

STATE OF MICHIGAN
IN THE SUPREME COURT

COVENANT MEDICAL CENTER, INC.

S.Ct Case No. 152758

Plaintiff/Appellee,

vs.

COA Case No. 324587

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY

Trial Ct. No. 13-020416-NF
Saginaw County Circuit Ct.
Hon. Robert L. Kaczmarek

Defendant/Appellant.

**BRIEF OF AMICUS CURIAE, MMRMA, IN SUPPORT OF DEFENDANT-
APPELLANT STATE FARM**

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A	<i>Bronson Health Care Group, Inc v Home-Owners Ins Co</i> , unpublished opinion per curiam of the Court of Appeals, issued July 16, 2015 (Docket Nos 321908, 32243)
B	Brief of Amicus Curiae Auto Club Insurance Association In Support of Leave to Appeal
C	Insure.com - Car Insurance Rates by State, 2016 edition
D	<i>Jago v Dept of State Police</i> , unpublished opinion per curiam of the Court of Appeals, issued August 2, 2011 (Docket No 297880)

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STATEMENT OF THE QUESTIONS PRESENTED

- I. Whether a healthcare provider has an independent claim against a No-Fault provider, such that a healthcare provider will not be bound by a release agreed upon by the No-Fault insured?

Covenant Answers: "Yes."

State Farm Answers: "No."

MMRMA Answers: "No."

- II. Whether the Court of Appeals correctly interpreted MCL 500.3112, in concluding that a medical provider is "some other person," as used in the second sentence of the statute?

Covenant Answers: "Yes."

State Farm Answers: "No."

MMRMA Answers: "No."

- III. Whether MCL 500.3112 requires an apportionment hearing in order to fully settle No-Fault cases between the No-Fault insurer and the No-Fault insured, thereby increasing filings and litigation in the Circuit Courts?

Covenant Answers: "Yes."

State Farm Answers: "No."

MMRMA Answers: "No."

INTRODUCTION

MCL 500.3101, *et seq.*, (the "No-Fault Act") provides for compulsory automobile insurance for all Michigan drivers. Due in large part to the potential for unlimited, lifetime medical benefits, Michigan consumers are paying the price for No-Fault through the highest average insurance premiums in the United States, \$2,738 in 2016, an amount which is nearly \$500 above the second highest average state, and more than double the national average of \$1,325. (**Exhibit C**). One of the goals of the No-Fault Act "is the containment of the premium costs of no-fault insurance." *Crowley v DAII*, 428 Mich 270, 283; 407 NW2d 372 (1987). In this regard, the No-Fault Act has failed the People of Michigan. The decision of the Michigan Court of Appeals in the instant case will only add to the heavy burden borne by the public, by making No-Fault cases that much more difficult and costly to settle. While litigation difficulties and costs are paid by each party to the litigation, ultimately, those difficulties and costs will be passed on to the consumers, making the already highest-in-the-nation average insurance premiums even higher.

MMRMA is a governmental group self-insurance pool whose over 300 Members operate some 14,500 governmental vehicles across the state. The decision in this case literally impacts all corners of the State, as MMRMA's obligations to provide No-Fault coverage include, but are not limited to, the vehicles operated by the following governmental entities: Troy, Mason County, Sterling Heights, Grand Rapids, Holland, Midland County, Bay City, Bay County, Berrien County, Benzie County, Southfield, Escanaba, Oscoda County, Calhoun County.

The facts of this case are common to those seen in many No-Fault cases, and the Court of Appeals decision will have a detrimental impact on the settlement prospects

of all future No-Fault cases. In fact, it is the run-of-the-mill nature of the facts of this case which makes its potential impact so great. The decision will apply to literally every future No-Fault settlement, and it will have the effect of deterring and/or preventing settlement of No-Fault cases throughout the State, and increasing the number of lawsuits exponentially, as a single motor vehicle accident ("MVA") can now give rise to multiple lawsuits, often in multiple courts, as the injured party, and each of his/her (potentially numerous) medical providers can now bring separate lawsuits. Put simply, a statute permitting alternate payees, MCL 500.3112, has been judicially expanded to such an extent, that the litigation and settlement of No-Fault cases has become unduly burdensome for both injured parties, and providers of No-Fault coverage, alike. Providers of No-Fault coverage already face a procedural burden due to Court of Appeals case law which has determined that the contract venue statute, not the tort venue statute, applies to No-Fault actions. *Shiroka v Farm Bureau Gen Ins Co of Mich*, 276 Mich App 98, 104 n15; 740 NW2d 316 (2007). As such, No-Fault providers who frequently do business all across the State, can be forced to litigate in counties wholly unrelated to the MVAs which form the basis of the claim for benefits, and frequently find themselves in Wayne County, regardless of where the MVA took place.

In this case, an individual sustained accidental bodily injury arising out of an MVA. The injured claimant brought suit against his No-Fault Provider, seeking payment of "allowable expenses," including expenses relative to numerous medical providers which provided him care and treatment for his MVA-related injuries. Rather than proceed to a trial, the No-Fault insurer and its insured¹ agreed to settle the case. In

¹ MMRMA is a group self-insurance pool created by intergovernmental contract pursuant to MCL 124.1, et seq. MMRMA is neither an insurance company nor an insurer and its business does not constitute the doing of an insurance business as specifically stated in MCL 124.6. Thus, MMRMA is a "provider" of No-Fault benefits, and only an "insurer" where context permits as "a person that

exchange for a cash payment of No-Fault benefits, the insured signed a release. The release included all of the insured's known, unknown, past, and present, injuries related to the MVA through a certain date, and specifically provided for the release of outstanding claims by known medical providers.

After the settlement and dismissal of the insured's case, one of the insured's medical providers brought a separate suit against the No-Fault insurer, seeking payment of its outstanding amounts for the insured's MVA-related care/treatment. The trial court granted summary disposition to the No-Fault insurer on the basis of the release executed by the injured claimant prior to the filing of the medical provider's lawsuit. The Court of Appeals reversed, and, in a published opinion, held that once a No-Fault insurer has notice of a medical provider's bill, the medical provider's ability to bring a claim for benefits is completely independent of the insured who actually sustained injury. Therefore, the insured cannot compromise the medical provider's claim, or bind the medical provider to any settlement.

The effects of the Court of Appeals decision on future No-Fault cases are staggering. Pursuant to MCL 500.3107(1)(a), persons injured in MVAs may claim "allowable expenses" (which includes medical care, attendant care, prescriptions, medical mileage), wage loss, and replacement services. No-Fault claimants frequently have numerous providers of "allowable expenses," meaning that for every one claimant, there can be scores of providers. The decision will alter decades of case law permitting an injured insured to bring suit against the No-Fault insurer and seek payment for services rendered by medical providers. Since the insured cannot compromise a

files the security as provided in this section." MCL 500.3101(4). However, to avoid any confusion (e.g. with a medical "provider"), in this brief, MMRMA shall use the more standard terms of "insurer" to refer to those who provide No-Fault benefits and "insured" to refer to those who are entitled to receive No-Fault benefits.

medical provider's claim, the insured can no longer fully and finally settle all claims related to his injuries in a single lawsuit, without obtaining the express written consent of all his medical providers. In other words, a No-Fault case can no longer settle through an agreement between insurer and insured, but rather, will need the consent of each and every provider of care or services to the insured. Instead of a single lawsuit to decide all outstanding claims, the decision invites a multiplicity of lawsuits for each and every MVA because the only claims the insured can now compromise are his own out-of-pocket expenses. An insurer can no longer settle with its insured and fully resolve the claim because it must be concerned with future lawsuits by any medical provider which sent a bill to the insurer prior to the execution of the settlement with the insured. Therefore, if an insured cannot obtain the consent of all his medical providers, settlement will be impossible, or any settlement will be limited to the insured's own out-of-pocket expenses, due to the inability to bind medical providers. Each and every medical provider would then file its own lawsuit against the insurer, and because the total amount owed to a given medical provider is often less than \$25,000, the District Courts of this State will be turned into full-time No-Fault courts, with multiple courts having jurisdiction and venue over injuries arising out of the same MVA, but many claims not exceeding \$25,000.

The Court of Appeals decision in this case took precedent regarding "standing" of medical providers to bring No-Fault suits and erroneously applied it to create wholly independent claims of the medical providers, unfettered by the actions of the injured claimant. Pursuant to the Court of Appeals decision, once a No-Fault insurer has notice of a medical provider's bill for services to its insured, the medical provider's claim becomes completely independent of any claim of the insured. Thus, once a No-Fault

insurer is aware of a medical provider's bill, benefits are no longer payable "to or for the benefit of an injured person" as permitted by MCL 500.3112, but are now only payable "to the medical provider for the injured person's benefit." The Court of Appeals decision has judicially re-written the text of the No-Fault Act.

For years, No-Fault insurers could negotiate and settle claims with the injured individuals, who, in turn, would distribute any amounts received among those medical and other providers claiming amounts due and owing for care on behalf of the injured party. It was the responsibility of the injured party to negotiate with these claimed amounts in mind, as it was the injured party who had requested the services, in the first place. If a provider of medical or other services felt that it was not receiving its due, it retained the right to proceed against the party which had requested the services. Therefore, the provider of medical or other services was not without remedy, and this system has well served No-Fault insurers, No-Fault insureds, and medical providers since the No-Fault Act took effect.

STATEMENT OF FACTS

While MMRMA would normally rely entirely on the facts as stated by the party whom it is supporting, State Farm. MMRMA recites the following relevant facts because they are so common to so many No-Fault cases, and to emphasize that the situation presented is not unique, but an everyday occurrence addressed by trial courts of this State each day.

I. The Accident and Release.

In this case, Jack Stockford was injured in an MVA on June 20, 2011. Covenant Medical Center, Inc. ("CMC") provided certain medical services for Mr. Stockford's MVA-related injuries in 2012. CMC billed State Farm for the services provided in 2012, but

apparently due to a dispute over Mr. Stockford's MVA-related injuries, State Farm did not pay the bills.

On June 4, 2012, Mr. Stockford brought suit against State Farm alleging entitlement to No-Fault personal protection insurance ("PIP") benefits. Prior to the trial scheduled in Mr. Stockford's case, a settlement was reached. On April 2, 2013, after State Farm had received certain CMC bills, but prior to any suit filed by CMC, Mr. Stockford executed a Release to effectuate his settlement with State Farm. The Release was similar to those used by numerous No-Fault providers. Mr. Stockford agreed to:

forever release, acquit, and discharge [State Farm] and its heirs, agents, employees, representatives, successors, and assigns, of and from any and all actual and potential claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses, complaints, compensation, attorney fees and liabilities of every sort and description whatsoever, on account of, or in any way growing out of, any and all known or unknown, past and present claims and damages incurred through January 10, 2013, resulting, or to result from, or otherwise related in any way to the allegations set forth in the complaint filed in the Circuit Court for the County of Saginaw, State of Michigan[.]

... It is understood and agreed that this full and final release is a complete release of [State Farm] regarding any and all past and present claims incurred through January 10, 2013, under the Michigan No-Fault Act the undersigned may have under the Michigan Automobile No-Fault Act, including but not limited to allowable expenses, medical bills, attendant care, medical mileage, work loss, replacement services, attorney fees, interest and costs arising from the June 20, 2011 accident alleged in the complaint.

The release specifically addressed certain known medical providers, demonstrating that the amounts sought by CMC were included in the settlement payment:

IT IS FURTHER UNDERSTOOD that the undersigned agrees to indemnify, defend and hold harmless [State Farm] from any liens or demands made by any provider, insurance

company, or health organization, including, but not limited to Blue Cross/Blue Shield, Medicaid and Medicare, Saginaw Covenant Medical Center, Dr. Mark Adams, M.D., Matrix Pain Management, P. C., for payments made or services rendered to Jack H. Stockford in connection with any injuries resulting from the above described accident

(emphasis added). Finally, the Release even addressed its intent:

It is the express intention of the parties to this settlement that this Release be read as broadly as possible such that [State Farm] shall have no further obligations or liability of any sort or nature to Jack H. Stockford, directly or indirectly, except as stated in this Release.

Thus, pursuant to the terms of the release, State Farm would owe no further amounts, directly or indirectly, to Mr. Stockford relative to the June 20, 2011 MVA.

II. CMC's Lawsuit Filed After Execution of the Release and the Court of Appeals Decision.

On April 25, 2013, 22 days after the Release was executed, CMC filed the instant lawsuit, seeking to recoup amounts related to MVA-related injuries to Mr. Stockford. The trial court granted summary disposition to State Farm based on the Release, but the Court of Appeals reversed.

The Court of Appeals first construed MCL 500.3112, which provides:

Personal protection insurance benefits are payable to or for the benefit of an injured person or, in the 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.

Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co, 313 Mich App 50, 52-53; 880 NW2d 294 (2015) ("*Covenant*"). The Court of Appeals focused only on the second sentence of the statute, "*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.*" *Id.* at 53 (quoting MCL 500.3112) (emphasis in original). The Court of Appeals concluded that because State Farm had notice of CMC's billing, that payment to the insured did not discharge liability relative to CMC; to extinguish CMC's claims, State Farm was required to "apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated." *Id.* at 53-54. Thus, the Court of Appeals has guaranteed that in every No-Fault case where a medical provider submits an invoice to the No-Fault insurer (*i.e.* every No-Fault case, period), the No-Fault insurer must move a Circuit Court to make an equitable apportionment of any amounts paid in settlement.² Otherwise, medical providers may still bring claims against the No-Fault insurer, even though the injured party has fully settled his or her claims.

The Court of Appeals determined that "When the relevant services were rendered and the insured received notice of the provider's claim before the settlement occurred, the payment and release does not extinguish the provider's rights." *Id.* at 54. The Court of Appeals continued, "while a provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the

² In cases where the total amount claimed does not exceed \$25,000, and the action is being pursued in District Court, this decision requires that every No-Fault case filed in District Court will necessarily have to be filed in Circuit Court as well, as MCL 500.3112 only permits the Circuit Courts to equitably apportion. Furthermore, District Courts generally lack equitable jurisdiction. MCL 600.8315. Thus, as to cases where the amount in controversy does not exceed \$25,000, the Court of Appeals decision has guaranteed that such cases will be filed in two courts.

insurer in exchange for a settlement, does not release the insurer as to the provider's noticed claims unless the insurer complies with MCL 500.3112." *Id.* In short, the Court of Appeals concluded that because CMC had submitted its bill to State Farm prior to the execution of the Release by the insured, the insured could no longer release State Farm from those amounts because the claim for those amounts belonged solely to CMC, not the State Farm insured.

