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From the Chair—Welcome 2021!

Nicole E. Wilinski
Collins Einhorn Farrell

I hope everyone is beginning to enjoy the nice weather that spring is bringing. As 2021 progresses we continue to navigate a new normal with continued use of video communications and restrictions on in person gatherings.

However, the Insurance and Indemnity Section has been resilient and continues to meet and provide educational services via ZOOM. It remains my hope that we will again be able to be together in person for the 2021 annual meeting.

Autonomous Vehicle Webinar

We are currently excited to be in the final planning stages of a webinar on Autonomous Vehicles. As use and development of autonomous vehicles increases, it is growing increasingly important to understand the technology behind the vehicles as well as the impacts on liability and insurance issues in the legal field. We are privileged to work with presenters Daniel Hinkle and Kellie Howard-Goudy to discuss the technology and legal implications associated with autonomous vehicles.

For those who missed the April 20th program and are interested, we do have a video of the presentation. If you'd like view it, please send me an email: *Nicole.Wilinski@ceflawyers.com*.

New Council Member

We are excited to welcome Glen Pickover to the council. Glen stepped up to fill a vacancy.

Scholarship Topic

This year our scholarship topic ties in with our April Webinar and asked laws students to discuss what impact autonomous vehicle use will have on one or two of these areas: theories of civil and criminal liability, privacy issues, fraudulent claims and/or who is responsible for carrying insurance. The scholarship recipient will be selected at our April meeting and their winning essay will be published here in the next *Journal.* Stay tuned!

Next meeting, Suggestions and Section Involvement

Please continue to follow our Facebook Page for information on upcoming meetings, educational events and notice of the Scholarship recipient.

If you have suggestions for topics or speakers for programs, please share!

Finally, this section is made up of a diverse group of policyholder and insurer sided attorneys. If you have any interest in getting more involved with the council, a great way to start is by attending a meeting or writing an article for Journal.

I hope to see many of you this year at our events and meetings whether that ends up being virtually or in person. ■

Editor's Notes

By Hal O. Carroll, *www.HalOCarrollEsq.com*

The *Journal* is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The *Journal* – like the Section itself – takes no position on any dispute between insurers and insureds. All opinions expressed in contributions to the *Journal* are those of the author. We welcome all articles of analysis, opinion, or advocacy for any position.

Copies of the *Journal* are mailed to all state circuit court and appellate court judges, all federal district court judges, and the judges of the Sixth Circuit who are from Michigan. Copies are also sent to those legislators who are attorneys.

The *Journal* is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at HOC@HalOCarrollEsq.com. ■

Too Much or Not Enough?

An Inside Look at Michigan's New Utilization Review Process

By Matthew LaBeau, *Collins Einhorn Farrell* [1]

Executive Summary

When the Michigan No-Fault Act was reformed on June 11, 2019, one of the many changes was the implementation of a utilization review process. This new process allows insurers and the Michigan Catastrophic Claims Association (MCCA) to seek further information, and make determinations, regarding treatment, products, services, or accommodations that were potentially overutilized or inappropriate. It also allows for providers to appeal these determinations to the Department of Insurance and Financial Services (DIFS).

Per the No Fault statute, the specific rules governing the utilization review process were left for DIFS to define through the administrative rules making process. Effective December 18, 2020, DIFS has promulgated rules that provide procedures for insurers and the MCCA to request more information from providers, and make determinations as to overutilization and appropriateness of treatment, products, services, or accommodations. The rules also provide for appeals of determinations by providers to DIFS, and judicial review of DIFS decisions by trial courts.

While these rules provide further guidance on the utilization review process, there are still several questions left unanswered. Once utilization reviews are implemented for claims throughout Michigan, various issues will likely be addressed through litigation. This article outlines the obligations for insurers and providers under the new rules for utilization reviews, and explores certain areas that are yet to be determined.

Recent Changes Brought On by No-Fault Reform

On June 11, 2019, the Michigan No-Fault Act was amended, bringing sweeping changes to several provisions of a law that had been substantially the same for almost 50 years. Prior to these amendments, there was no mechanism to address the overutilization or appropriateness of treatment outside of the normal claims adjustment process and subsequent litigation.

One of the changes ushered in by No-Fault reform was the addition of MCL 500.3157a, which provides for utilization reviews and related requirements. A utilization review is defined as "the initial evaluation by an insurer or the [Michigan Catastrophic Claims Association] of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided …. based on medically accepted standards."[2]

By rendering treatment, services, products, or accommodations to an injured person who is covered by personal injury protection (PIP) benefits, a physician, hospital, clinic, or other person is considered to have agreed to two obligations[3]. The first is to submit necessary records and other information concerning the treatment, products, services, or accommodations provided for the purpose of a utilization review. The second is to comply with any decision rendered by the director for DIFS.

Under this new statute, DIFS is required to promulgate rules under the Administrative Procedures Act to establish criteria for utilization reviews based on medically accepted standards and provide procedures for the utilization reviews[4]. The procedures are required to address acquiring records, bills, and other information. In addition, they are required to address allowing an insurer to request an explanation and requiring a provider to provide an explanation for the treatment, products, services or accommodations provided. The procedures are also required to address the appeal of DIFS determinations by insurers and the MCCA.

Under MCL 500.3157a, an insurer or the MCCA may require a provider to explain the necessity or indication for treatment, products, services, or accommodations under the procedures promulgated by DIFS[5]. In addition, if an insurer or the MCCA determines that the treatment, products, services, or accommodations were overutilized or that the cost was inappropriate, a provider may appeal under the rules created by DIFS.[6]

After a lengthy public comment period and several revisions, DIFS issued its final rules effective December 18, 2020. These rules define the scope of utilization reviews, as well as set forth procedures for insurers to initiate utilization reviews and appealing certain adverse determinations. The rules also provide for judicial review of decisions issued by DIFS, an issue not specifically addressed by MCL 500.3157a.

The Scope of Utilization Reviews[7]

Utilization review rules are only applicable to benefits for treatment, training, products, services, and accommodations[8] provided to an injured person who is insured under a Michigan no-fault automobile insurance policy. The rules also only

apply to treatment and training provided *after* July 1, 2020. The rules promulgated by DIFS apply to all automobile insurers providing coverage through a no-fault policy, a managed care plan, or through the Michigan Assigned Insurance Placement Facility (MAIPF). The rules also apply to the Michigan Catastrophic Claims Association (MCCA)[9].

The rules make it clear that insurers and the MCCA are not limited in their ability to contract with a medical review organization to perform utilization reviews on their behalf. The use of a medical review organization, however, does not absolve an insurer from complying with its obligations under the Michigan No-Fault Act or the administrative rules for utilization reviews.

The Request for Explanation[10]

A utilization review can be requested by an insurer or the MCCA when the treatment or training provided is:

- Not usually associated with a diagnosis or condition;
- Longer in duration than is usually required for a diagnosis for condition;
- More frequent than is usually required for the diagnosis or condition; or
- Extends over a greater number of days than is usually required for the diagnosis or condition.

In order to trigger the review, an insurer must submit a request to the provider[11] to explain the necessity or indication of the treatment in writing. The written request for information must be submitted within thirty (30) days of receiving a bill related to the treatment or training.

Once a provider receives a request for information, the provider must respond to the request within thirty (30) days of receiving the request. An insurer may request that the provider include medical records, bills, and other information concerning the treatment or training provided. If the request for medical records, bills, or other information exceeds the information customarily submitted to the insurer with a bill, the insurer must reimburse the provider at a reasonable and customary fee, plus the actual costs of copying and mailing. The provider must be reimbursed within thirty (30) days of the request for information by the insurer.

Determinations by the Insurer[12]

After reviewing the provider's written explanation, an insurer may make a determination that the provider overutilized, otherwise rendered or ordered inappropriate treatment or training, or that the cost[13] of the treatment or training was inappropriate. The insurer must issue a written notice of this determination, and must do so within thirty (30) days of receipt of the written explanation from the provider.

The written notice of the determination must include specific information. This includes:

- The criteria or standards the insurer relied on in making the determination;
- Specific reference to the insurer's utilization review process and procedure;
- The amount of payment to the provider based on the results of the determination;
- An explanation of the difference between the amount paid and the amount billed;
- If applicable, a description of any additional records the provider must submit to the insurer in order to reconsider its determination;
- The date of the determination;
- A form to appeal the decision to DIFS.

As suggested above, a provider can appeal to DIFS the denial of a provider's bill on the basis that the provider overutilized or provided inappropriate treatment or training, or that the cost was inappropriate. A provider is permitted to pursue such an appeal regardless of whether the insurer has requested a written explanation.

This section of the rules implicates an interesting issue. While the rules are set up for the insurer to initiate the utilization review process, the rules suggest that a provider can appeal *any* denial of a provider bill, as long as it was based on overutilization, inappropriate treatment, or inappropriate cost. For example, this would suggest that where an insurer did not request information pursuant to the rules, but denied on the basis of a medical examination, a provider could appeal to DIFS. Given the use of the word "may" for insurers and providers alike, the parties can likely choose to forego the utilization review process entirely, and address the claim through the normal litigation process. This will likely be resolved through litigation.

The Appeals Process to DIFS[14]

A provider must appeal a determination made by an insurer within ninety (90) days of the date of the disputed determination. The appeal must be submitted on a form approved by the department.[15] Within fourteen (14) days of receiving the appeal, DIFS must notify the insurer and injured person of the appeal and request any additional information necessary to review the appeal. Within twenty-one (21) days of the date of the DIFS' notice, an insurer or the MCCA may file a reply.

