PROTECTING THE INJURED:

A Summary Guide to the Michigan Auto No-Fault Law ©

By:

George T. Sinas • Stephen H. Sinas • Thomas G. Sinas

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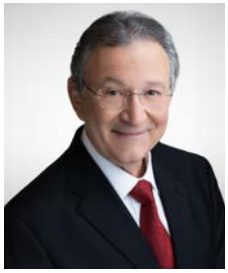
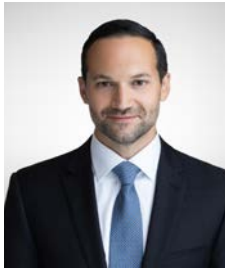


George T. Sinas – George Sinas has represented seriously injured persons throughout Michigan for over 35 years. He is a past President of the Michigan Association for Justice and a former Chairperson of the State Bar Negligence Law Section. During his career, George has obtained a number of million-dollar-plus judgments and settlements for his clients and received numerous honors for his work in the field of personal injury law. In 2018, George received the "Cline Schreier Award for Excellence" from the State Bar of Michigan, Negligence Law Council as well as the "Thomas E. Brennan Lifetime Achievement Award" from the Ingham County Bar Association. In 2015, he received the "Respected Advocate Award" from the Michigan Defense Trial Counsel. In 2014, he received the "Champion of Justice" award from the Michigan Association for Justice. In 2013, he received the "Michigan Lawyer of the Year" award from Michigan Lawyers Weekly. In 2009 and 2014, Best Lawyers named George "Lansing Personal Injury Litigator of the Year." In 2005, George received the Michigan Brain Injury Association "Legacy Society Professional Service Award" for his work representing the victims of serious brain injury. George has been listed in every edition of the book "The Best Lawyers in America" since 1989 in the field of personal injury law and also named a "Michigan Super Lawyer" every year since 2006 by Super Lawyer Magazine. Since 2017, Michigan Super Lawyers has listed George as one of the "Top 100 Super Lawyers" in Michigan, the only Lansing-area personal injury attorney receiving this recognition. In 2023, Michigan Lawyers Weekly named George the Michigan "Newsmaker of the Year." George has also authored two textbooks and numerous articles on the subject of motor vehicle injury cases and the Michigan Automobile No-Fault Insurance Law and has served as an Adjunct Professor at the Michigan State University College of Law, teaching a class on the auto no-fault law.



Stephen H. Sinas – Stephen Sinas specializes in representing people who have been injured or harmed by the negligence or wrongdoing of another person, company, institution, or governmental entity. He also specializes in litigating against insurance companies that have wrongfully denied coverage or benefits to injured people. He has litigated cases in numerous state and federal trial courts across Michigan and has handled cases at the Michigan Court of Appeals and the Michigan Supreme Court. Stephen is an Adjunct Professor at Michigan State University College of Law, where he teaches the course on Michigan Auto No-Fault Insurance Law. He currently serves as President of the Michigan Brain Injury Provider Council, President of the Ingham County Bar Association, and an Executive Board Member of the Michigan Association for Justice. He is the creator and lead editor of an open-access academic website regarding the Michigan Auto No-Fault Insurance Law, www.autonofaultlaw.com. Stephen is currently recognized in the *Best Lawyers in America* in the field of Plaintiff's Personal Injury Law. He is also recognized as a *"Super Lawyer"* by Super Lawyer Magazine and a *"Leading Lawyer"* by Leading Lawyer Magazine.

Thomas G. Sinas – Tom Sinas is a trial lawyer who has spent his career representing injured individuals and serving the public. Tom earned both a Bachelor of Arts and a Bachelor of Fine Arts from the University of Michigan, graduating with highest honors and high distinction. He obtained his law degree *magna cum laude* from the University of Minnesota Law School. After law school, Tom practiced with a national law firm in Minneapolis, where he represented catastrophically injured individuals and their families. He was then selected to join Minnesota's premier state prosecution office on a special assignment to prosecute complex financial crimes. Tom has tried to verdict civil and criminal cases in several Midwestern states and has lectured and written extensively about trial practice and substantive law. Tom has been elected to leadership positions in the Brain Injury Association of Michigan, the Grand Rapids Bar Association, the Legal Assistance Center, and the State Bar of Michigan. He is also a Fellow in the International Society of Barristers. In addition, Tom has also received numerous professional accolades, including being recognized as a *"Michigan Super Lawyer,"* a listing in *"Best Lawyers in America,"* selection as the *"Best Personal Injury Attorney in Grand Rapids"* by Grand Rapids Magazine, designation as a *"Top 10 Personal Injury Plaintiff's Lawyer"* by Leading Lawyers Magazine, and named a *"Go-To Negligence Lawyer"* and a *"Go-To Power Lawyer"* by Michigan Lawyers Weekly. Tom focuses his practice on personal injury, auto negligence, and auto no-fault litigation. Tom, his wife, and their two children live in Grand Rapids' historic Heritage Hill neighborhood.

About the Law Firm

The Sinas Dramis Law Firm was started in 1951 in Lansing, Michigan by Thomas G. Sinas, who was joined a short time later by his friend, Lee C. Dramis, to establish the firm that bears their name today. Over the many years since it was founded, the Sinas Dramis Law Firm has primarily focused its practice on the representation of seriously injured patients and their providers throughout the state of Michigan, particularly in cases involving motor vehicle collisions. Their practice in this field of law includes cases involving semitruck collisions, motorcycle accidents, bicycle injuries, pedestrian injuries, and claims for no-fault PIP benefits on behalf of patients and medical providers.

The attorneys at the Sinas Dramis Law Firm have also been very involved in professional leadership activities. In that regard, one of its partners was President of the State Bar of Michigan; three partners were Presidents of the Michigan Association for Justice; two partners were Chairs of the State Bar Negligence Law Section; and two partners were Presidents of the Ingham County Bar Association. The law firm has also been extensively involved in numerous activities designed to educate consumers and professionals about the operation of the Michigan Auto No-Fault Law, including writing, lecturing, teaching, and testifying about that subject in many different forums.

The Sinas Dramis Law Firm has offices in Lansing, Michigan, Grand Rapids, Michigan, Kalamazoo, Michigan, St. Clair Shores, Michigan and Ann Arbor, Michigan.

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INTRODUCTION.

The Michigan Auto No-Fault Insurance Act (MCL 500.3101, *et seq*) initially went into effect in October 1973 and was extensively amended by the Michigan Legislature in 2019. The no-fault law creates a compulsory insurance system that obligates the owners or registrants of all motor vehicles required to be registered in Michigan to purchase auto no-fault insurance. Failure to purchase this required insurance subjects the owner or registrant of the motor vehicle to criminal prosecution, including a fine and/or imprisonment.

The basic concept of the No-Fault Act is to guarantee payment of a certain level of benefits to all motor vehicle accident victims, ***regardless of who is at fault for causing the accident.*** In order to fund such a system, however, the No-Fault Act imposes certain limitations on the rights of accident victims to bring liability insurance claims against the at-fault drivers who cause the accident. It is this basic trade-off that forms the essence of Michigan's no-fault system.

The starting point in understanding how the Michigan no-fault law works, is to keep in mind that motor vehicle accidents occurring in this State typically involve two (2) separate and distinct claims. The first claim is for ***no-fault personal protection insurance (PIP) benefits***. There are essentially four different types of PIP benefits: the allowable medical expense benefit; the wage loss benefit; the replacement service expense benefit; and the survivors' loss benefit. These benefits are payable regardless of who was at fault for the accident. The second major claim that an injured person may have under the no-fault system is ***the tort liability claim*** that can be asserted against the at-fault driver who caused the accident. The tort liability claim can result in compensation for two distinct type of damages: ***noneconomic damages*** (i.e., compensation for pain and suffering, disability, loss of function, loss of social pleasure and enjoyment, etc.) and ***excess economic loss damages*** (i.e., compensation for expenses and wage loss that are not compensable with no-fault PIP benefits.)

SECTION 1: WHAT ARE NO-FAULT PIP BENEFITS?

Under the original no-fault law, the PIP allowable expense benefit was payable for life and did not have any monetary cap. However, the major changes to the Michigan no-fault law enacted in 2019 dramatically altered and limited the scope and extent of the PIP allowable expense benefit. In addition, the 2019 law made significant changes regarding the tort liability claim. The 2019 legislation has created considerable uncertainty and confusion with regard to the operation of the no-fault system. Although the original no-fault law was intended to simplify motor vehicle accident claims, in actuality, this area of law has become very complicated, with a number of important rules and requirements that must be followed in order to protect the legal rights of auto accident victims. This is particularly true with regard to the 2019 legislation. Therefore, it is critically important for consumers, medical providers, and auto accident victims to thoroughly understand this area of law so that important rights and benefits are not jeopardized.

A. THE FOUR BASIC PIP BENEFITS

Under the Michigan No-Fault Act, there are four specific categories of no-fault PIP benefits. These four benefits are summarized below:

1. **PIP BENEFIT #1: ALLOWABLE EXPENSE BENEFITS -** Section 3107(1)(a) of the No-Fault Act requires insurance companies to pay *"allowable expenses"* which are defined as *"all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation."* These benefits are very broad and include a number of things, including traditional medical expenses; barrier-free residential accommodations;[1] vocational and physical rehabilitation;[2] in-home attendant care;[3] special transportation;[4] medical mileage;[5] guardianship and conservatorship expenses;[6] and expenses for the services of an independent case manager.

   Under the original No-Fault Act enacted in 1973, allowable expense benefits were payable for life and had no monetary cap. The 2019 legislative changes have dramatically altered this basic rule. Under the new law, allowable expense PIP benefits are only payable for life if the consumer chooses to buy uncapped, lifetime coverage. If the consumer does not want to purchase the lifetime coverage, there are several lesser options available which cap allowable expense PIP benefits at different dollar maximums. Under the new

[1] *Sharp v Preferred Risk Mutual Ins Co*, 142 Mich App 499 (1985).
[2] *Bailey v DAIIE*, 143 Mich App 223 (1985).
[3] *Manley v DAIIE*, 425 Mich 140 (1986); *Sharp v Preferred Risk Mut Ins Co*, 142 Mich App 499 (1985); *VanMarter v American Fidelity Fire Ins Co*, 114 Mich App 171 (1982); and *Visconti v DAIIE*, 90 Mich App 477 (1979).
[4] *Admire v Auto-Owners Inse Co*, 494 Mich 10 (2013).
[5] *Swanteck v Automobile Club of Michigan Ins Group*, 118 Mich App 807 (1982).
[6] *Heinz v Auto Club Inse Ass'n*, 214 Mich App 195 (1995).

legislation, allowable expense PIP benefits can be purchased at the following option levels: $50,000 (only for Medicaid eligible consumers); $250,000; and $500,000. In addition, in certain limited situations, consumers can completely "*opt-out*" of any allowable expense PIP benefits. These new coverage options will be discussed in greater detail in Section 3.

Set forth below is a brief discussion of important issues related to the allowable expense benefit:

(a) **In-Home Attendant Care—** Under §3107(1)(a), an injured person has a right to hire commercial or non-commercial in-home health care to render personal services to the injured person that are reasonably necessary for that person's care, recovery, or rehabilitation. This in-home attendant care benefit is very important for seriously injured auto accident victims and their families. It enables the injured person to remain in their own home with proper assistance. The injured person has a right to hire commercial agencies or family, friends, neighbors, and others to render this in-home attendant care.[7]

Michigan Courts have held that attendant care benefits cover a wide range of "*hands on*" services, including bathing, dressing, feeding, personal assistance, personal hygiene, transportation to and from medical care, administration of medications, overseeing in-home therapies, etc. In addition, the court decisions have made it clear that attendant care benefits go beyond "*hands on*" care and include the *monitoring and supervision* of the patient.[8]

Frequently, attendant care benefit claims result in disputes with no-fault insurers that typically involve two major issues: (1) how many hours of attendant care are "*reasonably necessary*" for the injured person's care, recovery, or rehabilitation; and (2) what hourly or *per diem* rate is a "*reasonable charge.*" The statute does not specifically address these two issues, nor do any specific appellate court decisions. Therefore, each case is evaluated on its own merits. Regarding the reasonableness of the charges, there are court decisions that hold it is appropriate to consider commercial rates charged by professional agencies for similar services.[9] However, other cases have cast doubt on the utilization of commercial rates to establish the value of family-provided attendant care. Rather, they have suggested that the more appropriate valuation approach is to analyze the total

[7] *Manley v DAIIE*, 425 Mich 140 (1986); *Sharp v Preferred Risk Mut Ins Co*, 142 Mich App 499 (1985); *VanMarter v American Fidelity Fire Ins Co*, 114 Mich App 171 (1982); and *Visconti v DAIIE*, 90 Mich App 477 (1979).
[8] *Douglas v Allstate Ins Co*, 492 Mich 241 (2012).
[9] *Sharp v Preferred Risk Mut Ins Co*, 142 Mich App 499 (1985).

compensation package that is payable to employees of commercial agencies who render in-home attendant care.[10] Thus, claims involving family-provided attendant care can become contentious, given the uncertainty that exists regarding the valuation methodology. Under the 2019 legislative changes, attendant care rendered by family members and friends of the patient is capped at 56 hours per week beginning in July 2021.

(b) **Causation Issues—**Frequently, one of the major legal issues involved in allowable expense benefit claims is the question of ***causation***. The causation issue deals with the legally required connection that must be demonstrated between a motor vehicle injury and the claimed expense in order to make that expense payable under the allowable expense provisions of §3107(1)(a). In other words, to what extent must the auto accident injury be the cause of the need for the expense? This issue has been analyzed in several different scenarios by our appellate courts. Some of these scenarios are discussed below.

