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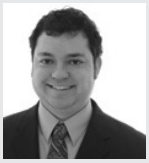

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President's Corner

By: Irene Bruce Hathaway, *Miller Canfield Paddock & Stone*
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Irene Bruce Hathaway has been an attorney with Miller Canfield since 1990 and has served as the Resident Director of the firm's largest office, in Detroit. She has a BA from the University of Michigan and a JD and from what is now known as Michigan State University School of Law, where she served as a law review editor. She concentrates her practice in catastrophic tort, commercial litigation and insurance law, with special emphasis on health care related disputes, automotive supplier disputes, fraud and on franchise litigation.

Irene is a Fellow of the State Bar Foundation, and was named a Charter Member and Senior Fellow, of the Litigation Counsel of America. She has been named yearly to the Best Lawyers in America, and in 2108 was named Lawyer of the Year Detroit, Mass Tort Litigation & Class Actions – Defendants. She has been recognized as a Michigan Super Lawyer, yearly and has been named by DBusiness to its list of Top Lawyers & Top Woman Attorneys, 2010-present. She has an av Martindale Hubble rating.

Irene is admitted to practice in Michigan and Ohio and to the United States Supreme Court as well as to federal courts throughout the country. She has been active with the MDTC since 1980 and has served on Board of Directors since 2016. She has also served on Board of Directors, Michigan State University College of Law Alumni Association, and the Transportation Club of Detroit Scholarship Committee. She is a member of the Oakland County Bar Association where she was two time chair of the Medical Legal Committee and served on the Circuit Court Committee Task Force on Rules Change and as a court Discovery Master. Irene has also served on many State Bar committees including as chair of the U.S. Courts Committee. She is a member of the Michigan Supreme Court Committee on Case Evaluation Rule Changes and has served as case evaluator in Wayne and Oakland Counties, and on the Detroit Bar Association Judicial Candidate Evaluation Panel. She was the co-Founder of the Women's Franchise Network of Southeast Michigan.

I am honored to begin my term as MDTC President. Outgoing President Josh Richardson has set a high bar for me. He has left the MDTC in excellent financial condition, with a growing and engaged membership. Firm sponsorships are at an all-time high.

Moreover, under his guidance over the last year the MDTC:

1. Developed a new website;
2. Had record attendance at the summer meeting;
3. Set up a board LISTSERVE so all leaders could easily communicate with one another;
4. Participated, at the request of Douglas Van Epps (the Director of the Office of Dispute Resolution for the Michigan Supreme Court) in a Supreme Court Committee on "the efficacy of case evaluation";
5. Started a Veterans' Committee;
6. Filed multiple amicus briefs;
7. Added Instagram to the social media platform; and
8. Coordinated board meetings with exciting guests including Judge Broc Swartzel, Justice Elizabeth Clement and sponsor Nate Kadau LCS Record Retrieval;

We are all in Josh's debt for such a great year!

As I start my Presidency, I have been reflecting on how much I have learned about the MDTC during my terms as an MDTC officer. Of course, we all know that the MDTC:

- Is an association of the leading lawyers in the State of Michigan;
- Is dedicated to the interests of attorneys defending individuals and corporations in civil litigation; and
- Produces top-flight seminars and publications.

But I have learned that there is much more to the MDTC than those things we see every day. So here are a few "did you knows?" about the MDTC:

Did you know??

1. The MDTC is available to draft Amicus Curiae briefs.

   MDTC volunteer appellate experts draft amicus curiae briefs (pro bono) in cases of interest to the civil defense bar. The Michigan Supreme Court often specifically requests that the MDTC file an amicus curiae brief in certain cases. It is not unusual for the MTDC's briefs to be the only *amicus curiae* brief opposing a plethora of amicus input from the plaintiff-side interests.

   Moreover, MDTC members can bring to the MDTC's attention cases in which the MDTC's participation would be valuable.

2. The MDTC has an active and useful LISTSERVE for members only.
3. MDTC seminars are often approved for CLE credit for adjoining states with CLE requirements.
4. MDTC's Michigan Defense Quarterly is sent to all Michigan judges, and most admit to reading it carefully, and keeping each issue on their desks for weeks or months.

5. The MDTC provides a way for members to increase their profile in the community through speaking and writing opportunities.
6. The MDTC offers a brief bank for members.
7. The MDTC provides information about employment opportunities.
8. The MDTC provides members with access to a database of facilitators and mediators.
9. The MDTC offers opportunities for discussions with judges from throughout the state in small settings, allowing for real exchanges of ideas.
10. The MDTC's events are fun and a great place to interact with your peers.

As you can see, there is a lot the MDTC has to offer you. But we can do more. I intend to make the theme of my Presidency: "What more can the MDTC do for you". To that end, please let me know what you would like from the MDTC! Let's make the MDTC even better together.

Michigan Defense Quarterly
Publication Schedule

Publication Date, Copy Deadline
January, December 1
April, March 1
July, June 1
October, September 1

For information on article requirements, please contact:

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

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

Executive Summary

Recently, there have been major legislative changes to the no-fault act. It likely will take several years before the impact of these changes on premiums, claims, and litigation is fully determined. Certain provisions take effect immediately, while others, including regulatory changes will take effect later. There are, however, a few predictions that can be made at this time. And one thing is for certain: this will be an interesting few years as courts throughout the state interpret these new statutory provisions. Stay tuned!

Matthew S. LaBeau focuses his practice on defense litigation in first party No-Fault claims, uninsured and underinsured motorist claims, automobile negligence, premises liability, general liability, and contractual disputes. Matthew has extensive experience in defending catastrophic No-Fault claims, including claims for attendant care, home modifications, and vehicle modifications, as well as consulting insurers regarding catastrophic claims prior to litigation. Matthew has vast experience in all aspects of the litigation process from the discovery process through trial and routinely achieves successful results for his clients. He can be reached at matthew.labeau@ceflawyers.com or 248-663-7724

Introduction

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

Coverage Choices for Allowable Expenses

The no-fault act provides for three primary categories of benefits: allowable expenses, work loss, and household replacement services. Allowable expenses includes a broad array of medical related benefits that previously were unlimited in amount and scope. This has now drastically changed. Insurers, under MCL 500.3107c and MCL 500.3107d, may now sell automobile insurance policies with coverage for allowable expenses in limited amounts. These limits do not apply to wage loss or household replacement services benefits. Coverage for allowable expenses will be available in the following amounts:

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

An insurer must provide a prospective insured with a form that explains the benefits and risks of each coverage option and allow the prospective insured to choose their desired option. The default option is unlimited coverage if the applicant or named insured does not make an effective selection. There is a rebuttable presumption as to a given coverage level, however, if a policy is issued or renewed with a certain coverage level and the premium charged matches that coverage level.[1]

For coverage levels that have limits on allowable expenses, carriers are required to reduce premiums a certain percentage at each level.[2] Carriers can be exempt from the premium reduction requirements, however, if they can show that the premium

reduction will result in a financial hardship or a constitutional violation as applied to the insurer.[3] It should be noted that the legislative changes for insurance carriers with regard to rates have changed so drastically that they should be reviewed for compliance.

In addition, automobile insurers may now offer a managed care option that provides for allowable expenses. This managed care option will operate like an HMO, with monitoring and adjudication of the injured person's care and the use of a preferred provider program. The option will include deductibles and co-pays in exchange for a reduced premium.[4]

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

Coordination of Benefits

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

The newly amended MCL 500.3109a added provisions to allow an insurer to offer an applicant or named insured, if they select allowable expenses coverage in the amount of $250,000, to be excluded from coverage for allowable expenses if the person has "qualified health coverage." This applies to policies issued or renewed after July 1, 2020.[5]

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

MCL 500.3109a provides that if the named insured has qualified health coverage, and the named insured's spouse and any resident relative residing in the same household also has qualified health coverage, the premium for allowable expenses on the policy must be reduced by 100 percent.[7] If a member, but not all members, of the household is covered by qualified health coverage, then the policy is subject to a reduced premium, but only individuals with qualified health coverage receive a 100 percent reduction in the premium for allowable expenses.[8] If there are members of the household who are not covered by qualified health coverage, then they would be able to claim up to $250,000 in allowable expenses should they suffer accidental bodily injury arising out of a motor vehicle accident.

If a person excluded from allowable expenses due to having qualified health coverage loses their health coverage, the named insured must notify the insurer that the person is no longer eligible.[9] The named insured then has 30 days to obtain coverage for allowable expenses under the policy applicable to that individual.[10] If the excluded individual suffers accidental bodily injury from a motor vehicle accident during that 30 day period, the individual must claim benefits under the Michigan Automobile Insurance Placement Facility (MAIPF).[11] If the coverage is not added by the end of the 30 day period, the injured person who was excluded is not entitled to coverage for allowable expenses.[12]

Fee Schedule Applies to Medical Expenses

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

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

- July 1, 2021 and before July 2, 2022, 230% of amount payable under Medicare (or 70% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 225% of amount payable under Medicare (or 68% of average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 220% of amount payable under Medicare (or 66.5% of average charge as of January 1, 2019 if Medicare does not provide an amount payable).[13]

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

- After July 1, 2021 and before July 2, 2022, 240% of amount payable under Medicare (or 75% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 235% of amount payable under Medicare (or 73% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 230% of amount payable under Medicare (or 71% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).[14]

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

- After July 1, 2021 and before July 2, 2022, 200% of amount payable under Medicare (or 55% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2022 and before July 2, 2023, 195% of amount payable under Medicare (or 54% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).
- After July 1, 2023, 190% of amount payable under Medicare (or 52.5% of the average charge as of January 1, 2019 if Medicare does not provide an amount payable).[15]

A neurological rehabilitation clinic is not entitled to payment or reimbursement unless the clinic is accredited by an approved organization.[16] This does not apply to a clinic that is in the process of obtaining accreditation as of July 1, 2023, unless three years have passed since the process began and the clinic is still not accredited.[17]

The Michigan Legislature and the governor have agreed on bipartisan legislation that drastically alters the provisions of the no-fault act.

Limits on Attendant Care

Along with a fee schedule, the no-fault act now provides limits on family-provided attendant care. MCL 500.3157 refers to the provisions of the Michigan Workers' Compensation Act which limits family-provided attendant care to 56 hours per week. This limitation only applies if the attendant care is being provided directly or indirectly by an individual who is related to the injured person, an individual who is domiciled in the household of the injured person, or an individual with whom the injured person had a business or social relationship before the injury.[18] An insurer may contract with an injured person to pay benefits in excess of the 56-hour limitation.[19] In the instance of a policy that provides limited allowable expenses, an insurer will be required to offer a rider that provides coverage for attendant care in excess of the coverage limits.[20]

Provider Lawsuits

For decades it has been argued that providers were entitled to an independent cause of action against no-fault insurers for payment for care and treatment provided to an injured insured. The Court in *Covenant v State Farm*[21] made it clear that providers did not have an independent cause of action, but may institute a cause of action if the provider procured a valid assignment from the claimant. Under the new law, a health care provider listed in MCL 500.3157 is allowed to make a claim and assert a direct cause of action against an insurer to recover overdue benefits.[22] MCL 500.3157 sets forth multiple requirements for a health care provider to qualify for reimbursement under the no-fault act.

Statute of Limitations

MCL 500.3145 provides a one-year-back rule that limits benefits to those incurred one year before the commencement of a lawsuit. Since *Devillers v ACIA*,[23] this statute had been interpreted as having a firm one-year-back rule, meaning that there was no tolling, absent a showing of fraud. Before the amendment of MCL 500.3145, if a claim was submitted, and the one-year deadline was coming up, a claimant would have to file a lawsuit to protect the right to seek payment for that claim.

MCL 500.3145 has been amended to allow tolling with regards to submission of a claim. Now, the one-year-back rule is tolled from the date of a specific claim for payment of benefits until the date the insurer formally denies the claim. Tolling does not apply, however, if the person seeking payment does not act with "reasonable diligence," with that term being left undefined.[24]

Order of Priority

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

When a claimant sustains injury while the operator or passenger of a vehicle in the business of transporting passengers, the insurer of the vehicle is responsible for the payment of benefits.[25] When the claimant in this scenario is a passenger in certain buses, a taxicab, or a transportation network vehicle (such as Uber or Lyft), the insurer of the vehicle is only responsible if there is no other coverage available to the passenger.[26] Now, if the passenger is in a vehicle that is insured under a policy that opted out of coverage for allowable expenses, he or she must look elsewhere first before seeking benefits from the insurer of the vehicle.[27]

Previously, if a person suffered accidental bodily injury as an occupant of a vehicle, and the person did not have coverage available through his or her own policy, or a spouse or resident relative, the person would seek coverage through the owner of the vehicle, and if none, then the operator of the vehicle. Now, a person who is an occupant of a vehicle in this circumstance will be required to seek coverage through the Michigan Automobile Insurance Placement Facility (MAIPF).[28]

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

that provide coverage for allowable expenses in the order of priority, then the claimant must seek benefits from the MAIPF.[29]

Under the newly reformed no-fault act, a person who sustains injury as a non-occupant, such as a pedestrian or bicyclist, must seek benefits from the MAIPF, unless there is available coverage through his or her own policy or that of a spouse or resident relative.[30] Previously, a non-occupant would seek benefits from the insurer of the owner or registrant of the motor vehicles involved, and then the insurers of operators of motor vehicles involved in the accident.

Michigan Automobile Insurance Placement Facility (MAIPF)

The MAIPF is the insurer of last resort and is funded by the State of Michigan. The MAIPF provides benefits when: no PIP coverage is applicable to the injury; no PIP coverage applicable to the injury can be identified; there is a dispute between two or more carriers concerning their obligation to provide benefits, or; the identifiable coverage is inadequate due to financial inability to fulfill its obligations.[31] A significant revision to the statute, as referenced in the order of priority section, is that more claimants are eligible to receive benefits through the MAIPF.

