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From the Chair

Lauretta Pominville, *McNish Group*

Thank you to all who joined us on July 14th at the Ford Piquette Avenue Plant for our Business Meeting and Michael Luberto's informative presentation on Title Insurance! It was wonderful to see everyone! Thanks again to Michael and the Real Property Law Section, and to Renee Vander Hagen for all her work to make the event happen.

Annual Meeting

Open positions for officers and council

We hope that you can join us for our Annual Meeting on Thursday, October 20, 2022, beginning at 3:00 pm at the Inn at St. John's in Plymouth, Michigan. We will be holding our Annual Elections at this meeting. If you are interested in joining the Council, or running for either the Treasurer or Secretary position, please email the Section at *sbminsuranceindemnity@gmail.com*. A panel discussion will follow at 4:00 pm concerning

> *"How inflation and rising costs of labor and material can increase an insured's losses after a major catastrophe."*

For details, please visit us on Facebook or at *https://connect.michbar.org/insurance/home*.

On a personal note, as this will be my final From the Chair, I would to thank all of my colleagues on Council – past and present – and the amazing State Bar staff. I have been involved with the Section since its inception in 2007, and it is a source of pride to see it grow and flourish. As Hal Carroll mentioned in his initial From the Chair in the January 2008 inaugural edition of *The Journal*, our Section serves as an intersection with many practice areas, and provides opportunities to exchange views and experiences as well as learn about and discuss the law surrounding those many facets. I wish the best to my successor, Rabih Hamawi, and know that you will be in good hands.

Comments on PIP Benefits for Motorcycles

Lastly, while I have the opportunity, I would like to highlight the conundrum created by the recent changes to the No-Fault structure specific to PIP benefits available to Michigan motorcyclists. MCL 500.3114(5). The issues created by the change need to be addressed and the law revised to give motorcyclists a choice on what PIP benefits are available should they be involved in an accident with a motor vehicle. Bills addressing the issue have been introduced each term since the law was revised, and they have promptly gone to committee to die.

As you may be aware, with the changes to the law, the motorcyclist's selection of PIP benefits is now third on the list of priority – with benefits potentially first coming from the owner or operator of the motor vehicle. Previously, just like everyone else involved in a motor vehicle accident, unlimited lifetime benefits were available. Now, for example, in the event of multiple motorcyclists being struck by one vehicle in one occurrence, which has already happened several times unfortunately since the law changed, all involved motorcyclists potentially split whatever limits the vehicle owner or operator had in place.

I anticipate that we all know more people who ride than we think we do - - your daily barista, plumber, electrician, or lawyer. I've often heard attorneys comment who practice in insurance "Who needs Vegas?" as they consider what a judge or jury may do with regard to a pending issue, but this puts a whole new twist on the concept of randomness and uncertainty, and I respectfully ask that those who have the power and ability to fix the problem - - whatever side of the political fence you're on - - do so.

(And, yes, that's my bike. Ride safe!) ■

Editor's Notes

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

For the record, this is issue number 60 of the *Journal*.

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

And you do not have to be a member to contribute.

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, so being published in the Journal is a good way to reach the decisionmakers in Michigan's judicial and legislative system.

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*. ■

Scenes from our Recent Title Insurance Program

Thursday, July 14, 2022 | Historic Ford Piquette Avenue Plant, Detroit

Moving? Changing Your Name?

In order to safeguard your member information, changes to your member record must be provided in one of the following ways:

- *Login to SBM Member Area* with your login name and password and make the changes online.
- *Complete contact information change form*_ and return by email, fax, or mail. Be sure to include your full name and P-number when submitting correspondence.
- *Name Change Request Form*—Supporting documentation is required

Forms can be found at https://www.michbar.org/programs/address_change

An Insurer's Right to Recoup Defense Costs for Uncovered Claims

By Andy Portinga, *Miller Johnson, PLC*

Often, an insured will be faced with a lawsuit that pleads both covered and uncovered claims. For example, a plaintiff may include a negligence count and an intentional tort in a complaint. While the negligence count is likely covered by a general liability policy, the intentional tort probably isn't. In this type of "mixed action," the insurer will usually agree to defend the case under a reservation of rights. In the reservation of rights letter, the insurer might purport to reserve the right to recoup defense expenses incurred in defending the uncovered claim. If the plaintiff prevails on the uncovered claim but not on the covered claim, can the insured recover defenses expenses incurred in defending an uncovered claim?

If the plaintiff prevails on the uncovered claim but not on the covered claim, can the insured recover defenses expenses incurred in defending an uncovered claim?

While the states are split on this issue, the answer in Michigan is "no." The Michigan Supreme Court definitively answered this question in *Hastings Mutual Ins. Co. v. Mosher Dolan Cataldo & Kelly, Inc.*[1]

In *Mosher*, a homeowner sued a construction firm for alleged defects in a home. Among other things, the homeowner alleged that the firm had used wet timber and, as a result, their home was contaminated with mold. Hastings Mutual agreed to defend the suit under a reservation of rights. In the reservation of rights letter, Hastings Mutual questioned whether the plaintiff's claims alleged an "occurrence" under the policy and whether the mold exclusion applied.[2]

Mosher has a long appellate history, with several trips to the Michigan Court of Appeals and the Michigan Supreme Court. In the case's last visit to the Court of Appeals, the court held that the fungi endorsement in the Hastings Mutual policy excluded any coverage for the homeowner's claims.[3] The court also held that Hastings Mutual's duty to defend was coterminous with its duty to its duty to indemnify.[4] Because of the fungi exclusion, the court held that Hastings Mutual had no duty to defend or indemnify its insured. The court further held that Hastings Mutual was entitled to reimbursement of its defense costs incurred in defending the uncovered claim.[5]

Duty to defend broader than duty to indemnify

The Michigan Supreme Court unanimously reversed.[6] The court noted that an insurer's duty to defend is broader than its duty to indemnify. Even if some claims in a lawsuit are not covered, the insurer still has a duty to defend if there are any theories of recovery that potentially fall within the policy.[7] The court noted that the homeowners in the underlying case alleged water damage to personal property, and that claim was not excluded from the policy. Thus, while the fungi exclusion applied to some of the claims, it did not apply to all of the claims. Because at least some of the claims were potentially covered, Hastings Mutual had a duty to defend the case. And because Hastings Mutual had a duty to defend, it was not entitled to restitution of its defense expenses.[8]

In *Mosher*, the court recognized that the general liability policy contains two independent duties: the duty to defend and the duty to indemnify. The two duties are different in scope and are triggered by different events. In the standard general liability policy, the insurer promises to defend any "suit" seeking damages covered by the policy. The promise to defend extends to "suits," not just claims or causes of action. If a single claim in a lawsuit "even arguably" falls within the scope of coverage, the insurer has the duty to defend the entire suit, despite theories of recovery that are not covered.[9] This is the benefit that the insurer contractually agreed to provide.

The general liability policy also contains a promise to indemnify the insured for damages to which the policy applies. The duty to indemnify is narrower than the duty to defend. An insurer must only indemnify its insured for the damages that actually fall within the scope of coverage.[10] Thus, if a judgment awards damages for both covered and uncovered claims, the insurer must only indemnify the insured for the covered portion of the judgment. If a plaintiff does not prevail on a covered claim, then the insurer has no duty to indemnify.

But the fact that an insurer may not have a duty to indemnify does not negate the insurer's duty to defend. The two duties are not coterminous.[11] Even if the plaintiff fails to prevail on a covered claim, the mere presence of a potentially covered claim triggers the insurer's contractual duty to defend the entire suit. That duty continues until all potentially-covered theories are eliminated from the lawsuit.[12]

The rule adopted by the Michigan Supreme Court in *Mosher* reflects that set forth in the recently-adopted Restatement of the Law of Liability Insurance.[13] The Restatement states, "Unless otherwise stated in the insurance policy or otherwise agreed to by the insured, an insurer may not obtain recoupment of defense costs from the insured, even when it is subsequently determined that the insurer did not have a duty to defend."[14] The Restatement notes that an insurer's failure to include a recoupment provision in the policy is contractually significant. An insurer can include such a provision if it so chooses.[15] But if the insurer does not contract for the right of reimbursement, then the right does not exist.

The *Buss* rule: a limited right to recoup

Not all states follow the rule set forth in the Restatement. Most notably, California follows the *Buss*[16] rule, named after a case involving Jerry Buss, the former owner of the Los Angeles Lakers. In *Buss,* the California Supreme Court held that an insurer could recoup the cost of defending uncovered claims, but the insurer bore the burden of proving that the expenses were incurred in defense of the uncovered claim. Under *Buss*, to the extent that there is uncertainty about whether expenses were incurred in defending covered or uncovered claims, the insurer must bear the expense.[17]

Other states have adopted the *Buss* rule. The Restatement notes that the *Buss* rule is slightly the majority rule, but it also notes that the trend is against adoption of this rule.[18] The Restatement notes that, absent an explicit agreement regarding reimbursement, an insurer that defends a suit containing both covered and uncovered claims is not performing beyond its contractual duties; rather, it is performing in a manner that is consistent with its contract.[19]

In the Eastern District of Michigan, Judge Tarnow endorsed the *Buss* rule in *Travelers Property Casualty Co v R L Polk*.[20] In *R L Polk*, Judge Tarnow held that the insurer had a duty to defend. Despite this holding, and citing *Buss*, Judge Tarnow held that the insurer was entitled to reimbursement of defense costs for those claims that were clearly not potentially or arguably covered by the policy. *R L Polk*, however, pre-dates the Michigan Supreme Court's pronouncement in *Mosher*. No Michigan case post-*Mosher* has adopted the *Buss* rule. *R L Polk* is an outlier and does not reflect current Michigan law.

The reservation of rights letter

But what of the insurer's reservation of rights letter? If an insurer's reservation of rights letter states that the insurer has the right to recoup defense expenses, does that change the analysis? Again, courts are split, but *Mosher* suggests that the answer is Michigan is "no." In *Mosher*, the insurer defended under a reservation of rights.[21] Despite this reservation, the Michigan Supreme Court held that the insurer did not have a right of recoupment.

The problem with an insurer's attempt to reserve the right to recoup defense expenses for uncovered claims is that it presumes the existence of a right that does not exist. If nothing in the policy creates a right of reimbursement, then the insurer has no right to reserve. As the Restatement points out, "Absent a provision in the policy authorizing reimbursement of defense costs, the insurer does not have such a right to preserve."[22] As the Fourth Circuit more colorfully noted, "Assiduous reservation of a non-existent right does not bring that right into existence."[23]

The insurer's implied contract argument

Some courts have held that a reservation of rights letter may allow the insurer to recoup defense expenses under an implied contract theory.[24] The problem with this rationale is that an implied contract cannot exist in the face of an express contract, and the policy is an express contract. By issuing the policy, the insurer promised to defend a suit that contains a potentially-covered claim, and an insurer may not escape that obligation through a unilateral reservation of rights letter.[25] Additionally, a court may only imply a contract to avoid unjust enrichment. But it is not unjust for an insured to expect the insurer to provide a contractually-provided benefit.