(c) **Pre-Existing Injuries/Multiple Causes—**Many years ago, court decisions established that if an accident victim sustains an aggravation or exacerbation of a pre-existing injury or condition as a result of the motor vehicle accident, that person is entitled to claim allowable expense benefits for the aggravated/exacerbated condition.[11]

In addition, Michigan Courts have made clear that motor vehicle accidents need not be the only cause or the major cause of the need to incur the allowable expense at issue.[12] These cases hold that a sufficient causal connection was demonstrated if the motor vehicle accident is "*one of the causes*" of the need to incur the expense, even though there may be other unrelated and independent causes. However, the Courts have cautioned that the causal connection between the motor vehicle accident and the need for the claimed benefits must be more than "*incidental.*"

(d) **Ordinary Needs Versus Accident-Related Needs—**Another aspect of the causation issue deals with those cases where the claimed allowable expense resembles an expense that the injured person would have incurred, even if he or she had not been injured in the subject accident. There have been several Michigan Supreme Court cases that have addressed this issue in various contexts. These cases make the point

[10] *Douglas v Allstate Ins Co*, 492 Mich 241 (2012).
[11] *Mollitor v Associated Truck Lines*, 140 Mich App 431 (1985).
[12] *Shinabarger v Citizens Inse Co*, 278 Mich App 578 (2008) and *Scott v State Farm Mut Auto Ins Co*, 278 Mich App 578 (2008).

that any allowable expense benefit claimed under §3107(1)(a) must be demonstrated to be "*for*" the claimant's "*injury.*" In other words, the claimant's injury or disability must cause the need for the allowable expense at issue. Accordingly, unless the claimed expense is reasonably necessary for the care, recovery, or rehabilitation of the injured person, it is frequently not compensable. For example, the Supreme Court has held that the cost of non-medical, non-special dietary food consumed by an injured person who is cared for at home, but which is unrelated to his or her motor vehicle injury, is not a recoverable allowable expense.[13] However, there is an exception to this exclusionary rule for food served to an injured person in a *hospital setting*. In addition, the Supreme Court has applied this general principle to cases involving *handicap-accessible vehicles*. In one case, the Supreme Court held that the base price of a van that was subsequently specially adapted to be handicap accessible, was not compensable as an allowable expense, because it was a "*ordinary every day expense*" that would have been incurred by the injured person regardless of the injury.[14] However, the Court did make clear that the cost of modifying the van was compensable. In reaching this holding, the Supreme Court recognized that expenses that were of a "*wholly different essential character*" than those expenses incurred by the injured person prior to the accident, are compensable as an allowable expense. In addition, those products and items that are considered to be "*integrated products*" may be compensable in their entirety if the cost of the item or product cannot be separated easily between that which represents a pre-existing need and that which represents an expense of a wholly different essential character related to the accident.

2. PIP BENEFIT #2: WORK LOSS BENEFITS—Section 3107(1)(b) provides that when an injured person cannot perform their normal work as a result of an auto accident, work loss benefits are payable for up to three years for "*loss of income from work an injured person would have performed . . . if he or she had not been injured.*" These work loss benefits are payable at the rate of 85% of gross pay, including lost overtime. However, the work loss benefit cannot exceed the monthly maximum, which is adjusted every October to keep pace with the cost-of-living. These annual adjustments are only applicable to accidents occurring after the adjustment date. The maximum work loss benefits for the last five (5) years are as follows:

October 1, 2019 – September 30, 2020: $5,718.00

October 1, 2018 – September 30, 2019: $5,700.00

[13] *Griffith v State Farm Mut Auto Ins Co*, 472 Mich 521 (2005).
[14] *Admire v Auto-Owners Ins Co*, 494 Mich 10 (2013).

October 1, 2017 – September 30, 2018: $5,541.00

October 1, 2016 – September 30, 2017: $5,452.00

October 1, 2015 – September 30, 2016: $5,398.00

The Act also provides for the payment of wage loss benefits to those individuals who are considered to be "*temporarily unemployed*" from full-time employment. Whether a person can be considered "*temporarily unemployed*" can be a complicated legal issue requiring careful consideration. Some important legal issues relating to work loss benefits are discussed below:

(a) **Applicable Disability Standard—**Under the No-Fault Act, it is not necessary to prove that the injured person is completely disabled from performing any type of employment. On the contrary, the statute requires payment of work loss benefits if the injured person cannot perform the work the injured person "*would have performed*" had the accident not occurred. In addition, Michigan Courts have held that work loss benefits must include salary increases, overtime, and other merit raises that would have been received during the person's disability.[15] However, any income earned by the injured person during a period of disability reduces the wage loss benefit otherwise payable for that same period.[16]

(b) **Duty to Mitigate—**Michigan appellate courts have imposed an obligation on an injured person who is receiving wage loss benefits to "*mitigate damages*" by seeking alternative employment if such employment is available and if it is otherwise reasonable under the circumstances for the injured person to accept such alternative employment.[17] The exact scope and nature of this duty to mitigate remains unclear.

(c) **Interplay With Employment Benefits—**Earlier court decisions have recognized that a no-fault insurer cannot reduce work loss benefits by an injured person's sick leave or vacation time.[18] However, in certain circumstances, no-fault work loss benefits can be reduced by "*wage continuation benefits*" that the employee is receiving.[19] Such a setoff can occur if the injured person has purchased "*coordinated no-fault*" coverage that is applicable to work loss benefits. This issue will be discussed in further detail in Section 5.

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[15] *Lewis v DAIIE*, 90 Mich App 251 (1979) and *Farquharson v Travelers Ins Co*, 121 Mich App 766 (1982).
[16] *Snellenberger v Celina Mut Ins Co*, 167 Mich App 83 (1988).
[17] *Bak v Citizens Ins Co*, 199 Mich App 730 (1993).
[18] *Orr v DAIIE*, 90 Mich App 687 (1979).
[19] *Jarrod v Integon*, 472 Mich 207 (2005).

(d) **Self-Employed Persons—**Self-employed accident victims are entitled to recover work loss benefits, but oftentimes experience difficulty with insurance companies in establishing the appropriate level of benefits. The Courts have generally held that a self-employed person's business expenses should be deducted from his or her gross receipts in order to determine the proper no-fault work loss benefit level. However, the Courts have rejected the principle that all business expenses reported on Schedule C of the individual's tax returns are fully and automatically deductible from gross receipts. Therefore, the question of which business-related expenses can be deducted from the gross receipts of a self-employed person to arrive at the proper work loss benefit level is a question that typically must be determined on a case-by-case basis.[20]

3. PIP BENEFIT #3: REPLACEMENT SERVICE EXPENSES—Section 3107(1)(c) of the Michigan No-Fault Act provides that an injured person may also receive reimbursement in an amount not to exceed $20 per day for expenses incurred in having others perform reasonably necessary services that the injured person would have performed for the benefit of themselves or their dependents. This benefit primarily consists of domestic type services, such as housekeeping, lawn work, snow removal, etc.

There is an important distinction between replacement service expense benefits and in-home attendant care benefits. This is a gray area that frequently can lead to disputes.[21] Generally speaking, if the services are related to the injured person's *"care, recovery or rehabilitation (i.e., personal care),"* it is considered to be an allowable expense payable under §3107(1)(a) discussed above. However, if the service is not related to personal care, recovery, or rehabilitation, but is more in the nature of a domestic service, it is probably a replacement service expense, payable under §3107(1)(c). This distinction is crucial, because replacement service expenses are limited to $20 per day and terminate three years from the date of the accident, whereas allowable expense benefits are not subject to the $20 per day, three-year cap. Therefore, service providers rendering care to injured persons in the injured person's home must be careful to separate these two types of service claims, so as to avoid improper application of the replacement service expense limitations.

4. PIP BENEFIT #4: SURVIVORS' LOSS BENEFITS—When a motor vehicle accident results in death, dependents of the decedent are entitled to recover survivors' loss benefits under §3108 of the Act. Survivors' loss benefits are payable for three years and are subject to the same monthly maximum benefit

[20] *Adams v Auto Club Ins Ass'n*, 154 Mich App 186 (1986).
[21] *Douglas v Allstate Inse Co*, 492 Mich 241 (2012) and *Johnson v Recca*, 492 Mich 169 (2012).

ceiling that is applicable to work loss benefits. These survivors' loss benefits essentially consist of the after-tax income that would have been earned by the decedent, plus the value of fringe benefits that have been lost as a result of the death of the decedent, plus replacement service expenses incurred because of the decedent's death. Some important legal issues relating to survivors' loss benefits are discussed below:

(a) **Nature of the Benefit—** The nature of the survivors' loss benefit is expressed in rather convoluted language set forth in §3108(1) of the Act. This section states that survivors' loss benefits are payable for *"loss . . . of contributions of tangible things of economic value . . . that dependents of the deceased . . . would have received for support during their dependency . . . if the deceased had not suffered the accidental bodily injury causing death and expenses, not exceeding $20 a day, reasonably incurred by these dependents during their dependency . . . in obtaining ordinary and necessary services in lieu of those that the deceased would have performed for their benefit if the deceased had not suffered the injury causing death."*

(b) **Multiple Elements of the Survivors' Loss Claim—** In light of this broad language in §3108(1), the Courts have held that the survivors loss benefit is a multifaceted benefit that includes several things, including: the after-tax income earned by the decedent; the value of fringe benefits that were available to the decedent and his/her family but are now lost or diminished because of his/her death; any other activity that resulted in the production of *"contributions of tangible things of economic value;"* and the same replacement service expense benefits that are payable in non-death cases. The Courts have also held that survivors' loss benefits are not to be reduced by the amounts that would have been attributable to the personal consumption of the decedent.[22]

(c) **Dependency—** Under §3108, only those persons who are classified as a *"dependent"* of the decedent may make a claim for survivors' loss benefits. Section 3110 of the Act identifies certain persons who are conclusively or presumably deemed to be dependents of the deceased. Clearly, spouses are dependent on their deceased spouse and minor children are dependent upon a deceased parent. However, in other cases, the determination of *"dependency"* can be a complicated factual and legal issue and must be approached on a case-by-case basis.

(d) **Funeral and Burial Expenses—** In addition to the survivors' loss benefits described above, §3107(1)(a) of the Act also allows recovery of certain expenses incurred for the funeral and burial expenses. For these

[22] *Miller v State Farm Mut Auto Ins Co*, 410 Mich 538 (1981).

expenses, no-fault insurers must cover at least $1,750, but no more than $5,000.

B. THE INCURRED REQUIREMENT

No-fault insurance companies have a legal obligation to pay claims for allowable expenses under §3107(1)(a) and replacement service expenses under §3107(1)(c), ***only when the expense has been "incurred."*** The statute does not define the word *"incurred."* However, a number of Michigan appellate cases have held that to incur an expense, a person must have either paid for the expense or become legally obligated to pay the expense. This also means that a no-fault insurer is not obligated to pre-authorize payment of a particular bill. Thus, the patient has to either pay for the expense or become legally obligated to pay the expense before requesting reimbursement from the no-fault insurer.

The incurred requirement has been very problematic for many patients, particularly those with catastrophic injuries who require products, services, and accommodations that are very expensive, i.e., handicap-accessible housing; special vehicular transportation; residential facility admission; etc. Unless the injured person has *"incurred"* expenses for such items, the insurer has no legal responsibility to pay the expense.

There are several ways that patients can *"incur"* expenses other than by paying the full cost of the item in cash. These include entering into contracts to purchase the product, service, or accommodation, or by borrowing money to pay for the needed item. In addition, patients can file *"declaratory judgment"* lawsuits asking for a court to rule whether the insurer is liable to pay for the cost of a specific product, service, or accommodation once the injured person has incurred the expense for such an item. However, declaratory judgment actions do not permit the plaintiff to recover penalty sanctions that are otherwise available under the No-Fault Act when expenses have actually been incurred. Therefore, declaratory judgment actions are not as effective as traditional lawsuits filed for the recovery of unpaid benefits after the plaintiff has actually incurred the expense that is the subject of the claim.

C. THE MICHIGAN CATASTROPHIC CLAIMS ASSOCIATION (MCCA)

Frequently, discussions regarding the Michigan no-fault law involve references to the *Michigan Catastrophic Claims Association*, which is typically referred to as the ***"MCCA."*** This is an entity that was created by §3104 of the No-Fault Act. The MCCA is, in essence, a reinsurance organization that reimburses auto no-fault insurers for an injured person's PIP benefits that exceed a certain monetary threshold amount. The PIP insurer that is responsible for the claim continues to pay the claim but is subsequently reimbursed by the MCCA once the claim hits the threshold limit. The threshold limit that was in effect from July 2019 through June 2021 is $580,000. Once the servicing PIP insurer pays this amount, any expense in excess of that amount is reimbursed by the MCCA.

Several years ago, the Michigan Supreme Court rendered a decision which held that the MCCA had the right to impose certain procedural guidelines that no-fault insurers would be required to follow in order to have claims reimbursed by the MCCA.[23] The net practical effect of that court case is that it has empowered the MCCA to now act as a "*super claims adjuster*" in virtually every catastrophic injury claim. Consequently, the MCCA frequently tells no-fault insurers what it will and will not reimburse, thereby effectively controlling what gets paid. As a result, the decision regarding claims for home accommodations, special vehicular transportation, and in-home attendant care are frequently made by the MCCA, rather than the injured person's insurance company. Unfortunately, this direct involvement by the MCCA in processing catastrophic injury claims has, in many situations, resulted in delay and has caused unnecessary litigation.