A person seeking benefits through the MAIPF must submit an application and the MAIPF or the carrier assigned to the claim must specify what materials constitute reasonable proof of loss within 60 days after receipt of the application.[32] The MAIPF or the carrier assigned to the claim are not responsible for interest for the period of time a claim is reasonably in dispute.[33]

A person seeking benefits must cooperate with the MAIPF and the MAIPF may suspend benefits until it procures cooperation. Along with submitting the above-referenced application, cooperation includes the obligation to appear for an examination under oath (EUO).[34] Previously, MCL 500.3173a required the assignment of a claim to a carrier for handling after an initial determination of eligibility. Now, the MAIPF may conduct its own investigation without referring the claim to a carrier, or it can refer the matter to a carrier for further investigation.[35]

The default limit of coverage for a person seeking benefits under the MAIPF is $250,000. If a person is claiming benefits from the MAIPF as a result of a lapse in qualified health insurance coverage in the instance of a policy with no allowable expenses coverage, the coverage limit is $2,000,000.[36]

Under MCL 500.3174, a claimant is required to notify the MAIPF of a claim within one year of the accident and is subject to the written notice and one-year-back limitation stated in MCL 500.3145. Additionally, under MCL 500.3175, the MAIPF may bring an action for indemnity or reimbursement against a responsible insurer or third party. The action must be brought within two years after the assignment of the claim, one year after the date of the last payment made to the claimant, or one year after the date the responsible third party is identified.[37]

Under the newly reformed no-fault act, a person who sustains injury as a non-occupant, such as a pedestrian or bicyclist, must seek benefits from the MAIPF, unless there is available coverage through his or her own policy or that of a spouse or resident relative.

Out-Of-State Residents

Before the no-fault reform, out-of-state residents could seek no-fault benefits in certain scenarios. This has changed drastically. Under the new laws, a person who is not a resident of the state of Michigan is completely excluded from no-fault benefits unless the person owned a motor vehicle that was registered and insured in Michigan.[38] Based upon this revision, admitted insurers are no longer required to file a certification under MCL 500.3163.

Penalty Interest and Attorney Fees

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

It also remains the law under MCL 500.3148 that an attorney is entitled to a reasonable fee for advising and representing a claimant in an action for overdue benefits. That attorney fee can be charged against the insurer if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed making proper payment. The new legislative changes to the no-fault act, however, added several important requirements and exceptions to a claim for attorney fees.

Specifically, an attorney cannot claim payment of an attorney fee until a payment for claimed benefits is **authorized** and **overdue**.[39] This would appear to preclude attorney fees asserted against claimants for voluntary and timely paid benefits. With regard to attorney fees for disputes involving attendant care or nursing services, attorney fees must not be awarded as to future payments ordered more than three years after the trial court judgment or order is entered.[40] This would likewise appear to be a limitation on an attorney's ability to charge a fee for payment of ongoing attendant care benefits resulting from a trial verdict or court ruling.

In addition, an attorney cannot be awarded an attorney fee where the attorney has a direct or indirect financial interest in the treatment, product, service, training, or accommodation provided to the claimant.[41]

Under the new legislative changes, an insurer continues to have a claim for attorney fees for defending a claim that was fraudulent or excessive. An insurer may now also seek attorney fees against a claimant's attorney for defending against a claim for which the client was solicited by the attorney in violation of Michigan law or the Michigan Rules of Professional Conduct.[42]

Under the new law, a health care provider listed in MCL 500.3157 is allowed to make a claim and assert a direct cause of action against an insurer to recover overdue benefits.

Claims Practices and Fraud Issues

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

MCL 500.6301 establishes an anti-fraud unit within DIFS that is a criminal-justice agency dedicated to prevention and investigation of criminal and fraudulent activities. The agency may investigate all persons who have allegedly engaged in criminal or fraudulent activity. The agency may also conduct criminal background checks on individuals seeking licensure, maintain records of fraudulent and criminal activity, and share information with other criminal agencies. The records within the agency are confidential and not subject to subpoena.

Pursuant to MCL 500.3157a, a new section under the no-fault act, medical providers are required to submit to utilization reviews performed by an insurer. An insurer may require a provider to explain the necessity or indication for treatment in writing. If an insurer deems treatment to be overutilized or inappropriate, or the cost of a treatment to be inappropriate, the provider may appeal the decision to DIFS and will be bound by the decision. A provider who knowingly submits false or misleading documents or other information to an insurer, the MCCA, or DIFS, commits a fraudulent insurance act and is subject to criminal penalty.

Medical Examinations

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

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

The Michigan Catastrophic Claims Association

For decades the Michigan Catastrophic Claims Association (MCCA) was instrumental in limiting exposure for insurers because it was required to reimburse no-fault carriers for claims paid in excess of the ultimate loss threshold. Now that policyholders are permitted to select policies that provide for limited allowable expenses, the MCCA will not be required to reimburse insurers on policies that provide less than unlimited, lifetime benefits. Accordingly, policyholders who opt out of coverage for allowable expenses or select an allowable expense cap of $50,000, $250,000 or $500,000, cannot be assessed a premium for the MCCA.[43] In addition, retention levels will be increased for policies that were issued after July 1, 2013.

Insurance carriers will still be assessed a premium by the MCCA for polices that provide lifetime allowable expenses. Insurers can pass that premium on to policyholders with lifetime policies, but the premium must be equal to the amount charged by the MCCA.[44]

The MCCA will be subject to an independent audit every three years, beginning on July 1, 2022. If the assets of the MCCA exceed 120 percent of the liabilities, policyholders who were assessed an MCCA premium will be refunded the excess beyond 120 percent of liabilities.[45] The MCCA must also issue a consumer statement regarding claims submitted to the MCCA and the financial condition of the MCCA.

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

Residual Bodily Injury Claims

For decades, the minimum bodily injury policy limits in Michigan were $20,000 per person and $40,000 per occurrence. After July 1, 2020, the default minimum policy limits will now be $250,000 per person and $500,000 per occurrence.[46] The minimum policy limits for property damage remain at $10,000. A person may

be able to select a policy with limits as low as $50,000 per person and $100,000 per occurrence if they complete the required form and the insurer makes certain necessary disclosures.[47] If the person did not make the choice, or if the required actions were not taken, the default policy is $250,000 person and $500,000 per occurrence.[48]

With limits being permitted for no-fault claims, damages available for residual bodily injury against an at-fault driver are expanded. An injured person can now seek economic damages in excess of the limits for allowable expenses available to the person.[49] This is in addition to a person's ability to claim damages for wage loss in excess of the monthly and yearly limits prescribed under the no-fault act.

Moreover, an out-of-state resident is able to claim such economic damages against an at-fault driver. The non-resident must show death, serious impairment of body function, or permanent serious impairment in order to recover damages.[50] A Michigan resident, however, is not required to make such a showing as to economic damages.

As for the tort threshold, an injured party must still demonstrate a serious impairment of body function in order to obtain non-economic damages. The statute has been amended to codify the standard for serious impairment of body function as stated in the Michigan Supreme Court's *McCormick v Carrier*[51] decision. "Serious impairment of body function" now means:

- It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.
- It is an impairment of an important body function which is a body function of great value, significance, or consequence to the injured person.
- It affects the injured person's general ability to lead his or her normal life, meaning it has had an influence on some of the person's capacity to live in his or her normal manner of living. Although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last. This examination is inherently fact and circumstance specific to each injured person, must be conducted on a case by case basis, and requires comparison of the injured person's life before and after the incident.[52]

Under the new legislative changes, a person involved in a motor vehicle accident after July 1, 2020 who suffers damage to their vehicle can now claim damages (aka a "mini-tort" claim) against the responsible party for up to $3,000 to the extent that the damages were not covered by insurance.[53] Previously, the amount was $1,000. This amendment is meant to cover the person's deductible.

Endnotes

1 MCL 500.3107c(3)
2 MCL 500.2111f(2)
3 MCL 500.2111f(7)
4 MCL 500.3181-MCL 500.3189
5 MCL 500.3109a(2)
6 MCL 500.3107d(7)(b); MCL 500.3109a(5)
7 MCL 500.3109a(2)(a)
8 MCL 500.3109a(2)(b)
9 MCL 500.3109a(2)(d)
10 MCL 500.3109a(2)(d)(i)
11 MCL 500.3109a(2)(d)(ii)
12 MCL 500.3109a(2)(e)
13 MCL 500.3157(4)
14 MCL 500.3157(6)
15 MCL 500.3157(2)
16 MCL 500.3157(12)
17 *Id.*
18 MCL 500.3157(10)
19 MCL 500.3157(11)
20 MCL 500.3107c(8)
21 *Covenant v State Farm,* 500 Mich 191; 895 NW2d (2017)
22 MCL 500.3112
23 *Devillers v ACIA,* 473 Mich 562; 702 NW2d 539 (2005)
24 MCL 500.3145(3)
25 MCL 500.3114(2)
26 MCL 500.3114(2)(a)-(g)
27 MCL 500.3114(2)(h)
28 MCL 500.3114(4)
29 MCL 500.3114(5)-(7)
30 MCL 500.3115
31 MCL 500.3172(1)
32 MCL 500.3172(3)
33 MCL 500.3172(4)
34 MCL 500.3172a(2)-(3)
35 MCL 500.3173a(1)
36 MCL 500.3172(7)
37 MCL 500.3175(3)
38 MCL 500.3113(c)
39 MCL 500.3148(1)(a)-(b)
40 MCL 500.3148(4)
41 MCL 500.3148(5)
42 MCL 500.3148(2)
43 MCL 500.3104(7)(d)
44 MCL 500.3104(20)
45 MCL 500.3104(21), (22), and (24)
46 MCL 500.3009(1)
47 MCL 500.3009(5)
48 MCL 500.3009(8)
49 MCL 500.3135(3)(c)
50 MCL 500.3135(d)
51 *McCormick v Carrier,* 487 Mich 180; 795 NW2d 517 (2010)
52 MCL 500.3135(5)
53 MCL 500.3135(3)(e)

Figuring Out What Rule Applies to Noncompetition Agreements with Independent Contractors

By: David F. Hansma, *Seybrun Kahn, PC*

Executive Summary

Michigan's law governing noncompetition agreements with respect to independent contractors is in a state of flux. Until recently, non-compete agreements with independent contractors were governed by a common-law rule of reason. Based on recent Michigan Supreme Court case law, however, non-compete agreements with independent contractors may now be governed by the federal rule of reason.

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Introduction

Michigan's law governing noncompetition agreements is in a state of flux. Employee non-compete agreements generally are governed by a specific section of the Michigan Antitrust Reform Act ("MARA") and their enforcement depends on their "reasonableness."[1] Non-compete agreements for independent contractors are governed by a common-law "rule of reason," which according to the Michigan Court of Appeals, the elements are very similar to the statute governing employee non-compete agreements.[2] Meanwhile, in 2016, the Michigan Supreme Court held that commercial non-compete agreements between businesses are governed by the federal antitrust rule of reason, not the common law rule of reason or the reasonableness factors applicable to employee non-compete agreements.[3]

What remains unsettled is whether the Michigan Supreme Court would continue to apply the common law rule of reason or apply the federal rule of reason to independent contractors if the issue were squarely presented. This is a significant issue, as numerous professionals—ranging from computer programmers to sales representatives, photographers to nurse anesthetists—operate as independent contractors. This article analyzes the current state of Michigan law governing non-compete agreements, and attempts to provide clarity regarding the rules governing independent contractor non-compete agreements.

The Law Governing Employment Non-Compete Agreements is Well-Settled

Noncompetition agreements in the employment context are governed by section 4a of the MARA (MCL 445.774a):

> An employer may obtain from an employee an agreement or covenant which protects an employer's reasonable competitive business interests and expressly prohibits an employee from engaging in employment or a line of business after termination of employment if the agreement or covenant is reasonable as to its duration, geographical area, and the type of employment or line of business. To the extent any such agreement or covenant is found to be unreasonable in any respect, a court may limit the agreement to render it reasonable in light of the circumstances in which it was made and specifically enforce the agreement as limited.[4]

The essential element is reasonableness. An enforceable noncompetition clause must protect a "reasonable" competitive business interest, must be "reasonable" in terms of duration and geographic scope, and must restrict the employee from only a "reasonable" type of employment or line of business.[5]

Non-compete agreements are disfavored in the employment context, and the burden is on the party enforcing the provision to prove its reasonableness.[6] Reasonable competitive business interests that may justify a non-compete include protecting confidential information, investment in specialized training, and preserving customer goodwill.[7] Even when otherwise enforceable, a non-compete agreement in the employment context cannot prevent the employee from working in the field in which he has expertise.[8]

Based on the reasoning of *Innovation Ventures,* it seems likely the Supreme Court would apply the federal rule of reason to independent contractor non-compete agreements.

Commercial Non-Compete Agreements are Governed by the Federal Rule of Reason

Section 445.774a, by its clear language, applies only to employee non-compete agreements. The rule governing non-compete agreements between businesses is significantly different. While courts have sometimes applied the four-part statutory test outside the employment context,[9] the Michigan Supreme Court put a stop to that in *Innovation Ventures, LLC v Liquid Mfg, LLC.*[10] After *Innovation Ventures*, the so-called "commercial non-compete agreements" are now evaluated under the federal rule of reason.

