc.net
Term ends 2019

Journal Editor
Hal O. Carroll
HOC@HalOCarrollEsq.com

Google Groups
Nina Abboud (248) 642-8591



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State Bar of Michigan

Michael Franck Building
306 Townsend St.
Lansing, MI 48933-2012

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