As a result of the 2019 legislative amendments, the MCCA will only be involved in cases where the injury occurred before July 2020, or in cases where the injury occurred after that date and the injured person had purchased uncapped allowable expense PIP coverage.

[23] *USF&G v MCC*, 482 Mich 414 (2008).

SECTION 2: WHO IS ELIGIBLE FOR PIP BENEFITS?

A. BASIC CONCEPT

The pivotal statutory section regarding entitlement to no-fault benefits is §3105(1) of the Act. This section states, "*Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter.*"

Section 3105(2) states that PIP benefits "*are due under this chapter without regard to fault.*" It is this subsection that gives "*no-fault*" its name.

Notably, the entitlement language of §3105(1) is very broad and goes beyond the typical scenario of bodily injury sustained in car crashes. In this regard, §3105(1) extends entitlement to PIP benefits to a number of ***non-collision scenarios,*** such as injuries arising out of motor vehicle maintenance, loading and unloading property, and occupying a vehicle.

In order for no-fault PIP benefits to be payable, there are a few basic requirements that must be satisfied, including the following: there must be a "*motor vehicle*" involved in the accident as that term is defined in the Act; there must be some form of bodily or mental injury,[24] which can include an aggravation of a pre-existing condition;[25] the injury giving rise to the claim must be accidental in the sense that it was not caused intentionally by the claimant;[26] there must be a sufficient causal connection between the injury and the use of the motor vehicle which is something more than an incidental connection;[27] and the injury must be closely related to the transportational function of the motor vehicle.[28]

B. PARKED VEHICLE SITUATIONS

The availability of no-fault benefits is narrowed in cases where the injury involves a ***parked vehicle***. This situation is addressed in §3106 of the Act, which provides that a person sustaining accidental bodily injury arising out of a parked vehicle is not entitled to PIP benefits unless the injury falls into one of ***the three scenarios set forth in §3106(1).*** The first scenario is where the vehicle was parked in such a way as to cause an unreasonable risk of the injury that occurred. The second scenario is where the injury occurs as a direct result of physical contact with either permanently mounted vehicle equipment while the equipment

[24] *Wheeler v Tucker Freight Lines*, 125 Mich App 123 (1983).
[25] *Mollitor v Associated Truck Lines*, 140 Mich App 431 (1985).
[26] *Mattison v Farmers Ins Exch*, 181 Mich App 419 (1989) and *Miller v Farm Bureau Gen Ins Co*, 218 Mich App 221 (1996).
[27] *Shinabarger v Citizens Ins Co*, 90 Mich App 307 (1979); *Thornton v Allstate Ins Co*, 425 Mich 643 (1986); *Marzonie v ACIA*, 441 Mich 522 (1992); *Bourne v Farmers Ins Exch*, 449 Mich 193 (1995); and *Morosini v Citizens Ins Co*, 461 Mich 303 (1999).
[28] *McKenzie v ACIA*, 458 Mich 214 (1998).

was being operated or used, or direct physical contact with property that was being lifted onto or lowered from the vehicle in the loading or unloading process. The third scenario is where the person was injured while occupying, entering into, or alighting from the parked vehicle.

The Michigan Supreme Court has also recognized a fourth scenario where benefits are payable if the injured person sustained injury while ***performing maintenance*** on a parked vehicle.[29]

It is also important to keep in mind that if a person is injured in an accident involving both a moving motor vehicle and a parked vehicle, the involvement of the moving motor vehicle makes it unnecessary for the injured person to fall into one of the four parked vehicle scenarios described above.

Section 3106(2) of the Act contains an exclusion stating that PIP benefits are not payable if an employee suffered an injury that gives rise to the payment of workers' compensation benefits and the employee sustained that injury while loading, unloading, or doing mechanical work on a vehicle, or while entering into or alighting from the vehicle. However, this exclusion does not apply if the employee was occupying a motor vehicle or if the injury arose from the use or operation of some other motor vehicle. This exclusion also does not apply if the employee sustains injury while actually driving a vehicle in the course of his or her employment.

C. STATUTORY DISQUALIFICATIONS

There are several very important statutory disqualifications that are contained in §3113 of the Act which, if applicable, will result in the injured person being totally ineligible for no-fault PIP benefits. For example, a claimant will be disqualified if the claimant was an owner or registrant of a motor vehicle that was involved in the accident which gives rise to the claimant's injury. In addition, a person will be disqualified if he or she was willingly operating or willingly using a motor vehicle or motorcycle that was taken unlawfully and the person knew or should have known that the vehicle was taken unlawfully; a person will be disqualified if he or she was the owner or registrant of a motor vehicle involved in the accident that was not insured as required by the no-fault law; and a person will be disqualified if he or she was operating a motor vehicle or motorcycle as to which he or she was named as an excluded operator. The courts have also held that a person can be disqualified from no-fault PIP benefits if that person was guilty of an act of fraud in the procurement of the no-fault policy. In addition, the courts have held that a person could be disqualified from no-fault PIP benefits if the person commits an act of fraud in the processing of a claim for PIP benefits. These fraud disqualification concepts are very important and have been strictly enforced by the courts in recent years.

[29] *Miller v Auto-Owners Ins Co*, 411 Mich 633 (1981)

D. OUT-OF-STATE RESIDENTS

Before the legislative changes enacted in 2019, out-of-state residents who were injured in motor vehicle accidents occurring in Michigan were entitled to full Michigan no-fault PIP benefits if the out-of-state resident was insured by an insurance company authorized to do business in the state of Michigan (a so-called "*§3163 insurer*"). In addition, before the 2019 legislation, out-of-state residents were entitled to full Michigan no-fault PIP benefits if they sustained injury while occupying a vehicle insured with a Michigan no-fault policy.

The 2019 legislation dramatically reduced the availability of no-fault PIP benefits to out-of-state residents. Specifically, §3113(c) states that out-of-state residents are no longer entitled to no-fault PIP benefits, unless the out-of-state resident is an owner of a vehicle that is both ***registered and insured*** in Michigan, regardless of whether the out-of-state resident was insured under an out-of-state policy issued by an insurance company authorized to sell insurance in Michigan (i.e., a §3163 insurer). This new exclusion creates very serious problems for out-of-state residents who are injured in Michigan or while occupying Michigan insured vehicles. Although no-fault PIP benefits would still be available to an out-of-state resident who is the owner of a vehicle that is both registered and insured in Michigan, it could be that family members of such an owner may not be entitled to PIP benefits because they are not "*the owner*" of that vehicle. This would be a very unfair interpretation of the law that would deny PIP benefits to entire families, even though there is a vehicle in the family household that is registered and insured with no-fault insurance in the State of Michigan.

Recognizing the harshness of this out-of-state resident exclusion, the 2019 legislation gives out-of-staters who are excluded from PIP benefits the right to sue the at-fault driver in a tort claim for medical expenses and other losses that were not compensated. Such tort claims will be further discussed in Section 6.

E. OUT-OF-STATE ACCIDENTS

Section 3111 of the Act provides that PIP benefits will be payable in certain situations where the insured person is involved in an out-of-state accident. This section states that PIP benefits "*are payable for accidental bodily injury suffered in an accident occurring out of this state, if the accident occurs within the United States, its territories and possessions, or in Canada.*" However, the injured person must show one of two things: (1) the injured person is a named insured under a Michigan no-fault policy or is the spouse or resident-relative of a person who is named insured under a no-fault policy; or (2) the injured person must show that he or she was an occupant of a vehicle whose owner or registrant insured that particular vehicle under a Michigan no-fault policy.

F. MOTORCYCLES AND THE NO-FAULT LAW

Motorcyclists are not required to buy mandatory auto no-fault insurance. However, motorcyclists sustaining injury in accidents involving ***motor vehicles*** are entitled to payment of full no-fault PIP benefits. Therefore, motorcycle accidents create a separate and distinct class of claimants who are subject to certain special rules which are briefly discussed below:

1. **ENTITLEMENT TO NO-FAULT PIP BENEFITS—**In light of the fact that a motorcycle is not defined as a *"motor vehicle"* under the Michigan No-Fault Act, a motorcycle is not entitled to no-fault PIP benefits if the injury involves only a motorcycle. However, if the motorcyclist is injured in an accident involving another motor vehicle (i.e., a car or a truck), the motorcyclist will be entitled to no-fault PIP benefits. In this situation, the motorcyclist is not required to show that there was actually physical contact between the motorcycle and the motor vehicle. Rather, the motorcycle injury must, in some way, *"arise out of"* the operation of the motor vehicle. Therefore, if the motor vehicle causes the motorcycle to lose control, or in some other way precipitates the collision with another object, a sufficient causal connection between the motorcycle and the operation of the motor vehicle will exist, thereby entitling the motorcyclist to PIP benefits.

2. **MOTORCYCLE DISQUALIFICATION—**Section 3113 of the Act contains two important disqualifications that are applicable to motorcycle owners. First, a motorcycle owner who has not purchased traditional liability coverage for his or her motorcycle (commonly referred to as PLPD coverage) is not eligible to recover PIP benefits in a motorcycle/motor vehicle accident. However, this disqualification extends only to the owner or registrant of the motorcycle and does not apply to a non-owner passenger on board an uninsured motorcycle. Second, a motorcyclist who operates a motorcycle as to which he or she was identified as an excluded operator is not eligible to recover no-fault PIP benefits in a motorcycle/motor vehicle accident.

3. **IDENTIFYING THE INSURER RESPONSIBLE TO PAY PIP BENEFITS IN MOTORCYCLE CLAIMS—**The No-Fault Act contains special *"priority rules"* that are applicable to motorcycle accidents and that identify the insurance company that bears legal responsibility for paying the claim. These priority rules are set forth in §3114(5) of the Act and basically state that an operator or a passenger of a motorcycle who sustains injury arising out of an accident involving a motor vehicle, must claim no-fault PIP benefits from insurers in the following order of priority: the insurer of the owner or registrant of the motor vehicle involved in the accident; the insurer of the operator of the motor vehicle involved in the accident; the auto no-fault insurer of the operator of the motorcycle involved in the accident; and the auto no-fault insurer of the

owner or registrant of the motorcycle involved in the accident. A person who is injured while an operator or passenger of a motorcycle who is unable to recover benefits under any of the above-referenced levels of priority will draw benefits through the ***Assigned Claims Plan***, which is discussed in connection with Section 4.

4. **MOTORCYCLE ACCIDENTS OCCURRING IN OTHER STATES —** The No-Fault Act also provides that a Michigan resident who sustains injury operating or riding a motorcycle in another state can recover no-fault PIP benefits, as long as the motorcyclist was, at the time of the accident, a named insured under a Michigan auto no-fault insurance policy or was the spouse or resident-relative of someone who was insured under a Michigan auto no-fault insurance policy. In that situation, the Michigan motorcyclist would recover no-fault PIP benefits directly from the motorcyclist's auto no-fault insurer. Presumably, in order to recover PIP benefits in an out-of-state accident, it would be necessary to show that the injury arises out of a "*motor vehicle accident,*" as opposed to an accident solely involving motorcycles. However, that point has not been specifically addressed by Michigan appellate courts and the issue is not absolutely clear. This is because the out-of-state accident provisions of §3111 of the No-Fault Act speak only about "*accidental bodily injury suffered in an accident occurring out of this state.*" This section does not refer to a "*motor vehicle accident.*" However, it is unlikely that a motorcyclist could recover PIP benefits if they are injured in an accident occurring outside of Michigan that did not involve a motor vehicle in some way.

G. OTHER NON-VEHICULAR OCCUPANTS (BICYCLISTS AND PEDESTRIANS)

Frequently, persons sustain bodily injury in accidents involving motor vehicles while they are not occupying a motor vehicle. Motorcyclists are in that category and their claims are discussed above. However, pedestrians and bicyclists also fall into this category. As with motorcycles, if a pedestrian or a bicyclist is injured as a result of the operation of a motor vehicle, the pedestrian or bicyclist is entitled to full no-fault PIP benefits. The issue of which insurer has the legal obligation to pay those PIP benefits is discussed in greater detail in connection with Section 4. However, the general rule is that the pedestrian or bicyclist will recover no-fault PIP benefits directly from their own auto insurer, or from the auto insurer of a resident-relative. If the pedestrian or bicyclist does not have their own auto no-fault insurance policy, or does not reside with a resident-relative who has a no-fault insurance policy, then the issue of who pays no-fault PIP benefits will depend on whether the claim is controlled by prior law or the 2019 legislative amendments. Under the prior no-fault law, benefits would be payable to such claimants pursuant to the following rules: persons injured while occupying a motor vehicle would draw PIP benefits from the insurer of the vehicle occupied; and persons injured while not occupying a motor vehicle would draw PIP benefits from the insurer of the motor vehicle that was involved in causing the claimant's

injury Under the old law, if there was no PIP coverage available under those rules the claimant would draw PIP benefits from the Assigned Claims Plan (ACP). As will be more fully discussed in Section 4, under the 2019 legislative amendments, claimants such as pedestrians and bicyclists who do not have their own no-fault insurance policy or are not domiciled with a relative who has a no-fault insurance policy, will have benefits paid by the ACP, subject to the monetary cap applicable to the plan

SECTION 3: WHAT REIMBURSEMENT LIMITS ARE APPLICABLE TO PIP BENEFITS?

The 2019 legislative changes to the no-fault law made dramatic changes to the monetary benefit levels applicable to motor vehicle bodily injury claims. Prior to the 2019 changes, there were no monetary benefit caps applicable to the PIP allowable expense benefit under §3107(1)(a) of the Act. That section provided that the allowable expense benefit required payment of "*all reasonable charges for reasonably necessary products, services, and accommodations for an injured person's care, recovery or rehabilitation.*" This meant that the allowable expense benefit was payable for the injured person's entire lifetime and was not limited by any monetary ceiling or coverage level.