Innovation Ventures involved a noncompetition agreement between two companies. The Court of Appeals "evaluated the reasonableness of the parties non-compete provision … under the standard governing non-compete provisions between an employer and employee[.]"[11] The Supreme Court rejected that analytical framework, holding that "a commercial non-compete provision must be evaluated for reasonableness under the [federal antitrust] rule of reason."[12]

The Supreme Court held that the reasonableness standard in section 445.774a is restricted to employee non-compete agreements and "does not address the proper framework for evaluating a non-compete between businesses."[13] Instead, the Court relied on section 445.784(2), which provides that "courts shall give due deference to interpretations given by the federal courts to comparable antitrust statutes, including, without limitation, the doctrine of per se violations and the rule of reason."[14] The Court held, "federal courts have assessed non-compete agreements between two commercial entities under the rule of reason."[15] Therefore, the Supreme Court concluded that "the parties' non-compete agreements should have been evaluated under the rule of reason."[16]

In adopting a rule-of-reason analysis, the Supreme Court made clear that it was referring to the federal rule of reason, not Michigan's common-law rule of reason.[17] The common-law rule of reason was articulated in the 1873 decision in *Hubbard v Miller.*[18] In that case, the Court held that a non-compete between two businesses "will be held valid" if "the restrained contracted for appears to have been for a just and honest purpose, for the protection of the legitimate interests of the party in whose favor it is imposed, reasonable as between them and not specifically injurious to the public[.]"[19] This framework is similar to the framework applicable to employment non-compete agreements, and has been applied by Michigan courts regularly since 1873.[20]

The Supreme Court in *Innovation Ventures* was obviously aware of, and even referenced, its own common-law rule of reason.[21] Even with the language of section 445.784(2) requiring "due deference" to federal precedent, it is not obvious why the Supreme Court insisted on applying the federal rule of reason. Specifically, the Court did not explain why "due deference" to federal precedents requires abandonment of Michigan's 146-year-old rule of reason. Nevertheless, it is clear that "commercial non-compete agreements" in Michigan are now governed by the federal rule of reason.

How Do the Rules Differ?

Under the common-law/employment framework, non-compete agreements are disfavored and the burden of proving reasonableness is on the party seeking to enforce the covenant.[22] What constitutes a "reasonable competitive business interest" is limited to a specific categories, and does not include simply preventing competition. [23] Importantly, much of the reasonableness analysis is focused on the harm to the restricted party.

The federal rule of reason adopted by *Innovation Ventures* requires a very different standard than the Michigan common-law rule of reason. A court applying the federal rule of reason must consider:

> [T]he facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts.[24]

As other commentators have noted, this rule of reason "requires detailed analysis of the anticompetitive effect on the overall relevant markets, [including] identifying a relevant affected product market … a geographic market … antitrust standing (including antitrust injury), and identifying whether competition in the overall market has been harmed[.]"[25] As a result, it should be "substantially more difficult for a party to successfully invalidate a commercial non-compete

clause that excludes a single competitor from some or all of [a] market[.]"[26]

Recent decisions bear this out. For example, in *Little Caesar Enterprises v Creative Restaurant, Inc*,[27] the defendant's challenge to a commercial non-compete clause failed because it failed to show "adverse, anticompetitive effects in the overall pizza or quick-service food market[.]"[28] Meanwhile, the Sixth Circuit held that the burden now rests with the party challenging a non-compete to show that it is unreasonable.[29]

> Even with the language of section 445.784(2) requiring "due deference" to federal precedent, it is not obvious why the Supreme Court insisted on applying the federal rule of reason. Specifically, the Court did not explain why "due deference" to federal precedents requires abandonment of Michigan's 146-year-old rule of reason.

What Rule Applies to Independent-Contractor Agreements?

We now return to the issue presented. What rule will the Supreme Court apply in the independent-contractor situation? Clearly, it is not the rule from section 445.774a, because that rule applies only to an agreement "between an employer and an employee[.]"[30] But, must an independent contractor prove adverse anticompetitive effects in the overall market to escape a noncompetition provision?

Strictly speaking, the *Innovation Ventures* decision applies to "a commercial non-compete provision,"[31] the definition of which seems to be limited to agreements "between two business entities[.]"[32] Independent contractors are sometimes organized as business entities, but not always. Often, independent contractors are natural persons. For that matter, the person employing the independent contractor could be a natural person too. It could be argued that the Supreme Court, which was addressing only commercial non-compete agreements, did not intend to extend the federal rule of reason to the independent-contractor scenario. The Supreme Court's comments, however, suggest otherwise.

In a footnote, the *Innovation Ventures* Court specifically addressed the Court of Appeals' opinion in *Bristol Window & Door v Hoogenstyn*, which held that an independent contractor non-compete agreement should have been analyzed under the common-law rule of reason.[33] The Supreme Court commented that *Bristol Window & Door* "properly identified and reasoned that MCL 445.772 codified the rule of reason, despite failing to refer to MCL 445.784(2) or to evaluate whether federal courts applied the rule of reason under comparable statutes."[34] So, on the one hand, *Bristol Window & Door* "properly identified and reasoned" that the Michigan rule of reason applies, but on the other hand, failed to look to the federal rule of reason.

How do the federal courts evaluate this issue? There are few federal court decisions actually considering independent contractor non-compete agreements under the Sherman Antitrust Act. In the limited cases available, federal courts have applied the federal rule of reason to independent contractors (and even employees).[35] Deference to federal precedent in this context would require a Michigan court to apply the federal rule of reason to independent contractor non-compete agreements. Based on the reasoning of *Innovation Ventures*, it seems likely the Supreme Court would apply the federal rule of reason to independent contractor non-compete agreements.

Endotes

1 See MCL 445.774a(1).

2 *Bristol Window & Door v Hoogenstyn*, 250 Mich App 478, 497-498; 650 NW2d 670 (2002).

3 *Innovation Ventures, LLC v Liquid Mfg, LLC*, 499 Mich 491; 885 NW2d 861 (2016).

4 MCL 445.774a(1).

5 *St Clair Med PC v Borgiel*, 270 Mich App 260, 266; 715 NW2d 914 (2006).

6 *Coates v Bastian Bro, Inc*, 276 Mich App 498, 507-508; 741 NW2d 539 (2007).

7 See e.g. *St Clair Med PC*, *supra* n 5, at 266-67.

8 *Hayes-Albion v Kuberski*, 421 Mich 170, 189; 364 NW2d 609 (1984); *Whirlpool Corp v Burns*, 457 F Supp 2d 806, 813 (WD Mich, 2006).

9 See, e.g. *Certified Restoration Dry Cleaning Network, LLC v Tenke Corp*, 511 F3d 535, 546-47 (CA 6, 2007).

10 *Innovation Ventures, supra* n 3.

11 *Id.* at 505-06.

12 *Id.* at 496.

13 *Id.* at 513.

14 MCL 445.784(2).

15 *Innovation Ventures, supra* n 3, at 514.

16 *Id.* at 515.

17 *Id.* at 514-15

18 *Hubbard v Miller*, 27 Mich 15 (1873).

19 *Id.* at 19.

20 See, e.g. *Staebler-Kempf Oil Co v Mac's Auto Mart*, 329 Mich 351; 45 NW2d 316 (1951) (commercial non-compete); *Follmer, Rudzewicz & Co, PC v Kosco*, 420 Mich 394; 362 NW2d 676 (1984) (employment non-compete prior to adoption of MCL 445.774a); *Cardiology Associates of Southwestern Michigan, PC v Zencka*, 155 Mich App 632; 400 NW2d 606 (1985) (non-compete in stock redemption agreement).

21 *Innovation Ventures, supra* n 3 at 512, 514 n 17.

22 *Coates, supra* n 5.

23 *St Clair Med PC*, *supra* n 5, at 26.

24 *Innovation Ventures, supra* n 3 at 514-15, quoting *Bd of Trade of City of Chicago v United States*, 246 US 231, 238 (1918).

25 Iwrey et al., *Innovation Ventures Paves the Way for Stronger Commercial Non-compete Agreements*, Michigan Bar Journal, p 22 (May 2017).

26 *Id.*

27 *Little Caesar Enterprises v Creative Restaurant, Inc*, 2017 US Dist LEXIS 174623 (ED Mich, Oct 23, 2017).

28 *Id.* at *5.

29 *Innovation Ventures, LLC v Custom Nutrition Labs, LLC*, 912 F3d 316, 341 (CA 6, 2018).

30 *Innovation Ventures, supra* n 3, at 513.

31 *Id.* at 496.

32 *Id.* at 513.

33 *Id.* at 515, n18.

34 *Id.*

35 See *Consultants & Designers, Inc v Butler Service Group, Inc*, 720 F2d 1553 (CA 11, 1983); *Eichorn v AT&T Corp*, 248 F3d 131 (CA 3, 2001); *Haines v Verimed Healthcare Network, LLC*, 613 F Supp 2d 1133 (ED Mo, 2009).

MDTC Schedule of Events

2019

September 13	Golf Outing – Mystic Creek, Milford
September 19	MDTC Board Meeting – Lansing, Foster Swift
October 16-19	DRI Annual Meeting – New Orleans
October 24	Defense Network – South Eastern Michigan – Jolly Pumpkin
November 7	MDTC Board Meeting – Sheraton Detroit Novi
November 7	Past Presidents Dinner - Sheraton Detroit Novi
November 8	Winter Conference - Sheraton Detroit Novi

2020

February 7	Future Planning – Hotel Indigo – Traverse City
February 7	Meet & Greet Reception/ Traverse City - TBA
February 8	Board Meeting – Hotel Indigo – Traverse City
March 19	Legal Excellence Awards – Gem
April 30	Board Meeting – Lansing – Foster Swift
June 18-19	Annual Meeting & Conference – Treetops Resort, Gaylord
September 11	Golf Outing - Mystic Creek, Milford
October 8	Meet the Judges- Sheraton Detroit Novi
October 21-24	DRI Annual Meeting – Washington DC
November 5	MDTC Board Meeting – Sheraton Detroit Novi
November 5	Past Presidents Dinner – Sheraton Detroit Novi
November 6	Winter Conference – Sheraton Detroit Novi

2021

June 18-19	Annual Meeting & Conference – Indigo, Traverse City

Appellate Practice Report

By: Phillip J. DeRosier, *Dickinson Wright PLLC*, and Trent B. Collier, *Collins Einhorn Farrell P.C.*
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Citing Unpublished Opinions

It's well-understood that unpublished decisions don't have precedential value under the doctrine of stare decisis. The Michigan Court of Appeals has even cautioned against citing them, warning that "[c]onsideration of unpublished cases is disfavored."[1] But practitioners also know that there isn't always a controlling published decision. Indeed, one of the topics of discussion at the 2019 Michigan Appellate Bench Bar Conference was whether the Court of Appeals should be publishing more of its decisions.[2]

And, of course, there are times when an unpublished opinion contains a particularly helpful discussion of an issue—especially one that is fact-specific. In that situation, it may well be appropriate to cite the unpublished opinion. After all, it has long been recognized that unpublished decisions, while nonbinding, "may be persuasive or instructive."[3]

In all cases, citing an unpublished opinion requires attention to the rules followed by the court you're in. For Michigan practitioners, those rules differ depending on whether you're in the Michigan Supreme Court or Court of Appeals, or in the Sixth Circuit.

Sixth Circuit

The Sixth Circuit "permits citation of any unpublished opinion, order, judgment, or other written disposition."[4] But if such a decision is "not available in a publicly accessible electronic database, the party must file and serve a copy as an addendum to the brief or other paper in which it is cited."[5]

Michigan Supreme Court and Court of Appeals

The rule governing the citation of unpublished opinions in the Michigan Supreme Court and Court of Appeals is more restrictive. As an initial matter, MCR 7.215(C) cautions that "[u]npublished opinions should not be cited for propositions of law for which there is published authority."[6] If a party does cite an unpublished opinion, "the party shall explain the reason for citing it and how it is relevant to the issues presented."[7] In addition, "[a] party who cites an unpublished opinion must provide a copy of the opinion to the court and to opposing parties with the brief or other paper in which the citation appears."[8]

The Automatic Stay, Debtor Standing, and Civil Appeals

A bankruptcy petition can affect an appeal in a civil action in a number of ways. This article focuses on just two of the issues that appellate counsel should evaluate: (1) the effect of the automatic stay imposed by 11 U.S.C. § 362 and (2) the debtor's standing to pursue an appeal in the wake of its bankruptcy petition.

The automatic stay

When a debtor files a bankruptcy petition, all litigation against the debtor must stop—including appeals. This rule is called the "automatic stay," and it's codified in 11 U.S.C. § 362.

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Trent Collier is a member of the appellate department at Collins Einhorn Farrell P.C., in Southfield. His practice focuses on the defense of legal malpractice, insurance, and general liability claims at the appellate level. His e-mail address is Trent.Collier@CEFLawyers.com.

Although it's rare for the stay to apply to parties other than the debtor itself, it's important not to underestimate the stay's breadth. The Bankruptcy Code stays more than just actions against the debtor. For example, appellate counsel should be aware that the stay also applies to "any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of the estate." To be sure, the debtor is usually the subject of the automatic stay. But some cases may require a more careful examination of the text of the Bankruptcy Code and relevant case law—or, better yet, a consultation with experienced bankruptcy counsel.

It's equally important not to *over*estimate the breadth of the automatic stay. The automatic stay generally applies to claims against particular parties or property, not to actions as a whole. If your client is appealing a judgment entered in favor of two parties, only one of which is a debtor in bankruptcy, you may be able to continue your appeal against the non-debtor, even though claims against the debtor are stayed. As the Sixth Circuit Court of Appeals put it, "In the absence of unusual circumstances, the automatic stay does not halt proceedings against solvent codefendants."

As for how to notify a court about the potential impact of the automatic stay, start with the court's Internal Operating Procedures. When a case is before the Michigan Court of Appeals, *all* parties have an obligation to assess the potential impact of the automatic stay. The Michigan Court of Appeals' Internal Operating Procedures provide that "*any party* who becomes aware of a proceeding in bankruptcy that *may* cause or impose a stay of proceedings of a case in this Court should immediately file a written notice with the clerk's office." This filing with the clerk's office must "include an explanation why the bankruptcy proceedings impact the pending case." Opposing parties may file contrary statements.

The clerk's office then makes an initial determination and either notifies the parties by letter that it believes the stay does not apply or recommends that the court enter an order staying the appeal. If a party believes that the clerk erred in declining to stay an appeal, it may file a formal motion with the court. A party who believes the court erred in staying an appeal may file a motion for reconsideration. Once the stay is removed or lifted, parties may file a motion to reopen the case.

The automatic stay generally applies to claims against particular parties or property, not to actions as a whole.

The real party-in-interest

The automatic stay raises the issue of whether a party may continue pursuing an appeal against a debtor/appellee (a claim against property of the estate). When the debtor is the *appellant*, a related question arises: is the debtor/appellant still the real party-in-interest after filing a bankruptcy petition?

