



## NO-FAULT REFORM – THE END OF AN ERA

For over 45 years, Michigan’s unique No-Fault Insurance Act has been an important part of this state’s legal landscape. As originally designed, one of the goals of the No-Fault 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 no-fault 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 No-Fault 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 no-fault 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 No-Fault 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 No-fault 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.

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 No-Fault 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 criteria.**

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 14<sup>th</sup> 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, SB 1 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 Legislation 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.

#### **NO-FAULT CHANGES – COVERAGE OPTIONS**

The linchpin 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. 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 no-fault 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, that the premium corresponds to the reduced premium levels set forth in subsections c(1)(a), c(1)(b) or c(1)(c), then 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 no-fault 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 no-fault 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 required 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?

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 no-fault 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 no-fault 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 no-fault “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 no-fault 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 No-Fault Act only if the injured person



was the named insured on a Michigan no-fault 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 no-fault 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 accident and Grandma is injured. Under the old version of MCL 500.3111, Grandma is entitled to recover Michigan no-fault 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 no-fault 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.**

Simply put, the question to be determined by the Legislature is whether or not it wants to grant

Michigan no-fault 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 no-fault policy. Under this scenario, both spouses will be able to obtain no-fault 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 no-fault 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 no-fault 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 no-fault 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 no-fault 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 no-fault 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 no-fault 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 no-fault 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 no-fault 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 no-fault 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 No-Fault 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?

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.

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 no-fault 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 no-fault 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 No-Fault 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 accommodations 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 no-fault insurance claims. This Bill effectively repeals section 3163, and provides that insurance companies are no longer required to provide Michigan no-fault 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 no-fault insurance system, whereby insurers of out-of-state residents traveling in the State of Michigan, were required to provide lifetime, unlimited no-fault 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 No-Fault 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 no-fault penalty attorney fees, because if there is no interest owing because the payment is not “overdue” there can be no award of no-fault 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 no-fault 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 no-fault 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 No-Fault Act under section 3109a(2), but lose their insurance coverage and fail to obtain no-fault coverage as otherwise required. It seems to the author that we are rewarding individuals who fail to comply with the No-Fault Insurance Act and obtain no-fault 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 no-fault 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.”