The 2019 legislative changes made a fundamental change in the allowable expense benefit. Beginning on July 1, 2020, no longer will every auto no-fault policy provide lifetime, uncapped allowable expense benefit coverage. Consumers will now be required to choose the amount of allowable expense benefits coverage they desire. In addition, in certain situations, consumers will be permitted to entirely *"opt-out"* from allowable expense PIP benefit coverage. Set forth below is a brief description of the various options that consumers may purchase under the 2019 legislation and the dollar limitations applicable to those coverages. Those options are as follows:

A. THE OPTIONAL DOLLAR CAPS ON ALLOWABLE EXPENSE PIP COVERAGE

1. OPTION #1: LIFETIME, UNCAPPED PIP ALLOWABLE EXPENSE COVERAGE.

Under the 2019 legislation, consumers can elect to purchase lifetime, uncapped PIP allowable expense coverage that was automatically available to them under the original no-fault law.

2. OPTION #2: THE $500,000 BENEFIT LEVEL.

Under the 2019 legislation, consumers can elect to purchase $500,000 of lifetime PIP allowable expense coverage. This option is available to any person without limitation.

3. OPTION #3: THE $250,000 BENEFIT LEVEL.

Under the 2019 legislation, consumers can elect to purchase $250,000 of lifetime PIP allowable expense coverage. This option is available to any person without limitation.

4. OPTION #4: THE $50,000 MEDICAID OPTION.

Under the 2019 legislation, a limited group of consumers will have a $50,000 allowable expense benefit option that will be available only when: (1) the named insured is covered under Medicaid, and (2) the spouse and domiciled relatives of the named insured are also covered under Medicaid, or have other "*qualified health insurance*," or have auto PIP coverage through a different policy. This level of choice applies to the named insured, that person's spouse, or any domiciled relative.

5. OPTION #5: THE $250,000 OPT-OUT PIP EXCLUSION.

Under the 2019 legislation, some consumers who have other health and accident insurance coverage available to them may be able to completely opt-out of any PIP allowable expense benefit coverage, subject to the following conditions: (1) the named insured, his/her spouse, and all domiciled relatives who desire such an opt-out must have other health and accident coverage that extends to auto-related injuries, and (2) the policy must provide for the payment of $250,000 of lifetime PIP benefits for all domiciled relatives of the named insured ***who do not have other qualifying health and accident coverage.***

The significance of this opt-out option is that any person who selects this option is not eligible for any PIP allowable expense benefit coverage for medical and rehabilitation expenses if those opt-outers are injured while occupying a motor vehicle. However, if such opt-outers are injured as non-occupants of a motor vehicle, they may be entitled to limited allowable expense benefits from the Assigned Claims Plan (ACP). Moreover, anybody purchasing the $250,000 opt-out exclusion and who subsequently experiences a lapse in his/her applicable health or accident coverage, has only 30 days following the lapse to select another level of PIP coverage. Failure to act within that 30-day period will result in no PIP coverage whatsoever, until PIP coverage is later selected and purchased. Moreover, if the lapse in other health and accident coverage occurs ***after a person has been injured***, there is a real question as to whether that person will be entitled to ***any*** no-fault PIP allowable expense coverage.

6. OPTION #6: THE MEDICARE NO-FAULT OPT-OUT.

The 2019 legislation allows a complete opt-out from all no-fault allowable expense benefits for those persons who are covered under both Parts A and B of Medicare, as well as the spouses and any resident-relatives of those persons who have Medicare coverage, other "*qualified health coverage,*" or other no-fault PIP coverage under a separate policy. As is the case with the $250,000

opt-outer, Medicare opt-outers will have no allowable expense benefit coverage if they are injured while occupying a motor vehicle. Rather, they must rely solely on the limited reimbursement provisions of the Medicare laws or other applicable qualified health coverages in the household. However, if such opt-outers are injured as non-occupants of a motor vehicle, they may be entitled to limited allowable expense benefits from the Assigned Claims Plan (ACP).

7. MANAGED CARE OPTION.

The new 2019 no-fault legislation allows insurance companies to begin selling *"managed care"* no-fault policies beginning in July 2020. The specific details of these policies remain to be seen. But, generally speaking, a victim would be limited to a network of insurance company medical providers and be forced to abide by new rules and decisions promulgated by the insurance industry.

B. MEDICAL PROVIDER FEE SCHEDULES

The 2019 legislation significantly changes prior law so as to subject medical providers to certain *"fee schedules"* that limit what provider charges are reimbursable by no-fault insurance companies. Prior to the 2019 legislative changes, providers rendering care and services to auto accident patients were not limited or regulated by any type of fee schedule. The only restriction was the provisions of §3107(1)(a) and §3157 which allowed a medical provider to be reimbursed for all *"reasonable charges,"* but prohibited the provider from charging any more than the provider's reasonable and customary charges assessed in cases not involving auto insurance. The 2019 legislation does away with this system and imposes a fee schedule mechanism on medical providers, the highlights of which are summarized below.

Beginning on July 1, 2021, all medical providers will be subjected to certain fee schedules that will limit the amount the provider is entitled to recover from the patient's auto no-fault insurer. In essence, the fee schedules are based upon a certain percentage of what would be paid by Medicare if the service was Medicare compensable. If the service rendered by a provider is not Medicare compensable, then under the 2019 legislation, the provider will only be able to recover certain percentages payable under the provider's *"charge description master,"* or a certain percentage of the provider's average charges as of January 1, 2019. It is likely that these new fee schedule rules will significantly reduce reimbursements to medical providers who treat accident victims. Some observers fear that these reduced reimbursements may adversely affect access to medical care. It also appears that these new medical fee schedules will be applicable to auto accident victims injured prior to the effective date of the 2019 legislation.

In addition, there appears to be some uncertainty in the language of the legislation as to whether a provider can pursue a patient directly for payment of provider charges that exceed the new fee schedules. The fee schedule provisions of §3157(2), (3), (6), and (7), all state that the providers who are subject to each of these provisions are "*not eligible for payment or reimbursement under this chapter,*" for more than the fee schedule amount. Does this language allow the provider to argue that a contractual relationship exists between the provider and the patient, permitting the provider to pursue the patient under contract law, rather than "*under this chapter?*" If so, the question then becomes whether those provider charges in excess of the new fee schedules can be recovered by the patient in a tort case against the at-fault driver. This question will probably require court interpretation. See Section 7 for further information regarding that issue.

C. UTILIZATION REVIEW LIMITATIONS

1. **CONCEPT**—Prior to the 2019 legislative changes, the Michigan no-fault law was not considered to be a "*managed care*" system.[30] However, the 2019 legislative changes have altered that characteristic somewhat by imposing a mandatory utilization review process for any medical provider rendering services to an injured person covered by no-fault PIP benefits. This utilization review process is intended to establish parameters and limitations regarding the "*appropriateness . . . of both the level and the quality of treatment, products, services, or accommodations . . . based on medically accepted standards*." [§3157a(6)]. The Michigan Department of Insurance and Financial Services (DIFS) will establish rules and criteria governing the utilization process. However, the utilization process itself will be implemented by insurance companies.

2. **CONSEQUENCES**—This new utilization review process will obligate medical providers to do many things and submit much information to the no-fault insurer in order to justify continued treatment of the patient. Moreover, providers who do not comply with their obligations under the utilization review process are subject to significant penalties and sanctions. The new utilization review provisions are intended to apply to treatment and services rendered after July 1, 2020. It also appears that these new utilization review rules will be applicable to auto accident victims injured prior to the effective date of the 2019 legislative changes.

D. FAMILY-PROVIDED ATTENDANT CARE LIMITATIONS

1. **CONCEPT**—Prior to the 2019 legislative changes, the no-fault law was clear that patients who required in-home attendant care could receive that care from family, friends, or commercial agencies. There was no specific limitation applicable to family-provided attendant care, other than proof the service was

[30] *Morgan v Citizens Ins Co*, 432 Mich 640 (1989).

reasonably necessary and that the charge was reasonable. This important feature of the prior no-fault law was significantly changed by the 2019 legislation. Under this new law, attendant care rendered by the family and friends of the patient are limited to reimbursement not to exceed 56 hours per week. This 56 hour per week limitation applies to attendant care that is provided in the patient's home by any relative, any person living with the patient, or any person who had a "*business or social relationship*" with the patient before the injury.

2. **OPTION TO CONTRACT—** The 2019 legislation provides that, in spite of the 56-hour per week limitation, an insurance company may contract to pay benefits for attendant care that are more than the statutory hourly limitations.

3. **DATE OF EFFECT—** Under the 2019 legislative changes, the weekly hourly limitations will apply to any attendant care provided after July 1, 2021. Furthermore, beginning on that date, it appears that those hourly limitations will apply to auto accident victims injured prior to the effective date of the 2019 legislative changes

E. CONSEQUENCES WHEN VICTIMS INCUR MEDICAL EXPENSES EXCEEDING THEIR PIP BENEFIT COVERAGES

It is a virtual certainty under the new law that many people who purchase one of the limited PIP benefit coverage options will sustain severe injury in a motor vehicle accident resulting in medical and rehabilitation expenses that exceed their chosen coverage. The question then becomes, what happens to those unfortunate victims? An equally important and related question is: what happens to the at-fault driver who causes those victims to incur these excess medical expenses? Unfortunately, the answer to both of these questions under the 2019 legislation will be brutally harsh.

1. CONSEQUENCES FOR THE VICTIM.

The victim who incurs medical and rehabilitation expenses in excess of the victim's PIP coverage has the following options: (1) sue the at-fault driver (if there is one) for the excess medical expenses, which option will, for all practical purposes, depend upon the amount of the at-fault driver's liability insurance; (2) pay the excess medical expenses out of the victim's personal financial assets; (3) go bankrupt; and/or (4) attempt to qualify for medical coverage through some kind of government program such as Medicaid.

2. CONSEQUENCES FOR THE AT-FAULT DRIVER.

At-fault drivers who cause victims to incur medical expenses in excess of the victim's no-fault PIP coverage will be personally financially liable for all of those excess medical expenses. This liability did not exist under the original no-fault law because all victims had full coverage for their medical expenses. Under the 2019 legislation, the only way drivers can protect against this new tort liability is by purchasing as much liability insurance coverage as they can afford.

SECTION 4: WHAT INSURANCE COMPANY PAYS PIP BENEFITS?

A. PRIORITY DUTY TO PAY PIP BENEFITS

One of the most important issues to address when processing a claim for PIP benefits is to determine what no-fault insurer is legally responsible for paying PIP benefits. In that regard, the Michigan No-Fault Act contains a *"priority of payment"* system that determines which no-fault insurer has primary liability for payment of PIP benefits. This priority system is set forth in §3114 and §3115 of the No-Fault Act. The major highlights of those sections are discussed below.

B. THE GENERAL RULE OF PRIORITY

The general priority rule contained in these statutory sections is that an injured person receives PIP benefits from his or her own no-fault insurer, or from a no-fault insurance policy issued to the injured person's spouse or a relative of either domiciled in the same household. This general rule applies regardless of whether the injured person was driving or occupying his or her own motor vehicle, is a passenger in another vehicle, is a pedestrian, or is a bicyclist.

C. EXCEPTIONS TO THE GENERAL PRIORITY RULE

There are a few exceptions to the general priority rule referenced above. For example, if the injured person was occupying a vehicle furnished by his or her employer, then the employer's no-fault insurer must pay PIP benefits. Likewise, if the injured person was operating a motorcycle and is injured in an accident involving a motor vehicle, the motorcyclist must turn to the insurer of the owner, registrant, or operator of the motor vehicle involved in the accident, as was more fully discussed in connection with Section 2.

D. INJURED PERSONS WHO DO NOT HAVE AUTO NO-FAULT INSURANCE

Before the 2019 legislative changes, for injured persons who did not have a personal no-fault insurance policy or were not domiciled with a relative who had a no-fault insurance policy, the insurance company responsible to pay benefits was determined based upon whether the injured person was *an occupant or non-occupant of a motor vehicle* at the time of the accident. If such a non-covered person sustained injury while *an occupant* of a motor vehicle, then the injured person obtained no-fault PIP benefits from the owner or operator of the vehicle occupied. However, if such a non-covered individual sustained injury while a *non-occupant* of a motor vehicle (i.e., a pedestrian or bicyclist), then the injured person would obtain PIP benefits from the "*vehicle involved"* in the accident. However, under the 2019 legislation, these non-covered injured persons will now draw their benefits directly from the *Michigan*

Assigned Claims Plan (ACP), unless they are excluded from receiving benefits from that Plan because of the application of the opt-out rules that were more fully discussed in connection with Section 3.

E. THE ASSIGNED CLAIMS PLAN (ACP)

If no-fault coverage is not available through any of the previously mentioned payment sources, and if the injured person is not statutorily disqualified from receiving benefits, then the injured person may be entitled to claim PIP benefits through the Michigan Assigned Claims Plan (ACP). When a claim is submitted to the ACP, it is randomly assigned to one of several automobile insurance companies who participate with the Plan. As of the date of this publication, the address, telephone number, and website of the ACP is as follows:

Michigan Assigned Claims Plan
P. O. Box 532318
Livonia, MI 48153
(734) 464-8111 (phone)
(734) 744-8552 (fax)

There are important legal issues pertaining to the operation of the ACP, particularly under the 2019 legislation, that are discussed briefly below:

1. **ALTERED PRIORITY RULES -** The 2019 legislation has resulted in the alteration of certain priority rules applicable to the Act from those that existed under previous law. In this regard, the following should be noted:

(a) *Vehicle occupants* not otherwise insured with PIP coverage and who are not Medicare opt-outers or $250K excluders will draw benefits from the ACP, not from the vehicles occupied. [§3114(4)].

