

STATE OF MICHIGAN
IN THE SUPREME COURT

COVENANT MEDICAL CENTER,

Plaintiff-Appellee

v.

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY, a Michigan insurance
corporation,

Defendant-Appellant.

Supreme Court No. 152758

Court of Appeals No. 322108

Saginaw County Circuit Court
Case No. 13-020416-NF

AMICUS CURIAE BRIEF OF
MICHIGAN HEALTH AND HOSPITAL ASSOCIATION

CLARK HILL PLC
Jennifer K. Green (P69019)
151 S. Old Woodward Ave, Suite 200
Birmingham, MI 48009
(248) 642-9692 | Fax (248) 642-2174
jgreen@clarkhill.com
Attorney for Amicus Curiae – Michigan
Health and Hospital Association

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STATEMENT OF QUESTION PRESENTED

I. Does a healthcare provider have an independent cause of action against a no-fault insurer for no-fault benefits?

Plaintiff-Appellee Covenant Answers:	Yes.
Defendant-Appellant State Farm Answers:	No.
Amicus Curiae MHA Answers:	Yes.
The Court of Appeals Answered:	Yes.
This Court Should Answer:	Yes.

II. Does a healthcare provider constitute “some other person” within the meaning of the second sentence of MCL 500.3112?

Plaintiff-Appellee Covenant Answers:	Yes.
Defendant-Appellant State Farm Answers:	No.
Amicus Curiae MHA Answers:	Yes.
The Court of Appeals Answered:	Yes.
This Court Should Answer:	Yes.

III. Is a hearing required by MCL 500.3112?

Plaintiff-Appellee Covenant Answers:	Yes.
Defendant-Appellant State Farm Answers:	No.
Amicus Curiae MHA Answers:	No.
The Court of Appeals Answered:	Yes.
This Court Should Answer:	No.

IV. If this Court holds that a provider does not have an independent cause of action, should the Court limit its decision to prospective application only due to the impact its holding would have on thousands of pending cases?

Plaintiff-Appellee Covenant Answers:	Did Not Address.
Defendant-Appellant State Farm Answers:	Did Not Address
Amicus Curiae MHA Answers:	Yes.
The Court of Appeals Answered:	Did Not Address.
This Court Should Answer:	Yes.

STATEMENT OF INTEREST OF *AMICUS CURIAE*

Amicus curiae Michigan Health & Hospital Association (“MHA”) advocates for Michigan hospitals and the patients they serve. Established in 1919, the MHA represents the interests of its member hospitals and health systems in both the legislative and regulatory arenas on key issues and supports their efforts to provide quality, cost-effective and accessible care. Using their collective voice, the MHA advocates for its members before the legislature, government agencies, the media and the public. In addition, the association provides members with essential information and analysis of healthcare policy and offers relevant education to keep hospital administrators and their staffs current on statewide issues affecting their facilities. The MHA appears before this Court as a representative of nearly 150 healthcare facilities, ranging from community hospitals, teaching hospitals, long term acute care hospitals, public hospitals (owned by city, county, state or federal government) and nonpublic hospitals (individually incorporated or owned and operated by a larger health system). The issues before the Court are the utmost concern for the MHA’s members, as services rendered to auto accident victims comprise a substantial portion of the revenue at the MHA member facilities, and any decrease in that revenue will inevitably result in less access to healthcare for the patients they serve.

SUMMARY OF ARGUMENT

Numerous appellate courts in Michigan have consistently—and correctly—held that medical providers have standing to assert their own cause of action against a no-fault insurer. This line of cases stands for the unremarkable proposition that a medical provider, having rendered medical services to a patient (many times at substantial cost), may directly pursue payment from an recalcitrant insurer in a court of law. While a provider’s right to a claim could be considered “derivative” to the extent that the provider’s right to recover is dependent upon

certain threshold questions being met by the injured party to demonstrate eligibility for benefits, the provider suffers its own distinct pecuniary harm giving rise to an independent right of action.

State Farm (and the Amici supporting its cause) improperly focus on a single phrase in Section 3112 of the No-Fault Act—*i.e.*, that “benefits are payable to or for the benefit of an injured person”—and argue that the entire analysis rises and falls with an interpretation of that language alone. But Michigan law is not so simplistic. The rules of statutory construction mandate that the Court view the statutory scheme as a *whole*, along with its stated purpose. As a result, while Section 3112’s language certainly supports a direct cause of action by a provider, other sections of the No-Fault Act (such as Section 3157, which mandates that a provider has a right to be paid a “reasonable” rate, and Sections 3142 and 3148, which set forth remedies for non-payment) also support this conclusion, because they demonstrate an intent by the Legislature to grant certain rights to providers and to not limit the remedies for non-payment to only the injured party. Further, while the No-Fault Act was adopted to ensure prompt reparations to the injured party, it was also adopted to prevent inequitable payment structures and curb rising healthcare costs. As a result, the rights of healthcare providers—providers who are *integral* in the No-Fault system and who incur significant cost providing critical services to accident victims—cannot be ignored. Upon undertaking a more fulsome review of the statute, and in particular, its purpose, the MHA is confident that this Court will affirm the lower court’s finding that providers have independent standing to pursue claims against insurers.

The Court should also affirm the lower court’s holding that a provider constitutes “some other person” within the meaning of Section 3112 of the No-Fault Act, which serves as a statutory protection for providers who many times are not involved with the lawsuit between an insurer and the injured party and who may not even be aware that a release has been executed

that may impact the providers' legal rights.

Moreover, this Court should affirm the Court of Appeals' holding on separate grounds with respect to the issue of whether Covenant is bound by the settlement between State Farm and Covenant's patient. Setting aside Section 3112, a provider should not be bound by a release that lacks the basic common law requirements of an enforceable contract, in particular, mutual assent to be bound. The fact that the claim by a provider may be "derivative" is irrelevant. Under Michigan law, even a derivative claim—for example, a loss of consortium claim—cannot be released by a third party. In fact, State Farm even *agrees* that this Court should apply the same rule that is applied to loss of consortium claims; however, State Farm fails to mention in its brief that with a loss of consortium claim, no one can release the consortium claim other than the party who actually holds the claim.

Lastly, if the Court were to rule that providers lack standing to bring an independent action, it would throw thousands of pending cases into procedural turmoil. Therefore, MHA strongly urges the Court to limit the effect of any ruling to a *prospective* application only.

STATEMENT OF FACTS

Amicus curiae MHA adopts as its own the Counter-Statement of Facts set forth in Covenant's Brief on Appeal to this Court.

STANDARD OF REVIEW

Amicus curiae MHA adopts as its own the Counter-Statement of Standard of Review set forth in Covenant's Brief on Appeal to this Court.

LAW AND ARGUMENT

I. MEDICAL PROVIDERS HAVE STANDING TO PURSUE AN INDEPENDENT CAUSE OF ACTION AGAINST INSURERS FOR BENEFITS OWED UNDER THE NO-FAULT ACT.

A. Michigan Rules of Statutory Construction Dictate That the No-Fault Act Be Read as a Whole

While State Farm focuses on one phrase out of the entire No-Fault Act (“for the benefit of”), Michigan law directs this Court to consider the statutory scheme as a whole—including its purpose. The overarching goal of statutory interpretation is to discern the “intent of the Legislature through reasonable construction in consideration of the purpose of the statute and the object sought to be accomplished.” *Frankenmuth Mut Ins Co v Marlette Homes*, 456 Mich 511, 515; 573 NW2d 611 (1998). “Individual words and phrases are not read in a vacuum” so courts must “examine the statute as a whole, reading individual words and phrases in the context of the entire legislative scheme.” *State ex rel Gurganus v CVS Caremark Corp*, 496 Mich 45, 59; 852 NW2d 103, 110 (2014).

The “object sought to be accomplished” by adoption of the No-Fault Act was “to eradicate problems inherent in the tort liability system, significantly, long payment delays, high legal costs, and an overburdened court system.” *Shavers v Attorney General*, 402 Mich 554, 578; 267 NW2d 72 (1978). “The goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses.” *Id.* at 578-579. Equally as important, the no-fault system was aimed at curtailing rising health care costs: “[t]he no-fault act was as concerned with the rising cost of health care as it was with providing an efficient system of automobile insurance.” *Dean v Auto Club Ass’n*, 139 Mich App 266, 274; 362 NW2d 247, 273 (1982).

