STATE OF MICHIGAN
MI Supreme Court

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Case Title:	Case Number:
ELLEN M ANDARY V USAA CASUALTY INSURANCE COMPANY	164772

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Recipient	Address	Type
Charles Raimi City of Detroit Law Department 29746	raimic@detroitmi.gov	e-Serve
Peter Ellsworth Dickinson Wright PLLC P23657	pellsworth@dickinsonwright.com	e-Serve
Kriss Gillengerten Sinas Dramis Law Firm	krissgillengerten@sinasdramis.com	e-Serve
Mary Massaron Plunkett Cooney P43885	MMASSARON@PLUNKETTCOONEY.COM	e-Serve
Lauren Kissel Sinas Dramis Law Firm 82971	lauren@sinasdramis.com	e-Serve
Jordan Wiener Hewson & Van Hellemont, P.C. P70956	jwiener@vanhewpc.com	e-Serve
Jeffery Stuckey Dickinson Wright PLLC 34648	JStuckey@dickinsonwright.com	e-Serve
Jacquelyn A. Klima Kerr, Russell and Weber, PLC P69403	jklima@kerr-russell.com	e-Serve
Nancy Thomas Miller Canfield	thomasn@millercanfield.com	e-Serve
Christopher Kerr Michigan Department of Attorney General P57131	kerrc2@michigan.gov	e-Serve
Liisa Speaker Speaker Law Firm P65728	lspeaker@speakerlaw.com	e-Serve
Paul Hudson	hudson@millercanfield.com	e-Serve

Miller Canfield 69844		
Latisha DeRouin	tish@granzottolaw.com	e-Serve
Courtney Kissel Dykema 74179	ckissel@dykema.com	e-Serve
Steven Hicks Attorney at Law P49966	steve@chair2consulting.com	e-Serve
George Sinas Sinas Dramis Law Firm P25643	georgesinas@sinasdramis.com	e-Serve
Mark Granzotto Mark Granzotto, PC 31492	mg@granzottolaw.com	e-Serve
Jill Wheaton Dykema 49921	jwheaton@dykema.com	e-Serve
KJ Miller Michigan Catastrophic Claims Association P62014	kjmiller@micatastrophic.com	e-Serve
Ryan Shannon Dickinson Wright PLLC P74535	rshannon@dickinsonwright.com	e-Serve
Stephen Sinas Sinas Dramis Law Firm P71039	stevesinas@sinasdramis.com	e-Serve
Joanne Geha Swanson Kerr, Russell and Weber, PLC 33594	jswanson@kerr-russell.com	e-Serve
Michelle Everett Vandeveer Garzia 76943	meverett@vgpclaw.com	e-Serve
Donald Brownell Vandeveer Garzia P48848	dbrownell@vgpclaw.com	e-Serve
Lori McAllister Dykema 39501	lmcallister@dykema.com	e-Serve
Taylor Pan Hewson & Van Hellemont P75350	tpan@vanhewpc.com	e-Serve
Wayne Miller Miller & Tischler, P.C. 31112	wmiller@msapc.net	e-Serve
Sajid Islam Vandeveer Garzia P81829	sislam@vgpclaw.com	e-Serve

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/s/ Latisha DeRouin

Signature

Mark Granzotto, PC

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Exhibit A - Act No. 21, Public Acts of 2019

Exhibit B - Act No. 22, Public Acts of 2019

Exhibit C - Substitute For Senate Bill No. 1

Exhibit D - House Substitute For Senate Bill No. 1

STATE OF MICHIGAN

IN THE SUPREME COURT

ON APPEAL FROM THE COURT OF APPEALS

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

Plaintiffs-Appellees,

-vs-

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

Defendants-Appellants.

Supreme Court No. 164772

Court of Appeals No. 356487

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

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PLAINTIFFS-APPELLEES' BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

SINAS, DRAMIS, LARKIN, GRAVES & WALDMAN, P.C.

GEORGE T. SINAS (P25643)
LAUREN E. KISSEL (P82971)
Attorneys for Plaintiffs-Appellees
3380 Pine Tree Road
Lansing, Michigan 48911
(517) 394-7500

MARK GRANZOTTO, P.C.

MARK GRANZOTTO (P31492)
Attorney for Plaintiffs-Appellees
2684 Eleven Mile Road, Suite 100
Berkley, MI 48072
(248) 546-4649

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STATEMENT OF QUESTIONS PRESENTED

I. DID THE COURT OF APPEALS PROPERLY CONCLUDE THAT THE 2019 AMENDMENTS TO MCL 500.3157(2), (7), AND (10) COULD NOT BE RETROSPECTIVELY APPLIED TO PLAINTIFFS, WHO WERE INSURED UNDER NO-FAULT POLICIES AND WHO SUFFERED INJURIES BEFORE THE EFFECTIVE DATE OF THOSE AMENDMENTS?

Plaintiffs-Appellees say "Yes."

Defendants-Appellants say "No."

II. DID THE COURT OF APPEALS CORRECTLY CONCLUDE THAT THE APPLICATION OF THE 2019 AMENDMENTS TO THE NO-FAULT ACT TO PLAINTIFFS, WHO WERE INSURED UNDER NO-FAULT POLICIES AND WHO WERE INJURED BEFORE THE EFFECTIVE DATE OF THOSE AMENDMENTS, WOULD VIOLATE PLAINTIFFS' RIGHTS UNDER THE CONTRACT CLAUSE OF THE MICHIGAN CONSTITUTION?

Plaintiffs-Appellees say "Yes."

Defendants-Appellants say "No."

III. DID THE COURT OF APPEALS PROPERLY CONCLUDE THAT SUMMARY DISPOSITION WAS PREMATURE ON PLAINTIFFS' DUE PROCESS AND EQUAL PROTECTION CLAIMS?

Plaintiffs-Appellees say "Yes."

Defendants-Appellants say "No."

STATEMENT OF MATERIAL PROCEEDINGS AND FACTS[1]

On March 10, 1990, Philip Krueger was involved in a motor vehicle accident while a passenger in a pickup truck. Complaint, ¶¶26-27 (App 86). He sustained multiple injuries in the

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[1]A brief comment on the "Statement of Facts" that finds its way into the defendants' brief is in order. After plaintiffs filed this case in October 2019, defendants, in lieu of filing an answer, responded by successfully moving to dismiss the case. Thus, this case arrives before this Court without a factual record and in the absence of any discovery. Yet, after intercepting plaintiffs' action at the earliest possible stage before any discovery could be taken, the defendants insist on filling their brief with "facts" that were not in the circuit court record in an effort to impress the Court with what defendants apparently believe are the economic reasons for reversing the Court of Appeals decision. Defendants have loaded their brief with "facts" as to the purported need for and the efficacy of the 2019 amendments to the no-fault act. Plaintiffs would suggest that if the defendants wanted the Court to consider the "facts" that they now marshal in support of their position, the defendants should have let this case proceed through discovery before bringing their dispositive motion. But, not only are the "facts" that the defendants include in their brief not part of the trial record, they are, by and large, irrelevant to the legal issues presented in this case. As such, a point-by-point rejoinder to the various "facts" that defendants present is unnecessary.

Nevertheless, the defendants' hyperbolic attack on the potential financial impact of the Court of Appeals opinion requires some limited response. The defendants seek to leave the Court with the impression that the decision rendered by the Court of Appeals majority in this case will have a profound impact on the costs of no-fault insurance going forward. The Court of Appeals definitively decided only the question of whether the benefit limitations now imposed in MCL 500.3157(7) and (10) applied to individuals who had a contractual right to no-fault benefits and who were injured before the effective date of the 2019 amendments to the no-fault act. The Court of Appeals did *not* decide the issue of whether these limitations were to be applied to individuals who suffered injuries *after* the statute's effective date. Nor did the Court of Appeals decision in any way affect a number of other cost-saving changes to the act contained in the 2019 amendments to the no-fault act. *See e.g.* MCL 500.3107c (allowing individuals with health coverage to opt out of no-fault benefits, or choose capped policies); MCL 500.3172(7) (limiting the amount of benefits available under the Michigan Assigned Claims Plan to $250,000); MCL 500.3113(c) (limiting the eligibility of out-of-state residents to claim no-fault benefits); MCL 500.3157(a) (establishing a utilization review process for challenging providers' treatment and charges); MCL 500.3181 (allowing insurers to sell managed care policies); MCL 500.6301 (creating a new department within the Department of Insurance and Financial Services to investigate alleged fraud). None of these additional changes, each of which is presumably designed to lower the cost of no-fault insurance, has been impacted by the Court of Appeals decision.

accident including a severe traumatic brain injury which has left him permanently disabled and incapable of taking care of himself. *Id.*, ¶28 (App 86). Prior to the March 1990 accident, Philip's father, Ronald Krueger, purchased an automobile no-fault policy of insurance through Citizens Insurance Company of America (hereinafter: "Citizens") under which Philip was insured. *Id.*, ¶29 (App 86). In accordance with the allowable expense provision of the no-fault act, MCL 500.3107(1)(a), the Krueger policy provided for reimbursement of "all reasonable charges incurred for reasonably necessary products, services, and accommodations for [Philip Krueger's] care, recovery, or rehabilitation." *Id.*, ¶30 (App 86-87).

In November 1997, Philip became a resident of an Ann Arbor facility, the Eisenhower Center, which specializes in providing rehabilitative products and services for individuals who have suffered traumatic brain injuries. *Id.*, ¶33, 37 (App 87-89). Among the services that the Eisenhower Center provides are inpatient living accommodations for individuals who have sustained brain injuries and who, like Mr. Krueger, are incapable of living independently. *Id.*, ¶¶34-35 (App 88).

When Mr. Krueger became a resident of Eisenhower Center, the two entered into a contract under which Eisenhower Center agreed to provide the necessary services and accommodations for his recovery and rehabilitation. *Id*., ¶38 (App 89). At the time this contractual relationship was entered into, the funding for the services that the Eisenhower Center provides to Mr. Krueger comes from Citizens by virtue of the insurance policy that was in effect at the time of his March 1990 accident.

Mr. Krueger represents a typical Eisenhower Center patient. The vast majority of Eisenhower Center's residential patients have suffered disabilities, in particular brain injuries, as a result of motor vehicle accidents. *Id.*, ¶36 (App 88). At the time the complaint in this case was filed, the Eisenhower

Center had 156 residential patients. Of that number, approximately 130 are motor vehicle accident victims whose rehabilitation and care is funded by benefits payable under Michigan's no-fault act. *Id*. Most of the patients that the Eisenhower Center treats have severe behavioral issues as a result of brain injuries. The Eisenhower Center is one of the few residential centers in Michigan with the ability to treat such patients.

On December 5, 2014, Ellen Andary was a passenger in a motor vehicle that was struck head-on by a drunk driver. *Id.*, ¶9 (App 82). As a result of that accident, Ms. Andary suffered severe injuries, including a catastrophic brain injury that has rendered her permanently disabled and incapable of caring for herself. *Id.*, ¶¶10-11 (App 82-83).

Years before the December 5, 2014 accident, Ms. Andary and her husband, Dr. Michael Andary, purchased an automobile no-fault policy of insurance through USAA Casualty Insurance Company (hereinafter: "USAA"). At the time of her 2014 accident, Ms. Andary was insured under this USAA policy. *Id.*, ¶17 (App 84). In accordance with the allowable expense provision of the no-fault act, this policy provided for reimbursement of "all reasonable charges incurred for reasonably necessary products, services and accommodations for [Ms. Andary's] care, recovery or rehabilitation" without regard to any government imposed fee limitation. (App 165). The Andary policy further provided that "[t]here is no maximum dollar amount for reasonable and necessary medical expenses for a covered person's care. . ." (App 166).

Due to Ms. Andary's severe brain injury, doctors have prescribed for her 36-hours of in-home attendant care services per day. Complaint, ¶12 (App 83). The majority of Ms. Andary's in-home attendant care has been provided by members of her family, including her children and her husband.

Id., ¶¶8, 13 (App 82-83). The care that Ms. Andary requires is intimate and personal. Her caregivers must assist her with such things as dressing, bathing, and toileting. In particular, Ms. Andary is given a daily suppository and is assisted with completing a bowel program because of her accident-related injuries. Ms. Andary is prone to developing urinary tract infections so her in-home caregivers apply a vaginal cream to prevent these infections.

In 2019, the Michigan Legislature passed two bills that made a number of substantial changes to Michigan's no-fault act. The first of these bills, 2019 PA 21, was passed by the Legislature on May 24, 2019. A copy of this Public Act is Exhibit A to this brief. The second bill, 2019 PA 22, was passed twelve days later. A copy of that Public Act is Exhibit B to this brief. Both of these acts were signed by the governor on June 11, 2019, and, because the Legislature voted to give each immediate effect, they became effective on that date.

Among the changes contained in the final version of these bills was a limitation on in-home attendant care services that can be provided by anyone who has a family, business or social relationship with the injured party. This amendment of the act, now codified in MCL 500.3157(10), provides that no-fault benefits are not payable for in-home attendant care beyond 56 hours per week if those services are provided by "[a]n individual who is domiciled in the household of the injured person," or "[a]n individual with whom the injured person had a business or social relationship before the injury." MCL 500.3157(10). This limitation on in-home family provided attendant care was to go into effect on July 1, 2021.

The 2019 amendments to the no-fault act also dramatically limited the reimbursement for a provider of medical services to motor vehicle accident victims. The 2019 amendments have

accomplished this through the creation of statutory caps on the reimbursement of benefits. Complaint, ¶46 (App 91-92). These fee limitations, which are codified in MCL 500.3157(2) and (7), set out maximum amounts that a physician, hospital, clinic or other person may charge for the care and treatment of accident-related injuries.

The no-fault act fee limitations established for the first time through the 2019 amendments of the act are divided into two categories. If the treatment or services being provided are covered by Medicare, the maximum amount that a provider may be reimbursed for the services it provides to motor vehicle accident victims after July 1, 2021 is 200% of the amount payable under Medicare. MCL 500.3157(2). If, however, Medicare does not provide coverage for a particular service, beginning July 1, 2021, the maximum amount that the provider may be reimbursed for the services it provides to motor vehicle accident victims is 55% of the amount that the provider charged for the services as of January 1, 2019. MCL 500.3157(7).

On October 3, 2019, Ellen Andary, Philip Krueger, and the Eisenhower Center filed this action in the Ingham County Circuit Court against USAA and Citizens. In their complaint, the plaintiffs alleged that the no-fault policies that covered them had been priced and sold based on the scope of the no-fault benefits that were available at the time the policies were purchased. Complaint, ¶¶21, 32, 61, 80, 98 (App 85-87, 96, 108-109). Thus, the costs of the premiums that were paid for the no-fault insurance applicable to Ms. Andary and Mr. Krueger were based on the coverage then available without regard to any limitation on any family provided attendant care or any statutory cap on the reimbursement of services. *Id*.

Plaintiffs sought a declaration that the limitation on in-home family-provided attendant care in MCL 500.3157(10) and the fee limitations of MCL 500.3157(7) could not be applied to

individuals who purchased automobile no-fault policies and who were injured in vehicular accidents prior to the effective date of the 2019 legislation. Plaintiffs alleged in their complaint that application of these amendments would be a violation of their constitutional rights under the Contract Clause of the Michigan Constitution, Const. 1963, art. 1, §10.

Ms. Andary and Mr. Krueger further sought a declaration that application of the changes to the no-fault act contained in MCL 500.3157(7) and (10) would deprive them of their due process rights to privacy in violation of article 1, §17 of the Michigan Constitution, by limiting their access to care and their ability to choose medical providers who render intimate and personal care. Eisenhower Center also sought a declaration that its due process right to property would be violated by the imposition of unsustainable price controls in the form of MCL 500.3157(7)'s fee schedules that will force Eisenhower Center to go out of business. Finally, Eisenhower Center also sought a declaration that its equal protection rights were violated by §3157(7) by dramatically reducing its right to reimbursement as a provider of non-Medicare compensable services, in contrast to other providers that render Medicare compensable services.

In January 2020, in lieu of filing an answer to the complaint, the defendants filed a motion to dismiss based on MCR 2.116(C)(8). In that motion, the defendants raised various arguments in support of their contention that all of plaintiffs' claims should be dismissed.

In their response to the defendants' motion, plaintiffs invoked MCR 2.116(I)(5), requesting that they be given the opportunity to amend their complaint to state an additional nonconstitutional claim – that the retroactive application of the 2019 legislative alterations of the no-fault act to plaintiffs would constitute a breach of their insurance contracts with the defendants under this Court's decision in *LaFontaine Saline, Inc v Chrysler Group, LLC*, 496 Mich 26; 852 NW2d 78

(2014), and other applicable Michigan law.

On November 13, 2020, the circuit court issued a written opinion granting the defendants' motion to dismiss. (App 1a-25a). The circuit court ruled that none of the constitutional claims alleged by the plaintiffs stated a claim on which relief could be granted.

Following the issuance of the circuit court's November 13, 2020 decision, plaintiffs filed a motion seeking reconsideration and also moved to amend their complaint to allege an additional nonconstitutional claim. The circuit court denied the motion for reconsideration in an order dated February 18, 2021. (App 27-30). Plaintiffs appealed the circuit court's decisions granting summary disposition and denying their right to amend to the Court of Appeals.

Following briefing and oral argument, a panel of the Court of Appeals on August 25, 2022 issued a 2-1 decision reversing the circuit court's ruling in part. (App 32-57). The Court of Appeals majority first addressed the question of whether the 2019 amendments to the no-fault act could be applied to the plaintiffs, who were insured under no-fault insurance polices and who were injured before the effective date of those amendments. Opinion, at 3-11 (App 34-42). The majority noted that statutory amendments are presumed to operate prospectively only and it found no language in the 2019 amendments to overcome this presumption. *Id.*, at 4-5 (App 35-36).

Based largely on this Court's decision in *LaFontaine*, the Court of Appeals majority also rejected the defendants' argument that application of the 2019 amendments to the plaintiffs did not involve the retroactive application of those amendments. *Id.*, at 6-9 (App 37-40).

The majority opinion further concluded that, even if the Legislature had intended to apply the 2019 amendments to plaintiffs, such retrospective changes to their no-fault benefits would violate the contract clause of the Michigan Constitution, Const 1963, art 1, §10. Opinion, at 11-13 (App 42-

44).

Finally, with respect to plaintiffs' equal protection and due process challenges to the prospective application of the 2019 amendments, the majority concluded that "we cannot now resolve the constitutional challenges given the lack of adequate record. . ." *Id.*, at 14 (App 45). As a result, the majority remanded the case for further discovery on these constitutional challenges to the prospective application of the 2019 amendments. *Id.*, at 14-15 (App 45-46).

The defendants applied for leave to appeal in this Court. On September 29, 2022, the Court issued an order granting the defendants' application. *Andary v. USAA Casualty Insurance Co.*, ___ Mich ___; 979 NW2d 823 (2022). In its order granting leave, the Court directed the parties to address three issues in their briefs on the merits:

> The parties shall address whether the Court of Appeals erred when it: (1) held that claimants injured before the effective date of 2019 PA 21 are not subject to the limitations on benefits set forth in MCL 500.3157(7) and (10); (2) held that application of the amended statute to such claimants would violate the Contracts Clause of the Michigan Constitution Const 1963, art 1, § 10; and (3) remanded the case to the circuit court for discovery to determine whether the no-fault amendments, even when applied only prospectively, pass constitutional muster.
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> ___ Mich ___; 979 NW2d 823 (2022).

ARGUMENT

I. THE COURT OF APPEALS CORRECTLY CONCLUDED THE PLAINTIFFS, WHO WERE INSURED UNDER NO-FAULT POLICIES AND WHO WERE INJURED BEFORE THE EFFECTIVE DATE OF THE 2019 AMENDMENTS TO THE NO-FAULT ACT, ARE NOT SUBJECT TO THE LIMITATIONS ON BENEFITS NOW PROVIDED IN MCL 500.3157(7) AND (10).

A central question addressed in the Court of Appeals August 25, 2022 opinion and the first issue on which this Court has requested briefing in its September 29, 2022 order granting leave to appeal is whether the limitations on no-fault benefits called for by the 2019 amendments to MCL 500.3157(7) and (10) can be applied to plaintiffs, who were insured under no-fault contracts and injured prior to the effective date of these amendments.

Michigan law recognizes that "[s]tatutes are presumed to apply prospectively unless the Legislature clearly manifests the intent for retroactive application." *Buhl v City of Oak Park*, 507 Mich 236, 244; 968 NW2d 348 (2021), quoting *Johnson v Pastoriza*, 491 Mich 417, 429; 818 NW2d 279 (2012). This Court has further recognized that the retroactive application of legislation "presents problems of unfairness . . . because it can deprive citizens of legitimate expectations and upset settled transactions." *LaFontaine*, 496 Mich at 38, quoting *Downriver Plaza Group v Southgate*, 444 Mich 656, 666; 513 NW2d 807 (1994). Based on this potential for unfairness, this Court has "required that the Legislature made its intentions clear when it seeks to pass a law with retroactive effect." *LaFontaine*, 496 Mich at 38. On the basis of this Court's decisions presumptively limiting statutory amendments to prospective effect only, the Court of Appeals majority ruled that the 2019 amendments to the no-fault act could not be applied retroactively to plaintiffs.[2]

[2]The Court of Appeals decision in this case was not the first in which that Court concluded that the 2019 changes to the no-fault act could not be applied retrospectively. In

There is a substantial body of law emanating from this Court that governs when newly enacted laws may be applied retroactively. *See Buhl*, 507 Mich at 244; *LaFontaine*, 496 Mich at 38-39. In their brief on the merits to this Court, the defendants largely avoid discussion of this body of law. Instead, the defendants primarily contend that the Court of Appeals majority erred because there is no retroactivity question presented in this case. In defendants' view, the 2019 amendments to MCL 500.3157 are only being applied prospectively. The defendants offer two different reasons why, in their view, the amendments passed in 2019 are not being applied retroactively. Neither of these arguments has merit.

A. Defendants' "Prospective Only" Argument Based On MCL 500.3157(7) and (14).

Defendants first contend that this case does not even involve the retroactive application of the 2019 amendments based on language contained in MCL 500.3157(7) and (14). MCL 500.3157(7) indicates that the limitation on no-fault benefits that it imposes is "[f]or treatment or training rendered after July 1, 2021. . ." MCL 500.3157(14) similarly indicates that all of the changes in that section "apply to treatment or rehabilitative occupational treatment rendered after July 1, 2021." The defendants contend that this language indicates that the changes embodied in §3157 are not being applied retrospectively at all; they are, in defendants' view, only being applied prospectively to services provided after July 1, 2021.

The defendants' argument based on the language contained in §3157(7) and (14) is erroneous in a number of respects. First and foremost, this argument seriously misperceives what constitutes

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several prior unpublished decisions, the Court of Appeals reached the same conclusion. *See e.g. Cherry v Progressive Marathon Ins Co*, Court of Appeals No. 357722 (June 16, 2022); *Mobile MRI Staffing LLC v Meemic Ins Co*, Court of Appeals No. 355162 (January 20, 2022); *Jones v Esurance Ins Co*, Court of Appeals No. 351772 (February 25, 2021).

a retroactive law. Contrary to the argument being raised by defendants, retroactive laws are not confined to those that are written in such a way as to take effect at a time predating their passage. Rather, as this Court recognized in *Hughes v Judge's Retirement Board*, 407 Mich 75; 282 NW2d 160 (1979): "A retrospective law is one which takes away or impairs vested rights acquired under existing laws or creates a new obligation and imposes a new duty, or attaches a new disability with respect to transactions or considerations already past." *Id.*, at 85; *see also People v Jackson*, 465 Mich 390, 401; 633 NW2d 825 (2001); *Buhl*, 507 Mich at 253 (Viviano, J., concurring).[3]

[3]In his concurring opinion in *Buhl*, Justice Viviano cited to Justice Joseph Story's discussion of this issue in *Society for Propagation of the Gospel v Wheeler*, 22 F Cas 756; 2 Gall 105 (C.C.N.H. 1814), which Justice Viviano aptly described as containing the "canonical definition" of a retrospective law. 507 Mich at 253. In *Wheeler*, Justice Story wrote:

> What is a retrospective law, within the true intent and meaning of this article? Is it confined to statutes, which are enacted to take effect from a time anterior to their passage? or does it embrace all statutes, which, though operating only from their passage, affect vested rights and past transactions? *It would be a construction utterly subversive of all the objects of the provision, to adhere to the former definition. It would enable the legislature to accomplish that indirectly, which it could not do directly. Upon principle, every statute, which takes away or impairs vested rights acquired under existing laws, or creates a new obligation, imposes a new duty, or attaches a new disability, in respect to transactions or considerations already past, must be deemed retrospective.*
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> 22 F Cas at 767 (emphasis added).

The Supreme Court of the United States has in more recent years relied on Justice Story's formulation of what constitutes a retroactive law. *See e.g. Landgraf v USI Film Products*, 511 US 294 (1994). In that case the Court noted that "retroactive statutes raise particular concern," *id.*, at 266, and it held on the basis of Justice Story's reasoning in *Wheeler* that, in determining whether a law applies retrospectively, "the court must ask whether the new provision attaches new legal consequences to events completed before its enactment." *Id.*, at 269-270. *See also Republic of Austria v Altman*, 541 US 677, 693 (2004) (again citing Justice Story's decision in *Wheeler* and concluding, "antiretroactivity concerns are most pressing in cases involving 'new provisions affecting contractual or property rights, matters in which predictability and stability are of prime importance.'").