Within twenty-eight (28) days of the insurer's reply, the director of DIFS is required to issue a decision. The director may take an additional twenty-eight (28) days upon written notice to the insurer and the provider. The director must base

his or her decision upon the written materials submitted by the parties. If the insurer does not file a reply, then the director will make a decision based on the information available.

Judicial Review of the DIFS Decision[16]

A party can seek judicial review of a DIFS decision pursuant to MCL 500.244(1), which permits a person aggrieved by a decision under the Michigan Insurance Code to invoke judicial review under the Administrative Procedures Act.[17] This permits judicial review only after the party has exhausted all the available administrative remedies. A petition seeking judicial review of the determination must be filed in the county where the petitioner resides, has a principal place of business, or in Ingham County Circuit Court[18].

A petition must be filed within sixty (60) days of mailing the notice of decision from director of DIFS. Within sixty (60) days of the filing of the petition, DIFS must provide the entire record of the proceedings unless the parties stipulate to shorten the record. Any party unreasonably refusing to shorten the record can be taxed additional costs.

The review is conducted by the court without a jury and is confined to the record, unless evidence of a procedural irregularity is necessary. The court may request oral argument and the submission of written briefs. In addition, a party can seek leave of the court to present additional evidence to DIFS, and the court can order additional evidence be taken by DIFS. The party must make a showing, however, that there was an inadequate record made to DIFS or that additional evidence is material, and there is a good reason for failing to submit it to DIFS in the original proceeding.

The court may affirm, reverse, or modify the ruling by DIFS. The Court has the authority to set aside the ruling by DIFS if the substantial rights of the petitioner have been prejudiced because the decision or order is:

- In violation of the constitution or a statute;
- In excess of the statutory authority or jurisdiction of the agency;
- Made upon unlawful procedure resulting in material prejudice to a party;
- Not supported by competent, material and substantial evidence on the whole record;
- Arbitrary, capricious or clearly an abuse or unwarranted exercise of discretion; or
- Affected by other substantial and material error of law.

Requirements of Insurers[19]

Within sixty (60) days of the effective date of the rules[20], i.e. February 16, 2021, insurers must have a utilization review program in place to review records and bills. The program must:

- Provide for bill review, including whether the provider charges for treatment and training comply with the Michigan No-Fault Act;
- Make determinations regarding the appropriateness of treatment and training based on medically accepted standards; and
- Issue determinations regarding whether treatment or training was overutilized or inappropriate, and if the cost was inappropriate.

"Medically accepted standards" means the most appropriate practice guidelines for the treatment or training provide to an injured person. These practice guidelines may include generally accepted practice guidelines, evidence-based practice guidelines, or any other guidelines developed by the federal government or national or professional medical societies, boards, and associations.[21]

Insurers must submit the program to the director of DIFS on an annual basis on a form approved by DIFS[22]. No later than ninety (90) days after submission of the carrier's plan[23], DIFS must issue either a conditional or unconditional certification. The director may issue an unconditional certification for a period of three (3) years. The director may issue a conditional certification if the insurer does not substantially satisfy the stated criteria and the insurer agrees to take corrective action. At any time, the director may modify the certification from unconditional to conditional if the director determines that the insurer fails to comply with the rules for utilization review. The certification can be revoked completely if the insurer violates the rules and fails to complete a corrective action plan.

Insurers must apply for renewal of its certification no less than ninety (90) days prior to the expiration of the current certification. Each insurer must submit an annual report no later than March 31 of each year regarding utilization review data and activities. The report will be subject to disclosure under the Michigan Freedom of Information Act[24]. Any proprietary information submitted by insurers is exempt from disclosure. Insurers must also retain copies of all requests, explanations, and determinations issued under the utilization review rules for at least (2) two years. The records must be submitted to DIFS upon request.

Issues Left to Be Determined

As referenced above, it is up to the insurers and the MCCA to develop a utilization review program. Certainly, it is possible that some carriers will create and administer their own program from scratch. However, it seems more likely that insurers and the MCCA will engage a medical review organization to assist with development of the program and, perhaps,

perform some or all of the utilization review. Previously, these medical review organizations were used to perform bill audits based on the CPT codes, to assist with evaluating the reasonable and customary charges for allowable expenses. These organizations can also be utilized for similar purposes in determining whether a certain treatment modality, or the length or frequency of treatment, is generally associated with a certain condition or diagnosis. One would expect that a medical professional would be involved in the process.

In litigation, such organizations have been subject to evidentiary foundation challenges by providers and claimants demanding to know the specific criteria and data used to reduce charges in conjunction with billing audits. With the rules directly referencing these organizations, insurers are further bolstered in using these organizations. However, it will be important that these organizations make their criteria and data available if requested.

It does not appear to be mandatory for an insurer to initiate the utilization review process to challenge a provider's claim. It also appears that providers may be able to utilize the appeal process to DIFS without the insurer performing a utilization review. Whether an insurer or provider avails themselves of the process may depend on whether they believe DIFS to be a more advantageous venue to challenge the issue. If they avail themselves of the process, the administrative process must be exhausted before litigation can commence.

If the utilization review process truly is permissive, and not an exclusive remedy, then the benefits of this review process are mitigated. It would seem that a goal of this process would be to streamline disputes over utilization and cost, and, subsequently, reduce litigation and expense to the parties. If parties can pick and choose whether to participate in this process, it could lead to a chaotic and costly system where insurers and providers are subject to two adjudication systems with varying results on the same issues.

If litigation is commenced, the scope of that litigation is yet to be determined. Obviously, if neither party avails themselves of the utilization review process, then litigation would proceed in same fashion as any standard no-fault case. However, if the process is utilized, then the litigation would essentially be an appeal of the DIFS ruling with a highly deferential standard of review. It is possible that future challenges will shape whether that deferential standard of review applies, or whether such a review would be "de novo" with no deference to the underlying decision as if it never happened. Case law will undoubtedly provide further guidance on this process.

Furthermore, what constitutes "medically accepted standards" is vague. Providers and insurers will no doubt have vastly different positions on what constitutes medically accepted standards. This is one of the issues most likely to be litigated extensively.

Lastly, the utilization review rules make an insurer subject to interest if DIFS finds that a provider is entitled to payment under MCL 500.3142. This is found nowhere in MCL 500.3157a, and would seem to be modifying the reasonable proof standard referenced in MCL 500.3142, and case law making this generally a question for the jury to decide. It will be interesting to see if this automatic entitlement to interest is upheld. It also may give rise to additional lawsuits by providers seeking interest and attorney fees, under MCL 500.3148, only.

Conclusion

The new rules promulgated by DIFS provide the procedures that providers and insurers are required to follow should they implement a utilization review process The rules also provide several requirements that insurers and the MCCA must follow when implementing these reviews. There are strategic considerations for all parties when determining whether to avail themselves of the utilization review process, including the nature and extent of the review. There are also several questions left unanswered which will require intervention by the courts. It will be essential for insurers, providers, and their counsel to become familiar with what these rules say, and don't say, going forward. ■

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 This document is for the purpose of providing information and does not constitute legal advice and should not be construed as such. This document or any portion of the document is not to be distributed or copied without the express written consent of Collins Einhorn Farrell PC.

2 MCL 500.3157a(6)

3 MCL 500.3157a(1)

4 MCL 500.3157a(3)

5 MCL 500.3157a(4)

6 MCL 500.3157a(5)

7 R 500.62

8 For the remainder of this article, the phrase "treatment or training" refers to "treatment, training, products, services, and accom-

modations", which mirrors the usage of the phrase throughout the no-fault reform legislation, including MCL 500.3157(13)(k). Of note, though, is while the rules refer to "training", MCL 500.3157a makes no such reference.

9 While the Rules indicate throughout that insurers and the MCCA can avail themselves of the utilization review process, in most cases it will be insurers utilizing this process. Therefore, this article will reference the applicability of the utilization review rules as they relate to insurers, only.

10 R 500.63

11 A provider includes a physician, hospital, clinic, or other person providing treatment, training, products, services, and accommodations to an injured person. R 500.61(l)

12 R 500.64

13 It should be noted that the cost of treatment or training is not mentioned as a trigger to initiate a utilization review, but the rules reference it as appropriate issue for determination.

14 R 500.65

15 The approved DIFS Provider Appeal Request form is attached as Appendix 1.

16 R 500.65(7)

17 MCL 24.301-306

18 This would be a departure from the normal venue rules for a no-fault lawsuit Michigan. Currently, an insurer is deemed to conduct business in every county in the state, thus, making it subject to being sued in any county.

19 R 500.66

20 The effective date of the rules is December 18, 2020.

21 R 500.61(i)

22 The approved form for the program is attached as Appendix 2

23 DIFS can extend the time an additional 30 days upon written notice to the insurer.

24 MCL 15.231-246

Builder's Risk Insurance – Another Insurance Industry Misnomer

By Michael S. Hale, *Hale & Hirn, PLC*

The insurance industry is famous for making things complicated. Some examples include that "personal injury" coverage under a commercial general liability policy is coverage for *nonbodily* injury. "Social engineering" crime coverage is a complicated way of saying coverage for email scams. "Hired" automobile liability coverage is coverage for liability for renting vehicles without a driver.

A builder's risk policy presents another misnomer. While it is designed to cover the structure going up, it is typically the owner's risk of loss if there is a fire or other casualty. Many view this type of "builder's risk" coverage as liability insurance. The insurance industry has made this even more confusing in classifying builder's risk policies as "inland marine" policies. Why is this policy not called construction property insurance or something similar? By the way, should it be referred to in the possessive with an apostrophe, or not?