The analysis may be different when no duty to defend in the first instance. For example, if the insured procures a policy through fraud and the insurer succeeds in a rescission action, then the policy is void *ad initio*. In this scenario, if the insurer has paid defense costs under a void policy, a court may imply a contract to avoid unjust enrichment.[26] Because the insurer never had a duty to defend in the first place, it would be inequitable to allow the insured to retain a benefit for which it never paid.

The Restatement likewise differentiates between a situation where there is a *factual* uncertainty regarding coverage and where there is a *legal* uncertainty about coverage. For example, in a policy with a pollution exclusion, whether a release of pollutants was "sudden and accidental" would be a factual uncertainty. Whether mold qualifies as a pollutant under the exclusion may be a legal uncertainty. If there is a factual uncertainty regarding coverage, then the insurer has to defend until the factual dispute is resolved in such a way as to preclude the possibility of coverage. If there is a legal uncertainty regarding coverage—that is, a dispute over what the policy means—and that dispute is resolved in favor of the insurer, then the insurer never had the contractual obligation to defend in the first place. In that scenario, the insurer may have the right to recoup a benefit that it was never obligated to pay.

Conclusion

While states are split on an insurer's ability to recoup defense expenses for uncovered claims, the Michigan Supreme Court has rejected such a right in cases where the insurer's

duty to defend is triggered. The Michigan Supreme Court's decision in *Mosher* is consistent with the Restatement, and it reflects the modern trend. It is also consistent with the language of the general liability policy, which imposes a duty to defend suits, not just claims. When the duty to defend is triggered, the insurer must defend the entire suit, even the uncovered portions. Absent an express agreement to reimburse the insurer for the cost of defending uncovered claims, the insured has no such obligation. ■

About the Author

Andy Portinga *is a member of Miller Johnson, PLC, in Grand Rapids, Michigan. His practice focuses on insurance coverage, ERISA, and general commercial litigation.*

Endnotes

1 497 Mich. 919, 856 N.W.2d 550 (2014).

2 *Hastings Mut. Ins. Co. v. Mosher Dolan Cataldo & Kelly*, No. 296791, 2013 WL 1149790 at *1 (Mich. Ct. App. Feb. 14, 2013)

3 *Hastings Mut. Ins. Co. v. Mosher Dolan Cataldo & Kelly*, No. 296791, 2014 WL 265506 at *4, 7 (Mich. Ct. App. Jan. 23, 2014)

4 *Id.*

5 *Id.* At *7.

6 497 Mich. 919, 856 N.W.2d 550 (2014).

7 *Id.*

8 *Id.*

9 *Am. Bumper and Mfg. Co. v. Hartford Fire Ins. Co.*, 452 Mich. 440, 451, 550 N.W.2d 475 (1996).

10 *Id.*

11 497 Mich. 919, 856 N.W.2d 550 (2014).

12 *Detroit Edison Co. v. Michigan Mut. Ins. Co.*, 102 Mich.App. 136, 301 N.W.2d 832, 835 (1980)

13 Restatement of the Law of Liability Insurance § 21 (Am Law Inst. 2019).

14 *Id.*

15 *Id.* cmt. a.

16 *Buss v. Superior Ct.*, 16 Cal. 4th 35, 939 P.2d 766, 65 Cal. Rptr.2d 366 (1997).

17 *Buss*, 939 P.2d at 775-778.

18 Restatement, *supra* cmt a.

19 *Id.* cmt. b.

20 No. 06-cv-12895, 2008 WL 786678 (March 24, 2008).

21 *Mosher*, 2013 WL 1149790 at *1.

22 Restatement, *supra* cmt. c.

23 *Am. Modern Home Ins. Co. v. Reeds at Bayview Mobile Hope Park, LLC*, 176 F. App'x 363, 366 (4th Cir. 2006).

24 See e.g., *United Nat'l Ins. Co. v. SST Fitness Corp.*, 309 F.3d 914 (6th Cir. 2002) (Ohio law).

25 See *Id.* at 923-928 (Clay, J., dissenting).

26 *NCMIC Ins. Co. v. Dailey*, No. 267801, 2006 WL 2035597 at *6 (Mich. Ct. App. July 20, 2006)

Court of Appeals Split Opinion Rules No-Fault Fee Schedules and Caps Do Not Apply to Injuries Prior to June 11, 2019

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

On August 25, 2022, the Court of Appeals released is long-awaited decision in *Andary v USAA Cas Ins Co,* Court of Appeals docket no. 356487. In a 2-1 decision, the Court of Appeals has declared the fee schedule/fee cap limitations set forth in MCL 500.3157(2) through (12) unconstitutional as applied to claims stemming from accidents that occurred prior to the effective date of the 2019 NoFault Reform Amendments. This article will analyze the key holdings from the majority opinion, the issues raised by the dissent, and the practical implications of the court's ruling from a claims perspective.

The Panel

First, some background on the judges who were assigned to the Court of Appeals' panel is in order. The majority opinion was authored by Judge Doug Shapiro. Judge Shapiro is a former Plaintiff's personal injury attorney from Ann Arbor, who was appointed to the Court of Appeals' bench in 2009 by former Democratic Governor Jennifer Granholm. Judge Shapiro was joined by Judge Sima Patel, who was just appointed to the Court of Appeals' bench earlier this year by Democratic Governor Gretchen Whitmer. Prior to being appointed to the Court of Appeals, Judge Patel was an appellate specialist with

the well-known Geoffrey Fieger Law Firm. The dissent was authored by Judge Jane Markey. Judge Markey was elected to the bench in 1994 and she is one of the longest serving judges on the Michigan Court of Appeals.

The Plaintiffs' Declaratory Action

The individual Plaintiffs, Ellen Andary and Philip Krueger, were catastrophically injured in motor vehicle accidents occurring in 2014 and 1990 respectively. The third Plaintiff is the Eisenhower Center, which is a traumatic brain injury rehabilitation facility in Ann Arbor which provided treatment to Phillip Krueger. Shortly after the NoFault Reform Amendments were passed in 2019, the three Plaintiffs filed suit in the Ingham County Circuit Court, seeking a declaratory judgment that the 2019 NoFault Reform Amendments, including the new fee schedule/fee cap limitations set forth in MCL 500.3157(2) through (12) were unconstitutional as applied to them.

In lieu of filing an answer to the complaint, the two insurers, USAA Casualty Insurance Company (which insured Ms. Andary) and Citizens Insurance Company of America (which insured Mr. Krueger) filed a motion to dismiss, arguing that the 2019 NoFault Reform Amendments were constitutional even as applied to claim stemming from accidents that had occurred prior to June 11, 2019, the date that the NoFault Reform Amendments became effective. Judge Wanda Stokes, of the Ingham County Circuit Court, granted Defendants' motion to dismiss following extensive briefing and oral argument. Plaintiffs filed a motion for reconsideration and to amend complaint in order to add a breach of contract claim. Judge Stokes denied these motions, noting that any such amendment to the complaint would be futile. Plaintiffs promptly filed a claim of appeal as of right with the Michigan Court of Appeals.

Issue I – Retroactivity

Generally speaking, statutes are presumed to operative prospectively. *Davis v State Employees' Retirement Board,* 272 Mich App 151, 155; 725 NW2d 56 (2006). In order to give a statute retroactive effect, the Legislature must clearly manifest an intent to do so. *Johnson v Pastoriza,* 491 Mich 417, 429; 818 NW2d 279 (2012). In this regard, the insurers pointed to two sections – one found in the NoFault Act itself (Chapter 31) and one found in Chapter 21 of the Insurance Code (dealing with insurance rates). MCL 500.3157(14) makes it clear that the fee schedule/fee cap limitations apply to all "treatment" (defined in MCL 500.3157(15)(k) as including "products, services, and accommodations") and all claims for expenses incurred after July 1, 2021, without regard to whether the accident giving rise to the claim occurred before or after June 11, 2019. The majority does not discuss this new statutory provision in any way, shape or form.

The second statute, relied upon by the defendants to demonstrate that the Legislature intended the statute to apply retroactively, is MCL 500.2111f(8), which, like the fee schedule/fee cap limitations, was part of the two bills that make up the 2019 NoFault Reform Amendments, 2019 PA 21 and 2019 PA 22. This particular amendment has a rather interesting history. In the first NoFault Insurance Reform Act, 2019 PA 21, the new statutory provision read as follows:

> "An insurer shall pass on, in filings to which the section applies, savings realized from the application of section 3157(2) to (12) to treatment, products, services, accommodations, or training rendered to individuals who suffered accidental bodily injury from motor vehicle accidents that occurred *before the effective date of the amendatory act* that added this section." (Emphasis added)

The second bill, 2019 PA 22, amended this section to its present form:

> "An insurer shall pass on, in savings to which this section applies, savings realized from the application of section 3157(2) to (12) to treatment, products, services, accommodations or training rendered to individuals who suffered accidental bodily injury from *motor vehicle accidents that occurred before July 2, 2021*. An insurer shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to evaluate the insurer's compliance with this subsection. After July 1, 2022, the director shall review all rate filings to which this section applies for compliance with this subsection." (Emphasis added)

In her dissent, Judge Markey noted the significance of the changes in MCL 500.2111f(8), brought about by 2019 PA 22, as follows:

> "It is clear that the change made to MCL 500.2111f(8) in 2019 PA 22 was to capture realized savings in regard to accidental bodily injuries occurring not only before June 11, 2019, but also those arising before July 2, 2021."
>
> *Andary*, dissenting opinion of Markey, J., p 6 fn 4.

Nonetheless, Judge Shapiro's majority opinion dismisses the import of MCL 500.2111f (8) by noting:

> "But this rate-setting provision does not mandate that the limits on benefits provided in MCL 500.3157 shall be applied to persons injured before its effective date. And the claim that it does so by implication is very weak. The statute merely provides that if there are such savings, they must be

> used to reduce future rates. Whether such savings will occur is not defined by this statute. For these reasons, we conclude that MCL 500.2111f does not 'clearly, directly and unequivocally' demonstrate an intent to apply the new limits retroactively."
>
> *Andary*, majority opinion @ pgs 5-6

Because there was nothing specifically in Chapter 31 of the Insurance Code (the NoFault Insurance Act) that indicated that the fee schedule was to apply to those individuals injured in motor vehicle accidents occurring before June 11, 2019, the majority concluded that the statute could not apply "retroactively."