Thus, in characterizing the 2019 amendments as retrospective or prospective, the question is not whether benefits paid to plaintiffs *after* July 1, 2021 are benefits received after the date that the amended provisions became effective. Instead, the question is whether the statute's application to the plaintiffs after July 1, 2021 would take away or impair rights that have already vested.

To constitute a vested right, "the interest must be something more than such a mere expectation as may be based upon an anticipated continuance of the present general laws; it must have become a title, legal or equitable, to the present or future enjoyment of property." *Rafaeli v Oakland County*, 505 Mich 429, 471; 952 NW2d 429 (2020), quoting *In re Certified Question*, 447 Mich 765, 788; 527 NW2d 468 (1994).

This Court has frequently reaffirmed that a principal basis on which a vested right may be grounded is on a party's contractual rights. *See e.g. Campbell v Judges' Retirement Board*, 378 Mich 169, 180; 143 NW2d 755 (1966) ("vested rights acquired under contract may not be destroyed by subsequent State legislation or even by amendment of the State Constitution."); *Hughes*, 407 Mich at 81, n. 2; *LaFontaine*, 496 Mich at 43 ("Kia's rights under its existing Dealer Agreement with Glassman were vested rights, as they were contractual rather than statutory."); *Selk v Detroit Plastic Products*, 419 Mich 1, 10-11; 345 NW2d 184 (1984) ("the rights in this case are contractual in nature and . . . a retroactive application of the statute would impair defendants' vested rights. . .").

In this case, any rights that Ms. Andary and Mr. Krueger have against their respective insurers are ultimately derived from the existence of the contracts of insurance that covered them at the time of their accidents.[4] Indeed, this Court has addressed this very question in the context of a

[4]The defendants, in contesting plaintiffs' constitutional claims under the Contract Clause of the Michigan Constitution, have suggested that plaintiffs' claims are not based on contract at all. This argument will be addressed in Issue II of this brief.

no-fault policy in *Clevenger v Allstate Ins Co*, 443 Mich 646; 505 NW2d 553 (1993). In that case, the Court held that a no-fault policy was in effect on the day that the plaintiff was injured because, "[t]he rights and obligations of the parties vested at the time of the accident." *Id.*, at 656. The same is true in this case. The rights that Ms. Andary and Mr. Krueger had under the applicable no-fault policies vested as of the date of their accidents.

Consistent with this Court's holding in *Clevenger*, the Court of Appeals has ruled in several cases addressing no-fault insurance policies that "[r]ights created under an insurance policy become fixed as of the date of the accident." *Universal Underwriters Group v Allstate Ins Co*, 246 Mich App 713, 729; 635 NW2d 52 (2001); *see also Hobby v Farmers Ins Exchange*, 212 Mich App 100, 184; 537 NW2d 229 (1995); *Cason v Auto Owners Ins Co*, 181 Mich App 600, 609; 450 NW2d 6 (1989); *Madar v League Gen Ins Co*, 152 Mich App 734, 742; 394 NW2d 90 (1986).

As this Court's ruling in *Clevenger* and this series of Court of Appeals rulings confirm, Ms. Andary and Mr. Krueger acquired at the time of their accidents vested rights in the no-fault benefits that they began receiving long before the 2019 amendments to the no-fault act took affect. The fact that the defendants' argument, if successful, would take away or impair those vested rights signifies that the Court is dealing in this case with a law that is being applied retroactively. The defendants' argument to the contrary must be rejected.

There is another important reason why the defendants' argument as to the 2019 amendment's prospective only effect premised on the language in §3157(7) and (14) is doomed. The defendants assert that the language in these two subsections indicating that they apply to services "rendered after July 1, 2021," reflects the Legislature's intent that these provisions were to apply to all recipients of no-fault benefits, including those individuals like Ms. Andary and Mr. Krueger, who were insured

under no-fault policies and injured before the 2019 amendments were passed.

But this language in §3157(7) and (14) does not address whether these provisions were intended to apply to individuals injured before the effective date of the 2019 amendments. The defendants' argument premised on these provisions is, therefore, comparable to that which was made to this Court in *LaFontaine.* There, the Court rejected the plaintiff's argument that ambiguous language in a statutory amendment evidenced legislative intent to apply that statute retroactively. The *LaFontaine* Court observed: "this argument begs the retroactivity question, failing to recognize that retroactive application of the . . . Amendment would 'create a new liability in connection with a past transaction.'" 496 Mich at 40-41. Similarly, the defendants' argument based on §3157(7) and (14) begs, rather than answers, the essential question of whether these provisions were intended to apply to individuals like Ms. Andary and Mr. Krueger, who were injured prior to the effective date of the 2019 amendments.

Defendants' argument based on the language of §3157 also overlooks one very important piece of legislative history pertaining to the 2019 amendment of that provision. The act that was later passed as PA 2019 No. 21 originated as Senate Bill No. 1. Attached as Exhibit C to this brief are the pages from that original Senate Bill pertaining to the proposed amendments to §3157. This original Senate Bill would have altered the existing payment structure under the no-fault act by adopting three subsections, §3157(2)-(5), which would have tied benefit levels under the act to those applicable under Michigan's workers' compensation act. Senate Bill 1 (Exhibit C), at 56-58. What is most significant for present purposes in the original version of Senate Bill No. 1 is subsection 6. That subsection read:

(6) Subsections (2) to (5) apply to a treatment, training, product, service, or

> accommodation rendered after the effective date of the amendatory act that added this subsection, *regardless of when the accidental bodily injury occurred*. Subsections (2) to (5) apply regardless of whether indemnification for the charge is being made by the catastrophic claims association under section 3104.
>
> Senate Bill 1 (Exhibit C), at 58 (emphasis added).

Thus, the amendment of §3157 in its original Senate form provided that the new reimbursement scheme that it proposed to implement would have been applicable to every claim for benefits *regardless of when the injury occurred*. This provision in the original Senate Bill, therefore, would have conveyed precisely what the defendants ask this Court to draw from the version of §3157 that was ultimately passed – the changes in reimbursement rates that section proposed would apply irrespective of when the recipient of the benefits was injured.

But §3157(6) in the original Senate Bill was *not* enacted by the Michigan Legislature. Instead, the bill went to the House of Representatives which approved a House Substitute. A copy of the relevant pages of §3157 from the House Substitute for Senate Bill No. 1 is Exhibit D to this brief. Section 3157(14) of that House Substitute replaced §3157(6) in the Senate version of the bill, removing the phrase "regardless of when the accidental bodily injury occurred," and simply indicating that §3157's limitations on no-fault benefits, "apply to treatment or rehabilitative occupational training rendered after July 1, 2021." It is this version of the statute that was enacted by the Legislature and signed by the governor.

The defendants rely on §3157(14) as primary support for their argument that the Legislature intended to apply the 2019 amendments to individuals who suffered injuries before those amendments went into effect. This legislative history behind the adoption of §3157 establishes precisely the opposite. The Legislature actually consciously removed from its final version of §3157

language that would have supported the defendants' present reading of the statute.[5]

The legal significance of this legislative history behind the adoption of §3157 has been addressed in a number of prior decisions of this Court. For example, in *People v Adamowski*, 340 Mich 422; 65 NW2d 753 (1954), the Court ruled:

> When the legislature affirmatively rejected the statutory language which would have supported the State's present view, *it thereby made its intention crystal clear. We should not, without a clear and cogent reason to the contrary, give a statute a construction which the legislature itself plainly refused to give*.
>
> *Id.*, at 429 (emphasis added).

The Court has expressed similar sentiments in a number of other cases. *See e.g. Miller v State Farm Mut Auto Ins Co*, 410 Mich 538, 567; 302 NW2d 537 (1981) ("we are asked, however, to hold . . . that the Legislature meant . . . not only what it did not say explicitly, but what it explicitly rejected. We are not inclined to do so."); *LaGuire v Kain*, 440 Mich 367, 396-397, n. 21; 487 NW2d 389 (1992) (Boyle, J. , concurring in part); *Nation v W.D.E. Electric Co*, 454 Mich 489, 497; 563 NW2d 233 (1997); *Wayne Co v Auditor General*, 250 Mich 227, 235-236; 229 NW2d 911 (1930); *see also Rouch World LLC v Dep't of Civil Rights*, ___ Mich ___; ___ NW2d ___ (2022) (Zahra, J., dissenting).

Here, the legislative history demonstrates that during the legislative deliberations, there was language that was removed from the final version of the bill that would have fully supported the interpretation of the statute that the defendants now ask this Court to adopt. Where the Legislature

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[5]In light of this legislative history, the most telling statement in the defendants' brief on the subject of the impact of §3157(7) and (14) is their claim that "[t]hese provisions plainly apply to all treatment provided to a claimant after July 1, 2021, *regardless of when that claimant's accident occurred*." Defs' Brf, at 21-22. Thus, the defendants ask the Court to read into these two subsections what amounts to the very language that the Legislature removed from the final version of the bill.

had made its intention "crystal clear" by removing this language from the final version of the bill, the Court must reject the defendants' arguments. *Adamowski*, 340 Mich at 429.

For all of these reasons, the defendants' argument that §3157(7) and (14) evidence the intent of the Legislature to apply the 2019 amendments prospectively only must be rejected.

B. Defendants' "Prospective Only" Argument Based On MCL 500.3110(4) And The Accrual Of A Claim For Unpaid Benefits.

The defendants also contend that the accrual of a claim for no-fault benefits offers support for their argument that §3157(7) and (10) are being applied prospectively only. The defendants rely on MCL 500.3110(4)[6] and this Court's decision in *Proudfoot v State Farm Mut Auto Ins Co*, 469 Mich 476; 673 NW2d 739 (2003), to argue that benefits to be paid on behalf of Ms. Andary and Mr. Krueger after July 1, 2021 were not payable until allowable expenses were incurred after that date. This, in defendants' view, means that the 2019 amendments to the act are operating prospectively only.

This argument must first be rejected for the reasons discussed in the previous section of this brief. Regardless of when a claim for benefits might accrue, the fact is that Ms. Andary and Mr. Krueger had a right to a level of no-fault benefits that "vested at the time of the accident." *Clevenger*, 443 Mich at 656.

Quite apart from this, the defendants' argument with respect to accrual again misperceives the retroactivity question at issue in this case. MCL 500.3110(4) and *Proudfoot* merely address when a no-fault insurer will be required to *pay* no-fault benefits for an expense that an insured has

[6]That provision states, "[p]ersonal protection insurance benefits payable for accidental bodily injury accrue not when the injury occurs but as the allowable expense, work loss or survivor loss is incurred."

incurred. But the essential question for purposes of the retroactivity of the 2019 amendments focuses not on when an insurer must pay benefits to an insured for incurred expenses, but on the date that the insurer became *obligated* to pay "all reasonable charges incurred for reasonably necessary products, services and accommodations," *whenever* those charges might be incurred in the future.

The facts of the Court's decision in *Proudfoot* illustrate this distinction. In that case, the plaintiff was involved in a vehicular accident in November 1995 that resulted in the amputation of her leg and left her wheelchair dependent. In December 1997, plaintiff notified her no-fault insurer of the fact that her wheelchair dependency required significant modifications to her home. When the insurer refused to pay for those home modifications, the plaintiff sued. At the trial held on her claim, the plaintiff presented evidence that the reasonable costs for the modifications of her home was $220,500, but plaintiff had not yet incurred any of those costs. The jury awarded plaintiff that amount, along with interest and no-fault attorney fees. Based on the jury's verdict, the circuit court entered a declaratory judgment providing that plaintiff could recover $220,500 for her future home modifications along with interest and attorney fees. The judgment entered by the circuit court further provided that this $220,500 was to be escrowed with the court for future distribution to the plaintiff.

The defendant in *Proudfoot* appealed the circuit court's judgment. On appeal, the Court of Appeals upheld the judgment entered by the circuit court to the extent it pertained to the $220,500 in home modifications and the escrowing of funds with the circuit court. *Proudfoot v State Farm Mut Ins Co*, 254 Mich App 702, 709-711; 658 NW2d 838 (2003). The Court of Appeals further upheld the circuit court's award of no-fault penalty interest and attorney fees. *Id.*, at 711-713, 718-719.

On appeal to this Court, the Court upheld the circuit court's declaratory judgment, but it reversed the provision in the circuit court's judgment that directed the defendant to escrow the

$220,500 for home modifications, "because the expenses in question have not yet been incurred." 463 Mich at 483.

What the facts of *Proudfoot* demonstrate is that, when the plaintiff sustained the injuries that left her wheelchair dependent, her no-fault insurer became obligated to provide her with all reasonable services for her injuries. These reasonable services included home modifications, a benefit that Michigan courts had already determined to be covered by the no-fault act. *See e.g. Manley v Detroit Automobile Inter-Insurance Exchange*, 425 Mich 140, 149; 388 NW2d 216 (1986). When the plaintiff in *Proudfoot* suffered the injuries that she did, her insurer became *responsible* for paying for home modifications *whenever* those charges happened to be incurred. Thus, the defendant in *Proudfoot* became legally *responsible* for paying for home modifications long before those charges accrued for purposes of §3110(4).

The fact that an insurer's legal responsibility for no-fault benefits is not tied to the actual accrual of the insurer's obligation to pay them is reflected in the procedural device that was common to both *Proudfoot* and this Court's earlier decision in *Manley* – the issuance of a declaratory judgment. In both of these cases, this Court approved a declaratory judgment imposing on an insurer a *responsibility* for no-fault benefits to the plaintiff even before those expenses had been incurred. This Court in *Manley* explained how such a declaratory judgment would operate:

> While a no-fault insurer is required to pay only necessary allowable expenses actually incurred, it does not follow that when a dispute arises a trial court is precluded from entering a declaratory judgment determining that an expense is both necessary and allowable and the amount that will be allowed. Such a declaration does not oblige a no-fault insurer to pay for an expense until it is actually incurred,
>
> 425 Mich at 157.

As this quotation from *Manley* makes clear, an insurer's legal responsibility for no-fault

benefits can and does precede the insurer's actual obligation to reimburse an insured for charges that have been incurred. The defendants' argument that their legal obligation to Ms. Andary and Mr. Krueger did not arise until charges were incurred must be rejected.

The defendants' attempt to avoid the retroactivity issue presented in this case is, therefore, flawed because their contention confuses the date that a contractual right *vests* and the date that an insured has a right to seek reimbursement for a specific allowable expense that has been incurred.[7] Plaintiffs do not dispute that an insurer's obligation to pay a particular expense does not accrue until the expense is incurred under §3110(4). But, as this Court's decision in *Clevenger* confirms, the plaintiffs' right to recover for reasonable expenses incurred *whenever* those reasonable expenses might be incurred, "vested at the time of the accident." 443 Mich at 656.

For all of these reasons, the defendants' attempts to portray this as a case that does not involve the retroactive application of the 2019 amendments must be rejected. This case, involving as it does the amendment of a statute that takes away or impairs vested rights, cannot be characterized as operating only prospectively.

C. The Retroactivity Factors.

Since the 2019 amendments to §3157 do have retroactive effect, the next question to be addressed is whether, under the Court's established precedents, these amendments may be applied retroactively. As noted previously, the defendants do not expend a considerable effort in their brief on the merits discussing this law. There is an obvious reason why the defendants avoid this body

[7]The defendants in their brief to this Court actually twice touch on this distinction when they note: "An accident may trigger an insured's right to coverage under MCL 500.3105," Defs' Brf., at 7. And they add, "[c]ertainly, an accident may trigger an insured's right to coverage under MCL 500.3105." Defs' Brf., at 23.

of law.

The Court has identified four factors as bearing on the question of whether a statute may be applied retroactively:

> First, we consider whether there is specific language providing for retroactive application. Second, in some situations, a statute is not regarded as operating retroactively merely because it relates to an antecedent event. Third, in determining retroactivity, we must keep in mind that retroactive laws impair vested rights acquired under existing laws or create new obligations or duties with respect to transactions or considerations already past. Finally, a remedial or procedural act not affecting vested rights may be given retroactive effect where the injury or claim is antecedent to the enactment of the statute.
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> *Buhl*, 507 Mich at 244, quoting *LaFontaine*, 496 Mich at 38-39.

The most important of these four factors is the first one. *Frank W. Lynch & Co v Flex Technologies, Inc*, 463 Mich 578, 583; 624 NW2d 180 (2001); *Franks v White Pine Copper Division*, 422 Mich 636, 670; 370 NW2d 715 (1985); *cf. Buhl*, 507 Mich at 253-256 (Viviano, J., concurring). Thus, statutory amendments are presumed to apply only prospectively "unless the Legislature clearly manifests the intent for retroactive application." *Buhl*, 507 Mich at 244; *cf. Davis v State Employees' Retirement Board*, 272 Mich App 151, 155; 725 NW2d 56 (2006)("[t]he Legislature's expression of intent to have a statute apply retroactively must be clear, direct, and unequivocal as appears from the context of the statute itself.). The need for the Legislature to make clear its intention to apply statutes retroactively "is especially true when a new statutory provision affects contractual rights, an area 'in which predictability and stability are of prime importance.'" *Lynch*, 463 Mich at 587.

On the subject of the intent of the Legislature, the Court should first take note of the amicus curiae brief that was filed in the Court of Appeals by State Representative Julie Brixie and the late

State Representative Andrew Schroeder. Attached to that brief was a Memorandum of Support signed by 73 current and former legislators expressing their view that the 2019 amendments to the no-fault act were never intended to be applied retroactively. This contents of this amicus brief represents a clear indication of the fact that the 2019 amendments to the no-fault act were not intended by the Legislature to be applied to Ms. Andary, Mr. Krueger, or any other individuals who had been injured before the effective date of those amendments.

The statements contained in the Brixie/Schroeder amicus brief are further confirmed by the complete lack of legislative intent to apply the 2019 amendments retrospectively in the language of the amendments themselves The defendants have suggested that the "clear manifestation" of the Legislature's intent to apply the 2019 amendments retroactively is to be found in §3157(7) and (14). But, as discussed previously, the Legislature refused to approve language in the final version of the bill that would have made clear that §3157's changes to the act were to apply "regardless of when the accidental bodily injury occurred," *see* Senate Bill 1 (Exhibit C), at 58. The Legislature's rejection of language that would have expressly applied the 2019 amendments of §3157 to Ms. Andary and Mr. Krueger provides clear support for the conclusion that the Legislature did *not* intend to apply the 2019 amendments to anyone injured before the effective date of those amendments. *Adamowski,* 340 Mich at 429; *Miller,* 410 Mich at 567.

The only other statutory language that defendants offer as a manifestation of legislative intent to apply the 2019 amendments retroactively is that contained in a provision in Chapter 21 of the Insurance Code, MCL 500.101, *et seq.* The provision in the Insurance Code that defendants rely on

is MCL 500.2111f(8).[8] That provision states:

> (8) An insurer shall pass on, *in filings to which this section applies*, savings realized from the application of section 3157(2) to (12) to treatment, products, services, accommodations, or training rendered to individuals who suffered accidental bodily injury from motor vehicle accidents that occurred before July 2, 2021. An insurer shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to evaluate the insurer's compliance with this subsection. After July 1, 2022, the director shall review all rate filings to which this section applies for compliance with this subsection.
>
> MCL 500.2111f(8) (emphasis added).

The defendants assert that §2111f(8)'s reference to "accidents that occurred before July 2, 2021," somehow signifies the Legislature's intent to apply the 2019 amendments to individuals like Ms. Andary and Mr. Krueger who were injured before the 2019 amendments to the no-fault act were passed.

The defendants' argument with respect to §2111f(8) disregards the most important phrase in that subsection – "in filings to which this section applies." This language is significant because

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[8]This Court has noted that the clarity of the legislative intent required if a court is to apply statutes retroactively is a byproduct of the fact that the Legislature "knows how to make clear its intention that a statute apply retrospectively." *Buhl*, 507 Mich at 245; *LaFontaine*, 496 Mich at 39. With that principle in mind, perhaps the first question that should be asked about the defendants' reliance on §2111f(8) is why would the Legislature, if it intended to make clear that the 2019 changes to the to the no-fault act applied retroactively to individuals injured before the effective date of those amendments, decide to insert that intent into a provision amending the Insurance Code, as opposed to the no-fault act itself? As the Court of Appeals majority correctly observed: "Chapter 21 of the Insurance Code does not define the benefits and payments that must be provided to no-fault policy beneficiaries. Rather, MCL 500.2111f merely defines how premium payments are to be determined under the no-fault scheme." Opinion, at 4 (App 35). The obvious related question is why would a legislative body which "knows how to make clear its intention that a statute apply retrospectively," confine itself to the oblique argument that defendants muster on the basis of §2111f(8)? A much more clear reference as to the retroactive application of §3157 (such as that found in the original Senate version of §3157(6), which was later removed) would have been very simple to draft.

another of the 2019 amendments to the Insurance Code specifically provides that "[t]he amendments to this chapter made by the amendatory act that added this subsection apply *beginning July 1, 2020*." MCL 500.2105(6) (emphasis added). Thus, the changes to Chapter 21 of the Insurance Code contained in PA 2019, No. 21, *including §2111f(8)*, apply only to policies issued *after* July 1, 2020. It has no application to policies issued before that date.

This point is further reinforced by the first subsection of §2111f itself, which provides:

> Before July 1, 2020, an insurer that offers automobile insurance in this state shall file premium rates for personal protection insurance coverage *for automobile insurance policies effective after July 1, 2020.*
>
> MCL 500.2111f(1) (emphasis added).

Thus, §2111f(1) specifically identifies "the filings to which this section applies." It applies only to filings for automobile insurance policies "effective *after* July 1, 2020." When §2111f(8) specifies that it is referring to "filings to which this section applies," it is by the express language of §2111f(1) limited to insurance policies that were issued *after* July 1, 2020. For this reason, §2111f(8) provides no basis for concluding that the Legislature intended to apply the 2019 amendments retroactively to Ms. Andary or Mr. Krueger.

Moreover, the legislative history associated with §2111f once again completely undermines any suggestion that this provision clearly manifests the Legislature's intent to apply §3157 to individuals injured before the effective date of the 2019 amendments.

A version of §2111f was included in both 2019 PA 21 and the act passed just days later, 2019 PA 22. What is significant is that the language of §2111f(8) in these two public acts differed in one

material respect.[9] In 2019 PA 21, §2111f(8) provided that an insurer was to pass on the savings realized from the application of the amendments to §3157 for "accidents that occurred *before the effective date of the amendatory act that added this section*." 2019 PA 21, §2111f(8) (Exhibit A), at 9 (emphasis added). Thus, as originally adopted, §2111f(8) was written in a way that would offer support for the argument that defendants are now making. It indicated in its original form that there would be cost-savings generated by the 2019 amendments to §3157 *associated with accidents that occurred before June 11, 2019*, the effective date of the 2019 amendments. This is precisely how defendants are now suggesting that §2111f(8) is to be read. The defendants insist that the Legislature must have intended to apply §3157 retroactively to individuals like Ms. Andary and Mr. Krueger because it envisioned that the 2019 amendments to that section would result in a cost-savings for injuries occurring before June 2019.

But the version of §2111f(8) contained in 2019 PA 21 did not survive the passage of 2019 PA 22. The Legislature took the language in the version of §2111f(8) in 2019 PA 21 that referenced accidents occurring before "the effective date of the amendatory act that added this section," and replaced it with language indicating it applied to accidents that "occurred before July 2, 2021." Since §2111f(1) made it clear that this provision pertained only to policies issued after July 1, 2020, the final version of §2111f(8), unlike the original version of that provision in 2019 PA 21, contains no reference to a time period before the effective date of the 2019 amendments.

Once again, in their argument based on §2111f(8), the defendants are left advocating a position that would have found support in language contained in an earlier version of the relevant

[9]Because it was the later expression of legislative will, it is the version of §2111f found in 2019 PA 22 that now controls.

law, but that language was not adopted in the final version of the statute. As discussed above, defendants' interpretation of the statute is foreclosed under numerous decisions of this Court. *Adamowski*, 340 Mich at 429; *Miller*, 410 Mich at 567.

In reality, the final version of §2111f(8) alluding to "accidents that occurred before July 2, 2021," is referring only to the narrow one-year window from July 2, 2020, when insurers began selling policies with capped no-fault benefit coverage, to July 2, 2021, when the fee cap limitations imposed by §3157 took effect. Thus, those insureds who first became eligible to buy capped benefit choice policies beginning on July 2, 2020, would be guaranteed a premium savings once the benefit limitations in §3157 went into effect on July 1, 2021. That was the only intent of the Legislature in the language in §2111f(8) that defendants erroneously rely on to claim that the 2019 amendments to the no-fault act apply to accidents occurring before the effective date of those amendments.

For each of these reasons, §2111f(8), when read in context, does not provide *any* indication of legislative intent to apply the 2019 changes to §3157 to individuals injured before the effective date of those amendments, much less the clear manifestation of such an intent. In this case, as in *Buhl*, "nothing in the plan language of the statute suggests that [it] was intended to apply retroactively." *Id.*, at 245.

The second factor identified in this Court's prior decisions on retroactivity – whether the statute relates to an antecedent event – is inapplicable here since §3157 does not relate to an antecedent event. *Buhl*, 507 Mich at 244.[10]

The third factor identified in *Buhl* is that retroactive laws "may impair vested rights acquired

[10]The only antecedent event identified in §3157 is January 1, 2019 which is referenced in §3157(7)-(9). These provisions, however, refer to that earlier date only for the purpose of fixing the maximum amount that a medical provider might charge for its services after July 1, 2021.

under existing laws or create new obligations or duties with respect to transactions or considerations already past." *Buhl*, 507 Mich at 244. For the reasons discussed earlier in this brief, the retroactive application of the 2019 amendments to §3157 would impair plaintiffs' vested rights. This third factor, therefore, counsels against the application of these amendments to Ms. Andary and Mr. Krueger.