The exposures for construction property insurance are significant and different from standard property insurance or homeowners' insurance. This area is plagued with potential problems worth reviewing. This article examines some of the issues in advising clients about "builders risk" insurance.

Following the much talked about June 2020 Michigan Supreme Court decision of *Skanska USA Building Inc v MAP Mechanical Contractors, Inc.*,[1] unintentionally faulty subcontractor work that damages an insured's work produce can be an occurrence. This often involves defective workmanship that must be repaired, a major risk to contractor's and their insurers. Why this is so important to insureds is that it can mean that the burden will shift to the insurer to show the applicability of an exclusion on the policy to get out of coverage on a dispositive motion.

While defective work and products are not covered under builders risk insurance, such policies vary among insurers and may cover other critical perils and exposures to loss in commercial or residential construction. Needless to say, the terms and conditions of such policies are important.

A builder's risk policy presents another misnomer. While it is designed to cover the structure going up, it is typically the owner's risk of loss if there is a fire or other casualty.

What Is Covered?

Builder's risk insurance is property insurance while a structure is under construction whether as a new building or a renovation to an existing structure. Such policies are used for both commercial buildings and residential structures. But why is a separate policy needed when most homeowners and commercial property insurance policies do not exclude damage to buildings being constructed or renovated? Don't these policies cover newly constructed buildings automatically? Not exactly.

Most standard property policies limit coverage provided for newly constructed buildings to up to thirty days and the terms of such insurance are limited. Insurance company underwriters for standard homeowners and commercial property insurance recognize that buildings going up are a different kind of risk and will often push for the purchase of a different policy. It also may be less expensive to insure buildings going up as the value increases over time. Further, there are unique risks that need to be covered such as building materials and soft costs such as architect fees.

Who Buys It?

Builder's risk policies are often purchased by the owner and this is as it should be. However, sometimes general contractors will build such premiums into the construction costs and attempt to insure the owner out of convenience. This should be avoided wherever possible.

A cardinal sin in all of property and casualty insurance is allowing someone else to insure a client's property for any reason. This author has seen many cases of major loss to landlords and other property owners for allowing tenants or contractors to insure the client's buildings. In most cases where the general contractor buys the builder's risk property insurance, the owner never will see the policy and may not even know if it is cancelled.

Builder's risk insurance is property insurance while a structure is under construction whether as a new building or a renovation to an existing structure. Such policies are used for both commercial buildings and residential structures. But why is a separate policy needed when most homeowners and commercial property insurance policies do not exclude damage to buildings being constructed or renovated?

Why The AIA's 2017 Construction Agreement Insurance Exhibit Is Flawed on Builders Risk

This author drafted an article in the July 2018 *Journal of Insurance and Indemnity Law* on the problems with the AIA's 2017 Construction Agreement from the perspective of owners.[2]

As to builders risk, the Insurance Exhibit requires that the owner obtain the builder's risk coverage and do so on an "all-risks" basis and that property coverage be maintained beyond the substantial completion of the job, including existing structures that most builder's risk policies do not automatically include. There is also no requirement that the contractor insured underground property nor are there requirements for flood or earthquake coverage.

In short, while the AIA standard contract and insurance exhibit are good starting points, insurance coverage counsel should be aware of other issues that should be addressed in representing the owner or the contractor.

Avoiding Common Pitfalls in Buying Builders Risk Insurance

Some of the pitfalls that this author has discovered in builders risk insurance are:

1. **Insurable interest, risk of loss and "insureds."** Construction agreements should be carefully reviewed as to when the risk of loss transfers, particularly if the general contractor is providing the builders risk. The owner should never be simply listed as a "loss payee" on such a policy because it would have not independent rights to pursue coverage and its rights to insurance would be only derivative of the contractor. One of the most common problems in this area is not listing the right named insureds.
2. **Existing structures**. Standard builders risk policies bar coverage for "[l]oss or damage to property in existence at the commencement of this policy" that is not part of the construction. Existing buildings should be included separately on the policy. This is often missed. For example, where an existing electrical system was not included in the total insured values shown on the schedule, there would be no coverage for subsequent fire damage to it.
3. **Liability Insurance.** Builder's risk is not liability insurance! Separate commercial general liability insurance of the owner, general contractor and subcontractors should be analyzed carefully under different criteria. The owner should never rely upon the general contractor's liability

insurance as an "additional insured" and should separately maintain its own CGL coverage.

4. **Completion clauses.** Typically, coverage starts on the policy inception date but when it ends is a more perplexing question. Unlike other property insurance, builders risk policies have automatic termination provisions than can occur before the policy end date. Some policies provide that coverage stops upon substantial completion. Others say coverage automatically terminates when a Certificate of Occupancy is granted by the municipality. Still others say no coverage applies where the building is even partially occupied during construction. There is a major potential gap here which the owner should be particularly aware of so that standard commercial property insurance can be secured before the "automatic" termination of the builders risk policy. Competent insurance requirements provision drafting is particularly crucial in this area.
5. **Deductibles.** If the general contractor is providing the builders risk policy and has a high deductible such as $50,000, those costs should be the obligation of that contractor. Again, insurance requirements and indemnity provisions are particularly important here.
6. **Coinsurance**. Some builder's risk policies require that insurance be maintained to a certain percentage of the completed value of the structure and if this is not met, a penalty would be imposed at the time a loss settlement. Such clauses should be negotiated away with the insurer where possible.
7. **Underground property**. Many builders risk policies contain exclusions for underground property. Where insuring sewer contractors or underground property of any sort, this should be addressed with the underwriter.
8. **Flood and earthquake coverage**. Like standard property insurance, these perils are typically excluded, and separate coverage is needed where exposures exist.
9. **Soft Costs and Business Interruption**. A soft cost is an indirect loss arising from a delay due to a casualty. Examples of this are construction loan interest, additional insurance premiums, legal fees, building permits and equipment rentals. This is not business interruption insurance! Direct loss of income from the casualty needs to be separately insured on the builders risk policy.
10. **Wrap-up programs**. So called "wrap-up" insurance programs are also known as Owner Controlled Insurance Programs ("OCIP's). These programs are where the general contractor buys all insurance for all involved including the owner and all subcontractors. This kind of insurance can be plagued with peril given that such parties may not ever get a copy of the policy. We frequently see gaps in this area. Some construction agreements allow the subcontractor to fill-in the gap if coverage is determined not to exist under the wrap-up for a particular needed area and then bill back the general contractor. As you might expect, this typically results in a disagreement with the general contractor. Attempt to rely upon the owner's own insurance, where possible. Where not possible, obtain insurance coverage counsel to review the coverages.

About the Author

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Endnotes

1 *https://courts.michigan.gov/Courts/MichiganSupremeCourt/Clerks/Recent%20Opinions/19-20-Term-Opinions/159510.pdf*,

2 See "Potential Issues with AIA's 2017 Construction Agreement Insurance Exhibit," *Journal of Insurance and Indemnity Law,* Vol. 11 No. 3 July 2018.

Is Workers' Compensation a Buzzkill When it Comes to Reimbursing for Medical Marijuana Treatment?

By Cassandra M. Lee-Casner, *Wayne State University Law School*

Despite voters legalizing marijuana for medical use in the state of Michigan over a decade ago, a former medical marijuana business owner was sentenced to sixteen years in federal prison on January 28, 2020.[1] On the topic, the sentencing judge said, "States are changing marijuana laws across the country, certainly that's true, but federal law has not changed."[2] Indeed, although thirty-three states have legalized medical marijuana use, the drug remains illegal under federal law.[3] The Controlled Substances Act (CSA), which regulates drugs,[4] recognizes marijuana with heroin, LSD, and ecstasy as a Schedule I Controlled Substance.[5] This designation is reserved for drugs that have a high potential for abuse, lack any known medical use, and lack accepted safety for medical use.[6] Federal law also prohibits a person from manufacturing, distributing, or possessing a controlled substance.[7] Thus, under federal law, marijuana is deemed to have no medically known use[8] and remains illegal to possess.[9]

Increasingly, however, states are legalizing medical marijuana, despite federal law to the contrary.[10] With increasing medical marijuana use comes resulting issues where state law conflicts with federal law.[11] Perhaps the most well-known case on the subject is the Supreme Court case, *Gonzales v. Raich*,[12] in which respondents, Raich and Monson, argued that enforcing the CSA would violate the Commerce Clause.[13] The court, however, held that Congress' power under the Commerce Clause includes the power to prohibit the local cultivation and use of marijuana, reasoning that production of marijuana had a substantial effect on the supply and demand in the national market.[14] As such, the CSA, which prohibits the possession and distribution of controlled substances, stands.[15]

With *Gonzales v Raich* upholding Congress's enactment of the CSA, how are states legalizing marijuana, a controlled substance under federal law? While the Supremacy Clause of the United States Constitution provides that federal law is the "supreme Law of the Land,"[16] courts generally recognize that a state law may be preempted in three ways.[17] The first way is by express preemption, which is when Congress expressly states that federal law preempts state law.[18] The second is by field preemption, "where Congress explicitly or implicitly leaves 'no room' for state law, or where federal law is 'so dominant' that it 'will be assumed to preclude enforcement' of the state law."[19] The final way, known as conflict preemption, occurs when the state law actually conflicts with federal law.[20]