Judge Markey was highly critical of the majority's dismissal of the import of MCL 500.2111f(8):

> "I find this logic in rejecting the plain and unambiguous language of MCL 500.2111f(8) to be 'very weak.' In fact, the reasoning escapes me. To the extent that we are truly dealing with retroactive application, MCL 500.2111f(8) clearly, directly, and unequivocally demonstrates legislative intent to reach accidents and injuries occurring before June 11, 2019. [Citation omitted] The majority indicates that if there are "such savings" by an insurer under MCL 500.2111f(8), the insurer must reduce future rates. This argument appears to suggest or accept that insurers can indeed reap savings by making PIP payments consistent with MCL 500.3157 in relation to accidents occurring before July 2, 2021, which necessarily includes dates before June 11, 2019. And the majority's concern regarding '[w]hether such savings will occur' entirely misses the point that under MCL 500.2111f(8) the Legislature was effectively directing no-fault insurers to apply the fee schedules and limitations in MCL 500.3157 to existing PIP cases in order to realize savings. Finally, the majority dismisses MCL 500.2111f(8) because it is in a different chapter of the Insurance Code of 1956, MCL 500.100 et seq., then MCL 500.3157. This contention ignores the fact that MCL 500.2111f(8) incorporates MCL 500.3157 by direct reference and that the statutes were both part of the overhaul of the No-Fault Act under 2019 PA 21 and 2019 PA 22."
>
> *Andary,* dissenting opinion of Markey, J, pg 6.

The author will leave it up to the reader to decide which side has the better argument.

At this point, the reader may be wondering whether the Legislature could quickly correct this defect by enacting a simple, one statute amendment to MCL 500.3157, which reads something like this:

> "The provisions of MCL 500.3157(2) through (12) apply to all claims for benefits incurred after July 1, 2021, regardless of the date of loss giving rise to the claims for benefits."

Any such amendments, though, would be futile because the majority went on to note that even if the statute was properly retroactive, it still violated the Contracts Clause in the Michigan Constitution, as it substantially impaired the obligations of the parties under the contracts that were in effect at the time of the accident- the insurance policy itself. It is to this topic that we now turn.

Accordingly, the majority concluded that even if there was a manifest intent to have the no fault fee schedule/fee cap limitations apply to all accidents, regardless of when they occurred, the statute would still be unconstitutional, at least as applied to claims arising out of accidents occurring before June 11, 2019. This holding effectively precludes the Legislature from trying to legislatively "cure" the retroactivity problems identified in part 1 of the Court's opinion.

Issue II – Contracts Clause Violation

Article 1, Section 10 of the Michigan Constitution contains the following provision:

> "No bill of attainder, ex post facto law or law impairing the obligation of contract shall be enacted."

The majority acknowledges that statutes are presumed to be constitutional, and that the statute must be interpreted as being constitutional unless its unconstitutionality is "clearly apparent." The majority noted that in order for there to be a violation of the Contracts Clause of the Michigan Constitution, three factors must be considered:

> (1) Whether a change in state law has resulted in a substantial impairment of a contractual relationship;
>
> (2) Whether the legislative disruption of contract expectancies is necessary to the public good; and,
>
> (3) Whether the means chosen by the Legislature to address the public need are reasonable.

With regard to the first factor, the majority concluded that application of the fee schedule/fee limitations to accidents that predated June 11, 2019, resulted in a "substantial impairment of the injured plaintiffs' rights under the policies." *Id*, majority opinion at p 12. The majority went on to note that prior to the no-fault reform measures, providers were paid without regard to fee schedules, and there was no cap on how many hours of attendant care could be provided by the injured person's family. However, under the new fee schedule limitations, providers of services not payable under Medicare would have their charges reduced by 45 percent from what they had been charging on January 1, 2019. As a result of these reductions, the majority recognized that, "The practical effect is that many providers will no longer be able to offer these services." *Id*, slip opinion at p 12. The majority summed up its analysis of this issue as follows:

> "In sum, the impairments are more than substantial; they wholly remove numerous duties to be performed by one party to the contract after the other party has fully performed their duties under the contract. Accordingly, we conclude that the impairment of contract is severe. *Id,* majority opinion at p 12."

With regard to the second prong, the majority did not quarrel with the insurers' contention that the provisions of 2019 PA 21 and 2019 PA 22 concerned a legitimate public purpose of lowering nofault insurance premiums. Nonetheless, the majority brushed aside these concerns by noting that:

> "Defendants do not explain what significant and legitimate public purpose justifies applying the amendments to those injured before the effective date. Nor do they explain how applying the amendments retroactively is 'reasonably related' to the public purpose of lowering nofault insurance rates. As discussed, the fee schedules and attendant care cap drastically reduce the previously unlimited PIP benefits, and there has been no demonstration that the rest of 2019 PA 21 would be affected if the amendments are applied prospectively only. The goal of lowering insurance rates is contingent on the lowering of benefits, but because the lowering of premiums is only prospective, it would severely limit the benefits promised in the policies when higher premium rates, reflective of the greater benefits, were charged and paid for. And since the insurers have already been paid for the benefits promised under those policies, retroactive application would permit insurers to retain all the premiums paid prior to the 2019 amendments while allowing them to provide only a fraction of the benefits set out in those policies. Giving a windfall to insurance companies who received premiums for unlimited benefits is not a legitimate public purpose, nor a reasonable means to reform the system."
>
> *Id,* majority opinion at p 13.

Accordingly, the majority concluded that even if there was a manifest intent to have the nofault fee schedule/fee cap limitations apply to all accidents, regardless of when they occurred, the statute would still be unconstitutional, at least as applied to claims arising out of accidents occurring before June 11, 2019. This holding effectively precludes the Legislature from trying to legislatively "cure" the retroactivity problems identified in part 1 of the Court's opinion.

Judge Markey disagreed with the majority's analysis of the constitutional issues. She noted that because the benefits are statutory in nature, they "may be revoked or modified at the will of the Legislature." *Romein v General Motors*, 436 Mich 515, 532, 462 NW2d 555 (1990). She also noted that given the well-documented concerns over the high cost of nofault insurance in this state, the means adopted by the Legislature were "significant, reasonable, and legitimate, serving the public good" because by passing the nofault reform measures, the Legislature required "insurance companies to pass cost savings onto insureds." *Andary,* dissenting opinion of Markey, J, p 9. In short, in the eyes of Judge Markey, there was "nothing arbitrary or irrational about the Michigan Legislature taking steps to make nofault insurance, which is mandatory for owners or registrants of motor vehicles, as affordable as possible for as many Michiganders as possible, especially where it is generally known that Michigan drivers had paid the highest auto insurance rates in the country." *Id*, at p 10.

Issue III – Application of the Fee Schedule to Claims Arising out of Accidents Occurring After June 11, 2019

Throughout the course of the *Andary* lawsuit, both sides were focused intently on the primary issue involved in that case; i.e., whether the 2019 NoFault Reform Amendments applied to claims stemming from accidents that occurred prior to June 11, 2019. Lost in the arguments was the fact that Plaintiffs were not only challenging the application of the nofault fee schedules/fee caps to losses occurring before June 11, 2019. They were also challenging the application of the fee schedule/ fee caps to losses occurring **after** June 11, 2019, as well. In this regard, Plaintiffs raised both due process and equal protection challenges. The Court of Appeals' majority agreed with the lower court that neither of the individual Plaintiffs, Ms. Andary or Mr. Krueger, had standing to challenge the application of the nofault fee schedule/fee caps to losses occurring after June 11, 2019, given the fact that their accidents occurred in 1990 and 2014.

However, the third Plaintiff, Eisenhower Center, clearly had an interest in whether or not the fee schedule/fee caps

were constitutional as applied to post-June 11, 2019, losses. In fact, the majority noted that "Eisenhower Center, as a provider of care and services to catastrophically injured accident victims, clearly retains a distinct and palpable injury that our decision regarding retroactive application does not resolve." Therefore, the Court of Appeals remanded the matter back to the trial court to determine whether or not the nofault fee schedules/fee caps were unconstitutional as being in violation of the equal protection and due process clauses of the Michigan Constitution, *even as applied to post-June 11, 2019, losses*. In this regard, the Court of Appeals may have sent the proverbial "shot across the bow" that even application of the nofault fee schedules/fee limitations to post-June 11, 2019, losses may be unconstitutional as well.

Where Do We Go From Here?

The Court of Appeals' decision, while not unexpected given the makeup of the panel which heard the case, is nonetheless a bombshell to the insurance industry. To the extent that the insurance industry pinned its premium reductions, along with the recent $400.00 per vehicle refund on the assurance that the fee schedule/fee cap limitations would apply to expenses incurred after July 1, 2021, but arising out of pre-June 11, 2019, losses, those hopes have now been dashed.

From a procedural standpoint, the insurers have until October 6, 2022, to file an Application for Leave to Appeal with the Michigan Supreme Court. They will undoubtedly do so. However, simply filing an Application for Leave to Appeal will not stay the effect of the Court of Appeals' decision, absent an Order for Stay of Proceedings. At this point, the Court of Appeals' decision is scheduled to take effect on Thursday, September 15, 2022 – 21 days after the date it was issued.

The author anticipates that a Motion to Stay the effective date of the Court of Appeals' judgment will be filed first with the Court of Appeals, along with a Motion for Immediate Consideration. Failing that, a Motion to Stay the effect of the Court of Appeals' judgment will be filed with the Michigan Supreme Court, along with another Motion for Immediate Consideration.

Although somewhat unusual, it would not be the first time that a court has delayed the effectiveness of a judgment declaring a part of a statute as being unconstitutional. Indeed, one need only review the Supreme Court's first decision regarding the constitutionality of the NoFault Insurance Act in general, *Shavers v Kelley,* 402 Mich 554, 267 NW2d 72 (1978). In that case, the Supreme Court declared that the compulsory insurance requirement set forth in the NoFault Insurance Act, as well as other sections of the Michigan Insurance Code, were unconstitutional because it did not afford policyholders due process protections. *Shavers,* 267 NW2d at 91. Nonetheless, in order to avoid disrupting the statutory scheme, and in order to allow the Legislature time to correct the deficiencies identified by the Supreme Court in its opinion, the Court delayed the effective date of its decree of unconstitutionality for 18 months. The Legislature eventually passed the Essential Insurance Act of 1980, which satisfied the due process concerns raised by the Supreme Court.

Absent a stay, though, the Court of Appeals' decision will have a dramatic impact on claims for benefits that have already been processed under the nofault fee schedules. We will next examine how the Court of Appeals' decision affects claims in three categories – pre-June 11, 2019, losses; post-June 11, 2019, losses; and MACP claims.