The final factor that the Court has identified as relevant is that a remedial or procedural act that does not affect vested rights may be applied retroactively. Again, this factor is of no relevance here since the amendments in question were not procedural in nature and would, in fact, impair vested rights if applied to Ms. Andary and Mr. Krueger. The Court of Appeals majority in its August 25, 2022 opinion correctly identified why the substantial substantive changes to the no-fault act's benefit structure contained in the 2019 amendments could not be characterized as merely remedial or procedural:

> Defendants in this case argue that the 2019 amendments to the no-fault act were "remedial" because the original no-fault act needed alteration in order to lower rates and benefits. To call that "remedial" legislation is far too broad a use of the term. The amendments were not aimed at a narrow problem regarding a technical or procedural difficulty or an attempt to correct what the legislature viewed as an erroneous judicial interpretation of an existing statute. See *Frank W Lynch Co v Flex Technologies, Inc*, 463 Mich 578, 585; 624 NW2d 180 (2001) ("'[R]emedial' in this context should only be employed to describe legislation that does not affect substantive rights."); *Allstate Ins Co v Faulhaber*, 157 Mich App 164, 167; 403 NW2d 527 (1987) ("A statute is considered remedial or procedural if it is designed to correct an existing oversight in the law or redress an existing grievance."). Rather, they enacted far-reaching alterations to a statutory scheme that had stood for 50 years and on which virtually the entire population of the state relied. It is a broad policy-based change, not a remedial statute.
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> Opinion, at 10 (App 41).

The defendants cannot and do not seriously argue that, under the multi-factor test that this

Court employs in deciding the retroactivity of statutes, the 2019 amendments of §3157 could be applied to Ms. Andary and Mr. Krueger, who were injured before those amendments took effect.

D. The Significance Of This Court's Decision In *LaFontaine*.

Quite apart from the retroactivity issues discussed previously, there is one other principle of Michigan law that comes into play in this case and precludes the application of the 2019 amendments to Ms. Andary and Mr. Krueger, who were insured under no-fault policies and injured in accidents that occurred before the effective date of those amendments. This principle is embodied in the Court's decision in *LaFontaine* and several prior rulings of this Court.

LaFontaine arose out of a contract between an automobile manufacturer and one of its dealers. The plaintiff in that case, LaFontaine, was an authorized dealer of vehicles manufactured by Chrysler under a contract that the parties entered into in 2007. At the time the contract was signed, a provision in the Motor Vehicle Dealer Act (MVDA), MCL 445.1566(1)(a), prohibited an automobile manufacturer from contracting with another dealer for the purpose of selling its vehicles within a six mile radius of any existing dealership. In 2010, the MVDA was amended and the distance between an existing dealership and a potential new dealership was extended by statute to nine miles.

Following the 2010 amendment of the MVDA, Chrysler entered into a letter of intent with another potential dealership that would be located more than six miles from LaFontaine's dealership, but less than nine miles from it. LaFontaine sued Chrysler to block the new dealership, arguing that the nine mile radius reflected in the 2010 amendment of the MVDA precluded the proposed new dealership location.

This Court, in a unanimous opinion, viewed the resolution of this issue as a question of

retroactivity. The Court went through the four factors that were discussed in the previous section of this brief and concluded that the 2010 amendment of the MVDA and its provision for a nine mile radius, could not be applied in that case. 496 Mich at 37-43.

The Court of Appeals majority in its August 25, 2022 opinion correctly noted that the mere fact that the *LaFontaine* Court resolved the case through retroactivity analysis was independently relevant to this case. As noted above, the defendants have argued that there are no retroactivity concerns presented in this case; according to defendants, they only seek to apply the new fee limitations imposed in the 2019 amendments to §3157 prospectively.

But, as the Court of Appeals majority recognized, precisely the same thing should have been true in *LaFontaine*. The plaintiff in *LaFontaine* was attempting to prevent Chrysler from entering into a new dealership that was less than nine miles from its dealership *after* the MVDA had been amended in 2010 to require at least a nine mile distance from an existing dealership. Thus, because any new contractual arrangement that Chrysler made with another dealership would have been *after* the 2010 amendments to the MVDA took effect, the plaintiff in *LaFontaine* had the same argument that defendants have advanced in this case – that it was only seeking to have the 2010 amendments to the MVDA applied prospectively.

But that is not how the Court viewed the issue presented in *LaFontaine*.[11] Rather, the Court

[11]This Court in *LaFontaine* also noted that the year before its decision in that case, the Sixth Circuit Court of Appeals had addressed precisely the same issues involving the applicability of the 2010 amendments to the MVDA in *Kia Motors America, Inc. v. Glassman Oldsmobile Saab Hyundai, Inc.*, 706 F3d 733 (6th Cir 2013). In *Kia Motors,* the dealership made an argument identical to that which the defendants have raised in this case – that there was no retroactivity issue involved since the new dealership contract that the manufacturer sought to enter into would not take effect until after the 2010 amendment of the MVDA and its establishment of a nine mile radius. The Sixth Circuit in *Kia Motors* rejected the argument that the amendments had only prospective effect:

saw the issue in the case as being based on the contract that the parties signed in 2007 and the vested rights that Chrysler acquired through that contract:

> Because the 2007 Dealer Agreement between Chrysler and LaFontaine established rights between the parties, we consider whether retroactive application of the 2010 Amendment's nine-mile relevant market area would impermissibly deprive Chrysler of any such rights.

Id., at 37.

As the Court of Appeals majority found in its August 25, 2022 opinion, this aspect of the Court's ruling in *LaFontaine* is significant here because it serves to refute the defendants' assertion that the 2019 amendments cannot be characterized as applying retroactively. The Court of Appeals majority ruled:

> It was immaterial in *LaFontaine* that the dealer was seeking to invoke the 2010 amendment after its effective date. Instead, the Court was concerned with how the application of the amended statute–even as to future events–would affect the rights and obligations established by the prior statute. This is because a retroactivity analysis requires courts to determine whether applying the new statute will "impair vested rights acquired under existing laws or create new obligations or duties with respect to transactions or considerations already past." . . . Accordingly, in this case, we must examine how the application of MCL 500.3157(7) and (10) to those injured before 2019 PA 21's effective date would impair the parties' pre-amendment rights

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> Glassman disputes that a retroactivity issue even exists in this case. Since Kia sought to establish the new dealer after the 2010 Amendment, argues Glassman, requiring Kia to comply with the Amendment would require applying it prospectively only. However, this argument ignores the fact that *the Amendment affects Kia's rights under a contract that predates the Amendment.*

706 F3d at 740 (emphasis added).

The Sixth Circuit's analysis in *Kia Motors* represents yet another reason why the defendants are wrong in their assertion that the 2019 amendments to §3157 are merely being applied prospectively. As the Sixth Circuit recognized, the 2010 amendment of the MVDA and the 2019 amendments involved herein cannot be said to apply only prospectively since both of those amendments "affect . . . rights under a contract that predates the Amendment." 706 F3d at 740. The same is true in this case.

and obligations.

Opinion, at 7 (App 38).

The Court's decision in *LaFontaine* is, therefore, important here because it demonstrates once again that the defendants are incorrect in asserting that the 2019 amendments to §3157 apply prospectively only. But there is another aspect of the Court's analysis in *LaFontaine* that is significant here. The Court ruled in that case that the contract the parties signed in 2007, while it made no explicit mention of the MVDA, represented a dealer agreement under that statute and, therefore, was subject to that statute. The Court in *LaFontaine* held that in these circumstances, that where the parties entered into a contract that was subject to a statute, the "well settled" law required the incorporation of the statute into the parties' contract:

> "the obligation of a contract consisted in its binding force on the party who makes it. *This depends upon the laws in existence when it is made. They are necessarily referred to in all contracts, and form a part of them, as the measure of obligation to perform them by the one party and right acquired by the other*." The doctrine asserted in that case . . . applies to laws in reference to which the contract is made, and forming a part of the contract.
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> 496 Mich at 35-36 (emphasis in original), quoting *Crane v Hardy*, 1 Mich 56, 62-63 (1848); *see also VonHoffman v City of Quincy*, 71 US 535, 540 (1866).

On the basis of the Court's conclusion that the 2007 version of the MVDA had to be read into the parties' contract, the Court concluded in *LaFontaine* that the 2010 amendment of that act would control only if that later act could be applied retroactively. 496 Mich at 35.

LaFontaine teaches that the contracts that Ms. Andary and Mr. Krueger had with their insurers prior to their accidents *must be read in conjunction with the law that existed at the time those contracts were entered. See also State Highway Commission v Detroit City Controller*, 331

Mich 337, 352-353; 49 NW2d 318 (1951). This means that, under the reasoning in *LaFontaine* and this Court's prior decisions in *State Highway Commission* and *Crane*, the policies that the plaintiffs entered into have to be read as incorporating the provisions of the no-fault act that existed as of the date those contracts were entered into.

In its August 25, 2022 opinion, the Court of Appeals majority grasped the significance of this aspect of the *LaFontaine* holding. The majority held:

> On the date of the accidents, the recovery of PIP benefits for an injured person's care, recovery or rehabilitation was limited only by the reasonableness and necessity of the provider's customary charges. See MCL 500.3107(1); former MCL 500.3157. *These statutory provisions were expressly referenced or incorporated into the pre-amendment no-fault policies.* See *LaFontaine*, 496 Mich at 35-36. *Therefore, insureds and those whose benefits are provided by their policies had a legitimate expectation that should they be injured in a motor vehicle accident, they would receive unlimited lifetime benefits, so long as the charges were reasonable and the care reasonably necessary*. These individuals "did not bargain for or contemplate," *id.* at 26, that limits would be placed on the amount of attendant care family members can provide an injured person, or that treatment not compensable by Medicare would be limited to 55 percent reimbursement from the insurer.
>
> Opinion, at 7-8 (App 38-39) (emphasis added).

This portion of the Court's ruling in *LaFontaine* constitutes an alternative basis for concluding that the rights claimed by Ms. Andary and Mr. Krueger have to be controlled by the law in effect at the time they sustained their injuries, not the law as it was amended in 2019. For this reason as well, the Court of Appeals majority did not err in rejecting the defendants' argument that the 2019 amendments to §3157 impacted the benefits to which Ms. Andary and Mr. Krueger were entitled.

II. THE COURT OF APPEALS CORRECTLY HELD THAT APPLICATION OF THE 2019 AMENDMENTS TO THE NO-FAULT ACT TO PLAINTIFFS WOULD VIOLATE THEIR RIGHTS UNDER THE CONTRACT CLAUSE OF THE MICHIGAN CONSTITUTION.

The Court of Appeals majority further concluded that, even if the defendants were correct and the 2019 amendments to §3157 could be applied retrospectively to Ms. Andary and Mr. Krueger, that retrospective application would be unconstitutional as a violation of the Contract Clause of the Michigan Constitution, Const. 1963, art 1, §10. Opinion, at 11-13 (App 42-44). That provision of the Michigan Constitution states: "No bill of attainder, ex post facto law or law impairing the obligation of contract shall be enacted."

This Court has recognized that "[t]he purpose of the Contract Clause is to protect bargains reached by parties by prohibiting states from enacting laws that interfere with preexisting contractual arrangements." *In re Certified Question*, 447 Mich at 777; citing *Allied Structural Steel Co v Spannaus*, 438 US 234, 242 (1978). This Court has also explained that the Contract Clause was designed to ensure that "[v]ested rights acquired under contract may not be destroyed by subsequent State legislation or even by amendment of the State Constitution." *Campbell,* 378 Mich at 180; *In re Certified Question*, 447 Mich at 776 ("the purpose of the contract clause is to protect bargains reached by parties by prohibiting states from enacting laws that interfere with preexisting contractual arrangements.").

One of the unique features of Michigan's no-fault act when it was originally passed in 1973 is that it allowed unlimited lifetime benefits for all "reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation." MCL 500.3107. *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 220; 815 NW2d 412 (2012). Michigan case law confirms that these benefits include all reasonably necessary attendant care services, regardless of the identity of the provider. *See Manley*, 425 Mich at 158; *Van Marter v American Fidelity Fire Ins Co*, 114 Mich App 171, 181-182; 318 NW2d 679 (1982); *Sharp v*

Preferred Risk Mutual Ins Co, 142 Mich App 499, 512-515; 370 NW2d 619 (1985).

Based on this case law, it is clear that under Ms. Andary's policy of no-fault insurance with USAA that was in effect at the time of her December 2014 accident, she had a right to reimbursement for all reasonable in-home attendant care services provided by her family members and friends, as long as those services were necessitated by accident-related injuries. And, her right to reimbursement for these services vested as of the date of her accident.

Similarly, years of Michigan precedents established that motor vehicle accident victims are entitled to be reimbursed for all reasonable charges they incur for reasonably necessary products, services, and accommodations for their care, recovery and rehabilitation. *Joseph*, 491 Mich at 220. In determining what constitutes a reasonable charge, Michigan courts held prior to the 2019 amendments to the no-fault act that fee schedules or amounts paid under the Medicare program could not be used to determine a reasonable rate. *See Johnson v Michigan Mutual Ins Co*, 180 Mich App 314, 321-322; 446 NW2d 899 (1989); *Mercy Mt. Clemens Corp v Auto Club Ins Assn*, 219 Mich App 46, 52-53; 555 NW2d 871 (1996); *Hoffman v Auto Club Ins Ass'n*, 211 Mich App 55, 107-110; 535 NW2d 529 (1996).

Thus, when Ms. Andary and her husband purchased the insurance policy from USAA that was in effect at the time of her December 2014 accident, she had the right to have all medical expenses reimbursed by USAA at a "reasonable charge" without any fee schedules. The same was true with respect to Mr. Krueger based on the insurance policy with Citizens that was in effect at the time of his March 1990 accident.

Finally, Eisenhower Center has contractual rights that are being violated by the recent amendments to §3157. Specifically, Eisenhower Center entered into a contract, express or implied,

with Mr. Krueger when he became a resident in its facility in 1997. That contract obligated Mr. Krueger to pay all of Eisenhower Center's "reasonable charges" for reasonably necessary products, services and accommodations of his care, recovery or rehabilitation. Under Mr. Krueger's no-fault insurance policy, Citizens is contractually obligated to reimburse Mr. Krueger for the reasonable charges he incurs from Eisenhower Center without regard to any fee schedule. Therefore, Eisenhower Center has a vested contractual right and entitlement to reimbursement for all reasonable charges for reasonably necessary accommodations it supplies to Mr. Krueger without regard to any fee schedules.

In response to this constitutional argument, defendants have first argued that plaintiffs cannot establish the initial essential component of a Contract Clause claim – the existence of enforceable contract-based rights. Relying on this Court's opinion in *Rohlman v Hawkeye-Security Ins Co*, 442 Mich 520; 502 NW2d 310 (1993), and the Court of Appeals decision in *Bronson Health Care Group, Inc v State Auto Property & Casualty Ins Co*, 330 Mich App 338; 948 NW2d 115 (2019), defendants contend that the source of the benefits that plaintiffs are claiming in this case is not the contract that was in effect between Ms. Andary and USAA or between Mr. Krueger and Citizens. Rather, defendants contend that it is the no-fault act itself that provides these benefits to the plaintiffs. Defs' Brf, at 30-31. This argument has no merit.

For purposes of plaintiffs' claim based on the Contract Clause, the short answer to this argument is that if there had been no auto insurance policy in effect between Ms. Andary and USAA on December 5, 2014, USAA would have no obligation to pay *any* of the no-fault benefits that it has paid on her behalf over the last eight years. The same holds true for Mr. Krueger; if he was not covered by a Citizens insurance policy as of March 10, 1990, Citizens would not have been obligated

to pay any of the no-fault benefits it has been responsible for paying for the last 33 years. Thus, contrary to defendants' contention, the existence of a contract between Ms. Andary and Mr. Krueger and their insureds is absolutely essential to the benefits that they are claiming in this case.

The defendants' suggestion that the no-fault act provides the exclusive source of the rights that Ms. Andary and Mr. Krueger claim is refuted by the one decision of this Court that defendants cites in support of their argument, *Rohlman*. In that case, the Court noted:

> The policy and the statutes relating thereto *must be read and construed together as though the statutes were a part of the contract,* for it is to be presumed that the parties contracted with the intention of executing a policy satisfying the statutory requirements, and intended to make the contract to carry out its purpose.
>
> 442 Mich at 525, n. 3 (emphasis added).

What this Court held in *Rohlman* is that there is no sharp demarcation between the rights plaintiffs have under the no-fault act and their rights under their no-fault policies. Rather, any rights they may have under the act "were a part of the contract." 442 Mich at 525, n. 3; *see also Bazzi v Sentinel Ins Co*, 502 Mich 390, 399; 919 NW2d 399 (2018) (where a policy provision is required by statute, "the policy and the statute must be construed together as though the statute were part of the policy."); *Yang v Everest Nat Ins Co*, 507 Mich 314, 321; 968 NW2d 390 (2021).

These decisions from this Court establish that, far from eliminating no-fault policies as a source of an insured's rights, the provisions of the no-fault act are to be read into the insured's policy. Thus, regardless of whether the benefits that plaintiffs claim in this case may emanate from a statute, under this Court's precedents, these statutory rights are part of the policies the parties entered into.

The defendants' contention that a no-fault policy has no independent significance in light of

the no-fault statute is also directly at odds with the rule of law that this Court reiterated in *LaFontaine*. What this Court held in *LaFontaine* is that, where a contract is subject to a statutory provision, that statutory provision *as it existed at the time of the contract's formation* becomes a part of the contract and becomes "the measure of obligation to perform then by the one party and the right acquired by the other." 496 Mich at 35-36; quoting *Crane*, 1 Mich at 62-63. To suggest that Ms. Andary and Mr. Krueger have no rights under the terms of the no-fault policies in existence at the time of their injuries is, therefore, completely contrary to this Court's decisions in *LaFontaine*, *Crane* and *State Highway Commission*.

No-fault policies are, therefore, both contractual and statutory in nature. In *Bazzi*, this Court recognized, "automobile insurance contracts are governed by a combination of statutory provisions and the common law of contracts. Insurance policies are contracts 'subject to the same contract construction principles that apply to any other species of contract.'" 502 Mich at 399; *see also Yang*, 507 Mich at 321.

There is without question a relationship between automobile insurance policies issued in this state and the no-fault act; that act prescribes the minimum no-fault coverage that each Michigan automobile insurance policy must provide. *See Rohlman*, 442 Mich at 530, fn. 10. But, with certain exceptions not applicable here, for a party to claim no-fault benefits against an insurer, there must be a *contractual* relationship between that insurer and the insured.

Moreover, while a no-fault insurance policy may not contain provisions that conflict with the no-fault act, the terms of such a policy are independent and enforceable provided that no such conflict exists. *Cruz v State Farm Mutual Auto Ins Co*, 466 Mich 588, 598-599; 648 NW2d 591 (2021); *Meemic Ins v Fortson*, 506 Mich 287, 300-303; 954 NW2d 115 (2020). In *Cruz*, this Court

stressed that basic principles of contract law applied to no-fault insurance policies as well: "Our approach is premised on the doctrine that contracting parties are assumed to want their contract to be valid and enforceable." *Id.*, at 5959.

For all of these reasons, the defendants' suggestion that plaintiffs' Contract Clause claim fails because no contract is involved here must be rejected.

The defendants make an additional argument based on the premise that Ms. Andary and Mr. Krueger have no contractual rights. They contend that, because their right to no-fault benefits are solely governed by statute, plaintiffs have no legitimate expectation of receiving the level of benefits that they obtained before the effective date of the 2019 amendments. Defendants thus contend that because the only rights Ms. Andary and Mr. Krueger possess are statutory in origin, their benefits are subject to modification whenever the Legislature chooses to amend the relevant statute.

What is most notable about the defendants' argument on this point is that the three principal decisions on which defendants rely in support of this argument have nothing to do with the no-fault act. Instead, in making this argument the defendants rely on this Court's decisions in *Romein v General Motors Corp*, 436 Mich 515; 462 NW2d 555 (1990); *Lahti v Fosterling*, 357 Mich 578; 99 NW2d 490 (1960), and *Rookledge v Garwood*, 340 Mich 444; 65 NW2d 785 (1954), each of which is a case involving workers compensation benefits. From these three workers compensation cases, the defendants draw the conclusion that "statutory benefits . . . may be revoked or modified at the will of the Legislature. . ." Defs' Brf, at 31.[12]

[12]It should be noted that this Court has not always spoken in a unified voice with respect to the principle of law that defendants claim from these workers compensation cases. These three workers compensation cases are cited by the defendants for the proposition that benefits under

But the difference between these workers compensation cases and the circumstances of this case was clearly set out in this Court's decision in *Romein.* In that case, the Court held that the statute under consideration "did not abrogate a vested or contractual right of the employers since workers compensation benefits and liabilities are statutory in origin and may be revoked or modified at the will of the Legislature." 436 Mich at 532.

In relying on *Romein, Lahti, Rookledge,* and other workers compensation cases that are based on rights that are solely statutory in origin, the defendants completely ignore the caselaw cited previously in this brief applicable to the rights obtained under the no-fault act. They ignore this Court's determination in *Clevenger* that "the rights of the parties vested at the time of the accident." And they disregard the Court of Appeals decisions applicable to no-fault benefits establishing the "[r]ights created under an insurance policy become fixed as of the date of the accident." *Universal Underwriters*, 246 Mich App at 729; *Hobby,* 212 Mich App at 184; *Cason,* 181 Mich App at 609; *Madar*, 152 Mich App at 742.

What obviously distinguishes the circumstances of this case from the workers compensation cases on which the defendants rely is that workers who receive workers compensation payments do

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that act can be modified by the Legislature at any time. Yet, only five years before the Court decided *Romein*, this Court ruled in *Nicholson v Lansing Board of Education*, 423 Mich 89; 377 NW2d 292 (1985), that "[i]t has long been the rule in Michigan that in workers compensation cases the law in effect at the time of the relevant injury must be applied unless the Legislature clearly indicates a contrary intention." *Id.*, at 93; *see also Gerlesits v Foundry & Machine Co*, 319 Mich 299, 238; 29 NW2d 856 (1947) ("In determining benefits under the [workers compensation] act that law controls which is in effect when the cause of action accrues."); *Wallin v General Motors Corp*, 317 Mich 650, 652-653; 27 NW2d 122 (1947). In contrast to the principle that defendants ask this Court to adopt based on the workers compensation cases they cite, these other precedents from the workers compensation area support the conclusion that, unless the Legislature makes clear its intent to alter benefits retroactively, the law in existence *as of the date of the worker's injury* will control the benefits allowed under the act.

not buy a policy of insurance to obtain these benefits nor do they obtain benefits from their employers under the terms of a contract. Instead, these benefits are, as this Court noted in *Romein,* available to the injured party solely on the basis of a statute. All that the Court has held in *Romein, Lahti,* and *Rookledge* is that these payments that are purely statutory in origin may be altered by legislation.

For all of these reasons, the defendants' contention that plaintiffs' rights were wholly statutory in origin, subject to modification at any time by the Michigan Legislature, must be rejected.

Turning to the merits of the plaintiffs' claim under the Contract Clause, Michigan courts in assessing such a constitutional challenge have adopted a three-pronged test:

> The first prong considers whether the state law has operated as a substantial impairment of a contractual relationship. The second prong requires that legislative disruption of contractual expectancies be necessary to the public good. The third prong requires that the means chosen by the Legislature to address the public need be reasonable.
>
> *Health Care Ass'n Workers Comp Fund v Bureau Of Workers Compensation*, 265 Mich App 236, 241; 694 NW2d 761 (2005)

In interpreting the Michigan Constitution's Contract Clause, Michigan Courts have adopted precedents from the United States Supreme Court which have recognized what might be described as a sliding scale in applying this three part test: "The severity of the impairment determines the height of the hurdle the act must clear." *VanSlooten v Larsen*, 410 Mich 21, 39; 299 NW2d 704 (1980), *citing Spannaus*, 438 US at 244-245; *see also Blue Cross and Blue Shield of Michigan v. Milliken*, 422 Mich 1, 21; 367 NW2d 1 (1985) ("The severity of the impairment is said to increase the level of scrutiny to which the legislation will be subjected.").

Here, the first prong of the three point test is satisfied. Application of §3157's 2019 amendments to the claims of Ms. Andary and Mr. Krueger would directly impact contractual rights that have been vested for years. Where, as here, the legislative impairment of a contract is direct and severe, "to be upheld it must be affirmatively shown that (1) there is a significant and legitimate public purpose for the regulation and (2) that the means adopted to implement the legislation are reasonably related to the public purpose." *Health Care Ass'n*, 265 Mich App at 241 (citing *Wayne Co Bd of Comm'rs v Wayne Co Airport Auth*, 253 Mich App 144, 163–164; 658 NW2d 804 (2002), citing *Blue Cross & Blue Shield*, 422 Mich at 23.

The test for a Contract Clause claim differs substantially from the traditional rational basis test that is ordinarily applied when due process and equal protection constitutional claims are raised. The rational basis test of due process and equal protection "does not test the wisdom, need, or appropriateness of the legislation, or whether the classification is made with "mathematical nicety. . ." *Crego v Coleman*, 413 Mich 248, 260; 615 NW2d 218 (2000). The same is not true of a challenge based on the Contract Clause.