Congressional intent and construction behind the CSA provides further guidance on the type of preemption that exists between the CSA and state medical marijuana laws. Under 21 U.S.C. § 903, the CSA provides:

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law *so that the two cannot consistently stand together*.[21]

Thus, it is quite clear that Congress intended the CSA to preempt state law only where it conflicts with federal law.[22]

There are two circumstances in which conflict preemption arises.[23] The first is where it is physically impossible to comply with both federal and state law because the laws irreconcilably conflict.[24] The second circumstance occurs where "state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."[25] The construction of the federal Controlled Substances Act makes it clear that it does not preempt state law unless compliance with both is impossible.[26] Consequently, through carefully constructed medical marijuana statutes, states can avoid conflicts with the CSA.[27]

Clearly, the CSA would preempt where state law required someone to violate the federal law.[28] Violation of the CSA would include possessing, manufacturing, or distributing a controlled substance.[29] Accordingly, effective state medical marijuana laws regulate private individuals who choose to grow or dispense marijuana, instead.[30] If state laws were to require individuals to grow and dispense marijuana, then state law would conflict with federal, and the federal law would preempt the state law.[31] As an example, the Michigan Marihuana Act provides a regulatory system for providing protections for medical use of marijuana, for qualifying patients and primary caregivers, for enforcing the act, among other regulatory objectives.[32]

The Tenth Amendment – States Have No Duty to Enforce Federal Law

An examination of state and federal marijuana law would be incomplete without a discussion of the Tenth Amendment of the Constitution. Under the Tenth Amendment, the federal government cannot require state agents to enforce federal laws.[33] Doing so would be unconstitutional. As the Michigan Medical Marihuana Act notes, "Although federal law currently prohibits any use of mari[j]uana except under very limited circumstances, states are not required to enforce federal law or prosecute people for engaging in activities prohibited by federal law."[34] Consequently, states continue to promulgate medical marijuana statutes, despite federal law restricting possession and distribution of marijuana as a controlled substance.

Workers' Compensation and Medical Marijauna

Medical marijuana statutes have not only presented legal questions regarding constitutionality. Issues regarding workers' compensation have also resulted.[35] Increasingly, workers' compensation insurers are receiving reimbursement requests for medical marijuana treatment. A few states have ruled on or adopted rules regarding whether reimbursement may be compelled for a substance that remains illegal under federal law.[36] The few states that have decided this issue are split. As an example of the current climate: Maine's Supreme Court ruled that reimbursement would subject the employer to penalties for violating the CSA;[37] the Superior Court of New Jersey ruled, in January 2020, that worker's compensation insurers should reimburse patients for medical marijuana;[38] and Minnesota's Department of Labor and Industry adopted a rule removing marijuana from its "illegal substances" list for reimbursement of medical treatment.[39]

Faced with this issue, the Supreme Court of Maine analyzed the Maine Medical Marijuana Act against the CSA.[40] Maine's Supreme Court found, in *Bourgoin v Twin Rivers Paper Co*, that complying with both the state and federal law was impossible.[41] The court reasoned that:

> Were Twin Rivers to comply with the hearing officer's order and knowingly reimburse Bourgoin for the cost of the medical marijuana as permitted by the [Maine Medical Use and Marijuana Act], Twin Rivers would necessarily engage in conduct made criminal by the CSA because Twin Rivers would be aiding and abetting Bourgoin—in his purchase, possession, and use of marijuana—by acting with knowledge that it was subsidizing Bourgoin's purchase of marijuana.[42]

In summary, the Maine Supreme Court concluded that a person's right to use medical marijuana could not require a third-party to engage in conduct – reimbursement for medical marijuana – that violated the CSA.[43]

> The construction of the federal Controlled Substances Act makes it clear that it does not preempt state law unless compliance with both is impossible. Consequently, through carefully constructed medical marijuana statutes, states can avoid conflicts with the CSA.

By contrast, the Superior Court of New Jersey, in *Hager v. M&K Construction*, reasoned that Congress expressed in "the plain language of the CSA that it only preempts a state law that requires the performance of an action specifically forbidden by the federal statute."[44] The court went on to explain that the CSA provides that possession, manufacture, and distribution of marijuana is a criminal and punishable offense.[45] Requiring an insurer to reimburse for medical marijuana, however, does not require it to possess, manufacture, or distribute marijuana.[46] Thus, the state and federal laws are not in conflict.[47] The court continued by refuting Maine's argument that reimbursement for medical marijuana would cause an insurer to aid and abet.[48]

The New Jersey Court reasoned that after-the-fact reimbursement does not establish a separate crime.[49] Because an insurer would not be an active participant in the commission of a crime, the insurer would not be aiding and abetting.[50] Moreover, the insurer would not have the requisite intent and active participation in the crime, as required for aiding and abetting.[51] The insurer's intent would be to reimburse a patient for the legal use of medical marijuana.[52] Finally, the court noted that "one cannot aid and abet a completed crime."[53] A patient purchases marijuana and then seeks reimbursement.[54] Naturally, the insurer is not aiding or abetting through reimbursement because the possession has already occurred.[55] Thus, an insurer cannot aid and abet the completed crime of possession.[56] Connecticut,[57] New Mexico,[58] and New Hampshire[59] courts have decided similarly to New Jersey.

Michigan's Approach – Bar Reimbursement

Michigan courts notably have not faced similar questions as Maine and New Jersey on this issue. This is likely because Michigan is more like Minnesota in this case. Minnesota's Department of Labor and Industry adopted a rule, which provides that the meaning of illegal substance is "a drug or other substance that is illegal under state or federal controlled substances law, but *does not include* a patient's use of medical cannabis permitted under Minnesota Statutes."[60] Similar to Minnesota, Michigan passed MCL 418.315a of Michigan's Worker's Disability Compensation Act. Under this statute, the state legislature specifically set out that an employer is not required to reimburse charges for medical marijuana treatment.[61]

Absent the statute, Michigan courts likely would have found medical marijuana reimbursement allowable under the

CSA. The legislative history of MCL 418.315a, states, "If medical mari[j]uana expenses are not expressly excluded from workers' compensation coverage, employers arguably are required to pay those costs."[62] Accordingly, the Michigan legislature decided this issue before insurers could raise it in the courts.

Although the legislature of Michigan addressed workers' compensation claims for medical marijuana in MCL 418.315a, many states are still plagued with the issue of whether an insurer should reimburse a patient for medical marijuana treatment. New Jersey and Maine have each set out opposing arguments on whether insurers would violate the CSA by reimbursing patients for medical marijuana. Minnesota and Michigan provide solutions through their state legislature before the issue comes before a court. As states continue to legalize medical marijuana, issues regarding workers' compensation reimbursement for a substance that remains illegal under federal law will continue.

About the Author

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Endnotes

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18 *Id*. (citing Hillsborough City v. Automated Med. Labs, Inc., 471 U.S. 707 (1985)).

19 *Id*. (quoting Hillsborough City v. Automated Med. Labs, Inc., 471 U.S. 707, 713 (1985)).

20 *Id*.

21 21 U.S.C. § 903 (1970) (emphasis added).

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23 *Id*.

24 *Id*. (citing Hillsborough City v. Automated Med. Labs, Inc., 471 U.S. 707 (1985)).

25 *Id*. (quoting Hillsborough City v. Automated Med. Labs, Inc., 471 U.S. 707, 713 (1985)).

26 *Id*.

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28 Hager v. M&K Constr., No. A-0102-18T3, 2020 WL 218390 at *7 (N.J. Super. Ct. App. Div. Jan. 13, 2020).

29 21 U.S.C. § 841(a)(1) (2018).

30 Robert A. Mikos, *Preemption Under the Controlled Substances Act*, J. Health Care L. & Pol'y 5, 14-15 (2013).

31 *Id*.

32 MCL § 333.26425 (2008).

33 *See* Prigg v Pennsylvania, 41 U.S. 589 (1842) ("The states cannot, therefore, be compelled to enforce them; and it might well be deemed an unconstitutional exercise of the power of interpretation, to insist that the states are bound to provide means to carry into effect the duties of the national government, nowhere delegated or instrusted to them by the Constitution").

34 MCL § 333.26422 (2008).

35 *See* Petrini v. Marcus Dairy, Inc., 6021 CRB-7-15-7, 2016 WL 6659149 (Conn. Work. Comp. Com. May 12, 2016) (where the state's Workers Compensation Commission affirmed a trial commissioner's finding that medical marijuana constitutes a "reasonable and necessary medical treatment" and is therefore reimbursable); *see also* Vialpondo v. Ben's Auto. Servs., 331 P.3d 975 (N.M. Ct. App. 2014) (where an employer was ordered to pay for an injured worker's medical marijuana under New Mexico's medical marijuana statute).

36 *See* Appeal of Panaggio, 205 A.3d 1099 (N.H. 2019) (because the Compensation Appeals Board found that the claimant's use of medical marijuana was reasonable, medically necessary, and causally related to his work injury, the court found that the carrier was not prohibited from reimbursing him for his costs); *see*

also Cockrell v. Farmers Ins., 2012 Cal. Wrk. Comp. P.D. LEXIS 456 (where the parties failed to consider the Health and Safety Code, which stated that the medical marijuana program shall not require a health insurance provider to reimburse for medical marijuana).

37 Borgoin v. Twin Rivers Paper, Co., 187 A.3d 10 (Me. 2018).

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42 *Id.*

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48 *Id.* at 8.