(b) *Pedestrians or bicyclists* not otherwise insured with PIP coverage draw benefits from the ACP, not from the involved vehicle. This appears to be true even if the pedestrian or bicyclist is a Medicare opt-outer or a $250K excluder. [§3115(1)].

(c) *Motorcyclists* can claim PIP benefits through the ACP when any of the vehicles in the listed order of priorities had no insurance or where the applicable insurance policy was a Medicare opt-out or a $250K exclusionary policy. As previously explained, a motorcyclist may be able to draw benefits from the ACP even when the motorcyclist was a Medicare opt-outer or a $250K excluder. [§3114(6)].

2. **THE ASSIGNED CLAIMS PLAN BENEFIT CAP -** Under the 2019 legislation, there is a $250,000 cap that applies to all persons claiming PIP benefits through the ACP. It would appear that this cap applies only to allowable expenses payable under §3107(1)(a), and not claims for wage loss benefits payable under §3107(1)(b), or replacement service expenses payable under §3107(1)(c). The only exception to the $250,000 cap is if the injured person claims benefits through the ACP when, pursuant to §3107d or §3109(a)(2), that person is injured during the 30-day window when the injured person experienced a lapse in qualified health insurance or other health and accident coverage. In that limited situation, the ACP cap amount is $2,000,000. [§3172(7)(b)].

3. **EXCLUDED CLAIMANTS—MEDICARE OPT-OUTERS OCCUPYING MOTOR VEHICLES—** Those persons who are described as Medicare opt-outers, and who are injured while occupying a motor vehicle, are not entitled to claim PIP benefits through the ACP. [§3114(4)]. The only exception is if these persons are injured during the previously mentioned 30-day health coverage lapse window, in which case the ACP will pay benefits up to $2,000,000. [§3172(7)(b)].

4. **$250K EXCLUDERS OCCUPYING MOTOR VEHICLES—** Those persons who were previously described as $250K excluders and who are injured while occupying a motor vehicle are not entitled to claim PIP benefits through the ACP. [§3114(4)]. The only exception is if these persons are injured during the previously mentioned 30-day health coverage lapse window, in which case the ACP will pay PIP benefits up to $2,000,000. [§3172(7)(b)].

5. **NON-OCCUPANT OPT-OUTERS AND EXCLUDERS—** What happens to Medicare opt-outers and $250k excluders who are injured as non-occupants of a motor vehicle? These persons will likely be entitled to claim PIP benefits through the ACP up to the $250,000 cap because the exclusionary language contained in the occupant priority provisions, §3114(4), is not contained in the non-occupant priority provisions of §3115(1).

6. **NEW ACP CLAIM PROCEDURES—** The ACP claim making process will become much more complicated under this legislation in several ways, including, but not limited to, the following:

(a) Claims must be made on a special form provided by the ACP. [§3172(3)].

(b) The claimant must provide *"reasonable proof of loss."* The ACP must specify in writing the materials that constitute reasonable proof of loss within 60 days after receipt of an application. There is no limitation on how the ACP can define this requirement. [§3172(3)].

(c) Benefits may be suspended if a claimant "*fails to cooperate*" with the ACP in one or more of the ways specified in the legislation, including failing to submit to an examination under oath. [§3173a(1)].

(d) A person making a claim through the ACP must do so within 1 year from the date of accident. [§3174].

7. **DATE OF EFFECT –** The new rules for ACP claimants are effective immediately for any accident occurring after June 11, 2019, except as to those claimants whose ACP eligibility will be affected by the new PIP choice policies that will be sold beginning July 1, 2020.

F. PRIORITY WHEN OTHER BENEFIT PAYMENT SOURCES ARE INVOLVED

Sometimes an injured person is entitled to various types of medical expense coverage and insurance benefits under other health and accident insurance or under various governmental benefit programs. In those situations, the question of who pays the benefit is dependent upon the provisions in the No-Fault Act regarding coordinated health and accident coverage and governmental benefit setoffs. This subject will be addressed in the discussion regarding Section 5.

SECTION 5: WHAT HAPPENS IF GOVERNMENTAL OR PRIVATE INSURANCE BENEFITS ARE ALSO PAYABLE?

Frequently, persons injured in automobile accidents not only have no-fault PIP benefits, they also have health insurance and, sometimes, eligibility for benefits under some governmental program. These situations create questions that are addressed by the governmental benefits setoff and coordination of coverage provisions set forth in §3109(1) and §3109a of the Act. The highlights of these issues are discussed briefly below.

A. GOVERNMENTAL BENEFITS SETOFFS

1. **THE BASIC CONCEPT—** Under the Michigan No-Fault Act, a no-fault insurer is permitted to reduce PIP benefits by any governmental benefits paid or payable to the injured person. This governmental benefit setoff provision is set forth in §3109(1) of the statute, which states: ***"Benefits provided or required to be provided under the laws of any state or federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury."*** The question of what kind of governmental benefit can be set off against PIP benefits and what cannot is often a complicated issue. In interpreting the language of §3109(1), the Michigan Supreme Court has held that *"benefits"* are *"provided or required to be provided"* if the benefits pass this two-part test: first, the governmental benefit must be payable as a result of the auto accident; and second, it must serve the same purpose as the no-fault benefit.[31] Some governmental benefits have *"flunked"* this two-part test and, therefore, cannot be set off against no-fault benefits. For example, the $225 *"death benefit"* payable under the U.S. Social Security Act cannot be offset against the no-fault funeral and burial expense benefit, because the death benefit was payable as a result of the person's death and not payable to cover actual costs incurred for funeral and burial expenses as required under §3107(1)(a).[32] It should be noted that in situations where a claimant is receiving survivors' loss benefits that include replacement services and is also receiving government benefits that are subject to setoff, the calculation of the setoff can be complicated under Michigan appellate case law. [33]

2. **TYPES OF GOVERNMENTAL BENEFITS RESULTING IN SETOFFS—** The courts have issued many decisions regarding the governmental benefit setoff provision of the Act and have held that, depending upon the facts of the case, the following kinds of governmental benefits can be deducted from PIP benefits: ***(1) Social Security disability benefits; (2) Social Security survivors' benefits; (3) workers' compensation benefits; and (4) certain kinds of veteran or military benefits.***

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[31] *Jarosz v DAIIE,* 418 Mich 565 (1984).
[32] *Gier v Auto-Owners Ins Co* 244 Mich App 336 (2001).
[33] *Wood v Auto-Owners Ins Co*, 469 Mich 401 (2003).

3. **MEDICARE RECIPIENTS—** Unlike other types of governmental benefits, Medicare benefits are not payable for any expense that is compensable under an automobile no-fault insurance system. Therefore, a no-fault insurer cannot take the position that an auto accident victim must first turn to Medicare for payment of auto-related medical expenses because federal law prohibits Medicare from paying benefits to persons insured under a no-fault system. ***Therefore, an accident victim should never knowingly submit, nor permit a treating medical provider to submit, any medical expenses to Medicare for payment if the expenses are otherwise covered under the Michigan No-Fault Act***. If Medicare mistakenly pays medical expenses that should have been paid by a no-fault insurer, the Medicare program has the legal right to seek reimbursement from a variety of sources, including the responsible no-fault insurer, the medical provider receiving the Medicare payment, and, under certain circumstances, even the patient. This is an area that requires great caution for both patients and providers. That being said, those Medicare patients who have opted out of no-fault coverage are permitted to submit their auto-related medical expenses to Medicare. However, Medicare will not cover many of the services and expenses that no-fault insurance would have paid. In addition, Medicare may demand reimbursement if the patient subsequently obtains a bodily injury liability settlement.

4. **MEDICAID—** As with Medicare, persons insured by Medicaid cannot submit auto accident-related expenses to Medicaid for payment if they are covered by auto no-fault insurance. Medicaid only pays the medical expenses of those individuals who are "*medically indigent.*" A person who is entitled to recover reimbursement for medical expenses under the No-Fault Act is not medically indigent and, therefore, not eligible for Medicaid benefits for that particular expense. Accordingly, the no-fault insurer must pay the full amount of all medical expenses even though the accident victim might otherwise be entitled to Medicaid. As with Medicare recipients, persons insured by Medicaid should not submit, nor allow treating medical providers to submit, auto-related medical expenses to Medicaid for payment. If the Medicaid program mistakenly pays medical expenses that should have been paid by the no-fault insurer, Medicaid has powerful reimbursement rights similar to the Medicare program referenced above. However, those persons who have purchased less than uncapped PIP benefits, as allowed under the 2019 legislative amendments, who then incur medical expenses exceeding their PIP coverages and who are otherwise qualified for Medicaid, may turn to the Medicaid program for payment of auto-related medical expenses.

B. COORDINATION OF NO-FAULT WITH OTHER HEALTH AND ACCIDENT COVERAGE

1. **THE BASIC CONCEPT—**The No-Fault Act allows a person to purchase either an ***"uncoordinated benefits"*** or a ***"coordinated benefits"*** no-fault insurance policy. If the insured purchases an *uncoordinated* benefits no-fault insurance policy, the no-fault insurer is obligated to pay no-fault benefits even though similar benefits may be payable to the injured person under another health insurance policy. On the contrary, if the insured person has purchased a *coordinated* benefits no-fault insurance policy, the no-fault insurer is obligated to pay only those expenses and benefits that are not paid by other applicable health or accident insurance coverage. In other words, a no-fault benefits policy that is coordinated is *secondary* to traditional health insurance plans such as Blue Cross/Blue Shield, health coverage through health maintenance organizations (HMOs), and health coverage through preferred provider organizations (PPOs). In light of the fact that the premium charged for a coordinated benefits policy is less than the premium for an uncoordinated policy, the majority of Michigan auto insurance consumers have purchased (either knowingly or unknowingly) coordinated no-fault coverages. The statutory section that permits coordinated no-fault policies is §3109a, which states that a coordinated no-fault policy is coordinated only with respect to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household. Therefore, unless the injured person falls into one of those three categories, no-fault benefits payable under such a coordinated policy cannot be coordinated with other health coverages. Auto insurance companies are not required to sell coordinated auto no-fault policies. However, if they do sell such a policy, the premium must be, to some extent, less than the premium charged for non-coordinated no-fault coverage.

2. **CONFLICTING COORDINATION CLAUSES—**Sometimes a person will purchase coordinated no-fault coverage and then discover that their health insurance policy also has a coordination of benefits provision. In that situation, the two coordination provisions may be in conflict, wherein each insurer is attempting to elevate the other insurer into the primary pay position and place itself into the secondary pay position. The Michigan Supreme Court has addressed this situation and has held that if the auto no-fault policy has a coordination of benefits clause that elevates health insurance into the primary pay position, and the health insurance policy has a coordination clause that attempts to elevate the no-fault insurer into the primary pay position, the auto no-fault policy *"wins"* and is only required to pay medical expenses that have been incurred and not paid by health insurance.[34]

[34] *Federal Kemper Ins Co v Health Ins Admin*, 424 Mich 537 (1986).

3. ERISA HEALTH PLAN COMPLICATIONS—Many individuals are insured through their employment under an employer self-funded health plan established pursuant to a federal law known as the Employee Retirement Insurance Security Act (ERISA). ERISA plans are different than traditional health insurance coverage such as Blue Cross Blue Shield. If the injured person is insured under an ERISA plan, there can be confusion over whether the auto or health insurer is primarily responsible to pay medical bills. That is, if the ERISA plan contains a coordination of benefits clause making it secondary to auto no-fault coverages, the courts have enforced such provisions even where the no-fault plan also has a coordinated benefits provision. In other words, where a no-fault policy is coordinated and an ERISA plan is coordinated, unlike the situation with ordinary health insurance, the auto no-fault plan will be primary and the ERISA plan will be secondary.[35] The result may be different, however, if there is some ambiguity in the language of the ERISA plan.[36] Such confusion can be avoided by purchasing an uncoordinated auto insurance policy.

In addition, because of the complex interplay between federal and state law, ERISA health plans have special *"lien"* rights that other health insurers do not have. Specifically, in some situations, an ERISA health plan may be able to assert a lien against the patient's bodily injury tort liability claim. Again, this potential problem can be avoided by purchasing an uncoordinated auto insurance policy.

4. MANAGED CARE HEALTH PLAN COMPLICATIONS—Consumers who are insured under a coordinated no-fault policy and who also are members of HMOs are confronted with special rules if they seek treatment outside of the HMO program. The Michigan Supreme Court has held that if the service or treatment is available within the HMO and the patient seeks the service or treatment outside of the HMO without following proper procedures to obtain HMO approval, the no-fault insurer is not obligated to pay for any of the cost of the service or treatment obtained outside of the HMO.[37] This rule, however, should only apply where the specific medical service is available within the HMO program. Where it is not, the no-fault insurer should not be released from its obligation to pay for treatment, if the treatment is otherwise "*reasonably necessary*" under §3107(1)(a). For example, if chiropractic treatment was deemed "*reasonably necessary*" under §3107(1)(a) and chiropractic services were not available through a patient's HMO, the patient's no-fault insurer would be obligated to pay for that chiropractic treatment.[38]

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[35] *Auto-Club Ins Ass'n v Frederick & Herrud,* 443 Mich 358 (1993).
[36] *Auto-Owners Ins Co v Thorn Apple Valley*, 31 F3d 371 (6th Cir 1994).
[37] *Tousignant v Allstate Ins Co*, 444 Mich 301 (1993).
[38] *Sprague v Farmers Ins Exch*, 251 Mich App 260 (2002).

