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STATE OF MICHIGAN

IN THE SUPREME COURT

ELLEN M. ANDARY, a legally incapacitated Adult, by and through her Guardian and Conservator, MICHAEL T. ANDARY, M.D., PHILIP KRUEGER, a legally incapacitated adult, by and through his Guardian, CLAY KRUEGER, & MORIAH, INC., d/b/a EISENHOWER CENTER, a Michigan Corporation,

Plaintiffs-Appellants,

v

USAA CASUALTY INSURANCE COMPANY, a foreign corporation, and CITIZENS INSURANCE COMPANY OF AMERICA, a Michigan Corporation,

Defendants-Appellees

Supreme Court No. 164772

Court of Appeals No.: 356487

Ingham County Circuit Court
Case No.: 19-738-CZ

THIS APPEAL INVOLVES A RULING THAT A PROVISION OF THE CONSTITUTION, A STATUTE, RULE OR REGULATION, OR OTHER STATE GOVERNMENTAL ACTION IS INVALID.

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THE MICHIGAN ASSOCIATION FOR JUSTICE'S AMICUS CURIAE BRIEF

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INTRODUCTION[1]

This appeal involves amendments to Michigan's No-Fault Act that were immediately effective on June 11, 2019.[2] Specifically at issue are the retroactivity and constitutionality of the newly imposed fee caps and hourly limitation on family-provided personal attendant care under amended MCL 500.3157.[3] The no-fault reforms were sweeping and completely changed the no-fault system as it was known. On August 25, 2022, the Court of Appeals (COA) correctly held that these amendments do not retroactively apply to pre-amendment accidents/losses. The COA also properly held that such retroactive application would be unconstitutional. After granting Appellant-insurers' Application for Leave to Appeal, the no-fault spotlight is now on this Court.

The No-Fault Act was originally enacted in 1973. It required Michigan residents driving on Michigan roads to contract with automobile insurance companies for personal protection insurance. "The goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, ***adequate***, and prompt reparation for certain economic losses." *Shavers v Attorney General*, 402 Mich 554, 578-579; 267 NW2d 72 (1978). While another goal was, admittedly, to do so at a low cost, these two goals are not mutually exclusive. That is, the goal was **not** to provide cheap insurance premiums at the expense of ensuring adequate care for accident victims. Yet this is precisely the effect of the amendments at issue. Under the old §3157, insurers contractually agreed to pay all "reasonable charges" for all "reasonably necessary" services for an accident victim's "care, recovery, or rehabilitation." Insurers (including Appellants in this case)

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[1] No party or their counsel authored this Brief, in whole or in part. No party or their counsel made any monetary contribution intended to fund the preparation or submission of this Brief.

[2] Although the amendments were "immediately effective" as of June 11, 2019, the Legislature expressly provided that the amendments at issue in this case were not to apply until after July 1, 2021.

[3] The fee caps are detailed in subsections (2) – (7) with the payment amount depending on whether the service is payable by Medicare. This case involves a challenge to the fee caps under subsection (7) relating to services that are not payable by Medicare (which would include personal attendant care and post-acute rehabilitation services). The hourly limitation on attendant care, which is a 56 hours/week limitation, is found in §3157(10).

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set the premiums for this promise (and received valuable consideration for same). Applying the amendments to pre-amendment accidents/losses unfairly upsets these settled bargains and gives the insurers a windfall (while also disrupting accident victims' care and essentially destroying an entire industry). The COA correctly recognized that Michigan's Constitution and case law precludes applying amended §3157(7) and (10) to pre-amendment accidents/losses under these circumstances.

Appellants' portrayal of the COA's decision as a complete unwinding of the 2019 no-fault reform is greatly exaggerated. To wit, Appellants repeatedly admit that catastrophic pre-amendment catastrophic accident/losses are a small group, in the context of all auto related losses subject to the law. As aptly noted by Appellees, this small group continues to shrink in size and will eventually disappear. **(See Appellee's Br., p. 44)**. Moreover, Appellants also admit that the 2019 no-fault reforms included "many" provisions aimed at reducing the cost of no-fault insurance. **(See Appellant's Br., p. 2)**. Yet the COA opinion only impacts ***two*** of these many provisions.

For more than a year after July 1, 2021, Michigan's catastrophically injured accident survivors (and their healthcare providers) lived in a hell of uncertainty and hopelessness. Thousands of legacy accident survivors were discharged from their sources of care; some died. (MAJ App'x, p 9-10, 25). Numerous healthcare providers were forced out of business (which meant thousands of lost jobs). *Id*. The healthcare providers that managed to survive did so by no longer accepting auto accident survivors as patients. (MAJ App'x, p 3, para. 8; and p 15). Such effects were a direct result of the newly imposed fee caps and attendant care limitation under amended MCL 500.3157.

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THE MICHIGAN ASSOCIATION FOR JUSTICE'S STATEMENT OF INTEREST

The Michigan Association for Justice (MAJ) is a non-profit association of more than 1500 Michigan attorneys engaged primarily in litigation and trial work. MAJ members tirelessly work to represent injured Michiganders and their professional service providers. Holding insurance companies accountable for their contractual obligations is central to MAJ's mission. One of MAJ's goals is to ensure that those who place profit over people cannot tilt the scales of justice in favor of the rich and the powerful. MAJ recognizes an obligation to assist this Honorable Court on important issues of law that would substantially affect the administration of justice in the State of Michigan.

Many MAJ members represent motor vehicle accident victims and/or their healthcare providers who are subject to the provisions of the Michigan No-Fault Act (and case law interpreting same). As noted above, allowable expense benefits under the old no-fault system were paid at "reasonable and customary" rates. Moreover, injured victims were entitled to have *all* personal attendant care provided by their close family and friends. These terms were incorporated into the no-fault insurance contracts covering the Plaintiffs/Appellants in this case, as well as in tens of thousands of other pre-amendment loss cases. The no-fault amendments deviate drastically from what was permitted under the insurance contracts in pre-amendment loss cases.

MAJ has a bona fide interest in the outcome of this case. Insurance companies now contend that the Legislature intended to apply these amendments to rights that vested under pre-amendment contracts. Absent from the amendments, however, is any clear, unequivocal statement of retroactivity by the Legislature. The constitutional sanctity of these pre-amendment contracts under which rights have already vested also must be upheld. To ignore these things would tilt the scales of justice in favor of insurance companies that have always benefitted from more bargaining

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power than the average person. This is precisely what MAJ members strive to prevent on behalf of their clients. As a part of this Brief, MAJ will highlight the disastrous consequences that the no-fault amendments have produced.

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ARGUMENT

I. THE NO-FAULT AMENDMENTS HAVE DEVASTATED MICHIGAN'S CATASTROPHICALLY INJURED POPULATION AND EVISCERATED THE REHABILITATION/CARE INDUSTRY.

Appellants claim that the no-fault fee caps and attendant care limitation only work to reduce reimbursement (as opposed to an injured person's reasonably necessary services). Appellants' ignorance of the practical effects of amended §3157(7) and (10) is astounding. It should be obvious to anyone that a 45% decrease in reimbursement rates would devastate just about any industry thusly targeted. The University of Michigan's Poverty Solutions has noted that "[t[he method used to cap medical fees may be unnecessarily stringent and out of line with national peers, causing a crisis in access to care for victims of catastrophic accidents that occurred prior to reform."[4] Indeed, the application of these amendments to pre-amendment loss cases has been ruinous. MAJ members have witnessed this devastation first-hand.

Among MAJ's clients is the Clark Family. Jared and Lela Clark are the parents of Brandon Clark (Brandon). (MAJ App'x, Affidavit of Jared and Lela Clark, p. 1). Brandon is a ventilator-dependent quadriplegic due to a March 2, 1996 motor vehicle accident. *Id*. He was then just 17 months old. *Id*. Brandon's care is extremely complex due to his spinal cord injury and related sequalae. *Id*. Skilled nursing and attendant care are prescribed for Brandon for 24 hours/day, 7 days/week. *Id*.

Jared and Lela experienced issues with their no-fault insurer (Farm Bureau) even before the new fee caps and attendant care limits. Farm Bureau refused to pay agency charges and made late payments. *Id*. Jared and Lela were ultimately forced to leave their jobs to become Brandon's full-time caregivers (putting them in financial strain). *Id*.

---

[4] Amanda Nothaft and Patrick Cooney, *Building on Michigan's Auto Insurance Reform Law*, M Poverty Solutions, December 2021.

Farm Bureau's application of the newly imposed fee caps and attendant care limitation severely exacerbated the Clarks' financial strain. *Id.* Pre-reform, Farm Bureau agreed that $30.00/hour for 24 hours/day was reasonable reimbursement for Brandon's skilled nursing and attendant care. *Id.* After the no-fault fee caps were implemented, Farm Bureau began paying Jared and Lela $22.00/hour for only 8 hours/day. *Id.* at p. 2. This was more than 75% less than what Farm Bureau was paying previously. The Clarks felt their only option was to hire a lawyer to enforce their rights (costing them additional money). *Id.* The Clarks sought and won an injunction. However, this only compelled payment going forward from the date of the injunction. It did not reinstate backpay. By that time, however, damage had already been done:

- Brandon became the most depressed that Jared and Lela had seen in years. *Id.* at para. 7;
- Jared and Lela were forced to split coverage of Brandon's care while each taking on outside jobs (that could be performed within the home) thereby exhausting themselves. They were unable to get any respite care because every facility they contacted told them the facilities were no longer accepting auto accident victims. *Id.* at para. 8;
- Jared and Lela blew through their savings and racked up high credit card balances. *Id.* at para. 6;
- Assets had to be sold off to generate income. *Id.*

The Clarks' worry was eased somewhat when the COA's decision in *Andary* came down on August 25 2022. Knowing that the Appellant-insurers would seek to appeal, however, has prevented them from completely letting go of the fear and anxiety:

> We breathed a huge sigh of relief when the Court of Appeals held that the new no-fault fee caps do not apply to pre-amendment accident/loss cases (including Brandon's). However, we are scared to death at the thought of the Court of Appeals' decision being overturned by [the Supreme Court]. We feel the Court of Appeals' decision is the correct, just result. Insurers should not be allowed to ignore previously entered, binding contract thereby permitting them a windfall at the expense of auto accident survivor and their families. We urge [the Supreme Court] to maintain the justice done by the Court of Appeals by affirming their decision. *Id.* at p. 3.

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Other adversely-affected MAJ member clients include the Marsden Family. Nicki Marsden is the mother and legal guardian of Zachary Marsden (Zach). (MAJ App'x, Affidavit of Nicki Marsden, p. 4). Zach sustained a severe traumatic brain injury due to a motor vehicle accident at 5 ½ years old. *Id*. Zach's case is complicated by pre-existing autism. The TBI-autism combination resulted in extreme behavioral challenges. *Id*. Zach's behavioral disability manifests in grotesque and unpredictable self-injurious behaviors (SIBs). *Id*. His caregivers also face risk of injury (some caregivers have actually been bitten by Zach). *Id*. Zach is now 21 years old and is the size of a large football player (6'5 and over 300 pounds). *Id*. Zach's caregivers need to be highly qualified given Zach's complex needs. Four-to-one attendant care (4 caregivers on a 24/7 basis) is now prescribed for Zach's (and his caregivers') safety. *Id*.

Titan Indemnity Company is the automobile insurer responsible to pay no-fault benefits for Zach. *Id*. When other home health agencies were unable to adequately staff Zach, Nicki began ZMC Services, Inc. (ZMC) to ensure her son was sufficiently staffed. Even under the old system, Titan refused to pay ZMC for the care level Zach required. *Id*. Still, things were better under the old system because "at least the law allowed [ZMC] to argue with Titan as to the reasonable value that would enable [ZMC] to attract and retain sufficiently qualified caregivers." *Id*. at para. 6. Under the fee caps, Titan paid ZMC an "all-inclusive" rate of $22.90/hour (barely enough to cover labor costs let alone other elements of overhead). *Id*. at para. 7.

According to Nicki, "[t]he fallout from the fee cap payments has been unimaginable." *Id*. at p. 2. ZMC could not adequately staff Zach at the $22.90/hour rate. *Id*. ZMC therefore had to rely on unqualified caregivers to make do (putting both Zach and other caregivers at risk). *Id*. But it was even hard to retain the unqualified caregivers, many having decided the low pay wasn't worth risking their own safety. *Id*. Moreover, ZMC was unable to pay the full cost of providing

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care for Zach, including competitive pay, overtime, and full benefits. ZMC's business account was continually in the negative. *Id*. Nicki was forced to try and bring in extra money where she could to keep ZMC afloat. This included settling non-attendant care claims with Titan and borrowing against her home. *Id*. Most recently, ZMC's accounting software, QuickBooks, suspended services (including payroll). *Id*. Additional employees quit for fear of not being paid (several others have threatened to quit). *Id*. On top of all of this, Nicki's health has severely deteriorated, forcing her to remove herself as one of Zach's direct caregivers. *Id*. Nicki is praying that this Court upholds the COA's decision:

> Prior to Zach's accident, Zach's father and I did our due diligence as Michigan residents: We purchased the mandated no-fault automobile insurance. We purchased this with the understanding that the only limitations on the amount Titan was responsible to pay was that of "reasonable and customary" charges. These terms were incorporated into the insurance policy. The no-fault fee caps have allowed Titan to further shirk its responsibility to ensure that Zach receives all reasonably necessary care. That the fee caps can permit Titan to disregard the insurance contract by permitting it to pay less than what used to be considered "reasonable" is terrifying. On behalf of Zach, I plead to the Michigan Supreme Court to hold Titan to its end of our bargain by affirming the Court of Appeals' decision in the *Andary* case. *Id*. at para. 9.