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52 *Id.*

53 *Id.* (quoting United States v. Ledezma, 26 F.3d 636, 642 (6th Cir. 1994)) (internal quotation marks omitted) (citing Roberts v. United States, 416 F.2d 1216 (5th Cir. 1969)).

54 *Id.*

55 *Id.*

56 *Id.*

57 Petrini v. Marcus Dairy, Inc., 6021 CRB-7-15-7, 2016 WL 6659149 (Conn. Work. Comp. Com. May 12, 2016).

58 Vialpondo v. Ben's Auto. Servs., 331 P.3d 975 (N.M. Ct. App. 2014).

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60 Minn. R. § 5221.6040(7a) (2015) (emphasis added).

61 MCL § 418.315a (2012).

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Legislative Update: Here We Go Again

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

Every two years we start a new legislative cycle. All bills expire, all committees re-form, and the process begins anew. That happened at the end of 2020 – Michigan's legislature adjourned and a new one formed. The legislature is bi-cameral (House of Representatives and Senate). Republicans hold majorities in each chamber – meaning, they create and chair all committees. There are two insurance-related committees: the House Insurance Committee (chaired by Rep. Daire Rendon) and the Senate Insurance and Banking Committee (chaired by Sen. Lana Theis).

In these quarterly updates, I'll report on all insurance-related bills, from introduction through final passage. But before I get to the new bills, let me wrap up two from the last legislature that weren't complete when I wrote my last update:

Adopted

- **Travel insurance -** 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 ***Passed the House (105-2) on 2/25/20; Passed the Senate (38-0) 12/10/20; Signed by the Governor (PA 266 '20 with immediate effect) on 12/31/20***
- **Reinsurers –** SB 1015 amends the insurance code regarding reinsurers, requires for reciprocal jurisdiction of assuming insurer and other technical amendments ***Passed the Senate (37-0) on 9/2/20; Passed the House (108-0) on 12/16/20; Signed by the Governor (PA 328'20 <u>without</u> immediate effect) on 12/30/20***

New Bills

Now on to new bills. So far, members have introduced 528 bills in the House and 247 bills in the Senate, with only a few referred to the insurance committees:

- **Physician certifications –** HB 4028 amends the Insurance Code to prohibit insurers from requiring physicians to hold certain certifications before reimbursing claims, unless required for licensure.
- **WDCA – cancer presumption -** HB 4171 amends the Workers Disability Compensation Act to extend a presumption to forest fire officers and fire/crash rescue officers that certain cancers were caused by job hazards ***Reported out of the Insurance Committee on 3/4/21***
- **WDCA – cancer presumption** HB 4172 amends the Workers Disability Compensation Act to extend a presumption to firefighters that certain cancers were caused by job hazards, and creates a First Responder Presumed Coverage Fund ***Reported out of the Insurance Committee on 3/4/21***
- **Oral administered cancer medicine --** HB 4354 amends the Insurance Code to prohibit health insurers from imposing costs or restrictions on orally administered anticancer medications that are higher or more restrictive than imposed on intravenous medication
- **No-Fault reimbursement for rehabilitation clinics –** HB 4486 amends the No-Fault Act to revise reimbursement provisions for rehabilitation clinics.
- **Continuing education credits –** SB 31 creates a system permitting insurance producers to earn continuing education credits by belonging to a professional insurance association. ■

Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*

Michigan Supreme Court

Does rescission bar subrogation?

Meemic INS Co v Jones
Docket No. 161865
January 20, 2021
Oral argument on the Application

The Supreme Court has ordered oral argument on Meemic's application for leave to appeal, directing it to: "file a supplemental brief . . . addressing whether its declaration that a homeowners insurance policy was void *ab initio* should be considered a denial of a claim under the policy such that it may invoke its right to subrogation when it was required by a standard mortgage clause to pay the balance of the appellee's mortgage."

Meemic rescinded a homeowners policy because of misrepresentation in the application but had to pay the lienholder under a standard mortgage clause. Meemic then commenced this action against the insured to recoup the amount paid on the lien. The Court of Appeals agreed that Meemic had grounds to rescind but concluded that because Meemic rescinded the policy as opposed to denying the claim, there was no contractual right of subrogation.

Underlying complaints and the duty to defend

Estate of Wells v. State Farm Fire and Casualty Company
Docket No. 161911
March 26, 2020
Oral argument on the Application

This is an appeal from the Court of Appeals holding that State Farm had no duty to defend its homeowner-insureds against claims of social host liability, where the underlying complaint alleged that the insureds knowingly furnished alcohol to minors and then knowingly allowed the alcohol-impaired minors to operate a motor vehicle. The Supreme Court has ordered oral arguments on the application for leave, directing plaintiff to "file a supplemental brief addressing:

> (1) whether the appellant's underlying complaint in its action against the insureds is a 'written instrument' under MCR 2.113(C)(1) . . ., a "pertinent part" of a written instrument under MCR 2.113(C)(1), or is otherwise part of "the pleadings" in this case such that the lower courts could properly consider it in the MCR 2.116(C)(8) analysis;
>
> (2) whether the Court of Appeals correctly concluded that the appellant's pleadings showed the insureds knowingly provided alcohol to minors and that this knowing act was a proximate cause of the appellant's damages;
>
> (3) whether pleading proximate causation is the equivalent of pleading that an act "created a direct risk of harm from which the consequences should reasonably have been expected by the insured, . . . and
>
> (4) whether the Court of Appeals erred in affirming the Macomb County Circuit Court's grant of summary disposition to appellee State Farm under MCR 2.116(C)(8).

Michigan Court of Appeals – Unpublished Decisions

Condominium unit owner has no direct cause of action against the association's insurer

Neff v Chapel Hill Condominium Assc
Docket Nos. 349444, 349976
January 14, 2021
Supreme Court Application pending

In an opinion addressing several non-insurance issues arising out of an unusually contentious trial court proceeding, the Court of Appeals held that plaintiff-owner of a condominium unit was neither a party to the insurance contract between the condominium association and the insurer, nor a third-party beneficiary of that contract. She failed to introduce any facts suggesting that the insurer committed to act directly on her behalf. She therefore had no cause of action against the insurer for failing to repair the damage to her basement caused by a sewer back-up.

False information in homeowners insurance application allows rescission

Council v Allstate Vehicle and Property Ins Co
Docket No. 351676
February 18, 2021

When plaintiff applied for his homeowners policy with Allstate, he listed the purchase price of his property as $75,000,

even though he had just purchased it for only $10,000. Plaintiff denied having provided the $75,000 figure and testified that the agent must have entered the number. But plaintiff also acknowledged that he was asked to read and sign the application and that he initialed every page, including the page with the purchase price listed as $75,000. When the home was damaged by fire, Allstate discovered the misrepresentation in the course of its investigation and rescinded the policy. Because there was no dispute that plaintiff had signed the application with the false information, the court granted Allstate's motion for summary disposition on lack of coverage.

No UM coverage under commercial policy

Loiacano v Home-Owners Ins Co
Docket No. 351876
February 18, 2021

In this priority dispute between two UM insurers, the Court of Appeals gave effect to the language in the commercial UM endorsement. The policy declarations limited UM coverage to two named individuals only. And an endorsement modifying the UM coverage form defined "who is an insured" as the individual identified for UM coverage, any family member, and "any passengers in a COVERED AUTO driven by the Designated Individual". Because plaintiff, who leased the vehicle from the insured entity, was neither a family member nor a passenger in a vehicle driven by a designated insured, there was no UM coverage under the commercial policy.

Time-barred homeowners claim

McIntosh v Auto-Owners Ins Co
Docket No. 351339
March 11, 2021
Motion for Reconsideration pending

In the spring or early summer of 2017, plaintiff-homeowner observed possible roof damage caused by the build-up of snow and ice the previous winter. A contractor confirmed the damage in August and plaintiff submitted a claim to Auto-Owners under his homeowner's policy in September. Auto-Owners denied the claim on December 14, 2017, after its engineer inspected the house and determined that the damage was the result of "long-term creep deflection" occurring over a period of years. Plaintiff filed suit, but it was too late. Under the terms of the policy, the homeowner had one year after the loss to file suit. The one-year period was tolled from the date the claim was submitted until the denial of coverage. Assuming the damage was caused by the build-up of snow and ice, the latest possible date of loss was the end of March 2017. Auto-Owners denied the claim 91 days after submission, so plaintiff had one year and 91 days to file suit, which gave him until June 18, 2018. He filed suit on September 13, 2018.

Federal District Court – Eastern District of Michigan

Three opinions addressing coverage for COVID -19 shutdowns

Salon XL Color & Design Group, LLC v West Bend Mut Ins Co
Case No. 20-11719
February 4, 2021

Salon XL operated a hair salon in Ann Arbor that was forced to close due to the Governor's Executive Orders. It filed this lawsuit to recover business losses under a commercial policy issued by West Bend, which included coverages for Business Income, Extra Expenses, Civil Authority, and Communicable Disease Business Income and Extra Expense. West Bend responded with a motion to dismiss under Rule 12(b)(6). The court initially found that Salon XL's complaint asserted a covered loss because it alleged that "COVID-19 particles have infected their property." The basic insuring agreement afforded coverage for loss of income caused by "direct physical loss of or damage to Covered Property . . . caused by or resulting from any Covered Cause of Loss."

The court went on to hold that the Virus exclusion in the policy barred coverages for Business Income, Extra Expense, and Civil Authority losses, but not for Communicable Disease Business Income and Extra Expense coverage, so the case would go forward on that one claim only.