Where legislation directly impacts a contractual relationship, the defendant must show that the law is "necessary" and that it is reasonably tailored to the achievement of that "necessary" goal. Michigan appellate courts have expressed this point in various ways. For example in *Selk v Detroit Plastic Products*, 419 Mich 1; 345 NW2d 184 (1984), this Court indicated that the direct legislative alteration of a contractual obligation "is permissible if the legislation is necessary to meet a broad and pressing social need and is reasonably related to that goal." *Id.*, at 13; *see also Health Care Association*, 265 Mich App at 241 ("The second prong requires that legislative disruption of constitutional expectancies be necessary to the public good."); *County of Ingham v Michigan County*

Road Commission Self-Insurance Pool, 321 Mich App 574, 583; 909 NW2d 533 (2017) ("A statute that substantially impairs a contractual relationship is unconstitutional unless the statutory impairment serves 'a significant and legitimate public purpose and . . . the means adopted to implement the legislation are reasonably related to the public purpose.'").

The enhanced level of judicial scrutiny in a Contract Clause claim is reflected in this Court's most recent decision with respect to that constitutional provision. In *AFT Michigan v State of Michigan (On Remand)*, 315 Mich App 602; 904 NW2d 417 (2017), the Court of Appeals considered a Contract Clause challenge to an amendment of the Public School Employees Retirement Act (PERA), MCL 38.1301, *et seq*. That amendment required all current public school employees to contribute 3% of their salaries to the Michigan Public School Employees' Retirement System. This mandatory salary reduction was at odds with the contracts that individual employees had signed with their employers. The plaintiffs in *AFT Michigan* challenged the mandatory contributions called for by the PERA amendment as unconstitutional under the Michigan Constitution's Contract Clause.

The Court of Appeals agreed with the plaintiffs and concluded that the amendment was unconstitutional under the Contract Clause. The panel in *AFT Michigan* recognized that the mandatory contribution was not a broad regulation "that impinges on certain contractual obligations by happenstance or as a collateral matter. Rather, the statute directly and purposefully required that certain employers not pay contracted-for wages." 315 Mich App at 616. The same is true here. The 2019 amendments of the no-fault act, if applied to Ms. Andary and Mr. Krueger, do not alter their existing contractual rights "by happenstance or as a collateral matter." Rather, if applied to the plaintiffs, they "directly and purposely" alter their vested contractual rights.

Under such circumstances, the Court of Appeals held in *AFT Michigan* that the State of Michigan had to make the following showing to save the PERA amendment from a Contract Clause challenge:

> In order to determine whether that impairment violates the Contracts Clause, we must determine whether the state has shown that it did not: "(1) 'consider impairing the ... contracts on par with other policy alternatives' or (2) 'impose a drastic impairment when an evident and more moderate course would serve its purpose equally well,' nor (3) act unreasonably 'in light of the surrounding circumstances[.]

315 Mich at 617.

The panel in *AFT Michigan* proceeded to find that the state could not meet its burden under the Contract Clause. *Id*., at 618-621. Following that decision, the defendants sought leave to appeal. This Court granted leave and, after further briefing and oral argument, issued an order on December 20, 2017. *AFT Michigan v State of Michigan*, 501 Mich 939; 904 NW2d 417 (2017). In that order, the Court, without dissent, affirmed the Court of Appeals ruling that the PERA amendment violated the Contract Clause:

> Further, we affirm the holding that 2010 Public Act 75 violated the respective Contract Clauses of both the federal and state constitutions, U.S. Const., art. 1, § 10; Mich. Const. 1963, art. 1, § 10, because it substantially impaired the plaintiffs' employment contracts by involuntarily reducing the plaintiffs' wages by 3%, and *the state failed to demonstrate that this measure was reasonable and necessary to further a legitimate public purpose.*

501 Mich at 939 (emphasis added).

This Court's decision in *AFT Michigan* is significant in that, after demonstrating that the PERA amendment substantially impaired the plaintiffs' employment contracts, the duty to demonstrate that the measure was "reasonable and necessary" rested with the state. And, the statute was found unconstitutional by the Court because the state failed to carry that burden.

In their brief to the Court, the defendants assert that the 2019 amendments served a significant public purpose, seeking to reduce the costs of no-fault insurance. The issue that the Court of Appeals decided in this case was limited solely to the question of whether the 2019 amendments to the no-fault act could be retroactively applied to individuals like Ms. Andary and Mr. Krueger who suffered injuries long before those amendments took effect. As the defendants acknowledge in their brief, "[i]n 2019, the Legislature passed No-Fault reform, making many changes to the No-Fault statute to achieve the goal of lower insurance costs." Defs' Brf, at 2. But, as noted in footnote 1 of this brief, most of these changes to the no-fault act that were at least designed to lower the cost of insurance have been totally unaffected by the Court of Appeals decision in this case. alterations of the *supra.*

While there was many purported cost-savings measures in the 2019 amendments, this case and the Court of Appeals decision in this case involves only the question of whether these changes can be applied to a class of individuals who were injured before the effective date of the amendments. The defendants' overheated arguments regarding the need for these amendments fails to take into account that a significant number of the changes that were made in what defendants claims will reduce the cost of automobile insurance are completely unaffected by this case.

The population of no-fault claimants who will be benefitted by the Court of Appeals decision in this case is, therefore, limited to a finite group of people who sustained injuries before the 2019 amendments were passed. Moreover, this finite group of claimants will, as time goes by, slowly shrink in size and will ultimately disappear altogether. The defendants' arguments as to the effects of the Court of Appeals majority opinion fails to take into account the limited effect of that opinion.

The Court of Appeals majority did not err in concluding that, if the 2019 amendments were

applicable to Ms. Andary and Mr. Krueger, their rights under the Contract Clause of the Michigan Constitution would be violated.

III. THE COURT OF APPEALS DID NOT ERR IN CONCLUDING THAT PLAINTIFFS' DUE PROCESS AND EQUAL PROTECTION CLAIMS WERE TO BE REMANDED FOR FURTHER DISCOVERY.

The final issue that the Court in its September 29, 2022 order has asked the parties to brief is whether the Court of Appeals majority erred in remanding the case for further discovery on plaintiffs' constitutional claims challenging the prospective application of the 2019 amendments. In their complaint, plaintiffs asserted that the prospective application of the 2019 amendments would violate the Equal Protection Clause, Const. 1963, art 1, §1, and the Due Process Clause, Const. 1963, art 1, §17, of the Michigan Constitution.

The defendants filed a motion to dismiss these claims. That motion predicated on MCR 2.116(C)(8), was filed at the earliest stage of these proceedings, before any discovery has been conducted. The circuit court granted that motion. On appeal, the Court of Appeals majority reversed that ruling, observing, "we cannot now resolve the constitutional challenges given the lack of adequate record." Opinion, at 14 (App 45a). The Court of Appeals did not err in reaching this result.

A motion filed under MCR 2.118(C)(8) "tests the legal sufficiency of the complaint on the basis of the pleadings alone." *Corley v District Board of Education*, 470 Mich 274, 277; 681 NW2d 342 (2004). In considering such a motion, "a trial court must accept all factual allegations as true, deciding the motion on the pleadings alone." *El-Khalil vs Oakwood Healthcare, Inc*, 504 Mich 152; 934 NW2d 665 (2019). A court must also construe the allegations contained in the complaint in the light most favorable to the plaintiffs. *Kuznar v Raksha Corp*, 481 Mich 169, 176; 750 NW2d 121 (2008). Dismissal under MCR 2.116(C)(8) was proper only if plaintiffs' claims were "so clearly

unenforceable that no factual development could possibly justify recovery." *El-Khalil*, 504 Mich at 160. *Kuznar,* 481 Mich at 176.

What the Court of Appeals majority ruled in this case is that further factual development of plaintiffs' due process and equal protection claims was in order. The decision of this Court that best demonstrates the propriety of the majority ruling happens to be the case in which the Court first considered the constitutionality of the no-fault act, *Shavers v Kelley,* 402 Mich 554; 267 NW2d 72 (1978). In *Shavers*, the Court considered due process and equal protection challenges to the act. The Court in *Shavers* acknowledged that the challenged act was cloaked with a rebuttable presumption of constitutionality and it recognized that judicial review of due process and equal protection challenges was deferential. 402 Mich at 613-614. Despite these considerations, the *Shavers* Court stressed the need for factual development of the plaintiffs' constitutional claims:

> There are, however, instances in which police power legislative judgments cannot be affirmed or rejected on the basis of purely legal arguments or indisputable, generally known or easily ascertainable facts which can be judicially noticed. In such instances, the facts upon which the existence of a rational basis for the legislative judgment are predicated "may properly be made the subject of judicial inquiry" (*United States v. Carolene Products*, *supra*, 304 U.S. 153, 58 S. Ct. 784.) *Thus, a court may require a trial so that it may establish adequate findings of facts to determine whether, on the one hand, plaintiffs have shown facts which reveal that the legislative judgment is without rational basis, or, on the other hand, whether there is any reasonable state of facts on the record which can be produced in support of the legislative judgment.*
>
> *Such an approach is particularly necessary when the challenged police power legislation is important, complicated, novel or experimental legislation.*
>
> *Shavers*, 402 Mich at 614–15 (emphasis added).

The Court in *Shavers* then cited with favor the Supreme Court of the United States' decision in *Borden's Farm Products Co, Inc v Baldwin*, 293 US 194 (1934), which also emphasized the need

for further factual development when presented with a constitutional challenge to a statute:

> (W)here the legislative action is suitably challenged, and a rational basis for it is predicated upon the particular economic facts of a given trade or industry, which are outside the sphere of judicial notice, these facts are properly the subject of evidence and of findings. With the notable expansion of the scope of governmental regulation, and the consequent assertion of violation of constitutional rights, it is increasingly important that when it becomes necessary for the Court to deal with the facts relating to particular commercial or industrial conditions, they should be presented concretely with appropriate determinations upon evidence, so that conclusions shall not be reached without adequate factual support.
>
> 402 Mich at 616, quoting *Borden's Farm*, 293 US at 213.

Thus, the Court in *Shavers* concluded that "it is inexpedient to determine grave constitutional questions upon a demurrer to a complaint, or upon an equivalent motion, if there is a reasonable likelihood that the production of evidence will make the answer to the questions clearer." *Id.*, quoting *Borden's Farm Products*, 293 US at 213. This Court has expressed similar views of the need for full factual development of constitutional issues in other cases. For example, in *Michigan Carriers & Freezers Ass'n v Agricultural Marketing & Bargaining Board*, 397 Mich 337; 245 NW2d 1 (1976), the Court declined to address a constitutional challenge in the absence of a developed record: "[t]o resolve these significant issues in such a vacuum would be imprudent where it appears that further factual development would substantially contribute to the proper disposition of the case. *Id.,* at 343.

In this case in which plaintiffs have properly alleged due process and equal protection claims, the Court of Appeals majority did not commit error in holding that the circuit court's grant of summary disposition on plaintiffs' due process and equal protection claims was premature and that a remand was necessary for further factual development of those claims.

RELIEF REQUESTED

Based on the foregoing, plaintiffs-appellees, Ellen M. Andary, *et al*, respectfully request that this Court affirm the Court of Appeals August 25, 2022 decision and remand this matter to the Ingham County Circuit Court for further proceedings.

SINAS, DRAMIS, LARKIN, GRAVES & WALDMAN, P.C.
/s/ George T. Sinas
GEORGE T. SINAS (P25643)
LAUREN E. KISSEL (P82971)
Attorneys for Plaintiffs-Appellees
3380 Pine Tree Road
Lansing, MI 48911
(517) 394-7500

MARK GRANZOTTO, P.C.
/s/ Mark Granzotto
MARK GRANZOTTO (P31492)
Attorney for Plaintiffs-Appellees
2684 Eleven Mile Road, Suite 100
Berkley, Michigan 48072
(248) 546-4649

Dated: January 16, 2023.

CERTIFICATION PURSUANT TO MCR 7.312(A)

Mark Granzotto, attorney for plaintiffs-appellees, hereby certifies pursuant to MCR 7.212(B)(1) that this brief was typed using the Corel Word Perfect word processing program. That program has a function which can calculate the total number of words contained in a document. According to that program function, there are 17,477 words in this brief.

/s/ Mark Granzotto
Counsel for Plaintiffs-Appellees

INDEX OF EXHIBITS

Exhibit A - Act No. 21, Public Acts of 2019

Exhibit B - Act No. 22, Public Acts of 2019

Exhibit C - Substitute For Senate Bill No. 1

Exhibit D - House Substitute For Senate Bill No. 1

EXHIBIT A

Act No. 21
Public Acts of 2019
Approved by the Governor
May 30, 2019
Filed with the Secretary of State
June 11, 2019
EFFECTIVE DATE: June 11, 2019

STATE OF MICHIGAN
100TH LEGISLATURE
REGULAR SESSION OF 2019

Introduced by Senators Nesbitt, Theis, LaSata, Horn, McBroom, Barrett, Lauwers and VanderWall

ENROLLED SENATE BILL No. 1

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 150, 224, 1244, 2038, 2040, 2069, 2105, 2106, 2108, 2111, 2118, 2120, 2151, 3009, 3101, 3101a, 3104, 3107, 3109a, 3111, 3112, 3113, 3114, 3115, 3135, 3142, 3145, 3148, 3151, 3157, 3163, 3172, 3173a, 3174, 3175, and 3177 (MCL 500.150, 500.224, 500.1244, 500.2038, 500.2040, 500.2069, 500.2105, 500.2106, 500.2108, 500.2111, 500.2118, 500.2120, 500.2151, 500.3009, 500.3101, 500.3101a, 500.3104, 500.3107, 500.3109a, 500.3111, 500.3112, 500.3113, 500.3114, 500.3115, 500.3135, 500.3142, 500.3145, 500.3148, 500.3151, 500.3157, 500.3163, 500.3172, 500.3173a, 500.3174, 500.3175, and 500.3177), section 150 as amended by 1992 PA 182, section 224 as amended by 2007 PA 187, section 1244 as amended by 2001 PA 228, section 2069 as amended by 1989 PA 306, section 2108 as amended by 2015 PA 141, section 2111 as amended by 2012 PA 441, sections 2118 and 2120 as amended by 2007 PA 35, section 2151 as added by 2012 PA 165, sections 3009 and 3113 as amended by 2016 PA 346, section 3101 as amended by 2017 PA 140, section 3101a as amended by 2018 PA 510, section 3104 as amended by 2002

PA 662, section 3107 as amended by 2012 PA 542, section 3109a as amended by 2012 PA 454, section 3114 as amended by 2016 PA 347, section 3135 as amended by 2012 PA 158, section 3163 as amended by 2002 PA 697, sections 3172, 3173a, 3174, and 3175 as amended by 2012 PA 204, and section 3177 as amended by 1984 PA 426, and by adding sections 261, 271, 2013a, 2111f, 2116b, 2162, 3107c, 3107d, 3107e, 3157a, and 3157b and chapters 31A and 63.

The People of the State of Michigan enact:

Sec. 150. (1) Any person who violates any provision of this act for which a specific penalty is not provided under any other provision of this act or of other laws applicable to the violation must be afforded an opportunity for a hearing before the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. If the director finds that a violation has occurred, the director shall reduce the findings and decision to writing and issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than $1,000.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this act, the director may order the payment of a civil fine of not more than $5,000.00 for each violation. With respect to filings made under chapters 21, 22, 23, 24, and 26, "violation" means a filing not in compliance with those chapters and does not include an action with respect to an individual policy based on a noncomplying filing. An order of the director under this subdivision must not require the payment of civil fines exceeding $50,000.00. A fine collected under this subdivision must be turned over to the state treasurer and credited to the general fund.

(b) The suspension, limitation, or revocation of the person's license or certificate of authority.

(2) After notice and opportunity for hearing, the director may by order reopen and alter, modify, or set aside, in whole or in part, an order issued under this section if, in the director's opinion, conditions of fact or law have changed to require that action or the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this section and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of $20,000.00 for each violation, or a suspension, limitation, or revocation of the person's license, or both. A fine collected under this subsection must be turned over to the state treasurer and credited to the general fund.

(4) The director may apply to the court of claims for an order of the court enjoining a violation of this act.

Sec. 224. (1) All actual and necessary expenses incurred in connection with the examination or other investigation of an insurer or other person regulated under the director's authority must be certified by the director, together with a statement of the work performed including the number of days spent by the director and each of the director's deputies, assistants, employees, and others acting under the director's authority. If correct, the expenses must be paid to the persons by whom they were incurred, on the warrant of the state treasurer payable from appropriations made by the legislature for this purpose.

(2) Except as otherwise provided in subsection (4), the director shall prepare and present to the insurer or other person examined or investigated a statement of the expenses and reasonable cost incurred for each person engaged on the examination or investigation, including amounts necessary to cover the pay and allowances granted to the persons by the Michigan civil service commission, and the administration and supervisory expense including an amount necessary to cover fringe benefits in conjunction with the examination or investigation. Except as otherwise provided in subsection (4), the insurer or other person, on receiving the statement, shall pay to the director the stated amount. The director shall deposit the money with the state treasurer as provided in section 225.

(3) The director may employ attorneys, actuaries, accountants, investment advisers, and other expert personnel not otherwise employees of this state reasonably necessary to assist in the conduct of the examination or investigation or proceeding with respect to an insurer or other person regulated under the director's authority at the insurer's or other person's expense except as otherwise provided in subsection (4). Except as otherwise provided in subsection (4), on certification by the director of the reasonable expenses incurred under this section, the insurer or other person examined or investigated shall pay those expenses directly to the person or firm rendering assistance to the director. Expenses paid directly to such person or firm and the regulatory fees imposed by this section are examination expenses under section 22e of the former single business tax act, 1975 PA 228, or under section 239(1) of the Michigan business tax act, 2007 PA 36, MCL 208.1239.

(4) An insurer is subject to a regulatory fee instead of the costs and expenses provided for in subsections (2) and (3). By June 30 of each year or within 30 days after the enactment into law of any appropriation for the department's operation, the director shall impose on all insurers authorized to do business in this state a regulatory fee calculated as follows:

(a) As used in this subsection:

(*i*) "A" means total annuity considerations written in this state in the preceding year.

(*ii*) "B" means base assessment rate. The base assessment rate must not exceed .00038 and must be a fraction, the numerator of which is the total regulatory fee and the denominator of which is the total amount of direct underwritten premiums written in this state by all insurers for the preceding calendar year, as reported to the director on the insurer's annual statements filed with the director.

(*iii*) "I" means all direct underwritten premiums other than life insurance premiums and annuity considerations written in this state in the preceding year by all insurers.

(*iv*) "L" means all direct underwritten life insurance premiums written in this state in the preceding year by all life insurers.

(*v*) Total regulatory fee must not exceed 80% of the gross appropriations for the department's operation for a fiscal year and must be the difference between the gross appropriations for the department's operation for that current fiscal year and any restricted revenues, other than the regulatory fee itself, as identified in the gross appropriation for the department's operation.

(*vi*) Direct premiums written in this state do not include any amounts that represent claims payments that are made on behalf of, or administrative fees that are paid in connection with, any administrative service contract, cost-plus arrangement, or any other noninsured or self-insured business.

(b) Two actual assessment rates must be calculated so as to distribute 75% of the burden of the regulatory fee shortfall created by the exclusion of annuity considerations from the assessment base to life insurance and 25% to all other insurance. The 2 actual assessment rates must be determined as follows:

(*i*) $\frac{L \times B + .75 \times B \times A}{L}$ = assessment rate for life insurance.

(*ii*) $\frac{I \times B + .25 \times B \times A}{I}$ = assessment rate for insurance other than life insurance.

(c) Each insurer's regulatory fee must be a minimum fee of $250.00 and must be determined by multiplying the actual assessment rate by the assessment base of that insurer as determined by the director from the insurer's annual statement for the immediately preceding calendar year filed with the director.

(5) Not less than 55% of the revenue derived from the regulatory fee under subsection (4) may be used for the regulation of financial conduct of persons regulated under the director's authority and for the regulation of persons regulated under the director's authority engaged in the business of health care and health insurance in this state.

(6) The amount, if any, by which amounts credited to the director under section 225 exceed actual expenditures under appropriations for the department's operation for a fiscal year must be credited toward the appropriation for the department in the next fiscal year.

(7) All money paid into the state treasury by an insurer under this section must be credited as provided under section 225.

(8) An insurer shall not treat a regulatory fee under this section as a levy or excise on premium but as a regulatory burden that is apportioned in relation to insurance activity in this state. A regulatory fee under this section reflects the insurance regulatory burden on this state as a result of this insurance activity. A foreign or alien insurer authorized to do business in this state may consider the liability required under this section as a burden imposed by this state in the calculation of the insurer's liability required under section 476a.

(9) An insurer may file with the director a protest to the regulatory fee imposed not later than 15 days after receipt of the regulatory fee. The director shall review the grounds for the protest and hold a conference with the insurer at the insurer's request. The director shall transmit his or her findings to the insurer with a restatement of the regulatory fee based on the findings. Statements of regulatory fees to which protests have not been made and restatements of regulatory fees are due and must be paid not later than 30 days after their receipt. Regulatory fees that are not paid when due bear interest on the unpaid fee, which must be calculated at 6-month intervals from the date the fee was due at a rate of interest equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months preceding July 1 and January 1, as certified by the state treasurer, and compounded annually, until the assessment is paid in full. An insurer who fails to pay its regulatory fee within the prescribed time limits may have its certificate of authority or license suspended, limited, or revoked as the director considers warranted until the regulatory fee is paid. If the director determines that a regulatory fee or a part of a regulatory fee paid by an insurer is in excess of the amount legally due and payable, the amount of the excess must be refunded or, at the insurer's option, be applied as a credit against the regulatory fee for the next fiscal year. An overpayment of $100.00 or less must be applied as a credit against the insurer's regulatory fee for the next fiscal year unless the insurer had a $100.00 or less overpayment in the immediately preceding fiscal year. If the insurer had a $100.00 or less overpayment in the immediately preceding fiscal year, at the insurer's option, the current fiscal year overpayment of $100.00 or less must be refunded.

(10) Any amounts stated and presented to or certified, assessed, or imposed on an insurer as provided in subsections (2), (3), and (4) that are unpaid as of the date that the insurer is subjected to a delinquency proceeding under chapter 81 are regarded as an expense of administering the delinquency proceeding and are payable as such from the general assets of the insurer.

(11) In addition to the regulatory fee provided in subsection (4), each insurer that locates records or personnel knowledgeable about those records outside this state under section 476a(3) or section 5256 shall reimburse the department for expenses and reasonable costs incurred by the department as a result of travel and other costs related to examinations or investigations of those records or personnel. The reimbursement must not include any costs that the department would have incurred if the examination had taken place in this state.

(12) As used in this section:

(a) "Annuity considerations" means receipts on the sale of annuities as used in section 22a of the former single business tax act, 1975 PA 228, or in section 235 of the Michigan business tax act, 2007 PA 36, MCL 208.1235.

(b) "Insurer" means an insurer authorized to do business in this state and includes nonprofit health care corporations, dental care corporations, and health maintenance organizations.

Sec. 261. (1) The department shall maintain on its internet website a page that does all of the following:

(a) Advises that the department may be able to assist a person who believes that an automobile insurer is not paying benefits, not making timely payments, or otherwise not performing as it is obligated to do under an insurance policy.

(b) Advises the person of selected important rights that the person has under chapter 20 that specifically relate to automobile insurers and the payment of benefits by automobile insurers.

(c) Allows the person to submit an explanation of the facts of the person's problems with the automobile insurer.

(d) Allows the person to submit electronically, or instructs the person how to provide paper copies of, any documentation to support the facts submitted under subdivision (c).

(e) Explains to the person the steps that the department will take and that may be taken after information is submitted under this section.

(2) The department shall maintain on its internet website a page that advises consumers about the changes to automobile insurance in this state that were made by the amendatory act that added this section, including, among any other information that the director determines to be important, ways to shop for insurance.

(3) The department shall maintain on its internet website a page or pages that allow a person to report fraud and unfair settlement and claims practices.

Sec. 271. By December 31 of 2022 and every year afterward through 2030, the department shall review the effect of changes made to section 3157 by the amendatory act that added this section and provide a report to the legislature on the department's findings.

Sec. 1244. (1) If the director finds that a person has violated this chapter, after an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director shall reduce the findings and decision to writing and shall issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than $1,000.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this chapter, the director may order the payment of a civil fine of not more than $5,000.00 for each violation. An order of the director under this subsection must not require the payment of civil fines exceeding $50,000.00. A fine collected under this subdivision must be turned over to the state treasurer and credited to the general fund of this state.

(b) A refund of any overcharges.

(c) That restitution be made to the insured or other claimant to cover incurred losses, damages, or other harm attributable to the acts of the person found to be in violation of this chapter.

(d) The suspension or revocation of the person's license.

(2) The director may by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the opinion of the director conditions of fact or of law have changed to require that action, or if the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this chapter and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of not more than $20,000.00 for each violation, a suspension or revocation of the person's license, or both. An order issued by the director under this subsection must not require the payment of civil fines exceeding $100,000.00. A fine collected under this subsection must be turned over to the state treasurer and credited to the general fund of this state.

(4) The director may apply to the court of claims for an order of the court enjoining a violation of this chapter.

Sec. 2013a. (1) The failure of an insurer to materially comply with section 3107e is an unfair method of competition and an unfair or deceptive act or practice in the business of insurance.

(2) This section does not affect any other right of a person under this chapter.

Sec. 2038. (1) If, after opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director determines that the person complained of has engaged in methods of competition or unfair or deceptive acts or practices prohibited by sections 2001 to 2050, the director shall reduce his or her findings and decision to writing and shall issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from engaging in that method of competition, act, or practice. The director may also order any of the following:

(a) Payment of a monetary penalty of not more than $1,000.00 for each violation but not to exceed an aggregate penalty of $10,000.00, unless the person knew or reasonably should have known he was in violation of this chapter, in which case the penalty must not be more than $5,000.00 for each violation and must not exceed an aggregate penalty of $50,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the person's license or certificate of authority if the person knowingly and persistently violated a provision of this chapter.