Although earlier court decisions dealt with patients who had health coverage through HMO plans, some no-fault insurers have attempted to extend the concepts in those cases to patients who have health insurance coverage with *preferred provider plans* (PPOs). In other words, if a patient has health insurance that will pay the full cost of a particular service if rendered by a *participating provider*, a coordinated no-fault insurer may attempt to deny payment of all or some of the medical expenses that the patient incurs by treating with a *non-participating provider*. As of the present date, no appellate court has specifically approved this approach. Nevertheless, great caution should be used in these situations.

5. UNCOORDINATED PIP POLICIES - Although not as common as coordinated policies, many Michigan citizens have purchased uncoordinated no-fault coverage. They have done so either because they do not have health insurance available to them, or because they want to avoid some of the complexities and pitfalls associated with coordinated coverages. As previously stated, an uncoordinated no-fault policy pays benefits without regard to whether there are other private insurance coverages. An uncoordinated policy makes life a great deal simpler for auto accident victims. That is because victims drawing benefits from uncoordinated policies do not have to deal with both health and PIP insurers at the same time. In addition, in most cases, victims who draw benefits from uncoordinated policies do not have to worry about a PIP insurer placing a lien against their tort liability claim.

Finally, uncoordinated policies create the possibility that, in certain limited circumstances, an injured person may have the legal right to "*double-dip*" and have medical expenses payable under the PIP policy as well as the health insurance policy. In recent years, the appellate courts have considerably narrowed when a *double-dip* situation can, if ever, occur. However, if a PIP policy and a health insurance policy are both truly uncoordinated and have no language whatsoever prohibiting duplication of benefits, an injured person theoretically remains entitled to a double recovery on the basis that a higher premium was paid to obtain two uncoordinated coverages.[39] However, in a recent case,[40] the Supreme Court set forth very significant limitations on the right to double-dip in the case of a motorcyclist who was injured when he was struck by an automobile. In that situation, due to the language of the health insurance policy and the fact that the injured person was drawing benefits under a policy purchased by someone else, there was no right to double-dip.

[39] *Haefele v Meijer, Inc*, 165 Mich App 485 (1987).
[40] *Harris v ACIA and Blue Cross/Blue Shield*, 494 Mich 462 (2013).

SECTION 6: WHAT SHOULD PATIENTS AND PROVIDERS KNOW ABOUT PROCESSING PIP CLAIMS?

The No-Fault Act contains some very strictly enforced rules and time limitations for processing PIP claims. In addition, there are important rules applicable to medical examinations requested by no-fault insurers. It is critically important that patients and medical providers understand these rules so that vitally important insurance benefits are not lost. Some of these important rules and limitations will be discussed briefly below.

A. TIME LIMITS

1. **THE ONE-YEAR NOTICE RULE**—Section 3145 of the No-Fault Act requires that a plaintiff provide written notice to the appropriate insurance company within one year of the date of the accident. This notice must include the name and address of the claimant/injured person, as well as the time, place, and nature of the injury. Failure to provide this notice within the one-year period will result in the complete forfeiture of the claim, unless some legally recognized exception applies.

2. **THE ONE-YEAR-BACK RULE**—Assuming that written notice has been given to the proper insurance company within one year of the date of the accident, a claimant must be prepared to take legal action if a particular expense is not paid by the insurance company within one year of the date the expense is incurred. If legal action is commenced, the claimant may not recover benefits for any portion of the expense incurred more than one year before the legal action was commenced, unless some legally recognized exception applies.

3. **TOLLING OF THE ONE-YEAR-BACK RULE**—Before the 2019 legislative changes, submitting a bill to a no-fault insurer within one year of the date the bill was incurred was not sufficient to toll (suspend) the running of the one-year-back rule. However, the 2019 legislation adopts a new tolling rule which, if properly implemented, will result in the one-year-back rule being "*tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim.*" However, the new legislation goes on to say that this rolling rule does not apply if the person claiming the benefits "*fails to pursue the claim with reasonable diligence.*" [§3145(3)]. This new tolling rule took effect on June 11, 2019.

4. **MINORS AND MENTALLY INCOMPETENT PERSONS**—The Michigan Supreme Court has ruled, in two cases, that the one-year-back rule applies to claims brought by minors or mentally incompetent people.[41] However, our appellate courts have declared that *the one-year notice rule* is not applicable to

[41] *Cameron v ACIA*, 476 Mich 55 (2006) and *Joseph v Allstate Ins Co*, 491 Mich 200 (2012).

the claims of minors or incompetent persons under the tolling provisions of the Michigan Revised Judicature Act (RJA). Therefore, the failure of a minor or a mentally incompetent person to serve written notice of the accident within one year of its occurrence will not result in forfeiture of the claim.

B. THE REASONABLE PROOF RULE

Under §3142(2) of the No-Fault Act, a no-fault insurer is not obligated to pay any benefits until the insurer "*receives reasonable proof of the fact and of the amount of loss sustained.*" If an insurer does not pay benefits within 30 days after receiving such reasonable proof, then payment of the benefit is deemed "*overdue.*" Unfortunately, the statute does not define the concept of "*reasonable proof.*" In one decision, the Michigan Court of Appeals held that a claimant is not required to document "*the exact amount of money that is [owed]. The statute requires only reasonable proof of the amount of loss, not exact proof.*"[42] Ordinarily, no-fault insurers require that the claimant submit several types of claim forms before payment on a claim is made. Typically, these three forms are: (1) an application for no-fault benefits; (2) an attending physician's report form; and (3) an employer's wage loss verification form. It is advisable for the claimant to provide these forms to the no-fault insurer so that the claimant cannot later be accused of failing to provide "*reasonable proof.*"

C. INDEPENDENT MEDICAL EXAMINATIONS

Section 3151 of the No-Fault Act provides that when the mental or physical condition of a person is at issue, a no-fault insurer can request to have the claimant undergo a "*mental or physical examination by physicians.*" These exams are sometimes referred to as "*independent medical examinations*" (IME). Section 3151 does not give the insurer the right to send claimants to other types of practitioners, such as psychologists or neuropsychologists.

The 2019 legislation adopts new limitations on the right of insurance companies to conduct an independent medical examination. The new legislation requires that medical evaluations performed at the request of insurance companies be performed by physicians with specializations similar to those of the injured person's treating physician. Specifically, the new statute states, "*If care is being provided to the person to be examined by a specialist, the examining physician must specialize in the same specialty as the physician providing the care, and if the physician providing the care is board certified in the specialty, the examining physician must be board certified in that specialty.*" [§3151(2)(a)]. The new legislation also provides that in all cases, an examining physician, during the year prior to the medical evaluation, must have devoted a majority of his or her time to the active clinical practice of medicine or to teaching in a medical school, or in an accredited residency or clinical research program for physicians. [§3151(2)(b)]. These new general qualification and specialization rules took effect on June 11, 2019.

[42] *Williams v AAA Michigan*, 250 Mich App 249 (2002).

Section 3152 of the No-Fault Act also states that a claimant who undergoes an independent medical examination may request a copy of the report. Section 3153 of the Act provides that if a claimant refuses to submit to an independent medical examination, a court can issue orders that are appropriate under the circumstances, including prohibiting the claimant from introducing any evidence of his or her mental or physical condition. Therefore, claimants should never ignore a request from their insurer to appear for an independent medical examination, as an unjustified failure to appear could jeopardize the claim.

D. PENALTIES FOR NON-PAYMENT OF PIP CLAIMS

The No-Fault Act contains specific penalties that can be assessed against no-fault insurers who do not honor their legal obligations to pay claims as required by the law. These basic penalties are: (1) penalty interest; and (2) penalty attorney fees. The statute does not make reference to any other penalties that can be imposed on a PIP insurer that does not honor its obligation to pay benefit. These two statutory penalties are summarized below.

1. **PENALTY INTEREST**—Section 3142 of the No-Fault Act states that when an insurance company does not pay PIP benefits within 30 days after receiving reasonable proof of the fact and the amount of the loss sustained, the insurer must pay simple interest at the rate of 12% per annum on the overdue expense. Moreover, the statute provides that "*if reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within thirty days after the proof is received by the insurer.*" Therefore, an insurance company cannot legally withhold payment on the entire claim if only a portion is in dispute. If this happens, the portion that is not in dispute is overdue and the 12% interest penalty is collectible.[43] Moreover, the courts have held that if an injured person is required to file a lawsuit against the insurance company to collect benefits and if the lawsuit results in an actual judgment in favor of the injured person, then the injured person is also entitled to recover "*civil judgment interest*" under the provisions of the Revised Judicature Act and the Michigan Court Rules.

   The 2019 legislation redefines when a benefit is deemed to be overdue. In this regard, the legislation states that if a bill is not provided to an insurer within 90 days after a product, service, accommodation or training was provided, the insurer has 60 additional days on top of the basic 30 days to issue payment before the payment is deemed to be "*overdue.*" [§3142(3)].
2. **PENALTY ATTORNEY FEES**—Section 3148 of the No-Fault Act states that an injured person is entitled to collect reasonable attorney fees against an insurance company if the PIP benefits are "*overdue*" and "*if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.*" This requires a showing of two elements. First, it must be

[43] *Farquharson v Travelers Ins Co,* 121 Mich App 766 (1982) and *McKelvie v ACIA*, 203 Mich App 331 (1994).

shown that the claim is "*overdue*" because an insurance company did not make payment within 30 days after receiving reasonable proof. Second, the court must find that the delay or denial was "*unreasonable.*" This latter point is significant because it requires a judicial finding of unreasonableness. As a practical matter, such a judicial finding cannot occur until there has been a trial or other motion that sets forth evidence of the insurance company's conduct. Nevertheless, if an injured person can meet the required showing, Michigan courts have held that an award of attorney fees under §3148 may be based upon an hourly rate or, where otherwise appropriate, on the basis of a contingency fee.[44] A claimant's ability to claim attorney fees turns about the unique facts and circumstances of each case.

The 2019 legislation adds some important rules to the attorney fee provisions contained in §3148 of the Act. These are summarized below:

(a) **Attorney Fee Liens on PIP Benefits—**The legislation states that an attorney advising or representing an injured person concerning a claim for payment of personal protection insurance benefits from an insurer "*shall not claim, file, or serve a lien for payment of a fee or fees until both of the following apply: (a) a payment for the claim is authorized under this chapter; and (b) a payment for the claim is overdue under this chapter.*" [§3148(1)(a)-(b)].

(b) **Attorney Fee Sanctions for Solicited Clients—**The legislation provides that a court may award an insurer "*a reasonable amount against a claimant's attorney as an attorney fee 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.*" [§3148(2)].

(c) **Limitations on Court-Ordered Attorney Fees—**A court cannot order payment of attorney fees "*in relation to future payment*" of attendant care or nursing services "*ordered more than 3 years after the trial court judgment or order is entered.*" [§3148(4)]. A court cannot order payment of attorney fees when the attorney or a related person of the attorney has or had, "*a direct or indirect financial interest in the person that provided the treatment, product, service, rehabilitative occupation training, or accommodation.*" The legislation defines a direct or indirect financial interest as including, but not limited to, "*the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation making a direct or indirect payment or granting a financial incentive to the attorney or a related person of the attorney relating to the treatment, product, service, rehabilitative occupational training, or*

[44] *Butler v DAIIE,* 121 Mich App 727 (1982); *In Re Estate of L'Esperance,* 131 Mich App 496 (1984); and *Univ Rehab Alliance v Farm Bureau Gen Ins Co,* 279 Mich App 691 (2008).

accommodation within 24 months before or after the treatment, product, service, rehabilitative occupational training, or accommodation is provided." [§3145(5)].

E. MEDICAL PROVIDER DIRECT LEGAL ACTIONS

1. **THE *COVENANT* DECISION—**Prior to the 2019 legislative changes, the Michigan Supreme Court had issued its Opinion in the case of *Covenant v State Farm*.[45] In that case, the Court held that under the text of the original no-fault law, a medical provider did not have a direct legal cause of action against a no-fault insurer to collect for unpaid medical services rendered to auto accident victims. However, providers were permitted to accept *"Assignment of Benefits"* from their patients to allow them to take legal action against insurance companies who did not pay patient bills.

2. **QUALIFIED REVERSAL OF *COVENANT*—**The 2019 legislation conditionally restores a medical provider's independent cause of action against a no-fault insurer for non-payment of expenses. In this regard, the legislation amended §3112 of the Act to state that a *"health care 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 section 3171 or 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person."* [§3112]. A provider's independent cause of action does not accrue until after a benefit is *"overdue."* The legislation revises the definition of when a benefit is overdue, as discussed above. Therefore, if providers wish to enforce their restored direct legal cause of action against insurance companies, providers must make sure that the unpaid charge is truly *"overdue"* so that the medical provider has proper standing to file a legal action.

[45] *Covenant Med Ctr, Inc. v State Farm Mut Auto Ins Co*, 500 Mich 191 (2017).

SECTION 7: WHAT LIABILITY CLAIMS CAN BE MADE AGAINST AT-FAULT DRIVERS?

Under the Michigan no-fault law, an accident victim has a right to pursue ***a tort liability claim*** against the at-fault driver to recover those damages that are not compensable with no-fault PIP benefits. There are two types of tort liability claims that can be pursued against at-fault drivers: claims for *"noneconomic loss damages"* and claims for *"excess economic loss damages."* Those claims will be briefly discussed below.