To answer this question, you'll need to start with the Bankruptcy Code. A bankruptcy estate is created when a debtor files a bankruptcy petition. The estate includes "all legal or equitable interests of the debtor in property as of the commencement of the case" and therefore includes any claims or causes of action the debtor may hold when the bankruptcy petition is filed. Whether the debtor has standing to pursue that claim on behalf of the estate (not on its own behalf) often depends on which chapter of the Bankruptcy Code the debtor's petition invokes.

When an appellant files a petition under Chapter 7 of the Bankruptcy Code, the Chapter 7 trustee has sole authority to pursue any prepetition claims or causes of action that the debtor possessed. So an appellant no longer has standing to pursue an appeal once it files a bankruptcy petition.

The analysis likely differs when a debtor files under other chapters, including Chapters 11 and 13. Although the Sixth Circuit Court of Appeals has not yet addressed the issue, most courts have held that Chapter 13 debtors and Chapter 13 trustees have overlapping rights to pursue prepetition causes of action. Although there's some debate about the issue, it's likely that the debtor *or* the trustee can pursue an appeal after the appellant files a Chapter 13 petition.

A debtor under Chapter 11 will ordinarily have standing to continue pursuing its appeal. This conclusion follows from the fact that a debtor-in-possession under Chapter 11 has many of the powers ordinarily conferred on trustees, including the authority to pursue causes of action on behalf of the estate. This authority ends if the Bankruptcy Court appoints a Chapter 11 trustee. Until that time, a debtor-in-possession likely has standing to continue pursuing an appeal on behalf of its bankruptcy estate.

Conclusion

These issues are among the first that appellate counsel should consider when an opposing or related party files a bankruptcy petition while an appeal is pending. Violating the automatic stay can expose both an attorney and his or her client to actual and punitive damages. And failing to identify an appellant/debtor's lack of standing can expose a client to unnecessary costs and expenses. A thorough examination of other obligations—including those necessary to preserve a claim—is a good idea, too. So it's usually worthwhile to consult experienced bankruptcy counsel about the impact of a new bankruptcy case and the steps necessary to protect your client's rights.

Endnotes

1 *Shinn v Michigan Assigned Claims Facility*, 314 Mich App 765, 773; 887 NW2d 635 (2016).

2 MCR 7.215(B) provides that an opinion "must be published" if it: "(1) establishes a new rule of law; (2) construes as a matter of first impression a provision of a constitution, statute, regulation, ordinance, or court rule; (3) alters, modifies, or reverses an existing rule of law; (4) reaffirms a principle of law or construction of a constitution, statute, regulation, ordinance, or court rule not applied in a reported decision since November 1, 1990; (5) involves a legal issue of significant public interest; (6) criticizes existing law; or [sic] (7) resolves a conflict among unpublished Court of Appeals opinions brought to the Court's attention; or (8) decides an appeal from a lower court order ruling that a provision of the Michigan Constitution, a Michigan Statute, a rule or regulation included in the Michigan Administrative Code, or any other action of the legislative or executive branch of state government is invalid."

3 *Kern v Kern-Koskela*, 320 Mich App 212, 241; 905 NW2d 453 (2017).

4 6th Cir R 32.1(a).

5 6th Cir R 32.1(a).

6 MCR 7.215(C)(1).

7 *Id.*

8 *Id.*

Legal Malpractice Update

By: Michael J. Sullivan and David C. Anderson, *Collins Einhorn Farrell, P.C.*[1]
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Causation and Damages Are Still Essential Elements of a Legal Malpractice Claim

Twice Baked, LLC, v. Lawyer Defendants, unpublished per curiam opinion of the Court of Appeals, issued February 26, 2019 (Docket No. 341378); 2019 WL 943191.

Facts:

Lawyer-Defendants represented Twice Baked, LLC, (Plaintiff) in the negotiation and creation of a purchase agreement with JB Development. Tubby's owned JB Development; Bill Kiryakoza and Robert Paganes owned Tubby's. Defendants were asked to include terms in the purchase agreement that would require JB Development to require all licensees to purchase cupcakes and supplies exclusively from Plaintiff. There was no legal mechanism, however, to force the inclusion of those terms and Plaintiff was without another viable business option. The terms were included but without what Plaintiff believed to be an adequate enforcement mechanism. The licensees subsequently refused to sign a service licensing agreement requiring them to purchase exclusively from Plaintiff. Plaintiff filed a legal malpractice claim against Defendants claiming that Defendants failed to include the exclusivity terms in the deal documents.

Defendants moved for summary disposition based on lack of proximate cause and relied principally on two affidavits in support of their motion. Defendants produced Kiryakoza's affidavit as evidence, proving that JB Development would not have entered into the agreement requiring licensees to purchase exclusively from Plaintiff. Kiryakoza stated that he offered the option to the licensees, but they refused.

Defendants also produced an affidavit from one of Plaintiff's former licensees. The affidavit supported the idea that the licensees would not have agreed to sign a licensing agreement that required them to purchase solely from Plaintiff.

Plaintiff offered no evidence to support the allegation that the parties had agreed to the terms. Plaintiff only offered an email to Defendant requesting that he add the terms.

The trial court granted Defendants' motion for summary disposition because Plaintiff could not establish causation. There was insufficient evidence proving that Defendants would have entered into the agreements had the requested terms been included.

On appeal, Plaintiff argued that: (1) Defendants' evidence was speculative and insufficient to establish that the licensees would not have purchased from Plaintiff if they had been required to sign a service licensing agreement because Kiryakoza's affidavit did not purport to have personal knowledge of the information or swear to the statement, and (2) Kiryakoza's statement that "'[e]ach of the … Franchisees I spoke to after the purchase… were adamant that they would not purchase from or do business with the [co-owner of Twice Baked] in any fashion'" was hearsay.

Ruling:

The Court held that the trial court did not err in granting Defendants' motion for summary disposition because the Defendants submitted a second affidavit from Kiryakoza that properly stated that he had personal knowledge of the statements contained therein and was a sworn witness. That affidavit contained the same information as the first.

Additionally, the Court found that the hearsay was negated by Kiryakoza's personal statement that JB Development would not have entered into the agreement had the terms been included. The Court also considered Kiryakoza's personal knowledge of

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when the licensees were offered but refused the opportunity to be solely supplied by Twice Baked.

Finally, the Court found that Plaintiff failed to provide evidence to support the allegation that Plaintiff suffered an injury as a result of Defendants' alleged negligence. Plaintiff did not present any evidence to show an accounting, including sales, operating expenses, and taxes; therefore, Plaintiff did not establish that it was making a profit. Plaintiff claimed a "reasonable expectation for sales," but a reasonable expectation for sales is speculative and is not enough to support an allegation of injury.

Practice Note:

Thankfully, Michigan law recognizes that lawyers are advisers, not guarantors of successful outcomes.

Endnotes

1 The authors would like to thank Kara Moore for her work on this article.

The Court held that the trial court did not err in granting Defendants' motion for summary disposition because the Defendants submitted a second affidavit from Kiryakoza that properly stated that he had personal knowledge of the statements contained therein and was a sworn witness.

MDTC Legislative Report

By: Graham K. Crabtree, *Fraser, Trebilcock, Davis & Dunlap PC*
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As I complete this report of legislative progress on June 12th, it appears that spring has finally arrived in Michigan, and if past experience can be relied upon, it may be assumed that it will soon be followed by the scorching heat of summer. And with that, our legislators will be looking forward to as much of a summer break as they can manage to take in this year with no election. It is hoped that work on the FY 2019-20 budget can be completed by the end of June or not too far into July, but there is still a great deal to be resolved and there is an unsettling feeling at the Capitol that no one should be leaving town until a plan for fixing the roads can be agreed upon.

In the three months since my last report, our Republican-controlled Legislature and new Democratic Governor have continued to become acquainted and have discovered that they can do business if they work together, as they must. The progress started with small steps and accelerated with surprising speed to negotiations leading to sweeping reforms of our no-fault auto insurance system – a subject which has produced nothing more than a series of stalemates in prior legislative sessions. Other politically charged issues remain, including most notably, that pesky question of how we can fix our long-neglected roads and bridges without paying the price, and we will watch with interest to see whether, and how, those questions may be resolved in the days ahead.

As of this writing, there are 22 Public Acts of 2019. Those of interest include:

2019 PA Nos. 7-9 – Senate Bill 2 (Lucido - R); House Bill 4001 (Wentworth - R); and **House Bill 4002 (LaGrand - D)** This package of tie-barred legislation will amend the Public Health Code to amend § 333.7523 and add two new sections establishing new procedures for forfeiture of property involved in violations of that act. These include, most notably, new requirements that a criminal conviction be obtained before forfeiture can be pursued in most cases. These amendatory acts will take effect on August 7, 2019.

2019 PA No. 10 – House Bill 4286 (Johnson - R), which has amended the Wrongful Imprisonment Compensation Act, MCL 691.1756, to require the Attorney General to make quarterly reports to the House and Senate Appropriations Committees, the House and Senate Fiscal Agencies and the State Budget Office providing information regarding payments made from the Wrongful Imprisonment Compensation Fund; claims for compensation made and settlements reached; claims denied; and the reasons for denial of the claims rejected. As passed by both houses, the bill also provided for an appropriation of $10,000,000 from the general fund to the Wrongful Imprisonment Compensation Fund.

The greater relevance of this amendatory act is for what it has revealed about the new order in Lansing rather than its substantive content. As I noted in my last report, Governor Whitmer made a pledge in her first State of the State Address that she would veto any legislation designed to thwart the People's constitutional right to challenge legislation by referendum. Her comment was made in reference to abuses of Const 1963, art 2, § 9, based upon its language specifying that, "[t]he power of referendum does not extend to acts making appropriations for state institutions or to meet deficiencies in state funds…" That language has often been relied upon by the party in control to insulate legislation from challenge by referendum by the simple expedient of adding a small appropriation to a bill proposing substantive changes – a practice which our courts have declined to disapprove.

When House Bill 4286 was presented to Governor Whitmer for her approval, she fulfilled her pledge by vetoing the appropriation, although supportive of the proposed funding, to preserve the People's reserved right to challenge the legislation by referendum. In doing so, she sent a clear message that appropriations should not be

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made outside of general or supplemental appropriation bills so that all may know that the practice of doing so in order to defeat the People's constitutional right of referendum will not be tolerated on her watch. The full amount of the vetoed funding for the wrongfully imprisoned has now been properly included in a regular supplemental appropriation bill – **Senate Bill 150 (Stamas – R) –** enrolled for presentation to the Governor on June 11th.

2019 PA 21 – Senate Bill 1 (Nesbitt – R), which has adopted numerous amendments of the Insurance Code of 1956 to make sweeping changes to the act's provisions governing no-fault auto insurance. This amendatory act provides another good example of how the enactment of legislation has changed in this new session.

As I noted in my last report, several bills proposing no-fault auto insurance reform were introduced in the House and Senate early on in this new legislative session. Most of those bills renewed proposals for changes suggested without success in prior legislative sessions, but all of them were motivated by the desire to reduce the painfully excessive cost of no-fault auto insurance in Michigan. This overall objective was shared by legislators of both parties, and all of them were able to see a pressing need to produce a viable solution. Senate Bill 1 was introduced on January 15th and referred to the Senate Committee on Insurance and Banking. As introduced, it contained only general statements of legislative purpose, with the details being left for resolution in subsequent discussions with the interested parties. In the House, a special Select Committee on Reducing Car Insurance Rates was created to study the issues and report appropriate legislation.

After much discussion, the legislation was revised and moved quickly. On May 7th, the Senate Committee reported a Substitute (S-1) for Senate Bill 1, and the rules were suspended to advance the bill to a vote on final passage later that same day. On May 8th, **House Bill 4397 (Sheppard – R)** was discharged from the House Committee on Insurance, and a Substitute (H-1) for that bill was passed the next day. At this point, Governor Whitmer made it clear that she would not sign either bill – that she intended to be a player and was not to be bypassed in a rush to final passage of this important legislation. Real negotiations ensued, which led to the passage of a Substitute (H-3) for Senate Bill 1 by the House, with immediate effect, on May 24th. The House Substitute was passed by the Senate without amendment and given immediate effect on the same day. The Enrolled Senate Bill 1 was presented to Governor Whitmer on May 30th and signed on Mackinac Island amid great pomp and ceremony the next day, but was not filed with the Secretary of State for assignment of a Public Act number until June 11th.

[O]ur Republican-controlled Legislature and new Democratic Governor have continued to become acquainted and have discovered that they can do business if they work together.

There had been discussion of linking no-fault auto insurance reform to a deal to fix the roads, which seemed like an overly ambitious objective to many observers. In the end, the issues could not be linked, but the prompt passage of Senate Bill 1 has been lauded by those in favor as a welcome sign of future bipartisan cooperation. Those opposed, most notably certain members of the plaintiffs' bar, have expressed bitter disappointment with strongly voiced suggestions for further legislation to address the perceived shortcomings.

The changes effected by Public Act 21 are too numerous and complex to permit a thorough summary here. Thus, our members engaged in the handling of no-fault cases are encouraged to spend the time required to review its provisions carefully. For today, it must suffice to mention a few of the most noteworthy points.

Like many of the initiatives that came before, Public Act 21 includes new provisions allowing insureds to choose between alternative levels of personal protection insurance (PIP) health coverage benefits. Beginning on July 1, 2020, insureds will have five levels of PIP health coverage benefits to choose from: 1) a coverage limit of $50,000 for Medicaid enrollees; 2) a coverage limit of $250,000, with an available exclusion of PIP benefits for members of an insured's household having other health coverage for injuries suffered in automobile accidents; 3) a coverage limit of $500,000; 4) an unlimited PIP benefit option; and 5) an option for individuals covered by Medicare to have no PIP health coverage. The legislation will require specified reductions of premiums to reflect the level of benefits selected for policies issued or renewed after July 1, 2020, but before July 1, 2028.