Effects on Claims Stemming from Pre-June 11, 2019 Losses

Re-Categorization of Claims

Assuming that both the Court of Appeals and the Supreme Court refuse to stay the effective date of the Court of Appeals' judgment, insurers that have issued insurance policies will need to contact their medical expense auditing company and have them segregate previously processed claims for expenses incurred after July 1, 2021 into two categories – one for pre-June 11, 2019, accidents and one for post-June 11, 2019, accidents. With regard to the first category, those expenses would need to be repriced, utilizing the old "reasonable and customary" standard, and to the extent that there is a difference between the "reasonable and customary" amount and the fee schedule amount, the insurer will need to issue differential payments to the medical provider.

Significant Increase in Provider Suits

This writer anticipates a significant increase in the number of provider suits that will be filed in the next few months, in which the provider will be attempting to secure these differential payments in the event that the Court of Appeals' decision is ultimately affirmed by the Michigan Supreme Court.

This would be a logistical nightmare for insurance carriers in this state. No doubt but that there are perhaps hundreds of thousands of claims that have been processed under the new fee schedule/fee cap limitations, even with regard to losses that occurred prior to June 11, 2019.

It also important to understand that the scope of the Court of Appeals' decision extends well beyond the attendant care and in-patient residential care that were specifically at issue in *Andary*. Every MRI scan, every physical therapy treatment, every injection, every chiropractic adjustment and every surgical procedure that arises out of a pre-June 11, 2019 loss will need to be repriced under the old "reasonable and customary" standard, and the appropriate differential payment issued.

Post-June 11, 2019, Losses

For the time being, the fee schedule/fee cap limitations apply to claims arising out of accidents occurring after June 11, 2019. However, as noted above, there is another constitutional challenge lurking, regarding the Due Process and Equal Protection claims referenced by Eisenhower Center in the Complaint, which will need to be addressed in the future. Right now, to the extent that the insurer has already paid those claims under the fee schedule, nothing needs to be done, assuming that there are no other issues (such as application of Medicare rules, improper coding, etc.)

It also important to understand that the scope of the Court of Appeals' decision extends well beyond the attendant care and in-patient residential care that were specifically at issue in Andary. Every MRI scan, every physical therapy treatment, every injection, every chiropractic adjustment and every surgical procedure that arises out of a pre-June 11, 2019 loss will need to be repriced under the old "reasonable and customary" standard, and the appropriate differential payment issued.

Michigan Assigned Claims Plan Issues

By definition, there are no insurance contracts at issue in claims that are being handled by the Michigan Automobile Insurance Placement Facility (MAIPF), which operates the Michigan Assigned Claims Plan (MACP), and its servicing insurers. The benefits paid by the MAIPF/MACP and its servicing insurers are purely statutory in nature.

Therefore, because the *Andary* majority opinion is based on the existence of contracts of insurance between the insurance companies and their insureds at the time of the accident, is the MAIPF/MACP bound by this decision?

In the author's opinion, the answer is no. In *Andary*, the insurers had argued that nofault benefits are purely statutory in nature, which could be modified at the will of the Legislature. Judge Shapiro, writing for the majority, rejected this argument, noting that:

> "Under *LaFontaine* [*v Chrysler Group LLC*, 496 Mich 26, 852 NW2d 78 (2014)], even if defendants are correct that no-fault benefits are purely statutory, the relevant statute is the one that existed when the policies were issued. **But we reject defendants' characterization; PIP benefits are not *purely* statutory in nature.** The no-fault act sets the mandatory minimum coverage for PIP policies and is the "rule book" for disputes over that coverage, [Citation omitted], but it does not follow that the policies sold by insurers promising unlimited lifetime care are nullities. Indeed, suits against insurers for PIP benefits are brought as contract actions, and insurers may pursue traditional contract defenses [which] have not been abrogated by the no-fault act. [Citation omitted]. It is clear therefore that a PIP policy confers enforceable contract rights upon those entitled to benefits."
>
> *Andary,* slip opinion at p 9.

In fact, Judge Shapiro's opinion overlooks the fact that there is an entire class of claimants out there who are receiving nofault insurance benefits without the benefit of an insurance contract – those individuals claiming under the MACP.

Since the majority opinion is based on the existence of a contract of insurance in effect between the claimant and the injured party (or one where the injured party is in an intended third party beneficiary of the insurance contract), the flip side should be true. If there is no contract of insurance (and there cannot be in the case of an MACP Claimant), then there can be no reliance on the existence of a contract which guarantees them lifetime, unlimited benefits.

Obviously, this issue was not before the Court of Appeals, as neither Andary nor Krueger were MAIPF/ MACP claimants. Therefore, it would seem that in cases involving MAIPF/MACP claimants, their benefits are, in fact, purely statutory in nature and as such, can be modified at will be the Legislature. Therefore, it is the author's opinion that the fee schedule/fee cap limitations set forth in MCL 500.3157(2) through (12) apply to MAIPF/MACP claimants, regardless of the date of loss.

Concluding Remarks

Obviously, all interested parties will have a better idea of how this significant decision affects their claims once we see if a Stay of Proceedings is entered and whether the Supreme Court decides to accept the Application for Leave to Appeal, and possibly review the matter on an expedited basis. As matters currently stand, there is nothing the Legislature can do with regard to the application of the fee schedule/fee cap limitations to pre-June 11, 2019 losses. Rather, it is up to the Supreme Court to weigh in on that issue.

In hindsight, wouldn't it have been better if the bills that eventually became 2019 PA 21 and 2019 PA 22 had been subject to committee hearings where no-fault experts, on both sides of the aisle, could have weighed in on the proposed reform measures, pointed out potential constitutional deficiencies (such as what has now come to fruition) and other

problems with the initial draft (such as the problems with motorcyclists being bound by the motor vehicle owner's PIP choice options) in order to give the Legislature a road map to correct these problems? Maybe explicitly "grandfathering in" claims arising out of accidents occurring before June 11, 2019, in exchange for a lesser reduction in PIP premiums and foregoing the $400 per vehicle premium refund would have been a better solution.

Wouldn't it have been better if those most affected by no-fault reform, including insurers, Claimants and providers, had an opportunity to weigh in on the specific provisions of the bills that affected their interests (most claims representatives I have spoken with have indicated that the fee schedule/ fee cap limitations are far too complex), in order to make sure that the reforms did what they were supposed to do, and that there would be no unintended consequences?

Maybe basing the fee schedule/ fee cap limitations on Michigan's already–existing workers compensation fee schedule would have been a simpler fix. Wouldn't it have been better if the Legislature had actually read the bill before they voted on it? After all, 2019 PA 21 was 115 pages in length and it took this writer literally hours over Memorial Day weekend in 2019 to read the bill and understand its implications. Wouldn't it have been better if the Governor had likewise read the bill and understood its implications before she signed it? As matters now stand, the Court of Appeals' decision in *Andary* represents a significant blow to the insurance industry, and this writer is not quite sure that it will be, or can be, fixed down the road. ■

Assignment of No-Fault Automobile Insurance Claims after 2019 PA 21

By Paul Carrier, Esq.

Persons injured in automobile accidents have long possessed the common-law right to assign their accrued claims to their services providers. The ability of assignees to pursue legal claims to no-fault automobile insurance benefits has features to recommend it. For example, services providers[1] can thusly take charge of their own claims, using their own billing systems and personnel to ensure recovery as well as benefitting from efficiencies and economies of scale.[2] A 2019 amendment to the No-Fault Act[3] has codified the right of qualifying services providers to bring their actions directly against no-fault insurers without the need for an actual, contractual assignment. A question becomes whether anything has changed in light of this new statutory empowerment.

Covenant and the Right of Direct Action

Prior to the Michigan Supreme Court's ruling in *Covenant Medical Ctr, Inc v State Farm Mut Auto Ins Co*,[4] a line of Michigan Court of Appeals cases had already recognized a right of certain licensed services providers[5] to bring an action for compensation directly against no-fault insurers.[6] A Michigan Supreme Court majority in *Covenant* found that the No-Fault Act,[7] and particularly the terms of MCL 500.3112, did not provide for a direct right of action in services providers under the clear language of the statute. 2019 PA 21, effective June 11, 2019 for the majority of changes made to the No-Fault Act in 2019, amended Section 3112 to specifically include the right in qualified services providers to make "…a claim and assert a direct cause of action against an insurer, or under the assigned claims plan under sections 3171 to 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person."[8] Accordingly, the pre-*Covenant* right of qualified services providers to maintain their own claims to no-fault benefits was statutorily restored.[9]

Because case law prior to *Covenant* already recognized the right of qualified services providers to bring their own causes of action directly, the statutory reinstatement of this right in 2019 does not appear to have led to any particularly noteworthy differences between the contractual and the statutory rights of services providers to bring claims directly against insurers. The same issues of potential disconnect remain, including those of *res judicata* when insureds and services providers both file their own claims involving the same accident and maintain respective claims to payment for services, the applicable statute of limitations in the case of intervention practice, etc.

The *Covenant* ruling did lead to some scrambling by services providers who had filed claims in their own capacity prior to this ruling but who had not secured contractual assignments of claims by the time that *Covenant* was decided. This left

these services providers without any claim(s) even after having filed their own complaints,[10] and the statute of limitations activity for purposes of the one-year-back rule was found to be the date of the assignment by the claimant rather than the date of the filing of the complaints. As expressed in *Jawad A. Shah MD., P.C. v. State Farm Mutual Auto Ins Co*, 324 Mich App 182, 204; 920 NW2d 148 (2018), services providers who had filed claims before *Covenant* was decided were afforded no greater rights than the insured possessed on the date of the assignment. Moreover, an argument by a services provider in this situation that it was amending its complaint rather than supplementing it would not prevail.[11] Incidentally, the provisions discussed herein apply equally to the situation where there is no responsible insurer such that a party injured in an accident involving a motor vehicle may seek redress from the Michigan Automobile Insurance Placement Facility ("MAIPF") and its managed Michigan Assigned Claims Plan ("MACP").[12]

Incidental Beneficiaries

Noteworthy is the fact that the line of cases overruled by *Covenant* avoided application of the common law rules on incidental beneficiaries as codified in MCL 600.1405. At common law and as this statute reflects, only intended beneficiaries would have the right to sue on the promisor's specific commitment to them. The mechanism to effectuate treatment of services providers as "intended" beneficiaries in the absence of its recent statutory recognition must have been a focus on the primacy of no-fault policy to afford "assured, prompt and adequate reparation" for certain economic losses over the common (and statutory) law on intended and incidental beneficiaries. The potential of extensive and complicated involvement in litigation on the part of what would otherwise be considered "incidental" beneficiaries likely facilitated this break from black letter, third-party beneficiary law.