The Court of Appeals decision has several major ramifications. First, once a No-Fault insurer receives a bill from a medical provider, the Court of Appeals concluded that the only way that bill can be discharged is by payment to the provider, itself, in complete derogation of the language MCL 500.3112, which provides that benefits "are payable to or for the benefit of an injured person." (emphasis added). Second, once a bill is submitted to a No-Fault insurer by a medical provider, it exists completely independent of the injured person. Third, by submitting a bill to a No-Fault insurer, the medical provider fully subrogates its claim, thereby depriving the subrogee, the injured insured, of any ability to compromise the medical provider's claim or to obtain benefits payable "to ... an injured person."

STANDARD OF REVIEW

Review of motions for summary disposition is *de novo*. *Spectrum Health Hosps v Farm Bureau Mut Ins Co of Mich*, 492 Mich 503, 515; 821 NW2d 117 (2012). Further, issues of statutory interpretation are also reviewed *de novo*. *Id.*

ARGUMENT

In just over four pages, the Court of Appeals has completely undermined the entire structure for settling No-Fault claims in the State of Michigan. In so doing, the Court of Appeals has altered decades of precedent, and ensured that the multiplicity of

lawsuits presently seen by providers and injured claimants will increase exponentially. Put simply, if left to stand, the Court of Appeals decision will guarantee that the trial courts of this State will become overloaded with No-Fault cases, as each provider which submits a bill to a No-Fault insurer will now have to file its own lawsuit, because the insured can no longer release claims relative to those providers. Since the insured lacks the ability to release such claims, the corollary must also be true, *i.e.* the insured can no longer recover amounts for which a medical provider has submitted a bill. Thus, insured individuals would only be able to recover their purely out-of-pocket expenses, as the other claims now belong to the individual medical providers, which must now each separately file suit to recover benefits.

As this issue involves statutory construction:

The primary goal of statutory construction is to give effect to the Legislature's intent. *Briggs Tax Serv., L.L.C. v. Detroit Pub. Sch.*, 485 Mich. 69, 76, 780 N.W.2d 753 (2010). This Court begins by reviewing the language of the statute, and, if the language is clear and unambiguous, it is presumed that the Legislature intended the meaning expressed in the statute. *Id.* Judicial construction of an unambiguous statute is neither required nor permitted. *In re MCI Telecom. Complaint*, 460 Mich. 396, 411, 596 N.W.2d 164 (1999).

McCormick v Carrier, 487 Mich 180, 191-92; 795 NW2d 517 (2010). "The goal of the no-fault insurance system was to provide victims of motor vehicle accidents with assured, adequate, and prompt reparation for certain economic losses." *Cruz v State Farm Mut Auto Ins Co*, 466 Mich 588, 595; 648 NW2d 591 (2002) (quoting *Shavers v Atty Gen*, 402 Mich 554, 578-79; 267 NW2d 72 (1978)).

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I. *The Court of Appeals Opinion is Based on a False Premise, as a Healthcare Provider does not have an Independent Claim Against a No-Fault Insurer.*

A. **The Court of Appeals Glossed over the Threshold Issue.**

The threshold issue is whether a medical provider has any direct right of action against a No-Fault provider. The Court of Appeals decision takes it for granted that a medical provider has a right to pursue a direct claim, stating:

Moody[*v Home Owners Ins Co*, 304 Mich App 415; 849 NW2d 31 (2014) ("*Moody*")] made it clear that a provider's right to no-fault benefits is based on the insured's right to benefits. *Id.* at 442–443, 849 N.W.2d 31. However, it is also well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits. *Wyoming Chiropractic Health Clinic, PC v Auto–Owners Ins Co*, 308 Mich App 389, 396–397, 864 NW2d 598 (2014) ["*Wyoming*"]; *Moody*, 304 Mich App at 440, 849 NW2d 31; *Mich Head & Spine[Institute PC v State Farm Mut Auto Ins Co*, 299 Mich App 442, 448 n1; 830 NW2d 781 (2013) ["*MHSI*"]; *Lakeland Neurocare[Ctrs v State Farm Mut Auto Ins Co*, 250 Mich App 35, 42-43; 645 NW2d 59 (2002) ("*Lakeland*")]; *Univ of Mich Regents v State Farm Mut Ins Co*, 250 Mich App 719, 733, 650 NW2d 129 (2002) ["*Regents*"].

Covenant, 313 Mich App at 54 (emphasis added). Thus, the Court of Appeals relied on *Wyoming* (2014), *Moody* (2014), *MHSI* (2013), *Lakeland* (2002), and *Regents* (2002) to note a "well settled" principle. Contrary to the Court of Appeals sweeping declaration, it is far from "well settled" that a medical provider has such independent standing.

1. The Five Cases Relied upon in *Covenant* Actually do Nothing to Establish any "Well Settled" Principle that a Medical Provider has Any Independent Claim.

Taking the five cases cited by the Court of Appeals in reverse chronologic order reveals that this concept has a common, and suspect, genesis. In fact, the genesis is not based on the No-Fault Act, itself, but rather, on the course of dealing between a single No-Fault insurer and a single medical provider in one case and on the particular

language of the No-Fault policy at issue in another case. Thus, the "well settled" rule is based on case-specific factors, not the No-Fault Act, itself.

In *Wyoming*, 308 Mich App at 393, the Court of Appeals stated:

This Court has discussed the issue whether a healthcare provider may sue an insurer for PIP benefits under the no-fault act. In *Munson Med Ctr v Auto Club Ins Ass'n*, [218 Mich App 375, 378; 554 NW2d 49 (1996) ("*Munson*")]] the plaintiff was a hospital, which sued an insurer for payment of unpaid bills under the no-fault act. This Court noted that the plaintiff had a "right to be paid for the injureds' no-fault medical expenses" under the no-fault statute.

Therefore, to the list of cases which supposedly make it "well settled" that a No-Fault provider has a right to an independent action, *Wyoming*, *Moody*, *MHSI*, *Lakeland*, and *Regents*, we may add *Munson* (1996), the oldest case yet cited for the "well settled" principle. The Court also relied upon *Lakeland*, but noted that in *Lakeland*, "On appeal, the defendant did not challenge the plaintiff's ability to recover for the medical services that the plaintiff provided to the injured individual." *Id.* at 393-94. Thus, the issue was not even determined by the Court of Appeals in *Lakeland*. The Court also relied upon *Regents*, but noted that *Regents* relied upon *Munson* for the proposition that a medical provider has a direct claim against a No-Fault insurer. Finally, the Court relied upon *MHSI*, which itself, cited to *Lakeland*, where the issue was not even determined. *Id.* at 396. As *Lakeland* did not even address the issue, and *Regents* relied upon *Munson*, both can be effectively removed from consideration as potentially establishing the "well settled" principle.

The next most recent case, *Moody*, 304 Mich App at 440, without citing to any authority, concluded, "While the providers may bring an independent cause of action against a no-fault insurer, the providers' claims against Home Owners are completely

derivative of and dependent on Moody's having a valid claim of no-fault benefits against Home Owners." Thus, *Moody* adds little to the analysis, but for a conclusory statement which cites to no authority. Furthermore, application for leave to appeal was granted in *Moody*, but the appeal was dismissed by the parties. --- Mich ---; 858 NW2d 462 (2015). Ultimately, this Court granted application in the companion case to *Moody*, *Hodge v State Farm*, 499 Mich 211; --- NW2d --- (2016), and ultimately reversed the Court of Appeals decision, *sub nom*, without discussion of the rights of medical care providers, as those parties were dismissed with *Moody*. *Hodge*, 499 Mich at 215-16, 223-24. *Moody* can be effectively removed from consideration as potentially establishing the "well settled" principle.

The next oldest case, *MHSI* from 2013 relied solely on *Lakeland*. *MHSI*, 299 Mich App at 448 n1. *Lakeland*, 250 Mich App at 37, as noted by the subsequent decision in *Moody*, above, did not address the ability of a medical provider to pursue a direct claim for No-Fault benefits, because, "defendant did not dispute that plaintiff had the legal right to commence this action for payment of medical services rendered to defendant's insured." "A point thus assumed without consideration is, of course, not decided." *Ajluni v Bd of Ed of W Bloomfield School Dist*, 397 Mich 462, 465; 245 NW2d 49 (1976) (quoting *Allen v Duffy*, 43 Mich 1, 11; 4 NW 427 (1880)). Thus, *Lakeland* adds nothing to the discussion, as the issue was not decided in *Lakeland*, and *MHSI* merely relied on two older cases. Therefore, both *MHSI* and *Lakeland* can be effectively removed from consideration as potentially establishing the "well settled" principle.

Regents addresses the issue in a single sentence:

Although plaintiffs may have derivative claims, they also have direct claims for personal protection insurance benefits. See, e.g., *Munson*[, 218 Mich App 375] (under the

no-fault act, when a person is injured in an automobile-related accident, a hospital that provides medical care is to be reimbursed by the injured person's no-fault insurance company); *LaMothe v Auto Club Ins Ass'n*, 214 Mich App 577, 585–586, 543 NW2d 42 (1995) [("*LaMothe*")].

Regents provides no further analysis of the issue. Therefore, of the five cases *Covenant* cited to note the "well established" principle that providers have a right to bring claims directly against the No-Fault insurer, none actually analyze the issue. Instead, the entire premise rests on two cases not even cited in *Covenant*: *Munson* (1996) and *LaMothe* (1995).

2. Neither *Munson* Nor *LaMothe* Even Analyzed the Legal Issue, but, Rather, Used the Facts of the Particular Case to Summarily Address the Matter.

The Court in *Munson*, 218 Mich App at 378, summarily concluded

Under Michigan's [N]o-[F]ault [A]ct, M.C.L. § 500.3101 et seq.; M.S.A. § 24.13101 et seq., when a person is injured in an automobile-related accident, a hospital that provides medical care is to be reimbursed by the injured person's no-fault insurance company.

No particular portion of the No-Fault Act was relied upon for this statement, and, furthermore, the course of dealing between the medical provider and the particular insurer appears to have played a major role, as the Court of Appeals noted:

Since 1973, a number of ACIA insureds were treated at Munson Medical Center for injuries arising out of automobile accidents. Historically, Munson would bill ACIA for the services, and, until 1992, ACIA paid the full no-fault amounts billed by Munson.

Id. Furthermore, the dispute was about partial payments, as the insurer had apparently already conceded an obligation, by paying some, but not all, of the amounts billed by the medical provider. *Id.* ("beginning in 1992, ACIA stopped paying the entire amount

of Munson's no-fault bills and began paying only a *portion* of the charges. ... In December 1992, Munson filed suit against ACIA under the [N]o-[F]ault [A]ct for the unpaid portion of its bills."). There was absolutely no discussion as to what particular provisions of the No-Fault Act permit direct medical provider suits. *Munson* was a fact-based conclusion, based on course of dealing, and not any particular section of the No-Fault Act. Therefore, *Munson* does not establish that a medical provider has a direct and/or independent cause of action against a No-Fault insurer. That leaves *LaMothe* as the potential source of the "well established rule."

In *LaMothe*, 214 Mich App at 579, the Court noted, "Defendant was plaintiff's automobile no-fault insurer and, pursuant to the insurance policy, was responsible for the payment of 'reasonable charges incurred' for plaintiff's medical services." (emphasis added). Thus, it was the insurance policy, itself, not the No-Fault Act, which provided a direct obligation to the medical provider. The Court noted that "This contractual provision is in harmony with the requirement in the automobile no-fault insurance statute that requires insurers to pay for all reasonable and necessary medical expenses," but equally important, it did not say that such a contractual provision was required by the No-Fault Act. *Id.* at 579 n1. Thus, while such a contractual provision is permitted by the No-Fault Act, the Court of Appeals never concluded it was required by the No-Fault Act.

Thus, of all the cases relied upon by the Court of Appeals in *Covenant*, none actually analyzed whether a medical provider has a direct right of action against a No-Fault insurer, but rather, each merely looked back to earlier cases. If one actually examines those earlier cases the conclusion was summarily made and based on case-specific factors, such as course of dealing and particular policy language. No meaningful analysis of the No-Fault Act, itself occurred. Thus, the "well settled"

threshold issue is actually a house of cards, or the proverbial castle built upon a foundation of sand.

B. The Language of MCL 500.3112 does not Support Any Right of Medical Providers to Directly Sue No-Fault Providers.

MCL 500.3105(1) provides "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." Further, MCL 500.3107(1)(a) addresses the grant of PIP benefits, in particular: "Except as provided in subsection (2), personal 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." Thus, MCL 500.3105(1) and MCL 500.3107(1)(a) state what is payable, but do not address who should be paid.

MCL 500.3112 addresses the latter question, and is titled, "Payees of personal protection benefits; payments as discharge of liability." Pursuant to MCL 500.3112:

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. In the absence of a court order directing otherwise the insurer may pay:

- (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
- (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

(emphasis added). The Michigan Court of Appeals has noted, "Black's Law Dictionary (6th ed) defines 'or' as: 'A disjunctive particle used to express an alternative or to give a choice of one among two or more things.'" *Beauregard-Bezou v Pierce*, 194 Mich App 388, 393; 487 NW2d 792 (1992). Indeed, "interpretation of the word 'or' indicates an alternative or choice between two things." *Id.* at 394. The word immediately preceding the disjunctive options is "payable." Thus, the choice belongs to the payor, *i.e.*, the No-Fault insurer. Therefore, by the plain language of the statute, the No-Fault insurer may choose to pay PIP benefits either 1.) to the injured person, or 2.) for the benefit of the injured person.

The Court of Appeals erred by focusing on the second sentence of MCL 500.3112, while wholly ignoring the first sentence. *Covenant*, 313 Mich App at 52-53. MCL 500.3112 establishes that a No-Fault insurer's obligations may be met by payment either to the injured person, or for the injured person's benefit. Note, the statute does not state that "after providing services, a medical provider is entitled to payment directly by the insurer." Instead, the statute provides for alternatives, either of which can discharge the No-Fault insurer's obligation. In fact, a No-Fault insurer could simply pay all amounts due and owing directly to the insured, leaving it to the insured to pay the medical providers, and satisfy MCL 500.3112. Permitting a direct cause of action by the medical providers strips the insurers of their statutory choice as to the payee. In short, medical providers do not have a "right" to be paid, but rather, the No-Fault insurer has

a choice, and may elect to pay either the provider or the insured. The second sentence merely provides a safe harbor, after the choice is made.