A. TORT CLAIMS FOR NONECONOMIC LOSS DAMAGES

Under the no-fault law, noneconomic loss damages consist of those losses that affect a person's ***quality of life***, such as pain and suffering, disability, incapacity, loss of function, diminished social pleasure and enjoyment, mental anguish, emotional distress, scarring, disfigurement, etc. Under the law, an accident victim is legally entitled to recover compensation for these noneconomic loss damages, only if the victim sustained a ***"threshold injury."*** Under the no-fault law, a threshold injury consists of one or more of the following: ***serious impairment of body function; permanent serious disfigurement; or death.*** The legal requirements for such threshold claims are discussed briefly below.

1. **SERIOUS IMPAIRMENT OF BODY FUNCTION DEFINITION—** Under the prior no-fault law, serious impairment of body function required proof of *an objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life.* [§3135(5)]. The 2019 legislation revised §3135 to restate the essence of this definition but in a more detailed manner by specifying what is required to prove serious impairment of body function. In that regard, the new legislation provides the following:

(a) The impairment must be objectively manifested, meaning that it is *"observable or perceivable from actual symptoms or conditions by someone other than the injured person."* [§3135(5)(a)].

(b) The impairment must be of an important body function, meaning that it is *"a body function of great value, significance, or consequence to the injured person."* [§3135(5)(b)].

(c) The impairment must affect the injured person's general ability to lead his or her normal life, meaning that the impairment must have *"had an influence on some of the person's capacity to live in his or her normal manner of living."* Moreover, this element is deemed to be fact specific and *"although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last."* [§3135(5)(c)].

2. PERMANENT SERIOUS DISFIGUREMENT— The No-Fault Act does not define the threshold element of *"permanent serious disfigurement."* Some appellate cases have interpreted that element to require some type of disfigurement that is readily noticeable by a casual observer. However, every scarring and disfigurement case is different and must be analyzed on a case-by-case basis.

B. CLAIMS FOR EXCESS ECONOMIC LOSS

The Michigan no-fault law, both before and after the 2019 legislation, provides that, in certain circumstances, an injured person can recover, in a tort liability claim against the at-fault driver, past, present, and future financial expenses that are not compensable by no-fault PIP benefits. These excess economic loss damage claims include medical expenses that exceed the amount of no-fault PIP allowable expense benefit coverage applicable to the injured person. Therefore, those patients who incur medical expenses in excess of their applicable PIP coverages can sue the at-fault driver for those economic losses. In this regard, the 2019 legislation states, *"damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies."* [§3135(3)(c)]. Accordingly, seriously injured persons who choose capped no-fault coverage, or who have opted-out of no-fault coverage, will be able to sue at-fault drivers to recover their uncovered medical expenses and work loss.

The 2019 legislation also makes it clear that principles of *pure comparative negligence* will apply to the payment of excess medical expenses. This means that a defendant's percentage of fault will be the only portion that the defendant's insurer will be required to pay for the plaintiff's excess medical expenses. [§3135(2)(b)]. This comparative negligence allocation will often require pursuing a tort claim to resolve.

In addition to medical expenses that exceed applicable PIP caps, excess economic loss tort claims under the 2019 legislation include the following types of claims:

1. MEDICAL EXPENSE CLAIMS OF OUT-OF-STATE RESIDENTS— The medical expenses of an out-of-state resident may be recovered in tort against the negligent driver without limitation. However, these expenses are only recoverable if the out-of-state person sustains ***a threshold injury*** (i.e., death, serious impairment of body function or permanent serious disfigurement), as set forth under §3135. [§3135(3)(d)]. Furthermore, all economic loss and noneconomic loss damage claims of out-of-state residents are subject to the 51% comparative negligence rule, which means that no damages are recoverable by an out-of-state plaintiff who is found to be more than 50% at fault for the accident. [§3135(2)(b)].

2. **EXCESS ECONOMIC LOSS CLAIMS BY ACP CLAIMANTS—**There is a question as to whether ACP claimants who are subject to the $250,000 and $2,000,000 caps can maintain excess economic loss tort claims against at-fault drivers for uncovered medical expenses in excess of those caps. The excess tort claim provisions of §3135(3)(c), quoted above, refer only to tort claims for expenses in excess of those limited under §3107 to §3110. The cap on ACP claimants, however, is found in §3172(7). Nevertheless, that section of the legislation specifically references expenses payable under §3107c(1)(b). Therefore, this cross-reference can fairly be read to permit excess economic loss tort claims by ACP claimants.

3. **EXCESS ECONOMIC LOSS CLAIMS FOR AMOUNTS EXCEEDING FEE SCHEDULES—**As indicated earlier, there is a question as to whether a medical provider can pursue a patient for the provider's charges that exceed those payable under the 2019 legislative fee schedules. If the patient is liable to the provider for such excess amounts, can the patient then recover those excess amounts in a tort claim against the at-fault driver? The answer is not clear from the text of the 2019 legislation. As indicated above, the excess economic loss tort claim created by §3135(3)(c) references only expenses in excess of those limited under §3107 to §3110. The new fee schedule limitations are found only in §3157. Therefore, this could present a situation where a patient may be financially liable for provider charges in excess of the new fee schedules but might not be able to recover those excess expenses from the at-fault driver.

C. WRONGFUL DEATH LIABILITY CLAIMS

If a person sustains wrongful death as a result of the negligence of a third party, the estate of the injured person is entitled to pursue a wrongful death liability claim against the party at fault for purposes of recovering noneconomic damages and certain economic-loss damages. Wrongful death liability claims are controlled by the ***Michigan Wrongful Death Act (MCL 600.2922)***. In addition, where the wrongful death arises out of a motor vehicle accident, then the provisions of the No-Fault Act will also control the claim. In this situation, it is imperative that the requirements and procedures of both statutes be strictly observed.

Under the Michigan Wrongful Death Act, close relatives of the decedent are entitled to be compensated for certain specific damages they may have suffered as a result of the decedent's death. These damages include: loss of financial support; loss of services; and most importantly, loss of the love, affection, companionship and society of the decedent. Those relatives entitled to be compensated for such losses include surviving spouses, children, parents, grandparents, brothers and sisters, and stepchildren of the decedent. However, in order to pursue a wrongful death claim, the statute requires that an estate be formally opened in the name of the decedent and that a Personal Representative be appointed for that estate by the probate court with jurisdiction over the matter. The

wrongful death claim is then pursued in the name of the decedent's estate, not in the individual names of the surviving relatives.

The designation of the Personal Representative is controlled by the Michigan probate law. Under the probate law, certain family members are given "*preference*" in terms of the appointment of a Personal Representative. In this regard, the parents of a deceased child have statutory preference to be appointed Personal Representative of the child's estate. Similarly, a surviving spouse has statutory preference to be appointed Personal Representative of the estate of his or her deceased spouse. Where the decedent is a non-married adult with children, the statutory preference regarding the appointment of a Personal Representative resides with the children, but it can only be enforced by an appropriate adult acting on the child's behalf after being formally appointed by the probate court. Therefore, the first order of business in pursuing a wrongful death claim is to identify the person or persons who should be appointed Personal Representative of the decedent's estate and file an appropriate petition in the probate court seeking to open an estate and designate a Personal Representative. Once this is done, the wrongful death claim can be officially pursued.

D. LIENS ON TORT LIABILITY CLAIMS

Every tort liability claim requires a careful analysis of whether there are any potential liens that could be asserted against any monetary recovery resulting from that claim. Typically, such liens are asserted by insurance companies or other payors who pay benefits to an injured person who purses additional compensation through a tort claim. If the lien is valid and substantial, it can have enormous implications for auto accident victims who pursue tort liability claims. There are several types of liens that can potentially apply to auto tort liability claims.

The first lien is the ***PIP lien*** that, in some circumstances, can be claimed by auto no-fault insurers who pay PIP benefits to the injured person. Such liens are very limited and controlled by §3116 of the No-Fault Act, and mainly arise in out-of-state accidents.

Another type of lien is a ***workers' compensation lien***, which can occur when a person suffers an auto accident injury in the course of his or her employment. These liens are controlled by the Michigan Workers' Compensation Act and important appellate case law.[46]

Another type of lien is a ***health insurance lien*** that can, in certain circumstances, be asserted by a health insurer or plan that pays medical expenses on behalf of an injured person. If the benefits were paid by a traditional health insurance policy, then the health insurer's lien rights are very limited and are typically treated the same as the liens of PIP insurers.[47] However, under the 2019 legislation, if the tort recovery results in medical expenses that

[46]*Great American Ins Co v Queen*, 410 Mich 73 (1980).
[47]*Great Lakes Am Life Ins Co v Citizens Ins Co*, 191 Mich App 589 (1991).

were paid by health insurance, then the health insurance company may very well have lien rights that can be asserted against such a tort recovery.

In addition, if medical expenses were paid by a self-funded ERISA health plan, then an ***ERISA lien*** may exist that can be very broad because such a lien is controlled by federal law, which gives ERISA plans more expansive rights than no-fault PIP insurers and traditional health insurance companies.

Finally, there may be ***Medicaid and Medicare Liens*** if those governmental programs paid benefits for auto accident injuries. These liens can be asserted on behalf of governmental bodies and are controlled by detailed state and federal law. Proper processing of the PIP benefit claim can often avoid altogether, or substantially reduce, these governmental liens.

A complete discussion regarding tort liens is beyond the scope of this publication. ***Suffice to say, however, that the issue of a potential lien must be carefully considered in all auto liability claims in order to protect the injured person's right to receive monetary compensation for their injuries.***

E. TIME LIMITS FOR TORT LIABILITY CLAIMS

The general rule under Michigan law is that tort liability claims are governed by a three-year statute of limitations that runs from the date of the injury.[48] This three-year limitation period applies to bodily injury as well as wrongful death claims. There are certain exceptions to this rule that apply to children or those who are mentally incompetent.[49] However, it is best to assume that the statute of limitations for tort liability claims is always three (3) years from the date of the accident, without regard to these possible exceptions. Moreover, it is generally the case that if the victim intends to pursue a tort liability claim, the process should begin immediately, so that valuable evidence is not lost or the claim is not otherwise weakened by the passage of time. Accordingly, accident victims who have potential tort liability claims should move quickly to protect their rights.

F. LIABILITY CLAIMS BETWEEN FAMILY MEMBERS AND THE *"STEP-DOWN"* PROBLEM

Some insurance companies sell auto insurance policies that contain very controversial provisions known as "*step-downs*." These provisions apply most often when one family member (e.g., spouse, child, parent, sibling, etc.) pursues a tort liability claim under that policy against another family member with whom they live. Step-down provisions can also apply when the policy holder or a member of his or her family is injured while riding in a family vehicle driven by a non-family member. Step-down provisions reduce the amount of liability insurance coverage available to the injured family member down to the

[48] MCL 600.5805 (10).
[49] MCL 600.5851 *et seq*.

state-mandated minimum regardless of how much liability insurance was purchased by the policy holder or the severity of the injury. In other words, these provisions treat the policy holder and his or family members more harshly than strangers injured in the same accident. Unfortunately, Michigan appellate courts have upheld an insurance company's enforcement of step-down provisions, even in catastrophic injury cases. Sadly, few people know that that they have a step-down provision in their policy until it is too late.

SECTION 8: WHAT LIABILITY CLAIMS CAN BE MADE AGAINST INSURERS?

Oftentimes, the injuries suffered by an auto accident victim are caused by a negligent party who either had no liability insurance or had inadequate liability insurance to fully compensate the injured person. In these situations, the uninsured or underinsured negligent driver is typically not collectible. However, if uninsured motorist coverage and/or underinsured motorist coverage has been purchased by the injured person or the owner of the vehicle occupied by the injured person, then the injured person will be able to pursue the liability claim against the insurance company that issued the uninsured/underinsured coverage. Basic principles regarding uninsured and underinsured motorist claims are summarized below.

A. UNINSURED MOTORIST BENEFITS

If an injured person's policy includes ***uninsured motorist coverage***, and if the injury was caused by an uninsured driver, the injured victim will be able to assert his/her liability claim directly against his/her own insurance company who will then *"stand in the shoes of the negligent driver."* The injured person will be able to recover noneconomic damages and excess economic damages up to the limits of his/her uninsured coverage in exactly the same manner they would have, had the negligent party been insured. If the injured person did not purchase uninsured motorist coverage but was a passenger in a vehicle that was covered by uninsured motorist coverage, the injured person may very well be covered under that policy.

There are certain strict rules that must be followed so that an uninsured motorist claim is not jeopardized, particularly in the case of hit-and-run accidents. Many insurance policies contain specific rules about what a victim must do in order to preserve a claim for uninsured motorist benefits when there is a hit-and-run. Moreover, the Michigan Supreme Court has strictly enforced these notice rules, even in extreme situations. For example, in 2012, the Michigan Supreme Court held that an insurer could deny uninsured motorist benefits to a seriously injured victim of a hit-and-run because the victim did not provide timely notice, despite the fact that the victim was incapacitated.[50] ***Therefore, extreme caution is necessary to protect these claims!***

[50]*DeFrain v State Farm Mut Auto Ins Co,* 491 Mich 359 (2012).

B. UNDERINSURED MOTORIST BENEFITS

If the injured person purchased ***underinsured motorist coverage*** and if the injury was the result of the negligence of someone who has inadequate liability limits to fully compensate the injured person, he/she can pursue that portion of the liability claim not covered by the at-fault driver's insurance through the injured person's own insurance company in much the same manner as one would pursue an uninsured motorist claim. If the injured person did not purchase underinsured motorist coverage but was a passenger in a vehicle that was covered by underinsured motorist coverage, the injured person may very well be covered under that policy.