With respect to payments of no-fault benefits to medical providers, seven key

provisions—sections 3105, 3107, 3112, 3142, 3145, 3148 and 3157—govern the analysis. See *Munson Medical Ct v Auto Club Ins Ass'n*, 218 Mich App 375, 378; 554 NW2d 49, 52 (1996) (noting the insurer’s “obligation to pay and [the provider’s] right to be paid for the injureds’ no-fault medical expenses arise pursuant to MCL 500.3105, 500.3107, and 500.3157”); see also *Lakeland*, 250 Mich App 35; 645 NW2d 59 (2002). These sections provide as follows:

1. Section 3105 sets forth **who is liable to pay** the benefits (*i.e.*, the insurer) and under what circumstances:

“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.” MCL 500.3105(1).

2. Section 3107 defines the **type of benefits** the insurer is liable to pay for:

“[P]ersonal protection insurance benefits are payable for the following. . . Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person’s care, recovery, or rehabilitation.” MCL 500.3107(1)(a).

3. Section 3112 sets forth, among other things, **who can be paid** the benefits:

“Personal protection insurance benefits are ***payable to or for the benefit of an injured person*** or, in case of his death, to or for the benefit of his dependents.” MCL 500.3112 (emphasis added).

4. Section 3157 provides the **amount** a provider may charge for its services must be reasonable and customary:

“A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, ***may charge a reasonable amount*** for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution ***customarily*** charges for like products, services and accommodations in cases not involving insurance.” MCL 500.3157 (emphasis added).

5. Sections 3142 and 3148 set forth the **statutory remedies for nonpayment** (*i.e.*, penalty interest and attorney fees):

“Personal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss

sustained . . . An overdue payment bears simple interest at the rate of 12% per annum.” MCL 500.3142(2)-(3).

“An attorney is entitled to a reasonable fee for advising and *representing a claimant* in an action for personal or property protection insurance benefits which are overdue.” MCL 500.3148(1) (emphasis added).

6. Section 3145 contains the limitations period for no-fault actions:

“[A]n action for recovery of benefits . . . may not be commenced more than 1 year after the date of the accident causing injury . . . However, *the claimant* may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.” MCL 500.3145(1) (emphasis added).

None of these provisions mandate that payments be made to the injured party only; in fact, Section 3112 states just the opposite—“benefits are payable to *or for the benefit of* an injured person[.]” Moreover, Section 3157 imposes a statutory duty for the insurer to reimburse a provider at a reasonable and customary rate. This is a legal obligation imposed by the No-Fault Act that runs between the insurer and the provider *only* and has nothing to do with the injured party. Further, neither of the No-Fault Act’s remedies are limited to the “insured” or the “injured party.” Instead, the attorney fee provision uses the term “claimant” (as does the limitations period provision), which indicates that the Legislature did not intend to limit claims to only the injured party.

B. Providers’ Standing Derives From Their Own Distinct Pecuniary Injury, Right to Payment, and a Substantial Interest in the Outcome of the Litigation

There is no question that a cause of action under the No-Fault Act exists with respect to the *insured*; thus, the question is not whether the statute confers a private right of action. Instead, the only question is who has standing to bring it. The doctrine of standing was recently summarized by this Court as follows:

In cases involving public rights, the Court held that a litigant established standing by demonstrating a “substantial interest [that] will be detrimentally affected in a manner different from the citizenry at large.” Additionally, however, the Court recognized that even if a statute did not expressly grant standing, it could be implied from duties created by law. Thus, where a statute did not expressly grant standing, this Court would consider whether the Legislature nonetheless intended

to confer standing on the plaintiffs. In a case involving private rights, the Court explained that the litigant should have “some real interest in the cause of action, or a legal or equitable right, title, or interest in the subject matter of the controversy.”

In summary, standing historically developed in Michigan as a limited, prudential doctrine that was intended to “ensure sincere and vigorous advocacy” by litigants. If a party had a cause of action under law, then standing was not an issue. But where a cause of action was not provided at law, the Court, in its discretion, would consider *whether a litigant had standing based on a special injury or right or substantial interest that would be detrimentally affected in a manner different from the citizenry at large, or because, in the context of a statutory scheme, the Legislature had intended to confer standing on the litigant.* *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 358-59, 372; 792 NW2d 686 (2010) (emphasis added) (citations and footnotes omitted).

Thus, under controlling Michigan Supreme Court authority—and contrary to State Farm’s position—providers need not show an “explicit” cause of action based upon the No-Fault Act, nor do providers need to show an absolute “right” to direct payment in order to establish standing to sue. Instead, a minimal showing of a “special injury” *or* a “right” or even a mere “substantial interest” is enough. *Id.* Perhaps this is why State Farm posits in its brief that “standing is not an express issue in this case” and attempts to re-frame the issue as something else altogether, because when the issue is presented as one of standing under the *Lansing* test, the answer is a resounding and easy “yes”—providers clearly have standing to pursue a cause of action.¹ (State Farm’s Brief on Appeal, pg. 21 n 9).

Lansing is instructive here. The issue in *Lansing* was whether plaintiffs, who were comprised of the Lansing School Education Association, the Michigan and National Education Association, and four teachers who had all been physically assaulted in the classroom, had standing to pursue claims under the Revised School Code, MCL 380.1 *et seq.*, which did not

¹ Notably, State Farm argued in *Chiro Rehab* that this exact issue *was* one of standing. *Chiro Rehab Group, PC v State Farm Mut Auto Ins Co*, 313 Mich App 113, 121-122; 881 NW2d 120 (2015) (“State Farm first argues. . . that healthcare providers do not have standing under the no-fault act to bring an action against an insurer to obtain no-fault PIP benefits. We disagree.”).

contain an express cause of action or confer standing on plaintiffs to enforce the act's provisions. The Court found that the teachers *did* have standing because “[t]o begin with, the text of MCL 380.1311a itself suggests that plaintiffs have a substantial and distinct interest” as it “requires that a qualifying student be expelled for physically assaulting an employee of the school, which was defined to include the plaintiff-teachers.” *Id.* at 374. Further, the Court reasoned that the “legislative history . . . make[s] clear that the purpose of the section is to create a safer school environment and, even more specifically, a safer and more effective working environment for teachers.” *Id.* Thus, the Court held that the plaintiff-teachers “have standing because they have a substantial interest in the enforcement of MCL 380.1311a(1) that will be detrimentally affected in a manner different from the citizenry at large if the statute is not enforced.” *Id.*

Just as the teachers in *Lansing* had standing to enforce the Revised School Code, medical providers can have standing even if the No-Fault Act does not explicitly state a cause of action for them. The No-Fault Act itself establishes a distinct interest for providers, because they have the right to be directly compensated (as benefits are payable to or “for the benefit of” the insured). Indeed, this was the basis for finding standing for providers in *Chiro Rehab Group, PC v State Farm Mut Auto Ins Co*, 313 Mich App 113, 124; 881 NW2d 120 (2015), where the Court reasoned that the second sentence of Section 3112 has been interpreted to include claims by providers because: “the word ‘or’ is a disjunctive term indicating a choice between alternatives[,]” thus, properly construed, the phrase “benefits are payable to or for the benefit of an injured person” and this reveals a “Legislative intent to allow either the injured person *or* a party that provided benefits to an injured person to recover the payment of benefits from an insurer; the injured party is not the only party who has this right.” Therefore, “given the text of MCL 500.3112, especially when read in conjunction with MCL 500.3105, MCL 500.3107, MCL

3157 . . . we conclude that the statutory scheme of the no-fault act indicates that the Legislature intended to confer standing on a healthcare provider to bring a claim against an insurer to enforce a provider's right to be reimbursed for medical services rendered to an injured party covered under a no-fault policy." *Id.* (citing *Lansing*, 487 Mich at 372).