The Clark and Marsden families' stories are appalling. Even more awful is the fact that the Clark and Marsden families are just *two of thousands* that faced the same or similar fallout from the no-fault amendments. The Michigan Public Health Institute (MPHI) conducted an independent study to assess the availability of services for people with accident-related catastrophic injuries. (MAJ App'x, p 9-10). The study found that, since July 1, 2021:

- **6,857** accident survivors have been **discharged from their home care agencies**;
- **10** home care agencies and/or rehabilitation facilities have **closed** with **14 additional closures expected** in the next year; and
- **4,082** jobs were **eliminated.**

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On top of this, **at least 5 accident survivors died** due to losing their care as a result of the fee caps. (MAJ App'x, p. 25).

Appellants and their amici contend that the fee caps were the solution to inflated medical charges. Common sense refutes this contention. Amended §3157(7)'s fee cap is based a provider's January 1, 2019 charge description master (CDM), or alternatively on the average amounts charged as of that date (where no CDM existed). The many service providers that were actually charging "reasonable" amounts (previously routinely paid by insurers without dispute) are now reimbursed a grossly unreasonable amount. These grossly inadequate amounts do not enable the providers to even cover their basic labor costs, therefore forcing them into financial ruin and ultimately closure.

Appellants incorrectly claim that the no-fault reforms were working. This truth is, these

II. APPELLANTS HAVE INFLATED THE IMPACT OF THE NO-FAULT REFORMS

reforms have **not** guaranteed that insurance rates will be lowered (and stay frozen for 8 years). In fact, DIFS recently approved rate *increases* for several insurance companies:

> DIFS approved a 12% rate increase for Allstate in March. DIFS also approved Allstate's 20% penalty surcharge for drivers who did not continuously maintain car insurance. Safeco has been approved for an 11.4% hike starting May 28; Auto Club, 9% effective July 1; Michigan Insurance Company's request for a 9% hike is pending. (MAJ App'x, p 32).

Similarly, Appellants and their amici cannot point to the MCCA surplus as proof that amended §3157(7) and (10) were working. That's because the MCCA generated a 5 billion surplus ***before*** amended §3157(7) and (10) went into effect. As noted by Governor Whitmer in her November 1, 2021 letter to the MCCA:

> My office recently reviewed the Annual Report of the Michigan Catastrophic Claims Association (MCCA) to the Legislature issued in September 2021. The report stated that the MCCA had **a surplus of $2.4 billion** **at the end of 2020**. In your annual statement **issued on June 30, 2021**, **the surplus is now $5 billion**. I am calling on you today to refund money to Michiganders. (MAJ App'x, p 33).

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Amended §3157 did not go into effect until July 2, 2021. Therefore, these amendments have **not** contributed to the savings to which Appellants (and their amici) point.

III. THE "SUPPOSED" RELIEF EFFORTS PRAISED BY APPELLANTS AND THEIR AMICI HAVE PROVIDED NO RELIEF

Appellants' amicus, The City of Detroit, touts the $25 million post-acute provider relief fund as a legislative fix to concerns about the 55% fee cap. The fund allows providers to apply to receive "*not more than* $500,000.00" (a nominal amount in terms of funding catastrophic care). But the requirements for obtaining any relief through the fund are extremely onerous and nearly impossible to satisfy. For example, the fund requires providers to show that is has a "systemic deficit" due to "*changes to charges*, as required by section 3157." (See the City of Detroit's Amicus Br. filed 9/19/22, Exhibit 5, p 2)[5] (Emphasis added). In other words, a provider has to show that it was charging 55% of its January 1, 2019 charges after July 1, 2021. Of course, virtually no provider can satisfy this requirement. That's because amended §3157 still allows providers to charge "reasonable and customary" amounts. See MCL 500.3157(1). So providers may ***charge*** their previous rates; the problem is that may not ***receive payment*** of more than the fee capped amount. As of August 2022, no provider that has applied for relief through the fund has received it. (MAJ App'x, pp 34 - 42). The record of this fund could not be more abysmal.

Moreover, the $25 million fund doesn't address all of the concerns surrounding the no-fault amendments. There are thousands of family members (such as Jared and Lela Clark and Nicki Marsden) who have forgone their own career opportunities to dedicate their lives to their injured loved-ones' care. These family members are on-call 24/7 and go without other employment benefits that would be available through traditional employment (i.e, paid time off, healthcare,

[5] The City of Detroit filed the exact same Amicus Brief as the one it filed in support of Appellants' motion to stay the precedential stay of the COA's decision. Exhibit 5, while referenced in both of its filings (see p. 17), was not included with The City's January 20, 2023 filing.

401K, etc.). These family member care givers are subject to the 55% fee cap **<u>and</u>** the attendant care hourly restriction. The City of Detroit laments "[a] family member with no formal medical training could charge a daily rate of $300 with little or no oversight." (See City of Detroit's Br., p 15). For a family member providing 24-hour care, $300/day amounts to a measly $12.50/hour, pre-fee cap. Post-fee cap, this hourly rate plummets to $6.88/hour (well *below* Michigan's minimum wage over the last few years). (MAJ App'x, p 43 - 46). *Then*, there's the 56-hour/week limitation (8 hours/day). Therefore, these family members end up being paid a daily rate of $55.04 when they continue to provide 24-hour care.[6] These family members might have had "no formal medical training" initially. However, they've accumulated extensive experience in providing skilled care throughout their years (decades) of service. Paying such family members only $55.04/day for 24-hour care is a windfall for insurers that, pre-amendment, contractually agreed to pay "reasonable" amounts for those services.

Amicus Insurance Alliance of Michigan (IAM) puts its self-created "rapid response teams" on a pedestal as a cure-all for those who have lost their care. (See IAM/NAMIC Br. filed 9/9/22, p 5). The insurance industry's creation of "rapid response teams" is an acknowledgement that access to care has, in fact, been impacted. But the 118 "closed complaints" IAM/NAMIC point to pales in comparison to the **nearly 7,000** accident survivors who have lost their care. It is highly doubtful that the "rapid response teams" can overcome the gross underfunding of care mandated by the amendments. Therefore, it is questionable that the "closed complaint" cases involve satisfactory resolution for the injured person.

[6] The chances of an agency providing care above the 8 hours of family-provided care are slim. That's because home care providers who have not gone out of business have had to refuse to take new auto patients due to their 55% fee cap.

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The fact is that accident survivors have been devastated by the no-fault fee caps and other restrictions. The homecare and rehabilitation industries have been nearly destroyed.

IV. APPELLANTS' AND THEIR AMICI HAVE EXAGGERATED THE REASONS FOR THE 2019 NO-FAULT REFORM

A portion of Appellants' Brief is dedicated to discussing the high costs of no-fault and claimed "pervasive fraud." (See Appellants' Br., p. 9-11). This portion of Appellants' Brief is a reiteration of the MCCA's Amicus Brief. (See Appellants' App'x., Exhibit H, p. 4-9). The MCCA states that its reimbursements in the last five years pre-reform had increased by more than 35x the amount reimbursed in the MCCA's first five years. The first five years was 1978 – 1983. The last five years was 2014-2019. This difference (a nearly 40-year gap between periods) is huge in terms of inflation in this economy. The bigger reason the MCCA's statistic is misleading is that there were far fewer claims in the no-fault system when it was just starting up than over time.

Moreover, the several examples of alleged fraud are hardly proof of same. The old no-fault reimbursement system was not perfect. But the one-sided examples of alleged fraud offered by the MCCA and Appellants are given without any context and/or distorted:

- Two of the cited examples involve non-Michigan services providers. Yet neither Appellants nor MCCA offer the percentage of claims that involve such service providers.

- Several examples of what some Michigan service providers have charged in certain cases are offered. Not offered is any proof of what the auto insurers in those cases *actually paid.*

- Appellants and the MCCA offer an example where a service provider allegedly charged the auto insurer 14.8x more than what the health insurer was billed. Yet the attached Explanation of Benefit forms (See Appellants' App'x, p. 364-368) make clear that the service provider *charged* the same to both the health and auto insurers (though the ultimate payment was different).

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Therefore, this Court should give no consideration to these alleged "facts."

V. MOST OF THE COST- CONTAINMENT PROVISIONS OF THE 2019 NO-FAULT AMENDMENTS ARE UNAFFECTED BY THE COA'S DECISION

On page 12 of their Brief, Appellants discuss the "critical components" of the 2019 no-fault reform. Appellants note these as:

(1) PIP choice under MCL 500.3107c (a huge cost saving component unaffected by the *Andary* decision)

(2) Mandatory discounted rates pursuant to MCL 500.2111f.

(3) The fee caps under MCL 500.3157(2) – (6).

Curiously missing from Appellants current Brief is discussion of other amendments aimed at cost-containment:

(4) Utilization review under MCL 500.3157a

(5) MCL 500.3172(7)(a)'s $250,000.00 cap on assigned claims cases; and

(6) MCL 500.3113(c)'s PIP coverage exclusion for out-of-state residents.

As previously noted, the COA's decision in this case effects only two of these many amendments: amended §3157(7) and (10). Furthermore, the COA's decision only effects application of these amendments in cases where the accidents occurred before June 11, 2019 (the amendments' effective date). Again, this group of catastrophic losses only continues to shrink over time. The many reform provisions unaffected by the COA's decision will continue to be utilized **in both pre-and-post amendment cases**. Any argument that the COA's decision completely upsets the cost-containment purposes of the no-fault amendments is false.

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CONCLUSION

Amended §3157(7) and (10) run afoul of one of the central goals of the no-fault act: ensuring *adequate* reparation. *Shavers*, 402 Mich at 578-579. The insurance industry's application of these amendments to pre-amendment accidents/losses has given it a windfall by enabling insurers to break long-standing contracts. At the same time, the catastrophically injured have been devastated and the care/rehabilitation industry demolished. The COA correctly recognized that Michigan law does not permit the insurers to retroactively apply these amendments in pre-amendment accident/loss cases. It's not about being stuck in "unfulfilled hopes and assumptions" of the past. It's about the fulfillment of promises made for valuable consideration where rights have long-vested.

WHEREFORE, Amicus Curiae, MAJ, respectfully requests that this Honorable Court AFFIRM the Court of Appeals' decision in this matter.

Respectfully submitted,

MILLER & TISCHLER, P.C.

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Dated: February 3, 2023

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STATE OF MICHIGAN

IN THE SUPREME COURT

ELLEN M. ANDARY, a legally incapacitated Adult, by and through her Guardian and Conservator, MICHAEL T. ANDARY, M.D., PHILIP KRUEGER, a legally incapacitated adult, by and through his Guardian, CLAY KRUEGER, & MORIAH, INC., d/b/a EISENHOWER CENTER, a Michigan Corporation,

Plaintiffs-Appellants,

v

USAA CASUALTY INSURANCE COMPANY, a foreign corporation, and CITIZENS INSURANCE COMPANY OF AMERICA, a Michigan Corporation,

Defendants-Appellees

Supreme Court No. 164772

Court of Appeals No.: 356487

Ingham County Circuit Court
Case No.: 19-738-CZ

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APPENDIX TO THE MICHIGAN ASSOCIATION FOR JUSTICE'S AMICUS BRIEF

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AFFIDAVIT OF JARED AND LELA CLARK

STATE OF MICHIGAN)
)SS
COUNTY OF EMMET)

We, Jared and Lela Clark, being first duly sworn, state and subscribe:

1. Our son, Brandon Clark (Brandon) was catastrophically injured in a March 2, 1996 motor vehicle accident. He was then only 17 months old. Brandon's accident-related injuries include a severe traumatic spinal cord injury (SCI) resulting in quadriplegia and quadriparesis.

2. Brandon is ventilator-dependent as a result of his SCI. He therefore breathes through a tracheostomy stoma. His primary mode of transportation is a powered wheelchair. As a result of his SCI, Brandon also suffers from other conditions including but not limited to:

   - Immobility creating a risk of pressure sores and other skin breakdown;
   - Exacerbation of pre-existing skin disorder, ichthyosis. This disorder causes his skin to be persistently thick, dry and flaky and makes him more vulnerable to skin breakdown;
   - Neuromuscular scoliosis;
   - Incontinence of bowel/bladder (i.e., Neurogenic bowel/bladder);
   - Spasticity and contractures;
   - Hearing loss;
   - Memory deficits due to seizures; and
   - Depression

3. Round-the clock (i.e., 24 hours, 7 days a week) skilled nursing and attendant care are prescribed for Brandon by his treating Physical Medicine and Rehabilitation (PM&R) physician, Maryam, Berri, M.D. In the first 5 years following the accident, Brandon's necessary skilled nursing and attendant care was provided partially by an agency with the remainder provided by us. However, there were problems staffing Brandon due to high turnover. Additionally, our no-fault insurer, Farm Bureau, refused to pay the agency's hourly rate and otherwise make timely payments. As a result, we began hiring our own staff, paying our staff out-of-pocket, and seeking reimbursement directly from Farm Bureau. Nevertheless, *we* continued to have issues obtaining timely payment from Farm Bureau. This led to difficulties in hiring and retaining our own staff. As a result, we were forced to leave our jobs and become Brandon's full-time caregivers. This put us in financial strain.

4. Our financial strain was exacerbated after July 2, 2021 (when the Michigan No-Fault Act's new fee caps went into effect). Prior to July 2, 2021, Farm Bureau voluntarily paid us \$30.00/hour on a 24 hour/day basis for all of Brandon's necessary skilled nursing and attendant care services. We feel this was already a huge windfall for Farm Bureau given the market rates for skilled nursing (at least \$40.00/hour individually or around \$60-

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$65/hour through agencies). Following implementation of the new fee caps, Farm Bureau started paying us only $22.00/hour. Even worse, Farm Bureau began paying us for only 8 of the 24 hours/day that skilled nursing and attendant care services are prescribed for Brandon (and that we provide for him). Therefore, there were 16 hours/day during which we are caring for Brandon but for which we were not being compensated.

5. We felt compelled to hire a lawyer to enforce our rights under our contract with Farm Bureau. Fortunately, we were able to obtain an injunction compelling Farm Bureau to pay the pre-July 2, 2021 rates and amount ($30.00/hour for 24 hours/day) for Brandon's skilled nursing and attendant care. However, the injunction only compelled Farm Bureau to pay from the date of the injunction order (6/6/2022) moving forward. At this time, Farm Bureau has not paid us the differential between what it paid under the fee caps and the pre-July 2, 2021 rates for pre-injunction services (notwithstanding the Court of Appeals' decision in this case).