(c) Refund of any overcharges.

(2) The filing of a petition for review does not stay enforcement of action under this section, but the director may grant, or the appropriate court may order, a stay on appropriate terms.

(3) If a petition for review has not been filed within the time allowed under section 244, until the time for filing the petition expires or, if a petition for review has been filed within that time, until the transcript of the record in the proceeding has been filed in the circuit court, as provided in this chapter, the director, on notice and in a manner as he or she considers proper, may modify or set aside in whole or in part an order issued under this section.

(4) After the expiration of the time allowed for filing a petition for review, if a petition has not been filed within that time, the director may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the director's opinion conditions of fact or of law have so changed as to require that action or if required by the public interest.

Sec. 2040. (1) A person who violates a cease and desist order of the director under this chapter while the order is in effect, after notice and an opportunity for a hearing and on order of the director, may be subject to any of the following:

(a) A monetary penalty of not more than $20,000.00 for each violation.

(b) Suspension or revocation of the person's license or certificate of authority.

(2) The filing of a petition for review does not stay enforcement under this section, but the director may grant, or the appropriate court may order, a stay on appropriate terms.

(3) A cease and desist order issued by the director under section 2043 must not contain fines or other penalties applicable to acts or omissions that occur before the date of the cease and desist order.

Sec. 2069. An insurer, agent, solicitor, or other person that violates section 2064 or 2066 is guilty of a misdemeanor. On conviction of violating section 2066, the offender must be sentenced to pay a fine of not more than $100.00 for each violation, or in the discretion of the court, to imprisonment in the county jail of the county in which the offense is committed. On conviction of violating section 2064, the offender must be sentenced to pay a fine of not more than $2,000.00 for each violation, or in the discretion of the court, to imprisonment in the county jail of the county in which the offense is committed.

Sec. 2105. (1) A policy of automobile insurance or home insurance must not be offered, bound, made, issued, delivered or renewed in this state unless the policy conforms to this chapter.

(2) Except as otherwise expressly provided in subsection (4) and this chapter, this chapter does not apply to insurance written on a group, franchise, blanket policy, or similar basis that offers home insurance or automobile insurance to all members of the group, franchise plan, or blanket coverage who are eligible persons.

(3) For purposes of this section, a group plan includes a franchise plan, and, except as provided in subsection (4), is exempt from this chapter if the group meets all of the following criteria:

(a) Individuals in the group share a common enterprise or an economic or social affinity or relationship.

(b) The group was not created for the purposes of obtaining insurance.

(c) Membership in the group is not conditioned on the purchase of insurance.

(d) The individual members of the group can be specifically identified.

(e) Any other criteria as prescribed by a rule promulgated by the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(4) An insurer, including, but not limited to, an insurer that writes insurance as described in subsection (2), shall not establish or maintain rates or rating classifications for automobile insurance based on a factor that is not allowed, or that is prohibited, under section 2111. This subsection does not prohibit a group discount offered to a group based on the losses or expenses, or both, of the group but does prohibit group membership based on home ownership or postal zone.

(5) The amendments to this chapter made by the amendatory act that added this subsection apply to an insurer exempted from any of the requirements of this chapter under section 2129.

(6) The amendments to this chapter made by the amendatory act that added this subsection apply beginning July 1, 2020.

Sec. 2106. (1) Except as specifically provided in this chapter, chapter 24 and chapter 26 do not apply to automobile insurance and home insurance.

(2) Subject to section 2108(6), an insurer shall file rates with the department for approval in compliance with this act.

(3) An insurer may use rates for home insurance as soon as those rates are filed.

(4) To the extent that other provisions of this act are inconsistent with this chapter, this chapter governs with respect to automobile insurance and home insurance.

Sec. 2108. (1) On the effective date of a manual of classification, manual of rules and rates, rating plan, or modification of a manual of classification, manual of rules and rates, or rating plan that an insurer proposes to use for home insurance, the insurer shall file the manual or plan with the director. For automobile insurance, an insurer shall file a manual or plan described in this subsection in accordance with subsection (6). Each filing under this subsection must state the character and extent of the coverage contemplated. An insurer that is subject to this chapter and that maintains rates in any part of this state shall at all times maintain rates in effect for all eligible persons meeting the underwriting criteria of the insurer.

(2) An insurer may satisfy its obligation to make filings under subsection (1) by becoming a member of, or a subscriber to, a rating organization licensed under chapter 24 or chapter 26 that makes the filings, and by filing with the director a copy of its authorization of the rating organization to make the filings on its behalf. This chapter does not require an insurer to become a member of or a subscriber to a rating organization. An insurer may file and use deviations from filings made on its behalf. The deviations are subject to this chapter.

(3) A filing under this section must be accompanied by a certification by or on behalf of the insurer that, to the best of the insurer's information and belief, the filing conforms to the requirements of this chapter.

(4) A filing under this section must include information that supports the filing with respect to the requirements of section 2109. The information may include 1 or more of the following:

(a) The experience or judgment of the insurer or rating organization making the filing.

(b) The interpretation of the insurer or rating organization of any statistical data it relies on.

(c) The experience of other insurers or rating organizations.

(d) Any other relevant information.

(5) Except as otherwise provided in this subsection, the department shall make a filing under this section and any accompanying information open to public inspection on filing. An insurer or a rating organization filing on the insurer's behalf may designate information included in the filing or any accompanying information as a trade secret. The insurer or the rating organization filing on behalf of the insurer shall demonstrate to the director that the designated information is a trade secret. If the director determines that the information is a trade secret, the information is not subject to public inspection and is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. As used in this subsection, "trade secret" means that term as defined in section 2 of the uniform trade secrets act, 1998 PA 448, MCL 445.1902. However, trade secret does not include filings and information accompanying filings under this section that were subject to public inspection before January 11, 2016.

(6) For automobile insurance, an insurer shall file a manual or plan in accordance with chapter 24, except that the manual or plan must remain on file for a waiting period of 90 days before it becomes effective, which period may not be extended by the director, and the waiting period applies regardless of whether supporting information is required by the director under section 2406(1). Upon written application by the insurer, the director may authorize a filing that he or she has reviewed to become effective before expiration of the waiting period.

(7) An insurer shall not make, issue, or renew a contract or policy except in accordance with filings that are in effect for the insurer under this chapter.

(8) A filing under this chapter must specify that the insurer will not refuse to insure, refuse to continue to insure, or limit the amount of coverage available because of the location of the risk, and that the insurer recognizes those practices to constitute redlining. An insurer shall not engage in redlining as described in this subsection.

Sec. 2111. (1) Notwithstanding any provision of this act or this chapter to the contrary, classifications and territorial base rates used by an insurer in this state with respect to automobile insurance or home insurance must conform to the applicable requirements of this section.

(2) Classifications established under this section for automobile insurance must be based only on 1 or more of the following factors, which must be applied by an insurer on a uniform basis throughout this state:

(a) With respect to all automobile insurance coverages:

(*i*) Either the age of the driver; the length of driving experience; or the number of years licensed to operate a motor vehicle.

(*ii*) Driver primacy, based on the proportionate use of each vehicle insured under the policy by individual drivers insured or to be insured under the policy.

(*iii*) Average miles driven weekly, annually, or both.

(*iv*) Type of use, such as business, farm, or pleasure use.

(*v*) Vehicle characteristics, features, and options, such as engine displacement, ability of the vehicle and its equipment to protect passengers from injury, and other similar items, including vehicle make and model.

(*vi*) Daily or weekly commuting mileage.

(*vii*) Number of cars insured by the insurer or number of licensed operators in the household. However, number of licensed operators must not be used as an indirect measure of marital status.

(*viii*) Amount of insurance.

(b) In addition to the factors prescribed in subdivision (a), with respect to personal protection insurance coverage:

(*i*) Earned income.

(*ii*) Number of dependents of income earners insured under the policy.

(*iii*) Coordination of benefits.

(*iv*) Use of a safety belt.

(c) In addition to the factors prescribed in subdivision (a), with respect to collision and comprehensive coverages:

(*i*) The anticipated cost of vehicle repairs or replacement, which may be measured by age, price, cost new, or value of the insured automobile, and other factors directly relating to that anticipated cost.

(*ii*) Vehicle make and model.

(*iii*) Vehicle design characteristics related to vehicle damageability.

(*iv*) Vehicle characteristics relating to automobile theft prevention devices.

(d) With respect to all automobile insurance coverage other than comprehensive, successful completion by the individual driver or drivers insured under the policy of an accident prevention education course that meets the following criteria:

(*i*) The course must include a minimum of 8 hours of classroom instruction.

(*ii*) The course must include, but not be limited to, a review of all of the following:

(A) The effects of aging on driving behavior.

(B) The shapes, colors, and types of road signs.

(C) The effects of alcohol and medication on driving.

(D) The laws relating to the proper use of a motor vehicle.

(E) Accident prevention measures.

(F) The benefits of safety belts and child restraints.

(G) Major driving hazards.

(H) Interaction with other highway users, such as motorcyclists, bicyclists, and pedestrians.

(3) Each insurer shall establish a secondary or merit rating plan for automobile insurance, other than comprehensive coverage. A secondary or merit rating plan required under this subsection must provide for premium surcharges for all coverages for automobile insurance, other than comprehensive coverage, based on any of the following, when that information becomes available to the insurer:

(a) Substantially at-fault accidents.

(b) Convictions for, determinations of responsibility for civil infractions for, or findings of responsibility in probate court for civil infractions for violations under chapter VI of the Michigan vehicle code, 1949 PA 300, MCL 257.601 to 257.750. However, an insured must not be merit rated for a civil infraction under chapter VI of the Michigan vehicle code, 1949 PA 300, MCL 257.601 to 257.750, for a period of time longer than that which the secretary of state's office carries points for that infraction on the insured's motor vehicle record.

(4) An insurer shall not establish or maintain rates or rating classifications for automobile insurance based on any of the following:

(a) Sex.

(b) Marital status.

(c) Home ownership.

(d) Educational level attained.

(e) Occupation.

(f) The postal zone in which the insured resides.

(g) Credit score as provided in section 2162.

(5) Notwithstanding other provisions of this chapter, automobile insurance risks may be grouped by territory.

(6) This section does not limit insurers or rating organizations from establishing and maintaining statistical reporting territories. This section does not prohibit an insurer from establishing or maintaining, for automobile insurance, a premium discount plan for senior citizens in this state who are 65 years of age or older, if the plan is uniformly applied by the insurer throughout this state. If an insurer has not established and maintained a premium discount plan for senior citizens, the insurer shall offer reduced premium rates to senior citizens in this state who are 65 years of age or older and who drive less than 3,000 miles per year, regardless of statistical data.

(7) Classifications established under this section for home insurance other than inland marine insurance provided by policy floaters or endorsements must be based only on 1 or more of the following factors:

(a) Amount and types of coverage.

(b) Security and safety devices, including locks, smoke detectors, and similar, related devices.

(c) Repairable structural defects reasonably related to risk.

(d) Fire protection class.

(e) Construction of structure, based on structure size, building material components, and number of units.

(f) Loss experience of the insured, based on prior claims attributable to factors under the control of the insured that have been paid by an insurer. An insured's failure, after written notice from the insurer, to correct a physical condition that presents a risk of repeated loss is a factor under the control of the insured for purposes of this subdivision.

(g) Use of smoking materials within the structure.

(h) Distance of the structure from a fire hydrant.

(i) Availability of law enforcement or crime prevention services.

(8) Notwithstanding other provisions of this chapter, home insurance risks may be grouped by territory.

(9) An insurer may use factors in addition to those permitted by this section for insurance if the plan is consistent with the purposes of this act and reflects reasonably anticipated reductions or increases in losses or expenses.

Sec. 2111f. (1) Before July 1, 2020, an insurer that offers automobile insurance in this state shall file premium rates for personal protection insurance coverage for automobile insurance policies effective after July 1, 2020.

(2) Subject to subsections (6) and (7), the premium rates filed as required by subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage under automobile insurance policies effective before July 1, 2028, must result, as nearly as practicable, in an average reduction per vehicle from the premium rates for personal protection insurance coverage that were in effect for the insurer on May 1, 2019 as follows:

(a) For policies subject to the coverage limits under section 3107c(1)(a), an average 45% or greater reduction per vehicle.

(b) For policies subject to the coverage limits under section 3107c(1)(b), an average 35% or greater reduction per vehicle.

(c) For policies subject to the coverage limits under section 3107c(1)(c), an average 20% or greater reduction per vehicle.

(d) For policies not subject to any coverage limit under section 3107c(1)(d), an average 10% or greater reduction per vehicle.

(3) For a policy under which an election under section 3107d has been made to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a), or for a policy to which an exclusion under section 3109a(2)

applies, the premium rates filed under subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage must result in no premium charge for coverage for personal protection insurance benefits payable under section 3107(1)(a).

(4) The director shall review a filing submitted by an insurer under subsections (1) to (3) for compliance with this section. Subject to subsection (7), the director shall disapprove a filing if after review the director determines that the filing does not result in the premium reductions required by subsections (2) and (3).

(5) If the director disapproves a premium rate filing under subsection (4), the insurer shall submit a revised premium rate filing to the director within 15 days after the disapproval. The premium rate filing is subject to review in the same manner as an original premium rate filing under subsection (4).

(6) For policies issued or renewed in the year beginning July 1, 2024 and for the year beginning July 1, 2026, an automobile insurer that offers automobile insurance in this state shall make filings demonstrating its compliance with this section.

(7) At any time, an insurer may apply to the director for approval to file rates that result in a lower premium reduction level or an exemption from the requirements of subsection (2) and the director shall approve the application if the rates otherwise comply with this act and compliance with the premium reductions required by subsection (2) will result in any of the following:

(a) The insurer reaching the company action level risk-based capital.

(b) A violation of the Fourteenth Amendment of the United States Constitution as to the insurer. This subdivision does not apply after July 1, 2023.

(c) A violation of section 17 of article I of the state constitution of 1963, as to deprivation of property without due process. This subdivision does not apply after July 1, 2023.

(8) An insurer shall pass on, in filings to which this section applies, savings realized from the application of section 3157(2) to (12) to treatment, products, services, accommodations, or training rendered to individuals who suffered accidental bodily injury from motor vehicle accidents that occurred before the effective date of the amendatory act that added this section. An insurer shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to evaluate the insurer's compliance with this subsection. After July 1, 2022, the director shall review all rate filings to which this section applies for compliance with this subsection.

(9) This section does not prohibit an increase for any individual insurance policy premium if the increase results from applying rating factors as approved under this chapter, including the requirements of this section.

(10) After July 1, 2020 and before July 1, 2028, an insurer shall not issue or renew an automobile insurance policy in this state unless the premium rates filed by the insurer for personal protection insurance coverage are approved under this section.

(11) For purposes of calculating a personal protection insurance premium or premium rate under this section, the premium must include the catastrophic claims assessment imposed under section 3104.

(12) If subsection (2) or the application of subsection (2) to any insurer is found to be invalid by a court, the remaining portions of the amendatory act that added this section are not severable and shall be deemed invalid and inoperable.

(13) As used in this section:

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC report, including risk-based capital instructions adopted by the National Association of Insurance Commissioners and the director.

(b) "Company action level risk-based capital" means 2 times the insurer's authorized control level RBC.

(c) "RBC report" means the report of the insurer's RBC levels as required by the annual statement instructions.

Sec. 2116b. (1) Subject to subsection (2), an automobile insurer shall not refuse to insure, refuse to continue to insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance for an eligible person solely because the person previously failed to maintain insurance required by section 3101 for a vehicle owned by the person.

(2) This section only applies to an eligible person that applies for automobile insurance before January 1, 2022.

Sec. 2118. (1) As a condition of maintaining its certificate of authority, an insurer shall not refuse to insure, refuse to continue to insure, or limit coverage available to an eligible person for automobile insurance, except in accordance with underwriting rules established as provided in this section and sections 2119 and 2120.

(2) The underwriting rules that an insurer may establish for automobile insurance must be based only on the following:

(a) Criteria identical to the standards set forth in section 2103(1).

(b) The insurance eligibility point accumulation in excess of the amounts established by section 2103(1) of a member of the household of the eligible person insured or to be insured, if the member of the household usually accounts for 10% or more of the use of a vehicle insured or to be insured. For purposes of this subdivision, a person who is the principal driver for 1 automobile insurance policy is rebuttably presumed not to usually account for more than 10% of the use of other vehicles of the household not insured under the policy of that person.

(c) With respect to a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(d) Except as otherwise provided in section 2116a or 2116b, failure by the person to provide proof that insurance required by section 3101 was maintained in force with respect to any vehicle that was both owned by the person and driven or moved by the person or by a member of the household of the person during the 6-month period immediately preceding application. The proof must take the form of a certification by the person on a form provided by the insurer that the vehicle was not driven or moved without maintaining the insurance required by section 3101 during the 6-month period immediately preceding application.

(e) Type of vehicle insured or to be insured, based on 1 of the following, without regard to the age of the vehicle:

(*i*) The vehicle is of limited production or of custom manufacture.

(*ii*) The insurer does not have a rate lawfully in effect for the type of vehicle.

(*iii*) The vehicle represents exposure to extraordinary expense for repair or replacement under comprehensive or collision coverage.

(f) Use of a vehicle insured or to be insured for transportation of passengers for hire, for rental purposes, or for commercial purposes. Rules under this subdivision must not be based on the use of a vehicle for volunteer or charitable purposes or for which reimbursement for normal operating expenses is received.

(g) Payment of a minimum deposit at the time of application or renewal, not to exceed the smallest deposit required under an extended payment or premium finance plan customarily used by the insurer.

(h) For purposes of requiring comprehensive deductibles of not more than $150.00, or of refusing to insure if the person refuses to accept a required deductible, the claim experience of the person with respect to comprehensive coverage.

(i) Total abstinence from the consumption of alcoholic beverages except if such beverages are consumed as part of a religious ceremony. However, an insurer shall not use an underwriting rule based on this subdivision unless the insurer was authorized to transact automobile insurance in this state before January 1, 1981, and has consistently used such an underwriting rule as part of the insurer's automobile insurance underwriting since being authorized to transact automobile insurance in this state.

(j) One or more incidents involving a threat, harassment, or physical assault by the insured or applicant for insurance on an insurer employee, agent, or agent employee while acting within the scope of his or her employment, if a report of the incident was filed with an appropriate law enforcement agency.

Sec. 2120. (1) Affiliated insurers may establish underwriting rules so that each affiliate will provide automobile insurance only to certain eligible persons. This subsection applies only if an eligible person can obtain automobile insurance from 1 of the affiliates. The underwriting rules must be in compliance with this section and sections 2118 and 2119.

(2) An insurer may establish separate rating plans so that certain eligible persons are provided automobile insurance under 1 rating plan and other eligible persons are provided automobile insurance under another rating plan. This subsection applies only if all eligible persons can obtain automobile insurance under a rating plan of the insurer. Underwriting rules consistent with this section and sections 2118 and 2119 must be established to define the rating plan applicable to each eligible person.

(3) Underwriting rules under this section must be based only on the following:

(a) With respect to a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(b) Except as otherwise provided in section 2116a or 2116b, failure of the person to provide proof that insurance required by section 3101 was maintained in force with respect to any vehicle owned and operated by the person or by a member of the household of the person during the 6-month period immediately preceding application or renewal of the policy. The proof must take the form of a certification by the person that the required insurance was maintained in force for the 6-month period with respect to the vehicle.

(c) For purposes of insuring persons who have refused a deductible lawfully required under section 2118(2)(h), the claim experience of the person with respect to comprehensive coverage.

(d) Refusal of the person to pay a minimum deposit required under section 2118(2)(g).

(e) A person's insurance eligibility point accumulation under section 2103(1)(h), or the total insurance eligibility point accumulation of all persons who account for 10% or more of the use of 1 or more vehicles insured or to be insured under the policy.

(f) The type of vehicle insured or to be insured as provided in section 2118(2)(e).

Sec. 2151. As used in this chapter:

(a) "Adverse action" means an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any personal insurance, existing or applied for.

(b) "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(c) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related must not be considered credit information, regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(d) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in the rating of personal insurance.

(e) "Credit score" means the numerical score ranging from 300 to 850 assigned by a consumer reporting agency to measure credit risk and includes FICO credit score.

(f) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

(g) "Personal insurance" means property/casualty insurance written for personal, family, or household use, including automobile, home, motorcycle, mobile home, noncommercial dwelling fire, boat, personal watercraft, snowmobile, and recreational vehicle, whether written on an individual, group, franchise, blanket policy, or similar basis.

Sec. 2162. An insurer shall not use an individual's credit score to establish or maintain rates or rating classifications for automobile insurance.

Sec. 3009. (1) Subject to subsections (5) to (8), an automobile liability or motor vehicle liability policy that insures against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle must not be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless the liability coverage is subject to all of the following limits:

(a) A limit, exclusive of interest and costs, of not less than $250,000.00 because of bodily injury to or death of 1 person in any 1 accident.

(b) Subject to the limit for 1 person in subdivision (a), a limit of not less than $500,000.00 because of bodily injury to or death of 2 or more persons in any 1 accident.

(c) A limit of not less than $10,000.00 because of injury to or destruction of property of others in any accident.

(2) If authorized by the insured, automobile liability or motor vehicle liability coverage may be excluded when a vehicle is operated by a named person. An exclusion under this subsection is not valid unless the following notice is on the face of the policy or the declaration page or certificate of the policy and on the certificate of insurance:

Warning—when a named excluded person operates a vehicle all liability coverage is void—no one is insured. Owners of the vehicle and others legally responsible for the acts of the named excluded person remain fully personally liable.

(3) A liability policy described in subsection (1) may exclude coverage for liability as provided in section 3017.

(4) If an insurer deletes coverages from an automobile insurance policy under section 3101, the insurer shall send documentary evidence of the deletion to the insured.

(5) An applicant for or named insured in the automobile liability or motor vehicle liability policy described in subsection (1) may choose to purchase lower limits than required under subsection (1)(a) and (b), but not lower than $50,000.00 under subsection (1)(a) and $100,000.00 under subsection (1)(b). To exercise an option under this subsection, the person shall complete a form issued by the director and provided as required by section 3107e, that meets the requirements of subsection (7).

(6) On application for the issuance of a new policy or renewal of an existing policy, an insurer shall do all of the following:

(a) Provide the applicant or named insured the liability options available under this section.

(b) Provide the applicant or named insured a price for each option available under this section.

(c) Offer the applicant or named insured the option and form under this subsection.

(7) The form required under subsection (5) must do all of the following:

(a) State, in a conspicuous manner, the risks of choosing liability limits lower than those required by subsection (1)(a) and (b).

(b) Provide a way for the person to mark the form to acknowledge that he or she has received a list of the liability options available under this section and the price for each option.

(c) Provide a way for the person to mark the form to acknowledge that he or she has read the form and understands the risks of choosing the lower liability limits.

(d) Allow the person to sign the form.

(8) If an insurance policy is issued or renewed as described in subsection (1) and the person named in the policy has not made an effective choice under subsection (5), the limits under subsection (1)(a) and (b) apply to the policy.

Sec. 3101. (1) Except as provided in sections 3107d and 3109a, the owner or registrant of a motor vehicle required to be registered in this state shall maintain security for payment of benefits under personal protection insurance and property protection insurance as required under this chapter, and residual liability insurance. Security is only required to be in effect during the period the motor vehicle is driven or moved on a highway.

(2) Except as provided in section 3107d, all automobile insurance policies offered in this state must include benefits under personal protection insurance, and property protection insurance as provided in this chapter, and residual liability insurance. Notwithstanding any other provision in this act, an insurer that has issued an automobile insurance policy may only delete portions of the coverages under the policy and maintain the comprehensive coverage portion on a motor vehicle that is not driven or moved on a highway in accordance with section 3009(4).

(3) As used in this chapter:

(a) "Automobile insurance" means that term as defined in section 2102.

(b) "Commercial quadricycle" means a vehicle to which all of the following apply:

(*i*) The vehicle has fully operative pedals for propulsion entirely by human power.

(*ii*) The vehicle has at least 4 wheels and is operated in a manner similar to a bicycle.

(*iii*) The vehicle has at least 6 seats for passengers.

(*iv*) The vehicle is designed to be occupied by a driver and powered either by passengers providing pedal power to the drive train of the vehicle or by a motor capable of propelling the vehicle in the absence of human power.

(*v*) The vehicle is used for commercial purposes.

(*vi*) The vehicle is operated by the owner of the vehicle or an employee of the owner of the vehicle.

(c) "Electric bicycle" means that term as defined in section 13e of the Michigan vehicle code, 1949 PA 300, MCL 257.13e.

(d) "Golf cart" means a vehicle designed for transportation while playing the game of golf.

(e) "Highway" means highway or street as that term is defined in section 20 of the Michigan vehicle code, 1949 PA 300, MCL 257.20.

(f) "Moped" means that term as defined in section 32b of the Michigan vehicle code, 1949 PA 300, MCL 257.32b.

(g) "Motorcycle" means a vehicle that has a saddle or seat for the use of the rider, is designed to travel on not more than 3 wheels in contact with the ground, and is equipped with a motor that exceeds 50 cubic centimeters piston displacement. For purposes of this subdivision, the wheels on any attachment to the vehicle are not considered as wheels in contact with the ground. Motorcycle does not include a moped or an ORV.

(h) "Motorcycle accident" means a loss that involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle, but does not involve the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle.