Dye Salon, LLC v Chubb Indemnity Ins
Case No 20-11801
February 10, 2021

and

Stanford Dental, PLLC v The Hanover Ins Group, Inc
Case No 20-11384
February 10, 2021

These two cases involve nearly identical claims for loss of income and other damage attributable to the COVID-19 shutdown. Both cases were assigned to the same judge and were decided by separate but nearly identical opinions. Initially, the court held that the insureds had no standing to sue the companies performing merely as claim administrators, limiting the cause of action to the insurers, only. Both insurers claimed lack of a Covered Cause of Loss because of the lack of any physical damage to the premises. Both insurers also asserted the Virus exclusions in their policies. The court addressed the exclusion only because it was dispositive. The Virus exclusion in both policies stated:

> We will not pay for loss or damage directly or indirectly by any of the following. Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss. * * *

I. Virus or Bacteria

(1) Any virus, bacterium or other microorganism that incudes or is capable of inducing physical distress, illness or disease.

The court rejected the argument that the closures were caused by Executive Orders rather than the virus, citing language in the order referring to the virus as the reason for the orders. The court also relied on the concurrent cause language in the exclusion. The court further rejected the argument that the exclusion was ambiguous and refused to apply the doctrine of regulatory estoppel. Both insureds argued that the insurers were estopped from enforcing the terms of the exclusion because of representations made to regulatory authorities in seeking approval of the exclusion. But the court found no Michigan precedent for regulatory estoppel and observed that the doctrine would directly conflict with Michigan law requiring the enforcement of insurance contracts according their plain and unambiguous terms.

Insurance appraisals and disputed coverage

Shina v State Farm Fire And Casualty Co
Case No. 20-10080
February 4, 2021

This case involves three separate claims by three separate insureds for property damage believed to be covered under their separate homeowners policies with State Farm. All three insureds demanded appraisals on their disputed claims. State Farm declined to participate because of the lack of coverage, and because it was not the function of appraisers to decide coverage. The court granted plaintiff's motion to compel State Farm to participate in the appraisal proceedings, holding that the appraisal process could resolve some of the factual disputes concerning losses and their causes. It denied plaintiffs' requests to declare certain provisions in the policies in violation of Michigan's insurance code because none of those provisions was relevant to coverage for these claims. And it ordered the parties to meet and confer within 10 days to determine whether any legal issues had to be resolved prior to the appraisals. Finally, it denied State Farm's motion to sever the claims.

Endorsements added without the insured's consent are unenforceable

ZMCC Properties, LLC v Primeone Ins Co
Case No. 19-12428
March 8, 2021

This is a first-party fire loss claim in which the court considered allegations of fraud in the initial application for the policy, and in the renewal application, and found questions of fact for the jury. But for purposes of going forward, the court rejected Primeone's reliance on certain loss payee endorsements. Initially, Primeone issued an endorsement naming plaintiff as a lenders loss payee, which provided coverage for the payee regardless of any action by the named insured. Primeone later replaced that endorsement with endorsements making plaintiff a mere loss payee, subject to the same coverage available to the named insured. Because the later endorsements were issued without the insured's consent, they were unenforceable.

Renovation exclusion applies to first-party property damage claim

Zedan v SGL No.1 Limited
Case No. 20-10680
March 22, 2021

Plaintiff's property was damaged during the course of building renovations. A contractor using a welding torch started a fire that caused substantial damage to the property. Plaintiff's policy with SGL expressly excluded coverage "for any loss or damage directly or indirectly arising out of or relating to any renovation or construction work being performed at or upon the insured premises during the period of this policy." Plaintiff claimed coverage because the renovation exclusion did not have a concurrent cause provision, i.e., a cause that expressly states coverage is excluded even if there is a concurrent cause of loss that would be covered. The court held that the exclusion applied on its plain terms.

Ordinary loss payee as third-party beneficiary with standing to sue

H&N Realty, Inc v The Travelers Indemnity Co of America
Case No. 20-12598
March 30, 2021

Plaintiff owned a building damaged by fire. Plaintiff leased the building to a business that insured the property with Travelers. Because plaintiff was named as a loss payee on the policy, Travelers issued a check in the amount of $116,000, made payable to both plaintiff and the named insured. When the named insured negotiated the check on its own, plaintiff sued Travelers for payment of its own loss. Travelers moved to dismiss for lack of standing. Plaintiff was a loss payee under an ordinary loss payable clause in the insurance policy, which meant its rights were no greater than the named insureds. The payee under an ordinary loss payable clause is "simply an appointee to receive the insurance fund to the extent of its interest." Ordinary loss payees have no privity of contract with the insurer and thus have no standing to sue for breach of contract. But the court found that such a loss payee does have a third-party beneficiary claim under MCL 600.1405. Plaintiff thus had standing to proceed with its claim.

Federal District Court – Western District of Michigan

Risk known prior to issuance of policy not covered

Arbre Farms Corporation v Great American E&S
Case No. 20-551
January 11, 2021
Appeal filed January 26, 2021

Plaintiff is in the business of producing locally grown vegetables, which it sells as food to manufacturers and distributors. Plaintiff's insurance policy with Great American covers losses incurred as the result of recalls of contaminated products. When a quarantined batch of green beans testing positive for listeria was accidentally mixed with non-contaminated beans, plaintiff ended up having to destroy 8 million pounds of product and sought coverage for the loss under it policies with Great American and two excess insurers. Great American denied coverage on two grounds but the court only addressed one because it was dispositive.

Great American's policy expressly excluded coverage for any "insured event or circumstance" that the insured knew or should reasonably have known about prior to the policy period. There was no dispute that plaintiff knew about the tainted green beans in September of 2017, when they were quarantined in a separate building. The policy incepted in October of 2018. "The quarantined green beans were a pre-policy circumstance that could give rise to an insured event." Plaintiff knew of the risk of cross-contamination before the policy issued. "This was not a risk for which Great American assumed liability, and so it will not be held liable." Because the excess policies followed form, the same coverage decision applied.

Another opinion on COVID-19 claims

St. Julian Wine Co, Inc v The Cincinnati Ins Co
Case No. 20-cv-374
March 19, 2021

In a fourth recent federal opinion addressing coverage for losses incurred as a result of COVID-19 shutdowns, the Western District assessed coverage under a policy without a Virus exclusion. It found that the insuring agreement in the policy was not triggered because the losses did not arise out of a Covered Cause of Loss. The term "loss" was defined in the policy as "accidental physical loss or accidental physical damage." Because the Executive Orders were intended to minimize the spread of the virus, the resulting shutdowns "had no connection to the physical condition of St. Julian's property, or to any physical damage or loss." As to coverage for the actions of a civil authority preventing access to the property, the Cause of Loss still had to involve damaged property, that is, damage to other property that resulted in a civil authority barring access to the insured property in response to a dangerous physical condition resulting from the damage. ■

Caught In Limbo – Who Pays Benefits for "Strangers to the Insurance Contract," for Losses Occurring After June 11, 2019?

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We are rapidly approaching the two-year anniversary of the passage of the 2019 No-Fault Reform Amendments, which made significant changes to Michigan's unique no-fault system. The author has been critical of many of these reform amendments, based primarily on the fact that the bills were drafted at a "midnight drafting session," with no ability for any interested parties to comment on the final product.

One of the most significant changes dealt with the priority provisions for "strangers to the insurance contract;" that is, those individuals who are occupying someone else's automobile or non-occupants involved in accidents with motor vehicles, who have no insurance of their own – whether individually or through a spouse or domiciled relative. Under the former provision of MCL 500.3114(4), occupants of motor vehicles, who did not have insurance of their own, would turn to the insurer of the owner, registrant or operator of the motor vehicle occupied for payment of their benefits. See MCL 500.3114(a) and (b). For non-occupants of motor vehicles, the former provisions of MCL 500.3115(1) provided that these individuals would turn to the insurer of the owner, registrant or operator of the motor vehicles involved in the accident. See MCL 500.3115(1)(a) and (b).

The 2019 reform amendments now provide that these individuals will receive their benefits through the Michigan Automobile Insurance Placement Facility (MAIPF), which operates the Michigan Assigned Claims Plan (MACP). These amendments took effect on June 11, 2019, but it was not at all clear when the changes to the priority scheme would take effect. If the statutory amendment took precedence over the old form policy language (discussed more fully below), these "strangers to the insurance contract" would turn to the MACP for payment of their benefits. If the old form policy language controlled over the amended statute, the insurer of the owner, registrant or operator of motor vehicle occupied by the injured claimant, or involved in the accident with the injured non-occupant, would provide the benefits under the old policy forms.

The issue of who pays is certainly of consequence, particularly with regard to serious or catastrophic injuries. "Allowable expense" payments under the MACP are capped at $250,000.00, except in certain circumstances not relevant here. The issue of whether or not this $250,000.00 cap applies for losses occurring between June 11, 2019, and July 2, 2020, is currently being litigated in the Court of Appeals. See *Michigan Automobile Insurance Placement Facility v Dep't of Financial and Insurance Services,* Court of Appeals docket no. 355331. For losses occurring after July 2, 2020, there is no dispute but that the MACP "allowable expense" cap of $250,000.00 will apply. However, if the insurer of the owner, registrant or operator of the motor vehicle occupied by the injured Claimant, or involved in the accident with the injured non-occupant had in effect the old policy forms, the injured Claimant could conceivably be entitled to lifetime, unlimited benefits.