6. By the time we obtained the injunction order, our family had already suffered tremendously. We have feared for Brandon's physical well-being. Given his complex care needs, someone must always be available to respond in the event of an emergency. As one example, Brandon's tracheostomy tubing disconnects on its own quite often. Some days the tubing may only disconnects a couple of times. In the last year or so, it has happened as many as a dozen times just during the day. It happens randomly without warning. If his tracheostomy tubing falls out and there is no one there to immediately reconnect it, Brandon will suffer brain damage (and ultimately death) from lack of oxygen. This is literally a life-or-death situation for our son. Moreover, we have absolutely exhausted ourselves between splitting coverage for Brandon's 24/7 care while also taking on outside jobs to make up the financial difference (so we can ensure that Brandon has a home to live in with working utilities). We have blown through our savings and have had to put an excessive number of expenses on our credit cards. Our credit card balances are the highest they've ever been. We've also had to sell off assets (e.g., our Jeep and motorhome) to account for the financial shortfall. We were also forced to put our Florida home up with a vacation rental company to generate additional income.

7. The loss of the use of the Florida home is especially devastating for Brandon. Because of his spinal cord injury (SCI), Brandon is a ventilator-dependent quadriplegic. He is wheelchair dependent. Michigan winters are therefore tough for Brandon. Brandon gets more ill in the Michigan winters. Breathing more difficult for him, and he requires a lot more suctioning. Moreover, Brandon's immobility is further reduced due to the snow (his wheelchair cannot maneuver well in the snow). This forces Brandon to stay inside, preventing him from engaging in social and recreational activities (such as taking his dog to the dog park for "walks"). He in unable to even go out into his own yard in the snow. This is extremely depressing for Brandon. Having our Florida home removed these issues and ensured that Brandon stayed in the best health (physically and psychologically/emotionally). We would love to move to Florida permanently, but Florida summers also present health concerns for Brandon. That's because Brandon also has temperature regulation issues due to his SCI. With losing our home, we were unable to go to Florida this last winter. Brandon was the most depressed that we've seen him be in the

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last seven years. This was heart-breaking for us as parents.

8. We are severely exhausted, strained, overworked, and underpaid. We have literally been killing ourselves trying to keep a roof over our family's heads and to keep Brandon alive. We feel that Farm Bureau has completely taken advantage of our love for our son. We asked Brandon's doctor to temporarily place him in a facility just so we could get some respite time. Nearly all of the facilities we contacted told us that they are no longer taking on auto-accident survivors due to implementation of the no-fault amendments. The only facility that would have taken him would have only taken him on a long-term basis. Moreover, the facility is downstate (5 hours away). Brandon was devastated at the thought of being so far away from his family and friends. He was also petrified at the thought of dying in a facility away from his family. We could not do that to our son, so we chose not to proceed with that placement.

9. We breathed a huge sigh of relief when the Court of Appeals held that the new no-fault fee caps do not apply to pre-amendment accident/loss cases (including Brandon's). However, we are scared to death at the thought of the Court of Appeals' decision being overturned by this Court. We feel the Court of Appeals' decision is the correct, just result. Insurers should not be allowed to ignore previously entered, binding contracts thereby permitting them a windfall at the expense of accident survivors and their families. We urge this Court to maintain the justice done by the Court of Appeals by affirming their decision in this case.

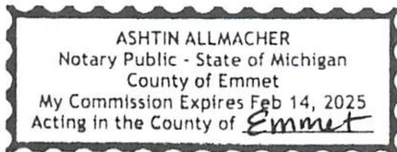
We swear the foregoing is true and accurate to the best of our knowledge and belief.

Jared Clark

Lela Clark

Subscribed and sworn to before me
This 3rd day of January, ~~2022~~ 2023

Ashtin Allmacher, Notary Public
My Commission Expires: 2/14/25


ASHTIN ALLMACHER
Notary Public - State of Michigan
County of Emmet
My Commission Expires Feb 14, 2025
Acting in the County of Emmet

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AFFIDAVIT OF NICOLETTE MARSDEN

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1. My name is Nicolette June Marsden. I am the mother (and court-appointed guardian) of Zachary Marsden (Zach). Zach was born on February 5, 2001. He was diagnosed with autism at 3 years old. At approximately 5 ½ years old, Zach sustained a severe Traumatic Brain Injury in an August 3, 2006 motor vehicle accident. Zach is currently a 21-year-old man of considerable size and strength. He is approximately 6'5 and weighs over 300 pounds.

2. Zach's combined TBI and pre-existing autism have resulted in profound behavioral disability. Specifically, Zach engages in violent and self-injurious outbursts. For example, at any moment during the day, Zach will begin pounding his fist into his head or attempt to slam his head against a wall. He has even bitten caregivers trying to restrain him. Zach's outbursts occur daily and are unpredictable and uncontrollable.

3. Since his accident, attendant care has been prescribed for Zach for 24 hours/day, 7 days/week ("24/7"). Zach only required one caregiver 24/7 when he was younger (and smaller in physical stature). As Zach got older (and bigger), however, the number of caregivers Zach required on a 24/7 basis increased. Four-to-one attendant care (i.e., four caregivers on a 24/7 basis) is now prescribed for Zach. In other words, no less than four caregivers at any time are necessary to keep Zach (and his caregivers) safe.

4. Zach's caregivers need to be sufficiently qualified given his complex needs. This means that each caregiver must be:

   - trained on how to safely restrain Zach;
   - physically able to restrain Zach;
   - proficient in handling nonverbal patients; and
   - willing to endure the inherent risk/responsibility of caring for Zach.

   Caregivers with these skills/qualities are extremely difficult to find and charge premium rates. Additionally, the turnover rate for such qualified caregivers is incredibly high due to burn out.

5. Titan Indemnity Company (Titan) is our no-fault insurer. Prior to July 2, 2021 and the fee caps under the no-fault law, the no-fault law allowed for home care reimbursement at market rates.

6. We had many problems with Titan as to paying our family agency (ZMC Services, Inc.) full compensation for the appropriate level of care under the old reimbursement system. But at least the law allowed us to argue with Titan as to the reasonable value that would enable us to attract and retain sufficiently qualified caregivers.

7. Things went from bad to worse when the no-fault fee caps were implemented on July 2, 2021. While Titan began paying ZMC $22.90/hour, this was an "all-inclusive" rate. As such, Titan refused to reimburse for overtime or any other elements of ZMC's overhead.

8. The fallout from fee cap payments has been unimaginable:

- ZMC has struggled more than ever to adequately staff Zach. Any administrative work has fallen to the wayside as our administrative staff has had to help cover Zach's direct care. ZMC has had such a hard time attracting necessary *qualified* caregivers that we had to rely on family and friends of some of our long-time caregivers (family and friends who were not sufficiently trained/qualified). It's been hard to even retain these people. Once people start the job, many decide the risk of injury in caring for Zach is not worth what they're being paid. Yet ZMC cannot afford to offer a more competitive wage. The result is a never-ending search for adequate caregivers.

- ZMC's business account has been continually in the negative and has racked up significant fees due to non-sufficient funds. We were forced to settle with Titan on non-attendant care claims just to quickly bring in funds to *try* and make payroll. However, the funds from those settlements were gone before we even received them. I have also had to borrow against my home several times to make up the difference. Again, those funds did not last long given the extreme financial deficit ZMC has continually been faced with.

- Things came to a head in or around November 2022. At that point, QuickBooks (ZMC's accounting software) suspended services (including payroll). The QuickBooks suspension delayed and canceled direct deposit for all future payroll. ZMC was forced to complete payroll manually. Completing payroll manually took a lot more time—time that should have been spent on caring for Zach. More than ever, ZMC employees feared not getting paid. Some employees quit and several others have threatened to quit (and it is hard to blame them).

- My own health has deteriorated due to extreme stress and anxiety—all because I want to ensure my son is adequately cared for. Recently, my blood pressure has gotten so high from the anxiety/stress that my doctor ordered weekly blood pressure monitoring. I also had to remove myself from Zach's direct care due to my own health issues.

9. Prior to Zach's accident, Zach's father and I did our due diligence as Michigan residents: We purchased the mandated no-fault automobile insurance. We purchased this with the understanding that the only limitations on the amount Titan was responsible to pay was that of "reasonable and customary" charges. These terms were incorporated into the insurance policy. The no-fault fee caps have allowed Titan to further shirk its responsibility to ensure that Zach receives all reasonably necessary care. That the fee caps can permit Titan to disregard the insurance contract by permitting it to pay less than what used to be considered "reasonable" is terrifying. On behalf of Zach, I plead to the Michigan Supreme Court to hold Titan to its end of our bargain by affirming the Court of Appeals' decision in the *Andary* case.

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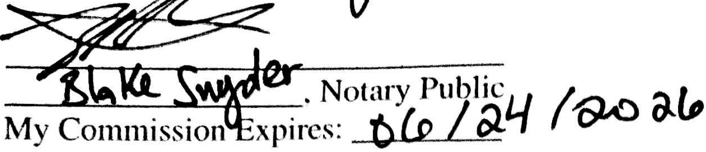
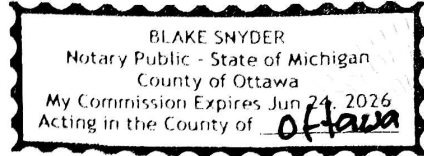
I swear the foregoing is true and accurate to the best of my knowledge and belief.



Subscribed and sworn to before me
this 23rd day of January, 2023

Blake Snyder, Notary Public
My Commission Expires: 06/24/2026

Nicolette Marsden



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Phase II
Provider Survey Results from a Study Tracking Impact of Fee Changes in No-Fault Auto Insurance Reform

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August 2022

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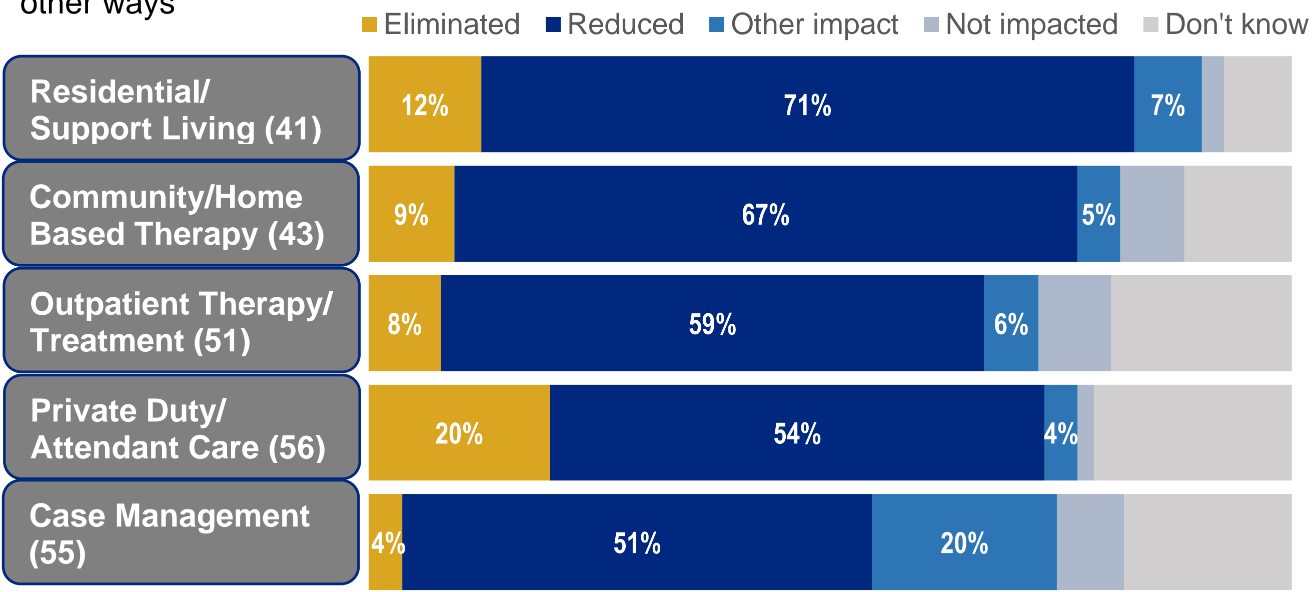
Executive Summary

The Brain Injury Association of Michigan (BIAMI) commissioned this independent study by the Michigan Public Health Institute (MPHI) to document the impact of the fee structure changes in the 2019 Michigan no-fault auto insurance reform law that took effect on July 1, 2021, on the availability of services for people with catastrophic injuries resulting from an auto crash. MPHI was chosen because of its expertise and depth of understanding of public health research. This report summarizes the results from the second survey of brain injury service providers, distributed between March 9 and May 15, 2022. The report on the first survey was released in January 2022.