The same status as "intended beneficiary" would apply where claims are brought against MAIFP/MACP even in the absence of an underlying contract. Presumably, by legislative fiat, a contract is "implied in law," based on a theory akin to quantum meruit. Furthermore, the influence of the pro-coverage policy enshrined in the No Fault Act and by cases such as *Shavers v. Kelley*[13] is also evidenced by the development of case law on the issue of innocent third parties who seek benefits.[14] The following address some of the more common issues regarding assignment of no-fault claims.

Assignment of Accrued Claims

MCL 500.3143 clearly prohibits the assignment of future claims.[15] Accordingly, attempts by services providers to seek pre-injury prohibition on assignment of (future) claims are unavailing. With regard to accrued claims, which may be assigned, there are three key factors: 1) a claim accrues when services have been rendered and payment becomes due (i.e., that moment when a claimant is liable);[16] 2) a claimant has submitted reasonable proof of loss (the duty over which is suspended until sufficient proof is established);[17] and 3) where necessary, that moment when a required payment becomes overdue.[18] In the case that the last factor becomes relevant, the responsible insurer becomes liable for statutory interest[19] and attorney's fees.[20]

Anti-Assignment Clauses in Policies and in Settlement Agreements

Insurers have tried in the past to prevent assignment of no-fault claims by including anti-assignment clauses in their policies. Generally, unambiguous language in a contract should be enforced.[21] However, there is long-standing precedent denying the ability of a contractual party to prevent assignment of accrued claims. *See Jawad A Shaw, MD, PC v State Farm Mutual Auto Ins Co*, 324 Mich App 182, 197-201; 920 NW2d 148 (2018). The mechanism to effectuate divergence from specific contractual language is the interpretation of a contract of insurance not only based on its specific language but also by weaving in the statutory requirements of the No-Fault Act as if they were part of the agreement.[22] Stated another way, anti-assignment clauses in general violate public policy for accrued claims.[23]

Additionally, claimants to no-fault benefits are not required to assign all of their rights but may do so piecemeal. Preventing assignment of claims in piecemeal fashion does have some appeal, such as permitting insurers to coordinate their activities with a single claimant (and counsel). However, an attempt to rely on the common law rule requiring joinder of claims to deny partial assignments was rejected in *Henry Ford Health Systems v Everest Nat'l Ins. Co.*, 326 Mich App 398; 927 NW2d 717 (2018). In *Henry Ford Health Systems*, the Court of Appeals panel per curiam ruled that MCR 2.205 on necessary joinder of parties replaced the common law rule against splitting a cause of action. *Id.*, 326 Mich. App. at 407-408. Notably, this permits multiple filings that often lead to motions to intervene, which in turn poses the risk of potential, increased strain on judicial resources. This, however, may be counterbalanced by reaching the right results in that there are more parties, with counsel involved, to ensure that the process unfolds in the best interest of all parties involved. This provides every services provider with its own day in court, so to speak, if such is desired.[24]

There is one exception to the prohibition against assignation of claims including future claims, i.e., where a claimant has filed a complaint and has entered into a settlement agreement with the insurer before an assignee has provided notice of claim to the insurer. In *Michigan Ambulatory Surgical Ctr v Farm Bur Gen Ins Co of Michigan*, 334 Mich App 622; 965 NW2d 650 (2020), the Court of Appeals, over one dissent, ruled that an agreement not to assign claims (even future ones) that was contained in a *settlement agreement established after the claimant had filed a complaint* was enforceable where such

agreement was reached *prior to* any notification by a services provider of its claim(s) and as set out in MCL 500.3112. This has been justified first by the tenet protecting freedom of contract and its corollary - the policy favoring settlement agreements. *Id.*, 334 Mich. App. at 631-632.[25]

Licensing Requirements

While nothing has changed since the enactment of MCL 2019 PA 21, the importance of proper licensing remains a major subject of litigation. MCL 500.3157(1) pronounces that services providers "lawfully render" services where they possess the proper professional license.[26] The lack of a license to conduct business in the state, of itself, is not fatal to the exercise a direct cause of action for no-fault benefits by services providers.[27] The lack of a professional license, however, has been held to violate the requirement of lawful rendering required by §3157(1).[28] The requirement of a professional license, however, applies equally to rights asserted either by contractual assignment or by statutory right.[29] This involves the licensing requirements of medical doctors and physician's assistants,[30] chiropractors,[31] physical therapists,[32] and other professions related to physical restoration and rehabilitation.

Res Judicata and Collateral Estoppel[33]

It is often said an assignee stands in the shoes of the assignor.[34] By unanimous decision in *Mecosta County Med Ctr v Metropolitan Group Prop & Cas Ins Co*, ___ Mich ___; ___ NW2d ___ (2022) (Docket No. 161628), the Michigan Supreme Court upheld this principle. The injured insured pursued claims in one circuit court after he had assigned certain of his claims to services providers. In the insured's case, it was determined that the claimant was not entitled to benefits for failure to properly insure his vehicle as its co-owner. However, because the assignment had already been made, the ruling in the claimant's case was asserted against the insurer in the insurer's case in front of a different circuit court. The doctrines of res judicata and collateral estoppel were asserted to prevent the assignee's claims, but the respective circuit court ruled that the doctrines did not apply to the assignees because they were neither party to the other lawsuit nor in privity with that claimant.

Statute of Limitation

Perhaps the most litigated issues stemming from the two distinct rights to assert claims, i.e., those of a claimant which may be assigned and those of services providers to bring their own claims directly, involve statute-of-limitations questions. MCL 500.3145 sets forth the applicable statutes of limitation applicable to claims for no-fault automobile insurance benefits. A significant question is the application of the statute of limitations in the case where an injured insured has filed a claim and a services provider (whether by contractual or statutory assignment) subsequently seeks to intervene. Does the limitations period commence with the filing of the injured claimant's action, or on the date of the assignment? As a general rule, the statute of limitations period focuses upon the filing of a complaint for intervention and does not relate back to the date of the filing of the complaint. *See Miller v Chapman Contracting*, 477 Mich 102, 106; 730 NW2d 462 (2007) (attempt to add bankruptcy trustee as a new party was substantive and not corrective of a misnomer, and so amendment did not relate back to original pleading). On the other hand, in at least two unpublished Court of Appeals opinions, those courts ruled that in the case of claims stemming from a particular accident, the addition of a "new party" intervening plaintiff involved technically "new" parties but not any new, unanticipated claims. *See Jones v Farmers Ins Exchange*, unpublished opinion per curiam of the Court of Appeals, decided November 23, 2010 (Docket No. 293206); *Oostdyk v. Auto Owners Ins. Co*, unpublished opinion per curiam of the Court of Appeals decided December 30, 2014 (Docket No. 317221), *lv den* 498 Mich 913 (2015).

Conclusion

Data strongly suggests that automobile accident insurance rates in Michigan have consistently been among the highest in the nation. Attribution has been made to climbing medical costs as well as to increased litigation,[35] although there are recent indications of lowering rates.[36] Whereas the direct cause of action in services providers could be used to streamline the collection process and therefore lead to efficiencies, there is the risk that this system may incentivize horizontally and vertically connected businesses to provide unnecessary services from a business perspective. This is perhaps the reason behind proposed amendment of the No-Fault Act proposed in HB 5931(2022), which seeks to rescind the MCL 500.3112 language authorizing the direct cause of action in services providers to recover overdue benefits from insurers. Arguably, a better approach is to more fully define, by statute if necessary, the parameters of the "necessity" elements for services and charges as required by MCL 500.3107(1)(a), or minimum standards for the nature of proof required to meet these requirements. ■

About the Author

Paul Carrier *is law clerk to Judge John A. Murphy of the Third Circuit Court Civil Division, where the majority of his work involves automobile no-fault insurance law. Paul also worked as a research attorney for the Michigan Court of Appeals - Detroit Prehearing including several special clerking assignments with judges helping to reduce the docket, as well as for former Michigan Supreme Court Justice Dorothy Comstock Riley. His email address is Paul.Carrier@3rdcc.org.*

Endnotes

1 MCL 500.3107(1)(a) requires reimbursement for reasonably supported and reasonably charged products, services and accommodations. For purposes of simplicity, reference will be to "services providers" or similar, intended to include products or accommodations where appropriate.

2 The most obvious economy is not having to collect and send what may be reams of medical data to opposing counsel and efforts to coordinate with said counsel until payment is received.

3 MCL 500.3101 *et seq*.

4 500 Mich 191; 895 NW2d 490 (2017). Justice Zahra wrote the majority opinion, signed onto by four other Justices. One Justice dissented (Bernstein) and one did not participate in the disposition (Wilder).

5 The basic description of authorized services providers is found in MCL 500.3157. Subsection (1) requires that such providers "lawfully render" treatment to victims of automobile accidents, which in turn implicates state licensing requirements of facilities found in the Public Health Code's Article 17, 1978 PA 368, *see e.g.* MCL 333.20101 *et seq*., as well as for licensing of professionals authorized to provide health care services found in Article 15, *see* MCL 333.16101 *et seq*.

6 A list of Court of Appeals cases that were overruled by *Covenant* is found at 500 Mich. at 201-203.

7 MCL 500.3101 *et seq*.

8 Certain other amendments took effect in July 2021, for example a weekly-hours caps to home health care benefits for services provided by non-licensed individuals such as family members. *See* MCL 500.3157(1); DIFS Bulletin 2019-22-INS. Other amendments, such as caps to benefits tied to Medicare reimbursement amounts, also took effect on July 1, 2021. 2019 PA 21, §3157(2)(a), *codified at* MCL 500.3157(2). Another change that took effect from July 1, 2021, is a cap on catastrophic claims. 2019 PA §3104(2), *codified at* MCL 500.3104(2). (In a recent plurality opinion, the Court of Appeals invalidated the retroactive application of these caps. *Andary v. USAA Cas. Ins*. Co., --- Mich. App. ---; --- N.W.2d --- (2022), decided August 25, 2022, Docket No. 356487). The direct cause of action also applies to claims where there is no identifiable no-fault insurer who may be liable, leaving resort to the Michigan Automobile Insurance Placement Facility and the Michigan Assigned Claims Plan. MCL 500.3171-MCL 500.3175.

9 *See, Spectrum Health Hospitals v. Michigan Assigned Claims Plan*, 300 Mich. App. 21, 28 and n. 4; 944 N.W.2d 412 (2019).

10 Court clarification of statutory language is typically remedial and therefore immediately applicable rather than subject to prospective treatment. Pronouncements by courts with supreme jurisdiction overruling former decisions are treated as correcting bad law and apply to past events, absent some statutory construction relied upon and incorporated into a contract. *Spectrum Health Hospitals v. Farm Bureau Mut. Ins. Co. of Michigan*, 492 Mich. 503, 536 and n. 1; 821 N.W.2d 117 (2012), citing *Gentzler v. Constantine Village Clerk*, 320 Mich. 394, 398, 31 N.W.2d 668 (1948)(addressing the distinction between bad law and new law). *See also Jawad A Shah, supra*, 324 Mich. App. 182, 195 (recognizing that the *Covenant* ruling had retroactive application) . This permitted courts to summarily dismiss claims filed in reliance on the perceived, direct cause of action against insurers on the part of services providers on the basis of MCR 2.116(C)(8).

