Mich. Order Muddles No-Fault Reform For Auto Insurers

By **Eric Conn and Stephanie Burnstein** (October 24, 2019)

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On Sept. 20, the director of the Michigan Department of Insurance and Financial Services issued order number 19-048-M, which has a direct impact on the ability of automobile insurers to implement the recent Michigan No-Fault Reform Act.

Per the act, most provisions were effective June 11, with a limited number not taking effect until July 2020. As would typically be the case, on June 11, insurers followed the new provisions of the No-Fault Act, consistent with the implementation language included by the Legislature. Those provisions included changes to insurer priority determinations pursuant to MCL 500.3114, which results in more claims being assigned to the Michigan Assigned Claims Plan.

However, the department's order has now effectively put an end to insurers implementing the new provisions in accordance with the legislative intent.

Relying upon various statutes that permit it to review forms and rates, the department has responded to insurers' implementation of the new reform provisions by stating "[i]nsurers that implement the amended provisions that affect the scope of coverage required to be provided under automobile insurance policies without first revising their forms or rates are in violation of Sections 2106, 2108, and 2236 of the Code, MCL 500.2106, 500.2108 and 500.2236."

The message from the department is, until insurers modify their forms and rates, they are unable to implement the reforms that affect the scope of coverage.

The troubling aspect of the department's order is the fact that it does not identify which provisions affect the scope of coverage. And, the reforms that were passed by the Legislature provided significant changes to the Michigan No-Fault Act, many of which may impact the scope coverage.

One such example is the changes that were made that impact which insurer is first in priority for the payment of personal insurance protection benefits. The Legislature made a significant change to MCL 500.3114, and specifically the rules of priority for occupants of motor vehicles who seek benefits.

If an occupant does not have auto insurance, and also does not have a resident relative that has auto insurance, under the old priority rules, the insurer of the owner of the vehicle, followed by the insurer of the operator of the vehicle would be in priority. However, with the recent change, an occupant under these circumstances now much seek benefits from the assigned claims plan.

Given the change in the priority rules, insurers are no longer responsible for the payment of benefits for otherwise uninsured occupants. Because of the reduction in risk, arguably the change in priority affects "the scope of coverage" and, therefore, implementation of the change cannot be performed for those insurers that have not revised their forms and rates

per the department's order. This poses a significant problem because some insurers (including those that are new to writing policies within the state) likely have updated their forms and rates, while others have not.

Therefore, the department's order will inevitably lead to a different set of priority rules for different insurers until all are able to change their forms and rates (a sometimes-lengthy process). In fact, the Michigan Assigned Claims Plan is currently denying claims that should fall within their purview under the new changes due to the director's order, leaving insurers to scramble to determine whose guidance to follow — the Legislature or the director.

Changes were also made to the personal insurance protection statute of limitations, otherwise known as the one-year back rule, MCL 500.3145. Under the old provisions, a claimant was required to give notice to an insurer of an accident within one year, and if she filed suit to recover benefits, she was limited to recovering only those benefits that were incurred within the one year prior to the filing of suit.

Under the reform, there is a new tolling provision that permits a claimant to recover expenses for up to a year from the date of a formal denial of benefits, if a specific claim for payment has been made by the claimant and she pursue that claim with reasonable diligence.

This change certainly affects the scope of coverage but in this instance, the change actually benefits the claimant, not the insurer. However, there is no indication in the department's order that provisions that affect the scope of coverage must adversely impact the insurer. Indeed, there is no reference within the order to whom the scope of coverage must impact for it to apply (or not).

Thus, where there is a clear mandate from the Legislature that claimants should be provided statute of limitations protections where they have made a specific claim for benefits and have diligently pursued them, insurers can seemingly rely upon the department's order to apply the statute and preclude the payment of certain stale claims. Not only does the department's order undermine the Legislative intent to protect claimants, but it also has a secondary impact of maintaining the current level of litigation, something the Legislature was presumably trying to avoid.

Another provision that may impact the scope of coverage is the change the requirements of insurer requested physical examinations, or independent medical examinations. The provisions related to insurer examinations are now more stringent, and place restrictions on the qualifications as physician that performs such an examination must have.

For example, a physician that is examining a claimant must now be of the same specialty as the claimant's treating physician(s). Further, the physician must either have an active practice or teach at an accredited medical school.

Admittedly, on its face this does not directly affect the scope of coverage. However, it is common practice for insurers to obtain medical experts' opinions when cutting off benefits. That begs the question, if an insurer obtains a medical expert opinion, and that medical expert's opinion is used to cut off benefits, and the expert does not meet the new qualifications, can the insurer use and rely upon the expert's opinions?

Certainly, if an insurer is going to cut off benefits, that action affects the scope of coverage. Thus, it may stand that even a modest change such as this will cause uncertainty when insurers are evaluating and adjusting claims.

This conversation could go on, as an argument can be made that each of the many reforms that were enacted impact the scope of coverage. From this perspective, it appears the department's order does more to confuse the recent changes than clarify the obligations of insurers.

This, where there is already ample confusion as to what insurers, providers and attorneys should be doing to protect their customers, patients and clients, is an unwelcome complication that could easily be remedied by identifying the provisions the department intended to impact.

Short of that, all players but especially insurers are left in an unenviable position of making a section-by-section assumption of what applies, which will only create further delays in coverage, an impact the department and Legislature did not intend.

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