Results

General Impact

- 209 unique organizations participated in the second survey, including 166 organizations that also participated in the first survey
- The 73 organizations with data on amount of revenue loss reported a combined total of **$81,366,027** loss in revenue during the last 12-month period
- The 109 organizations with data on percentage of revenue loss reported an average of **41%** loss of revenue during the last 12-month period
- Out of 19,994 employees from the 154 organizations with employment data, **4,082 (29%) jobs were eliminated** since July 2021
- In terms of patients with auto insurance funding, the 144 organizations with patient count data reported serving a total of 15,596 patients before July 2021 and 8,739 currently, that is a total of **6,857 discharges** and an average of **42% reduction in their capacity of serving patients with auto insurance funding since July 2021**
- Among the top five services most frequently provided, **73-90%** of organizations reported that these services have been either eliminated, reduced, or impacted in other ways



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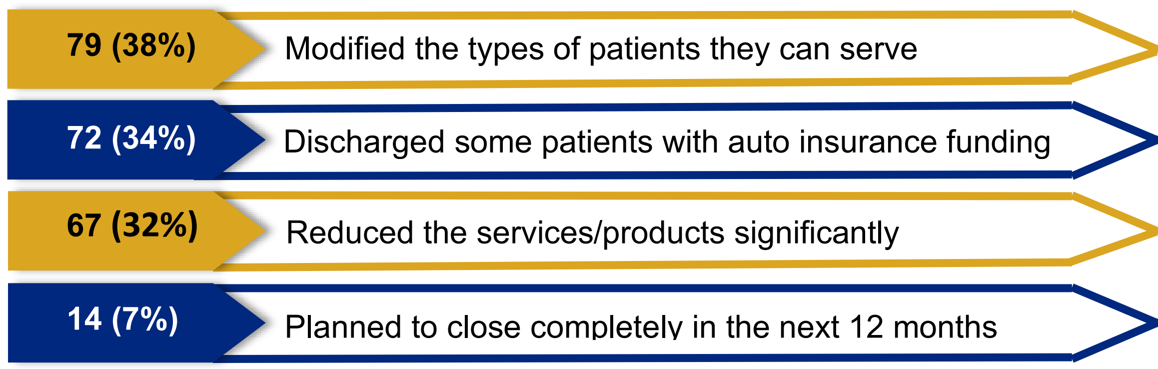
- Among the 209 organizations, there have been **10 business closures** due to the changes and **expected 14 more closures** in the next 12 months.



Impact of Fee Caps and Reimbursement

- 119 (57%) organizations reported being impacted by the 55% fee cap, while 52 (25%) reported being impacted by the 200% Medicare cap
- Of the 99 organizations impacted by the 55% cap and with data on profit margin, **67 (68%)** reported **no more than 20% annual profit margin** prior to July 2021
- Of the 48 organizations impacted by the 200% cap and with data on Medicare reimbursement rates, **24 (50%)** reported that **none of their Medicare payable claims have been paid at 200%** Medicare rates since July 2021
- Of the 140 organizations with data on overall reimbursement, **7 (5%)** reported that they **had not received any reimbursement** since July 2021
- The 84 organizations with data on denied services reported an average of **28% of their patients had been denied services** since July 2021, due to insurance company utilization review process

Utilization Review Process with DIFS

- 49 organizations have filed appeals with DIFS through utilization review process on denied services since July 2021. Of those **36 (73%) have not gotten any services reinstated**

- 48 organizations have filed a total of 1,284 complaints to DIFS since July 2021, **176 (14%) have been resolved** in their favor

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About this Study

Limitations

The target population of this survey are providers representing the organizations that provided services and care to auto crash survivors. MPHI does not have a mailing list of the target population. The first survey was distributed as a public link, sent to BIAMI's networks and their members by BIAMI and partners. The respondent list from the first survey was invited to participate in the second survey, and the second survey was also distributed through a public link. There is no way to know whether the survey invitations reached all target providers, and whether the respondents are representative of the target population.

MPHI Research Team

MPHI is a public-private partner with a variety of public health, government, and community organizations and is committed to conducting public health work based on strong scientific evidence and the needs of Michigan residents. This study is conducted by a team from MPHI's Center for Data Management and Translational Research (CDMTR), including Dr. Clare Tanner, director; Dr. Shaohui Zhai, Statistician; Dr. Issidoros Sarinopoulos, Senior Research Scientist; and Kayla Kubehl, Research Assistant.

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Methodology

Survey Development

The Auto Crash Service Providers Surveys were collaboratively developed by MPHI and BIAMI. The surveys contained questions about their employer organizations, also collected individual names and contact information in order to recontact them for the subsequent surveys. MPHI researchers trained in survey development finalized all questions to ensure readability, clarity, and lack of bias.

Survey Implementation

The survey was implemented in REDCap (Research Electronic Data Capture) by MPHI. REDCap is a secure web application for building and managing online surveys and databases. While REDCap can be used to collect virtually any type of data in any environment (including compliance with 21 CFR Part 11, FISMA, HIPAA, and GDPR), it is specifically geared to support online and offline data capture for research studies and operations.

Survey Distribution

The second survey was distributed in two batches, one was by MPHI through email to the first survey respondents who provided contact emails, the other was by BIAMI and partners through a public link to their members and networks to recruit organizations that did not respond to the first survey. The survey was distributed between March 9 and May 15, 2022. At least three rounds of reminders were sent out during the distribution period.

Internal Review Board Approval

MPHI's Internal Review Board (IRB) operates following FDA regulations and is formally designated to review and monitor biomedical research involving human subjects with the authority to approve or disapprove research. This review is designed to ensure researchers protect the rights and welfare of research participants. The IRB review assures appropriate steps are taken to protect the rights and welfare of research participants. MPHI's IRB panel reviews research protocols and related materials to ensure protection of the rights and welfare of research participants.

The MPHI research team submitted a Human Participant Protections Application to the MPHI IRB, and the approval of the project was granted on September 27, 2021.

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Provider Survey Results

Services Provided and Impacted

Respondents reported the services their organizations provided before July 2021, and how these services were impacted by the fee caps that took effect in July 2021. The chart on the next page presents the service categories and the percentages of the organizations reporting these services being eliminated, reduced, other impact, or no impact.

- The number of organizations that provided the listed services ranged from 4 (Orthotic/Prosthetics) to 56 (Private Duty/Attendant Care).
- Every type of service has been impacted – with a majority of organizations across all service categories except three (*Orthotic/Prosthetics, Chiropractic Therapy, and Guardian/Conservator Services*) reporting having to eliminate or reduce services.
- The top 8 services provided by at least 20 organizations are, *Private Duty/Attendant Care, Case Management, Outpatient Therapy/Treatment, Community/Home Based Therapy, Residential/Supported Living, Transportation, Recreational Therapy, and Vocational Services/Counseling Services.*
- Among these commonly provided 8 services, those most impacted are:
  - *Residential/Supported Living:* 83% organizations reported eliminating or reducing services
  - *Recreational Therapy:* 77% organizations reported eliminating or reducing services
  - *Community/Home Based Therapy:* 76% organizations report eliminating or reducing services
- It is also worth noting that 24% of *Transportation* and 20% of *Private Duty/Attendant Care services* organizations reported eliminating those services entirely.
- 32 organizations reported providing other services not in the answer options, including general healthcare, medical technology, neuropsychology, driver rehabilitation, and various therapy services. 62% of the organizations reported these services being either eliminated, reduced, or impacted in other ways.
- Other impacts reported include, decreased or delayed reimbursement, reduced salary and benefits, and reduced staff.

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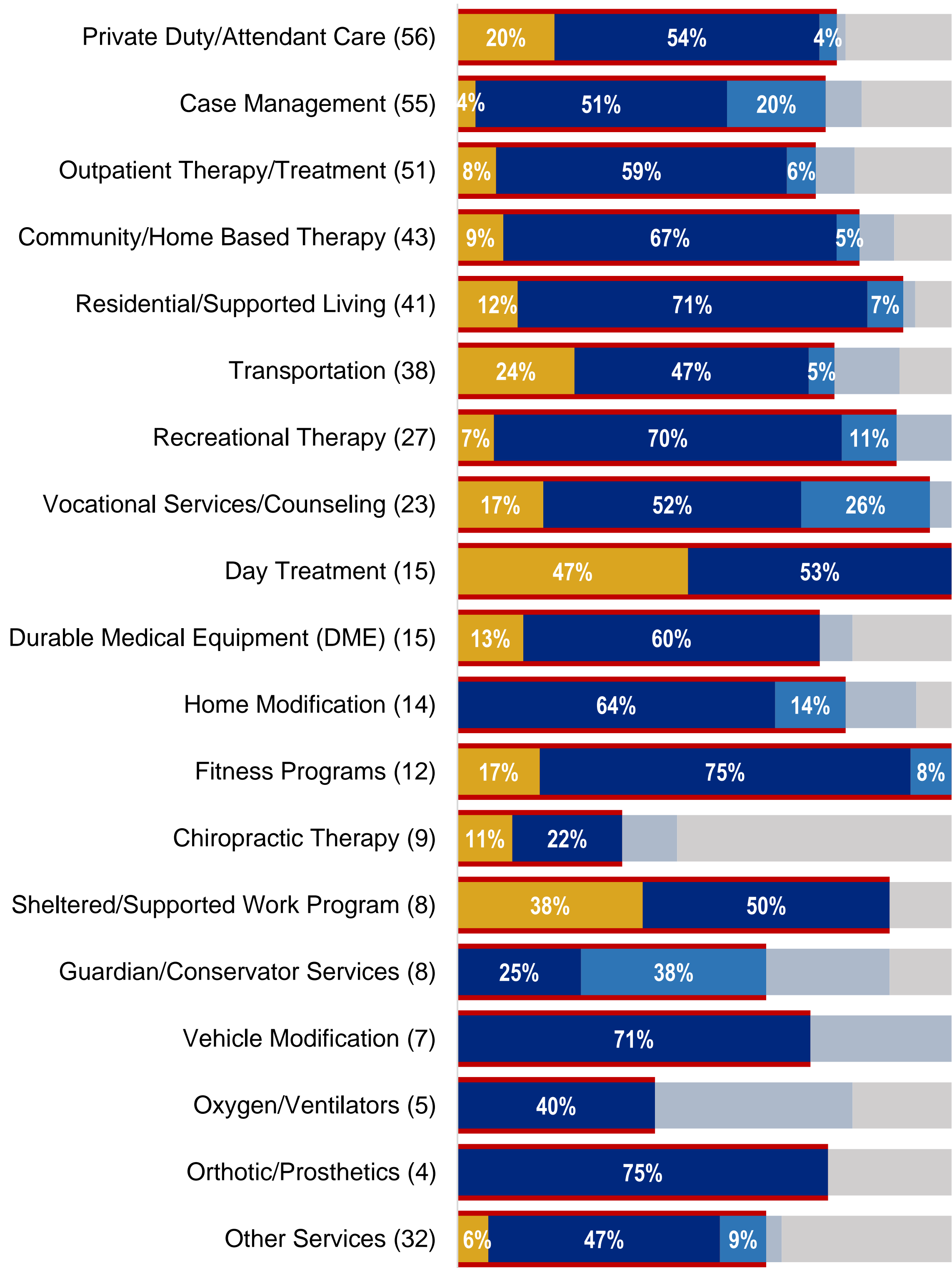

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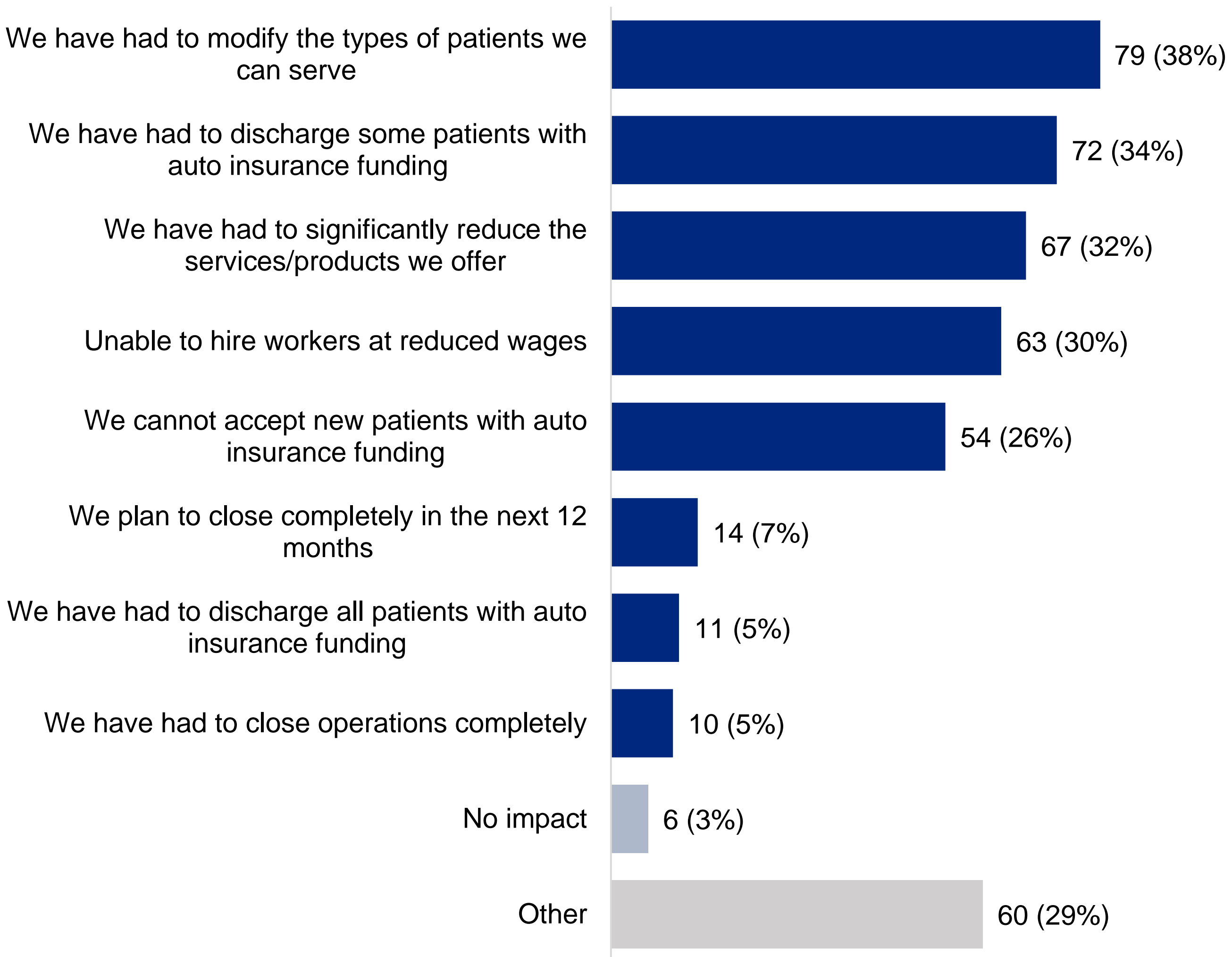
Impact on business operations

Providers were asked about the impact on the general operations of their organizations.