11 *Covenant Medical Ctr., Inc. v. Employers Mut. Cas. Co.*, unpublished opinion per curiam of the Court of Appeals, decided February 11, 2021 (Docket No. 342379), *lv. den.* 508 Mich. 958; 965 N.W.2d 96 (2021).

12 MCL 500.3171-3175. The MAIPF/MACP mechanism is specifically referenced in the two no-fault provisions primarily considered herein, i.e., MCL 500.3112 and MCL 500.3157. Possible distinctions in the treatment of reporting and fraud may exist as between cases involving private insurers on the one hand and the MAIPF/MACP or its designate on the other, but review of cases does not indicate major differences based on this distinction.

13 402 Mich. 554; 267 N.W.2d 72 (1978).

14 Outside the scope of this article, the law now is that an innocent third party whose claims stem from another who failed to properly maintain a no-fault policy (particularly for rescission of a policy based on misrepresentation in the application) are entitled to a "balancing of the equities" and may still be entitled to coverage. *See, e.g., Pioneer State Mut. Ins. Co. v. Wright*, 331 Mich. App. 396 952 N.W.2d 586 (2020).

15 *See also, e.g., Bronson v. Health Care Group v. USAA Cas. Ins. Co.*, 335 Mich. App. 25; 966 N.W.2d 393 (2020).

16 *Karmol v. Encompass Prop. & Cas. Co*., 293 Mich. App. 382; 389-390; 809 N.W.2d 631 (2011); MCL 500.3142(1).

17 *See Moore v. Secura Ins*., 482 Mich. 507, 518-519; 759 N.W.2d 833 (2008); MCL 500.3142(2).

18 MCL 500.3142(2) provides that payment of claims becomes overdue if not paid within 30 days of the insurer's receipt of reasonable proof of the fact and the amount sustained. In the case that a bill is not submitted within 90 days of provision of a qualifying benefit, an insurer has an additional 60 days in addition to the 30 days from the date of receipt of reasonable proof of the fact and the amount.

19 MCL 500.3142(4) provides that the interest rate is 12% per annum.

20 MCL 500.3148(1).

21 *See, e.g., Titan Ins. Co. v. Hyten,* 491 Mich. 547, 553; 817 N.W.2d 562 (2012).

22 *See Id.,* 491 Mich. at 554.

23 *See, e.g. Jawad A. Shah*, *supra*.

24 To the extent that there is a limited pool of insurance from which to recover and no other good sources of recovery, this could operate much like the transactional mechanism of "material breach" clauses. Such clauses put different creditors on the same footing by establishing that a material breach of one contract is a breach of others with a "material breach" clause. Because all breaches occur at the same time by this convention, creditors are at the

same table as dissolution, bankruptcy, or restructuring is contemplated.

25 In this aspect, a two-judge majority of the Court of Appeals declined to follow *Jawad A Shah*, *supra*. *See, generally*, *Clark v. Al-Amin*, 309 Mich.App. 387, 395; 872 N.W.2d 730 (2015). The law of contract is only superseded when there is some definite, contrary expression of policy in the No-Fault Act. *Bronner v. City of Detroit*, 507 Mich. 158, 165-166; 968 N.W.2d 310 (2021) (indemnity agreement requiring contractor to reimburse City for payment of no-fault benefits did not impermissibly shift responsibility to ensure speedy recovery of non-economic losses in violation of the No-Fault Act). *Cf. Jawad A. Shah,* 324 Mich. App. at 197 ("[i]n ascertaining the parameters of our public policy, we must look to policies, in fact, have been adopted by the public through our various legal processes, and are reflected in our state and federal constitutions, our statutes, and the common law"). *See also* Laurie E. Biery, *2020-2021 Contracts Survey Article*, 67 WAYNE L. REV. 483, 491-492 (Spring 2022).

26 MCL 500.3157(1) provides that a "physician, hospital, clinic, or other person that *lawfully renders* treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the treatment or training" (*Emphasis added*).

27 *See, e.g., Miller v. Allstate Ins. Co.*, 275 Mich. App. 649, 656-657; 739 N.W.2d 675 (2007).

28 *See Jawad A. Shah, supra* n. 1; *see also, e.g., Healing Place at North Oakland Med. Ctr. v. Allstate Ins. Co.*, 277 Mich. App. 51; 744 N.W.2d 174 (2007), *lv. den.* 482 Mich. 880 (2008).

29 MCL 500.3112, the direct cause of action provision, authorizes direct actions only for services providers who are in compliance with the professional licensing requirement found in MCL 500.3157(2).

30 MCL 333.17011.

31 MCL 333.16401.

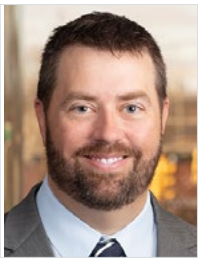
32 MCL 333.17820.

33 For an analysis of the difference between the doctrines of *res judicata* and collateral estoppel, *see Braxton v. Litchalk*, 55 Mich. App. 708, 717-718; 223 N.W.2d 316 (1974).

34 *See, e.g., Burkhardt v. Bailey*, 260 Mich. App. 636, 653; 680 N.W.2d 453 (2004).

35 *Study blames medical claims for high auto insurance rates in Michigan*, Detroit Free Press April 24, 2019, *available at https://www.freep.com/story/money/business/2019/04/24/michigan-auto-insurance-medical-claims/3538720002/.*

36 Kayleigh Fongers, *Report*: *Michigan retains ranking among states with the highest auto insurance rates*, Grand Rapids Business Journal, publ. August 18, 2022, available at *https://grbj.com/news/government/report-michigan-retains-ranking-among-high-auto-insurance-rates/*



Recent Notable No-Fault Opinions

By Eric Conn and Amine Zreik,, Jacobs Diemer, PC

Published Court of Appeals Cases

For legislative amendments to apply retroactively to the no-fault act, the State Legislature must make clear its intent that the amendment is to be applied retroactively and must not substantially impair existing policy contracts between policy holders and the insurer

Andary v USAA Casualty Insurance Co,
__ Mich App __; __ NW2d __ (2021)

Two plaintiffs were involved in a motor vehicle accident prior to June 11, 2019. The plaintiffs suffered traumatic brain injuries and were permanently disabled because of their respective accidents. One plaintiff, Andary, requires 24-hour in-home attendant care, most of which is performed by family members. The second plaintiff, Krueger, is a patient at the Eisenhower Center, which provides inpatient living accommodations and rehabilitative services to brain trauma patients. The services provided by the Eisenhower Center are reimbursed through the no-fault system. Andary was covered under a PIP policy issued by defendant USAA Casualty Insurance Company and Krueger was covered under a PIP policy issued by the defendant Citizens Insurance Company of America.

Since the inception of the No-Fault act in 1973, Michigan law has required that personal protection insurance policies provide for payment of "all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation." MCL 500.3107(1)(a). However, on June 11, 2019, the Michigan Legislature enacted the 2019 PA 21 and 2019 PA 22, both

of which made drastic amendments to the No-Fault Act. The newly enacted legislation limited a medical provider's reimbursement amount.

The plaintiffs brought a declaratory action arguing that because their respective injuries took place before the enactment of the 2019 PA 21 and due to the vested contractual rights under the policy in effect when they were injured, they are not subject to the 2019 PA 21's limitations on the benefits recoverable under MCL 500.3107(7) and (10). The court found no clear, direct, and unequivocal expression of intent to have the subsections (7) and (10) to apply retroactively to individuals who were injured before its effective date, even as to services provided after its effective date.

Moreover, the contracts clause states that "[n]o bill of attainder, ex post facto law or law impairing the obligation of contract shall be enacted." Const 1963, art 1, § 10. The court applied a three-part balancing test to determine whether a violation of the contracts clause has occurred: (1) whether a change in state law has resulted in a substantial impairment of a contractual relationship; (2) whether the legislative disruption of contract expectancies is necessary to the public good; and (3) whether the means chosen by the legislature to address the public need are reasonable. The court found that the impairments are more than substantial and that they remove numerous duties to be performed by one party to the contract. The court held this to be a severe impairment of the contractual relationship and a violation of the Michigan Contracts Clause.

Takeaway: Tracking dates in PIP cases has always been important, such as when determining whether benefits are more than 30 days past due, or if a claimant complied with the one-year back rule. Adding to the list of dates to remember is the *Andary* case, as practitioners must now remember the date of the no-fault reforms (June 11, 2019) and the date of their clients'/claimants' motor vehicle accident.

There can be more than one "owner" of a vehicle under the no-fault act

Abraham v State Farm Mutual Auto Ins Co, No. 356748, 2022 WL 3006782 (Mich. Ct. App. July 28, 2022)

In *Abraham*, the plaintiff was injured in a December 2018 accident. At the time of the accident, plaintiff worked for Nexen, a business that provides delivery services for household goods, and made deliveries through Nexen for Amazon. The plaintiff was driving a transit van that Nexen provided to her. Enterprise Leasing held legal title to the transit van, and was self-insured, but denied issuing an insurance policy for the van. Nexen rented the van from Enterprise through a continuing series of 28-day rental agreements. At the end of each rental period, the rental agreement was "closed out and rewritten." Nexen remained in possession of the transit for six months and did not return the vehicle to Enterprise between the lease periods. The plaintiff's personal vehicle was insured through a policy with State Farm.

The plaintiff sought payment of outstanding PIP benefits from State Farm, Nexen, and Enterprise Leasing Company of Detroit, among others. Enterprise and State Farm filed countermotions for summary disposition arguing that the other was in priority for payment of the plaintiff's PIP benefits. State Farm argued that Nexen and Enterprise were both owners of the transit under the no-fault act and that Enterprise was the insurer of the transit.

As this case involved a 2018 accident, and the No-Fault Reforms did not apply, the old version of the priority statute (MCL 500.3114) was examined. Generally, per section 3114, an injured party should look to his or her own personal no-fault policy when seeking PIP benefits after an accident. If the individual was occupying a vehicle owned or registered by his or her employer, then they must look to the insurer of the furnished vehicle. The Court of Appeals also held that an individual need not possess legal title of a vehicle to be considered an "owner" under the no-fault act.