Another provision of the No-Fault Act (one that State Farm largely ignores) also independently supports standing for a provider: Section 3157. The No-Fault Act sets forth a statutory guarantee that providers must be reimbursed a "reasonable" and "customary" fee for their services, rather than some arbitrary fee set solely by the No-Fault insurer. See MCL 500.3157. This section of the No-Fault Act was specifically included to protect a provider's reimbursement and to ensure that arbitrary payment schedules were not imposed by insurers. Accordingly, just like the teachers in *Lansing* who were found to have standing to enforce a statute that was specifically intended to protect their interests by creating a safer work environment in the classroom, providers have standing to enforce to a statute that was specifically designed to protect their economic interests. If a provider is unpaid (or underpaid, as is common), it suffers its own distinct pecuniary harm and would be "detrimentally affected in a manner different than the citizenry at large if the statute is not enforced." *Lansing*, 487 Mich at 359. Further, such action by the insurer would be a violation of its statutory duty to pay a "reasonable" rate under Section 3157, thereby giving rise to a cause of action by the provider.

In short, standing to pursue legal claims can be "implied from duties created by law" and standing for a provider under the No-Fault Act is implied from the duties created under Sections 3112 and 3157. *Lansing*, 487 Mich at 358.

Lastly, as acknowledged by the *Lansing* Court, the public policy rationale behind the statute must be considered. The "policy of this state [is] that the existence of no-fault insurance

shall not increase the cost of health care.” *Dean*, 139 Mich App at 274 (emphasis in original). Indeed, “[t]he no-fault act was as concerned with the rising cost of health care as it was with providing an efficient system of automobile insurance.” *Id.* at 273. If major medical centers are unable to pursue direct reimbursement from insurers, the cost of delivering healthcare will certainly rise, as hospitals will be unable to pursue hundreds millions of dollars’ worth of claims² and will be forced to spread those unreimbursed costs to other patients and the public. If the Court were to hold that a provider lacks standing to sue independently, then providers’ ability to recover unpaid bills will be at the complete mercy of the injured party. If the injured party does not want to be involved in litigation, then under State Farm’s proffered system, providers would simply go unpaid. Hospitals and other providers would be hamstrung by an injured party who does not want to participate in litigation. The No-Fault system would fall apart and medical costs would skyrocket if hospitals and other providers were reliant upon the patient pursuing their bills. Thus, a provider’s claim may be derivative to the extent that it is contingent upon certain threshold issues being met with respect to eligibility for benefits, but a provider’s claim cannot be dependent upon the injured party’s decision to file suit or not file suit. As the Court of Appeals has aptly observed:

² According to the Michigan Catastrophic Claims Association (“MCCA”), 8.66% of all payments made by the MCCA from July 1, 2014 to June 30, 2015 were for hospitalization. (Source: <http://www.michigancatastrophic.com/ConsumerInformation/ClaimStatistics/tabid/106/Default.aspx>, last visited September 14, 2016). Thus, for the 2014 fiscal year, out of the \$1.067 billion dollars spent by the MCCA for catastrophic claims—which does not even represent *all* of the no-fault claims in Michigan, only the small percentage of claims that qualify for MCCA reimbursement—hospital bills represent approximately \$125 million dollars (or \$124,250,177.60, to be exact). The actual hospital revenue for *all* car accidents is exponentially higher. If Michigan hospitals lose even fraction of this figure due to the inability to pursue payment directly from the insurers, it will have an impact on hospitals’ ability to provide services to accident victims and hospitals will have little choice but to pass these economic losses on to the consumer.

[P]ublic policy favors provider suits . . . Allowing a healthcare provider to bring a cause of action expedites the payment process to the healthcare provider when payment is in dispute. Thus, provider standing meets the goal of prompt reparation for economic losses. ***Healthcare provider standing also offers a healthcare provider a remedy when an injured individual does not sue an insurer for unpaid PIP benefits, thus preventing inequitable payment structures and promoting prompt reparation.*** [*Wyoming Chiro Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389, 404-402 (2014) (emphasis added)]

C. Without Direct Provider Actions, There Is No Mechanism to Enforce an Insurer’s Duty to Pay Reasonable Charges Under Section 3157, Which Would Render Section 3157 Nugatory and Frustrate the Legislature’s Intent

In order to fully understand why a provider not only *can* but in some cases *must* have a direct cause of action against an insurer, a brief overview of the evolution of the case law on this subject is essential.

In 1994, the Court of Appeals held that an injured party cannot sue on behalf of a provider who was only partially reimbursed because there was no direct “injury” to the insured. *McGill Auto Ass’n of Mich*, 207 Mich App 402, 404 (1994). In *McGill*, a group of insureds sued their respective insurance companies under the theory that they were at risk of being sued by their health care providers as a result of the insurers’ failure to pay the full amounts billed by the providers. The trial court denied class certification and dismissed the case on the basis that the plaintiffs had “suffered no pecuniary injuries” because their providers had not actually sought payment of the unpaid balance from the insureds. *Id.* The Court of Appeals agreed, and found that there was no injury to the insured where the insurer paid only a portion of the medical bills. Further, the *McGill* court reasoned, the Commissioner of Insurance had issued an Interpretive Statement, Bulletin 92-03, which declared that No-Fault insurers must “provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance” and must “act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit or lawsuit as a result of a dispute

between the health care provider and the insurer.” *Id.* at 406-407 (citing Michigan Department of Commerce, Insurance Bureau Bulletin 92-03, Oct. 23, 1992 (hereafter, the “Insurance Bulletin”). Based upon this, the court held there was no “injury” to the plaintiffs, because the insurers had an obligation to protect their insureds from incurring damages as a result of a healthcare provider suing for any unpaid balance. *Id.* at 407. In fact, the Court went so far as to hold there was no “case or controversy” to support a claim by the insured for under payment. *Id.*

Therefore, due to *McGill*, a provider *must* sue the insurer directly if dissatisfied with the amount of its bill paid by the insurer because insureds are not permitted to do so.

In 1995, in *LaMothe v Auto Club Ins Ass’n*, 214 Mich App 577; 543 NW2d 42 (1995), the Court of Appeals reiterated that an individual insured could not sue an insurer for its failure to pay the insured’s medical bills in full. In *LaMothe*, the Auto Club initially paid plaintiff’s medical bills in full, but it performed an audit in 1992 and determined that some of plaintiff’s expenses were not “reasonable” and began paying only a portion. The court, finding that *McGill* was “dispositive,” held that the insured (just like the plaintiffs in *McGill*) had suffered no injury due to his insurer’s partial payment of his medical bills. *Id.* at 581. As a result, the court held that the insured “failed to state a cause of action because even if a contract breach could be established, he has suffered no damages as a matter of law.” *Id.* at 582. Instead, the *LaMothe* court observed that “in the circumstance where the health care services provider felt that the reasonability determination of the insurer was flawed . . . we can anticipate that health care service providers, as practical litigants, would bypass the insured and directly sue, pursuant to third party-beneficiary theories . . . the insurer.” *Id.* at 585-86.

A year later in *Munson Medical Ct v Auto Club Ins Ass’n*, 218 Mich App 375, 378; 554 NW2d 49 (1996), a provider did sue the insurer directly for underpayment of its bills, as

anticipated by the *LaMothe* court. In *Munson*, the Auto Club had been routinely short-paying Munson's bills because it was paying bills according to a fee schedule promulgated under Michigan's workers compensation law, even though the patients at issue in *Munson* had been injured in auto accidents—not workplace accidents—and were undisputedly governed by the No-Fault Act. *Id.* The *Munson* court began its analysis by noting that the insurer's "obligation to pay and Munson's right to be paid for the injureds' no-fault medical expenses arise pursuant to MCL 500.3105, 500.3107, and 500.3157" of the No-Fault Act. *Id.* at 381. The court ultimately ruled that a No-Fault insurer could not place arbitrary limits (like a fee schedule) on the amount it would pay because "only the statutory qualification of reasonableness limits the amount that must be paid by a no-fault carrier[.]" *Id.* at 384-385 (citing *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55, 95-96, 535 NW2d 529 (1995)).