As with uninsured motorist claims, there are certain strict rules that must be followed so that the underinsured motorist claim is not jeopardized. For example, underinsured motorist policies typically require that the injured person ***completely exhaust*** the negligent party's liability limits before pursuing the claim for underinsured motorist coverage. In addition, most policies require that the injured person obtain ***written consent*** from his/her insurance company before settling with the negligent party. There may be other very important conditions set forth in the policy that must be complied with in order to pursue such a claim, such as shorter notice-of-claim requirements. Failure to follow these policy conditions can result in the loss of underinsured motorist benefits. ***Once again, extreme caution is necessary to protect these claims!***

SECTION 9: WHAT SHOULD VICTIMS DO TO PROTECT THEIR RIGHTS?

Even though the Michigan No-Fault Act, as written, creates broad and expansive legal rights for seriously injured persons, those rights can be jeopardized if injured persons do not clearly understand the nature of their rights and the many things that should be done to protect them. Set forth below are some specific suggestions for protecting an injured person's claim for PIP benefits and the injured person's tort liability bodily injury claim.

A. PROTECTING THE PIP BENEFIT CLAIM

It is very important for an injured person to move quickly to establish their right to receive no-fault PIP benefits so that necessary medical treatment is not delayed or denied. Among other things, the PIP benefit claimant should do the following:

(1) ***ELIGIBILITY*** — Determine whether the injury occurred in such a manner as to create eligibility for no-fault PIP benefit coverage.

(2) ***PRIORITY*** — Determine the appropriate insurer that has priority responsibility for payment of the PIP claim.

(3) ***NOTICE*** — Submit appropriate written notice of the claim that fully complies with §3145 of the Michigan No-Fault Act. This is particularly important with regard to the description of injuries, which must be thorough and comprehensive.

(4) ***PHOTOGRAPHS*** — Take photographs of the patient's injuries and the vehicular damage sustained by all vehicles involved in the collision.

(5) ***CASE MANAGERS*** — In cases of serious injury, determine whether the accident victim would benefit from the services of an independent case manager. If so, the patient's primary physician should be asked to write a prescription for case management services, and the patient should be the one to decide who will serve as the Case Manager.

(6) ***TIME LIMITS*** — Be mindful of the time limitations applicable to enforcing claims for PIP benefits — particularly the one-year-notice rule and the one-year back rule.

(7) ***COORDINATION*** — If the no-fault policy is a coordinated policy, determine whether the patient's health insurance plan is applicable to auto injuries and, if so, any limitations with respect to coverage under that plan.

(8) ***PROOF*—**Submit all claims for no-fault benefits in writing, with proper documentation complying with the "*reasonable proof*" rule. Copies of all submitted correspondence should be retained to document the fact that it was submitted.

(9) ***LEGAL CONSULT*—**At the first sign of claim denial or claim dispute, consult with a professional who has specialized expertise in matters dealing with the Michigan No-Fault Law.

B. PROTECTING THE BODILY INJURY TORT LIABILITY CLAIM

When motor vehicle accidents result in serious injury or death as a result of the fault of another driver, the injured person or the person's estate should immediately determine whether a tort liability claim should be pursued. Many accident victims significantly weaken their liability claim by not moving quickly to protect it. This is unfortunate, because it is a virtual certainty that in serious injury cases, the insurance company for the party at fault will indeed be taking quick action to conduct a thorough investigation for purposes of building a defense to the claim. Therefore, the injured person should also move quickly and do certain things to protect the tort liability claim, which include the following:

(1) ***INVESTIGATION*—**The injured person should initiate a thorough investigation through an appropriate investigator or legal representative. Such an investigation should include interviewing witnesses, photographing the scene and the vehicles involved in the accident, taking measurements, collecting physical evidence, interviewing police officers, etc.

(2) ***PHOTOGRAPHS*—**The injured person should arrange for photographs to be taken that fully show the injuries suffered by the victim and various aspects of the victim's care and treatment. This is particularly true in cases involving visible injuries such as burns, wounds, surgical scarring, etc. Such photographs should be taken with excellent equipment, so as to ensure proper detail.

(3) ***NON-COMMUNICATION*—**(a) the injured person should avoid speaking with investigators or insurance adjusters representing the interest of the party at fault, as such discussions are frequently contrary to the best interests of the injured person; and (b) the injured person should refuse to sign any documents, releases, or other types of authorizations that have been requested by investigators or insurance adjusters representing the interest of the party at fault.

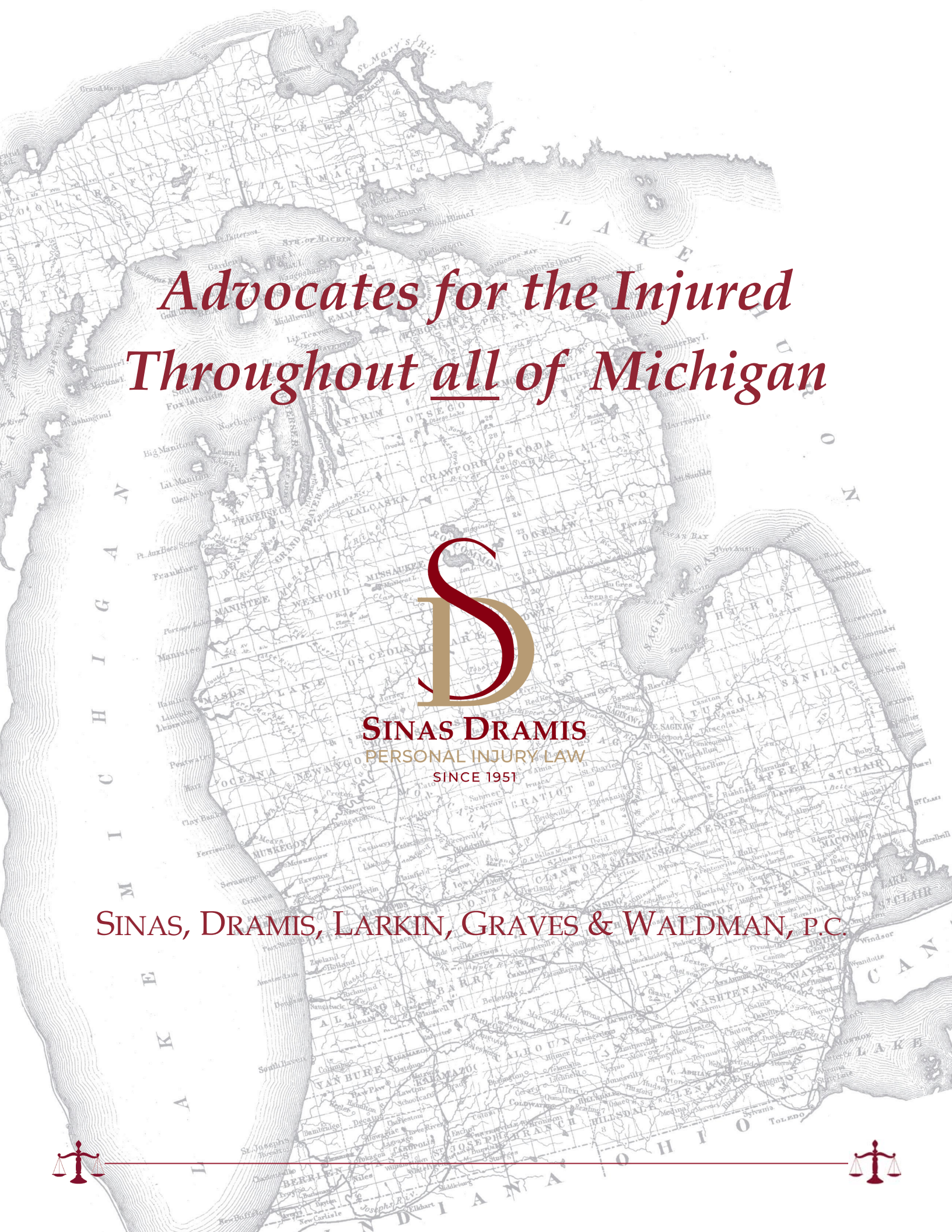
(4) ***NON-NEGOTIATION*—**The injured person should avoid conducting any premature settlement negotiations without proper legal advice. Many times the insurance company representing the party at fault will approach a

seriously injured victim and offer to make a settlement of the bodily injury tort claim in exchange for the victim signing a full release of liability. It is absolutely foolhardy to consider entering into such settlement negotiations with an insurance company unless all of the following facts have first been established: (a) the victim is reasonably certain that he or she has fully recovered from all accident-related injuries; (b) the victim has fully investigated the accident and knows the identity of any and all potential defendants and insurance companies who may have liability; (c) the release is only a release of the liability claim and not a release of any other rights the victim may have; (d) the victim has completely researched whether such a settlement will jeopardize other claims the victim may have against other parties or against the victim's own insurance company for additional benefits, such as uninsured or underinsured motorist benefits; and (e) the victim has obtained competent legal advice from a motor vehicle personal injury specialist regarding the wisdom of entering into such a settlement. Remember, once a release is signed, the victim cannot *"undo the deal."*

C. THE BIG POINT

As of July 2020, accidents resulting in serious injury will become much more complicated than they ever were under the original law. If a victim has purchased limited coverage that is not enough to pay for the victim's medical expenses, then the victim must seriously consider promptly pursuing a tort liability claim against the at-fault driver to recoup some of the excess loss. Such liability claims will typically involve an analysis of *"fault allocation,"* which means that the victim will only be able to recover that portion of the victim's excess medical expenses that corresponds to the percentage of fault allocated to the other driver. These fault allocation issues can be complicated and will frequently require the attention of an experienced attorney. In addition, there will be disputed liability situations where ***both drivers*** incur excess medical expenses and are making a claim against one another for those uncompensated losses. These situations create complexities beyond the scope of this summary. Suffice it to say, however, that the new law will usher in an era of complicated questions that will require all victims to proceed with great caution and with a full understanding of their legal rights. ***One thing is clear: if there is any uncertainty, don't go it alone.***

Advocates for the Injured Throughout all of Michigan



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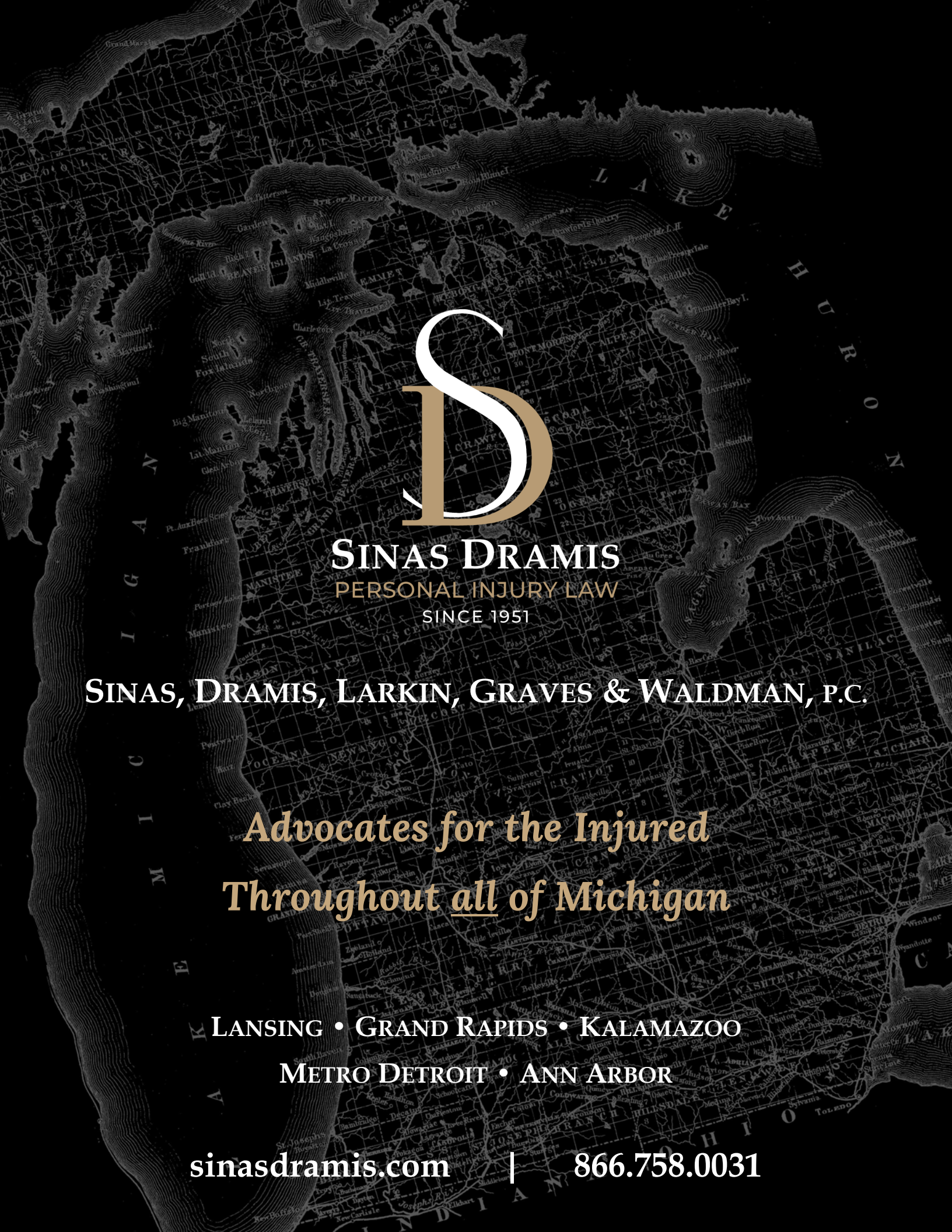

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