(i) "Motor vehicle" means a vehicle, including a trailer, that is operated or designed for operation on a public highway by power other than muscular power and has more than 2 wheels. Motor vehicle does not include any of the following:

(*i*) A motorcycle.

(*ii*) A moped.

(*iii*) A farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan vehicle code under section 216 of the Michigan vehicle code, 1949 PA 300, MCL 257.216.

(*iv*) An ORV.

(*v*) A golf cart.

(*vi*) A power-driven mobility device.

(*vii*) A commercial quadricycle.

(*viii*) An electric bicycle.

(j) "Motor vehicle accident" means a loss that involves the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle regardless of whether the accident also involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle.

(k) "ORV" means a motor-driven recreation vehicle designed for off-road use and capable of cross-country travel without benefit of road or trail, on or immediately over land, snow, ice, marsh, swampland, or other natural terrain. ORV includes, but is not limited to, a multitrack or multiwheel drive vehicle, a motorcycle or related 2-wheel, 3-wheel, or 4-wheel vehicle, an amphibious machine, a ground effect air cushion vehicle, an ATV as defined in section 81101 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.81101, or other means of transportation deriving motive power from a source other than muscle or wind. ORV does not include a vehicle described in this subdivision that is registered for use on a public highway and has the security required under subsection (1) or section 3103 in effect.

(*l*) "Owner" means any of the following:

(*i*) A person renting a motor vehicle or having the use of a motor vehicle, under a lease or otherwise, for a period that is greater than 30 days.

(*ii*) A person renting a motorcycle or having the use of a motorcycle under a lease for a period that is greater than 30 days, or otherwise for a period that is greater than 30 consecutive days. A person who borrows a motorcycle for a period that is less than 30 consecutive days with the consent of the owner is not an owner under this subparagraph.

(*iii*) A person that holds the legal title to a motor vehicle or motorcycle, other than a person engaged in the business of leasing motor vehicles or motorcycles that is the lessor of a motor vehicle or motorcycle under a lease that provides for the use of the motor vehicle or motorcycle by the lessee for a period that is greater than 30 days.

(*iv*) A person that has the immediate right of possession of a motor vehicle or motorcycle under an installment sale contract.

(m) "Power-driven mobility device" means a wheelchair or other mobility device powered by a battery, fuel, or other engine and designed to be used by an individual with a mobility disability for the purpose of locomotion.

(n) "Registrant" does not include a person engaged in the business of leasing motor vehicles or motorcycles that is the lessor of a motor vehicle or motorcycle under a lease that provides for the use of the motor vehicle or motorcycle by the lessee for a period that is longer than 30 days.

(4) Security required by subsection (1) may be provided under a policy issued by an authorized insurer that affords insurance for the payment of benefits described in subsection (1). A policy of insurance represented or sold as providing security is considered to provide insurance for the payment of the benefits.

(5) Security required by subsection (1) may be provided by any other method approved by the secretary of state as affording security equivalent to that afforded by a policy of insurance, if proof of the security is filed and continuously maintained with the secretary of state throughout the period the motor vehicle is driven or moved on a highway. The person filing the security has all the obligations and rights of an insurer under this chapter. When the context permits, "insurer" as used in this chapter, includes a person that files the security as provided in this section.

(6) An insurer that issues a policy that provides the security required under subsection (1) may exclude coverage under the policy as provided in section 3017.

Sec. 3101a. (1) An insurer, in conjunction with the issuance of an automobile insurance policy, shall provide to the insured 1 certificate of insurance for each insured vehicle and for private passenger nonfleet automobiles listed on the policy shall supply to the secretary of state the automobile insurer's name, the name of the named insured, the named insured's address, the vehicle identification number for each vehicle listed on the policy, and the policy number. The insurer shall transmit the information required under this subsection in a format as required by the secretary of state. The secretary of state shall not require the information to be transmitted more frequently than every 14 days.

(2) The secretary of state shall provide policy information received under subsection (1) to the Michigan automobile insurance placement facility as required for the Michigan automobile insurance placement facility to comply with this act. Information received by the Michigan automobile insurance placement facility under this subsection is confidential and is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. The Michigan automobile insurance placement facility shall only use the information for purposes of administering the assigned claims plan under this chapter and shall not disclose the information to any person unless it is for the purpose of administering the assigned claims plan or in compliance with an order by a court of competent jurisdiction in connection with a fraud investigation or prosecution.

(3) The secretary of state shall provide policy information received under subsection (1) to the department of health and human services as required for the department of health and human services to comply with 2006 PA 593, MCL 550.281 to 550.289.

(4) The secretary of state shall accept as proof of vehicle insurance a transmission of the insured vehicle's vehicle identification number. Policy information submitted by an insurer and received by the secretary of state under this section is confidential, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and must not be disclosed to any person except the department of health and human services for purposes of 2006 PA 593, MCL 550.281 to 550.289, or pursuant to an order by a court of competent jurisdiction in connection with a claim or fraud investigation or prosecution. The transmission to the secretary of state of a vehicle identification number is proof of insurance to the secretary of state for motor vehicle registration purposes only and is not evidence that a policy of insurance actually exists between an insurer and an individual.

(5) A person who supplies false information to the secretary of state under this section or who issues or uses an altered, fraudulent, or counterfeit certificate of insurance is guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than $1,000.00, or both.

(6) The department of health and human services shall report to the senate and house of representatives appropriations committees and standing committees concerning insurance issues on the number of claims and total dollar amount recovered from automobile insurers under 2006 PA 593, MCL 550.281 to 550.289. The reports required by this subsection must be given to the appropriations committees and standing committees concerning insurance issues by December 30 of each year and must cover the preceding 12-month period.

(7) As used in this section:

(a) "Automobile insurance" means that term as defined in section 3303.

(b) "Private passenger nonfleet automobile" means that term as defined in section 3303.

Sec. 3104. (1) The catastrophic claims association is created as an unincorporated, nonprofit association. Each insurer engaged in writing insurance coverages that provide the security required by section 3101(1) in this state, as a condition of its authority to transact insurance in this state, shall be a member of the association and is bound by the plan of operation of the association. An insurer engaged in writing insurance coverages that provide the security required by section 3103(1) in this state, as a condition of its authority to transact insurance in this state, is considered to be a member of the association, but only for purposes of premiums under subsection (7)(d). Except as expressly provided in this section, the association is not subject to any laws of this state with respect to insurers, but in all other respects the association is subject to the laws of this state to the extent that the association would be if it were an insurer organized and subsisting under chapter 50.

(2) For all motor vehicle accident policies issued or renewed before July 2, 2020 and for a motor vehicle accident policy issued or renewed after July 1, 2020 to which section 3107c(1)(d) applies, the association shall provide and each member shall accept indemnification for 100% of the amount of ultimate loss sustained under personal protection insurance coverages in excess of the following amounts in each loss occurrence:

(a) For a motor vehicle accident policy issued or renewed before July 1, 2002, $250,000.00.

(b) For a motor vehicle accident policy issued or renewed during the period July 1, 2002 to June 30, 2003, $300,000.00.

(c) For a motor vehicle accident policy issued or renewed during the period July 1, 2003 to June 30, 2004, $325,000.00.

(d) For a motor vehicle accident policy issued or renewed during the period July 1, 2004 to June 30, 2005, $350,000.00.

(e) For a motor vehicle accident policy issued or renewed during the period July 1, 2005 to June 30, 2006, $375,000.00.

(f) For a motor vehicle accident policy issued or renewed during the period July 1, 2006 to June 30, 2007, $400,000.00.

(g) For a motor vehicle accident policy issued or renewed during the period July 1, 2007 to June 30, 2008, $420,000.00.

(h) For a motor vehicle accident policy issued or renewed during the period July 1, 2008 to June 30, 2009, $440,000.00.

(i) For a motor vehicle accident policy issued or renewed during the period July 1, 2009 to June 30, 2010, $460,000.00.

(j) For a motor vehicle accident policy issued or renewed during the period July 1, 2010 to June 30, 2011, $480,000.00.

(k) For a motor vehicle accident policy issued or renewed during the period July 1, 2011 to June 30, 2013, $500,000.00.

(*l*) For a motor vehicle accident policy issued or renewed during the period July 1, 2013 to June 30, 2015, $530,000.00.

(m) For a motor vehicle accident policy issued or renewed during the period July 1, 2015 to June 30, 2017, $545,000.00.

(n) For a motor vehicle accident policy issued or renewed during the period July 1, 2017 to June 30, 2019, $555,000.00.

(o) For a motor vehicle accident policy issued or renewed during the period July 1, 2019 to June 30, 2021, $580,000.00. Beginning July 1, 2021, this $580,000.00 amount must be increased biennially on July 1 of each odd-numbered year, for policies issued or renewed before July 1 of the following odd-numbered year, by the lesser of 6% or the Consumer Price Index, and rounded to the nearest $5,000.00. The association shall calculate this biennial adjustment by January 1 of the year of its July 1 effective date.

(3) An insurer may withdraw from the association only on ceasing to write insurance that provides the security required by section 3101(1) in this state.

(4) An insurer whose membership in the association has been terminated by withdrawal continues to be bound by the plan of operation, and on withdrawal, all unpaid premiums that have been charged to the withdrawing member are payable as of the effective date of the withdrawal.

(5) An unsatisfied net liability to the association of an insolvent member must be assumed by and apportioned among the remaining members of the association as provided in the plan of operation. The association has all rights allowed by law on behalf of the remaining members against the estate or funds of the insolvent member for money due the association.

(6) If a member has been merged or consolidated into another insurer or another insurer has reinsured a member's entire business that provides the security required by section 3101(1) in this state, the member and successors in interest of the member remain liable for the member's obligations.

(7) The association shall do all of the following on behalf of the members of the association:

(a) Assume 100% of all liability as provided in subsection (2).

(b) Establish procedures by which members must promptly report to the association each claim that, on the basis of the injuries or damages sustained, may reasonably be anticipated to involve the association if the member is ultimately held legally liable for the injuries or damages. Solely for the purpose of reporting claims, the member shall in all instances consider itself legally liable for the injuries or damages. The member shall also advise the association of subsequent developments likely to materially affect the interest of the association in the claim.

(c) Maintain relevant loss and expense data relating to all liabilities of the association and require each member to furnish statistics, in connection with liabilities of the association, at the times and in the form and detail as required by the plan of operation.

(d) In a manner provided for in the plan of operation, calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association that the association will likely incur during the period for which the premium is applicable. The total premium must include an amount to cover incurred but not reported losses for the period and must be adjusted for any excess or deficient premiums from previous periods. Excesses or deficiencies from previous periods must either be fully adjusted in a single period or be adjusted over several periods in a manner provided for in the plan of operation. Each member must be charged an amount equal to that member's total written car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state during the period to which the premium applies, with the total written car years of insurance multiplied by the applicable average premium per car. The average premium per car is the total premium, as adjusted for any excesses or deficiencies, divided by the total written car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state of all members during the period to which the premium applies, excluding cars insured under a policy with a coverage limit under section 3107c(1)(a), (b), or (c), cars as to which an election to not maintain personal protection insurance benefits has been made under section 3107d, or as to which an exclusion under section 3109a(2) applies, except for any portion of total premium that is an adjustment for a deficiency in a previous period. A member may not be charged a premium for a car insured under a policy with a coverage limit under section 3107c(1)(a), (b), or (c), as to which an election to not maintain personal protection insurance benefits has been made under section 3107d, or as to which an exclusion under section 3109a(2) applies, other than for the portion of the total premium attributable to an adjustment for a deficiency in a previous period. A member must be charged a premium for a historic vehicle that is insured with the member of 20% of the premium charged for a car insured with the member.

(e) Require and accept the payment of premiums from members of the association as provided for in the plan of operation. The association shall do either of the following:

(*i*) Require payment of the premium in full within 45 days after the premium charge.

(*ii*) Require payment of the premiums to be made periodically to cover the actual cash obligations of the association.

(f) Receive and distribute all money required by the operation of the association.

(g) Establish procedures for reviewing claims procedures and practices of members of the association. If the claims procedures or practices of a member are considered inadequate to properly service the liabilities of the association, the association may undertake or may contract with another person, including another member, to adjust or assist in the adjustment of claims for the member on claims that create a potential liability to the association and may charge the cost of the adjustment to the member.

(h) Provide any records necessary or requested by the director for the actuarial examination under subsection (21).

(i) Subject to subsection (23), obey an order of the director for a refund under subsection (22).

(8) In addition to other powers granted to it by this section, the association may do all of the following:

(a) Sue and be sued in the name of the association. A judgment against the association does not create any direct liability against the individual members of the association. The association may provide for the indemnification of its

members, members of the board of directors of the association, and officers, employees, and other persons lawfully acting on behalf of the association.

(b) Reinsure all or any portion of its potential liability with reinsurers licensed to transact insurance in this state or approved by the director.

(c) Provide for appropriate housing, equipment, and personnel as necessary to assure the efficient operation of the association.

(d) Pursuant to the plan of operation, adopt reasonable rules for the administration of the association, enforce those rules, and delegate authority, as the board considers necessary to assure the proper administration and operation of the association consistent with the plan of operation.

(e) Contract for goods and services, including independent claims management, actuarial, investment, and legal services, from others in or outside of this state to assure the efficient operation of the association.

(f) Hear and determine complaints of a company or other interested party concerning the operation of the association.

(g) Perform other acts not specifically enumerated in this section that are necessary or proper to accomplish the purposes of the association and that are not inconsistent with this section or the plan of operation.

(9) A board of directors is created and shall operate the association consistent with the plan of operation and this section.

(10) The plan of operation must provide for all of the following:

(a) The establishment of necessary facilities.

(b) The management and operation of the association.

(c) Procedures to be utilized in charging premiums, including adjustments from excess or deficient premiums from prior periods. The plan must require that any deficiency from a prior period be amortized over not fewer than 15 years.

(d) Procedures for a refund to members of the association, for distribution to insureds as provided in subsection (24), as ordered by the director under subsection (22). The procedures must provide for a distribution of a refund attributable to a historic vehicle equal to 20% of the refund for a car that is not a historic vehicle.

(e) Procedures governing the actual payment of premiums to the association.

(f) Reimbursement of each member of the board by the association for actual and necessary expenses incurred on association business.

(g) The investment policy of the association.

(h) Any other matters required by or necessary to effectively implement this section.

(11) The board must include members that would contribute a total of not less than 40% of the total premium calculated under subsection (7)(d). Each board member is entitled to 1 vote. The initial term of office of a board member is 2 years.

(12) As part of the plan of operation, the board shall adopt rules providing for the composition of the board and the terms of board members, consistent with the membership composition requirements in subsections (11) and (13). Terms of the board members must be staggered so that the terms of all the board members do not expire at the same time and so that a board member does not serve a term of more than 4 years.

(13) The board must consist of 5 board members and the director, who shall serve as an ex officio member of the board without vote.

(14) The director shall appoint the board members. A board member shall serve until his or her successor is selected and qualified. The board shall elect the chairperson of the board. The director shall fill any vacancy on the board as provided in the plan of operation.

(15) The board shall meet as often as the chairperson, the director, or the plan of operation requires, or at the request of any 3 board members. The chairperson may vote on all issues. Four board members constitute a quorum.

(16) The board shall furnish to each member of the association an annual report of the operations of the association in a form and detail as determined by the board.

(17) Any amendments to the plan of operation are subject to majority approval by the board, ratification by a majority of the membership of the association having a vote, with voting rights being apportioned according to the premiums charged in subsection (7)(d), and approval by the director.

(18) An insurer authorized to write insurance providing the security required by section 3101(1) in this state, as provided in this section, is bound by and shall formally subscribe to and participate in the plan of operation as a condition of maintaining its authority to transact insurance in this state.

(19) The association is subject to all the reporting, loss reserve, and investment requirements of the director to the same extent as is a member of the association.

(20) Premiums charged members by the association must be recognized in the rate-making procedures for insurance rates in the same manner that expenses and premium taxes are recognized. If a member of the association passes on any portion of the premium payable under this section to an insured, the amount passed on must equal the portion of the premium payable by the member under this section attributable to the car or historic vehicle insured, including any adjustments for excesses or deficiencies from a previous period.

(21) The director or an authorized representative of the director may visit the association at any time and examine any and all of the association's affairs. Beginning July 1, 2022, and every third year after 2022, the director shall engage 1 or more independent actuaries to examine the affairs and records of the association for the previous 3 years. The actuarial examination must be conducted using sound actuarial principles consistent with the applicable statements of principles and the code of professional conduct adopted by the Casualty Actuarial Society. By September 1, 2022 and by September 1 of every third year after 2022, the director shall provide a report to the legislature on the results of the audit conducted under this subsection.

(22) If the actuarial examination under subsection (21) shows that the assets of the association exceed 120% of its liabilities, including incurred but not reported liabilities, and if the refund will not threaten the association's ongoing ability to provide reimbursements for personal protection insurance benefits based on sound actuarial principles consistent with the applicable statements of principles and the code of professional conduct adopted by the Casualty Actuarial Society, the director shall order the association to refund an amount equal to the difference between the total excess and 120% of the liabilities of the association, including incurred but not reported liabilities, under subsection (10)(d) and order the members of the association to distribute the refunds under subsection (24).

(23) Within 30 days after receiving an order from the director under subsection (22), the association may request a hearing to review the order by filing a written request with the director. The department shall conduct the review as a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(24) A member of the association shall distribute any refund it receives under subsection (10)(d) to the persons that it insures under policies that provide the security required under section 3101(1) or 3103(1), or both, and that are subject to a premium under this section on a uniform basis per car and historic vehicle in a manner and on the date or dates provided by the director in accordance with an order issued by the director. A refund attributable to a historic vehicle must be equal to 20% of the refund for a car that is not a historic vehicle.

(25) By September 1 of each year, the association shall prepare, submit to the committees of the senate and house of representatives with jurisdiction over insurance matters, and post on the association website an annual consumer statement, written in a manner intended for the general public. The statement must include all of the following:

(a) The number of claims opened during the preceding 12 months, the amount expended on the claims, and the future anticipated costs of the claims.

(b) For each of the preceding 10 years, the total number of open claims, the amount expended on the claims, and the anticipated future costs of the claims.

(c) For each of the preceding 10 years, the total number of claims closed and the amount expended on the claims.

(d) For each of the preceding 10 years, the ratio of claims opened to claims closed.

(e) For each of the preceding 10 years, the average length of open claims.

(f) A statement of the current financial condition of the association and the reasons for any deficit or surplus in collected assessments compared to losses.

(g) A statement of the assumptions, methodology, and data used to make revenue projections. As used in this subdivision, "revenue" means return on investments.

(h) A statement of the assumptions, methodology, and data used to make cost projections.

(i) A list of the association's assets, sorted by category or type of asset, such as stocks, bonds, or mutual funds, and the expected return on each asset.

(j) The total amount of the association's discounted and undiscounted liabilities and a description and explanation of the liabilities, including an explanation of the association's definition of the terms discounted and undiscounted.

(k) Measures taken by the association to contain costs.

(*l*) A statement explaining what portion of the assessment to insureds as recognized in rates under subsection (20) is attributable to claims occurring in the previous 12 months, administrative costs, and the amount, if any, to adjust for past deficits.

(m) A statement explaining any qualifications identified by the independent auditors in the most recent audit report prepared under subsection (21).

(n) A loss payment summary for each of the preceding years by category.

(o) For each of the preceding 10 years, an injury type summary, categorizing the injuries suffered by claimants the payment of whose claims are being reimbursed by the association, by brain injuries, injuries resulting in quadriplegia, injuries resulting in paraplegia, burn injuries, and other injuries.

(p) A summary of investment returns over the preceding 10 years showing the investment balance, the investment gain, and the percentage return on the investment balance.

(q) A summary of the mortality assumptions used in making cost projections.

(r) A summary of any financial practices that differ from those found in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

(26) By September 1 of each year, the association shall prepare and provide to the committees of the senate and house of representatives with jurisdiction over insurance matters an annual report of the association. The report must contain all of the following:

(a) An executive summary.

(b) A discussion of the mortality assumptions used by the association in making cost projections.

(c) An evaluation of the accuracy of the association's actuarial assumptions over the preceding 5 years.

(d) The annual consumer statement prepared under subsection (25).

(e) Anything else the association determines is necessary to advise the legislature about the operations of the association.

(27) The association does not have liability for losses occurring before July 1, 1978. After July 1, 2020, the association does not have liability for an ultimate loss under personal protection insurance coverage for a motor vehicle accident policy to which a limit under section 3107c(1)(a), (b), or (c) is applicable.

(28) As used in this section:

(a) "Association" means the catastrophic claims association created in subsection (1).

(b) "Board" means the board of directors of the association created in subsection (9).

(c) "Car" includes a motorcycle but does not include a historic vehicle.

(d) "Consumer Price Index" means the percentage of change in the Consumer Price Index for all urban consumers in the United States city average for all items for the 24 months before October 1 of the year before the July 1 effective date of the biennial adjustment under subsection (2)(o) as reported by the United States Department of Labor, Bureau of Labor Statistics, and as certified by the director.

(e) "Historic vehicle" means a vehicle that is a registered historic vehicle under section 803a or 803p of the Michigan vehicle code, 1949 PA 300, MCL 257.803a and 257.803p.

(f) "Motor vehicle accident policy" means a policy providing the coverages required under section 3101(1).

(g) "Ultimate loss" means the actual loss amounts that a member is obligated to pay and that are paid or payable by the member, and do not include claim expenses. An ultimate loss is incurred by the association on the date that the loss occurs.

Sec. 3107. (1) Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses do not include either of the following:

(*i*) Charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations, unless the injured person requires special or intensive care.

(*ii*) Funeral and burial expenses in excess of the amount set forth in the policy, which must not be less than $1,750.00 or more than $5,000.00.

(b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date on which the injured person dies. Because the benefits received from personal protection insurance for loss of income are not taxable income, the benefits payable for the loss of income must be reduced 15% unless the claimant presents to the insurer in support of his or her claim reasonable proof of a lower value of the income tax advantage in his or her case, in which case the lower value must be applied. For the period beginning October 1, 2012 through September 30, 2013, the benefits payable for work loss sustained in a single 30-day period and the income earned by an injured person for work during the same period together must not exceed $5,189.00, which maximum must be applied pro rata to any lesser period of work loss. Beginning October 1, 2013, the maximum must be adjusted annually to reflect changes in the cost of living under rules prescribed by the director, but any change in the maximum must be applied only to benefits arising out of accidents occurring after the date of change in the maximum.

(c) Expenses not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.

(2) Both of the following apply to personal protection insurance benefits payable under subsection (1):

(a) A person who is 60 years of age or older and in the event of an accidental bodily injury would not be eligible to receive work loss benefits under subsection (1)(b) may waive coverage for work loss benefits by signing a waiver on a form provided by the insurer. An insurer shall offer a reduced premium rate to a person who waives coverage under this subdivision for work loss benefits. Waiver of coverage for work loss benefits applies only to work loss benefits payable to the person or persons who have signed the waiver form.

(b) An insurer is not required to provide coverage for the medical use of marihuana or for expenses related to the medical use of marihuana.

Sec. 3107c. (1) Except as provided in sections 3107d and 3109a, and subject to subsection (5), for an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured shall, in a way required under section 3107e and on a form approved by the director, select 1 of the following coverage levels for personal protection insurance benefits under section 3107(1)(a):

(a) A limit of $50,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a). The selection of a limit under this subdivision is only available to an applicant or named insured if both of the following apply:

(*i*) The applicant or named insured is enrolled in Medicaid, as that term is defined in section 3157.

(*ii*) The applicant's or named insured's spouse and any relative of either who resides in the same household has qualified health coverage, as that term is defined in section 3107d, is enrolled in Medicaid, or has coverage for the payment of benefits under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(b) A limit of $250,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(c) A limit of $500,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(d) No limit for personal protection insurance benefits under section 3107(1)(a).

(2) The form required under subsection (1) must do all of the following:

(a) State, in a conspicuous manner, the benefits and risks associated with each coverage option.

(b) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands the options available.

(c) Allow the applicant or named insured to mark the form to make the selection of coverage level under subsection (1).

(d) Require the applicant or named insured to sign the form.

(3) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective selection under subsection (1) but a premium or premium installment has been paid, there is a rebuttable presumption that the amount of the premium or installment paid accurately reflects the level of coverage applicable to the policy under subsection (1).

(4) If an insurance policy is issued or renewed as described in subsection (1), the applicant or named insured has not made an effective selection under subsection (1), and a presumption under subsection (3) does not apply, subsection (1)(d) applies to the policy.

(5) The coverage level selected under subsection (1) applies to the named insured, the named insured's spouse, and a relative of either domiciled in the same household, and any other person with a right to claim personal protection insurance benefits under the policy.

(6) If benefits are payable under section 3107(1)(a) under 2 or more insurance policies, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any 1 of the policies.

(7) This section applies for a transportation network company vehicle, but an applicant or named insured that is a transportation network company shall only select limits under either subsection (1)(b), (c), or (d). As used in this subsection:

(a) "Transportation network company" means that term as defined in section 2 of the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2102.

(b) "Transportation network company vehicle" means that term as defined in section 3114.

(8) This section also applies to security required under section 3101(1) that is provided by a rental car company certified by the director as a self-insurer under section 3101d. The director shall provide a form for the rental car company to provide to allow a customer to make the selection of a coverage level under subsection (1)(b), (c), or (d).

(9) An insurer shall offer, for a policy that provides the security required under section 3101(1) to which a limit under subsection (1)(a) to (c) applies, a rider that will provide coverage for attendant care in excess of the applicable limit.