This trio of cases—*McGill*, *LaMothe*, and *Munson*—highlight the common scenario in which a medical provider is not paid in full by the insurer and suffers its own economic injury. These cases also illustrate the uniqueness of a provider's interest under Section 3157 of the No-Fault Act and demonstrate the inefficiency of requiring individual insureds to serve as nominal "plaintiffs" when the real party in interest—the one suffering the actual economic harm—is the provider. Most importantly, though, these cases demonstrate that under current Michigan law, lawsuits brought by individual insureds for underpayment of their provider's bills would not even be *viable*. Thus, direct provider actions are a necessity; otherwise, there is no mechanism to enforce an insurer's duty to pay "reasonable" amounts and Section 3157 would be rendered a nullity. The Legislature clearly did not intend this. *Jespersion v Auto Club Ins Ass'n*, 499 Mich 29, 34; 878 NW2d 799 (2016) (noting that when determining legislative intent, the court "must

give effect to every word, phrase, and clause in a statute and *avoid an interpretation that renders nugatory or surplusage any part of a statute*”) (citation omitted) (emphasis add).

D. No-Fault Remedies Are Not Limited to the Injured Party, Which Further Demonstrates the Legislature Contemplated Direct Provider Actions

The No-Fault Act’s remedial provisions further bolster the conclusion that the Legislature contemplated that parties other than the insured may bring suit, because none of the remedies are limited to the insured. For example, in *Lakeland Neurocare Centers v State Farm Mut Auto Ins Co*, 250 Mich App 35, 39; 645 NW2d 59 (2002), the court held a provider was entitled to the same No-Fault penalty interest under MCL 500.3142 and attorney fees under MCL 500.3148 as an insured would be. To reach this conclusion, the *Lakeland* court analyzed the language of Section 3142 and found no limitation by the Legislature that would prevent a medical provider from seeking penalty interest for overdue benefits. *Id.* at 39-40 (“MCL 500.3142 does not limit the right to seek penalty interest solely to the injured person and if the Legislature intended to limit the penalty interest provision, it could have done so. MCL 500.3142 (1) could have been written as ‘personal protection insurance benefits are payable *to the injured person* as loss accrues.’”) (emphasis in original). The court also found Section 3112 supported its conclusion, reasoning: “the fact that plaintiff was not the injured person is not dispositive” because “MCL 500.3112 specifically contemplates the payment of benefits to someone other than the injured person as reflected by its inclusion of the phrase ‘benefits are payable to or for the benefit of an injured person’ and by its discharge of an insurer’s liability upon payment made in good faith to a payee ‘who it believes is entitled to the benefits[.]’” *Lakeland*, 250 Mich App at 39.

The court next analyzed the language in the attorney fee provision of the No-Fault Act, which provides: “An attorney is entitled to a reasonable fee for advising and *representing a claimant* in an action for personal or property protection insurance benefits which are overdue.”

Lakeland, 250 Mich App at 40 (quoting MCL 500.3148) (emphasis added).³ The insurer argued that the word “claimant” meant that only the injured person may pursue attorney fees. The court rejected this argument, and held that a provider qualified as a “claimant” by applying the dictionary definition of “claimant” which included “a person who makes a claim” and a “claim” includes “a demand for something as due; an assertion of a right or an alleged right,” and “a request or demand for payment in accordance with an insurance policy[.]” *Id.* (quoting Random House Webster's College Dictionary (1997)). Thus, contrary to the assertions in State Farm's brief, the *Lakeland* court *did* thoroughly analyze the relevant statutory language and did not simply base its decision on the fact that it is “common practice” for insurers to directly reimburse health care providers for services rendered to their insureds.

Lastly, the *Lakeland* court reiterated what earlier courts had observed, which was that providers bear the economic burden on non-payment. *Lakeland*, 205 Mich App at 43 (noting “[t]his case present an example of the economic burden that is often imposed on health care providers . . . defendant agreed . . . that plaintiff was entitled to such payment but only after plaintiff had incurred the loss of income, the use of that income, the interest it would bear, its investment potential, and the additional expense of legal action.”) The court also recognized the crucial role that direct provider lawsuits play in a balanced No-Fault system:

Finally, the enforcement of these penalty provisions against a recalcitrant no-fault insurer also serves to offer some protection against further economic loss faced by an injured person. The impermissible payment behavior of an insurer has an economic effect on the injured person, both directly and indirectly, usually in the form of damaged credit ratings, difficulties in securing health care services,

³ The term “claimant” is also used in the No-Fault Act's statute of limitations section, which further suggests the Legislature did not intend to limit claims to the injured party, only. See MCL 500.3145(1) (“[A]n action for recovery of benefits . . . may not be commenced more than 1 year after the date of the accident causing injury . . . However, *the claimant* may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.”)

harassment, and lawsuits initiated by health care providers for reimbursement. *Permitting the imposition of these penalty provisions by health care providers provides a legitimate and enforceable incentive to no-fault insurers to perform their payment obligations, imposed by operation of law, in a reasonable and prompt manner.* Similarly, health care providers have incentive to submit reasonable payment claims because no-fault insurers are permitted to recover attorney fees for defending against a claim “that was in some respect fraudulent or so excessive as to have no reasonable foundation.” [*Lakeland*, 250 Mich App at 43-44 (quoting MCL 500.3148(2)) (emphasis added)]

As noted by the *Lakeland* court, direct rights of action by medical providers serve an important function in the No-Fault system. The threat of penalty interest and fees furthers the goal of prompt payment and serve an important function under the No-Fault act—a monetary check and balance to encourage the insurer to pay. By ensuring that providers are paid at a reasonable rate and that the economic interests of medical providers are protected, the system can achieve its twin aims of providing prompt reparations to insureds and not increasing the cost of health care.

E. Prior Courts Have Consistently—and Correctly—Held That Providers Have Independent Standing to Assert Legal Claims

State Farm argues *Lakeland* did not directly hold that providers have an independent right of action because that issue was not challenged on appeal; rather, the specific issues on appeal were whether the provider could recover interest and fees. Even if true, later cases—*Univ of Mich Regents v State Farm Mut Ins Co*, 250 Mich App 719, 731-734; 650 NW2d 129 (2002), *Wyoming Chiro Health Clinic, PC v Auto-Owners Ins Co*, 308 Mich App 389; 864 NW2d 598 (2014), and *Chiro Rehab* (discussed *supra*)—all directly addressed the issue and held they did.

(1) University of Michigan Regents

In *Univ of Mich Regents v State Farm Mut Ins Co*, 250 Mich App 719, 731-734; 650 NW2d 129 (2002), the regents of University of Michigan sued two insurers under the No-Fault Act for services rendered to George Estes at the University of Michigan’s Hospital (“U of M”). The insurers argued U of M’s claim was time-barred under MCL 500.3145, which imposes a

one-year limitations period under the No-Fault Act. U of M argued that the No-Fault limitations period did not apply to it, because Michigan law (specifically, MCL 600.5821(4)) exempts political subdivisions of the State from complying with limitations periods. The insurers argued that MCL 600.5821 did not apply to U of M because its claim for benefits “derives from Estes [the insured] and Estes is subject to MCL 500.3145” of the No-Fault Act. The Court of Appeals rejected State Farm’s argument that U of M’s claim was solely derivative, reasoning that “[a]lthough plaintiffs [the U of M regents] may have derivative claim, they also have direct claims for personal protection benefits.” *Id.* at 733. Significantly, the finding of a direct right of action was integral to the actual holding of the court on the limitations period issue. Therefore, it was not sheer dicta that was only mentioned “in passing” as State Farm claims.