The "right" to benefits belongs only to one person: the injured party. See, e.g., *Belcher v Aetna Cas & Sur Co*, 409 Mich 231, 251-52, 255; 293 NW2d 594 (1980) ("Section 3114 and s 3115 ... are entitlement provisions in the sense that they are the only sections where persons are given the right to claim personal protection insurance benefits from a specific insurer. ... The Legislature clearly intended that surviving dependents recover certain losses in the event the injured person dies from his injuries. To effectuate this intent and to provide survivors with a source of recovery, it is necessary to infer from the language of [MCL 500.]3114 and [MCL 500.]3115 that where an injured person is given the right to recover benefits from a specific insurer, his surviving dependents have the same right of recovery for their losses.") (emphasis added). "The right to benefits belongs only to one party: it either belongs to the injured person or, in the case of the injured person's death, it belongs to the injured person's dependents." *Jago v Dept of State Police*, unpublished opinion per curiam of the Court of Appeals, issued August 2, 2011 (Docket No 297880) (**Exhibit D**, p. 8). Indeed, the Court of Appeals has recognized "that the trial court correctly held that the right to bring a personal protection insurance action, including claims for attendant care services, belongs to the injured party." *Hatcher v State Farm Mut Auto Ins Co*, 269 Mich App 596, 600; 712 NW2d 744 (2005). "The right to collect no-fault insurance benefits accrues to the injured person, even though another person may be legally responsible for the expenses incurred as a result of the injury." *Commire v Auto Club of Mich Ins Group*, 183 Mich App 299, 302; 454 NW2d 248 (1990). A medical provider has no "right." Rather, the No-Fault insurer has an "option." Covenant's argument that MCL 500.3157

creates a "right" is in contravention of the published decisions of this Court stating that only MCL 500.3114 and MCL 500.3115 create entitlements. (**Covenant Brief**, p. 9).

II. *The Court of Appeals Failed to Apply the Entirety of MCL 500.3112, and Erroneously Concluded that a Healthcare Provider is "Some Other Person" as that Phrase is Used in the Statute.*

A. The Entirety of the Statute Must be Read, as a Whole.

Even assuming, *arguendo*, that the No-Fault Act confers the right upon a medical provider to bring its own claim, thereby stripping the No-Fault provider of its statutory choice, the Court of Appeals still misread MCL 500.3112. The Court of Appeals erred by focusing on the second sentence of MCL 500.3112, while wholly ignoring the first sentence discussed *supra*, and, in effect, re-writing that first sentence.

This Court has held:

Under the doctrine of *noscitur a sociis*, a phrase must be read in context. A phrase must be construed in light of the phrases around it, not in a vacuum. Its context gives it meaning. *Koontz v. Ameritech Services, Inc.*, 466 Mich. 304, 318, 645 N.W.2d 34 (2002). Similarly, it is a well-settled rule of law that, when construing a statute, a court must read it as a whole. *G C Timmis & Co. v. Guardian Alarm Co.*, 468 Mich. 416, 421, 662 N.W.2d 710 (2003); *Arrowhead Dev. Co. v. Livingston Co. Rd. Comm.*, 413 Mich. 505, 516, 322 N.W.2d 702 (1982); *Layton v. Seward Corp.*, 320 Mich. 418, 427, 31 N.W.2d 678 (1948).

Apsey v Mem'l Hosp, 477 Mich 120, 130; 730 NW2d 695 (2007) (emphasis added). "It must be remembered that in assessing legislative intent the act is to be construed as a whole and its provisions are to be construed so as to harmonize rather than conflict with one another." *Gusler v Fairview Tubular Prods*, 412 Mich 270, 291; 315 NW2d 388 (1981).

The reading by the Court of Appeals fails to account for the whole of the statutory text. In effect, the decision by the Court of Appeals uses the language of the second

sentence to re-write the first sentence. When it comes to benefits for a medical provider who has submitted a bill to a No-Fault insurer, the Court of Appeals decision has rewritten the statute. No longer does MCL 500.3112 require that PIP "benefits are payable to or for the benefit of an injured person," but now MCL 500.3112 requires that PIP "benefits are only payable to a billing medical provider for the benefit of the injured person." As this Court has held, "The Court may not assume that the Legislature inadvertently made use of one word or phrase instead of another." *Pohutski v City of Allen Park*, 465 Mich 675, 683-84; 641 NW2d 219 (2002) (quoting *Robinson v Detroit*, 462 Mich 439, 459; 613 NW2d 307 (2000)).

Furthermore, if the statute is read in the manner advocated by the Court of Appeals, the option of benefits being payable "to... an injured person" is removed. "This violates 'the fundamental rule of [statutory] construction that every word of a statute should be given meaning and no word should be treated as surplusage or rendered nugatory if at all possible.'" *Pittsfield Charter Twp v Washtenaw County*, 468 Mich 702, 714; 664 NW2d 193 (2003). It would be an odd conclusion, indeed, to read the statute to strip the "right" to collect No-Fault benefits from the one individual intended to benefit under the No-Fault Act: the injured person.

Furthermore, nothing in this case changes the ability of an injured person to bring a suit for PIP benefits, as MCL 500.3114, titled "Persons entitled to personal protection or personal injury benefits," explicitly makes clear that a No-Fault policy "applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, if the injury arises from a motor vehicle accident." The remaining sections confirm that "a person suffering accidental bodily injury" is "entitled" to benefits (MCL 500.3114(2) and (3)) or shall "claim" benefits

(MCL 500.3114(4) and (5)).³ Thus, the statute specifically contemplates that the entitlement or claim belongs to the person who has sustained "accidental bodily injury." Indeed, this Court has recognized "Section 3114 and s 3115 constitute both entitlement provisions and priority provisions in certain respects. They are entitlement provisions in the sense that they are the only sections where persons are given the right to claim personal protection insurance benefits from a specific insurer." *Belcher*, 409 Mich at 251-52 (emphasis added). Notably lacking from the provisions creating an entitlement to bring an action seeking benefits is any reference to a medical provider.

The reading of MCL 500.3112 permitting a direct claim by a medical care provider alters the commands of MCL 500.3114 and MCL 500.3115, regarding entitlement. As the statute must be read as a whole, MCL 500.3112 must be read in such a way so to not alter other provisions of the No-Fault Act. The retort from the medical providers will no doubt be, "If the insured does not press for benefits, then the medical provider has no recourse to seek payment." This retort is unsupported, as the medical providers do have recourse. The providers may bring suit against the injured person for payment, who, in turn, would likely bring the No-Fault insurer in as a third-party. This mechanism completely complies with MCL 500.3112, MCL 500.3114, and MCL 500.3115, while the present mechanism of direct medical provider lawsuits contravenes the "entitlement" provisions. As has long been the rule, "the entire act must be read, and the interpretation to be given to a particular word in one section, arrived at after due consideration of every other section so as to produce, if possible, a harmonious and consistent enactment as a whole." *Joslin v Campbell, Wyant & Cannon Foundry Co*,

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³ MCL 500.3115(1) also permits a "claim" by "a person suffering accidental bodily injury."

359 Mich 420, 426; 102 NW2d 584 (1960) (quoting *City of Grand Rapids v Crocker*, 219 Mich 178, 182; 189 NW 221 (1922)).

B. Even Assuming, *Arguendo*, that a Medical Provider has a Direct Right of Action Against the Medical Provider, that right is not Independent of the Injured Person.

The notion of an "independent" cause of action by a medical provider was created by *MHSI*, 299 Mich App at 448 n1 (citing *Lakeland*, 250 Mich App at 39) ("We note that the language 'or on behalf of' in the release is similar to the phrase 'or for the benefit of' in MCL 500.3112, which this Court has recognized creates an independent cause of action for healthcare providers.")⁴ As noted, *supra*, *Lakeland* actually stands for no such proposition, as the No-Fault insurer did not contest the ability of the medical provider to directly bring suit, so the issue was never decided. *Lakeland*, 250 Mich App at 37. Interestingly, some of the cases cited for the proposition that a medical provider has an independent right to bring an action against a medical provider actually stand for the opposite conclusion, and they state that even though a "direct" claim may exist, it is also "derivative." *Regents*, 250 Mich App at 733.

This conclusion is in line with the provisions regarding an "entitlement" to benefits. Argument II(A), *supra*. If the entitlement to benefits arises through the injured person, then anyone claiming a right to payment of those benefits must be claiming

⁴ The very first reference to an "independent" claim comes from *Borgess Med Ctr v Resto*, 273 Mich App 558, 569; 730 NW2d 738 (2007). The majority opinion in that case was vacated, and the reasoning of the concurrence was adopted in its place. *Borgess Med Ctr v Resto*, 482 Mich 946; 754 NW2d 321 (2008). The concurrence did not address whether a medical provider had an "independent" claim or not. *Borgess Med Ctr*, 273 Mich App at 585 (White J, concurring). As the opinion was vacated, it lacks any precedential value. *People v Mungo*, 295 Mich 537, 554; 813 NW2d 796 (2012) ("Because the Michigan Supreme Court vacated *Mungo I* and *Mungo II*, they have no precedential value."). In fact, even *Wyoming* realized that this case had no value, and could not be relied upon, as the Court of Appeals noted, "The Michigan Supreme Court affirmed this Court's judgment based on the reasoning of the concurring opinion. The concurring opinion did not discuss whether the plaintiff had standing to sue. Therefore, this Court cannot rely on the majority opinion in *Resto I*." *Wyoming*, 308 Mich App at 396.

through the entitled, injured person. In fact, in the context of survivor benefits, this very principle was recognized:

The Legislature clearly intended that surviving dependents recover certain losses in the event the injured person dies from his injuries. To effectuate this intent and to provide survivors with a source of recovery, it is necessary to infer from the language of s 3114 and s 3115 that where an injured person is given the right to recover benefits from a specific insurer, his surviving dependents have the same right of recovery for their losses. In this way, a survivor's entitlement to benefits may be said to be derivative of or dependent upon the deceased injured person's entitlement to benefits had he survived.

Belcher, 409 Mich at 255 (emphasis added). Further, just like MCL 500.3112, MCL 500.3108(1), which creates the derivative right of survivors, speaks of benefits being "payable": Compare MCL 500.3112 ("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") and MCL 500.3108(1) ("Except as provided in subsection (2), personal protection insurance benefits are payable for a survivor's loss ... that dependents of the deceased at the time of the deceased's death would have received for support during their dependency from the deceased if the deceased had not suffered the accidental bodily injury causing death and expenses") (emphasis added). If the language of benefits being "payable" creates a derivative right for survivors, then it can only create, at best, a derivative right for medical providers. "A phrase that is found in multiple sections throughout the no-fault act should be consistently construed." *Bronson Methodist Hosp v Allstate Ins Co*, 286 Mich App 219, 227; 779 NW2d 304 (2009).

Further confusing matters, other case law holds that a medical provider "stands in the shoes" of the injured party, a conclusion which is at odds with the "independent" claims recognized in other cases. *E.g., TBCI, PC v State Farm Mut Auto Ins Co*, 289

Mich App 39, 44; 795 NW2d 229 (2010) (noting that a medical provider, "by seeking coverage under the policy, is now essentially standing in the shoes of [the insured]."). If the medical provider stands in the shoes of the insured, then settlement by the insured would extinguish the medical provider's claim as well.

Additionally, the conclusion that medical providers have an independent right of recovery would also create preferential classes of providers, based on the same benefits permitted by MCL 500.3107(1)(a), *i.e.* "allowable expenses." Attendant care is an "allowable expense." *E.g.*, *Booth v Auto-Owners Ins Co*, 224 Mich App 724, 729-30; 569 NW2d 903 (1997); *Douglas v Allstate Ins Co*, 492 Mich 241, 266-73; 821 NW2d 472 (2012) (analyzing attendant care as an "allowable expense"). In the context of attendant care, the Michigan Court of Appeals has considered whether a claim for attendant care belongs to the individual providing the care, or to the injured party:

Plaintiff Kimberly Hatcher, as next friend of her daughter, Aris Hatcher, filed a claim seeking personal protection insurance benefits pursuant to the Michigan no-fault act. State Farm moved for summary disposition pursuant to MCR 2.116(C)(8), relying on this Court's decision in *Cameron v. Auto Club Ins Ass'n*, that MCL 600.5851 does not toll the one-year-back rule. Kimberly Hatcher responded, arguing that the *Cameron* decision violated due process and equal protection. State Farm replied, arguing that MCL 600.5851 did not apply because the claim for attendant care services belonged to Kimberly Hatcher, not Aris Hatcher. The trial court denied State Farm's motion, holding that "the right to attendant care belongs to the injured person" and that *Cameron* violates equal protection.

Hatcher, 269 Mich App at 598-99 (emphasis added). The Court of Appeals determined the attendant care claim was a derivative one, belonging to the injured party:

State Farm argues that the trial court erred in denying its motion for summary disposition because MCL 600.5851 does not apply to Kimberly Hatcher's claim for attendant care services. More specifically, State Farm contends that the "claimant" in the instant case is Kimberly Hatcher, not

Aris Hatcher, because, as the one legally responsible for Aris Hatcher's expenses, Kimberly Hatcher is the one entitled to payment for the services rendered. State Farm asserts that Aris Hatcher does not have an identifiable or appreciable loss if Kimberly Hatcher is not paid. However, MCL 500.3112 provides in part, "Personal protection insurance benefits are payable to or for the benefit of an injured person [.] The statute confers a cause of action on the injured party and does not create an independent cause of action for the party who is legally responsible for the injured party's expenses. Further, a parent's cause of action to recover benefits for expenses incurred during an insured's minority is derivative of the injured minor's rights under the no-fault act. Therefore, we conclude that the trial court correctly held that the right to bring a personal protection insurance action, including claims for attendant care services, belongs to the injured party."

Id. at 599-600 (emphasis added). Therefore, the same statute creating the benefits for "allowable expenses", MCL 500.3107(1)(a), as viewed through MCL 500.3112 has been found to create only a derivative claim for attendant care. Thus, the Court of Appeals has concluded that defenses to claims, such as tolling, are applied to the injured claimant, not the provider of an "allowable expense," because the provider's claim is derivative. If the claim of an attendant care provider is purely derivative, then the claim of a medical provider, at best, must also be purely derivative, as both attendant care and medical care are based upon the same benefit, *i.e.* an MCL 500.3107(1)(a) "allowable expense."