The court determined that the arrangement between Nexen and Enterprise gave Nexen the use of the vehicle for approximately six months before the accident, a period significantly longer than the 30 days required by MCL 500.3101(3)(l)(i). Despite the 28-day period established by the individual rental agreements, and because Nexen had use of the transit for more than 30 days before the accident, the Court ruled Nexen was an "owner" of the transit under MCL 500.3101(3)(l)(i). Moreover, because the lease at issue provides for Nexen's use of the transit for 28 days, not 30, Enterprise was also considered an "owner" of the transit.

Takeaway: Priority cases under the old version of MCL 500.3114 are always complicated. Adding an employment situation to the mix makes it worse. Companies that lease vehicles to ridesharing drivers may still be held as owners of the vehicles in the absence of legal title, so long as the court construes the possession of the vehicle to satisfy the requirement of MCL 500.310(3)(l)(i). A secondary "owner" may be liable under the no-fault act if given higher priority to another owner.

Unpublished Court of Appeals Cases

Court's may deny an insurer's rescission of an insurance policy, including no-fault insurance policies, even in the event of misrepresentation, if the greater weight of evidence does not implicate the insured third party's involvement of fraud, or contribution to his/her own injury.

Finn v Marsh, No. 358501 (Mich. Ct. App. Aug. 18, 2022)

On May 25, 2019, the plaintiff was riding as a passenger in a 1929 Ford Assembled Model A vehicle, also known as a "rat rod," which was driven by the defendant, and owned by defendant's wife. The plaintiff sustained injuries after an ac-

cident. The vehicle was insured by Foremost at the time of the accident. The defendant's wife also had two other vehicles insured with Farm Bureau. Meanwhile, the plaintiff's son, who lived with the plaintiff, had a policy with Auto Club, which was also in effect at the time of the accident. The policy held by the son imposed a duty on its insured to report changes within 30 days to Auto Club, including changes to resident-relatives of driving age. The plaintiff's son did not identify any resident-relatives of driving age on the application for the Auto Club policy. Auto Club rescinded the policy after discovering the material misrepresentation that the son was the only resident of driving age at his home. The plaintiff filed a PIP and third party claim against the defendant, his wife, Foremost and Auto Club. Foremost filed a cross claim against Auto Club, contending that Auto Club was in a higher priority to pay the plaintiff's PIP benefits.

Foremost moved for summary disposition arguing that Auto Club was higher in priority. Auto Club also moved for summary disposition arguing that its recission of the policy meant it could not be in priority to pay benefits. The trial court ruled that Auto Club was permitted to rescind based on a material misrepresentation made by the son, but that Auto Club could not rescind the policy as it pertained to the plaintiff, who was an innocent third party. An appeal was taken from the trial court's order as of right.

The Court of Appeals explained that when an insured makes a material misrepresentation on the application for insurance, including no-fault insurance, the insurer is entitled to rescind the policy and declare it void *ab initio*. However, consistent with *Bazzi*, the Court of Appeals held that it cannot uphold rescission if it would result in an outcome that is unjust or inequitable. The primary issue before the court was to determine if the plaintiff was an innocent third party, and if so, must not permit rescission of the policy as to him. Whenever determining if rescission is appropriate, the court will use the *Wright* factors to analyze the matter: (1) the extent to which insurer could have uncovered the fraud before suffering an injury; (2) the relationship between the fraudulent insured and the innocent third party to determine if the third party had knowledge of the fraud; (3) the nature of the innocent third party's conduct, in the injury causing event; (4) the availability of an alternative avenue for recovery if the insurance policy is not enforced; (5) a determination of whether policy enforcement only serves to relieve the fraudulent insured of what would otherwise be the fraudulent insured's personal liability to the innocent third party.

The factors were found to be of equal weight. Consequently, the Court of Appeals affirmed the trial court's decision that denied Auto Club's motion for summary disposition and granted Foremost's request for reimbursement from Auto Club.

Takeaway: The *Bazzi* case and its impact is still having ripples in the Court of Appeals. To the extent necessary when confronting these issues, pointed discovery on the *Wright* factors is important to win your case, regardless of which side of the 'V' you find yourself.

When two drivers contribute to a collision, the court will allow the jury to determine the matter of comparative negligence.

Holt v Detroit Dep't of Transp, No.357329
(Mich. Ct. App. Aug. 18, 2022)

This case involves an automobile crash that took place in May, 2019 in Detroit. The plaintiff was in the front passenger seat and traveling eastbound on Fort Street near Trumbull. The plaintiff's wife was driving the vehicle he occupied. Plaintiff's wife pulled over to the far right of the road so that the plaintiff could drop off a letter in a mailbox. The wife then intended to turn left. When she made the turn, she collided with a DDOT bus that claimed to have a green light. The plaintiff sued his wife, DDOT, and the driver of the bus claiming that he suffered a serious impairment of bodily function from the crash.

At the conclusion of discovery, the plaintiff's wife moved for summary disposition on the basis of the plaintiff's testimony that she did nothing wrong. DDOT and its bus driver jointly filed a response brief and moved for summary disposition in their own right based on governmental immunity and based on the argument that the bus driver had the right of way by virtue of the green light. The trial court granted both motions and dismissed the plaintiff's claim.

The Court of Appeals held that the trial court erred in granting the wife's motion for summary disposition despite the plaintiff's testimony that he did not believe she did anything wrong. The court explained that the plaintiff's opinion amounts to an opinion of a lay witness and that the plaintiff is not qualified to testify on matters of the legal effect of a driver's conduct. Thus, the court held because the wife failed to yield to a vehicle approaching from the other direction, she breached a statutory duty to allow opposing traffic stopped at the light to pass through the intersection before she attempted to make a left turn.

Moreover, the Court of Appeals determined that the bus driver unlawfully passed vehicles on the right, and that such action violated the Michigan Motor Vehicle Code. Although governmental agencies are immune from tort liability when engaged in a governmental function, some exceptions apply. For example, the motor-vehicle exception to governmental immunity provides, "governmental agencies shall be liable for bodily injury and property damage resulting in negligent operation by an officer, agent, or employee of the governmental agency, of a motor-vehicle of which the governmental agency is owner." MCL 691.1405. DDOT claimed that it did not dispute that its driver violated MCL 257.637 but instead suggested that the statute was not designed to prevent the harm that occurred in this case. The court disagreed, explaining that in this case when the plaintiff's wife initiated her turn, she did

not see the oncoming bus that was traveling in the outside parking lane to the right of stopped vehicles, hence imposing a duty of care on the bus driver.

The court ultimately held that both drivers breached multiple statutory duties. The bus driver failed to observe the plaintiff's vehicle making a left turn across multiple lanes of traffic and failed to make reasonable efforts to avoid the collision while the driver of the plaintiff's vehicle also initiated a left turn from the far-right lane, rather than the left turn lane and made the turn before allowing the opposing traffic to pass through the intersection. The court found evidence that both drivers breached duties that contributed to the crash. Therefore, the issue of comparative negligence was left to the jury.

Takeaway: Testimony of non-negligence from family members, while a primary tactic taken in cases against family members, is insufficient to support a ruling of summary disposition when the evidence confirms a breach of the Michigan Motor Vehicle Code. Further, learned knowledge of the Michigan Motor Vehicle Code can lead to a question of fact even in green light cases such as this.

An insured plaintiff loses PIP benefits for making misrepresentations of his injuries prior to the commencement of litigation.

Jonathan Jones v. Home-Owners Insurance Company, 355118 (Mich. Ct. App. Aug. 18, 2022)

On October 28, 2017, plaintiff was stopped at a red light when the defendant, who was traveling at a high rate of speed, drove through the red light and struck the plaintiff's vehicle. The plaintiff's vehicle was insured under a no-fault policy issued by ACIC, which listed Sons of Alice Transportation, LLC (Sons of Alice) as the named insured. The plaintiff claims that he was also covered under policies issued by Home-Owners and Hartford. The Home-Owners policy was for the plaintiff's personal vehicle and listed the plaintiff as the insured. The Hartford policy was for a different vehicle and listed Jonathan Jones, d/b/a Jones Landscaping, as the name insured. The plaintiff filed an action against all three insurers for recovery of outstanding no-fault PIP benefits and for uninsured/underinsured motorist benefits.

At the close of discovery, the defendants argued that the plaintiff made material misrepresentations regarding his physical limitations during his deposition. In support of their motions for summary disposition on the issue, the defendants relied on surveillance evidence from February, June, and July 2018 which contradicted the plaintiff's statements regarding the scope of his injuries and pain, physical limitations, and his inability to work. The trial court declined to address the priority dispute and instead found that there was no genuine issue of material fact that the plaintiff committed fraud by making material misrepresentations in his depositions, and that all three defendants were entitled to summary disposition based on the antifraud provisions of their policies. The plaintiff appealed as of right.

The Court of Appeals affirmed in part and reversed in part the trial court's decision. The Court of Appeals found that it was necessary to determine which insurer had priority for payment of PIP benefits to ascertain which anti-fraud provision applied. The purpose for making a priority determination is that, under *Shelton*, a claimant cannot be subject to an anti-fraud provision if the claimant is not a named insured, and only one of the policies named the plaintiff as a named insured. Because the trial court did not determine priority, the Court of Appeals remanded to the trial court for that determination.

As for the uninsured/underinsured (UM/UIM) claims, the Court of Appeals affirmed the trial court's order dismissing them. The Court of Appeals determined that the statements made by the plaintiff indicated that he was unable to clean, cook, get dressed, shower, and bathe without the assistance of family members. However, the surveillance evidence appeared to contradict these statements when the video showed the plaintiff bent over in his vehicle and carried two arms full of groceries to his residence. The Court of Appeals found that the video is clear and uncontroverted evidence demonstrating the plaintiff's ability to care for himself and undermining his claims to the extent of his injuries and physical limitations. Because UM/UIM benefits stem from the contract directly, the anti-fraud provisions apply to the claim regardless of whether the plaintiff is a named insured. Consequently, the Court of Appeals held that the trial court did not err by dismissing the plaintiff's claims for uninsured and underinsured motorist benefits on the bases of fraudulent misrepresentations.

Takeaway: The case law on fraud has solidified post-*Shelton*. If PIP benefits stem from the No-Fault Act, instead of the policy, fraud cannot bar recovery. When benefits flow from the policy, however, the opposite is true.

Cases to Watch

Andary v. USAA Casualty Insurance Co., application for leave to appeal pending in the Michigan Supreme Court.

We have added *Andary* back to the list of cases to watch, as an application for leave to appeal in the Michigan Supreme Court has been filed. The Supreme Court has not made a decision on the application, and as of the time of writing, a response to the application had not been filed. ■

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Cryptocurrencies and blockchain technologies present both emerging risks, and opportunities, for insurers and consumers alike. As increasing numbers of companies worldwide begin using bitcoin and other digital assets for a host of investment, operational, and transactional purposes, it raises an important question: How is cryptocurrency defined for the purposes of insurance coverage? What are some of the coverage issues that could be anticipated for both businesses and consumers?