(2) *Wyoming Chiro*

In *Wyoming*, the court began by canvassing the prior two decades of case law (including *Munson*, *Lakeland*, and *Regents*) relating to provider lawsuits and held “Wyoming Chiropractic had standing to bring a cause of action against Auto-Owners for PIP benefits under the no-fault act.” *Id.* at 398-397 (citing MCL 500.3112). The *Wyoming* court also rejected the same argument that State Farm raises here—*i.e.*, that the *Lakeland* court did not decide the issue of whether a provider is entitled to sue since the issue was “uncontested” on appeal. *Id.* The *Wyoming* court noted that “the fact that a healthcare provider is entitled to payment, as well as the fact that a healthcare provider can sue to enforce the penalty provision of the no-fault act, indicates that a healthcare provider may bring a cause of action to recover the PIP benefits under the no-fault act” and also noted that it was basing its holding on the language of Section 3112 and not simply “industry practice.” *Id.*

(3) *Chiro Rehab*

As noted above, in *Chiro Rehab*, the court directly addressed the standing issue and held:

“given the text of MCL 500.3112, especially when read in conjunction with MCL 500.3105, MCL 500.3107, MCL 3157 . . . we conclude that the statutory scheme of the no-fault act indicates that the Legislature intended to confer standing on a healthcare provider to bring a claim against an insurer to enforce a provider’s right to be reimbursed for medical services rendered to an injured party covered under a no-fault policy.” *Chiro Rehab*, 313 Mich App at 124 (citing *Lansing Sch Ed Ass’n*, 487 Mich at 372).

By the time *Chiro Rehab* was decided in 2015, it was deeply engrained in Michigan jurisprudence that a provider has a direct right of action—and for good reason. By this point, Michigan courts had analyzed *numerous* sections of the No-Fault Act and found that they all supported one inescapable conclusion—that providers were entitled to a direct right of action.

For example, the courts had:

- (1) determined that the injured party lacked the requisite pecuniary harm to bring their own lawsuit if their provider is underpaid (*McGill* and *LaMothe*);
- (2) interpreted Section 3157 to mean that a provider had a direct right of action to enforce an insurer’s statutory duty to pay a “reasonable” amount (*Munson*);
- (3) parsed the language in Section 3142 and determined that penalty interest was recoverable by a provider (*Lakeland*);
- (4) analyzed Section 3148’s use of the word “claimant” and held that an award of attorney fees was not limited to the injured party (*Lakeland*);
- (5) determined that a provider who was a subdivision of the state was not bound by the No-Fault limitations period because it had a direct right of action (*Regents*);
- (6) determined that a provider has standing to assert its own independent cause of action under Section 3112 (*Wyoming, Lakeland, Regents*).

Clearly, contrary to State Farm’s assertion, the recent case law holding that providers have a direct right of action was not “built on a house of sand[;]” rather, the case law developed incrementally and was decided by performing exactly the thoughtful and careful analysis that

Michigan law demands—*i.e.*, by not reading individual words and phrases “in a vacuum” but instead examining “the statute as a whole, reading individual words and phrases in the context of the *entire* legislative scheme[.]” *State ex rel*, 496 Mich at 59 (emphasis added).

E. Other Jurisprudential Concerns Weigh in Favor of Provider Actions

Beyond the statutory analysis and existing Michigan case law, there are a multitude of other reasons militating in favor of direct actions by providers, including real party in interest rules, conflict of interest concerns, and similar holdings by courts in other No-Fault jurisdictions.

(1) Providers Satisfy the Real Party in Interest Rule in Michigan and Ensure Sincere and Vigorous Advocacy Occurs

State Farm argues that permitting a provider to sue directly would run afoul of the No-Fault Act because it would “create a ‘right’ for a third party that belongs only to the injured person.” (State Farm’s Brief on Appeal, pg. 20). Not true; permitting a provider to directly sue the insurer actually *ensures* that the matter will be pursued with “sincere and vigorous advocacy,” which is the rationale behind the real party in interest rule. Plus, as established above, there are certain statutory “rights” that run *only* to a provider and not to the injured party.

Under Michigan law, “[a]n action must be prosecuted in the name of the real party in interest.” MCR 2.201(B). “A real party in interest is one who is vested with the right of action on a given claim, although the beneficial interest may be in another.” *Stillman v Goldfarb*, 172 Mich App 231, 237; 431 NW2d 247 (1988) (citation omitted). “This standing doctrine recognizes that litigation should be begun only by a party having an interest that will assure sincere and vigorous advocacy.” *Id.* Indeed, in *Hofmann*, 211 Mich App at 95-96, the court held that medical providers (specifically, chiropractors) were the “real party in interest” in a lawsuit seeking repayment for no-fault benefits, reasoning:

The purpose of the [real party in interest] rule is to protect the defendant by requiring that the claim be prosecuted by the party who by the substantive law in

question *owns the claim* asserted against the defendant.

[E]ach of the claims asserted by plaintiffs [chiropractors] relate to products or services that were provided by them personally to ACIA's insureds and for which they billed ACIA but were denied payment. The fact that the MCLAC [Michigan Chiropractic Legal Action Committee] may be financing this lawsuit does not change the fact *that the asserted claims belong only to plaintiffs*. Therefore, plaintiffs are the real parties in interest. (emphasis added)

Moreover, the stark reality is that the overwhelming majority of No-Fault claimants cannot afford the out-of-pocket medical costs associated with their care after an automobile accident (hence the need for insurance in the first place). While a hospital may have the right to pursue payment from its patient for any medical expenses not paid for by insurance, such a "right" rings hollow since in most instances a claimant is uncollectible or "judgment proof" so a provider is unlikely to recoup payment if the No-Fault insurer does not pay. For this same reason, the most "sincere and vigorous advocacy" in pursuing reimbursement for a patient's medical bills often comes from the provider that performed those services and suffered the economic loss of providing those services, not the patient. The patient has already received the life-saving services at issue and may know that if a judgment is in fact obtained, he cannot pay it anyway. Thus, a patient/insured may actually have little to no sincere interest in obtaining payment.

(2) Conflict of Interest Concerns Support Direct Rights of Action

The interests of the provider and its patient are not always aligned. A medical provider is technically a creditor of its patient. Thus, a medical provider—although often aligned as a co-plaintiff with the patient in a lawsuit—is simultaneously a creditor of its patient, which can lead to a conflict of interest between the patient and the provider. See e.g., *Krywy v State Farm Mut Auto Ins Co*, unpublished opinion of the Court of Appeals, issued April 24, 2008 (Docket Nos. 274663, 277313) at 9-10 n 4 ("we do not condone the reckless decision of plaintiff's trial counsel to remain employed by both [the medical provider] (a creditor) and plaintiff (its debtor) on a

matter directly related to the outstanding debt”).⁴ As a result, an ethical conflict arguably arises if the same attorney brings one lawsuit and jointly represents both the patient and the provider. See MRPC 1.7. If this Court were to hold that a provider lacks a direct right of action, providers would be forced to join patients’ lawsuits and rely upon lawyers who may not have their best interests at heart. Or perhaps the opposite would occur; the lawyer would place the providers’ interests—since they usually have the largest bills in a PIP case—over that of the injured party. This is also an undesirable outcome.

An attorney representing both a provider and the injured party suffers from an ethical dilemma because maximizing the recovery for one often means a diminished recovery for the other. As a result, it is often impossible to zealously represent the interests of both providers and the injured party. In order to avoid this ethical dilemma, a system which allows the injured party to pursue his own claims with an attorney of his choosing and permitting the provider to do the same is the only viable option.

(3) The No-Fault Act’s Policy Goals Are Best Served by Direct Provider Claims

As demonstrated above, provider actions are crucial in order for the No-Fault system to operate effectively. Without provider actions, there is no mechanism to police the insurers’ duty to pay reasonable amounts. Further, there is a practical necessity of direct actions by medical providers. While an underpaid provider could technically seek reimbursement for the balance from the patient, the reality is that most patients lack the ability to pay. This would leave medical providers with no real avenue for repayment, which would ultimately increase the cost of healthcare—a result the No-Fault Act was designed to avoid. Moreover, such a system

⁴ The MHA is cognizant that under MCR 7.215(C)(1), an unpublished opinion is not precedentially binding and should not be cited for propositions of law for which there is published authority; however, while there do not appear to be published cases discussing the conflict of interest inherent between a no-fault provider and its patient.