What the Court of Appeals in the instant case (and the line of cases permitting an "independent" claim for medical providers), has done is to create preferential treatment for "professional" medical providers over other providers of "allowable expenses." Such "professional" medical provider providing "allowable expenses" are permitted an "independent" right of action, while non-professional provider of "allowable expenses" have only a "derivative claim. There is no justification in the statute for such

distinction between providers of "allowable expenses," and preferential treatment afforded to one class of providers over the other.

Furthermore, in an unpublished opinion, the Michigan Court of Appeals has recognized this derivative nature, in reversing a trial court's determination denying a medical provider the ability to intervene:

Finally, while Bronson's post-judgment intervention will extend the time for resolution of the case, we do not find that it would "have the effect of delaying the action or producing a multifariousness of parties and causes of action." *Precision Pipe & Supply, Inc.*, [195 Mich App 153, 156; 489 NW2d 166 (1992)]. The root of the declaratory judgment action remains the determination of whether Brown was entitled to statutory no-fault benefits from Home-Owners; Bronson's claims are derivative of that entitlement. See MCL 500.3107; *Moody v. Home-Owners Ins Co*, 304 Mich.App 415, 440; 849 NW2d 31 (2014), lv granted on other grounds 497 Mich. 957 (2015).

Bronson Health Care Group, Inc v Home-Owners Ins Co, unpublished opinion per curiam of the Court of Appeals, issued July 16, 2015 (Docket Nos 321908, 32243) (Exhibit A, p. 4).

C. The Court of Appeals in the Instant Case Extended the Prior, Erroneous Case Law Even Further, Completely Severing the Claim of a Medical Provider from the Claim of the Injured Insured.

Furthermore, the Court of Appeals in the instant case, did not just apply the erroneous conclusions of prior panels of the Court of Appeals regarding the ability of a medical provider to bring a direct claim against a No-Fault insurer, it extended the erroneous conclusion even further. According to the Court of Appeals, not only does the medical provider have a direct claim, but that direct claim is now completely free and independent of the claim of the injured party.

The Court of Appeals took *Wyoming*, a decision recognizing a direct action, *i.e.* standing, on the part of the medical providers, and converted that recognition of "standing" to a wholly independent right of action, such that when services are provided, the right to recover for those services now belongs solely to the medical provider.⁵ In so doing, the Court of Appeals confused two separate and distinct areas of the law.

"Standing" is merely a procedural device designed to ensure that a party to litigation has a legal interest in the subject matter sufficient to ensure sincere and vigorous advocacy. *Barclae v Zarb*, 300 Mich App 455, 487; 834 NW2d 100 (2013) ("To have standing, a party must have a legally protected interest that is in jeopardy of being adversely affected.' *Dep't of Treasury v. Comerica Bank*, 201 Mich.App. 318, 329–330, 506 N.W.2d 283 (1993). ... 'This standing doctrine recognizes that litigation should be begun only by a party having an interest that will assure sincere and vigorous advocacy.' [*City of Kalamazoo v Richland Twp*, 221 Mich App 531, 534; 562 NW2d 237 (1997)]."). In contrast, "Subrogation, simply defined, involves 'the substitution of one person in the place of another with reference to a lawful claim or right.'" *Atlanta Int'l Ins Co v Bell*, 438 Mich 512, 521; 475 NW2d 294 (1991) (quoting 73 Am Jur 2d, Subrogation, § 1, p. 598).

While multiple parties may have standing to litigate the same issue, that does not mean that one party is subrogated to another party regarding the issue, let alone that an equitable subrogor can be deprived of a statutory right. Indeed, where there is a comprehensive statute, the common law is superseded. *Trentadue v Buckler Lawn*

⁵ It appears the Court of Appeals applied rationale similar to that in *State Auto Ins Cos v Velazquez*, 266 Mich App 726, 731-32; 703 NW2d 223 (2005), wherein it was held that an insurer's payment of PIP benefits to its insured before the signing of a release between the insured and a tortfeasor did not preclude the insurer's subrogation action because the insurer was "already standing in 'the shoes of the subrogor' insured with regard to the paid benefits" thereby depriving the insured the ability to release the subrogated rights.

Sprinkler, 479 Mich 378, 389-90; 738 NW2d 664 (2007). In fact, in the context of the No-Fault Act, itself, this Court has already concluded that the statute controls over equitable principles. *Devillers v ACIA*, 473 Mich 562, 591; 702 NW2d 539 (2005). Even if the No-Fault Act permitted either the insured or the medical provider to bring suit to recover benefits, the medical provider's claim remains completely derivative of, and alternative to, the injured party, because a No-Fault insurer remains free to pay either to the injured party or for the benefit of the injured party. However, in the instant case, once the medical provider submits its bill, the claim of the medical provider becomes absolute, and cannot be compromised, or otherwise affected, by any action of the injured insured. This is, in effect, full equitable subrogation, in derogation of the plain statutory language.

If the Legislature meant for subrogation to apply, it could have made that clear by including words to the effect that "a person who renders services for the care, recovery, or rehabilitation of an injured person is subrogated to the rights of the injured person." However, that is not what the Legislature did. Instead, it permitted payment to either the injured insured or for the benefit of the injured insured. The Michigan Legislature is well aware of the concept of subrogation, and could have provided for subrogation favoring the provider of covered No-Fault services. *E.g.*, MCL 18.364; MCL 440.5117(2); and MCL 330.1813 (applying subrogation to a recovery of insurance benefits). However, the Legislature did not provide for subrogation, but rather provided that only the injured party is entitled to benefits (MCL 500.3114, MCL 500.3115); and that benefits are alternately payable "to or for the benefit of an injured person." The Court of Appeals in the instant case ignored the clear words chosen by the Legislature, and, in their place, created a subrogation interest. "The words chosen by the

Legislature are presumed intentional. We will not speculate that it used one word when it meant another." *Coblentz v City of Novi*, 475 Mich 558, 572; 719 NW2d 73 (2006).

D. A Medical Provider is not "Some Other Person."

In addition to failing to read the statute as a whole, the Court of Appeals has also misread the second sentence of MCL 500.3112, in any event.

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.

(emphasis added). There are three "persons" addressed by MCL 500.3112: 1.) the injured person ("to ... a person"); 2.) a person providing services to the injured person ("for the benefit of a person"); and 3.) "some other person." Thus, "some other person" must be separate and distinct from either the injured party or a party who has benefitted the injured party. Logically, as a medical provider would be paid "for the benefit of a person," it cannot also be "some other person." In short, medical providers cannot be both persons paid "for the benefit of a person" and "some other person." If "some other person" included those to be paid "for the benefit of a person," then it would not have used the different term, "some other person."

When the Legislature uses different words, the words are generally intended to connote different meanings. Simply put, "the use of different terms within similar statutes generally implies that different meanings were intended." 2A Singer & Singer, *Sutherland Statutory Construction*, (7th ed.), § 46:6, p. 252. If the Legislature had intended the same meaning in both statutory provisions, it would have used the same word.

US Fid Ins & Guar Co v MCCA, 484 Mich 1, 14; 795 NW2d 101 (2009). Therefore, based on the rules of statutory construction, "some other person" must be distinct from a person payable "for the benefit of a person." As a provider of medical services is

payable "for the benefit of a person," the medical provider cannot also be "some other person."

"Some other person" is a distinct category. For example, it may include a lienholder on the amounts to be paid, such as an attorney seeking to assert a claim based on a contingent fee arrangement. *Aetna Cas & Sur Co v Starkey*, 116 Mich App 640, 646-47; 323 NW2d 325 (1982).⁶

III. *MCL 500.3112 does not Evidence an Intent to Abrogate the Common Law of Contracts and Does not Require a Hearing.*

The Court of Appeals concluded that once a medical provider submits a bill to a No-Fault insurer, MCL 500.3112 provides the only method for an insurer to discharge its liability. *Covenant*, 313 Mich App at 53. This conclusion is incorrect, as MCL 500.3112, in pertinent part, states:

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.

(emphasis added). "The Legislature's use of the word 'shall' in a statute generally 'indicates a mandatory and imperative directive.'" *Costa v Cmty Emergency Med Servs, Inc*, 475 Mich 403, 409; 716 NW2d 236 (2006) (quoting *Burton v Reed City Hosp Corp*, 471 Mich 745, 752; 691 NW2d 424 (2005)). In contrast:

⁶ The Court of Appeals declined to follow *Starkey*, as being distinguishable and, alternatively due to its age, in *Garcia v Butterworth Hosp*, 226 Mich App 254, 256-57; 573 NW2d 627 (1997). *Wyoming* also held that "To the extent that *Starkey* prohibits a direct cause of action by a healthcare provider against an insurer under the no-fault act, *Starkey* has been abrogated by *Munson, Lakeland Neurocare, and Regents*." *Wyoming*, 308 Mich App at 399. However, as noted in Argument I, *supra*, the reasoning of *Wyoming* is dubious and flawed.

"may" designates discretion, *People v. Brown*, 249 Mich.App. 382, 386, 642 N.W.2d 382 (2002). As a general rule, "the word 'may' will not be treated as a word of command unless there is something in the context or subject matter of the act to indicate that it was used in such a sense." *Mill Creek Coalition v. South Branch of Mill Creek Intercounty Drain. Dist.*, 210 Mich.App. 559, 565, 534 N.W.2d 168 (1995). Therefore, the Legislature's use of the word 'may' signifies that it intended the section to outline a permissive, as opposed to mandatory, action available[.]

Old Kent Bank v Kal Kustom Enterprises, 255 Mich App 524, 532; 660 NW2d 384 (2003). If MCL 500.3112 contained the exclusive method to discharge an insurer from liability, and required a hearing, then MCL 500.3112 would have used the word "shall" instead of "may."

Furthermore, the common law of contracts permits a party to release another party from further liability, and can further bar all those who may claim through the releasor. *Skotak v Vic Tanny Int'l Inc*, 203 Mich App 616, 619; 513 NW2d 428 (1994) (holding that a decedent's release of claims barred the decedent's estate); *Beardslee v Mich Claim Servs, Inc*, 103 Mich App 480, 489; 302 NW2d 896 (1981) (concluding that a wife's loss of consortium claim was barred by the release of the husband).⁷ Further, "Where a release is unambiguous and unequivocal, the parties' intent as expressed in the release governs its scope." *Burgess v Clark*, 215 Mich App 542, 547-48; 547 NW2d 59 (1996).

⁷ *But see, Oldani v Liberman*, 144 Mich App 642, 649; 375 NW2d 778 (1985) (concluding *Beardslee* really turned on application of the Workers Disability Compensation Act ("WDCA")). To begin with, *Oldani* is not dispositive, as it was issued in 1985, and only published opinions of the Court of Appeals issued after November 1, 1990 are binding. MCR 7.215(J)(1). Furthermore, the language of *Beardslee* demonstrates that the Court was discussing the effect of the release, not necessarily the effect of the WDCA. *Beardslee*, 103 Mich App at 489 ("The language of the release is equally clear. The negligent acts of defendants for which recovery is sought were expressly waived in the redemption proceeding and expressly released in the instrument quoted at the beginning of this opinion and voluntarily agreed to by plaintiff Lawrence A. Beardslee. To the extent his wife's claim is derivative and relies upon losses caused by the original injury, it is likewise extinguished.").

The decision of the Court of Appeals in the instant case would be to hold that MCL 500.3112 has modified the common law, and has permitted a release only pursuant to the procedures of MCL 500.3112, *i.e.* following an apportionment hearing.

[W]e presume that the Legislature has knowledge of the common law when it acts. *Dawe v. Dr. Reuven Bar-Levav & Assoc., PC*, 485 Mich. 20, 28, 780 N.W.2d 272 (2010). The common law remains in effect until modified, and abrogation is not lightly presumed. *Id.* Therefore, the Legislature "should speak in no uncertain terms" when it chooses to modify the common law. *Id.*, quoting *Hoerstman Gen. Contracting, Inc. v. Hahn*, 474 Mich. 66, 74, 711 N.W.2d 340 (2006).

Cichewicz v Salesin, 306 Mich App 14, 25; 854 NW2d 901 (2014). Indeed:

Language used by the Legislature should show a clear intent to abrogate the common law. ... Common-law principles are not to be abolished by implication. *People v. Williams*, 288 Mich.App. 67, 81, 792 N.W.2d 384 (2010), *aff'd* 491 Mich. 164, 814 N.W.2d 270 (2012).

People v Woolfork, 304 Mich App 450, 497; 848 NW2d 169 (2014).

However, "[w]e will not lightly presume that the Legislature has abrogated the common law. Nor will we extend a statute by implication to abrogate established rules of common law." *Velez v Tuma*, 492 Mich 1, 11;] 821 N.W.2d 432 [2012] (citation omitted). Absent "a contrary expression by the Legislature, well-settled common-law principles are not to be abolished by implication...." *Marquis v. Hartford Accident & Indemnity (After Remand)*, 444 Mich. 638, 652, 513 N.W.2d 799 (1994). "Rather, the Legislature should speak in no uncertain terms when it exercises its authority to modify the common law." *Velez*, 492 Mich. at 11–12, 821 N.W.2d 432 (citations and quotation marks omitted).

Braverman v Granger, 303 Mich App 587, 597; 844 NW2d 485 (2014). In this case, there are no clear unequivocal terms abrogating the common law of contracts, and holding that the common law related to contracts has been abrogated would actually

hinder the goals of the No-Fault Act. The Legislature merely added an additional way to extinguish liability, but it never addressed the existing common law methods.

IV. The Practical Ramifications of the Court of Appeals Decision are Immense, Will have a Chilling Effect on Settlement of No-Fault Cases.