- 79 (38%) organizations reported having to modify the types of patients they serve, such as by looking at the insurance/PIP coverage to determine if they will serve a new patient.
- 10 (5%) had to close completely, and another 14 (7%) plan to close in the next 12 months.
- 60 (29%) reported other impacts, including difficulty getting reimbursement from insurance companies (partial payment, no payment, inconsistency in payment, more required documentations), having lost money, having to cut employees pay, and having to downsize the workforce.

Impact on organizational operations (n=209 organizations)



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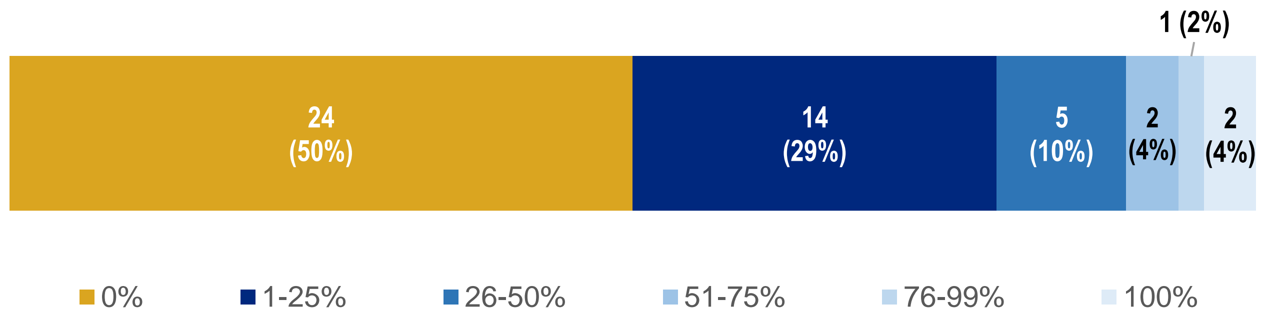
Impact of the 200% reimbursement cap for Medicare payable codes

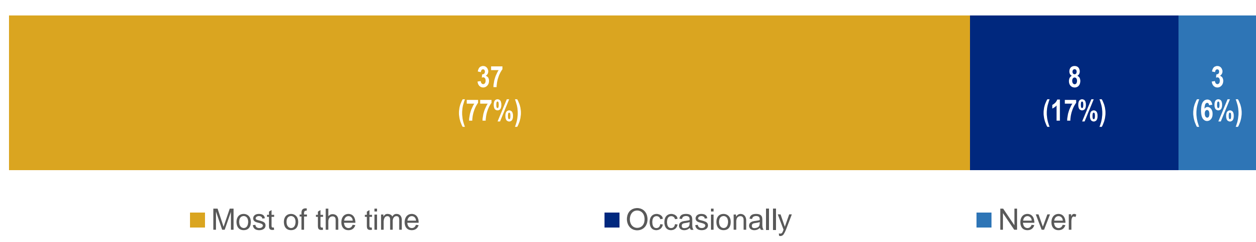
52 (25%) of the 209 organizations reported that their businesses have been impacted by the 200% reimbursement cap for Medicare payable codes.

- 24 (50%) of the 48 organizations with data reported they were never reimbursed at 200% of Medicare payable rates; 2 (4%) organizations reported that all their Medicare payable claims were reimbursed at 200% of the Medicare rates.
- 37 (77%) of the 48 organizations with data reported that same Medicare payable codes were reimbursed at inconsistent rates most of the time; 3 (6%) organizations reported that same Medicare payable codes were reimbursed at the same rates consistently.
- When reimbursed at less than 200% Medicare rates, the top reasons were, *not a Medicare service*, *multi procedure code reductions*, *missing/wrong form or codes*, and *no charge master provided.*
- When reimbursed at less than 200% Medicare rates, 33 (73%) organizations have attempted to rebill. Of those, 11 (33%) reported never being able to recoup the remaining balance, and 15 (45%) reported being able to recoup the balance only up to one quarter of the time.

Percentage of claims funded by auto insurance have been paid at 200% Medicare rates (n=48 organizations)



Frequency being reimbursed at inconsistent rate for the same Medicare payable codes (n=48 organizations)



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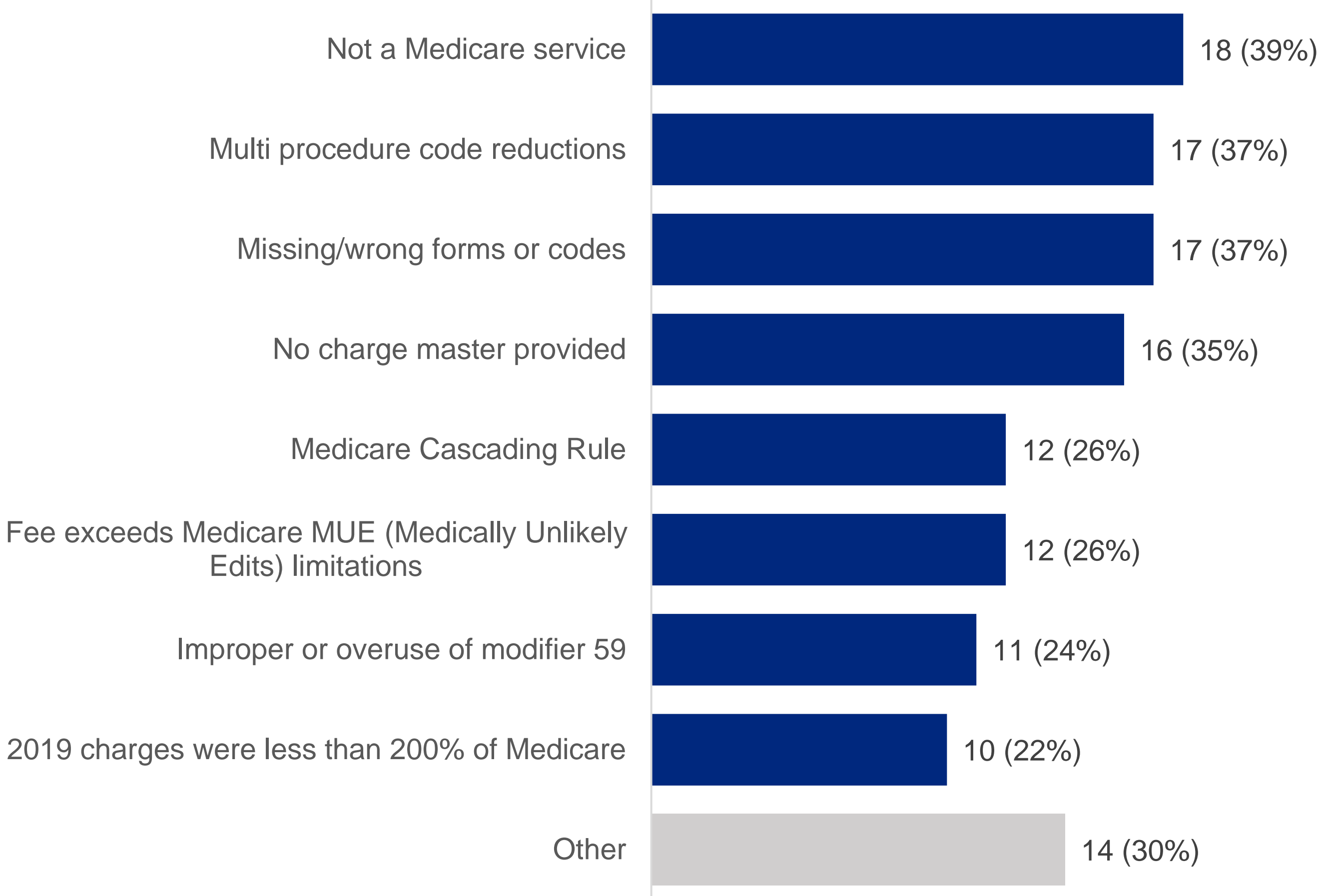
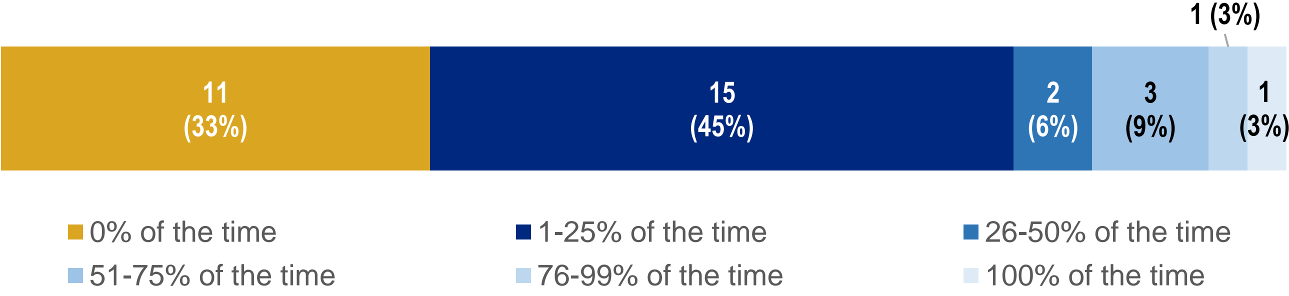
Reasons for being reimbursed at less than 200% Medicare rates (n=46 organizations)



Percent of the time being able to recoup remaining balance when rebilled (n=33 organizations)



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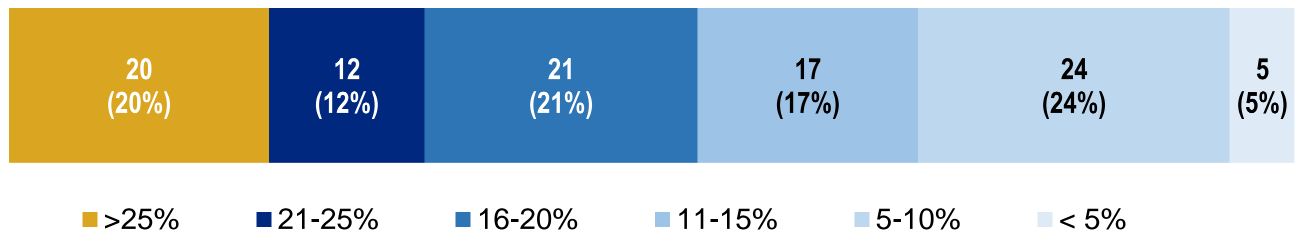
Impact of 55% of 2019 charges for non-payable Medicare codes

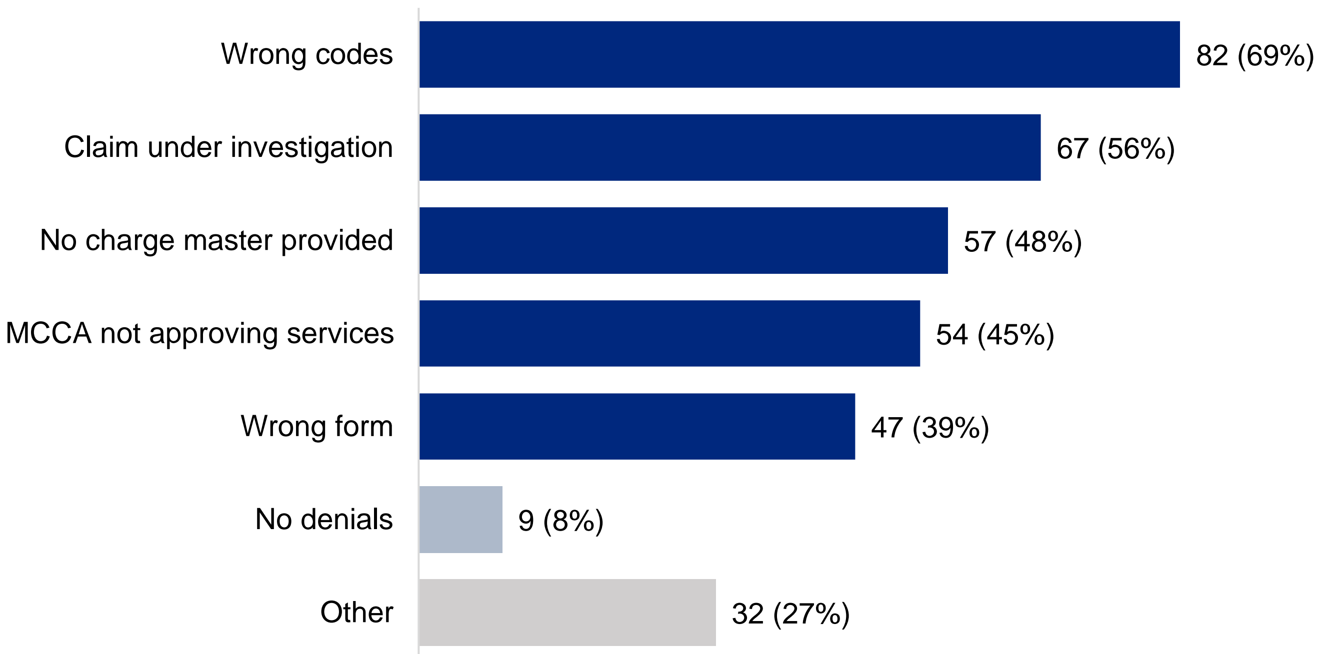
119 (57%) of the 209 organizations reported that their businesses have been impacted by the 55% reimbursement cap of 2019 charges for non-Medicare payable codes.

- 67 (68%) organizations reported having annual profit margin no more than 20% before July 2021 (n=99).
- Top two reasons for denial of claims *were wrong codes* and *claim under investigation.* Other reasons for denials include not enough documentation for services provided, services were medically unnecessary, and client had received the maximum amount.
- 9 (8%) organizations did not experience claims denied.