(providers suing patients) would only add more litigation—another result the No-Fault Act was intended to avoid. Further complicating that litigation is the Insurance Bulletin cited in *McGill*, under which the insurer has an obligation to “act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit or lawsuit as a result of a dispute between the health care provider and the insurer.” If a provider sues the patient for the unpaid bill, the insurer arguably has a duty to protect the insured from the lawsuit under the Insurance Bulletin, which may create a separate cause of action by the insured against the insurer and give rise to a third-party claim against his insurer. If a provider was forced to undertake this convoluted process each time its bills were in dispute (*i.e.*, suing its patient who may then sue the insurer), this complicated system would cause significant delay and increase the amount of litigation, plus, at the end of the day, the insurer would still potentially involved in the litigation. At most, taking away direct provider actions might reduce litigation *for the insurer* but it certainly would not reduce litigation overall, because providers would instead be forced to initiate litigation against their own patients (who typically cannot pay, leaving providers with no recovery). All of this flies in the face of the policy rationale of implementing a no-fault system in the first place—*i.e.*, to prevent payment delays, reduce litigation, and stabilize health care costs. Again, direct provider actions are the most efficient method of handling these disputes for everyone involved—particularly the injured party, who can be left out of the litigation altogether in many instances.⁵

⁵ While it may seem odd to leave the injured party out of the lawsuit altogether, it must be remembered that with respect to first party benefits, the vast majority of benefits typically in dispute are owed to the medical providers rather than to the injured party himself (other than, for example, wage loss). The bulk of the payments owed for “allowable expenses” are for medical services rendered by healthcare providers (*e.g.*, hospitals, treating physicians, physical therapists, home health care agencies, transportation companies, *etc.*). The cost of performing those services is incurred by the provider and the economic loss if there is no payment is born by the provider.

(4) Other Courts Hold Third Party Beneficiary Theories Support Direct Actions

The court in *LaMothe* acknowledged that it anticipated that “health care service providers. . . would bypass the insured and directly sue, pursuant to third-party beneficiary theories. . . the insurer.”⁶ *LaMothe*, 214 Mich App at 586. While Michigan courts have not addressed whether this statute gives rise to third-party beneficiary status to a provider under the No-Fault Act, courts in other no-fault jurisdictions have held that providers have standing to pursue direct claims against insurers under third party beneficiary theories. “[S]everal of the courts of states which have no-fault laws similar to New York’s no-fault law have held that medical costs which are incurred by a third party on behalf of an accident victim may be recovered . . . and that persons other than the accident victim may obtain compensation under the no-fault law[.]” *United States v Gov’t Employees Ins Co*, 605 F2d 669, 672 (CA 2, 1979) (citations omitted); see also *Orion Ins Co v Magnetic Imaging Sys I*, 696 So2d 475, 478 (Fla Dist Ct App 3d 1997) (determining that under Florida’s No-Fault law, “[w]hile the policy is between

For the sake of efficiency, it makes sense to permit the provider to directly assert a claim for reimbursement to the insurance company rather than to sue “through” the injured party, who in many cases would only be a nominal party. Further, the No-Fault Act is designed to encourage “prompt” payment. If a provider, such as a hospital, has to first locate the plaintiff and obtain permission to file suit utilizing the patient as the “plaintiff”—setting aside for the moment the conflict of interest problem that will be discussed *infra*—this will add delay to the entire process. This concern is especially true for hospitals, who by the nature of the services they provide, often treat car accident victims in the acute phase of the injuries but do not maintain an ongoing relationship with the patient upon release from the hospital.

⁶ Notably, Michigan’s third-party beneficiary statute uses the same exact phrase as the No-Fault Act—“for the benefit of.” That statute provides in pertinent part:

Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.

(1) A promise shall be construed to have been made **for the benefit of a person** whenever the promisor of said promise has undertaken to give or to do or refrain from doing something directly to or for said person. [MCL 500.1405(1)]

Orion and its insured, Magnetic is a third-party beneficiary of that contract. Medical service providers like Magnetic have been recognized as third party beneficiaries of insurance contracts.”) (citing cases).

In the *Gov't Employees* case, the federal government provided medical care to a military member without charge as required by federal law but the government later sought reimbursement from the individual's No-Fault insurer. *Gov't Employees*, 605 F2d at 670 n1. The issue was whether the government could sue directly for the benefits, since the No-Fault law in New York provided only for benefits to “persons” suffering injuries arising out of the use of a motor vehicle. The Second Circuit, in holding that the government could sue directly, reasoned:

Section 672(1)(a) [of New York's No-Fault law] does not expressly limit recovery thereunder to those expenses incurred by a claimant as a result of physical injuries suffered by that claimant. It merely requires that the expense for which reimbursement is sought be among the compensable items listed as a “first party benefit” in section 671 and that it be related to an injury caused by the use or operation of a motor vehicle within the state . . . ***The broad language of section 672(1)(a) suggest that a third party claimant who incurs the medical costs of an accident victim may recover those expenses under this section.***

The appellant nonetheless urges a narrow interpretation of these sections. Such a narrow construction would not, however, further the legislative goals embodied in the no-fault law . . . a principal objective of the legislature was to “assure the prompt and full reimbursement of the ‘economic’ losses those injured in automobile accidents may suffer” A second legislative goal was, however, to reduce the “inordinate strain on the State's court systems and judicial resources.” It would be inconsistent with the intent of the legislature to ensure reimbursement for medical costs for this Court to hold that the government is not entitled, under section 672, to compensation for the medical care it rendered to an accident victim, particularly since “providers of health services” are entitled to obtain compensation for medical services[.] [*Id.* at 671-672 (internal citations omitted)]

The court concluded: “Absent a clear showing that the legislature intended to permit only a claimant himself to recover costs related to physical injuries he has suffered, such a limited interpretation of section 672 is not warranted.” *Id.* The court also noted that a second policy rationale was served by permitting direct actions—the government, if it could not directly sue the

No-Fault insurer, could seek reimbursement pursuant to a separate federal statute. *Id.* at 672. As a result, the court reasoned that “denial of compensation to the government under section 672 would not promote the legislative goal of reducing litigation involving motor vehicle accidents” because the government would still sue under a different theory. *Id.*

The same is true here. The statutory language of the No-Fault Act is broad and should not be limited, particularly when the legislative goals include keeping healthcare costs and litigation at a minimum. The most efficient manner of resolving claims—and the one most aptly achieves the Legislature’s goals of prompt payment, reduced litigation and stabilizing healthcare costs—is direct provider actions.

II. A PROVIDER IS “SOME OTHER PERSON” WITHIN THE MEANING OF MCL 500.3112 BUT A HEARING IS NOT REQUIRED IN ALL INSTANCES

State Farm takes the erroneous position that an injured party has carte blanche authority to waive benefits and enter into releases that bar a provider’s ability to seek repayment. Not so. Releases of No-Fault benefits should be subject to the same interpretations under Michigan as all releases, and therefore, an insured should not be permitted to unilaterally waive existing claims held by a provider under basic rules of contract law. It matters not that the claim of a provider is “derivative.” Section 3112 adds an additional layer of statutory protection which reinforces that an insurer cannot discharge its liability where it has been notified of another’s claims.

A. Section 3112 Prevents an Insurer From Discharging Providers’ Claims If It Has Notice of the Claim

Section 3112 provides in pertinent part:

Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. *Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer’s liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.* If there is doubt about the proper person to receive the benefits or the proper apportionment among

the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. [MCL 500.3112]

A provider qualifies as “some other person” within the meaning of MCL 500.3112.⁷ As the Court of Appeals aptly noted in the instant case, “the plain text of the statute provides that if the insurer has notice in writing of a third party’s claim, then the insurer cannot discharge its liability to a third party simply by settling with its insured.” *Covenant Medical Center, Inc v State Farm Mut Auto Ins Co*, 313 Mich App 50, 53; 880 NW2d 294, 296 (2015).