In practice, if the Court of Appeals decision were to stand, settlement of No-Fault cases would be rendered exceedingly difficult, if not impossible. Virtually all medical providers submit bills directly to No-fault insurers after service is rendered. Therefore, CMC's contention that "the insurer can settle with its insured before it receives notice in writing of any other claims" is fanciful. (**CMC Response to Application**, p. 9). In practice, the No-Fault insurer likely receives the medical provider's bill before the injured person even receives it, and therefore, there is no opportunity to settle with the insured. Likewise the carve-out alternative proposed by CMC is also impractical. (*Id.*). If the insurer must carve out all amounts billed by any provider, then in virtually all cases, the injured insured would have no claim to bring, because everything would be carved out, from hospital stays, to x-rays, to prescriptions. This would, in practicality, eliminate the option of payment "to ... the injured person." MCL 500.3112.⁸ Further, negotiating directly with every provider who has submitted a bill, or requiring the injured insured's attorney to obtain authorization from each and every medical provider would prove unworkable. In practice this would require multi-party negotiations in every No-Fault case, perhaps involving dozens of providers, depending on the extent of treatment received by the insured. In fact, *amici* Auto Club Insurance Association has already

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⁸ Question would remain about attendant care and replacement services, as those non-professional providers are apparently not granted the preferential treatment of professional medical service providers. However, one would have to question whether, if such a non-professional provider submitted a log of services provided, those claims would remain with the injured person, or whether they now also become the fully independent claims of the individuals providing services.

demonstrated that the reality will be a multiplicity of lawsuits related to the same MVA, pending in multiple courts, as injured No-Fault claimants frequently have scores of medical providers.⁹ (**Exhibit B**, pp. 1-2).

The alternate payment scheme also creates situations rife with novel issues which will need to be addressed. For example, what happens in the reverse of the instant case, that is if a medical provider accepted payment from a No-Fault insurer and released the insurer relative to the bill paid, would the No-Fault insured still be able to make a claim for the same benefits, arguing that the medical provider lacked the ability to bind the insured? Further, what incentive would No-Fault insureds have to bring lawsuits (which often are all-encompassing for all outstanding benefits from all providers), if each medical provider which has provided its bills to the No-Fault insurer has the unfettered right to proceed with its own claim, regardless of the action of the insured? The claim of No-Fault insured would be reduced to a *de minimis* amount, virtually guaranteeing that multiple lawsuits by each provider will become the new norm. What was once a single lawsuit will now spawn volumes of duplicate cases in multiple courts.

Since the No-Fault Act became effective, negotiations over disputed benefits took place between the injured claimant and the No-Fault insurer. The claimant had to be mindful of any outstanding invoices in negotiating a resolution. After all, it was the claimant who requested the medical provider's services, and who ultimately remained responsible for payment. Therefore, insureds would negotiate to compensate any

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⁹ The issue is further exacerbated by the realities of the medical profession, whereby hospitals frequently utilize independent contractors, such that someone who may only present to a single location for treatment, may receive separate bills from a radiology group, an emergency medicine group, an anesthesiology group, surgeons, the hospital itself, and numerous other individuals who provide services at the hospital, but not as employees of the hospital.

outstanding providers, knowing that if a provider of medical or other services decided it was entitled to more, it could proceed against the insured. Medical providers were never without remedy, and this system served No-Fault insurers, No-Fault insureds, and medical providers from the inception of the No-Fault Act through the recent misreadings of the Act by the Court of Appeals. This two-party negotiation has been turned into a necessary conference of numerous parties, where a holdout, or small group of holdouts can prevent resolution of a No-Fault claim, and file a multiplicity of lawsuits that the primary parties (the injured insured and the No-Fault insurer) want to settle. Therefore, battles will rage on, even after the primary parties have come to terms. In fact, settlements which used to be concluded rather quickly now routinely take months to complete as so-called "*Covenant Motions*" are clogging the dockets of the trial courts on motion days.

Further, such motions are littered with providers seeking payment for services for which No-Fault insurers are charged many times more than in other circumstances. For example, an MRI which may cost Medicare \$500, or a Workers' Compensation insurer \$750, or a health insurer \$1,000, will cost a No-Fault insurer \$4,000! The only persons "benefitting" from the Court of Appeals decision are opportunistic medical providers seeking to get at the un-capped pockets of a No-Fault insurer so they can charge the No-Fault insurer exorbitant amounts that no other payer can be charged. Thus, in addition to litigation costs, costs for medical services are also increasing.

"[T]he no-fault insurance system ... is designed to provide victims with assured, adequate, and prompt reparations *at the lowest cost to both the individuals and the no-fault system.*" *Griffith ex rel Griffith v State Farm Mut Auto Ins Co*, 472 Mich 521, 539 n15; 697 NW2d 895 (2005) (quoting *Celina Mut Ins Co v Lake States Ins Co*, 452

Mich 84, 89; 549 NW2d 834 (1996)) (emphasis by court). This Court has explicitly held that it is cognizant of costs to the system in deciding No-Fault cases, as it has held that a process "would largely obliterate cost containment for this mandatory coverage. We have always been cognizant of this potential problem when interpreting the no-fault act, and we are no less so today." *Id.* at 539. Numerous, duplicative, lawsuits related to the benefits provided to a single individual will undoubtedly raise costs on the No-Fault system as a whole. And who will pay for the exponential increase in these litigation costs? The costs will ultimately be paid by the insurance purchasing public, which already pays the highest average automobile insurance premiums in the nation. (Exhibit C). No-Fault will have failed one of its basic goals, again.

CONCLUSION

For all these reasons, and for those reasons advanced by State Farm, and other *amici* in support of State Farm, MMRMA requests this Honorable Court reverse the Court of Appeals, and conclude that a No-Fault medical provider does not have an independent claim against a No-Fault insurer, and will be bound by the No-Fault insured's actions in resolving whatever claim the insured may bring against the No-Fault insurer.

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DATED: September 26, 2016

EXHIBIT A

STATE OF MICHIGAN
COURT OF APPEALS

BRONSON HEALTH CARE GROUP, INC, d/b/a
BRONSON METHODIST HOSPITAL, a
Michigan nonprofit corporation,

Plaintiff-Appellant,

v

HOME-OWNERS INSURANCE COMPANY, a
Michigan insurance agency,

Defendant-Appellee.

UNPUBLISHED
July 16, 2015

No. 321908
Kalamazoo Circuit Court
LC Nos. 2013-000399 NF

HOME-OWNERS INSURANCE COMPANY, a
Michigan insurance agency,

Plaintiff-Appellee,

v

ROBERT WENDELL BROWN, III,

Defendant-Appellee,

and

BRONSON HEALTH CARE GROUP, INC, d/b/a
BRONSON METHODIST HOSPITAL, a
Michigan nonprofit corporation,

Appellant.

No. 322243
Kalamazoo Circuit Court
LC No. 2012-000643 CK

Before: SERVITTO, P.J., and BECKERING and BOONSTRA, JJ.

PER CURIAM.

In this consolidated appeal,¹ Appellant Bronson Health Care Group, Inc (“Bronson”) appeals in both docket numbers. In Docket No. 321908, Bronson appeals by delayed leave granted the trial court’s denial of its motion for post-judgment intervention. In Docket No. 322243, Bronson appeals by right from the trial court’s grant of summary disposition to Appellee Home-Owners Insurance Company (“Home-Owners”) on the grounds that Bronson’s claims were barred by res judicata. We reverse in both cases and remand for further proceedings consistent with this opinion.

I. PERTINENT FACTS AND PROCEDURAL HISTORY

These cases arise from an August 31, 2012 motor vehicle accident involving an automobile driven by a non-party and a motorcycle driven by defendant Robert Brown, III (“Brown”). Brown was injured in the accident and received treatment from, among other providers, Bronson. Home-Owners insured the automobile involved in the accident. Bronson provided bills to Home-Owners and requested payment under the no-fault act, MCL 500.3101, et seq.

Home-Owners filed a complaint for declaratory judgment against Brown² in December of 2012, alleging that it had “made several efforts to try to investigate whether there is coverage available, pursuant to its policy, for the injuries sustained in this matter by Defendant and Ms. York;[³] however, Defendant has failed to cooperate with that investigation.” Home-Owners was unable to personally serve Brown. The trial court granted Home-Owners’s motion for alternate service. After Brown failed to respond to the alternate service, the trial court granted Home-Owners a default against Brown. Home-Owners then moved the trial court for entry of a default judgment against Brown. Counsel for Brown appeared at the motion hearing and argued against the entry of a default judgment on the grounds that the alternate service was defective and the trial court had not obtained personal jurisdiction over Brown. The trial court granted Home-Owners a default judgment on June 3, 2013.

Bronson filed suit against Home-Owners, seeking reimbursement for services provided to Brown, on August 24, 2013.⁴ Then, on October 21, 2013, Bronson and Borgess Medical Center⁵ jointly moved the trial court for post-judgment intervention in Home-Owners’s declaratory action. The trial court denied that motion, stating in relevant part:

¹ See *Home-Owners Ins Co v Brown*, unpublished order of the Court of Appeals, issued November 13, 2014 (Docket No. 322243).

² Home-Owners did not name Bronson as a defendant in that action.

³ York was a passenger on Brown’s motorcycle. She was not a party to either of the cases below and is not a party to this appeal.

⁴ Both cases were presided over by the same trial judge.

⁵ Borgess Medical Center also provided medical services to Brown. Borgess is not a party to this appeal and was not involved in any of the litigation below apart from filing the joint motion to intervene.

I am going to deny the motion. It certainly is a tricky situation because you have someone who has not been cooperative and an insurance company has to go and they have to do their investigation to see whether their coverage applies or not.

And I certainly understand that it puts the hospitals in a bind because they may or may not have certain arguments. But I'm not aware of any requirement in general practice that all of the medical care providers, if there are claims that have been made, that they're obligated to go out and find those individuals and sue those individuals, too.

* * *

But I'm not going to grant the request to intervene post-judgment in this case. I think the file reflects that, unfortunately, Mr. Brown was not cooperating and appeared to be, in the Court's eyes, avoiding service, which is why the request for alternate service was made.

On March 6, 2014, Home-Owners moved for summary disposition in Bronson's action against it. The trial court granted the motion on the grounds that Bronson's claims were barred by res judicata due to the default judgment in the other case. These appeals followed.

II. DOCKET NUMBER 322243

In Docket No. 322243, Bronson argues that the trial court erred in denying its motion for post-judgment intervention. We agree. We review a trial court's decision on a motion to intervene for an abuse of discretion. *Auto-Owners Ins Co v Keizer-Morris, Inc*, 284 Mich App 610, 612; 773 NW2d 267 (2009). A trial court abuses its discretion when its decision falls outside the principled range of outcomes. *Id.*

MCR 2.209 addresses intervention, and provides in relevant part:

(A) Intervention of Right. On timely application a person has a right to intervene in an action:

* * *

(3) when the applicant claims an interest relating to the property or transaction which is the subject of the action and is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

"The rule for intervention should be liberally construed to allow intervention where the applicant's interests may be inadequately represented." *Neal v Neal*, 219 Mich App 490, 492; 557 NW2d 133 (1996). However, "intervention may not be proper where it will have the effect of delaying the action or producing a multifariousness of parties and causes of action." *Precision Pipe & Supply, Inc v Meram Const, Inc*, 195 Mich App 153, 156; 489 NW2d 166 (1992). To

that end, the requirement of a timely application requires an intervenor to be diligent in seeking intervention and not “sit on its rights.” *Id.* at 157. Further, although there is not a blanket prohibition on post-judgment intervention, see *Scion, Inc v Martinez*, 491 Mich 889; 810 NW2d 33 (2012), “[t]here should be considerable reluctance on the part of the courts to allow intervention after an action has gone to judgment and a strong showing must be made by the applicant.” *Dean v Dep’t of Corrections*, 208 Mich App 144, 150; 527 NW2d 529 (1994).

Our review of the record leads us to conclude that Bronson had a right to intervene under MCR 2.209(A)(3). Bronson had an interest in the “property or transaction” that was the subject of Home-Owner’s declaratory action, i.e., no-fault benefits paid or payable to Brown. The record indicates that Bronson provided over \$140,000 in medical services to Brown. The resolution of the issue of whether Brown was entitled to benefits from Home-Owners would affect Bronson’s collection of those funds. See MCL 500.3105; MCL 500.3107; see also *Munson Med Ctr v Auto Club Ins Ass’n*, 218 Mich App 375, 378; 554 NW2d 49 (1996). Further, because Brown failed to participate in the litigation apart from his appearance at the default judgment motion hearing, Bronson’s absence impaired or impeded its ability to protect its interests.

Further, Bronson did not “sit on its rights.” *Precision Pipe & Supply, Inc*, 195 Mich App at 157. The record is devoid of evidence that Bronson was aware of the declaratory action prior to the entry of the default judgment. Although Home-Owners argues that statements made by Brown’s attorney suggest some communication between the attorney and Bronson, such an inference is tentative at best. The record does reflect that Bronson was aware of the default judgment by August 12, 2013. Two weeks later, Bronson filed suit to protect its rights. Within two months, it had moved to intervene in the declaratory judgment action. While Bronson could have moved to intervene earlier rather than filing a separate suit, we do not find the relatively short delay in filing significant, especially in light of the fact that Bronson almost immediately took *some* action to protect its rights.

Finally, while Bronson’s post-judgment intervention will extend the time for resolution of the case, we do not find that it would “have the effect of delaying the action or producing a multifariousness of parties and causes of action.” *Precision Pipe & Supply, Inc*, 195 Mich App at 156. The root of the declaratory judgment action remains the determination of whether Brown was entitled to statutory no-fault benefits from Home-Owners; Bronson’s claims are derivative of that entitlement. See MCL 500.3107; *Moody v Home-Owners Ins Co*, 304 Mich App 415, 440; 849 NW2d 31 (2014), lv granted on other grounds 497 Mich 957 (2015).

We therefore conclude that the trial court abused its discretion in failing to grant Bronson’s motion for post-judgment intervention. Accordingly, we reverse the trial court’s order in Docket No. 322243, and remand for further proceedings consistent with this opinion.⁶

⁶ Should other healthcare providers seek to intervene in the action below, the trial court should analyze whether their application is timely under MCR 2.209(A). With regard to Borgess Medical Center, which jointly with Bronson moved for intervention below, our reversal of the

III. DOCKET NUMBER 321908

In Docket No. 321908, Bronson argues that the trial court erred in granting it summary disposition on the grounds that the default judgment barred its claims through res judicata. We agree. Although the trial court was correct in stating that in general res judicata principles may apply to a default judgment, see *Richards v Tibaldi*, 272 Mich App 522, 531; 726 NW2d 770 (2006), we find that it erred concluding that the default judgment barred Bronson's claims in the instant case. The application of res judicata, as well as a trial court's decision on a motion for summary disposition, is reviewed de novo on appeal. *Phinisee v Rogers*, 229 Mich App 547, 551-552; 582 NW2d 852 (1998).