Among other things, the legislation will also increase the minimum amount of required liability coverage from $20,000 per person / $40,000 per accident to $50,000 per person / $100,000 per accident; add a new Chapter 31A allowing insurers to offer a managed care option for PIP benefits; establish medical provider reimbursement limits for PIP health coverage benefits tied to amounts approved for payment by Medicare; prohibit insurers from establishing or maintaining rates or rating classifications for automobile insurance based upon home ownership, educational level attained, occupation, postal zip code, or credit scores; add a new Chapter 63 establishing an anti-fraud unit as a criminal justice agency within the Department of Insurance and Financial Services, with responsibility for prevention and investigation of criminal and fraudulent activities in the insurance market; provide a new more expansive definition of "serious impairment of body function" intended as a codification of the standard established in *McCormick v Carrier,* 487 Mich 180 (2010); and increasing fines for various violations of the act.

When the excitement had died down, legislators on both sides of the aisle quickly realized that the expedited passage of Senate Bill 1 had left a few technical defects and unforeseen problems that needed to be fixed before the matter of no-fault insurance reform could be considered a done deal. Most notably, Senate Bill 1 would have caused an unintended short-term increase in the already high cost of no-fault insurance by requiring immediate implementation

of the new requirement for increased liability coverage when the anticipated rate reductions associated with the new options for lesser amounts of PIP health benefit coverage would not take effect until July of next year. In similar situations where a rush to final passage has left problems requiring remedial action, it has been the Legislature's practice to resolve the problems, more or less expeditiously, by means of a subsequent "trailer Bill." House Bill 4397 was quickly adapted for that purpose, passed by both houses on June 4th and presented to the Governor on June 6th. The Governor delayed her filing of the previously-signed Senate Bill 1 pending her review of House Bill 4397. She signed House Bill 4397 on June 11th, and both bills were filed with the Secretary of State on that date. House Bill 4397 is now 2019 PA No. 22.

Our members involved in the handling of no-fault cases will also need to carefully review the somewhat shorter but still substantial provisions of 2019 PA 22, which has amended several of the same sections amended and added by 2019 PA 21. When reviewing and reconciling the provisions of the two acts, the reader should bear in mind that the versions of the commonly amended sections appearing in 2019 PA 22 will control over the versions of those sections appearing in 2019 PA 21 because 2019 PA 22 was signed and filed later in time.

What Do You Think?

Our members are again reminded that the MDTC Board regularly discusses pending legislation and positions to be taken on bills and resolutions of interest. Your comments and suggestions are appreciated and may be submitted to the board through any officer, board member, regional chairperson or committee chair.

Insurance Coverage Report

By: Drew W. Broaddus, *Secrest Wardle*
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Murad Mgt, Inc v Hastings Mut Ins Co, unpublished per curiam opinion of the Court of Appeals, issued December 18, 2018 (Docket No. 339206).

This action arose out of a first-party claim for a leaking roof in a commercial office building. After one of the tenants complained of the leak, an inspection revealed that one or more of the building's trusses had failed, causing a portion of the roof surrounding an air conditioning unit to visibly sag. The displacement of the roof also caused two water pipes to break and begin pouring water into a tenant's unit. *Murad Mgt,* unpub op at 1.

The insured had the roof inspected by a structural engineer, who concluded that the roof failure was the result of "an abnormal event." *Id.* at 2. But the insurer had the roof inspected by another engineer, who found "no proximate causal relationship between the roof failure and any specific weather-related event or occurrence." *Id.* Based on those results, the insurer denied the claim with respect to the roof damage, citing policy exclusions.

The insured had the roof replaced at its own expense and then sued for breach of contract. *Id.* The complaint also sought an appraisal. *Id.* Defendant Hastings moved for summary disposition, and the trial court agreed with Hastings that there "was no genuine issue of material fact that plaintiff's roof damage claim fell within the exclusion for deterioration and continuous or repeated seepage or leakage of water…." *Murad Mgt,* unpub op at 3. The trial court also rejected the insured's alternative reliance on an additional coverage provision applicable to "collapse," finding that there was no evidence of a collapse, as defined by the policy. *Id.* The insured appealed, and the Court of Appeals affirmed in part, reversed in part, and remanded for further factual development.

The Court first addressed the insured's request for an appraisal. *Murad Mgt,* unpub op at 4. The panel found that the trial court erred by dismissing this claim, because the insured had already admitted liability for interior water damage. *Id.* Hastings argued on appeal that there was no coverage for interior water damage, but the panel found that the insurer had waived any such coverage defense. When "plaintiff submitted its claim, defendant admitted that 'a water event'like that at issue here was not excluded." *Id.* "Defendant's adjuster testified that the policy provided coverage for the interior damage caused by the broken water pipes, which was why defendant issued the partial payment to plaintiff." *Id.* "By agreeing with plaintiff that the water damage constituted a covered loss, defendant voluntarily and intentionally abandoned any argument that this water damage was excluded under the policy." *Id.* at 4-5. With coverage for the interior water damage admitted, the insured was entitled to an appraisal under the policy terms. *Id.* at 4.

The panel next considered whether the roof damages were excluded. *Murad Mgt,* unpub op at 5. This issue centered around whether the roof failed due to a single event, or whether the failure resulted from long-term "wear and tear" and deterioration. *Id.* at 6. The panel found that there were conflicting expert statements in the record on this point, so the insurer was not entitled to summary disposition. *Id.* To the extent that defendant introduced evidence that the damage was caused by "wear and tear," rust, corrosion, decay, deterioration or defects in the property, there was evidence that these excluded causes of loss resulted in a "specified cause of loss" – i.e., water damage or damage caused by weight of snow or ice. *Id.* at 7. Similarly, while there was evidence that the damage was caused by "[c]ontinuous or repeated seepage or leakage of water, or the presence or condensation of humidity, moisture or vapor, that occurs over a period

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of 14 days or more" – which would place the claim squarely under an exclusion – the evidence in this regard was, as noted, conflicting. *Id.* at 7.

The Hastings policy also included language discussing "collapse coverage." *Murad Mgt,* unpub op at 8. But the panel agreed with the trial court's determination that this coverage did not apply because there was no evidence of a collapse. *Id.* The evidence showed that a portion of the roof abruptly fell in or down at the subject property. However, the policy provided that a part of the building is not considered to have collapsed if that part of the building "is standing . . . even if it has separated from another part of the building." *Id.* The policy also provided that a building is not considered to have collapsed "even if it shows evidence of … sagging…." *Id.* Reading these provisions together, the panel found that what happened here could not be considered a "collapse" under the terms of the policy. *Id.*

Finally, the panel considered whether the insured may be entitled to the costs of "removal and replacement of the entire roof" under the policy's "Ordinance or Law" coverage. *Murad Mgt,* unpub op at 9. The trial court dismissed the entire suit without considering this part of the policy, presumably in light of its holding that the roof damage was not a covered loss. Because the panel found a question of fact in that regard, the trial court would need to consider, on remand, "whether plaintiff is entitled to coverage for the full roof replacement under the terms of the ordinance or law coverage." *Id.*

The Court's opinion was a mixed bag for the insurer. Hastings persuaded the panel that there was no "collapse coverage" as a matter of law, but Hastings was unable to make the summary disposition ruling "stick" as to other coverages. The panel's finding of a question of fact, as to coverage for the roof damages, was record-specific (the trial court apparently considered one expert report but disregarded another). But the panel's finding of a limited waiver, as to the interior water damage, is more notable because Michigan insureds are rarely successful with such arguments. "The application of waiver and estoppel is limited, and, usually, the doctrines will not be applied to broaden the coverage of a policy to protect the insured against risks that were not included in the policy or that were expressly excluded from the policy." *Kirschner v Process Design Assocs, Inc,* 459 Mich 587, 594; 592 NW2d 707 (1999). The fact that Hastings was asserting an exclusion here was likely critical to the insured's success on this point, as the insurer bears the burden of demonstrating that an exclusion applies.

Illinois Nat'l Ins Co v AlixPartners LLP, unpublished per curiam opinion of the Court of Appeals, issued February 26, 2019 (Docket No. 337564).

Unlike *Murad Mgt,* this action involved a liability claim (rather than a first-party claim) where the insurer paid the claim in full – to the tune of over $18.5 million – then tried to recoup payment from the insured on the grounds that there was no coverage. But here, the dismissal of the insured's recoupment claim was affirmed in all respects. *AlixPartners,* unpub op at 1.

Illinois National's insured, AlixPartners, was sued in a complex professional liability claim related to the acquisition of a German business by a firm located in the U.K. Illinois National's insured was hired by the purchaser to perform a "due diligence" inquiry of the German company. The U.K. firm was satisfied with the results of that inquiry and went through with the purchase. The newly acquired company then entered into its own agreement with AlixPartners to manage the newly acquired business. But the business performed poorly, and the purchaser pointed the finger at AlixPartners. *AlixPartners,* unpub op at 1-2.

The ensuing litigation resulted in an arbitration award against AlixPartners. *Id.* at 2. Illinois National agreed to fund the arbitration award subject to a reservation of rights. *Id.* There were issues regarding when AlixPartners notified its insurer of the claim, and those issues were complicated by the fact that Illinois National issued multiple policies to AlixPartners (with different policy periods) as well as the fact that it was not immediately clear whether the threatened suit was based on AlixPartners' alleged negligence in the pre-acquisition "due diligence" or the post-acquisition management. *Id.*

After sorting through the lengthy factual and procedural history, the panel of Judges Deborah Servitto, Elizabeth Gleicher, and Cynthia Diane Stephens unanimously determined that there were no issues with the notice provided to Illinois National, and that liability coverage was owed under what the panel dubbed "Policy 2" (to distinguish it from "Policy 1" and "the Tail Policy"). *AlixPartners,* unpub op at 5. The policy period for the Tail Policy was from February 25, 2006 to February 25, 2007 with an Extended Reporting Period ("ERP") from October 12, 2006 to October 12, 2008. *AlixPartners,* unpub op at 1. The policy period for Policy 1 was from October 12, 2006 to March 15, 2008. *Id.* The policy period for Policy 2 was retroactive from February 15, 1998 through the ERP of August 30, 2009. *Id.*

All three policies contained the same "claims first made and reported" language which provided: "We shall pay on your behalf those amounts, in excess of the retention, you are legally obligated to pay as damages resulting from a claim first made against you and reported to us during the policy period or [ERP] for your wrongful act in rendering or failing to render professional services for others, but only if such wrongful act first occurs on or after the retroactive date and prior to the end of the policy period." *Id.* at 2-3.

The insurer argued that "claims first made and reported" policies only covered claims that were both made against defendant and reported by defendant to plaintiff during the policy period or an ERP. *Id.* at 3. The insurer concluded that all claims against AlixPartners "were one in the same claim because they both involved the same wrongful act, i.e. [AlixPartners'] due diligence concerning" the aforementioned acquisition. *Id.* On this basis, Illinois National decided that the "claim" was first made against the insured in December 2007 or, at the latest, in a March 2008 letter – when questions first arose about the post-acquisition management aspect of the insured's work – but was not reported to the insurer until August 2009. So Illinois National took the position that the "claims first made and reported" language foreclosed coverage. *Id.*

The lynchpin of the insurer's argument was that the claims made orally in December 2007, and in March and April

2008 letters, were the same as those later made in the arbitration complaint. But the panel characterized those earlier "claims" as being in the nature of a fee dispute, for which none of the Illinois National policies would have afforded coverage. *AlixPartners,* unpub op at 5. The panel found that the insurer was under no obligation to report uncovered claims. *Id*. at 6-7. When the insured was later served with the arbitration complaint, it then became clear that the dispute was about AlixPartners' pre-acquisition "due diligence" work, and that "claim" – which the arbitration award was based upon – was timely reported. *Id.*

The panel went on to reject, under agency principles, the insurer's argument that the March and April 2008 letters were actually sent on behalf of the U.K. purchaser – which would therefore relate then to the subsequent arbitration complaint. *AlixPartners,* unpub op at 7. The panel simply found no record evidence of an agency relationship, actual or apparently, between the U.K. purchaser that AlixPartners worked for pre-acquisition, and the German company that AlixPartners managed post-acquisition. *Id.* at 8.

Skanska USA Building Inc v Amerisure Ins Co, unpublished per curiam opinion of the Court of Appeals, issued March 19, 2019 (Docket No. 340871).

This case has things in common with both of the two opinions discussed above. Like *AlixPartners,* it deals with liability coverage. And like *Murad Mgt,* coverage turned on whether the loss could be characterized as the result of an unforeseen event. The panel of Judges David Sawyer, Mark Cavanagh, and Kirsten Frank Kelly unanimously found that Amerisure was entitled to summary disposition, there being no genuine issue of material fact that plaintiff sought coverage for replacement of its own work product, and there was therefore no "occurrence."

The panel described the case as "a commercial liability insurance coverage dispute, arising from the faulty installation of parts in the steam heat system of a hospital construction project." *Skanska,* unpub op at 2. "The resulting damage required extensive repairs, in excess of $1 million." *Id.* Skanska was the construction manager for the project. *Id.* Skanska subcontracted the heating and cooling portion of the project to M.A.P. Mechanical Contractors ("MAP"). *Id.* MAP obtained a commercial general liability ("CGL") policy from Amerisure. *Id.* Skanska was an additional insured under that policy. *Id.*

MAP installed a steam boiler and related piping for the hospital's heating system. *Skanska,* unpub op at 2. MAP's installation included several expansion joints, which are designed to accommodate the expansion of the piping caused by the flowing steam. *Id.* The heating system did not function properly, and *Skanska* eventually determined that MAP had installed some of the expansion joints backward. *Id.* This caused significant damage; Skanska fixed the problems and then made a claim to Amerisure. *Id.* Amerisure denied the claim and Skanska filed suit. *Id.* at 3.