Average annual profit margin prior to July 1, 2021 (n=99 organizations)



Reasons for denial of claims (n=119 organizations)



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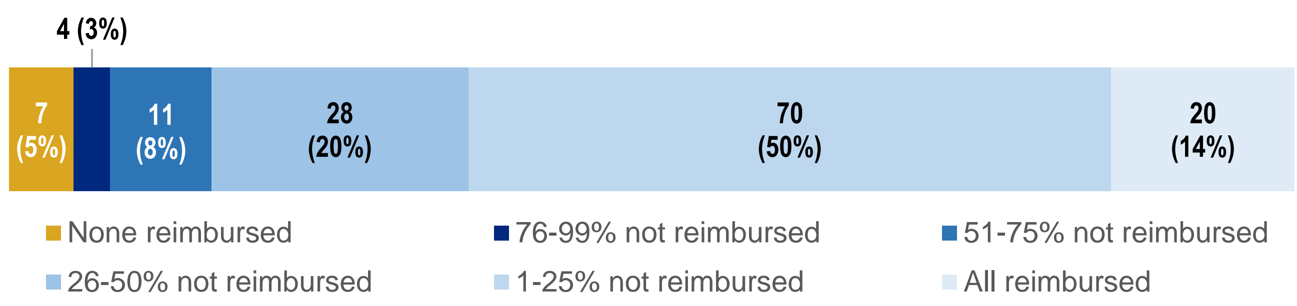
Reimbursement

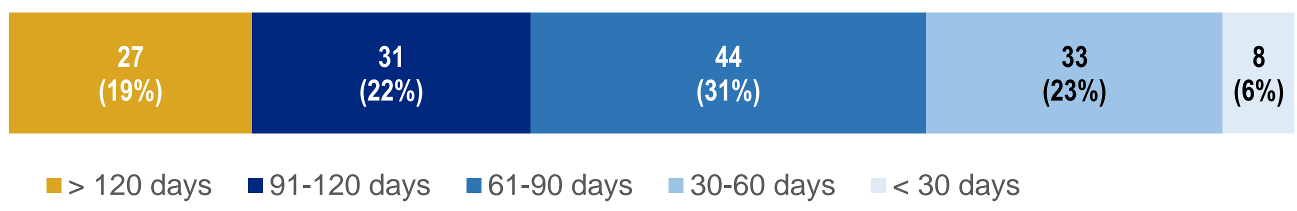
Respondents were asked about reimbursement for the services they provided to their auto insurance funded patients.

- 7 (5%) have not received any reimbursement at all since July 2021 (n=140).
- 27 (19%) organizations reported having to wait for more than 120 days before receiving any reimbursement (n=143).
- 84 organizations reported an average of 28% patients had been denied services since July 2021 due to insurance company utilization review process, 6 of them reported 100% of their patients have been denied services (n=84).

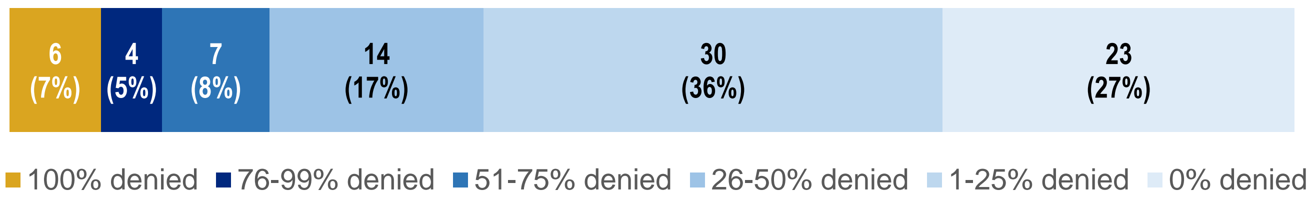
Proportion of claims that have not received any reimbursement since July 1, 2021 (n=140 organizations)



Days to wait to receive reimbursement (n=143 organizations)



Proportion of patients denied services since July 2021 (n=84 organizations)



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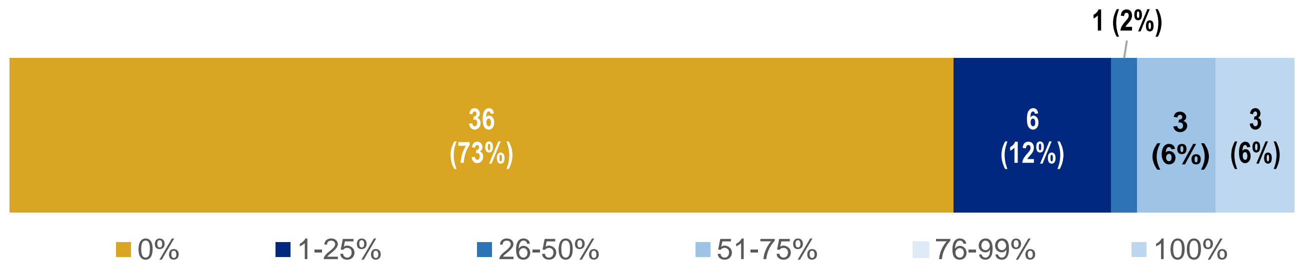
Working with DIFS and Insurance Adjusters

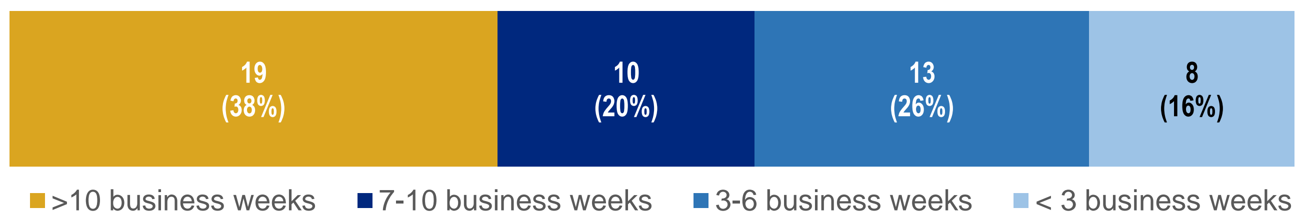
Under Michigan's auto insurance law, medical care provided to a person injured in an auto crash must meet requirements for medical appropriateness. Auto insurers must establish utilization review programs to make these determinations, which can be appealed by health care providers to the Michigan Department of Insurance and Financial Services (DIFS) Utilization Review section. Respondents were asked about their experiences with the DIFS Utilization Review process, filing a complaint to DIFS, and working with insurance adjusters.

- 54 organizations have filed appeals with DIFS through the Utilization Review Process on denied services since July 1, 2021. Among the 49 reported, 36 (73%) organizations reported that none of their appeals resulted in reinstatement of services for their patients.
- 29 (58%) organizations reported having to wait for more than 7 weeks to get a determination from DIFS (n=50).
- 48 organizations have filed a total of 1,284 complaints to DIFS since July 2021, 176 (14%) of the complaints were resolved in their favor.
- 92 (69%) organizations reported that their ability to productively discuss cases with insurance adjusters has gotten worse, compared to before July 2021 (n=134).
- 69 (51%) reported having heard from insurance adjusters that the MCCA is directing pre-approval of services and/or reimbursement (n=134).

Proportion of appeals to DIFS Utilization Review resulted in reinstatement of services for patients (n=49 organizations)



Weeks to get a determination from DIFS (n=50 organizations)



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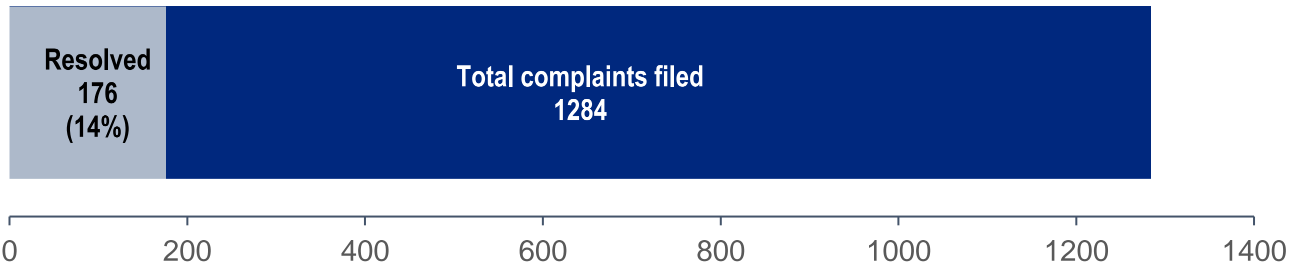
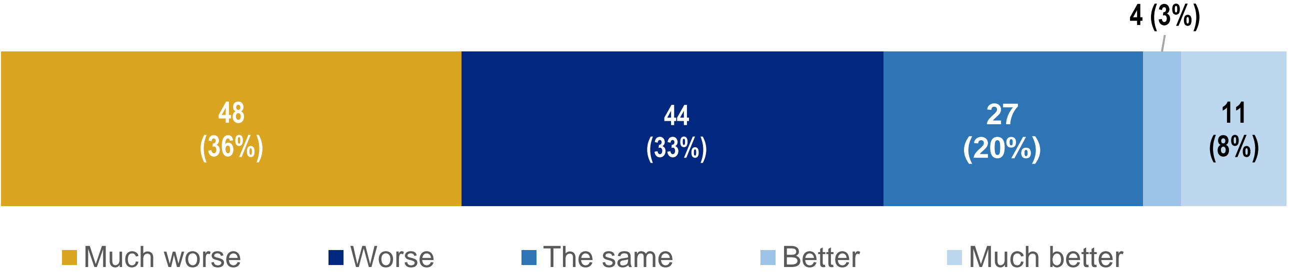
Total number of complaints filed to DIFS and resolved in provider's favor since July 2021 (n=48 organizations)



Organization's ability to productively discuss cases with insurance adjusters, compared to before July 2021. (n=134 organizations)



Respondents were asked if they have tried to contact their state representatives and/or senators about issues resulted from the fee caps. 107 (78%) of the 136 respondents who answered this question have tried. Of those, 67 (63%) had dialogues, 40 (37%) got no responses.

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Provider perspectives

104 providers described in their own words what these changes meant to them. Responses fell within the following 15 themes, accompanied by selected quotes.

Theme	Quote
Financial loss Providers are at a financial loss since they are not being paid or reimbursed.	*"I had no income for six months I cannot hire and am working 100 + hours a week myself due to short staffing. I lost a client I had been caring for nine years. She employed 32 hours a day."*
Patient discharge or discontinued services Providers have needed to discharge patients, or the organizations will continue to lose money.	*"It has been an injustice to our clients as they have had to be discharged from services for needs that are no longer being covered leaving them and their families w/ minimal resources and emotional upheaval."*
Aide shortages Lack of reimbursement led to aide shortages and burnout among staff.	*"Finding caregivers is impossible, we are thankful that the handful we have haven't left us but will when we can no longer pay them."*
Difficulty to work with insurers Providers sense that insurance companies are putting up unnecessary barriers over and above the payment caps.	*"[Insurance company] makes us use US mail (during pandemic) there are at least 25 pages per patient bill per month, many get 'lost ' and unpaid, we end up having to retain an attorney to get paid at all."*
Transportation shortages Transportation has become problematic and reduced, which prevents clients from receiving needed therapies and care.	*"They will not pay for travel code T2003 even with the charge master. They will only pay for travel code S0215 and only pay mileage - not travel time and it is a fight and very difficult. Most of my clients are home bound and cannot drive"*
Code confusion	*"I would like to add in general there is much more billing issues where the billing companies coding invoices wrong, and I have to spend a lot more time calling insurance companies and billing companies to try to get paid and correct these issues."*

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Inadequate insurance or DIFS help Providers are frustrated with the lack of help and communication with insurance companies or DIFS, including explanations regarding what services will be covered.	*"To date we've received 0 communication from any auto insurance carrier that we're waiting to be re-imbursed for services."*
Unable to accept no-fault auto patients	*"Since October 1, 2021, our organization has had to stop accepting auto insurance clients and it feels terrible to deny services to those individuals who truly need in-home care."*
More paperwork and longer wait Providers indicated they are spending more time completing paperwork and waiting for payments than they did prior to the changes.	*"It is more time-consuming and takes much longer."*
Stress Providers face increased stress in trying to work in the new system.	*"We are under stress and do not see consistency in reimbursements and fear that the insurance company will continue to target anyone that had a contract before the law change and leave them destitute."*
Out of businesses Providers have been unable to sustain the new changes and have had to close their companies altogether.	*"It forced us out of business, we could not find a way to absorb a 45% fee cut and provide services."*
Downsizing Providers indicated the changes led them to lay off staff or downsize their organizations to adjust for lack of reimbursement.	*"We have had to reduce staffing ratios, we cannot provide 1:1 service even though it is still needed, but the reimbursement is not enough to cover our costs for 1:1 staffing."*
Limited referrals The changes have caused some providers to have less referrals being submitted.	*"The fee schedule changes have impacted smaller providers by severely limiting referrals for services. We know of other providers in Northern Michigan that have not had new referrals in six months, and we have not had any new referrals in that time either."*

Fear for auto crash survivors' transition to nursing homes Providers indicated they did not feel auto crash survivors would transition well to living in nursing homes. Some even expressed survivors would die as a result.	*"The client has already/previously said she will run away, hitchhike somewhere, dies before she lives in a home."* *"Without the full no-fault reimbursement for ALL of my daughter's needs, she probably would have had to be in a nursing home, and I'm sure she would have been neglected & abused & would have lost her life very early on."*
Lack of company growth Providers indicated the changes stunted the growth of their companies.	*"I have to turn away care constantly, which affects my business growth, my therapists, my ability to hire and the quality of life of the patients."*

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This project was funded by BIAMI.

The study was conducted by MPHI with assistance from BIAMI.

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Car crash survivors who died after losing care are memorialized in service at Lansing church

Michigan Radio | By Tracy Samilton

Published March 2, 2022 at 2:37 AM EST

LISTEN • 4:09

Tracy Samilton / Michigan Radio

State Representative Julie Rogers and Kim Nolan at memorial service for crash survivors who died after losing care.

A coalition of faith groups held a memorial service in Lansing Tuesday for car crash survivors who died after losing care that was keeping them alive.