The doctrine of res judicata allows the disposition of a previous suit to bar a subsequent suit if certain conditions are met. *Id.* "For res judicata to apply, defendant must establish the following: (1) the former suit was decided on the merits, (2) the issues in the second action were or could have been resolved in the former action, and (3) both actions involved the same parties or their privies." *Id.* at 551. "A default judgment is treated the same as a litigated judgment and is considered a decision on the merits." *Richards*, 272 Mich App at 531. "Privity between a party and a non-party requires both a substantial identity of interests and a working or functional relationship . . . in which the interests of the non-party are presented and protected by the party in the litigation." *Phinisee*, 229 Mich App at 553 (quotation marks and citations omitted).

In the instant case, Home-Owners argued below, and the trial court agreed, that this Court's decision in *TCBI, P.C. v State Farm Mutual Automobile Ins Co*, 289 Mich App 39; 795 NW2d 229 (2010), indicates that Bronson's suit is barred by res judicata. We disagree. The factual situation in *TCBI* was substantially different from the instant case. In *TCBI*, the injured party had initially brought suit against his automobile insurer for non-payment of his no-fault claims. *Id.* at 41. The injured party received a jury verdict of no cause of action in his case. *Id.* Subsequently, the trial court held that TCBI's claim against the insurer for medical services provided to the injured party was barred by res judicata. *Id.* This Court affirmed, stating:

Plaintiff, by seeking coverage under the policy, is now essentially standing in the shoes of Afful. Being in such a position, there is also no question that plaintiff, although not a party to the first case, was a "privity" of Afful. "A privity of a party includes a person so identified in interest with another that he represents the same legal right. . . ." [*Id.* at 44 (citation omitted).]

By contrast, it was Home-Owners that initially brought a declaratory judgment action against Brown. Brown did not "seek coverage" under a policy or otherwise, and asserted no claims; rather, he was named as the defendant in the original suit, and appears to have been interested principally in avoiding service, not in asserting his own claims for no-fault benefits or in protecting Bronson's (or other healthcare providers') interests in determining whether Home-Owners was liable for no-fault benefits or securing payment for services rendered by healthcare providers. The only action taken by Brown, through his counsel, in the initial suit was a post hoc

trial court's order permits it to intervene in the declaratory action, should it still have an interest in the resolution of that action.

effort to have the default set aside and to prevent the resulting entry of a default judgment. Thus, certainly at the time the default was entered, and unlike the injured party and the plaintiff in *TCBI*, Bronson and Brown did not have a “substantial identity of interests,” nor did they have “a working or functional relationship . . . in which the interests of the non-party are presented and protected by the party in the litigation.” *Phinisee*, 229 Mich App at 553 (quotation marks and citations omitted).⁷ *TCBI* does not compel a different conclusion, in light of the fact that the privity of the parties in that case was not at issue, and in any event was established through the insured’s litigation of his claim for no-fault benefits. *TCBI*, 289 Mich App at 44. We therefore reverse the trial court’s grant of summary disposition in Docket No. 321908.⁸

Reversed in both dockets and remanded for further proceedings. We do not retain jurisdiction.

/s/ Deborah A. Servitto
/s/ Jane M. Beckering
/s/ Mark T. Boonstra

⁷ The default judgment against Brown resulted from his inability to demonstrate “good cause” for failing to answer the complaint against him and for setting aside the default. The most critical stage of the proceedings, therefore, was the time period leading up to the entry of default, at which time (if ever) Brown and Bronson were not in privity.

⁸ We need not decide, in either docket, whether the statements made by Home-Owners’s attorney at the default judgment motion hearing constituted a “waiver” of the application of the default judgment to Bronson’s claims, or that the doctrine of judicial estoppel should be applied in light of those statements.

EXHIBIT B

STATE OF MICHIGAN
IN THE SUPREME COURT

COVENANT MEDICAL CENTER,

Plaintiff-Appellee,

v

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

Defendant-Appellant.

Supreme Court No. 152758

Court of Appeals No. 322108

Saginaw County Circuit Court
No. 13-020416-NF

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BRIEF OF AMICUS CURIAE
AUTO CLUB INSURANCE ASSOCIATION
IN SUPPORT OF APPLICATION FOR LEAVE TO APPEAL

REASONS FOR GRANTING LEAVE TO APPEAL

The past several years have seen an explosion of cases filed against no-fault insurers by healthcare providers. The decision in the instant case has added an element of chaos to an already burdensome situation by materially complicating the process of settling no-fault claims with the insured persons.

This Court has before it two cases which, taken together, afford a signal opportunity to remedy the situation. One is the instant case. The other is *Chiropractors Rehabilitation Group, PC v State Farm Mutual Automobile Ins Co*, Supreme Court No. 152807/*Elite Health Centers, Inc v State Farm Mutual Automobile Ins Co*, Supreme Court No. 152808. For the following reasons, this Court should seize the opportunity.

The Scope of the Problem: Volume of Cases

Recent years have seen an explosion of satellite litigation involving healthcare providers suing no-fault insurers to recover for services rendered to insureds who are injured in auto accidents. In one instance, a single motor vehicle accident in which two persons were injured spawned seven separate suits in four different courts.¹ Globally, the picture is even more bleak. **As of September 2013, two insurers, STATE FARM and AAA Michigan, had more than 1,000 pending cases filed against them directly by healthcare providers -- in addition to suits by the insureds.** (Appendices F, G).

¹*Russell & Young v State Farm*, Wayne County Circuit Court No. 11-009075-NF; *Russell & Young v State Farm*, Wayne County Circuit Court No. 11-010633-NF; *Maple Millennium Medical Center, PLLC v State Farm*, 46th District Court No. 11-3761-GC; *Maple Millennium Medical Center, PLLC v State Farm*, 46th District Court No. 11-3744-GC; *Summit Medical Group, PLLC v State Farm*, 50th District Court No. 12-157483-GC; *Summit Medical Group, PLLC v State Farm*, Wayne County Circuit Court No. 12-008722-NF; *Daudi, PC, Back-In-Line v State Farm*, 31st District Court No. 12-51424-GC.

Other data provide a snapshot over time of the torrent of these cases. Rather than rely on anecdotal perception, FOIA requests were sent out in April 2015 to many different district courts throughout southeast Michigan as well as a few circuit courts. While the circuit court numbers are proving difficult to obtain, five separate district courts have responded. These numbers do not reflect the hundreds of no-fault lawsuits in which medical providers intervene on a daily basis:

- Affiliated Diagnostics of Oakland, LLC: 2012 to the present: **674 lawsuits** filed (44th and 46th District Courts only)
- Mendelson Orthopedics, P.C.: 2011 to the present: **320 lawsuits** filed (37th District Court only)
- Summit Medical Group, LLC: 2011 to the present: **259 lawsuits** filed (19th District Court only)
- Infinite Strategic Innovations, Inc.: 2013 to the present: **190 lawsuits** filed (19th District Court only)
- Northland Radiology, Inc.: 2014 to the present: **101 lawsuits** filed (46th District Court only)
- Doctors Medical, LLC: 2013 to the present: **74 lawsuits** filed (19th District Court only)
- Silver Pine Imaging, LLC: 2013 to present: **57 lawsuits** filed (15th District Court only)

(Appendix D).

The result has been a multiplication of the transactional costs to insurers and, ultimately, to the motoring public, as well as an increased burden on the time and resources of the courts of this State.

Complicating the Problem: Inability To Settle

As if the burden of tracking and litigating spurious claims filed in different courts were not burdensome enough, the Court of Appeals in the instant case added to the problem. Until recently, a no-fault insurer could confidently settle a case with an insured, and be secure in the knowledge that it was the responsibility of the insured's attorney to see that all claims were included in the settlement. *Clark v Al-Amin*, 309 Mich App 387, 390-91; 872 NW2d 730 (2015).

Through a misreading of MCL 500.3112 (which is demonstrated in Issue I., *infra*), the panel in the instant case held that an insurer cannot settle with its insured alone. Rather, it must include in the process any provider which has submitted a bill, and obtain an "apportionment order" from the circuit court. The circuit courts are now inundated with requests for "apportionment hearings". In one pending case, the no-fault insurer must notify 85 separate providers of the apportionment hearing. (Appendix E).

The source of both of the foregoing problems is a chronic misreading of §3112. For reasons set forth below, §3112 does not confer any rights on a healthcare provider, much less an entitlement to abort a settlement between a no-fault insurer and its insured. The issues presented are, without question, of major significance to the jurisprudence of this State, MCR 7.302(B)(3). In addition, the decision of the Court of Appeals in the instant case directly conflicts with published authority holding that an injured person may waive or settle the provider's claim against the no-fault insurer. *Miller v Citizens Ins Co*, 490 Mich 905; 804 NW2d 740 (2011); *Moody v Home Owners Ins Co*, 304 Mich App 415, 442-43; 849 NW2d 31 (2014), MCR 7.302(B)(5).

This Court should grant leave to appeal in the instant case.

EXHIBIT C

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Car insurance rates by state, 2016 edition

Mark Vallett - Last updated: Mar. 2, 2016

Michigan comes out on top for the third year in a row in a contest that no state wants to win: the most expensive car insurance rates in the nation. Insure.com's 2016 state-by-state comparison of auto insurance premiums found that the Great Lakes State is still the most expensive state in the country to insure a car.

Michigan has been in the No. 1 or No. 2 spot for the six years that Insure.com has commissioned the annual report. Montana captured the No. 2 spot for the second year in a row. New Jersey broke into the top five for the first time ever, Louisiana was No. 4, and Oklahoma rounded out the top five.

Rank	State	Premium
	National average	\$1325
1	Michigan	\$2738
2	Montana	\$2297
3	New Jersey	\$1905

On the flipside of the cost coin, Maine grabbed the No. 1 spot for the cheapest car insurance in the country. Maine has been in the top three for the least expensive car insurance for all six years of the study. This year, Ohio came in No. 2, Wisconsin was three, Idaho took fourth, and New Hampshire earned No. 5.

4	Louisiana	\$1842
5	Oklahoma	\$1778
6	DC	\$1773
7	California	\$1752
8	Florida	\$1654
9	Maryland	\$1610
10	Rhode Island	\$1608
11	Delaware	\$1607

Use the interactive map below and hover over any state to display the average annual rate, comparison to national average, and the percent of change from last year.

This year's best-selling vehicles

The annual study compiles rates from six large insurance carriers in 10 ZIP codes in every state. Rates were for the same full-coverage policy for the same driver -- a 40-year-old man with a clean driving record and good credit.

The rates are an average for the 20 best-selling vehicles in the U.S. in order to present more accurate rates for the average driver -- without high-end sports or luxury cars skewing the data. Each model was rated on its cheapest-to-insure trim level. This year's 20 best-selling vehicles list included:

1. Ford F-150 XL SFE
2. Ford Fusion S
3. Ford Escape S
4. Ford Explorer XLT
5. Chevrolet Silverado 1500 LT
6. Chevrolet Malibu LS
7. Dodge Ram 1500 Tradesman
8. Toyota Camry LE
9. Toyota Corolla L
10. Toyota RAV4 LE
11. Honda Civic LX
12. Honda Accord LX
13. Honda CR-V LX
14. Chevrolet Equinox LS
15. Nissan Altima 2.5 S
16. Nissan Rogue S
17. Nissan Sentra S
18. Hyundai Sonata SE
19. GMC Sierra 1500
20. Jeep Cherokee Sport

The national average for a full-coverage policy as featured in the Insure.com report came in at \$1,325

this year – a slight increase from last year’s average of \$1,311. Rates varied from a low of \$808 a year in Maine to a budget-busting \$2,738 in Michigan. Insurance rates in Michigan are more than double (107 percent) the national average.

Insurance rates are influenced by a number of different factors. Everything from traffic, crime rates, state and local laws, the percentage of uninsured drivers, as well as the number of insurance companies competing in a market can all result in higher, or if you’re lucky, lower insurance premiums in your state.

States with highest car insurance

The reasons behind the highest state rates include everything from Personal Injury Protection (PIP) coverage (a big factor in two of the states) to high fatality rates and litigious-minded drivers.

Here are the top three most expensive states for car insurance and why they are so expensive:

#1 Michigan -- Michigan’s no-fault insurance structure is largely responsible for the high cost of car insurance in the state.

“Michigan auto consumers pay more than most states for car insurance due to the state’s high medical mandate. Michigan is the only state in the country that requires auto consumers to purchase unlimited, lifetime medical benefits as part of the auto insurance policy,” explains Lori Conarton with the Insurance Institute of Michigan.

“Unfortunately, it’s Michigan’s auto insurance consumers who pay the price for this unique auto insurance law,” continues Conarton.

Michigan, like most other no-fault states, requires its drivers to buy personal PIP insurance. PIP coverage will pay the medical bills of the policyholder as well as any passengers and family members that are in the vehicle at the time of the accident.

The big difference is in the amount of PIP coverage that Michigan requires of its drivers. Florida, for example, only requires drivers to carry \$10,000 in PIP coverage, while Michigan’s no-fault policies must offer unlimited medical benefits, which pushes the price up dramatically.

Michigan requires insurers to cover medical claims up to \$530,000. The nonprofit Michigan Catastrophic Claim Association (MCCA) covers damages above that amount. In addition to high insurance premiums, Michigan drivers must pay an annual assessment to the MCCA, which in 2016 is \$150.

The high cost of car insurance pushes many drivers out of the market. According to the Insurance Information Institute (III), an estimated 21 percent of Michigan drivers were uninsured in 2012. High numbers of uninsured drivers raise rates because there are fewer drivers (and their premiums) to share the risk pool.

The high cost also leads to – while technically legal – unscrupulous behavior. Some Michigan drivers will purchase a seven-day policy (which insurers in Michigan sell) so they have proof of insurance

when registering their vehicle and then let the policy expire after a week, leaving them uninsured.

Unfortunately, rates are probably not coming down anytime soon. Until the PIP requirement is changed or ditched altogether, insurance rates will remain high in Michigan.

#2 Montana -- Montana stayed in the No. 2 spot for the second year in a row with an average premium of \$2,297, which is 73 percent higher than the national average and a whopping \$411 increase over last year's Insure.com Montana average.

There are a number of factors that increase rates in Big Sky country, but one of the biggest is the accident rate. Wide-open spaces and lonely roads lead to a lot of car accidents and fatalities. According to the Insurance Institute for Highway Safety, Montana has the highest vehicle accident fatality rate in the country with 22.6 deaths per 100,000 people – twice the national average.

#3 New Jersey --The Garden State makes the top five for the first time. The average premium in New Jersey came in at \$1,905, which is 44 percent higher than the national average.