Sec. 3107d. (1) For an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured may, in a way required under section 3107e and on a form approved by the director, elect to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a) if the applicant or named insured is a qualified person, and if the applicant's or named insured's spouse and any relative of either that resides in the same household have qualified health coverage or have coverage for benefits payable under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(2) An applicant or named insured shall, when requesting issuance or renewal of a policy under subsection (1), provide to the insurer a document from the person that provides the qualified health coverage stating the names of all persons covered under the qualified health coverage.

(3) The form required under subsection (1) must do all of the following:

(a) Require the applicant or named insured to mark the form to certify whether all persons required to be qualified persons under subsection (1) are qualified persons.

(b) Disclose in a conspicuous manner that qualified persons are not obligated to but may purchase coverage for personal protection insurance coverage benefits payable under section 3107(1)(a).

(c) State, in a conspicuous manner, the coverage levels available under section 3107c.

(d) State, in a conspicuous manner, the benefits and risks associated with not maintaining the coverage.

(e) State, in a conspicuous manner, that if during the term of the policy the qualified health coverage ceases, the person has 30 days after the effective date of the termination of qualified health coverage to obtain insurance that provides coverage under section 3107(1)(a) or the person will be excluded from all personal protection insurance coverage benefits under section 3107(1)(a) during the period in which coverage under this section was not maintained.

(f) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands it and that he or she understands the options available to him or her.

(g) If all persons required to be qualified persons under subsection (1) are qualified persons, provide the person a way to mark the form to elect to not maintain the coverage.

(h) Require the applicant or named insured to sign the form.

(4) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective election under subsection (1), the policy is considered to provide personal protection benefits under section 3107c(1)(d).

(5) An election under this section applies to the applicant or named insured, the applicant or named insured's spouse, a relative of either domiciled in the same household, and any other person who would have had a right to claim personal protection insurance benefits under the policy but for the election.

(6) If, during the term of an insurance policy under which coverage for personal protection insurance benefits payable under section 3107(1)(a) are not maintained under this section, the persons required to have qualified health coverage under subsection (1) cease to have qualified health coverage, all of the following apply under this subsection:

(a) Within 30 days after the effective date of the termination of qualified health coverage, the named insured shall obtain insurance that includes coverage under section 3107(1)(a).

(b) An insurer that issues policies that provide the security required by section 3101(1) shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee to, or increase the insurance premiums for a person who is an eligible person, as that term is defined in section 2103, solely because the person previously failed to obtain insurance that provides coverage for benefits under section 3107(1)(a) in the time required under subdivision (a).

(c) If the applicant or named insured does not obtain insurance as required under subdivision (a) and a person to whom the election under this section applies as described in subsection (6) suffers accidental bodily injury arising from a motor vehicle accident, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury but is entitled to claim benefits under the assigned claims plan.

(8) As used in this section:

(a) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(b) "Qualified health coverage" means either of the following:

(*i*) Other health or accident coverage to which both of the following apply:

(A) The coverage does not exclude or limit coverage for injuries related to motor vehicle accidents.

(B) Any annual deductible for the coverage is $6,000.00 or less per individual. The director shall adjust the amount in this sub-subparagraph on July 1 of each year by the percentage change in the medical component of the Consumer Price Index for the preceding calendar year. However, the director shall not make the adjustment unless the adjustment, or the total of the adjustment and previous unadded adjustments, is $500.00 or more.

(*ii*) Coverage under parts A and B of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(c) "Qualified person" means a person who has qualified health coverage under subdivision (b)(*ii*).

Sec. 3107e. (1) A form under section 3009, 3107c, or 3107d must be delivered to the applicant or named insured using 1 of the following methods:

(a) Personal delivery.

(b) First-class mail, postage prepaid.

(c) Electronic means in accordance with section 2266.

(2) A person must make a selection under section 3009 or 3107c, or an election under section 3107d in 1 of the following ways:

(a) Marking and signing a paper form.

(b) Giving verbal instructions, in person or telephonically, that the form be marked and signed on behalf of the person. To be an effective selection or election, the verbal instructions must be recorded and the recording maintained by the person to whom the instructions were given. If there is a dispute over the effectiveness of a selection or election under this subdivision, there is a presumption that the selection or election was not effective and the insurer has the burden of rebutting the presumption with the recording.

(c) Electronically marking the form and providing an electronic signature as provided in the uniform electronic transactions act, 2000 PA 305, MCL 450.831 to 450.849.

Sec. 3109a. (1) An insurer that provides personal protection insurance benefits under this chapter may offer deductibles and exclusions reasonably related to other health and accident coverage on the insured. Any deductibles and exclusions offered under this section must be offered at a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both, are subject to prior approval by the director, and must apply only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

(2) An insurer shall offer to an applicant or named insured that selects a personal protection benefit limit under section 3107c(1)(b) an exclusion related to other health or accident coverage. All of the following apply to that exclusion:

(a) If the named insured, his or her spouse, and all relatives domiciled in the same household have accident and health coverage that will cover injuries that occur as the result of a motor vehicle accident, the premium for the personal protection insurance benefits payable under section 3107(1)(a) under the policy must be reduced by 100%.

(b) If a member, but not all members, of the household covered by the insurance policy has health or accident coverage that will cover injuries that occur as the result of a motor vehicle accident, the insurer shall offer a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both. The reduction must be in addition to the rate rollback required by section 2111f and the share of the premium reduction for the policy attributable to any person with accident and health coverage must be 100%.

(c) Subject to subdivision (d), a person subject to an exclusion under this subsection is not eligible for personal protection benefits under the insurance policy.

(d) If a person subject to an exclusion under this subsection is no longer covered by the health coverage, the named insured shall notify the insurer that the named insured or resident relative is no longer eligible for an exclusion. All of the following apply under this subdivision:

(*i*) The named insured shall, within 30 days after the effective date of the termination of the health coverage, obtain insurance that provides the security required under section 3101(1) that includes coverage that was excluded under this subsection.

(*ii*) During the period described in subparagraph (*i*), if any person excluded suffers accidental bodily injury arising from a motor vehicle accident, the person is entitled to claim benefits under the assigned claims plan.

(e) If the named insured does not obtain insurance that provides the security required under section 3101(1) that includes the coverage excluded under this subsection during the period described in subdivision (d)(*i*) and the named insured or any person excluded under the policy suffers accidental bodily injury arising from a motor vehicle accident, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury that occurred during the period in which coverage under this section was excluded.

(3) An automobile insurer shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance for an eligible person solely because the person previously failed to obtain insurance that provides the security required under section 3101(1) in the time period provided under subsection (2)(d)(*i*).

(4) The amount of a premium reduction under subsection (1) must appear in a conspicuous manner in the declarations for the policy, and be expressed as a dollar amount or a percentage.

Sec. 3111. Personal protection insurance benefits are payable for accidental bodily injury suffered in an accident occurring out of this state, if the accident occurs within the United States, its territories and possessions, or Canada, and the person whose injury is the basis of the claim was at the time of the accident a named insured under a personal protection insurance policy, the spouse of a named insured, a relative of either domiciled in the same household, or an occupant of a vehicle involved in the accident, if the occupant was a resident of this state or if the owner or registrant of the vehicle was insured under a personal protection insurance policy or provided security approved by the secretary of state under section 3101(4).

Sec. 3112. Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his or her death, to or for the benefit of his or her dependents. A health care provider listed in section 3157 may make a claim and assert a direct cause of action against an insurer, or under the assigned claims plan under sections 3171 to 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled to the benefits, the insurer, the claimant, or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:

(a) To the dependents of the injured person, the personal protection insurance benefits accrued before his or her death without appointment of an administrator or executor.

(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

Sec. 3113. A person is not entitled to be paid personal protection insurance benefits for accidental bodily injury if at the time of the accident any of the following circumstances existed:

(a) The person was willingly operating or willingly using a motor vehicle or motorcycle that was taken unlawfully, and the person knew or should have known that the motor vehicle or motorcycle was taken unlawfully.

(b) The person was the owner or registrant of a motor vehicle or motorcycle involved in the accident with respect to which the security required by section 3101 or 3103 was not in effect.

(c) The person was not a resident of this state, unless the person owned a motor vehicle that was registered and insured in this state.

(d) The person was operating a motor vehicle or motorcycle as to which he or she was named as an excluded operator as allowed under section 3009(2).

(e) The person was the owner or operator of a motor vehicle for which coverage was excluded under a policy exclusion authorized under section 3017.

Sec. 3114. (1) Except as provided in subsections (2), (3), and (5), a personal protection insurance policy described in section 3101(1) applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, if the injury arises from a motor vehicle accident. A personal injury insurance policy described in section 3103(2) applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, if the injury arises from a motorcycle accident. If personal protection insurance benefits or personal injury benefits described in section 3103(2) are payable to or for the benefit of an injured person under his or her own policy and would also be payable under the policy of his or her spouse, relative, or relative's spouse, the injured person's insurer shall pay all of the benefits up to the coverage level applicable under section 3107c to the injured person's policy, and is not entitled to recoupment from the other insurer.

(2) A person who suffers accidental bodily injury while an operator or a passenger of a motor vehicle operated in the business of transporting passengers shall receive the personal protection insurance benefits to which the person is entitled from the insurer of the motor vehicle. This subsection does not apply to a passenger in any of the following, unless the passenger is not entitled to personal protection insurance benefits under any other policy:

(a) A school bus, as defined by the department of education, providing transportation not prohibited by law.

(b) A bus operated by a common carrier of passengers certified by the department of transportation.

(c) A bus operating under a government sponsored transportation program.

(d) A bus operated by or providing service to a nonprofit organization.

(e) A taxicab insured as prescribed in section 3101 or 3102.

(f) A bus operated by a canoe or other watercraft, bicycle, or horse livery used only to transport passengers to or from a destination point.

(g) A transportation network company vehicle.

(h) A motor vehicle insured under a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d or as to which an exclusion under section 3109a(2) applies.

(3) An employee, his or her spouse, or a relative of either domiciled in the same household, who suffers accidental bodily injury while an occupant of a motor vehicle owned or registered by the employer, shall receive personal protection insurance benefits to which the employee is entitled from the insurer of the furnished vehicle.

(4) Except as provided in subsections (2) and (3), a person who suffers accidental bodily injury arising from a motor vehicle accident while an occupant of a motor vehicle who is not covered under a personal protection insurance policy as provided in subsection (1) shall claim personal protection insurance benefits under the assigned claims plan under sections 3171 to 3175. This subsection does not apply to a person insured under a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d or as to which an exclusion under section 3109(2) applies, or who is not entitled to be paid personal protection benefits under section 3107d(6)(c) or 3109a(2)(d)(*ii*).

(5) Subject to subsections (6) and (7), a person who suffers accidental bodily injury arising from a motor vehicle accident that shows evidence of the involvement of a motor vehicle while an operator or passenger of a motorcycle shall claim personal protection insurance benefits from insurers in the following order of priority:

(a) The insurer of the owner or registrant of the motor vehicle involved in the accident.

(b) The insurer of the operator of the motor vehicle involved in the accident.

(c) The motor vehicle insurer of the operator of the motorcycle involved in the accident.

(d) The motor vehicle insurer of the owner or registrant of the motorcycle involved in the accident.

(6) If an applicable insurance policy in an order of priority under subsection (5) is a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d, or as to which an exclusion under section 3109(2) applies, the injured person shall claim benefits only under other policies, subject to subsection (7), in the same order of priority for which no such election has been made. If there are no other policies for which no such election has been made, the injured person shall claim benefits under the next order of priority or, if there is not a next order of priority, under the assigned claims plan under sections 3171 to 3175.

(7) If personal protection insurance benefits are payable under subsection (5) under 2 or more insurance policies in the same order of priority, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any 1 of the policies.

(8) Subject to subsections (6) and (7), if 2 or more insurers are in the same order of priority to provide personal protection insurance benefits under subsection (5), an insurer that pays benefits due is entitled to partial recoupment from the other insurers in the same order of priority, and a reasonable amount of partial recoupment of the expense of processing the claim, in order to accomplish equitable distribution of the loss among all of the insurers.

(9) As used in this section:

(a) "Personal vehicle", "transportation network company digital network", and "transportation network company prearranged ride" mean those terms as defined in section 2 of the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2102.

(b) "Transportation network company vehicle" means a personal vehicle while the driver is logged on to the transportation network company digital network or while the driver is engaged in a transportation network company prearranged ride.

Sec. 3115. Except as provided in section 3114(1), a person who suffers accidental bodily injury while not an occupant of a motor vehicle shall claim personal protection insurance benefits under the assigned claims plan under sections 3171 to 3175.

Sec. 3135. (1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

(2) For a cause of action for damages under subsection (1) or (3)(d), all of the following apply:

(a) The issues of whether the injured person has suffered serious impairment of body function or permanent serious disfigurement are questions of law for the court if the court finds either of the following:

(*i*) There is no factual dispute concerning the nature and extent of the person's injuries.

(*ii*) There is a factual dispute concerning the nature and extent of the person's injuries, but the dispute is not material to the determination whether the person has suffered a serious impairment of body function or permanent serious disfigurement. However, for a closed-head injury, a question of fact for the jury is created if a licensed allopathic or osteopathic physician who regularly diagnoses or treats closed-head injuries testifies under oath that there may be a serious neurological injury.

(b) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(c) Damages must not be assessed in favor of a party who was operating his or her own vehicle at the time the injury occurred and did not have in effect for that motor vehicle the security required by section 3101(1) at the time the injury occurred.

(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:

(a) Intentionally caused harm to persons or property. Even though a person knows that harm to persons or property is substantially certain to be caused by his or her act or omission, the person does not cause or suffer that harm intentionally if he or she acts or refrains from acting for the purpose of averting injury to any person, including himself or herself, or for the purpose of averting damage to tangible property.

(b) Damages for noneconomic loss as provided and limited in subsections (1) and (2).

(c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies. The party liable for damages is entitled to an exemption reducing his or her liability by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

(d) Damages for economic loss by a nonresident. However, to recover under this subdivision, the nonresident must have suffered death, serious impairment of body function, or permanent serious disfigurement.

(e) Damages up to $3,000.00 to a motor vehicle, to the extent that the damages are not covered by insurance. An action for damages under this subdivision must be conducted as provided in subsection (4).

(4) All of the following apply to an action for damages under subsection (3)(e):

(a) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(b) Liability is not a component of residual liability, as prescribed in section 3131, for which maintenance of security is required by this act.

(c) The action must be commenced, whenever legally possible, in the small claims division of the district court or the municipal court. If the defendant or plaintiff removes the action to a higher court and does not prevail, the judge may assess costs.

(d) A decision of the court is not res judicata in any proceeding to determine any other liability arising from the same circumstances that gave rise to the action.

(e) Damages must not be assessed if the damaged motor vehicle was being operated at the time of the damage without the security required by section 3101(1).

(5) As used in this section, "serious impairment of body function" means an impairment that satisfies all of the following requirements:

(a) It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.

(b) It is an impairment of an important body function, which is a body function of great value, significance, or consequence to the injured person.

(c) It affects the injured person's general ability to lead his or her normal life, meaning it has had an influence on some of the person's capacity to live in his or her normal manner of living. Although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last. This examination is inherently fact and circumstance specific to each injured person, must be conducted on a case-by-case basis, and requires comparison of the injured person's life before and after the incident.

Sec. 3142. (1) Personal protection insurance benefits are payable as loss accrues.

(2) Subject to subsection (3), personal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained. Subject to subsection (3), if reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within

30 days after the proof is received by the insurer. Subject to subsection (3), any part of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. For the purpose of calculating the extent to which benefits are overdue, payment must be treated as made on the date a draft or other valid instrument was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(3) For personal protection insurance benefits under section 3107(1)(a), if a bill for the product, service, accommodations, or training is not provided to the insurer within 90 days after the product, service, accommodations, or training is provided, the insurer has 60 days in addition to 30 days provided under subsection (2) to pay before the benefits are overdue.

(4) An overdue payment bears simple interest at the rate of 12% per annum.

Sec. 3145. (1) An action for recovery of personal protection insurance benefits payable under this chapter for an accidental bodily injury may not be commenced later than 1 year after the date of the accident that caused the injury unless written notice of injury as provided in subsection (4) has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.

(2) Subject to subsection (3), if the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

(3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence.

(4) The notice of injury required by subsection (1) may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits for the injury, or by someone in the person's behalf. The notice must give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place, and nature of the person's injury.

(5) An action for recovery of property protection insurance benefits may not be commenced later than 1 year after the accident.

Sec. 3148. (1) Subject to subsections (4) and (5), an attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits that are overdue. The attorney's fee is a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment. An attorney advising or representing an injured person concerning a claim for payment of personal protection insurance benefits from an insurer shall not claim, file, or serve a lien for payment of a fee or fees until both of the following apply:

(a) A payment for the claim is authorized under this chapter.

(b) A payment for the claim is overdue under this chapter.

(2) A court may award an insurer a reasonable amount against a claimant as an attorney fee for the insurer's attorney in defending against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation. A court may award an insurer a reasonable amount against a claimant's attorney as an attorney fee for defending against a claim for which the client was solicited by the attorney in violation of the laws of this state or the Michigan rules of professional conduct.

(3) To the extent that personal or property protection insurance benefits are then due or thereafter come due to the claimant because of loss resulting from the injury on which the claim is based, an attorney fee awarded in favor of the insurer may be taken as an offset against the benefits. Judgment may also be entered against the claimant for any amount of an attorney fee awarded that is not offset against benefits or otherwise paid.

(4) For a dispute over payment for allowable expenses under section 3107(1)(a) for attendant care or nursing services, attorney fees must not be awarded in relation to future payments ordered more than 3 years after the trial court judgment or order is entered. If attendant care or nursing services are subsequently suspended or terminated, attorney fees on future payments may be again awarded for not more than 3 years after a new trial court judgment or order is entered.

(5) A court shall not award a fee to an attorney for advising or representing an injured person in an action for personal or property protection insurance benefits for a treatment, product, service, rehabilitative occupational training, or accommodation provided to the injured person if the attorney or a related person of the attorney has, or had at the time the treatment, product, service, rehabilitative occupational training, or accommodation was provided, a direct or indirect financial interest in the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation. For purposes of this subsection, circumstances in which an attorney has a direct or indirect

financial interest include, but are not limited to, the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation making a direct or indirect payment or granting a financial incentive to the attorney or a related person of the attorney relating to the treatment, product, service, rehabilitative occupational training, or accommodation within 24 months before or after the treatment, product, service, rehabilitative occupational training, or accommodation is provided.

Sec. 3151. (1) If the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, at the request of an insurer the person shall submit to mental or physical examination by physicians. A personal protection insurer may include reasonable provisions that are in accord with this section in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits.

(2) A physician who conducts a mental or physical examination under this section must be licensed as a physician in this state or another state and meet the following criteria, as applicable:

(a) The examining physician is a licensed, board certified, or board eligible physician qualified to practice in the area of medicine appropriate to treat the person's condition.

(b) During the year immediately preceding the examination, the examining physician must have devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of medicine and, if subdivision (a) applies, the active clinical practice relevant to the specialty.

(*ii*) The instruction of students in an accredited medical school or in an accredited residency or clinical research program for physicians and, if subdivision (a) applies, the instruction of students is in the specialty.

Sec. 3157. (1) Subject to subsections (2) to (14), a physician, hospital, clinic, or other person that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the treatment or training. The charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance.

(2) Subject to subsections (3) to (14), a physician, hospital, clinic, or other person that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is not eligible for payment or reimbursement under this chapter for more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 200% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 195% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 190% of the amount payable to the person for the treatment or training under Medicare.

(3) Subject to subsections (5) to (14), a physician, hospital, clinic, or other person identified in subsection (4) that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is eligible for payment or reimbursement under this chapter of not more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 230% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 225% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 220% of the amount payable to the person for the treatment or training under Medicare.

(4) Subject to subsection (5), subsection (3) only applies to a physician, hospital, clinic, or other person if either of the following applies to the person rendering the treatment or training:

(a) On July 1 of the year in which the person renders the treatment or training, the person has 20% or more, but less than 30%, indigent volume determined pursuant to the methodology used by the department of health and human services in determining inpatient medical/surgical factors used in measuring eligibility for Medicaid disproportionate share payments.

(b) The person is a freestanding rehabilitation facility. Each year the director shall designate not more than 2 freestanding rehabilitation facilities to qualify for payments under subsection (3) for that year. As used in this subdivision, "freestanding rehabilitation facility" means an acute care hospital to which all of the following apply:

(*i*) The hospital has staff with specialized and demonstrated rehabilitation medicine expertise.

(*ii*) The hospital possesses sophisticated technology and specialized facilities.

(*iii*) The hospital participates in rehabilitation research and clinical education.

(*iv*) The hospital assists patients to achieve excellent rehabilitation outcomes.

(*v*) The hospital coordinates necessary post-discharge services.

(*vi*) The hospital is accredited by 1 or more third-party, independent organizations focused on quality.

(*vii*) The hospital serves the rehabilitation needs of catastrophically injured patients in this state.

(*viii*) The hospital was in existence on May 1, 2019.

(5) To qualify for a payment under subsection (4)(a), a physician, hospital, clinic, or other person shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to determine whether the person qualifies. The director shall annually review documents and information provided under this subsection and, if the person qualifies under subsection (4)(a), shall certify the person as qualifying and provide a list of qualifying persons to insurers and other persons that provide the security required under section 3101(1). A physician, hospital, clinic, or other person that provides 30% or more of its total treatment or training as described under subsection (4)(a) is entitled to receive, instead of an applicable percentage under subsection (3), 250% of the amount payable to the person for the treatment or training under Medicare.

(6) Subject to subsections (7) to (14), a hospital that is a level I or level II trauma center that renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, if the treatment is for an emergency medical condition and rendered before the patient is stabilized and transferred, is not eligible for payment or reimbursement under this chapter of more than the following:

(a) For treatment rendered after July 1, 2021 and before July 2, 2022, 240% of the amount payable to the hospital for the treatment under Medicare.

(b) For treatment rendered after July 1, 2022 and before July 2, 2023, 235% of the amount payable to the hospital for the treatment under Medicare.

(c) For treatment rendered after July 1, 2023, 230% of the amount payable to the hospital for the treatment under Medicare.

(7) If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under subsection (2), (3), (5), or (6), the physician, hospital, clinic, or other person that renders the treatment or training is not eligible for payment or reimbursement under this chapter of more than the following, as applicable:

(a) For a person to which subsection (2) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

(*i*) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 55%.

(*ii*) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 54%.

(*iii*) For treatment or training rendered after July 1, 2023, 52.5%.

(b) For a person to which subsection (3) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment or training on January 1, 2019:

(*i*) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 70%.

(*ii*) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 68%.

(*iii*) For treatment or training rendered after July 1, 2023, 66.5%.

(c) For a person to which subsection (5) applies, 78% of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, 78% of the average amount the person charged for the treatment on January 1, 2019.

(d) For a person to which subsection (6) applies, the applicable following percentage of the amount payable for the treatment under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

(*i*) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 75%.

(*ii*) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 73%.

(*iii*) For treatment or training rendered after July 1, 2023, 71%.

(8) For any change to an amount payable under Medicare as provided in subsection (2), (3), (5), or (6) that occurs after the effective date of the amendatory act that added this subsection, the change must be applied to the amount

allowed for payment or reimbursement under that subsection. However, an amount allowed for payment or reimbursement under subsection (2), (3), (5), or (6) must not exceed the average amount charged by the physician, hospital, clinic, or other person for the treatment or training on January 1, 2019.

(9) An amount that is to be applied under subsection (7) or (8), that was in effect on January 1, 2019, including any prior adjustments to the amount made under this subsection, must be adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment.

(10) For attendant care rendered in the injured person's home, an insurer is only required to pay benefits for attendant care up to the hourly limitation in section 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.315. This subsection only applies if the attendant care is provided directly, or indirectly through another person, by any of the following:

(a) An individual who is related to the injured person.

(b) An individual who is domiciled in the household of the injured person.

(c) An individual with whom the injured person had a business or social relationship before the injury.

(11) An insurer may contract to pay benefits for attendant care for more than the hourly limitation under subsection (10).

(12) A neurological rehabilitation clinic is not entitled to payment or reimbursement for a treatment, training, product, service, or accommodation unless the neurological rehabilitation clinic is accredited by the Commission on Accreditation of Rehabilitation Facilities or a similar organization recognized by the director for purposes of accreditation under this subsection. This subsection does not apply to a neurological rehabilitation clinic that is in the process of becoming accredited as required under this subsection on July 1, 2021, unless 3 years have passed since the beginning of that process and the neurological rehabilitation clinic is still not accredited.

(13) Subsections (2) to (12) do not apply to emergency medical services rendered by an ambulance operation. As used in this subsection:

(a) "Ambulance operation" means that term as defined in section 20902 of the public health code, 1978 PA 368, MCL 333.20902.

(b) "Emergency medical services" means that term as defined in section 20904 of the public health code, 1978 PA 368, MCL 333.20904.

(14) Subsections (2) to (13) apply to treatment or rehabilitative occupational training rendered after July 1, 2021.

(15) As used in this section:

(a) "Charge description master" means a uniform schedule of charges represented by the person as its gross billed charge for a given service or item, regardless of payer type.

(b) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(c) "Emergency medical condition" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(d) "Level I or level II trauma center" means a hospital that is verified as a level I or level II trauma center by the American College of Surgeons Committee on Trauma.

(e) "Medicaid" means a program for medical assistance established under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5.

(f) "Medicare" means fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration.

(g) "Neurological rehabilitation clinic" means a person that provides post-acute brain and spinal rehabilitation care.