In essence, Section 3112 imposes an obligation of “good faith” on an insurer. To the extent that an insurer *knows* of some other claim it cannot discharge that liability. This ensures fairness in what can be a complex situation where the provider is not involved in its patient’s lawsuit, and may not even be aware of the settlement. Further, as is common, the provider bills the insurance company *only* and the insured does not immediately receive a copy of the bill. As

⁷ The term “person” is not a defined term in the definitional section of the No-Fault Act. See e.g., MCL 500.3101. However, “person” *is* defined in the general Insurance Code an “individual, insurer, company, association, organization, Lloyds, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, and any other legal entity.” MCL 500.114. Further, dictionary definitions can be employed to define common words or phrases. *People v Thompson*, 477 Mich 146, 151; 730 NW2d 708 (2007). Numerous definitions of “person” exist, including “one (as a human being, a partnership, or a corporation) that is recognized by law as the subject of rights and duties.” See Merriam-Webster (<http://www.merriam-webster.com/dictionary/person>) (accessed September 30, 2014). Providers qualify as a “person” under both definitions, so a business entity can be “some other person.”

Moreover, there are numerous examples business entities being considered juridical “persons” in the law. *Grosjean v American Press Co, Inc*, 297 US 233, 244; 56 S Ct 444 (1936) (noting a corporation is a “person” within the meaning of the equal protection and due process clauses); *Safiedine v City of Ferndale*, 482 Mich 995, 995-996 (2008) (discussing whether juridical persons could state a cognizable claim for a violation of the Elliot-Larson Civil Rights Act where the statute only protections “an individual”); MCL 450.1108(2) (defining a “person” under Michigan’s Business Corporation Act to mean “an individual, a partnership, a domestic or foreign corporation, a limited liability company, or any other association, corporation, trust, or legal entity”). Thus, the Legislature’s use of the word “person” in Section 3112 should not be read to mean only an “individual” or a “natural person.”

a result, there are often circumstances where the injured party does not know every bill that exists or what amounts have been billed to the insurance company on his behalf, particularly in complex cases with a multitude of providers. Section 3112 serves as a “check and balance” on the insurer and prevents it from taking advantage of this fact by settling directly with the insured and leaving providers without reimbursement. In other words, Section 3112 protects against precisely what occurred in the instant case—Covenant providing services totaling \$43,484.80 to State Farm’s insured, sending three bills to State Farm, and later learning that State Farm settled directly with its insured, who purportedly released Covenant’s bills. The Court of Appeals’ decision here was absolutely correct—because State Farm was on notice of Covenant’s bills, State Farm could not discharge its liability as to Covenant because State Farm had been “notified in writing of the claim of some other person.”

While a hearing is one way to procedurally address with these issues, it not necessarily expressly *required* by the text of Section 3112 unless the circumstances necessitate a hearing and the insurer seeks to take advantage of Section 3112’s safe harbor provision.

B. Regardless of Section 3112, the Common Law Prevents an Injured Party from Releasing Providers’ Claims Without Their Assent

At the heart of this case is the question of whether the injured party can unilaterally waive claims on behalf of their providers. Under Section 3112, an insured cannot unilaterally waive a provider’s existing claim for benefits. Under the common law, the answer is the same: Just because a provider’s claim may be derivative of the injured party’s claim, it does not automatically follow that the injured party can waive or release the legal rights of the provider. Fundamental principles of contract law dictate this result—a non-party’s rights cannot be released without their knowledge and approval. It would be an anomaly in Michigan law if a third party’s legal claim could be released without their knowledge or consent. Yet this is what

State Farm urges in this case—that providers’ No-Fault claims could be waived unbeknownst to them by the patient, without any due process (like the one set forth in Section 3112) and without basic contract requirements having been met, such as mutual assent to be bound. The rule does not change where the cause of action is derivative; in fact, Michigan law explicitly holds that even a derivative claim (such as a loss of consortium claim) *cannot* be released by someone other than the holder of the claim.

(1) Even If Derivative, Legal Claims Cannot Be Released by a Third Party

In State Farm’s brief, it argues that a loss of consortium claim “is informative” and “makes sense in our context” because a loss of consortium claim is also derivative and dependent upon a successful recovery by the actual injured party. (See State Farm’s Brief on Appeal, pg. 32). Applying this analogy, State Farm further argues that:

The same logic should hold when it comes to releases—if an injured person cannot recover a claim because he signed a release, then neither can the provider; if the injured person settled their claims with the insurance company, extinguishing their right to any further payment, then the provider’s right to receive payment is also extinguished. [State Farm’s Brief on Appeal, pg. 33]

The MHA agrees that a claim brought by a provider under the No-Fault Act is analogous and should be treated the same as a loss of consortium claim. A provider’s claim is derivative to the extent that it is contingent upon certain threshold findings, just as a loss of consortium claim is contingent upon the success of the spouse’s underlying negligence claim. However, consortium claims are also independent causes of action that need not be joined with the underlying tort victim’s lawsuit. See e.g., *Wesche v Mecosta County Rd Comm'n*, 480 Mich 75, 85; 746 NW2d 847 (2008) (“a claim for loss of consortium is an independent cause of action. . . . Although a loss-of-consortium claim is derivative of the underlying bodily injury, it is nonetheless regarded as a separate cause of action and not merely an item of damages.”) (citations omitted); *Oldani v*

Lieberman, 144 Mich App 642, 646; 375 NW2d 778 (1985) (“Although loss of consortium is an independent action, it is derivative of the underlying bodily injury” and noting that “[t]herefore, in order for Nora [wife] to recover, William [husband] must be successful on his underlying negligence and bodily injury claims.”) (citations omitted); *Oliver v Department of State Police*, 160 Mich App 107, 112; 408 NW2d 436 (1987) (“Michigan law does not require a consortium claim to be joined to the claims raised by the principal plaintiff.”). By the same token, a provider has an independent claim (despite the fact that it is contingent upon eligibility thresholds being met by the injured party) that is not required to be joined with a lawsuit by the injured party.

Further, the spouse of a tort victim suffers his or her own distinct injury in a loss of consortium claim, just as the provider suffers its own distinct economic harm when an insurer fails to pay. See e.g., *Montgomery v Stephan*, 359 Mich 33, 35-42 (1960) (recognizing that a wife’s loss of consortium claim is not for the physical injury to her husband, rather “[h]er cause of action involves a hurt directly to her. . . the wife is suing for damages to her interest”).

Because the consortium claim is held by the spouse, not the tort victim, Michigan law is clear that the loss of consortium claim *cannot* be released by the tort victim. *Oldani*, 144 Mich App at 650. For example, in *Oldani*, the plaintiff, Harry Oldani, had a loss of consortium claim arising out of his wife’s medical malpractice claim. Judith later settled her claim unbeknownst to Harry (they were going through a divorce) and the defendant attempted to enforce Judith’s release against Harry to argue that his claim for loss of consortium was barred. The court rejected this argument, reasoning:

Where the action for loss of consortium is seen as purely derivative of the original cause of action for the injury, it has been held that once the original cause of action has been released, the action for loss of consortium is also barred. However, the more prevalent view seems to be that ***the loss of consortium suit is not barred as it is a separate and independent cause of action which is the***

property of the spouse and cannot be controlled by the injured person. [*Id.* at 648 (citing 29 ALR4th 1201)]

Thus, the court concluded “Judith’s settlement with defendants did not operate to release Harry’s claims against defendants” because “Judith did not have authority to settle and release Harry’s claim.” *Id.* at 650; see also *Bowen v Kil-Kare, Inc*, 585 NE2d 384, 391-392 (1992). The Ohio Supreme Court expounded upon this rationale in *Bowen* where it held that a wife’s claim for loss of consortium could not be released by her husband, the injured party, under contract principles:

[The] release does not defeat Brenda Bowen’s claim against appellees for loss of consortium even if her husband properly executed the release and even if the release bars him from recovering against appellees. Brenda’s claim is a separate and independent claim against appellees for the damages she sustained as a result of appellees’ conduct, and it is not a claim that her husband could effectively release. . . ***As a simple matter of contract law, the release, as a contract, could only bar Brenda’s claim if she was a party to the agreement.***

Accordingly, we hold that an action for loss of consortium occasioned by a spouse’s injury is a separate and distinct cause of action ***that cannot be defeated by a contractual release of liability which has not been signed by the spouse who is entitled to maintain the action.*** [*Bowen*, 585 NE2d 384, 391-392 (1992) (citations omitted, emphasis added)]

Accordingly, regardless of whether a provider’s claim is “derivative,” it still cannot be waived by an injured party who has not been given authority to release rights of a medical provider.