See *United Am. Corp. v. Bitmain, Inc.*, 530 F.Supp. 3d 1241 (S.D. Fla. 2021) and *Kimmelman v. Wayne Ins. Group*, Case No. 18 CV 1041, 2018 WL 11417314 (Ohio Com. Pl. Sep. 25, 2018).

Submission Details

Submit an article of original work, up to 2,500 words or 6–8 pages double-spaced, in 12-point font, analyzing and advocating a position supported by appropriate legal authority, such as case law, statutes, legislative history, scholarly articles or other authoritative sources with proper citations. Submission is deemed permission for publication in the July edition of *The Journal of Insurance and Indemnity Law*, the quarterly publication of the Insurance and Indemnity Law Section.

By February 28, 2023

Email your submission with a cover page containing your name, phone number, email address, law school, and anticipated year of graduation to sbminsuranceindemnity@gmail.com.

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Selected Insurance Decisions

By Christopher T. Lang, *Collins, Einhorn, Farrell PC*

Sixth Circuit Court of Appeals

Published Opinion

To demonstrate that the claimant remains disabled under an ERISA plan, he or she must present a preponderance of evidence that he or she remains disabled.

Messing v Provident Life & Accident Ins Co,
No. 21-2780, 2022 WL 4115873
(CA 6, September 9, 2022).

The attorney plaintiff obtained a long-term disability benefit insurance policy from the defendant in 1985. In 1994, the plaintiff began suffering from depression, which prevented him from practicing law. Beginning in 2000, the plaintiff received monthly disability benefits under the defendant's policy. In 2018, the defendant began a review of the plaintiff's claim in order to determine if he was still disabled from practicing law. Following an investigation, and medical multiple examinations, the defendant terminated benefits on the basis that the plaintiff could return to work. The district court upheld the termination, but the 6th Circuit reversed on appeal.

The 6th Circuit ultimately found that the plaintiff, by a preponderance of evidence, demonstrated that he remained disabled from the practice of law. Specifically, the court noted that each of the medical examiners found that the plaintiff's mental health was fragile, that a stressful working environment could cause a relapse of major depression, and one of the doctors concluded that the plaintiff could not return to work while the other two doctors did not offer a specific opinion regarding his ability to return to work.

In addition, the 6th Circuit also noted that the plaintiff provided affidavits from three other lawyers stating that the practice of law was not only a stressful profession, but that the plaintiff was unable to effectively practice law after nearly 20 years out of practice. Regarding the defendant's counterclaim for an equitable lien for alleged overpayment of benefits, the court found that the defendant failed to demonstrate that the plaintiff's alleged misrepresentations regarding his ability to practice law induced an overpayment of benefits. Finally, the court also held that the plan at issue did not provide any remedy to the defendant for a recoupment of any overpayment of benefits.

Michigan Court of Appeal

Published Opinion

Claimant must strictly comply with requirements of policy to change beneficiaries.

Sec Mut Life Ins Co of New York v Amira-Bell,
___ Mich App _____, No. 357105,
(Mich Ct App, July 21, 2022).

This case concerns the determination of the proper beneficiaries under an insured's life-insurance policy. Security Mutual Life Insurance Company of New York issued a life insurance policy to Omari Bell. When Bell first obtained this policy, in December 2018, he designated five beneficiaries the selection of which was confirmed by Security Mutual Life Insurance. One year later, in January 2019, Bell completed a beneficiary designation change form requesting a change to the beneficiaries on the policy and naming his estate as the sole beneficiary.

Mistakenly, Bell also designated a second beneficiary also receive 100% of the benefits in a separate capacity. In February 2019, Security Mutual Life notified Bell that the requested change could not be processed due to this error. Nine months later, without having completed a new change-of-beneficiary form, Bell died. The trial court found that Bell had substantially complied with the policy's change of beneficiary requirements and ordered the funds be released solely to the estate.

On appeal, the Court of Appeals overturned the ruling and held that Bell's policy required Security Mutual Life Insurance to first approve of the change for any modification to be effective. The Court of Appeals found that Security Mutual Life Insurance, by notifying Bell of the error and mailing him a new form to complete, never approved of the change to the beneficiaries. The Court of Appeals ultimately held that this requirement was unambiguous and Bell's attempt to modify – regardless of intent – did not satisfy the policy's modification requirements.

Unpublished Opinions

Absent a showing of a special relationship, an independent insurance agent does not have a duty to advise an insured of the adequacy of coverage.

Cloverleaf Car Co v Cascade Underwriters Inc, unpublished opinion of the Court of Appeals, issued June 16, 2022 (Docket No. 357435), 2022 WL 2182474.

In this case, the insureds claimed that the defendant agents breached their fiduciary duty to them regarding the scope of their coverage, had made "errors and omissions" in the policy obtained, and had committed silent fraud. Specifically, the insureds alleged that the defendant agents breached their duty to *advise* them as the adequacy of the coverage provided. The Court of Appeals, however, disagreed and found that the defendant agents did not have a duty that required them to advise regarding the adequacy of coverage because there was no "special relationship" between the insurer and the insured.

In finding that no special relationship or duty existed between the parties, the Court of Appeals noted that the insureds: (1) never requested "full coverage" for their property and buildings, (2) they never asked defendants any questions regarding the adequacy of their coverage, (3) there was no evidence that the defendant agents misrepresented the nature or extent of the coverage offered, and (4) there was no evidence that the defendant agents promised to provide all of the coverage needed.

Failure to identify a co-owner of a vehicle constituted a material misrepresentation that allowed for recission.

Kodra v Am Select Ins Co, unpublished opinion of the Court of Appeals, issued June 23, 2022 (Docket No. 356166), 2022 WL 2285584.

The plaintiff, in her insurance application, verified that she was the sole owner of the 2004 Ford Escape that she sought to be insured. However, this vehicle was in fact co-owned by her fiancé, who had a suspended driver's license. After the policy was issued, the plaintiff removed the 2004 Ford Escape from the policy and added a 2015 Chrysler 200C to the policy that was also co-owned by her fiancé. Once again, the plaintiff failed to disclose this co-ownership to the defendant.

After the plaintiff was sued for third-party benefits, the insurer learned of this co-ownership. The defendant then produced an affidavit indicating that it would not have issued the policy to the plaintiff had it known of the vehicles' co-ownership. In reversing the trial court's denial of the defendant's motion for summary disposition, the Court of Appeals found that that the plaintiff's misrepresentation was material and a valid basis for recission. While the trial court found that any misrepresentation was immaterial because the plaintiff's fiancé was not driving the vehicle at the time of the subject accident, the Court of Appeals disagreed and held that the plaintiff's misrepresentation occurred when the policy was enacted, rather than at the time of the accident.

A Pizza Hut delivery driver does not satisfy a public or livery conveyance exclusion.

Michigan Pizza Hut, Inc v Home-Owners Ins Co, unpublished opinion of the Court of Appeals, issued July 14, 2022 (Docket No. 356737), 2022 WL 2760358.

In this case, Justin Kiry worked as a pizza hut delivery driver, and used his mother's 2005 Nissan Altima to deliver pizzas for Pizza Hut. The 2005 Nissan Altima was insured by the defendant. After Kiry was injured in a motor vehicle accident, while in the course and scope of his employment, the defendant denied coverage under the policy's "public or livery conveyance" exclusion. The Court of Appeals, however, found that this exclusion did not apply under these circumstances. In reaching this holding, the Court of Appeals relied on its prior interpretation of this exclusion, specifically that the exclusion requires that the at-issue conveyance to be for the public in order to be triggered. The Court of Appeals found that the act of delivering pizzas for profit did not equate to holding out for public use. On that point, the Court of Appeals held that the use of a vehicle in the capacity of delivering pizzas for Pizza Hut was limited to a specific client base, rather than the public at large. ■

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Legislative Update: Sea Change for the House Insurance Committee

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

There's been a structural change in the House for addressing insurance-related legislation. Apparently due to the recent allegations against House Insurance Committee Chair Daire Rendon, the House began referring all insurance legislation to the House Committee on Rules and Competitiveness.

But only a few insurance bills have moved since the last update. And given that the Legislature recently returned from summary recess, the upcoming election season, and the limited number of remaining session days, there likely won't be much insurance-related work between now and the end of the year.

Here are the four bills that advanced since the last update:

- **Increased gift cap for life insurance.** HB 6144 amends the Insurance Code to increase the cap (from $5 to $50) on gifts that a life insurance company can give to applicants and policyholders *Passed the House (83-23) on 6/30/22; Referred to the Senate Committee on Insurance and Banking on 9/7/22*
- **Disclosure of group health claim utilization.** SB 447 amends the Insurance Code to require disclosure of group health claim utilization in certain circumstances *Passed the Senate (35-0) on 11/10/21; Passed the House (102-2) on 6/9/22; Signed by the Governor (PA 119'22) with Immediate Effect on 6/30/22*
- **Interest rate in annuities.** SB 624 amends the Insurance Code to modify the interest rate used in determining the minimum nonforfeiture amount in annuities *Passed the Senate (34-1) on 11/10/21; Passed the House (102-3) on 6/30/22; Signed by the Governor (PA 150'22) with Immediate Effect on 7/20/22*
- **Liquidation and rehabilitation of fraternal benefit societies.** SB 712 amends the Insurance Code to modify the liquidation and rehabilitation procedures for fraternal benefit societies *Passed the Senate (38-0) on 6/30/22; Referred to the House Committee on Rules and Competitiveness on 6/30/22*

New Bills Introduced

And the bill count continues to grow – 2,369 total bills introduced in the House and 1161 in the Senate, with several new insurance referrals to the House Committee on Rules and Competitiveness:

- **Insurer's bad faith failure to pay.** HB 6114 amends the Insurance Code to modify the standard and penalties for an insurer's bad faith failure to timely pay a claim
- **Insurer continuing education.** HB 6167 amends the Insurance Code to provide continuing education credits to an insurance producer for membership in a professional association, if certain conditions are met
- **Adjust death benefits for inflation.** HB 6261 amends the Insurance Code to adjust death benefits for cemetery and funeral goods by changes in the Consumer Price Index
- **Federally excepted benefits.** HB 6287-6288 amends the Insurance Code to eliminate from the definition of health insurance policy, a policy that only provides federally excepted benefits
- **Holding companies' capital calculation.** HB 6297-6303 amends the Insurance Code to modify the procedures for insurance holding companies' annual capital calculation
- **STDs contracted in an auto. HB 6335** amends the Insurance Code to prohibit auto policies from covering sexually transmitted diseases or pregnancy arising out of the use of an auto
- **12-month supply of contraceptives.** HB 6366 amends the Insurance Code to require health insurance policies that cover prescription contraceptive to cover a 12-month supply ■