This article will discuss the current conflict between the MAIPF/MACP and the Department of Insurance and Financial Services (DIFS) over which insurer would be responsible for paying first-party, no-fault insurance benefits to these "strangers to the insurance contract." Unfortunately, there are no clear answers, which leaves these "strangers to the insurance contract" in limbo regarding which insurer will ultimately pay their nofault benefits and, with regard to catastrophic losses, the extent of those benefit payments.

Typical Insurance Policy Language Regarding Who Is An "Insured"

Most old form insurance policies include language which define which individuals qualify as an "insured" under the policy. These individuals can include "strangers to the insurance contract." For example, a typical old form insurance policy will contain the following insuring agreement:

> "INSURING AGREEMENT
>
> A. We will pay Personal Injury Protection benefits to or for an ***insured*** who sustains ***bodily injury***. The ***bodily injury*** must:
>
> 1. be caused by the accident; and
>
> 2. result from the ownership, maintenance, or use of an ***auto*** as an ***auto***.
>
> B. These benefits are subject to the provisions of the Michigan Insurance Code. Subject to the limits shown in the Schedule or Declarations,

> Personal Injury Protection benefits consist of the following:
>
> 1. Medical expenses. Reasonable and necessary medical expenses incurred for an ***insured's***:
>
> a. care;
>
> b. recovery; or
>
> c. rehabilitation."

The typical old form insurance policy language will also define the term "insured" to include "anyone . . . injured in an ***auto accident*** . . . while ***occupying your covered auto***" or, if a non-occupant, "involved in an accident with ***your covered auto***." (The bold print usually indicates terms that are specifically defined in the policy.) These policies will also contain an exclusion, which preclude coverage in those situations where the insured is either the named insured or a spouse or family member of a "named insured" on another nofault policy. These exclusions were designed to effectuate the purposes behind the former provisions of MCL 500.3114(4) and MCL 500.3115(1), which was to make the injured person's household insurer (whether individually or through a spouse or domiciled relative) as the highest priority insurer. The question, of course, is whether this contractual language regarding these "strangers to the insurance contract" remains in effect, or whether the policy provisions were supplanted by the NoFault Reform Amendments.

In order to illustrate the quandary these "strangers to the insurance contract" find themselves in, consider the following scenarios:

> l. Anne is seriously injured in an accident while occupying her boyfriend Brian's automobile on February 1, 2020. Brian had a nofault policy in effect with ZZZ Insurance Company, with an effective date of January 1, 2020, and a scheduled expiration date of January 1, 2021. Because the policy was not issued or renewed on or after July 2, 2020, this old form policy still provided for lifetime, unlimited benefits, which would theoretically include Anne, who is clearly a "stranger to the insurance contract."
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> 2. Cathy is seriously injured in an automobile accident on August 1, 2020, after the PIP choice provisions took effect. She was occupying a motor vehicle operated by her boyfriend, David. David's automobile was insured under a one-year policy of insurance issued by ABC Insurance Company on May 1, 2020, with an expiration date of May 1, 2021. However, because the policy was issued prior to July 2, 2020, the policy issued by ABC Insurance Company still contains the old policy form language regarding who qualifies as an "insured" and still provides for payment of lifetime, unlimited benefits

Again, assume that both Anne and Cathy are catastrophically injured, and both Anne and Cathy have incurred medical expenses well in excess of $250,000.00 during their inpatient hospital stays. We will return to Anne and Cathy later in this article.

Legal Analysis

As previously noted, the 2019 NoFault Reform Amendments dramatically altered the no-fault priority scheme, particularly with regard to PIP claims filed by "strangers to the insurance contract;" that is, occupants and non-occupants of motor vehicles, involved in the accident, who do not have insurance of their own, whether individually or through a spouse or domiciled relative. Again, prior to June 11, 2019, those individuals would turn to the insurer of the owner or registrant of the motor vehicle occupied, or the insurer of the owner or registrant of the motor vehicle involved in the accident, pursuant to MCL 500.3114(4)(a) and MCL 500.3115(1), respectively. As amended, MCL 500.3114(4), dealing with occupants of a motor vehicle, now provides that such individuals "shall claim personal protection insurance benefits under the Assigned Claims Plan under sections 3171 to 3175." Unfortunately, the statutory amendments did not specify precisely when the change in priority was to take place. For the next few months after the No-Fault Reform Amendments took effect on June 11, 2019, there was a dispute as to whether or not the statutory amendment took precedence over the policy language, or whether the policy language would control over the statutory amendment.

After three months of uncertainty, the Insurance Director, Anita Fox, stepped into the fray and issued DIFS Order 19-048-M on September 20, 2019. This order essentially provided that until the insurance companies revised their policy forms to reflect the new priority provisions (and lowered premiums to reflect the lowered exposure), the old priority provisions reflected in the old policy forms would remain in effect. Furthermore, this order provided that insurance companies had to obtain approval from DIFS before they could implement any new policy forms, so that the Insurance Director could ensure that the appropriate premium savings were incorporated into the new filings. To put it another way, the *status quo* was to be maintained until the new policy forms could be issued, and for many carriers, they chose to implement the new policy forms in conjunction with the new PIP choice provisions, which would be applied to policies issued or

renewed on or after July 2, 2020.

Prior to the issuance of DIFS Order 19-048-M, whenever a policy insurer attempted to refer a claim involving a "stranger to the insurance contract" to the MAIPF/MACP, the MAIPF/MACP would demand a certified copy of the underlying insurance policy in order to determine if the policy language would provide greater coverage for the injured person than what the new statutory amendment provided. Obviously, this meant a lot of work for the MAIPF and the servicing insurers. The MAIPF initially challenged the constitutionality of DIFS Order 19-048-M in the Michigan Court of Claims, which seemed unusual, given the fact that DIFS Order 19-048-M actually made it easier for the MACP and its servicing insurers and their adjusters to do their job, by shifting such claims back to the policy insurers! In other words, they no longer had to scrutinize each and every policy form involving these "strangers to the insurance contract." In reality, the reason why DIFS challenged Order 19-048-M was because it really focused its sight on DIFS Order 19-049-M, issued four days later on September 24, 2019, which required the MAIPF/MACP to continue providing lifetime, unlimited no-fault benefits to Claimants who were injured in auto accidents occurring on or before July 2, 2020.

DIFS Order 19-049 was issued in response to an article that appeared in the Detroit Free Press on Sunday, September 22, 2019. In that article, Mitch Album described the plight of a three-year-old girl, who was struck by an uninsured motor vehicle as she was running across the street. The parents did not have insurance of their own in their household. As a result, they filed a claim for no-fault benefits with the MAIPF/MACP. The problem was that this accident took place after the effective date of the No-Fault Reform Amendments — June 11, 2019 — which reduced the "allowable expense" coverage under the MACP to $250,000.00. The girl and her family incurred medical expenses from Children's Hospital totaling $140,000.00, which meant that there was only $110,000.00 available to the girl and her family to cover any remaining PIP claims. After that, they would have to obtain health coverage through Medicaid. The Insurance Director, Anita Fox, remedied the situation on September 24, 2019 by issuing DIFS Order 19-049-M, which delayed the effective date of the $250,000.00 "allowable expense" cap to July 2, 2020.

The MAIPF subsequently instituted suit against the Insurance Director in the Michigan Court of Claims, and in the original complaint, the MAIPF referenced both DIFS Order 19-048 (regarding changes to the priority scheme) and DIFS Order 19-049 (regarding the imposition of the $250,000.00 "allowable expense" cap). The MAIPF was broadly challenging the Insurance Director's legal ability to issue these orders as being outside the scope of her authority. She was, in essence, "making law" when that prerogative is reserved for the Legislative branch. The MAIPF subsequently abandoned its challenge to DIFS Order 19-048-M by way of a First Amended Complaint and focused its attention solely on the constitutionality of the DIFS Order 19-049-M pertaining to the $250,000.00 statutory cap on benefits. Court of Claims Judge Michael J. Kelly subsequently upheld DIFS Order 19-048-M, and his decision is currently under review by the Court of Appeals. See docket no. 355331. As matters now stand, the $250,000.00 "allowable expense" cap applies only to MACP claims arising on or after July 2, 2020

Most of us in the no-fault world believed that the issue was now resolved, except for USAA Casualty Insurance Company. USAA was sued by two "strangers to the insurance contract" who were involved in separate, unrelated motor vehicle accidents. Specifically, one John Thomas filed suit against USAA Casualty Insurance Company and the Michigan Automobile Insurance Placement Facility in the Wayne County Circuit Court. This lawsuit was given docket number 20-006497-NF and was assigned to the Honorable Leslie Kim Smith. The MAIPF filed a motion for summary disposition, presumably based upon the provisions of DIFS Order 19-048-M and the language of the USAA Casualty Insurance Company contract. Pursuant to an Order dated September 28, 2020, Judge Smith denied the MAIPF's Motion for Summary Disposition and further indicated that:

> "It is further ordered that Defendant Michigan Automobile Insurance Placement Facility, is first in the order of priority pursuant to the Revised NoFault Act."