Indeed, the same logic applies to all releases in Michigan. Courts generally apply principles of contract law to disputes involving the terms of a release. *Shay v Aldrich*, 487 Mich 648, 660; 790 NW2d 629 (2010). There are five elements of a valid contract: “(1) parties competent to contract, (2) a proper subject matter, (3) a legal consideration, (4) mutuality of agreement, and (5) mutuality of obligation.” *Calhoun Co v Blue Cross Blue Shield of Mich*, 297 Mich App 1, 13; 824 NW2d 202 (2012). “Where mutual assent does not exist, a contract does not exist.” *Quality Products & Concepts Co v Nagel Precision, Inc*, 469 Mich 362, 372; 666 NW2d 251 (2003). Thus, “any release, to be sustained, must be ‘fairly and knowingly’ made.”

Denton v Utley, 350 Mich 332, 342; 86 NW2d 537 (1957).

If a provider's claims are "waived" or "released" by the insured without a provider's knowledge—let alone its actual *assent*—there is no valid release to begin with vis-a-vis the provider.⁸ Michigan law is clear that a parties are not bound by a release when someone lacking authority purports to bind them.⁹ See *Woodman v Kera LLC*, 486 Mich 228, 242-243; 785 NW2d 1 (2010). For example, in *Woodman*, this Court considered whether a pre-injury liability waiver signed by a parent on behalf of a minor child was enforceable and held that a parent lacked authority to waive a child's legal rights, reasoning:

This Court does not, under freedom of contract principles, enforce contracts that the parties otherwise have no authority to enter. Mr. Woodman [father] possesses no greater authority to waive the property rights of his son Trent than he possesses to waive the property rights of any other nonconsenting third party, such as his neighbor or a coworker. Thus, the answer to defendant's freedom of contract argument is simple: ***the freedom to contract does not permit contracting parties to impose obligations upon and waive the rights of third parties in the absence of legally cognizable authority to do so.***

Woodman, 486 Mich at 242-243 (emphasis added). The same logic applies to a non-consenting medical provider—if a provider is not a party to release, it should not be bound. Basic rules of

⁸ The MHA is cognizant of the decision in *Clark v Progressive Ins Co*, 309 Mich App 387, 401-402; 872 NW2d 730 (2015) and others which may be interpreted to go the other way. The *Clark* case, however, makes no mention of Section 3112, and further, the parties in *Clark* appear to have only argued mutual mistake as a defense to the release, not mutual assent by the provider. *Clark* should have been decided differently given Section 3112 and/or basic contract formation requirements.

⁹ Presumably, courts rely on concepts of privity in order to find providers are bound by the injured party's release. Privity is defined as "mutual or successive relationships to the same right of property, or such an identification of interest of one person with another as to represent the same legal right." *Sloan v Madison Heights*, 425 Mich 288, 295; 389 NW2d 418 (1986). While there are multiple cases that have found privity between a provider and an injured party, the two do not always have an "identification of interest of one person with another as to represent the same legal right," particularly because the patient/provider relationship is that of a debtor/creditor. See *Krywy, supra* (noting "we do not condone the reckless decision of plaintiff's trial counsel to remain employed by both CRCI (a creditor) and plaintiff (its debtor) on a matter directly related to the outstanding debt"). Thus, the interests are not always aligned and privity should not always be assumed.

contract dictate this result.

Thus, even if derivative, legal claims are still a property right held by a provider that cannot be released by a third party.¹⁰ The same rules that apply to a loss of consortium claim (as acknowledged by State Farm) should apply to No-Fault provider claims, as should common law rules that govern all other releases in Michigan. When applied properly, the common law simply does not permit legal claims held by providers to be bargained away by third parties.

III. THE COURT’S DECISION SHOULD NOT BE GIVEN RETROACTIVE EFFECT IF IT HOLDS A PROVIDER LACKS A DIRECT RIGHT OF ACTION

If the Court rules that a provider does not have a direct cause of action, it could throw into question the validity of thousands of pending lawsuits. Therefore, the Court should limit its decision to prospective application only.

In general, decisions of the Michigan Supreme Court are given “full retroactive effect.” *Bezeau v Palace Sports & Entm’t, Inc*, 487 Mich 455, 462; 795 NW2d 797 (2010) (citation omitted). There are exceptions, however, and the Court “should adopt a more flexible approach if injustice would result from full retroactivity.” *Id.* To determine whether only prospective application should be ordered, the Court must first decide the threshold question of “whether the decision clearly established a new principle of law.” *Id.* at 463. Then the Court should weigh the following factors: (1) the purpose to be served by the new rule, (2) the extent of reliance on the old rule, and (3) the effect of retroactivity on the administration of justice. *Id.*

A. A New Principle of Law Would Clearly Be Set Forth If the Court Holds a Provider Lacks a Direct Right of Action

If the Court holds that medical providers do *not* have an independent cause of action, it

¹⁰ Both the *Oldani* and *Woodman* courts characterized the legal claims as a “property right” that could not be released by another. *Woodman*, 486 Mich at 242-243 (equating the son’s negligence claim with a “property right” that his father could not waive); *Oldani*, 144 Mich App at 648 (deeming the loss of consortium claim a “separate and independent cause of action which is the *property* of the spouse and cannot be controlled by the injured person”) (emphasis added).

would be reversing nearly two decades' worth of case law. As noted above, an unbroken line of cases spanning two decades have all recognized a provider's direct right of action. Thus, the threshold question is easily met here. See e.g., *Bezeau*, 487 Mich at 463 (finding the threshold question met where "[t]he decision in *Karaczewski* to overrule *Boyd* established a new interpretation of MCL 418.845 that broke from longstanding interpretation of the statute. . . the Court's interpretation established a new rule of law because it affected how the statute would be applied to parties in workers' compensation cases in a way that was inconsistent with how the statute had been previously applied").

B. Balancing of Factors Weighs in Favor of Prospective Application Only

Next, the Court must weigh the purpose of the new rule of law, reliance on the old rule, and the impact on the administration of justice. In this case, the first factor is largely neutral, as the purpose would be to clarify the meaning and purpose of the No-Fault Act as it applies to medical providers. The second two factors, however, both militate strongly in favor of only permitting prospective application. For decades, medical providers across the State have been operating under the line of cases which all uniformly hold that the provider has its own direct cause of action. As such, there are currently hundreds—if not thousands—of cases currently pending in Michigan brought directly by the provider. If the providers' pending cases are all dismissed without prejudice in one fell swoop for lack of standing, it will be a needless waste of time, as they could arguably re-file their cases utilizing the insured as a nominal plaintiff. It would be a Pyrrhic victory for the insurers, who will be faced with re-litigating cases all over again and incurring even more cost and attorneys' fees as a result.

This issue is further complicated by the fact that some pending cases are brought first by the insured and a provider intervenes as a party at a later date. Procedural questions would arise,

such as whether the providers could continue to pursue reimbursement for their bills through the existing plaintiff's lawsuit or whether the provider should be dismissed altogether and have to start all over again.¹¹ Either way, giving retroactive application and dismissing thousands of lawsuits would be a waste of time and judicial resources, when many cases could be refiled except that the entire litigation process would have to recommence. The turmoil and uncertainty that a retroactive application would have on the administration of justice for all parties involved—the insurers, the providers, and the courts—is something all parties want to avoid. As a result, the MHA urges the Court to limit the effect of its ruling to prospective, only.

Respectfully submitted,

CLARK HILL PLC

By: /s/ Jennifer K. Green
Jennifer K. Green (P69019)
151 S. Old Woodward Ave, Suite 200
Birmingham, MI 48009
(248) 642-9692 | Fax (248) 642-2174
jgreen@clarkhill.com
Attorney for Amicus Curiae — Michigan Health
and Hospital Association

Date: October 6, 2016

¹¹ Statute of limitations issues may be raised as a barrier to refile; however, the limitations period would have arguably been tolled during the pendency of the prior lawsuit pursuant to MCL 600.5856.