Amerisure moved for summary disposition on the grounds that (1) MAP's defective construction was not a covered occurrence within the CGL policy; (2) Skanska failed to provide proper notice of a claim; (3) Skanska entered into a settlement without Amerisure's consent; and (4) several exclusions barred coverage. *Skanska,* unpub op at 3. The trial court denied summary disposition based on "a question of material fact … as to the extent of the property affected by the defective workmanship of MAP and whether it extends beyond the scope of work to be performed by Plaintiff for the contract with MMMC." *Id.* at 4. According to the trial court, "[t]he resolution of this question of fact requires the matter be submitted to the trier of fact, so summary disposition is not appropriate at this time." *Id.*[1] Both sides appealed, Skanska believing that the existence of coverage could be decided in its favor under MCR 2.116(I)(2). Id. at 5-6.

The Court of Appeals reversed, finding that the undisputed facts established that there was no "occurrence" within the meaning of the policy. *Skanska,* unpub op at 3. The panel's analysis involved a close look at *Hawkeye-Security Ins Co v Vector Construction Co*, 185 Mich App 369; 460 NW2d 329 (1990). Skanska argued that Hawkeye was not controlling because it interpreted "a prior version of the CGL form." *Skanska,* unpub op at 7-8. The panel acknowledged that the form at issue in Hawkeye had a slightly different definition of "occurrence" than the Amerisure policy at issue here. *Skanska,* unpub op at 8. But the panel found that this was a distinction without a difference; "cases that have considered the post-1986 language … still followed *Hawkeye* such that what defines 'occurrence' is a principle of law." *Skanska,* unpub op at 8, citing *Radenbaugh v Farm Bureau Gen Ins Co of Michigan*, 240 Mich App 134; 610 NW2d 272 (2000).

Radenbaugh held that, because the damage was to property other than the insured's work product, the insureds properly alleged an "occurrence." *Skanska,* unpub op at 10. The *Skanska* panel noted that "*Radenbaugh* examined the precise policy term at issue … and clearly affirmed *Hawkeye's* admonishment that an 'occurrence' cannot include an accident that results in damage to the insured's own work product." *Skanska,* unpub op at 10. The panel also looked to *Liparoto Constr, Inc v Gen Shale Brick, Inc*, 284 Mich App 25; 772 NW2d 801 (2009), a holding which "confirmed that an accident *can* arise from the insured's negligence or breach of warranty, *if* the damage extended beyond the insured's own work product." *Skanska,* unpub op at 10 (emphasis added). The policy provision at issue in *Liparoto* defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions," *Skanska,* unpub op at 10 – the same definition contained in Amerisure's policy here, *Id.* at 3. Based on these and other decisions published since *Hawkeye*, the *Skanska* panel concluded that it "is an established principle of law that an 'occurrence' cannot include damages for the insured's own faulty workmanship." *Skanska,* unpub op at 10. Applying that principle to the record in this case, the *Skanska* panel found that, as a matter of law, the incident for which Skanska sought liability coverage was not an "occurrence" under the policy. *Id.*

Endnotes

1 The trial court tweaked this holding through the course of deciding multiple motions, but ultimately came back to this question of fact. *Skanska,* unpub op at 4-5.

Municipal Law Report

By Lisa A. Anderson and Matthew J. Zalewski, *Rosati Schultz Joppich & Amtsbuechler, PC*
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Property Owners Lacked Standing To Mount A Constitutional Challenge To A Rental Property Registration And Inspection Ordinance.

Harold Vonderhaar et al v Village of Evendale, Ohio, 906 F3d 397 (CA 6, 2018).

Facts

On October 3, 2018, the Sixth Circuit issued a published opinion holding that rental property owners lacked standing to challenge the constitutionality of a municipality's rental property registration and inspection ordinance, where the property owners were never subjected to warrantless searches, and where the challenged ordinance could not be interpreted as authorizing warrantless searches.

Like many communities, the Village of Evendale requires property owners to obtain a permit before they rent their properties. Permit issuance is conditional on the property owner allowing the Village building commissioner to inspect the property for code compliance. Alternatively, the property owner can sign a sworn affirmation that the property complies with the code. However, even when an affirmation is signed, the building commissioner can inspect the property if a violation is suspected. An inspector seeking entry to a rental property must present credentials and request entry for an occupied property or make reasonable efforts to contact the person responsible for an unoccupied property. When entry is refused, the Village's building code provides that the inspector can use "the remedies provided by law to secure entry."[1]

Harold Vonderhaar owned 13 rental properties in Evendale. He and the co-plaintiff investment company sued the Village, alleging that the rental property code violated the Fourth Amendment by authorizing warrantless searches, and the Fifth Amendment by requiring property owners to swear to the property's compliance with the code.

The record evidence showed that the Village had never relied upon the code to conduct any warrantless search. It also never actually inspected plaintiffs' properties. The building commissioner testified that, if an owner or occupant were to refuse an inspection, he would ask the Village solicitor to start the process for obtaining an administrative search warrant. The Village even amended its code to expressly provide for a warrant in the event that an inspection was refused.

The district court granted a preliminary injunction on the basis that the Village's inspection procedures facially violated the Fourth Amendment. However, it rejected the plaintiffs' as-applied Fourth Amendment challenge since plaintiffs' properties had not been inspected. It declined to rule on the Fifth Amendment issues. The Village appealed the preliminary injunction. The Sixth Circuit limited its review to the issue of whether plaintiffs had standing to raise their Fourth Amendment claim, which had not been addressed by the district court.

Ruling

The Sixth Circuit vacated the preliminary injunction upon holding that the plaintiffs did not have standing to raise a pre-enforcement Fourth Amendment action.[2] To have standing, plaintiffs would need to satisfy the familiar standard of *Lujan v. Defenders of Wildlife*, which requires "1) a concrete and particularized injury, actual or imminent, 2) traceable to the defendant," and 3) proof that the alleged harm is redressable.[3] In *Vonderhaar*, the plaintiffs failed at the first part of the inquiry.

The Sixth Circuit opened with the significant observation that the Village's code did not facially authorize warrantless inspections. It reasoned that the code language

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requiring the Village to gain entry only through "the remedies provided by law" implied that no warrantless searches were authorized since warrantless searches are not a "remedy provided by law."[4]

The rest of the evidence indicating that the Village would seek a warrant when consent is refused, and showing that the Village amended the code to include a warrant requirement only "bolstered" the Sixth Circuit's interpretation. Therefore, to the extent that plaintiffs or their tenants feared a future warrantless search, their fears were not warranted based on the face of the ordinance. Combined with the evidence that the plaintiffs had not actually had their properties searched, they lacked "past, present, or future" harm, and therefore lacked standing to raise a facial or as-applied Fourth Amendment challenge.

The Sixth Circuit colorfully summarized its holding as follows: "Article III standing is to federal courts as a ball is to soccer. If you have it, you can play. If you don't you can just pretend. Vonderhaar and Lemen can only pretend."[5] Plaintiffs' lawsuit was a "phantom case to invalidate an authentic law," which could not be entertained by the Court.[6]

The Court ruled that a municipality's alleged past failure to enforce a zoning ordinance does not constitute approval of an unlawful use or preclude a municipality from enforcing the zoning ordinance in the present.

Practice Note

It is notable that the Sixth Circuit pointed out that the Village did not challenge the plaintiffs' standing in the trial court. When faced with a lawsuit that looks plausible on its face, it can be all too easy to focus on the merits. *Vonderhaar* provides a reminder that the standing of each plaintiff should be thoroughly vetted and challenged where appropriate. In addition, as challenges to rental property ordinances and similar programs are common, defense counsel should consider whether language alleged to be missing in an ordinance (such as an explicit warrant requirement) can be implied from other language (such as the Village's requirement that inspections only be conducted as provided by law).

A Property Owner Failed To Establish Exceptional Circumstances Sufficient To Justify Estopping A Township From Enforcing Ordinances That Prohibit Short Term Rentals Of Residential Property.

Reaume v Township of Spring Lake, ____ NW___; 2019 WL 2195030 (May 21, 2019).

Facts

On May 21, 2019, the Michigan Court of Appeals issued a published opinion holding that Spring Lake Township was not estopped from enforcing zoning regulations that prevented the plaintiff from using her property for short term rentals, although the plaintiff argued that she had been given assurances by Township staff that short term rentals were not restricted and she had spent a considerable amount of money renovating the property in reliance on the staff assurances.

Plaintiff owned a home in Spring Lake Township in an R-1 single-family residential zoning district. In 2015, she hired a property management company and began renting the property as a short term seasonal vacation rental. Plaintiff alleged that the property management company contacted the Township before engaging in rental activity and was told by an employee that the Township had no restrictions on short- and long-term rental properties. Plaintiff stated that she made substantial improvements to the property in reliance on the employee's assurances.

In December 2016, the Township adopted ordinances to prohibit short term rentals in R-1 single-family residential zoning districts where plaintiff's property was located. Ordinance No. 255 prohibited short term rentals in R-1 zoning districts but allowed long term rentals of more than 28 days. The Township also adopted Ordinance No. 257, which allowed short term rentals in certain zoning districts but not in the R-1 districts. Instead, Ordinance 257 permitted "limited short-term rentals" in R-1 districts, defined as one or two rental periods of up to 14 days, not to exceed 14 days total in a calendar year. Short term rental property owners were required to register their property and obtain a license before rental activity could occur.

The Court ruled that a municipality's alleged past failure to enforce a zoning ordinance does not constitute approval of an unlawful use or preclude a municipality from enforcing the zoning ordinance in the present.

Plaintiff applied for and was denied a short-term rental license. She appealed that decision to the Township Zoning Board of Appeals (ZBA), which denied her appeal. She then appealed the ZBA decision to Circuit Court, which affirmed the ZBA decision. Following the Circuit Court defeat, plaintiff moved for leave to appeal, which the Court of Appeals granted.

On appeal, plaintiff argued that the Township should be estopped from enforcing Ordinance 255 and 257 because the Township had given assurances that it did not restrict short term rentals, and she had spent a considerable amount of money on property renovations in reliance on those assurances.

Ruling

The Michigan Court of Appeals affirmed the Circuit Court's ruling and rejected plaintiff's challenge. The Court held that the plaintiff failed to establish exceptional circumstances that would justify estopping the Township from enforcing its zoning ordinances.

A municipality will generally be estopped from enforcing zoning regulations only in exceptional circumstances. The underlying circumstances applicable to an estoppel determination must be viewed as a whole, with no one factor weighing more heavily than others.[7]

The Court reaffirmed the longstanding principle that not all municipal employees have the authority to bind the municipality. A person dealing with a municipality is charged with knowledge

of the extent of the authority an officer or employee has to bind the municipality. A plaintiff's reliance on casual advice offered by an employee who has no authority to bind the municipality does not constitute an exceptional circumstance that justifies estopping a municipality from enforcing its zoning regulations.

The record lacked evidence to show that the employee who gave the assurances to the property management company had any authority to bind the Township. The Court made the added observation that the fact that the Township had no formal regulations restricting short term property rentals did not mean that the Township permitted short term rental use.

In addition to rejecting plaintiff's argument involving assurances given by a Township employee, the Court also rejected the argument that the Zoning Administrator implicitly approved plaintiff's rental activity when he approved her revised rental listing. On this issue the Court again noted the lack of evidence establishing any authority on the part of the Zoning Administrator to bind the Township. The Court further noted that the Zoning Administrator's determination that the revised rental listing did not violate one provision of an ordinance could not reasonably be interpreted to mean that the rental activity complied with all zoning regulations. The Court ruled that a municipality's alleged past failure to enforce a zoning ordinance does not constitute approval of an unlawful use or preclude a municipality from enforcing the zoning ordinance in the present.

The Court also rejected plaintiff's argument that the short term rental use was a lawful nonconforming use of the property because it was permitted prior to the adoption of Ordinance 255 and 257. The Court explained that even before the two ordinances were adopted to specifically preclude short term rental use in certain residential zoning districts, the terms "Dwelling," "single-family" and "family" were defined under the zoning ordinance to exclude transient or temporary use of residential property, and clearly barred the short term rental use of property in R-1 zones.

Practice Note

Reaume provides an important reminder that not all municipal officers and employees have the authority to bind the municipality. Defense counsel should closely evaluate whether statements which are attributed to an officer or employee of a municipality were made by an individual with authority to bind the municipality. *Reaume* also establishes that the short term rental use of residential properties are not necessarily lawful uses that must be permitted to continue after the adoption of a zoning ordinance that prevents the rental activity.

Endnotes

1 *Vonderhaar v Village of Evendale, Ohio,* 906 F3d 397, 400 (CA 6, 2018).

2 *Id.* at 402.

3 *Id.* at 401, citing *Lujan v Defenders of Wildlife,* 504 US 555, 560; 112 S Ct 2130; 119 L Ed 2d 351 (1992).

4 *Id.* at 401.

5 *Id.* at 400.

6 *Id.* at 399.

7 *Reaume v Township of Spring Lake,* ___ Mich App ___; __NW2d__; 2019 WL 2195030, at *2 (May 21, 2019).

No-Fault Report

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No-Fault Reform—The End of an Era

For over 45 years, Michigan's unique no-fault act has been an important part of this state's legal landscape. As originally designed, one of the goals of the no-fault act was to decrease the amount of tort litigation arising out of motor-vehicle accidents. This was accomplished by ensuring that accident victims would receive all of their medical expenses, plus three years of work-loss benefits and household-service expenses, directly from their own insurer, and reserving tort lawsuits for non-economic damages for "serious" injury cases and excess work-loss benefits. By all accounts, just the opposite is true. Currently, there is a proliferation of first-party no-fault suits being filed by injured persons and their providers. With the loosened threshold requirements, brought about as a result of the Supreme Court's decision in *McCormick v Carrier*, 487 Mich 180, 795 NW2d 517 (2010), it is easier than ever to recover on tort claims as well. With the ever-increasing insurance premiums and the ever-larger payouts being made by insurance companies, it was just a matter of time before our representatives in Lansing would "do something" to "reform" the system.