Members of the Michigan Interfaith Coalition said the deaths are a consequence of changes to Michigan's auto no-fault insurance law.

The Reverend Timothy Flynn of St. Michael's Episcopal Church began the ceremor

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building.

"We pray for all of us gathered here, especially for the families and the loved ones of those that have departed this life," he said, as mourners held flickering (flameless) candles. "We pray that our legislators and our governor be blessed with courage and a thirst for justice."

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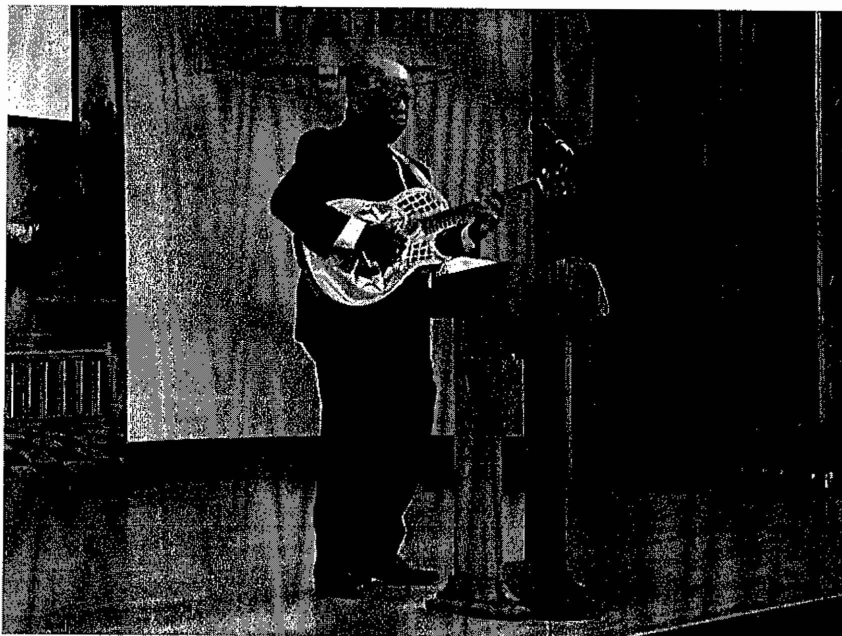

Tracy Samilton / Michigan Radio

Rev. Robert Jones of Sweet Kingdom Missionary Baptist Church, Detroit, sings Washington Phillips' "What are they doing in heaven today," at memorial for car crash survivors who died after losing their care

Grieving relatives and friends sat in the front row, waiting to speak.

Across the state, more than 1,500 people who suffered catastrophic injuries in car crashes have lost their care, according to an independent study conducted by the Michigan Public Health Institute.

Changes to Michigan's auto no-fault insurance law have slashed insurance company payments to long-term care providers by nearly half. People rely on those providers to stay alive after their crashes, but the cuts are so deep that some are going out of business.

State legislators and the governor were warned that the changes would be devastating and result in massive suffering and deaths.

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One by one, relatives, faith leaders, and care providers offered their remembrances.

For Sandra Cain, who died on January 28 after losing her care at home. For Susan Ann Meagher, who died on July 21, 2021.

For Richard Shueneman, whose daughter grieved that he survived a horrific accident, but couldn't survive his loss of care. He died in January.

For Linda, a woman so private her care provider Kim Nolan thought she should preserve her privacy even in death.

And for Jim Bourdage, whose wife Angelina moved him into a nursing home when he lost his home care agency. He died December 21, 2021.

"I had no recourse, or path to take to help him," she said, "because all of those were stripped from us by the no-fault law changes."

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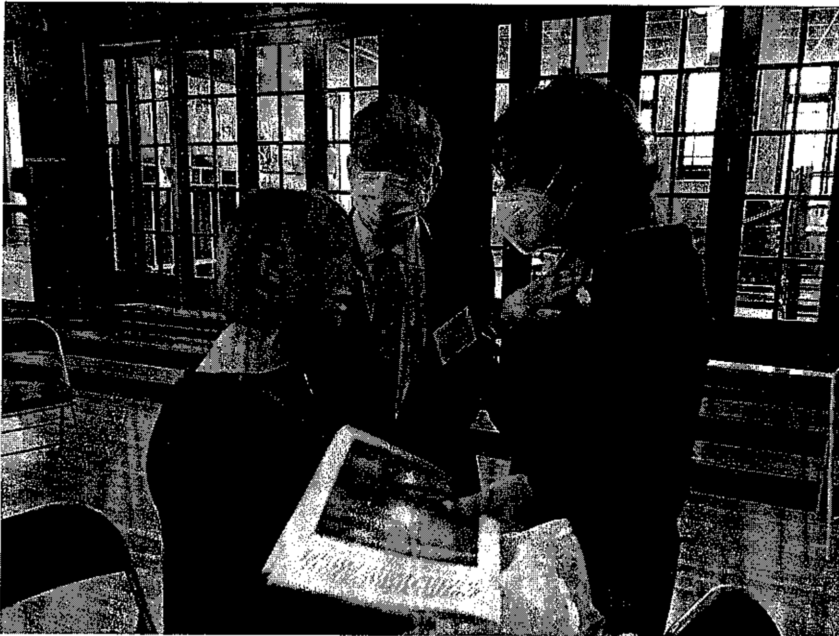

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Linda St. Amant, Owen Perlman, and Angelina Bourdage at no fault memorial service

Angelina said within 24 hours of the move to the nursing home, Jim was put on a ventilator. He got sick and never recovered. She struggled to speak through tears, saying he didn't deserve to die "tortured and alone."

"He just gathered wounds, as the months went along," she said. "Then infections fi

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very slow, very painful death. We weren't able to be with him in the end. We will always love him and miss him — and I appreciate you all listening to his story, but I hope his passing can help someone who is able to be helped."

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Tom Constand said there are many people who can still be helped. He's the president of the Brain Injury Association of Michigan. He said the ceremony Tuesday brought home the humanity of the people who are being hurt by the no-fault changes, and it's time for the Governor and the state legislature to pay attention to what's happening and amend the no-fault law.

"Enough is enough," Constand said. "When you go through a service like this today and hear about the lives that were lost because of the change in their care, and how quickly they slipped off the scale, it's time to do something."

A bipartisan majority of members of the state House have co-sponsored bills to try to fix the no-fault law. But Republican leaders haven't agreed yet to schedule hearings for those bills.

The Insurance Alliance of Michigan was asked to comment on the memorial service.

They responded with a statement saying the no-fault changes are working to lower insurance costs, and drivers are anticipating $400-per-vehicle checks coming in the mail soon.

Those checks will come from a surplus in the state's catastrophic care fund for accident survivors.

Tags Community | no-fault | Fallout of No-Fault Reform | no fault auto insurance | Instagram

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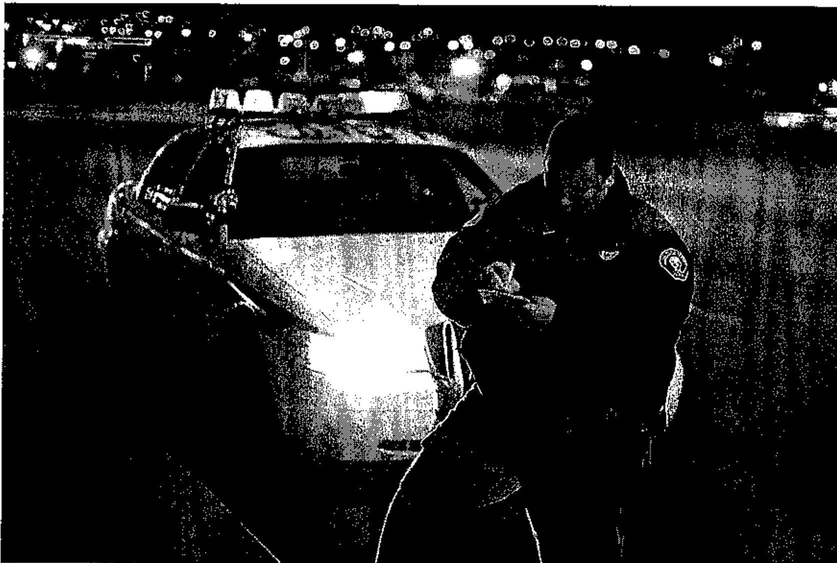
Reports: Michigan's 2019 no-fault overhaul is failing to lower rates and help Detroit drivers as promised

Michigan Radio | By Tracy Samilton

Published May 4, 2022 at 3:26 PM EDT



Thomas Hawk / Flickr/Creative Commons

Michigan's 2019 auto no-fault overhaul promised to lower rates for Detroiters and reduce the number of people driving without insurance because they can't afford it.

Evidence that 2019 Michigan's auto no-fault overhaul has failed to deliver on its promises continues to grow.

Insure.com, which ranks car insurance costs by state, says Michigan climbed back to most expensive for car insurance in the nation just a year after the changes were signed into law by Governor Gretchen Whitmer. That's after the state briefly dropped to the number two spot.

In addition, insurance company filings with the Department of Insurance and Financial

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rates for car insurance based on their incomes and where they live — if they can afford those higher premiums at all.

Data suggest discriminatory PIP rates based on lower income

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Doug Heller, Director of Insurance for the Consumer Federation of America, combed through the past year's worth of insurance company auto premium rate filings with DIFS.

The filings show that low-income drivers on Medicaid pay ***more*** on average for the ***lowest*** personal injury protection (PIP) coverage level ($50,000) than other drivers pay for the ***highest*** coverage level (so-called "unlimited.")

PIP is just one portion of an insurance policy. It pays for treatment of injuries sustained in a crash.

The statewide average for PIP for drivers on Medicaid, who can choose $50,000 of PIP, was $591. The average for drivers who chose unlimited PIP was $478.

"If you are poor, you pay more to get less," Heller said. "If you do the math on PIP, somebody buying $50,000 of PIP is getting 8% of the coverage compared to full unlimited PIP. And yet you're paying 50% more. That's the second class citizenship that we've created through this law."

The different in price varied by insurance company. One company, State Farm, actually charged drivers on Medicaid $130 less for $50,000 PIP, compared to drivers paying for unlimited.

"If you are poor, you pay more to get less."

Doug Heller, Director of Insurance, Consumer Federation of America

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But Progressive charged the low income drivers $337 more for their $50,000 of PIP, compared to drivers choosing unlimited. And MEEMIC charged a whopping $530 more.

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Amicus Curiae MAJ's App'x 30 of 46

Heller said the filings show that rate relief promised for Detroiters and others hasn't happened.

"People on Medicaid — they're too broke to buy insurance," he said. "And when we have this persistent discriminatory pricing, they continue to be too broke to buy insurance. It (reform) didn't resolve the problem."

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It's not just PIP — Detroit drivers still pay dramatically more for policies

Insurance companies in Michigan are not required by state law or by DIFS to disclose rates by zip code or census tract.

But Heller said it's easy to discover that drivers in the city of Detroit pay far more on average for their insurance than drivers elsewhere.

Heller compared two hypothetical drivers applying for insurance with Allstate, both with the same coverage level, same age, and type of vehicle (a 2016 Ford Fusion.)

What was different was the zip code. One of these hypothetical drivers lives in Northville; the other, just 30 miles away, in an East Detroit neighborhood.

Heller said the policy quotes differed dramatically, both in overall price, and PIP coverage levels. The Northville driver would be charged $394 per month by Allstate, including unlimited PIP. The Detroit driver would be charged $516 per month, including only $50,000 in PIP.

Heller said having the Detroit driver pay for unlimited would bring the policy cost up by hundreds of dollars per month.

The example is similar to one I did. My insurance company is AAA Michigan. I currently pay $110 a month for maximum coverage levels, including unlimited PIP, and no collision, for two cars (a 2007 Saturn Vue, and a 2010 Ford Focus.)

If I lived in an East Detroit neighborhood, my AAA insurance would more than triple to over $350 per month.

Rate hikes on the way — and a return of penalties for those not continuously insured

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Proposed rate hikes starting this spring are likely to keep Michigan secure in its number-one-most-expensive ranking in the U.S.

DIFS approved a 12% rate increase for Allstate in March. DIFS also approved Allstate's 20% penalty surcharge for drivers who did not continuously maintain car insurance.

Safeco has been approved for an 11.4% hike, starting May 28; Auto Club, 9%, effective July 1; Michigan Insurance Company's request for a 9% hike is pending.

Other insurance companies have asked for lower increases, including Citizens, which has requested a total of 1.8% in rate hikes this year. But buried in that request is the company's plan to lower rates in southern central Michigan by more than 10% — and increase them more than 10% in urban southeastern Michigan — namely, Detroit.

Insurance Alliance of Michigan continues to insist reform is working

IAM, the lobbying group for insurance companies in Michigan, continues to decline our numerous requests for interviews.

The group also continues to claim that the law is "driving the costs down for consumers."

Meanwhile, the law is also driving multiple home care agencies that care for auto accident patients out of business — and leaving vulnerable crash victims without care. That's because fee cuts in the law allow insurance companies to pay far less than the cost of care.

IAM has remained silent about car crash patients losing their medical care.

DIFS did not respond to a request for comment for this story.

Politics & Government

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November 1, 2021

R. Kevin Clinton
Executive Director
Michigan Catastrophic Claims Association
17584 N. Laurel Park Dr.
Livonia, MI 48152

Dear Mr. Clinton,

My office recently reviewed the Annual Report of the Michigan Catastrophic Claims Association (MCCA) to the Legislature issued in September 2021. The report stated that the MCCA had a surplus of $2.4 billion at the end of 2020. In your annual statement issued on June 30, 2021, the surplus is now $5 billion. I am calling on you today to refund money to Michiganders.

As we stay laser-focused on growing our economy and ushering in a new era of prosperity, we need to use every resource we have to help people thrive. These refunds will help us continue to put Michiganders first and drive down costs for working families.

