Gallagher Sharp LLP

Newsflash
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Gallagher Sharp Michigan Law Update: Michigan Governor Signs No-Fault Reform Bill

By Attorneys Danielle Haberstroh and Beth Reno

On May 30, 2019, Gov. Gretchen Whitmer signed a bill reforming Michigan's no-fault auto insurance laws. The changes apply to various facets of Michigan's no-fault system, including how insurance rates are set, the Michigan Catastrophic Claims Association, the type and amount of benefits available, priority for claiming no-fault benefits, the limitation on actions against the insurer, attorney fees recoverable in an action against the insurer, the Assigned Claims Plan, anti-fraud and anti-solicitation provisions, and the introduction of a new managed care plan (for medical expenses), to name a few. While all of these sections will work in conjunction with each other and alter the longstanding no-fault system, we wanted to highlight a few important changes under the law.

Coverage and Limit Options

First, and most notably, an insured can elect different levels of coverage for allowable expenses pursuant to MCL 500.3107(a)(1), which essentially covers all medical and attendant care expenses. The coverage choices for allowable expenses include the following:

- $50,000 per person per accident, IF the named insured is enrolled in Medicaid AND their spouse and any resident relative of either are also enrolled in Medicaid or have qualifying health coverage or have coverage under another no-fault policy;
- $250,000 per person per accident;
- $500,000 per person per accident;
- Unlimited lifetime benefits.

The new coverage levels for allowable expenses also include a number options for the insured such as:

- An insured can opt-out of having coverage for allowable expenses entirely if they have a qualifying health policy.
- An insured can purchase a separate rider to provide more coverage for attendant care expenses, only.
- If an insured is able to collect no-fault benefits under 2 or more policies, the applicable limits of coverage are aggregated, so that the policies do not stack.

Another significant change to the no-fault system is that an insured may now recover expenses above their coverage limit, i.e. excess medical expenses, and other economic damages above their chosen limits (as outlined in Section 3107) by suing the at-fault driver in a third-party tort lawsuit.

With more damages recoverable in a third-party lawsuit, the statutory minimum for liability insurance has increased from the former $20,000 per person/$40,000 per occurrence to $50,000 per person/$100,000 per occurrence.

Cost Containment for Medical Services

Even if an insured chooses a lower coverage for allowable expenses, that coverage will likely extend farther due to a new fee schedule for medical services. Section 3157 was revised to provide for a lengthy and complex fee schedule for providers that is based, in part on:

- The year the services are rendered;
- The number of indigent patients the treater services; and
- The level of care being provided by the treater to the patient

Those factors determine the allowable charges based on a varying percentage of the amount paid by Medicare for the same service.

Additionally, the new fee schedule limits the amount of attendant care to 56 hours per week, if it is rendered by a relative, someone domiciled in the same household, a friend or business associate.

Who pays and When is a Benefit Overdue?

The priority rules for insurers have generally remained the same, but with one notable exception; an occupant and/or pedestrian no longer looks to the insurer of the owner of the vehicle or the insurer of the operator of the vehicle for coverage, but instead recovers benefits from the assigned claims plan, when the claimant does not have another applicable policy of their own, a spouse, or resident relative.

Another section that has generally remained the same is that a benefit is overdue if not paid within 30 days of receiving reasonable proof of the fact and amount of loss sustained. However, this 30-day period is tolled for an additional 60 days, if the insurer is not provided with a bill for the service (or product or accommodation) within 90 days after being rendered.

The same one-year notice is required in order to file a lawsuit against the insurer. However, the one-year back rule limitations on damages in lawsuits only applies if the claim has been formally denied by the insurer. Otherwise, the one-year limitation is tolled from the date the person makes a claim for benefits until the date the insurer formally denies the claim, so long as the person claiming the benefits pursues the claim with reasonable diligence.

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Questions, Comments or Concerns?

While all of these changes will have a significant impact on both insurers and insureds, those discussed above will have a direct impact on claims and litigation arising from same. As you review the new law and try to navigate through the changes, do not hesitate to contact Elizabeth Reno and Danielle Haberstroh with any questions or for a more in-depth analysis of any particular section. We look forward to hearing your thoughts!

See link to the Bill: 2019-SNB-0001.

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