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

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

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

Underwriting Changes

The new bill makes a number of changes that impact on the Michigan Department of Insurance and Financial Services (DIFS) and underwriters. The new legislation almost certainly ensures further involvement by the Insurance Director in both the

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underwriting process and in the claims process. For example, new section 261 of the Insurance Code requires that the DIFS must maintain a website that, among other things:

> Advises that the department may be able to assist a person who believes that an automobile insurer is not paying benefits, not making timely payments, or otherwise not performing as it is obligated to do under an insurance policy.

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

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

The amendment also imposes a duty on the part of the injured person to cooperate with the MAIPF or its assigned insurer, and includes a requirement to attend Examinations Under Oath and IMEs, as required by the servicing insurer.

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

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

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

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

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

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

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

Residual Bodily Injury Liability Limits

At the present time, MCL 500.3009 sets forth minimum residual bodily injury liability limits of $20,000 per person, $40,000 per occurrence, and $10,000 in property damage not otherwise covered by Property Protection Insurance (such as property damage occurring outside the State of Michigan). Had these limits been indexed to the rate of inflation, the current liability limits would have been just under $120,000 per person or $225,000 per occurrence. However, SB 1 requires that the residual bodily injury liability limits be **approximately doubled** from these inflation-adjusted figures to $250,000 per person and $500,000 per occurrence. However, the legislation also provides that a person can opt out of these higher limits, and obtain lower policy limits of not less than $50,000 per person or $100,000 per occurrence if the applicant signs a form which explains the various liability policy limit choices, the costs of each option and an explanation of

the risks of accepting lower liability policy limits. If no election is made, the default provision is $250,000/$500,000.

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

The Legislature has now brought the IME provision in MCL 500.3151 in line with the expert-witness requirement from the medical-malpractice arena.

No-Fault Changes – Coverage Options

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

- $50,000 per individual per loss occurrence for "allowable expense" coverage , **if** (1) the applicant or named insured is enrolled in Medicaid, and (2) the applicant or named insured's spouse and relatives residing [but not domiciled?] in the same household have "qualified health coverage," Medicaid or no-fault coverage on other vehicles – see MCL 500.3107c(1)(a);
- $250,000 per individual per loss occurrence for "allowable expense" payments under MCL 500.3107(1)(a) – see MCL 500.3107c(1)(b);
- $500,000 per individual per loss occurrence for "allowable expense" coverage – see MCL 500.3107c(1)(c);
- Unlimited "allowable expense" coverage – see MCL 500.3107c(1)(d).

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

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

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

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

Somewhat surprisingly, there is also a provision that allows certain individuals to **opt out** of the no-fault system altogether. Section 3107d is a lengthy statutory provision that allows an individual to opt out of purchasing "allowable expense" coverage under MCL 500.3107(1)(a) if a person is a "qualified person." In addition to being a "qualified person," the applicant or the named insured's spouse and relatives residing [not domiciled?] in the household must have either "qualified health coverage" or have no-fault benefits from other sources. A "qualified person" is defined as a person covered by Medicare. "Qualified health coverage" is defined as including Medicare coverages, or health and accident coverage that "does not exclude or limit coverage for injuries related to motor vehicle accidents" and for which the individual deductible is $6,000.00 or less per individual. **Although "the person that provides the qualified health coverage" is required to provide a list of individuals covered to the insurer, there is apparently no type of certification required from such "persons" regarding the lack of exclusions or limitations of coverage for auto-accident-related injuries.** Having reviewed countless self-funded ERISA plans over the years, and even some insured ERISA plans, there are a fair number of plans out there that exclude coverage for auto-accident injuries altogether. Are applicants or agents expected to become experts in ERISA plan analysis?

So what happens if a "qualified person" somehow loses their "qualified health coverage?" Section 3107d(3)(e) provides that the person has thirty days after "the effective date of the termination of

qualified health coverage" to obtain first-party no-fault insurance coverage, or they will be excluded from all "allowable expense" coverage "during the period in which coverage under this section was not maintained." However, there is another section, 3107d (6) (c) which provides that a person who allows their "qualified health coverage" to lapse and fails to obtain no-fault coverage, "the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1) (a) for the injury but is entitled to claim benefits under the assigned claims plan," unless the injured person is entitled to benefits under some other no-fault policy. So a person does not recover "allowable expenses" but recovers other benefits, like work-loss and household-service expenses from the assigned claims plan? Furthermore, that person gets a $2,000,000.00 cap on benefits (yes, you read that right—two million dollars), even though they are not entitled to any "allowable expense" coverage? This writer respectfully submits that this purported exclusion and the assigned claims plan cap, simply make no sense.

However, the legislative amendment provides that, if a provider of "allowable expenses" under MCL 500.3107(1)(a) fails to submit a bill to the insurer within 90 days after the service has been provided, the insurer has an additional 60 days, along with the existing 30-day provision, to make payment before the benefits are "overdue" and interest is owing.

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

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

So to re-cap how this provision works:

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

Out-Of-State Accidents

At the present time, accidents occurring outside the State of Michigan are compensable under the Michigan no-fault act only if the injured person was the named insured on a Michigan no-fault policy, the spouse of a named insured, or a relative or either domiciled in the same household. There is also a provision for payment of benefits to occupants of a motor vehicle insured under a Michigan no-fault policy. When teaching this topic, I refer my students to the case of "Grandma in Oklahoma," who has never stepped foot inside the State of Michigan in her life. You are out to visit grandma in Oklahoma, and you are driving her to a grocery store. On the way to the store, you are involved in an accident and grandma is injured. Under the old version of MCL 500.3111, grandma is entitled to recover Michigan no-fault insurance benefits under your Michigan policy, simply because she was an occupant of your vehicle.

As indicated below, the Legislature clearly intends to exclude non-residents from recovering Michigan no-fault benefits, and the Legislature attempted to do so in the amendment to MCL 500.3111. The statute now provides that an occupant of a Michigan-registered and insured vehicle can obtain benefits "if the occupant was a resident of this state." So far, so good. **However, the amendment also provides that Michigan PIP benefits are payable to "an occupant of a vehicle involved in the accident**, if the occupant was a resident of this state **or if the owner or registrant of the vehicle was insured under a personal protection insurance policy** …." By definition, in order to be entitled to benefits at all, arising out of an out-of-state accident, the non-resident must be occupying a Michigan-registered and Michigan-insured vehicle! **In other words, it appears that what the Legislature intended to take away, it gave right back.**

Simply put, the question to be determined by the Legislature is whether

or not it wants to grant Michigan no-fault benefits, arising out of out-of-state accidents, to non-residents. If it does, this section needs to be redrafted.

One final note. The legislative amendment does not change the difference in treatment between married persons and boyfriends-girlfriends. For example, imagine a situation where a married couple travel to Florida and are involved in an accident in Florida while walking across the street. Assume that the husband is the named insured on a no-fault policy. Under this scenario, both spouses will be able to obtain no-fault benefits. However, if that same scenario involves a boyfriend-girlfriend, the boyfriend will recover benefits because he is the named insured on his policy. Assuming that the girlfriend is living with the boyfriend, the girlfriend will not be able to recover benefits at all, unless she has her own policy of insurance on which she is the named insured.

Covenant Fix

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

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

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

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

This, in turn, will drive up the insured's exposure on the tort side of the equation. In other words, the Legislature has shifted the "pot of money" from the PIP pot to the tort pot!

Section 3113 Exclusions

SB1 amends the "out-of-state" resident exclusion in MCL 500.3113(c) to exclude benefits where "the person was not a resident of this state." However there is an exception for those out-of-state residents where "the person owned a motor vehicle that was registered and insured in this state." This is arguably in conflict with MCL 500.3111, discussed above, which provides that Michigan no-fault benefits are payable to "an occupant of a vehicle involved in the accident . . . if the owner or registrant of the vehicle was insured under a personal protection insurance policy." **In other words, section 3111 grants coverage to those individuals who occupy a Michigan-registered and insured vehicle, while amended section 3113(c) takes it away.** Again, if it is the intent of the Legislature to preclude out-of-state residents from recovering Michigan no-fault benefits, unless they own a Michigan-registered and insured motor vehicle, it needs to reconcile the conflict between MCL 500.3111 and MCL 500.3113(c).

Changes in Priority

MCL 500.3114(1), which provides the "general rule" for payment of no-fault benefits, has been amended to indicate that if a person is the named insured on his or her own policy, and could potentially be entitled to benefits from another household member's policy, he or she recovers benefits up to the limit prescribed in their own policy, without recoupment from the other household policies.

The "super priority" provision set forth in MCL 500.3114(2) has likewise been amended to exclude coverage for passengers in a motor vehicle, operated in the business of transporting passengers, who have elected not to maintain coverage under section 3017d (pertaining to Medicare recipients) or as to which the exclusion under section 3109a(2) applies. This begs the question as to why the Legislature chose to allow owners of motor vehicles "operated in the business of transporting passengers" to opt out of the no-fault system altogether?

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

Changes in Priority- motorcycles and non-occupants

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

What if the owner, registrant, or

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

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

A suggested fix – maintain the same order of priority, but indicate that, after the exhaustion of no-fault benefits payable from the insurer of the owner, registrant, or operator of the motor vehicle involved in the accident, the motorcyclist's motor-vehicle insurer will pick up the remaining no-fault benefits, up to the limits of insurance chosen by the injured motorcyclist for his motor vehicle.

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

As drafted, it certainly appears that I am bound by whatever level of coverage the operator of the motor vehicle involved in the accident chose. In other words, no matter how hard I, as a responsible motor-vehicle owner and motorcyclist, try to protect myself, it seems that I am at the mercy of the owner of the other motor vehicle involved in the accident.

Changes in Tort Liability

As presently written, the no-fault act is quite clear. An insured owner/operator of a motor vehicle is immune from tort liability except for above-threshold non-economic losses, and excess wage loss. Now, with the imposition of allowable expense coverage caps, discussed above, the tortfeasor, and by implication his or her insurer, remains responsible for payment of those "allowable expenses" that are not covered under the injured person's PIP coverage.

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

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

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

PIP Processing Changes

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

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

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

This language is fraught with all of the problems identified by the Michigan Supreme Court in *Devillers*. Imagine a scenario where a person requires a two-week hospitalization, and the facility proceeds to submit hospital charges, physician charges, and radiology charges.

One of the radiology bills "slips through the cracks" and is not paid by the insurer. The injured claimant subsequently makes a claim for attendant-care services, going back 3 years. Does the insurer's failure to pay that old radiology bill allow the injured claimant to recover benefits beyond one-year back from the date the complaint was filed?

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

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

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

There is also a provision that precludes an award of no-fault penalty attorney fees if the plaintiff's attorney, or a related person of the attorney, has a direct or indirect financial interest in the person or entities that provided the treatment, product, service, rehabilitative occupational training, or accommodations to the injured person. This seems to be a rather weak provision, since most PIP cases are settled before trial, without an award of no-fault penalty attorney fees. **Nonetheless, this provision does allow an insurer and its counsel to delve into the medical provider's financial interest holders during discovery, so that the insurer can evaluate a potential attorney-fee claim by plaintiff's counsel should the matter proceed to trial.**

No longer will occupants of motor vehicles, who have no insurance of their own in their households, go to the insurer of the owner, registrant, or operator of the motor vehicle they are occupying for payment of their no fault benefits. Rather, they will turn to the Michigan Assigned Claims Plan, and, as shown below, their benefits will be capped at $250,000.

IMEs

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

Fee Schedules

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

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

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

individuals can obtain an even higher rate of reimbursement – 250% of Medicare.

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

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

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

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

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

Utilization Review

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

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

Medical providers are required to submit "necessary records and other information" and to comply with any decision of the Department of Insurance regarding utilization reviews. If it is determined that a provider provides treatment, products, services, or accommodations that "are longer in duration than, are more frequent than, or extend over a greater number of days than the treatment, products, services or accommodations usually required for the diagnosis or condition for which the patient is being treated," the insurer can ask the provider to explain why such treatment is necessary. If the provider is not satisfied with the decision by the insurance company to deny the claim based on the department's utilization review, the provider "may appeal the determination to the Department" under the procedures to be promulgated by the department. For those of us who have been out of law school for some time, it may be time to dust off years of cobwebs and re-familiarize ourselves with administrative-law practice!

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

Out-of-State Residents

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

Michigan Assigned Claims Plan

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

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

- If a person opts out of the no-fault system because he or she is a Medicare recipient, as allowed under section 3107d, and if that coverage somehow ends, and that person fails to obtain no-fault insurance as otherwise required under the act, the person "is entitled to claim benefits under the Assigned Claims Plan" but, as noted above, "the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a)."

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

This same $2,000,000 cap likewise applies to those individuals who exempt themselves from the No-Fault Act under section 3109a(2), but lose their insurance

coverage and fail to obtain no-fault coverage as otherwise required. It seems to the author that we are rewarding individuals who fail to comply with the No-Fault Act and obtain no-fault coverage when they lose coverage through either Medicare or their health insurance.

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

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

Managed Care Options

SB 1 amends the Insurance Code to allow no-fault insurers to offer a managed-care option, which will apply to all medical care except for "emergency care." Insurers offering this managed-care option must also provide for "allowable expense" coverage that would not be subject to this managed-care option.

Anti-Fraud Unit

In the negotiations leading up to the passage of SB1, there was a dispute between the Attorney General's Office, which had established its own Insurance Fraud Unit, and the Legislature, which wanted to have the unit located in the Department of State Police. Ultimately, the Legislature decided to house the Anti-Fraud Unit "as a criminal justice agency in the Department" of Insurance! The Legislature provides that the Anti-Fraud Unit has the power to investigate "persons subject to the person's regulatory authority, consumers, insureds, and any other persons allegedly engaged in criminal and fraudulent activities in the insurance market." It can conduct background checks on applicants for licenses and current licensees, collect and maintain claims of criminal and fraudulent activities in the insurance industry, and share records with other criminal-justice agencies. **However, the Anti-Fraud Unit cannot share information with insurers or their defense counsel, who are on the front lines of combatting insurance fraud!** Specifically, section 6302 provides that documents, materials, or information related to an investigation by the Anti-Fraud Unit "is confidential by law and privileged, is not subject to the Freedom of Information Act, … is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action." The amendment further provides that the director "or any other person that received documents, materials, or information while acting on behalf of the Anti-Fraud Unit" is not allowed to testify in any private civil action. Furthermore, as far as prosecution of insurance fraud activities are concerned, the Anti-Fraud Unit has no authority to initiate prosecutions on its own. Rather, it only has the authority to:

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

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

Conclusion

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

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

Endnotes

1 This article was prepared just before Governor Whitmer signed SB1 on May 30, 2019 and before it was filed with the Secretary of State on June 11, 2019. Therefore, SB 1, now 2019 PA 20, took effect on June 11, 2019, subject to the different effective dates contained in the bill itself.