Another lawsuit was filed by one Donnie Walker against USAA Casualty Insurance Company and the MAIPF's servicing insurer, AAA. Plaintiff Donnie Walker was an occupant of a motor vehicle whose owner was insured with USAA. The accident itself occurred in August 2019. USAA filed its motion for summary disposition, arguing that pursuant to the NoFault Reform Amendments, which took effect on June 11, 2019, "coverage can be obtained only by applying to the Michigan Automobile Insurance Placement Facility (MAIPF)." AAA responded to the motion for summary disposition and relied upon DIFS Order 19-048-M. The court refused to follow DIFS Order 19-048-M by arguing that the change in priority did not effect "the scope of coverage required to be provided under automobile policies." As stated by Judge Craig Strong, in his opinion and order dated October 21, 2020, granting USAA's motion for summary disposition:

> "The remaining parties oppose the motion by focusing on the provisions of the order preventing 'implementation' of the amendments 'until automobile insurers have submitted revised forms and rates for the Director's review and approval.' According to these respondents, the accident at issue occurred before USAA submitted such forms, so that the

amended provisions of the NoFault Act do not apply to Plaintiff's claim. The problem with this argument is that the 'revised forms' provisions of the DIFS Order apply only to amendments that affect 'the scope of coverage required to be provided under automobile policies.' The amendments at issue in this motion, however, do not involve the scope of coverage, but the priority for payment of benefits when the Claimant is otherwise uninsured. Thus, even if USAA had not submitted its revised forms, this fact would not preclude USAA from invoking the new amendments."

Judge Strong concluded his opinion as follows:

"In light of the foregoing, the Court agrees that the amendments to MCL 500.3114 regarding priority for otherwise uninsured vehicle occupants took effect on June 11, 2019 and applied to the August 2019 accident at issue in this case. Thus, Plaintiff can recover against USAA only if MAIPF assigns it to handle coverage for the August 2019 accident. And as it is undisputed that MAIPF has made no such assignment, USAA is therefore entitled to dismissal of the claims asserted against it in this case."

No appeals were filed from the rulings of Judge Smith or Judge Strong.

Based upon these two rulings, the MAIPF/MACP issued a Bulletin in late December 2020, which marked a dramatic shift in the MAIPF/MACP's position regarding which insurer was responsible for paying these claims. This Bulletin invited policy insurers who were handling claims of "strangers to the insurance contract," who were injured in motor vehicle accidents occurring after June 11, 2019, to refer those claims over to the MAIPF/MACP for further handling. As noted in this bulletin:

"As insurers are likely aware, based on court ruling indicating that the NoFault Statute did not support the Department of Insurance and Financial Services Director's Order requiring the MAIPF to only accept claims for which filings had been approved, the MAIPF is notifying the Director that it will no longer be denying claims incurred post June 11, 2019, at 3:22 pm for which the owner and/or driver's insurance was in effect on the date of loss, but the insurer had not received approval for revised filings. Therefore, each insurer must now determine if it is in its best interest to send those qualifying claims to the MAIPF for handling."

The bulletin then sets forth the procedures to be followed by the insurer which wishes to refer such claims to the MAIPF for further handling. In the FAQ Section, the MAIPF indicates that DIFS has not approved this change in position, but "they have been advised as to the position taken by the MAIPF."

The MAIPF/MACP Bulletin also makes it clear that for purposes of transferring matters involving these "strangers to the insurance contract" over to the MAIPF/MACP, the MAIPF/MACP will be waiving the One Year Notice requirement, set forth in MCL 500.3145(1), as well as the One Year Back Rule set forth in MCL 500.3145(2). The MAIPF/MACP has also agreed to utilize the Application for Benefits forms utilized by the policy insurer, even though that form is nowhere near as detailed as the MAIPF/MACP Application for Benefits. However, the Bulletin also makes it clear that some type of Application for Benefits must be filled out by the injured Claimant, as "this is a required document pursuant to MCL 500.3172 *et seq*."

The MAIPF/MACP Bulletin also indicates that the MAIPF/MACP would reimburse the policy insurer for all benefits paid by the policy insurer, although the details regarding the reimbursement procedures were still being worked out.

Fallout From The MAIPF/MACP Bulletin

As noted by Judge Strong in his opinion, the DIFS Order 19-048 applies only to policy amendments that affect "the scope of coverage required to be provided under automobile policies." In most cases, the "scope of coverage" is not affected by which insurer is paying the benefits — the policy insurer or the MAIPF. If the damages sustained by the injured claimant are less than $250,000.00, it makes no difference as to which insurer is actually paying those benefits.

However, the "scope of coverage required to be provided under automobile policies" may come into play if the claims exceed $250,000.00, as is the case with Anne and Cathy, in the two scenarios referenced above. With regard to the Court of Claims' lawsuit, challenging the validity of DIFS Order 19-049, regarding the $250,000.00 cap on allowable expense coverage, the MAIPF has already lost in the Michigan Court of Claims. In that case, Court of Claims Judge Michael Kelly ruled that consistent with other provisions of the No-Fault Reform Amendments, DIFS was within its rights to order the MAIPF to delay implementation of the $250,000.00 cap to accidents occurring on or after July 2, 2020. That decision is now being reviewed in the Michigan Court of Appeals, but we do not anticipate a resolution of that issue, at the Court of Appeals level, until sometime in late 2021. In the FAQ section of the MAIPF Bulletin, the MAIPF indicates that if a claim

in excess of $250,000.00 is being transferred to the MAIPF for further handling, any reimbursement to the policy insurer exceeding the $250,000.00 allowable expense limit "will be paid under a Reservation of Rights." Specifically, the MAIPF indicates the following:

> "However, the MAIPF will be accepting all eligible claims for which the insurer provides on the form, regardless if they are in litigation or if the allowable expenses will exceed $250,000.00. Please note, it is the MAIPF's position that claims with dates of loss post-June 11, 2019, 3:22 pm are subject to the $250,000.00 allowable expense limit, however, that position continues to be litigated and claims are not being subjected to the $250,000.00 allowable expense limit at this time. Payments exceeding the $250,000.00 allowable expense limit will be paid under Reservation of Rights."

If the MAIPF prevails in the Court of Claims on this issue, the author foresees a situation where if the MAIPF has issued a reimbursement payment to a policy insurer in excess of $250,000.00, the MAIPF will be asking the policy insurer to reimburse the MAIPF for any amounts above $250,000.00.

Department of Insurance and Financial Services Response

Two months after the MAIPF/MACP released its Bulletin, inviting policy insurers to refer their "strangers to the insurance contract" claims to the MAIPF/MACP, DIFS finally responded and notified the MAIPF/MACP that DIFS Order 19-048-M (which essentially preserved the former priority provisions in policies with the old form policy language) remains in effect except for the parties who were directly involved in the *John Thomas v USAA Casualty Ins Co* litigation (Wayne County Circuit Court docket no. 20006497) and the *Donnie Walker v USAA Casualty Ins Co* litigation (Wayne County Circuit Court docket no. 19-008892-NF). The response from DIFS to the MAIPF threatens policy insurers with "administrative action" if they fail to comply with the terms of DIFS Order 19-048-M and attempt to refer these "strangers to the insurance contract" claims over to the MAIPF/MACP, as noted in the MAIPF/MACP Bulletin of late December 2020.

This threat of possible "administrative action" should not be taken lightly. One may ask who would possibly complain over transferring a file from the policy insurer to the MAIPF/MACP. Certainly not the policy insurer, as they are able to get a claim off of their books. Certainly not the MAIPF/MACP, since it has invited policy insurers to refer such claims to them, pursuant to its Bulletin issued in late December 2020. However, the injured claimant may very well complain if they feel that they are being bounced around like a Ping-Pong ball, from insurer to insurer, for payment of their benefits.

To see how this plays out, consider the plight of Anne, in Scenario #1. Again, she was injured during the "window period" between June 11, 2019, and July 2, 2020, during which time the MAIPF was ordered to pay lifetime, unlimited benefits to MACP Claimants pursuant to DIFS Order 19-049. If Judge Kelly's decision upholding this Order 19-049 is affirmed on appeal, the Anne may not care which insurer is paying her benefits – the policy insurer or the MAIPF/MACP. She is still receiving lifetime, unlimited no-fault benefits. If, however, Judge Kelly's decision is reversed by the Court of Appeals, and the MAIPF/MACP is permitted to impose the $250,000.00 "allowable expense" cap, Anne may very well end up filing a DIFS complaint if the MAIPF/MACP decides to pursue her or her medical providers for reimbursement of "allowable expense" payments made above $250,000.00. After all, if Anne had been covered by the policy insurer, she would have been entitled to lifetime, unlimited benefits.

This situation is even more pronounced in the case of Cathy, under Scenario #2. Because her accident occurred after July 2, 2020, there is no doubt but that her benefits through the MAIPF/MACP are capped at $250,000.00. However, if she is allowed to claim through the policy insurer, she is entitled to recover lifetime, unlimited benefits. A complaint by Cathy to DIFS over a referral of her claim by the policy insurer to the MAIPF/MACP would almost certainly provoke "administrative action" against the policy insurer, notwithstanding the MAIPF's invitation to refer such claims over to it, as her benefits are undoubtedly being reduced from lifetime, unlimited coverage to a $250,000.00 "allowable expenses" cap.

Maybe all this is academic. Maybe there are no "Annes" or "Cathys" in Michigan who find themselves in this quandary. The author suspects that, in fact, there may quite a few "Annes" or "Cathys" out there, and in the next few months, the issues raised in this article will be played out in the courts.

In conclusion, one might simply throw up their hands and say, "Let the courts sort it out." Frankly, it would have been better for everyone involved in the process – claimants, their providers, and insurers alike – if members of the Legislature and the Governor had taken the time to actually read the bill, understand what's in it, and consult with knowledgeable practitioners on both the plaintiff and defense side over the impact these provisions. The version of SB 1 that was voted on should have been treated as a working draft- not a final product. If they had done so, the uncertainty that all parties find themselves in, regarding not only these issues but others as well, almost certainly could have been avoided.

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