The surplus reflects premium overcharges and is partly a reflection of the cost-saving measures implemented in the historic, bipartisan no-fault reform legislation I signed into law in 2019. Since then, many Michiganders have experienced financial hardships during the ongoing COVID-19 pandemic. Now is not the time for the MCCA to withhold money owed to Michiganders. I urge you to move swiftly to return the surplus funds to policyholders in the form of lump-sum checks.

Billions in surplus funds should not be held by insurers to invest for their own profit or be conditioned on the renewal of a policy. **The surplus belongs to Michigan policyholders and should promptly be returned directly to them in full, in the form of refund checks.**

Sincerely,

Gretchen Whitmer
Governor

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Department of Insurance and Financial Services

Post-Acute Auto Injury Provider Relief Fund

Quarterly Report for Period August 13, 2021 – November 12, 2021

This report is being made pursuant to Public Act 65 of 2021 (Act), which created the Post-Acute Auto Injury Provider Relief Fund (Fund). Under Section 301(8) of the Act, the Department of Insurance and Financial Services (DIFS) must produce a quarterly report regarding the Fund. The report must be provided to the Michigan Legislature, made available on a publicly accessible website, and include all of the following:

- The number of providers that have applied for funding from the Fund.
- A list of the providers that have been approved for funding and the amounts awarded.
- A list of providers that have been denied funding and the reason for each denial.
- For each provider approved for a funding distribution, metrics on all charges and payments received in response to those charges under MCL 500.3157 that were determined to be inadequate.
- Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.
- The total amount expended and remaining in the Fund.

Accordingly, the Director reports the following as required by Section 301(8) of the Act for the quarter ending November 12, 2021:

(a) The number of providers that have applied for funding from the Fund.

Applications Received	1
Complete Applications Received	0
Applications Pending Review	0[1]

(b) A list of the providers that have been approved for funding and the amounts awarded.

- There have been zero providers approved for funding.

(c) A list of providers that have been denied funding and the reason for each denial.

Denial Date	Provider Name	Denial Reason
October 4, 2021	TLC In-Home Services	Incomplete Application

[1] The one application received is no longer pending because it was incomplete.

(d) For each provider approved for a funding distribution, metrics on all charges and payments received in response to those charges under MCL 500.3157 that were determined to be inadequate.

- Not applicable at this time.

(e) Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.

- Not applicable at this time.

(f) The total amount expended and remaining in the Fund.

Initial Fund Balance	$25,000,000
DIFS' Administrative Expenses[2]	$18,345
Fund Disbursements	$0
Remaining Fund Balance	$25,000,000

[2] DIFS' administrative expenses are current as of October 31, 2021.

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Department of Insurance and Financial Services

Post-Acute Auto Injury Provider Relief Fund

Quarterly Report for Period November 13, 2021 – February 11, 2022

This report is being made pursuant to Public Act 65 of 2021 (Act), which created the Post-Acute Auto Injury Provider Relief Fund (Fund). Under Section 301(8) of the Act, the Department of Insurance and Financial Services (DIFS) must produce a quarterly report regarding the Fund. The report must be provided to the Michigan Legislature, made available on a publicly accessible website, and include all of the following:

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- Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.
- The total amount expended and remaining in the Fund.

Accordingly, the Director reports the following as required by Section 301(8) of the Act for the quarter ending February 11, 2022:

(a) The number of providers that have applied for funding from the Fund.

Applications Received	3
Complete Applications Received	0
Applications Pending Review	0

(b) A list of the providers that have been approved for funding and the amounts awarded.

- There have been zero providers approved for funding.

(c) A list of providers that have been denied funding and the reason for each denial.

Denial Date	Provider Name	Denial Reason
January 28, 2022	Irvine Head Injury Homes, Inc.	Missing documentation required by Legislature
January 28, 2022	Best Care Nursing Services, Inc.	Missing documentation required by Legislature

February 9, 2022	ABA HomeCare LLC	Missing documentation required by Legislature

(d) For each provider approved for a funding distribution, metrics on all charges and payments received in response to those charges under MCL 500.3157 that were determined to be inadequate.

- Not applicable at this time.

(e) Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.

- Not applicable at this time.

(f) The total amount expended and remaining in the Fund.

Initial Fund Balance	$25,000,000
DIFS' Administrative Expenses[1]	$20,771
Fund Disbursements	$0
Remaining Fund Balance	$24,979,229

[1] DIFS' administrative expenses are current as of January 31, 2022. However, due to the timing of disbursements to DIFS for administrative expenses, the "Remaining Fund Balance" may not always reflect administrative expenses incurred but not yet disbursed to DIFS.

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Department of Insurance and Financial Services

Post-Acute Auto Injury Provider Relief Fund

Quarterly Report for Period February 12, 2022 – May 13, 2022

This report is being made pursuant to Public Act 65 of 2021 (Act), which created the Post-Acute Auto Injury Provider Relief Fund (Fund). Under Section 301(8) of the Act, the Department of Insurance and Financial Services (DIFS) must produce a quarterly report regarding the Fund. The report must be provided to the Michigan Legislature, made available on a publicly accessible website, and include all of the following:

- The number of providers that have applied for funding from the Fund.
- A list of the providers that have been approved for funding and the amounts awarded.
- A list of providers that have been denied funding and the reason for each denial.
- For each provider approved for a funding distribution, metrics on all charges and payments received in response to those charges under MCL 500.3157 that were determined to be inadequate.
- Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.
- The total amount expended and remaining in the Fund.

Accordingly, the Director reports the following as required by Section 301(8) of the Act for the quarter ending May 13, 2022:

(a) The number of providers that have applied for funding from the Fund.

Applications Received	17
Complete Applications Received	0
Applications Pending Review	1

(b) A list of the providers that have been approved for funding and the amounts awarded.

- There have been zero providers approved for funding.

(c) A list of providers that have been denied funding and the reason for each denial.

Denial Date	Provider Name	Denial Reason
March 17, 2022	Irvine Head Injury Homes, Inc	Missing documentation required by Legislature
March 25, 2022	Origami Rehabilitation	Missing documentation required by Legislature

March 25, 2022	Origami Rehabilitation	Missing documentation required by Legislature
March 25, 2022	Origami Rehabilitation	Missing documentation required by Legislature
April 19, 2022	Origami Rehabilitation	Missing documentation required by Legislature
April 19, 2022	Origami Rehabilitation	Missing documentation required by Legislature
April 19, 2022	Origami Rehabilitation	Missing documentation required by Legislature
April 19, 2022	Origami Rehabilitation	Missing documentation required by Legislature
April 19, 2022	Best Care Nursing Services, Inc	Missing documentation required by Legislature
April 19, 2022	Great Lakes Home Care Unlimited	Missing documentation required by Legislature
April 20, 2022	Origami Rehabilitation	Missing documentation required by Legislature
May 2, 2022	Origami Rehabilitation	Missing documentation required by Legislature
May 2, 2022	Origami Rehabilitation	Missing documentation required by Legislature
May 2, 2022	Origami Rehabilitation	Missing documentation required by Legislature
May 11, 2022	Freedom House of Lakeland LLC	Missing documentation required by Legislature
May 11, 2022	Independence House LLC	Missing documentation required by Legislature
May 11, 2022	Lakeland House Inc	Missing documentation required by Legislature

(d) For each provider approved for a funding distribution, metrics on all charges and payments received in response to those charges under MCL 500.3157 that were determined to be inadequate.

- Not applicable at this time.

(e) Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.

- Not applicable at this time.

(f) The total amount expended and remaining in the Fund.

Initial Fund Balance	$25,000,000

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DIFS' Administrative Expenses[1]	$26,362
Fund Disbursements	$0
Remaining Fund Balance	$24,973,638

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[1] DIFS' administrative expenses are current as of April 30, 2022. However, due to the timing of disbursements to DIFS for administrative expenses, the "Remaining Fund Balance" may not always reflect administrative expenses incurred but not yet disbursed to DIFS.

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Department of Insurance and Financial Services

Post-Acute Auto Injury Provider Relief Fund

Quarterly Report for Period May 14, 2022 – August 12, 2022

This report is being made pursuant to Public Act 65 of 2021 (Act), which created the Post-Acute Auto Injury Provider Relief Fund (Fund). Under Section 301(8) of the Act, the Department of Insurance and Financial Services (DIFS) must produce a quarterly report regarding the Fund. The report must be provided to the Michigan Legislature, made available on a publicly accessible website, and include all of the following:

- The number of providers that have applied for funding from the Fund.
- A list of the providers that have been approved for funding and the amounts awarded.
- A list of providers that have been denied funding and the reason for each denial.
- For each provider approved for a funding distribution, metrics on all charges and payments received in response to those charges under MCL 500.3157 that were determined to be inadequate.
- Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.
- The total amount expended and remaining in the Fund.

Accordingly, the Director reports the following as required by Section 301(8) of the Act for the quarter ending August 12, 2022:

(a) The number of providers that have applied for funding from the Fund.

Applications Received	0
Complete Applications Received[1]	1
Applications Pending Review	0

(b) A list of the providers that have been approved for funding and the amounts awarded.

- There have been zero providers approved for funding.

[1] This application was pending when the Quarterly Report for the period of February 12, 2022 to May 13, 2022 was prepared and was subsequently reviewed for completeness and legislative requirements for a distribution from the Fund.

(c) A list of providers that have been denied funding and the reason for each denial.

Denial Date	Provider Name	Denial Reason
June 10, 2022	Best Care Nursing Services, Inc	Did not meet legislative criteria of experiencing a "systematic deficit" and billing at rates below the cost of providing the services

(d) For each provider approved for a funding distribution, metrics on all charges and payments received in response to those charges under MCL 500.3157 that were determined to be inadequate.

- Not applicable at this time.

(e) Except for information the disclosure of which is prohibited by law, information on provider charges and payments received in response to those charges and how those charges and payments compare to similar charges and payments in the non-auto insurance market.

- Not applicable at this time.

(f) The total amount expended and remaining in the Fund.

Initial Fund Balance	$25,000,000
DIFS' Administrative Expenses[2]	$29,385
Fund Disbursements	$0
Remaining Fund Balance	$24,970,615

[2] DIFS' administrative expenses are current as of July 31, 2022. However, due to the timing of disbursements to DIFS for administrative expenses, the "Remaining Fund Balance" may not always reflect administrative expenses incurred but not yet disbursed to DIFS.

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Michigan.gov

Labor and Economic Opportunity

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The Michigan minimum wage effective January 1, 2022, is $9.87.

The unemployment rate for 2020 exceeded 8.5%, therefore the minimum wage rate for 2021 was $9.65, the rate did not increase. *Reference 408.934(2) of Public Act 337 of 2018, as amended.*

The unemployment rate for 2021 did not exceed 8.5%, therefore the previous scheduled increase of $9.87 will be the minimum wage rate for 2022.

For questions regarding minimum wage, please contact us at 517-284-7800 or email us at whinfo@michigan.gov.

The Michigan minimum wage effective January 1, 2022, is $9.87.

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Labor and Economic Opportunity

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Michigan's Minimum Wage Set to Increase on January 1, 2023

December 05, 2022

Contact Wage and Hour

whinfo@michigan.gov

1-855-464-9243 (4MI-WAGE)

LANSING, Mich. – On January 1, 2023, Michigan's minimum wage rate will increase from $9.87 to $10.10 per hour as set by Michigan's Improved Workforce Opportunity Wage Act of 2018 establishing the annual schedule of increases.

Effective January 1, 2023:

- The minimum hourly wage will increase to $10.10 per hour.
- The 85% rate for minors aged 16 and 17 will increase to $8.59 per hour.
- The tipped employee rate of hourly pay increases to $3.84 per hour.
- The training wage of $4.25 per hour for newly hired employees ages 16 to 19 for their first 90 days of employment remains unchanged.

There is pending litigation that might affect this minimum wage increase:

- In 2018, a petition initiative organized by One Fair Wage sought to allow voters to decide on raising Michigan's minimum wage to $12 an hour by 2022 and raise the minimum wage for tipped workers to 80% of the standard minimum wage in 2022, 90% in 2023 and ultimately match it in 2024.

- The Legislature adopted the legislation and then amended it in 2018, putting in lower wage thresholds that increased the minimum wage to $12.05 by 2030 instead of 2022 and kept the tipped minimum wage at 38% of the standard one. As a result, the state's current hourly minimum wage is $9.87 and $3.75 for workers who are expected to make up the difference in tips.
- The Legislature's amendment has been challenged in court as unconstitutional. On July 19, 2022, the Court of Claims issued a decision that agreed with that challenge and voided the amended versions of the Michigan Improved Workforce Opportunity Wage Act and Paid Medical Leave Act in favor of their original, unamended versions.
- On July 29, 2022, the Court of Claims entered an order staying the effect of this decision until February 19, 2023, to give employers and the relevant state agencies time to accommodate the changes required by the ruling.
- The Court of Claims' ruling has been appealed. Pending final resolution of the appeal, and lifting of the stay, under the potential implementation of the originally adopted petition, the minimum wage rate for 2023 would be $13.03 and $11.73 for tipped employees.

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For further information regarding the pending minimum wage litigation, and potential amended minimum wage rates as a result of that litigation, or a copy of the Improved Workforce Opportunity Wage Act and related resources, including the required poster, visit Michigan.gov/WageHour.

Labor and Economic Opportunity

Related News

New report from MiSTEM Advisory Council outlines recommendations to accelerate STEM opportunities in Michigan

Michigan 1099G tax forms for jobless benefits now available online

UIA Modernization Workgroup will help guide agency reforms

Michigan High-Speed Internet Office Launches $238M Grant Program to Support Unserved Areas

Braille services and resources available to support Michiganders who are blind or visually impaired

Unemployment offices will close Monday in honor of MLK Day

State Launches New Workplace Mental Health Hub, Upcoming Webinar Series

Lt. Governor Gilchrist Announces MI Connected Future Statewide Tour

Audit of unemployment claims processing ignores context, reforms

Currency readers now available to eligible Michiganders who are blind or visually impaired

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Michigan's Minimum Wage Set to Increase on January 1, 2023

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