Supreme Court

By: Daniel A. Krawiec, *Clark Hill PLC*
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Supreme Court Update

As discussed in this issue's Amicus Report, on April 22, 2019, the Michigan Supreme Court clarified the interplay between MCL 600.2957(2) and MCR 2.112(K) by ruling the provisions are complementary and create two alternative means of adding a non-party at fault as a defendant. That is, a party may elect to amend a complaint without seeking leave to amend under the rule, or may file a motion for leave to amend that the trial court is obligated to grant under the statute. Moreover, the claims against the added defendant will relate-back to the original complaint regardless of which procedure a plaintiff follows. *Stenzel v Best Buy Co*, ___ Mich ___; ___ NW2d ___; 2019 WL 1769589 (Apr. 22, 2019) (Docket No. 156262).

Facts: Paulette Stenzel purchased a refrigerator/freezer manufactured by Samsung Electronics, Inc. from Best Buy Co., Inc. on May 21, 2011. Two days later Best buy installed the refrigerator/freezer and connected it to a preexisting waterline in Stenzel's home. According to Stenzel, after installation the waterline began to spray water on her floor, causing her to slip, fall and sustain severe injuries. Stenzel brought suit against Best Buy on April 29, 2014, alleging a products liability claim subject to a three-year limitations period. On March 16, 2015, after the limitations period was expired, Best Buy sought and was granted leave to file a notice of non-party at fault naming Samsung Electronics. Stenzel filed an amended complaint adding Samsung as a defendant pursuant to MCR 2.112(K). Samsung moved for summary disposition on the basis that the limitations period was expired, arguing that the amendment did not relate back because it was filed under MCR 2.112(K), which does not reference a relation-back privilege, instead of after receiving leave under MCL 600.2957(2), which does. The trial court granted the motion.

The Court of Appeals initially affirmed the trial court, in pertinent part, on the basis that it was controlled by a prior decision in *Williams v Arbor Homes, Inc*, 254 Mich App 439; 656 NW2d 873 (2002). *Williams* held MCL 600.2957(2) and MCR 2.112(K) did not conflict but that the statute contained more detail than the rule and therefore a party must seek leave of court before an amended pleading adding a party was effective. As a result, the Court of Appeals held Samsung was never added as a party at all, but noted it would have reversed and held the amendment was proper and timely if it were not controlled by *Williams*. A special panel was convened to resolve this conflict, which reversed the trial court and overruled *Williams*. The special panel concluded that the statute and rule conflicted but that the rule, because it was procedural, controlled the amendment process.

Judge Gleicher concurred in this result but wrote separately that the rule and statute did not conflict and instead created separate means of amendment, both of which attach the relation-back privilege. Judge Gleicher started from the premise that the Michigan Supreme Court has exclusive authority to promulgate procedural rules and only in cases of irreconcilable conflict should a court declare a statute supplants a court rule. She concluded that the rule and statute were entirely consistent with regard to the central and controlling issue of a plaintiff's right to amend to add a non-party at

[T]he Michigan Supreme Court clarified the interplay between MCL 600.2957(2) and MCR 2.112(K) by ruling the provisions are complementary and create two alternative means of adding a non-party at fault as a defendant.

Daniel A. Krawiec is a senior attorney in the Labor and Employment practice group in Clark Hill PLC's Detroit office. A member of the state bars of Michigan and Florida, Dan counsels employers in both states on all facets of labor and employment law. Dan also represents employers and other business clients in all manner of employment and commercial litigation and arbitration, as well as before administrative agencies. Dan can be reached at dkrawiec@clarkhill.com or (313) 309-9497.

fault and the two methods for doing so can coexist (and, indeed, may be utilized for different purposes). Moreover, the rule's silence on the relation-back issue does not create a conflict, but rather the statute fills in for the rule's silence because that interpretation is consistent with the legislature's directive in the statute.

Ruling: The Michigan Supreme Court affirmed the judgment of the special panel but for the reasons stated in Judge Gleicher's concurring opinion. Stenzel's amendment was proper and timely because a party may amend a pleading upon receipt of a notice of non-party at fault pursuant to MCR 2.112(K) without filing a motion for leave to amend, and the amended pleading relates back to the original action pursuant to MCL 600.2957(2).

Practice Note: The *Stenzel* decision will decrease gamesmanship by preventing unnamed defendants from colluding with named defendants to run out the statute of limitations. Nevertheless, named defendants might find it in their interest to file a notice of non-party at fault as soon as possible anyway. Doing so could enlarge the pool of potential settlement contributors, including insurers, and thereby enhance the possibility of an early, economical settlement. And even without an early settlement, the existence of two defendants may reduce a single defendant's litigation costs by permitting some division of labor. Perhaps most importantly, it will ensure the newly named defendant preserves all evidence and can be compelled to participate in discovery without a subpoena.

MEMBER NEWS

Work, Life, and All that Matters

Simmons Attains Master of Jurisprudence Degree in Federal Indian Law

Jana Simmons (Wilson Elser, Of Counsel-Michigan) has earned the University of Tulsa College of Law's Attorneys prestigious Master of Jurisprudence in Federal Indian Law, a specialized degree in federal Indian law, tribal law and governments, and Native American history and federal policy. Jana is a civil defense litigator with a focus on federal Indian law and tribal law. She also is engaged in assisting tribal governments with drafting laws, preventative risk and liability initiatives, and internal investigations. She recently was named to the Advisory Board of the National Native American Cannabis Association. "My professors were the very best and brightest scholars in Indian Country," said Jana. "It was exciting to learn from them and I am especially grateful for the insights they shared with me."

Member News *is a member-to-member exchange of news of* ***work*** *(a good verdict, a promotion, or a move to a new firm),* ***life*** *(a new member of the family, an engagement, or a death) and* ***all that matters*** *(a ski trip to Colorado, a hole in one, or excellent food at a local restaurant). Send your member news item to Michael Cook (Michael.Cook@ceflawyers.com).*

Court Rules Report

By: Sandra Lake, *Hall Matson PLC*
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PROPOSED AMENDMENTS

2002-37 – Amendments of e-filing rules

Rule affected:	Numerous
Issued:	May 15, 2019
Comment Period:	September 1, 2019

The proposed amendments are a continuation of the process to implement a statewide e-filing system. There are numerous proposed changes, particularly with respect to a request to change venue in general civil and domestic cases.

2018-12 – Proposed amendment of MCR 2.612

Rule affected:	2.612
Issued:	April 18, 2019
Comment Period:	August 1, 2019

The proposed amendment would clarify that writs of coram nobis, coram vobis, audita querela, and bills of review are abolished. The procedure for obtaining any relief from a judgment shall be by motion or by an independent action.

ADOPTED AMENDMENTS

2016-05 – Oral recitation of jury instructions

Rule affected:	2.513
Issued:	March 13, 2019
Effective:	May 1, 2019

This amendment modifies MCR 2.513(A) and (N) to require the court to orally provide the jury with preliminary and final jury instructions. The modified rule clarifies that the jury is to be provided a written copy of the instructions as well. This modification is intended to conform to the ruling in *People v Traver*.

2002-37 – E-filing rules

Rule affected:	Numerous
Issued:	March 20, 2019
Effective:	May 1, 2019

These comprehensive amendments are designed to conform the court rules to a statewide e-filing system, including the requirement that attorneys "must" electronically file documents in courts where electronic filing has been implemented. The majority of the amendments are non-substantive in nature and merely modify terminology to reflect that documents are being filed electronically. There are some substantive changes, however, such as requiring a jury demand to be filed in a separate document (as opposed to being included in a pleading); requiring the party, not the clerk, to serve a default judgment on the parties; and modifications to service requirements given electronic serve.

2018-04 – Disclosure requirements for amicus briefs

Rule affected:	7.212 and 7.312
Issued:	April 3, 2019
Effective:	May 1, 2019

This amendment requires amicus briefs to include disclosures regarding preparation of the brief and monetary contributions.

Sandra Lake is a 1998 graduate of Thomas M. Cooley Law School. She is Of Counsel at Hall Matson, PLC in East Lansing, specializing in appellate practice, medical malpractice defense, insurance coverage, and general liability defense. She is also the Vice President of the Ingham County Bar Association and previously served as Chair of its Litigation Section. She may be reached atslake@hallmatson.law.

Amicus Report

By: Anita Comorski, *Tanoury, Nauts, McKinney & Garbarino, P.L.L.C.*
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On April 22, 2019 the Michigan Supreme court released its decision in *Stenzel v Best Buy Co, Inc*.[1] At issue in *Stenzel* was the interpretation of and interplay between the statute, MCL 600.2957(2), and court rule, MCR 2.112(K), addressing amendment of a complaint upon receipt of a notice of **non-party at** fault. In its order granting leave, the Supreme Court invited amicus participation by Michigan Defense Trial Counsel. The MDTC's amicus brief in support of the defense position in *Stenzel* was authored by Daniel G. Beyer and Derek R. Boyd of Kerr, Russell & Weber, PLC. Ultimately, the Court held that the statute and court rule are complementary, meaning that a party can proceed under either the statute or the court rule when amending a complaint to add an identified **non-party** at fault as a party.

Factually, the *Stenzel* case arose from injuries allegedly sustained by the plaintiff when the Samsung refrigerator the plaintiff purchased from Best Buy began spraying water. The plaintiff slipped, fell, and was injured when she was trying to clean up the water. The plaintiff filed suit against Best Buy only, alleging various theories. In turn, Best Buy obtained leave to file a notice of non-party at fault identifying Samsung. The plaintiff then filed an amended complaint adding Samsung as a defendant. Samsung obtained dismissal on statute of limitations grounds, arguing that a complaint that is amended following the filing of a notice of non-party at fault only relates back if the plaintiff moved for leave to amend pursuant to MCL 600.2957(2), which the plaintiff did not do.

On appeal, the Court of Appeals affirmed the dismissal, but stated that it was only doing so because it was bound by precedent.[2] Were it not bound by precedent, the Court would have held that the court rule, MCR 2.112(K), prevailed as a matter of procedure. Since the plaintiff followed the requirements of that rule, the Court would have held that Samsung was timely added and dismissal was improper.

Given the stated conflict, a special panel of the Court of Appeals was convened to resolve that conflict. The majority opinion held that the statute and court rule conflict on a matter of procedure regarding whether leave of court is required to file an amended complaint to add a non-party.[3] In such a situation, the court rule prevails, meaning that a motion is not required before a party files an amended complaint in response to a notice of non-party at fault. The majority opinion reversed the grant of summary disposition to Samsung. In a separate concurrence, three judges agreed with the reversal of the order granting summary disposition, but stated that they would have found no conflict, as the statute and court rule simply present "two alternative methods of accomplishing the same goal." Samsung filed an application for leave to appeal to the Supreme Court, which granted leave to appeal.

In its order granting leave to appeal, the Supreme Court directed the parties to address three issues: "(1) whether the Court of Appeals special panel correctly held that there is a conflict between MCL 600.2957(2) and MCR 2.112(K); (2) whether, in any event, a party may amend a complaint upon receipt of a notice of non-party at fault without first filing a motion to amend; and (3) if so, whether the amendment relates back to the date the complaint was filed."[4]

At issue in *Stenzel* was the interpretation of and interplay between the statute, MCL 600.2957(2), and court rule, MCR 2.112(K), addressing amendment of a complaint upon receipt of a notice of **non-party** at fault.

Anita Comorski is a principal in the Appellate Practice Group at Tanoury, Nauts, McKinney & Garbarino, P.L.L.C. With over fifteen years of appellate experience, Ms. Comorski has handled numerous appellate matters, obtaining favorable results for her clients in both the State and Federal appellate courts.

In its amicus brief, MDTC argued that there was no conflict between the statute and court rule. The two provisions could be read in a complementary manner, simply by applying both provisions. Under this interpretation, the statute would provide an additional component to the court rule, meaning that a motion would be required to add an identified non-party at fault.

The Supreme Court concluded that, consistent with the first argument raised in MDTC's amicus brief, the statute and court rule do not irreconcilably conflict. However, the Court held that, rather than requiring a party to comply with both provisions, a party seeking to add an identified non-party at fault could proceed under either the statute or the court rule. Adopting the rationale stated in the Court of Appeals' concurring opinion, the Supreme Court held that the statute and court rule provide "alternative methods of accomplishing the same goal," meaning that a motion is not required, although a party may choose to proceed by motion. Thus, under either the court rule method or the statutory method, an amended complaint adding an identified non-party at fault relates back to the original complaint, rendering the *Stenzel* plaintiff's claims against Samsung timely.

This update is only intended to provide a brief summary of the complex issues addressed in the amicus briefs filed on behalf of the MDTC. The MDTC does maintain an amicus brief bank on its website accessible to its members. For a more thorough understanding of the issues addressed in these cases, members are encouraged to visit the brief bank to review the complete briefs filed on behalf of this organization.

Endnotes

1 Michigan Supreme Court Docket No. 156262.

2 *Stenzel v Best Buy Co, Inc*, 318 Mich App 411; 898 NW2d 236 (2016).

3 *Stenzel v Best Buy Co, Inc*, 320 Mich App 262; 906 NW2d 801 (2017).

4 *Stenzel v Best Buy Co, Inc*, 501 Mich 1042; 909 NW2d 255 (2018).

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Cline Cline & Griffin PC

Distinguished Service Award 2019:
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2019 Winter Meeting and Conference
November 8th, 2019 | Sheraton Detroit Novi Hotel

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