# Client Alert

# *LOOKING DOWN THE ROAD AT CHANGES TO THE MICHIGAN NO-FAULT ACT*

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## *EXECUTIVE SUMMARY*

It will likely take several years before the impact on premiums, claims, and litigation is fully determined as a result of no-fault reform. Certain provisions take effect immediately. Others, such as the choice of allowable expenses and MCCA provisions, will take effect on July 1, 2020, and some regulatory changes even 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. Instead, it is now the obligation of the insurer to decide whether a claim is payable before it can be barred by the one-year-back rule. In addition, insurers will now have more time to evaluate if claims 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 significantly impact the value of most claims. In contrast, catastrophically injured claimants without lifetime allowable expenses will certainly be limited. As a result, one would expect that the MCCA will be pared down in both its assets and liabilities, as well as overall claims triggering MCCA involvement. As a result of the revamped order of priority, an increased number of claimants will be required to seek coverage through the 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 proceeding to trial.

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

## *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 now 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. Allowable expenses include a broad array of medical related benefits which were previously unlimited in amount and scope. This has now drastically changed. Insurers, under MCL 500.3107C and MCL 500.3107D, may now sell automobile insurance policies with coverage for allowable expenses in limited amounts. 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.

As in the past, insurers can offer policies that are coordinated with the insured's health insurance. Now, under MCL 500.3109a(2), an applicant or named insured who selects the $250,000 coverage limit, is allowed to essentially opt out of allowable expenses and coordinate benefits based upon "other health or accident coverage." The insured would receive a 100% reduction in premium for allowable expenses. The reduction in premium would apply if the named insured, his/her spouse and all resident relatives have accident and health coverage that will cover them should they sustain injuries in a motor vehicle accident. The coverage under another auto-insurance policy (i.e. 3101) is not a requirement as it is under 3107D(1).

For coverage levels that have limits on allowable expenses, carriers are required to reduce premiums a certain percentage at each level. 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. 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.

## *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 freestanding 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. An insurer may contract with an injured person to pay benefits in excess of the 56-hour limitation. 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.

## *PROVIDER LAWSUITS*

For decades it has been argued that providers were entitled to an independent cause of action. The *Covenant v. State Farm* decision made it clear that providers did not have an independent cause of action, but provider suits continued, especially 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. 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*, this statute had been interpreted as having a firm one-year-back, meaning that there was no tolling, absent a showing of fraud. MCL 500.3145 has been amended to allow tolling with regard 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.

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 regard 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.

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 through 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).

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 the 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.

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. 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. 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. 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.

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).

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.

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.

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.

## *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. 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*. 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. 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.

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.

## *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, the examining physician is now subject to mandatory criteria as follows:

- The physician must be board certified in Michigan or another state;
- The physician must be licensed, board certified, or board eligible, and qualified to practice in the area of medicine appropriate to treat the person's condition;
- In the year prior to the examination, the physician must have devoted a majority of his or her professional time to either an active clinical practice, or instruction of students in an accredited medical school or clinical research program.

## *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. 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 policyholders with lifetime policies, but the premium must be equal to the amount charged by the MCCA.

The MCCA will be subject to an independent audit every three years, beginning on July 1, 2020. 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. 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. The default minimum policy limits are now $250,000 per person and $500,000 per occurrence. The minimum policy limit for property damage remains 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. 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.

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. 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 NFA.

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. 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* 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.

A person suffering damage to their vehicle can now claim damages (a/k/a a "mini-tort" claim) against the responsible party for up to $3,000 to the extent that the damages were not covered by insurance. Previously, the amount was $1,000. This is meant to cover the person's deductible.

Should you have further questions regarding details of this new legislation, or how it might affect you or your organization, please contact our attorneys at Collins Einhorn Farrell PC and we would be happy to assist.

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## AREAS OF PRACTICE

General & Automotive Liability Insurance Coverage

Matthew focuses his practice on defense litigation in first party No-Fault claims, uninsured and underinsured motorist claims, automobile negligence, premises liability, general liability, and contractual disputes. Matthew has extensive experience in defending catastrophic No-Fault claims, including claims for attendant care, home modifications, and vehicle modifications, as well as consulting insurers regarding catastrophic claims prior to litigation. Matthew has vast experience in all aspects of the litigation process from the discovery process through trial and routinely achieves successful results for his clients.

## PROFESSIONAL ACTIVITIES

- Association of Defense Trial Counsel (President from 2015-2016)
- Michigan Defense Trial Counsel
- Monroe County Bar Association
- Oakland County Bar Association
- State Bar of Michigan
  - Insurance and Indemnity Law Section (Council Member 2017-2018)

## PROMINENT OUTCOMES

Successfully argued and obtained summary disposition in Calhoun County Circuit Court in a lawsuit for first-party, no-fault benefits. A hospital claimed that, under an assignment clause in the hospital's consent-for-treatment form and the hospital's fee agreement with Cofinity/PPOM, it had standing to claim over $400,000 in no-fault benefits. The Court rejected this argument, finding that the assignment was invalid and that the Cofinity/PPOM agreement didn't give the hospital standing. The Court dismissed the case in its entirety.

Successfully argued and obtained summary disposition in a claim for first-party No-Fault benefits. The Court granted summary disposition and dismissed the case on the basis that the Plaintiff had failed to submit reasonable proof in support of her claim for attendant care benefits. Plaintiff was seeking over $300,000 in outstanding attendant care benefits.

Successfully argued and obtained summary disposition in a claim for first-party No-Fault benefits. The Court granted summary disposition and dismissed a large portion of the case on the basis that Plaintiff had failed to incur a claim for medical benefits. Plaintiff was seeking almost $1,000,000 in outstanding medical benefits.

## EDUCATION

- Wayne State University Law School (J.D. 2006)
- Western Michigan University (B.B.A. *cum laude,* 2003)

## ADMISSIONS

- State Bar of Michigan
- U.S. District Court, Eastern District of Michigan

## ACCOMPLISHMENTS & AWARDS

- Listed "Rising Star" by Michigan Super Lawyers® Magazine (2012-2018)