According to Kacy Campion Renna, vice president of the Professional Insurance Agents of New Jersey, high accident rates may have something to do with New Jersey's costly insurance. "New Jersey ranks No. 1 when it comes to population density, which means there's a greater chance of having an auto incident here."

Renna also cites other factors that can impact rates in New Jersey. "Other factors to consider are high medical costs, high rates of auto and medical fraud combined with the fact that the New Jersey residents tend to be pretty litigious."

Fraud has become a fact in New Jersey's PIP coverage. New Jersey allows PIP coverage levels up to \$250,000, which is the second highest in the country, behind Michigan. Unfortunately, PIP fraud has shot up which raises the cost of insurance for everyone in the state.

States with the cheapest car insurance

The low cost of car insurance in the least expensive insurance premium states can be attributed to a number of factors, including fierce insurer competition and low numbers of uninsured drivers.

#49 Wisconsin – The Badger State is No. 3 when it comes to inexpensive insurance. A yearly premium of \$912 makes car insurance a bargain in Wisconsin. Wisconsin benefits from a pretty rural environment and a very competitive insurance market. A lack of major cities helps keep accident rates down.

According to numbers from Highway Loss Data Institute (HLDI), Wisconsin has 1 death per 100

million vehicle miles traveled in 2013. Montana, the second-most expensive state on the list, recorded 1.96, which was the highest on the list in the same year.

In addition, Wisconsin residents are not particularly litigious, which makes insurance companies happy and leads to lower rates across the state.

#50 Ohio – With an average annual premium of \$899, Ohio is No. 2 for affordable car insurance for the second year in a row, and the state has spent quite a bit of time in the top five over the last six years.

“Ohio is home to many national and regional insurers because of its stable legal and regulatory environment. This creates a competitive marketplace for consumers, leading to great rates and a variety of products and services from which to choose,” explains Perk Reichley, President of Reichley Insurance Agency.

According to the Ohio Insurance Institute, there are currently more than 650 insurance carriers writing policies in the state. Compare that number to the approximately 134 in California and just over 40 in New Jersey, and it’s plain to see how competition has positively affected the rates.

#51 Maine – Maine has hit the No. 1 spot for two years running, and it’s finished in the top three every year of the Insure.com study. The average premium came in at \$807 per year, which was a tiny \$2 increase over last year.

Maine is a convergence of favorable factors; they have very few large urban areas so traffic is usually not a problem, which in turn keeps down accident rates. In addition, though Maine gets a lot of snow, the state doesn’t usually suffer from major weather incidents like tornadoes and hailstorms, which can do serious and expensive damage to a car.

Maine drivers take their insurance responsibility seriously with a mere 4.7 percent of uninsured drivers, according to the Insurance Information Institute. This makes them No. 2 in the country for uninsured drivers with only Massachusetts beating them out. When everyone is insured, prices go down.

Providing real cost estimates

The Insure.com study differs from other studies, such as the National Association of Insurance Commissioners (NAIC) rankings, in that it compares how much it would cost a driver to buy the same coverage in each state. The NAIC rankings calculate the average amount drivers spend on auto insurance -- regardless of what coverages and levels of coverage are purchased.

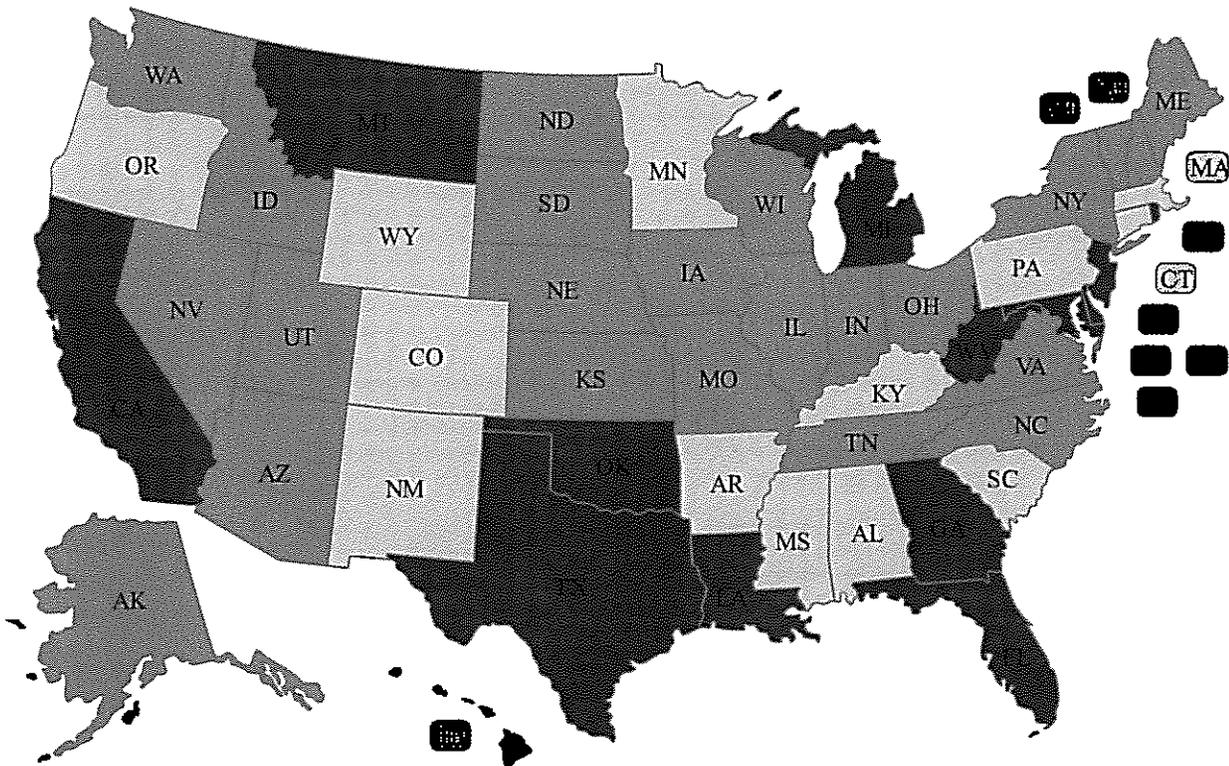
How much does car insurance cost?

It's important to remember that these numbers are averages and will not reflect your actual policy price. Insurance prices are highly personalized, and many factors will affect your rates, including the type of vehicle you drive, the coverages you choose to carry, your specific neighborhood and, in certain states, even your credit rating.

Insure.com's study of the most and least expensive vehicles for 2016 includes [easy-to use tool](#) for viewing nationwide [car insurance rates for 2016 vehicles](#) or looking at state specific average rates, and allows you to compare up to 10 vehicles at once.

Shop your coverage annually to make sure you are getting the best car insurance rates available, ask for discounts and consider bundling your coverages to save money.

Average cost of car insurance by state



- More than \$100 below national average
- Within \$100 of national average
- More than \$100 above national average

Methodology

[Insure.com](#) commissioned Quadrant Information Services to calculate auto insurance rates from six large carriers (Allstate, Farmers, GEICO, Nationwide, Progressive and State Farm) in 10 ZIP codes per state. Rates were compiled in February 2016.

We averaged rates in each state for the cheapest-to-insure 2016 model-year versions of America's 20

best-selling vehicles and ranked each state by that average. Rates are for comparative purposes only within the same model year.

Rates are based on full coverage for a single, 40-year-old male who commutes 12 miles to work each day, with policy limits of 100/300/50 (\$100,000 for injury liability for one person, \$300,000 for all injuries and \$50,000 for property damage in an accident) and a \$500 deductible on collision and comprehensive coverage. The hypothetical driver has a clean record and good credit. The rate includes uninsured motorist coverage. Actual rates will depend on individual driver factors.

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EXHIBIT D

STATE OF MICHIGAN
COURT OF APPEALS

LESLEY JAGO, as Personal Representative of the
Estate of MICHAEL JOHN JAGO II, Deceased,

UNPUBLISHED
August 2, 2011

Plaintiff-Appellee/Cross-Appellant,

v

No. 297880
Court of Claims
LC No. 09-000029-MZ

DEPARTMENT OF STATE POLICE,

Defendant-Appellant/Cross-
Appellee.

Before: MURRAY, P.J., and HOEKSTRA and STEPHENS, JJ.

PER CURIAM.

In this wrongful death action, defendant Department of State Police appeals as of right, and plaintiff Lesley Jago, as personal representative of the estate of her husband Michael John Jago II (Jago), cross appeals by delayed leave granted, the trial court's order granting in part and denying in part defendant's motion for summary disposition under MCR 2.116(C)(7). Under the motor vehicle exception to governmental immunity, a governmental agency is liable only for "bodily injury" or "property damage." At issue in this case is whether under *Wesche v Mecosta Co Rd Comm*, 480 Mich 75; 746 NW2d 847 (2008), a claim for survivor's loss benefits is a form of damages for "bodily injury" or is an independent cause of action. We conclude that survivor's loss benefits are damages for the "bodily injury" suffered by a deceased injured person and, therefore, a governmental agency can be liable for survivor's loss benefits. We further hold in answer to the issue raised on cross appeal that a governmental agency, like any other defendant, is not liable for survivor's loss benefits incurred in the first three years after the date of the accident when the deceased injured person was operating his own vehicle and the vehicle was uninsured. We therefore affirm.

I. FACTS AND PROCEDURAL HISTORY

Late at night on January 26, 2009, Jago was driving his vehicle southbound on County Road 403 near Newberry, Michigan. As Jago entered the M-28 intersection, a patrol vehicle, owned by defendant, broadsided Jago's vehicle. At the time of the accident, Jago's vehicle was not insured under a no-fault insurance policy. Jago died in the accident. His survivors included plaintiff and a young son.

In her second amended complaint, plaintiff claimed that defendant was liable under the motor vehicle exception to governmental immunity for all injuries suffered by Jago and his estate. She asserted those injuries included trauma resulting in death, “wage loss or actual future loss of earnings to the extent that such losses are recoverable in excess of the no-fault statutory monthly and yearly maximums,” and other damages related to the accident to the extent that the damages are recoverable under the no-fault act or the wrongful death act.

Defendant moved for summary disposition under MCR 2.116(C)(7). It began its argument with two “fundamentals” regarding a claim against a governmental agency for the negligent operation of a government-owned vehicle: (1) the plaintiff must satisfy the requirements of the no-fault act and the motor vehicle exception to governmental immunity and (2) a plaintiff’s damages are those allowed under the no-fault act and the wrongful death act, as limited by the governmental tort liability act. Based on these fundamentals, defendant argued that plaintiff had no right to recover any damages because Jago’s vehicle was not insured at the time of the accident. To support this conclusion, defendant relied on the fact that under the no-fault act, noneconomic damages are not available to a driver injured while operating his own uninsured motor vehicle. Further, under the no-fault act, survivor’s loss, a form of first-party benefits, cannot be recovered by the dependents of the deceased injured person if the injured person would not have been entitled to first-party benefits, and damages recoverable by a motorist driving his own uninsured vehicle are limited to the damages listed in MCL 500.3135(3)(a) and (e), neither of which concern excess economic damages. Moreover, defendant maintained the excess economic benefits that plaintiff sought were loss of consortium damages, and the Supreme Court stated in *Wesche* that loss of consortium damages cannot be recovered under the motor vehicle exception to governmental immunity.

In response, plaintiff argued that recovery of damages was governed by the motor vehicle exception and that the requirements of the exception were met: Jago suffered “bodily injury” as the result of the negligent operation of a motor vehicle by an employee of a governmental agency. Because the exception makes liability unconditional when the requirements are met, plaintiff claimed that Jago’s status as an uninsured motorist was irrelevant. Plaintiff further argued that even if the no-fault act applied, the act only precludes an uninsured motorist from recovering noneconomic damages. The act’s prohibition against an uninsured motorist’s recovery of damages, applies to the recovery of noneconomic damages; the prohibition does not apply to the recovery of excess economic damages under MCL 500.3135(3)(c). According to plaintiff, all excess economic damages listed in MCL 500.3135(3)(c) are available to an uninsured motorist.

The trial court granted in part and denied in part defendant’s motion for summary disposition. It granted the motion as to plaintiff’s claim for noneconomic damages. It held that, under *Hardy v Oakland Co*, 461 Mich 561; 607 NW2d 718 (2000), where the Supreme Court held the no-fault threshold requirements must be met in order for a plaintiff to recover noneconomic damages from a governmental agency under the motor vehicle exception, plaintiff was not entitled to noneconomic damages because Jago’s vehicle was not insured by a no-fault policy. It denied the motion as to plaintiff’s claim for excess economic benefits. It held that because plaintiff’s claim for excess economic benefits was not a loss of consortium claim, but rather a claim for wage loss or future loss of earnings, the claim was not barred by the Supreme Court’s decision in *Wesche*.

II. ANALYSIS

On appeal, defendant argues that because the motor vehicle exception to governmental immunity permits recovery only for “bodily injury” and “property damage,” and because survivor’s loss benefits do not compensate the dependents of the deceased injured person for bodily injury or property damage, the trial court erred in denying its motion for summary disposition as to plaintiff’s claim for excess economic benefits. On cross appeal, plaintiff argues that the no-fault act does not limit her right to recovery of damages under the motor vehicle exception and, therefore, the estate is entitled to collect survivor’s loss benefits from the date of the accident.

A. STANDARDS OF REVIEW

We review de novo a trial court’s decision on a motion for summary disposition under MCR 2.116(C)(7). *Grimes v Dep’t of Transp*, 475 Mich 72, 76; 715 NW2d 275 (2006). Summary disposition is proper under MCR 2.116(C)(7) when the claim is barred by immunity granted by law. *Fane v Detroit Library Comm*, 465 Mich 68, 74; 631 NW2d 678 (2001). In reviewing a summary disposition motion under MCR 2.116(C)(7), we “consider all documentary evidence submitted by the parties, accepting as true the contents of the complaint unless affidavits or other appropriate documents specifically contradict them.” *Id.* “If the pleadings or other documentary evidence reveal no genuine issues of material fact, the court must decide as a matter of law whether the claim is statutorily barred.” *Holmes v Mich Capital Med Ctr*, 242 Mich App 703, 706; 620 NW2d 319 (2000). We review de novo issues of statutory interpretation. *Allen v Bloomfield Hills Sch Dist*, 281 Mich App 49, 52; 760 NW2d 811 (2008).

B. BASIC LEGAL PRINCIPLES

The issues raised by the parties in this case require us to address the interplay between the governmental tort liability act (GTLA), MCL 691.1401 *et seq.*, the no-fault act, MCL 500.3101 *et seq.*, and the wrongful death act (WDA), MCL 600.2922. In interpreting statutes, our goal is to ascertain and give effect to the intent of the Legislature. *Tevis v Amex Assurance Co*, 283 Mich App 76, 81; 770 NW2d 16 (2009). If the statutory language is unambiguous, the Legislature is presumed to have intended the meaning clearly expressed, and we must enforce the statute as written. *Ameritech Publishing, Inc v Dep’t of Treasury*, 281 Mich App 132, 136; 761 NW2d 470 (2008).

Under the GTLA, a governmental agency is immune from tort liability when the agency is engaged in the exercise or discharge of a governmental function. MCL 691.1407(1); *Bennett v Detroit Police Chief*, 274 Mich App 307, 315; 732 NW2d 164 (2007). This grant of immunity is subject to six statutory exceptions, *Wesche*, 480 Mich at 84, including the motor vehicle exception, MCL 691.1405. The motor vehicle exception provides:

Governmental agencies shall be liable for bodily injury and property damage resulting from the negligent operation by any officer, agent, or employee of the governmental agency, of a motor vehicle of which the governmental agency is owner, as defined in Act No. 300 of the Public Acts of 1949, as amended, being sections 257.1 to 257.923 of the Compiled Laws of 1948.

According to the Supreme Court, the language of MCL 691.1405 is clear: the waiver of immunity for liability resulting from a governmental employee's negligent operation of a motor vehicle is limited to damages for "bodily injury" and "property damage." *Wesche*, 480 Mich at 84. "Bodily injury" is "a physical or corporeal injury to the body." *Id.* at 85.

The motor vehicle exception provides a broad statement of liability. *Hardy*, 461 Mich at 565. But this broad statement of liability is controlled by restrictions contained in the no-fault act. *Id.*

MCL 500.3135, which sets forth when a person is subject to tort liability arising from the ownership, maintenance, or use of a motor vehicle, provides in pertinent part:

(1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

(2) For a cause of action for damages pursuant to subsection (1) filed on or after July 26, 1996, all of the following apply:

* * *

(c) Damages shall not be assessed in favor of a party who was operating his or her own vehicle at the time the injury occurred and did not have in effect for that motor vehicle the security required by [MCL 500.3101] at the time the injury occurred.

(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by [MCL 500.3101] was in effect is abolished except as to:

* * *

(c) Damages for allowable expenses, work loss, and survivor's loss as defined in [MCL 500.3107 to MCL 500.3110] in excess of the daily, monthly, and 3-year limitations contained in those sections. . . .^[1]

In *Hardy*, the plaintiff was injured when his vehicle was rear-ended by a patrol vehicle driven by a sheriff's deputy. He argued that because of the broad statement of liability contained in the motor vehicle exception, he was not required to show serious impairment of body function

¹ The damages referred to MCL 500.3135(3)(c) are generally referred to as excess economic damages.

before the governmental agency was liable for noneconomic damages. The Supreme Court disagreed. *Hardy*, 461 Mich at 565-566. It stated that the apparent conflict between MCL 500.3135(1) and MCL 691.1405 was resolved by the plain language of MCL 500.3135(3).² *Id.* at 565. It explained:

Subsection 3135([3]) of the no-fault act, which contains the partial abolition of tort liability, opens with the introductory clause, “Notwithstanding any other provision of law” On its face, therefore, this measure reflects the Legislature’s determination that the restrictions set forth in the no-fault act control the broad statement of liability found in the immunity statute. [*Id.*]

Accordingly, the Supreme Court held that in order for a plaintiff to recover noneconomic damages from a governmental entity he must show serious impairment of a body function. *Id.* at 566.

An action for injuries that result in death shall be prosecuted under the WDA. MCL 600.2921; *Wesche*, 480 Mich at 89. The WDA provides:

(1) Whenever the death of a person, injuries resulting in death, or death as described in [MCL 600.2922a] shall be caused by wrongful act, neglect, or fault of another, and the act, neglect, or fault is such as would, if death had not ensued, have entitled the party injured to maintain an action and recover damages, the person who or the corporation that would have been liable, if death had not ensued, shall be liable to an action for damages, notwithstanding the death of the person injured or death as described in [MCL 600.2922a], and although the death was caused under circumstances that constitute a felony.

* * *

(6) In every action under this section, the court or jury may award damages as the court or jury shall consider fair and equitable, under all the circumstances including reasonable medical, hospital, funeral, and burial expenses for which the estate is liable; reasonable compensation for the pain and suffering, while conscious, undergone by the deceased during the period intervening between the time of the injury and death; and damages for the loss of financial support and the loss of the society and companionship of the deceased. . . .

The WDA acts as a “filter” through which the underlying claim proceeds. *Wesche*, 480 Mich at 88. Thus, any statutory limitations on the underlying claim apply to the wrongful-death action. *Id.* at 89. And specifically, the WDA “does not waive a governmental agency’s immunity

² At the time of the accident in *Hardy*, the language of MCL 500.3135(3) was found in MCL 500.3135(2). *Hardy*, 461 Mich at 565 n 10.

beyond the limits set forth in the underlying statutory exception.” *Id.* at 87. At the same time, damages that would have been available in the underlying action must be recognized in the wrongful-death claim. *Thorn v Mercy Mem Hosp Corp*, 281 Mich App 644, 659; 761 NW2d 414 (2008).

C. DEFENDANT’S APPEAL

Defendant argues that because the waiver of governmental immunity in the motor vehicle exception is limited to “bodily injury” and “property damage,” and because survivor’s loss does not compensate surviving dependents for physical injuries or for property damage, plaintiff’s claim for excess economic benefits, i.e., survivor’s loss incurred three years beyond the date of the accident, does not fall within the motor vehicle exception to governmental immunity. We disagree.

Defendant’s argument is premised on *Wesche*, 480 Mich 75, where the Supreme Court addressed the issue whether the motor vehicle exception allows a claim for loss of consortium against a governmental agency. In *Wesche*, a governmental employee rear-ended the plaintiff-husband’s vehicle, injuring the plaintiff-husband’s spine. The plaintiff-wife, who was not in the vehicle at the time of the accident or at the accident scene, asserted a claim of loss of consortium as a result of her husband’s injury. The Supreme Court held that the motor vehicle exception did not waive the governmental agency’s immunity for the loss of consortium claim. *Id.* at 85. First, the Supreme Court reasoned that a loss of consortium is not a physical injury to a body; rather, it is a claim for loss of society and companionship. *Id.* Second, the Supreme Court explained that a loss of consortium is not merely an item of damages. It stated that a claim for loss of consortium, while derivative of the underlying bodily injury, has long been recognized as a separate, independent cause of action. *Id.* In reaching its conclusion, the Supreme Court rejected the argument that the motor vehicle exception creates a threshold that, once met, permits recovery for loss of consortium. It reasoned that nothing in MCL 691.1405 “state[s] or suggest[s] that governmental agencies are liable for *any* damages once a plaintiff makes a threshold showing of bodily injury or property damage.” *Id.* at 85-86 (emphasis in original).³

Pursuant to *Wesche*, whether a governmental agency is liable under the motor vehicle exception for excess survivor’s loss depends on whether survivor’s loss is an item of damages for “bodily injury” or whether a claim for survivor’s loss is an independent cause of action. To determine whether survivor’s loss is a form of damages for “bodily injury” or an independent cause of action, we must examine the nature and purpose of survivor’s loss.

Under the no-fault act, an insurer is liable to pay personal protection insurance benefits to its insureds for accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle. MCL 500.3105(1). “Bodily injury” includes death

³ Although plaintiff contends that *Wesche* was wrongly decided, this Court is bound by the rule of stare decisis to follow the decisions of the Supreme Court. *Tenneco Inc v Amerisure Mut Ins Co*, 281 Mich App 429, 447; 761 NW2d 846 (2008).

resulting from the injury. MCL 500.3105(3); *Belcher v Aetna Cas & Surety Co*, 409 Mich 231, 243; 293 NW2d 594 (1980).

“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 500.3112.⁴ The personal protection insurance benefits payable to the injured person are listed in MCL 500.3107. *Belcher*, 409 Mich at 247. These benefits include work loss. MCL 500.3107(1)(b). The personal protection insurance benefits payable to the deceased injured person’s dependents are listed in MCL 500.3108, *Belcher*, 409 Mich at 247, and are known as survivor’s loss.

MCL 500.3108(1) provides:

Except as provided in subsection (2), personal protection insurance benefits are payable for a survivor’s loss which consists of a loss, after the date on which the deceased died, of contributions of tangible things of economic value, not including services, that dependents of the deceased at the time of the deceased’s death would have received for support during their dependency from the deceased if the deceased had not suffered the accidental bodily injury causing death and expenses, not exceeding \$20.00 per day, reasonably incurred by these dependents during their dependency and after the date on which the deceased died 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. . . . [T]he benefits payable for a survivors’ loss . . . is not payable beyond the first three years after the date of the accident.

In *Belcher*, 409 Mich at 249, the Supreme Court recognized that survivor’s loss benefits “may fairly be regarded as a partial substitute for work-loss benefits which were or would have been paid to the injured person during his lifetime.” It explained:

A survivor’s loss of support does not accrue until after the injured person’s death. Prior to the injured person’s death, any loss of support a dependent suffers as a result of the injury is neither recognized nor expressly compensated for by the act. Rather, benefits are paid to the injured person for loss of work-related income. The Legislature could have fairly contemplated that in most instances the injured person would use a portion of his work-loss benefit to provide support for his dependents. Benefits paid for a survivor’s loss of support can thus be regarded as a close substitute for funds likely to have been received out of the work-loss

⁴ A dependent is a person who was receiving support and services from the deceased injured person before the person’s death. *Belcher*, 409 Mich at 244. The spouse of the deceased person and the deceased person’s children under the age of 18 are generally conclusively presumed to be dependents. MCL 500.3110(1)(a)-(c).

benefit which would have been paid to the injured person had he survived. [*Id.* at 249.]⁵

With this understanding of the nature and purpose of survivor's loss benefits, we hold that survivor's loss benefits are damages for the "bodily injury" suffered by the person who died in the motor vehicle accident. It cannot be disputed that a person who dies from injuries suffered in a motor vehicle accident has suffered "bodily injury." MCL 500.3105(3). The person has suffered a physical or corporeal injury to the body. *Wesche*, 480 Mich at 85. Because the injuries resulted in death, the no-fault act dictates that benefits, in the form of survivor's loss, are to be paid to the deceased injured person's dependents. MCL 500.3112. Generally, through survivor's loss benefits, the dependents are compensated for the economic support they would have received had the injured person survived. *Miller v State Farm Mut Auto Ins Co*, 410 Mich 538, 561; 302 NW2d 537 (1981); *Belcher*, 409 Mich at 249. Accordingly, survivor's loss benefits do not compensate the deceased injured person's dependents for injuries that the dependents themselves have suffered. Rather, it compensates the dependents for economic loss suffered by them that resulted from the injured person's death. Moreover, as defendant recognizes, a claim for survivor's loss is not a cause of action separate and independent from the injured person's right to receive benefits. The right to benefits belongs only to one party: it either belongs to the injured person or, in the case of the injured person's death, it belongs to the injured person's dependents. The dependents of the injured person have no right to survivor's loss benefits unless and until the injured person has died. Because survivor's loss is an item of damages for the "bodily injury" suffered by the deceased injured person, the waiver of immunity in the highway exception applies to claims for excess survivor's loss benefits. Accordingly, we conclude that the trial court did not err in denying defendant's motion for summary disposition on plaintiff's claim for excess survivor's loss benefits.⁶

D. PLAINTIFF'S CROSS-APPEAL

⁵ But the amount of survivor's loss benefits is not determined solely by the deceased injured person's wages and salary. In *Miller v State Farm Mut Auto Ins Co*, 410 Mich 538, 561; 302 NW2d 537 (1981), the Supreme Court stated:

[T]he measurement of § 3108 survivors' loss benefits should include the value of tangible things other than, and in addition to, wages and salary. The dollar value of such items as employer-provided health insurance coverage, pensions, disability benefits, and other tangible things of economic value that are lost to the surviving dependents by reason of the insured's death must be taken into account.

⁶ We do not address or decide whether dependents of a deceased injured person are prohibited from collecting excess survivor's loss benefits when, because the injured person was driving an uninsured vehicle, the dependents are not entitled to survivor's loss benefits in a first-party action. See *Belcher*, 409 Mich at 260-261. This issue was not raised by defendant in its brief on appeal.

On cross-appeal, plaintiff argues that the trial court erred in holding that defendant could only be liable for survivor's loss incurred three years beyond the date of the accident. We disagree.

As already stated, the restrictions set forth in the no-fault act control the broad statement of liability found in the motor vehicle exception. *Hardy*, 461 Mich at 565.⁷ Because he was the owner of the uninsured vehicle involved in the accident, Jago, had he survived, would not have been entitled to be paid personal protection insurance benefits for bodily injury suffered in the accident. MCL 500.3113(b). When the person who suffered bodily injury is not entitled to be paid personal protection insurance benefits, his dependents are not entitled to receive survivor's loss benefits as a personal protection insurance benefit. *Belcher*, 409 Mich 260-261. Because survivor's loss is a personal protection insurance benefit to be paid for three years after the date of the accident by a no-fault insurer, MCL 500.3108(1), the trial court did not err in holding that plaintiff is not entitled to receive survivor's loss for the three years after the date of the accident from defendant.

Affirmed.

/s/ Christopher M. Murray
/s/ Joel P. Hoekstra
/s/ Cynthia Diane Stephens

⁷ Contrary to plaintiff's assertion, the provision at dispute is not MCL 500.3135(2)(c), which states that noneconomic damages shall not be assessed in favor of a party who, at the time of the accident, was operating his or her own uninsured vehicle. The governing provision is MCL 500.3135(3). This provision sets forth the limited circumstances when tort liability arising out of the use of a motor vehicle has not been abolished; these circumstances include liability for damages for survivor's loss beyond the three-year limitation. MCL 500.3135(3)(c). In *Hardy*, 461 Mich at 565, the Supreme Court held that the restrictions of MCL 500.3135(3) control the liability of a governmental agency under the motor vehicle exception.