(h) "Person", as provided in section 114, includes, but is not limited to, an institution.

(i) "Stabilized" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(j) "Transfer" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(k) "Treatment" includes, but is not limited to, products, services, and accommodations.

Sec. 3157a. (1) By rendering any treatment, products, services, or accommodations to 1 or more injured persons for an accidental bodily injury covered by personal protection insurance under this chapter after July 1, 2020, a physician, hospital, clinic, or other person is considered to have agreed to do both of the following:

(a) Submit necessary records and other information concerning treatment, products, services, or accommodations provided for utilization review under this section.

(b) Comply with any decision of the department under this section.

(2) A physician, hospital, clinic, or other person or institution that knowingly submits under this section false or misleading records or other information to an insurer, the association created under section 3104, or the department commits a fraudulent insurance act under section 4503.

(3) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to do both of the following:

(a) Establish criteria or standards for utilization review that identify utilization of treatment, products, services, or accommodations under this chapter above the usual range of utilization for the treatment, products, services, or accommodations based on medically accepted standards.

(b) Provide procedures related to utilization review, including procedures for all of the following:

(*i*) Acquiring necessary records, medical bills, and other information concerning the treatment, products, services, or accommodations provided.

(*ii*) Allowing an insurer to request an explanation for and requiring a physician, hospital, clinic, or other person to explain the necessity or indication for treatment, products, services, or accommodations provided.

(*iii*) Appealing determinations.

(4) If a physician, hospital, clinic, or other person provides treatment, products, services, or accommodations under this chapter that are not usually associated with, are longer in duration than, are more frequent than, or extend over a greater number of days than the treatment, products, services, or accommodations usually require for the diagnosis or condition for which the patient is being treated, the insurer or the association created under section 3104 may require the physician, hospital, clinic, or other person to explain the necessity or indication for the treatment, products, services, or accommodations in writing under the procedures provided under subsection (3).

(5) If an insurer or the association created under section 3104 determines that a physician, hospital, clinic, or other person overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under this chapter, the physician, hospital, clinic, or other person may appeal the determination to the department under the procedures provided under subsection (3).

(6) As used in this section, "utilization review" means the initial evaluation by an insurer or the association created under section 3104 of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided under this chapter based on medically accepted standards.

Sec. 3157b. Any proprietary information or sensitive personally identifiable information regarding a patient that is submitted to the department under section 3157a is exempt from disclosure under section 13(d) of the freedom of information act, 1976 PA 442, MCL 15.243, and the department shall exempt any such information from disclosure under any other applicable exemptions under section 13 of the freedom of information act, 1976 PA 442, MCL 15.243.

Sec. 3163. An insurer authorized to transact automobile liability insurance and personal and property protection insurance in this state is not required to provide personal protection insurance or property protection insurance benefits under this chapter for accidental bodily injury or property damage occurring in this state arising from the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle by an out-of-state resident who is insured under the insurer's automobile liability insurance policies, unless the out-of-state resident is the owner of a motor vehicle that is registered and insured in this state.

Sec. 3172. (1) A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may claim personal protection insurance benefits through the assigned claims plan if any of the following apply:

(a) No personal protection insurance is applicable to the injury.

(b) No personal protection insurance applicable to the injury can be identified.

(c) No personal protection insurance applicable to the injury can be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss.

(d) The only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

(2) Unpaid benefits due or coming due as described in subsection (1) may be collected under the assigned claims plan, and the insurer to which the claim is assigned is entitled to reimbursement from the defaulting insurers to the extent of their financial responsibility.

(3) A person entitled to claim personal protection insurance benefits through the assigned claims plan under subsection (1) shall file a completed application on a claim form provided by the Michigan automobile insurance placement facility and provide reasonable proof of loss to the Michigan automobile insurance placement facility. The Michigan automobile insurance placement facility or an insurer assigned to administer a claim on behalf of the Michigan automobile

insurance placement facility under the assigned claims plan shall specify in writing the materials that constitute a reasonable proof of loss within 60 days after receipt by the Michigan automobile insurance placement facility of an application that complies with this subsection.

(4) The Michigan automobile insurance placement facility or an insurer assigned to administer a claim on behalf of the Michigan automobile insurance placement facility under the assigned claims plan is not required to pay interest in connection with a claim for any period of time during which the claim is reasonably in dispute.

(5) Except as otherwise provided in this subsection, personal protection insurance benefits, including benefits arising from accidents occurring before March 29, 1985, payable through the assigned claims plan must be reduced to the extent that benefits covering the same loss are available from other sources, regardless of the nature or number of benefit sources available and regardless of the nature or form of the benefits, to a person claiming personal protection insurance benefits through the assigned claims plan. This subsection only applies if the personal protection insurance benefits are payable through the assigned claims plan under subsection (1)(a), (b), or (d). As used in this subsection, "sources" and "benefit sources" do not include the program for medical assistance for the medically indigent under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, or health insurance for the aged and disabled under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(6) If the obligation to provide personal protection insurance benefits cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss, and if a method of voluntary payment of benefits cannot be agreed upon among or between the disputing insurers, all of the following apply:

(a) The insurers who are parties to the dispute shall, or the claimant may, immediately notify the Michigan automobile insurance placement facility of their inability to determine their statutory obligations.

(b) The Michigan automobile insurance placement facility shall assign the claim to an insurer and the insurer shall immediately provide personal protection insurance benefits to the claimant or claimants entitled to benefits.

(c) The insurer assigned the claim by the Michigan automobile insurance placement facility shall immediately commence an action on behalf of the Michigan automobile insurance placement facility in circuit court to declare the rights and duties of any interested party.

(d) The insurer to whom the claim is assigned shall join as parties defendant to the action commenced under subdivision (c) each insurer disputing either the obligation to provide personal protection insurance benefits or the equitable distribution of the loss among the insurers.

(e) The circuit court shall declare the rights and duties of any interested party whether or not other relief is sought or could be granted.

(f) After hearing the action, the circuit court shall determine the insurer or insurers, if any, obligated to provide the applicable personal protection insurance benefits and the equitable distribution, if any, among the insurers obligated, and shall order reimbursement to the Michigan automobile insurance placement facility from the insurer or insurers to the extent of the responsibility as determined by the court. The reimbursement ordered under this subdivision must include all benefits and costs paid or incurred by the Michigan automobile insurance placement facility and all benefits and costs paid or incurred by insurers determined not to be obligated to provide applicable personal protection insurance benefits, including incurred attorney fees and interest at the rate prescribed in section 3175 applicable on December 31 of the year preceding the determination of the circuit court.

(7) The Michigan automobile insurance placement facility and the insurer to whom a claim is assigned by the Michigan automobile insurance placement facility are only required to provide personal protection insurance benefits under section 3107(1)(a) up to whichever of the following is applicable:

(a) Unless subdivision (b) applies, the limit provided in section 3107c(1)(b).

(b) If the person is entitled to claim benefits under the assigned claims plan under section 3107d(6)(c) or 3109a(2)(d)(*ii*), $2,000,000.00.

Sec. 3173a. (1) The Michigan automobile insurance placement facility shall review a claim for personal protection insurance benefits under the assigned claims plan, shall make an initial determination of the eligibility for benefits under this chapter and the assigned claims plan, and shall deny a claim that the Michigan automobile insurance placement facility determines is ineligible under this chapter or the assigned claims plan. If a claimant or person making a claim through or on behalf of a claimant fails to cooperate with the Michigan automobile insurance placement facility as required by subsection (2), the Michigan automobile insurance placement facility shall suspend benefits to the claimant under the assigned claims plan. A suspension under this subsection is not an irrevocable denial of benefits, and must continue only until the Michigan automobile insurance placement facility determines that the claimant or person making a claim through or on behalf of a claimant cooperates or resumes cooperation with the Michigan automobile insurance placement facility. The Michigan automobile insurance placement facility shall promptly notify in writing the claimant and any person that submitted a claim through or on behalf of a claimant of a denial and the reasons for the denial.

(2) A claimant or a person making a claim through or on behalf of a claimant shall cooperate with the Michigan automobile insurance placement facility in its determination of eligibility and the settlement or defense of any claim or

suit, including, but not limited to, submitting to an examination under oath and compliance with sections 3151 to 3153. There is a rebuttable presumption that a person has satisfied the duty to cooperate under this section if all of the following apply:

(a) The person submitted a claim for personal protection insurance benefits under the assigned claims plan by submitting to the Michigan automobile insurance placement facility a complete application on a form provided by the Michigan automobile insurance placement facility in accordance with the assigned claims plan.

(b) The person provided reasonable proof of loss under the assigned claims plan as described in section 3172.

(c) If required under this subsection to submit to an examination under oath, the person submitted to the examination, subject to all of the following:

(*i*) The person was provided at least 21 days' notice of the examination.

(*ii*) The examination was conducted in a location reasonably convenient for the person.

(*iii*) Any reasonable request by the person to reschedule the date, time, or location of the examination was accommodated.

(3) The Michigan automobile insurance placement facility may perform its functions and responsibilities under this section and the assigned claims plan directly or through an insurer assigned by the Michigan automobile insurance placement facility to administer the claim on behalf of the Michigan automobile insurance placement facility. The assignment of a claim by the Michigan automobile insurance placement facility to an insurer is not a determination of eligibility under this chapter or the assigned claims plan, and a claim assigned to an insurer by the Michigan automobile insurance placement facility may later be denied if the claim is not eligible under this chapter or the assigned claims plan.

(4) A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan automobile insurance placement facility, or to an insurer to which the claim is assigned under the assigned claims plan, for payment or another benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 that is subject to the penalties imposed under section 4511. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment of personal protection insurance benefits under the assigned claims plan.

(5) The Michigan automobile insurance placement facility may contract with other persons for all or a portion of the goods and services necessary for operating and maintaining the assigned claims plan.

Sec. 3174. A person claiming through the assigned claims plan shall notify the Michigan automobile insurance placement facility of his or her claim within 1 year after the date of the accident. On an initial determination of a claimant's eligibility for benefits through the assigned claims plan, the Michigan automobile insurance placement facility shall promptly assign the claim in accordance with the plan and notify the claimant of the identity and address of the insurer to which the claim is assigned. An action by a claimant must be commenced as provided in section 3145.

Sec. 3175. (1) The assignment of claims under the assigned claims plan must be made according to procedures established in the assigned claims plan that assure fair allocation of the burden of assigned claims among insurers doing business in this state on a basis reasonably related to the volume of automobile liability and personal protection insurance they write on motor vehicles or the number of self-insured motor vehicles. An insurer to whom claims have been assigned shall make prompt payment of loss in accordance with this act. An insurer is entitled to reimbursement by the Michigan automobile insurance placement facility for the payments, the established loss adjustment cost, and an amount determined by use of the average annual 90-day United States treasury bill yield rate, as reported by the Council of Economic Advisers as of December 31 of the year for which reimbursement is sought, as follows:

(a) For the calendar year in which claims are paid by the insurer, the amount must be determined by applying the specified annual yield rate specified in this subsection to 1/2 of the total claims payments and loss adjustment costs.

(b) For the period from the end of the calendar year in which claims are paid by the insurer to the date payments for the operation of the assigned claims plan are due, the amount must be determined by applying the annual yield rate specified in this subsection to the total claims payments and loss adjustment costs multiplied by a fraction, the denominator of which is 365 and the numerator of which is equal to the number of days that have elapsed between the end of the calendar year and the date payments for the operation of the assigned claims plan are due.

(2) An insurer assigned a claim by the Michigan automobile insurance placement facility under the assigned claims plan or a person authorized to act on behalf of the plan may bring an action for reimbursement and indemnification of the claim on behalf of the Michigan automobile insurance placement facility. The insurer to which the claim has been assigned shall preserve and enforce rights to indemnity or reimbursement against third parties and account to the Michigan automobile insurance placement facility for the rights and shall assign the rights to the Michigan automobile insurance placement facility on reimbursement by the Michigan automobile insurance placement facility. This section does not preclude an insurer from entering into reasonable compromises and settlements with third parties against

whom rights to indemnity or reimbursement exist. The insurer shall account to the Michigan automobile insurance placement facility for any compromises and settlements. The procedures established under the assigned claims plan of operation must establish reasonable standards for enforcing rights to indemnity or reimbursement against third parties, including a standard establishing an amount below which actions to preserve and enforce the rights need not be pursued.

(3) An action to enforce rights to indemnity or reimbursement against a third party must not be commenced after the later of the following:

(a) Two years after the assignment of the claim to the insurer.

(b) One year after the date of the last payment to the claimant.

(c) One year after the date the responsible third party is identified.

(4) Payments for the operation of the assigned claims plan not paid by the due date bear interest at the rate of 20% per annum.

(5) The Michigan automobile insurance placement facility may enter into a written agreement with the debtor permitting the payment of the judgment or acknowledgment of debt in installments payable to the Michigan automobile insurance placement facility. A default in payment of installments under a judgment as agreed subjects the debtor to suspension or revocation of his or her motor vehicle license or registration in the same manner as for the failure by an uninsured motorist to pay a judgment by installments under section 3177, including responsibility for expenses as provided in section 3177(4).

Sec. 3177. (1) The insurer obligated to pay personal protection insurance benefits for accidental bodily injury to a person arising out of the ownership, maintenance, or use of an uninsured motor vehicle as a motor vehicle may recover all benefits paid, incurred loss adjustment costs and expenses, and incurred attorney fees from the owner or registrant of the uninsured motor vehicle or from his or her estate. Failure of the owner or registrant to make payment within 30 days after a judgment is entered in an action for recovery under this subsection is a ground for suspension or revocation of his or her motor vehicle registration and license as defined in section 25 of the Michigan vehicle code, 1949 PA 300, MCL 257.25. For purposes of this section, an uninsured motor vehicle is a motor vehicle with respect to which security as required by sections 3101(1) and 3102 is not in effect at the time of the accident.

(2) The Michigan automobile insurance placement facility may make a written agreement with the owner or registrant of an uninsured vehicle or his or her estate permitting the payment of a judgment described in subsection (1) in installments payable to the Michigan automobile insurance placement facility. The motor vehicle registration and license of an owner or registrant who makes a written agreement under this subsection must not be suspended or revoked and, if already suspended or revoked under subsection (1), must be restored if the payment of any installments is not in default.

(3) The secretary of state, on receipt of a certified abstract of court record of a judgment described in subsection (1) or notice from an insurer or the Michigan automobile insurance placement facility or its designee of an acknowledgment of a debt described in subsection (1), shall notify the owner or registrant of the provisions of subsection (1) at the owner or registrant's last address recorded with the secretary of state and inform the owner or registrant of the right to enter into a written agreement under this section with the Michigan automobile insurance placement facility or its designee for the payment of the judgment or debt in installments.

(4) Expenses for the suspension, revocation, or reinstatement of a motor vehicle registration or license under this section are the responsibility of the owner or registrant or of his or her estate. An owner or registrant whose registration or license is suspended under this section shall pay any reinstatement fee as required under section 320e of the Michigan vehicle code, 1949 PA 300, MCL 257.320e.

CHAPTER 31A

MANAGED CARE

Sec. 3181. As used in this chapter, "managed care option" means an optional coverage selected by an insured at the time a policy is issued that includes, but is not limited to, the monitoring and adjudication of an injured person's care, the use of a preferred provider program or other network, or other similar option.

Sec. 3182. This chapter applies to all automobile insurance whether written on an individual or group basis.

Sec. 3183. An automobile insurer may offer a managed care option that provides for allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation. This managed care option is subject to all of the following:

(a) It must be uniformly offered in all areas where the managed care option is available.

(b) It must provide a discount that reflects reasonably anticipated reductions in losses or expenses or both.

(c) It must not apply to emergency care. Emergency care includes, but is not limited to, all care necessary to the point where no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

Sec. 3184. An automobile insurer that offers a managed care option under this chapter shall also offer personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option.

Sec. 3185. The managed care option must apply to the insured who selects the managed care option and any person who resides in an area where the managed care option is available and who is claiming personal protection insurance benefits under the policy with the managed care option.

Sec. 3186. A managed care option may provide for deductibles, co-pays, or both deductibles and co-pays.

Sec. 3187. A managed care option must provide for all of the following:

(a) That personal protection insurance benefits are primary and will not be coordinated with other health and accident coverage on the individual claiming personal protection insurance benefits under the policy with the managed care option.

(b) That personal protection insurance benefits must be exhausted by the individual claiming those benefits under the policy with the managed care option before the individual may seek benefits from another health or accident coverage provider.

(c) That deductibles, co-pays, or other similar sanctions will not be assessed or collected from other health and accident coverage providers for the individual claiming personal protection insurance benefits under the policy with the managed care option.

Sec. 3188. At the time of the initial selection of the managed care option by the insured, an automobile insurer shall obtain a signed acknowledgment that the insured received a written disclosure statement approved by the director or a written disclosure statement that includes all of the following:

(a) A summary of the provisions of the managed care option.

(b) The estimated range of the percentage of the discount provided by the managed care option.

(c) A general description of the differences between a managed care option under this chapter and personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option, including any procedural differences in seeking treatment and filing a claim.

(d) The consequences for violating any provisions of the managed care option, including the possibility of a claim denial, the payment of a deductible and the amount of that deductible, and any additional out-of-pocket expenses that may be incurred.

(e) An explanation of whether the insurer offers an opt-out provision that would enable the insured to change his or her policy from a managed care option to personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option and any restrictions placed upon the insured in regard to opting out of the managed care option.

Sec. 3189. The disclosure statement under section 3188 must include a postal mailing address and either a toll-free telephone number or an internet website address that insureds or applicants for insurance may write, call, or otherwise access for information on the managed care option.

CHAPTER 63

ANTI-FRAUD UNIT

Sec. 6301. (1) An anti-fraud unit is established as a criminal justice agency in the department, dedicated to prevention and investigation of criminal and fraudulent activities in the insurance market.

(2) The anti-fraud unit is a criminal justice agency with full access to criminal justice information and criminal justice information systems. The anti-fraud unit may investigate all persons, including, but not limited to, persons subject to the department's regulatory authority, consumers, insureds, and any other persons allegedly engaged in criminal and fraudulent activities in the insurance market. The anti-fraud unit may investigate criminal and fraudulent activity related to any matter under the jurisdiction and authority of the department under Executive Reorganization Order No. 2013-1, MCL 550.991.

(3) The anti-fraud unit may do any of the following:

(a) Conduct criminal background checks on applicants for licenses and current licensees in accordance with state and federal law.

(b) Collect and maintain claims of criminal and fraudulent activities in the insurance industry.

(c) Investigate claims of criminal and fraudulent activity in the insurance market that, if true, would constitute a violation of applicable state or federal law, including, but not limited to, the Michigan penal code, 1931 PA 328, MCL 750.1 to 750.568, and this act.

(d) Maintain records of criminal investigations.

(e) Share records of its investigations with other criminal justice agencies.

(f) Review information from other criminal justice agencies to assist in the enforcement and investigation of all matters under the authority of the director.

(g) Conduct outreach and coordination efforts with local, state, and federal law enforcement and regulatory agencies to promote investigation and prosecution of criminal and fraudulent activities in the insurance market.

Sec. 6302. (1) A document, material, or information related to an investigation of the anti-fraud unit is confidential by law and privileged, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the director may use the documents, materials, or information in the furtherance of any supervisory activity or legal action brought as part of the director's duties.

(2) The director, or any person that received documents, materials, or information while acting on behalf of the anti-fraud unit, is not permitted and may not be required to testify in any private civil action concerning any confidential documents, materials, or information described in subsection (1).

(3) To assist in the performance of the anti-fraud unit's duties, the director may do any of the following:

(a) Share documents, materials, or information, including the confidential and privileged documents, materials, or information that is subject to subsection (1), with any of the following:

(*i*) Other state, federal, and international regulatory agencies.

(*ii*) Other state, federal, and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or information.

(*iii*) Any other person as the director considers necessary to discharge the anti-fraud unit's duties under section 6301 or other applicable law.

(b) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from any of the following:

(*i*) Other state, federal, and international regulatory agencies.

(*ii*) Other state, federal, and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or information.

(*iii*) Any other person as the director considers necessary to discharge his or her duties under this act or any other applicable act.

(c) Enter into agreements governing the sharing and use of information that are consistent with this section.

(4) The director shall maintain as confidential and privileged any documents, materials, or information received under subsection (3)(b) with notice or the understanding that the documents, materials, or information is confidential and privileged under the laws of the jurisdiction that is the source of the documents, materials, or information.

(5) The disclosure of any documents, materials, or information to the director, or the sharing of documents, materials, or information under subsection (3), is not a waiver of, and must not be construed as a waiver of, any privilege applicable to or claim of confidentiality in those documents, materials, or information.

Sec. 6303. (1) Beginning July 1 of the year after the effective date of the amendatory act that added this section, the anti-fraud unit shall prepare and publish an annual report to the legislature on the anti-fraud unit's efforts to prevent automobile insurance fraud.

(2) The anti-fraud unit shall submit the annual report to the legislature required by this section to the standing committees of the senate and house of representatives with primary jurisdiction over insurance issues and the director.

Sec. 6304. This chapter does not limit the power of the anti-fraud unit to conduct activities under Executive Order No. 2018-9 with respect to the financial services industry or markets.

Enacting section 1. Section 3112 of the insurance code of 1956, 1956 PA 218, MCL 500.3112, as amended by this amendatory act, applies to products, services, or accommodations provided after the effective date of this amendatory act.

Enacting section 2. Section 3135 of the insurance code of 1956, 1956 PA 218, MCL 500.3135, as amended by this amendatory act, is intended to codify and give full effect to the opinion of the Michigan supreme court in *McCormick v Carrier*, 487 Mich 180 (2010).

This act is ordered to take immediate effect.

Secretary of the Senate

Clerk of the House of Representatives

Approved .....

Governor

EXHIBIT B

Act No. 22
Public Acts of 2019
Approved by the Governor
June 11, 2019
Filed with the Secretary of State
June 11, 2019
EFFECTIVE DATE: June 11, 2019

STATE OF MICHIGAN
100TH LEGISLATURE
REGULAR SESSION OF 2019

Introduced by Reps. Sheppard, Miller, LaFave, Kahle and Bellino

ENROLLED HOUSE BILL No. 4397

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 3009, 3109a, 3111, 3116, 3135, and 3151 (MCL 500.3009, 500.3109a, 500.3111, 500.3116, 500.3135, and 500.3151), section 3009 as amended by 2016 PA 346, section 3109a as amended by 2012 PA 454, and section 3135 as amended by 2012 PA 158, and by adding sections 2111f, 3107c, and 3107d.

The People of the State of Michigan enact:

Sec. 2111f. (1) Before July 1, 2020, an insurer that offers automobile insurance in this state shall file premium rates for personal protection insurance coverage for automobile insurance policies effective after July 1, 2020.

(2) Subject to subsections (6) and (7), the premium rates filed as required by subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage under automobile insurance policies effective before July 2, 2028, must result, as nearly as practicable, in an average reduction per vehicle from the premium rates for personal protection insurance coverage that were in effect for the insurer on May 1, 2019 as follows:

(a) For policies subject to the coverage limits under section 3107c(1)(a), an average 45% or greater reduction per vehicle.

(b) For policies subject to the coverage limits under section 3107c(1)(b), an average 35% or greater reduction per vehicle.

(c) For policies subject to the coverage limits under section 3107c(1)(c), an average 20% or greater reduction per vehicle.

(d) For policies not subject to any coverage limit under section 3107c(1)(d), an average 10% or greater reduction per vehicle.

(3) For a policy under which an election under section 3107d has been made to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a), or for a policy to which an exclusion under section 3109a(2) applies, the premium rates filed under subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage, must result in no premium charge for coverage for personal protection insurance benefits payable under section 3107(1)(a).

(4) The director shall review a filing submitted by an insurer under subsections (1) to (3) for compliance with this section. Subject to subsection (7), the director shall disapprove a filing if after review the director determines that the filing does not result in the premium reductions required by subsections (2) and (3).

(5) If the director disapproves a premium rate filing under subsection (4), the insurer shall submit a revised premium rate filing to the director within 15 days after the disapproval. The premium rate filing is subject to review in the same manner as an original premium rate filing under subsection (4).

(6) For policies issued or renewed in the year beginning July 1, 2024 and in the year beginning July 1, 2026, an automobile insurer that offers automobile insurance in this state shall make filings demonstrating its compliance with this section.

(7) At any time, an insurer may apply to the director for approval to file rates that result in a lower premium reduction level or an exemption from the requirements of subsection (2) and the director shall approve the application if the rates otherwise comply with this act and compliance with the premium reductions required by subsection (2) will result in any of the following:

(a) The insurer reaching the company action level risk-based capital.

(b) A violation of the Fourteenth Amendment of the United States Constitution as to the insurer. This subdivision does not apply after July 1, 2023.

(c) A violation of section 17 of article I of the state constitution of 1963, as to deprivation of property without due process. This subdivision does not apply after July 1, 2023.

(8) An insurer shall pass on, in filings to which this section applies, savings realized from the application of section 3157(2) to (12) to treatment, products, services, accommodations, or training rendered to individuals who suffered accidental bodily injury from motor vehicle accidents that occurred before July 2, 2021. An insurer shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to evaluate the insurer's compliance with this subsection. After July 1, 2022, the director shall review all rate filings to which this section applies for compliance with this subsection.

(9) This section does not prohibit an increase for any individual insurance policy premium if the increase results from applying rating factors as approved under this chapter, including the requirements of this section.

(10) After July 1, 2020 and before July 2, 2028, an insurer shall not issue or renew an automobile insurance policy in this state unless the premium rates filed by the insurer for personal protection insurance coverage are approved under this section.

(11) For purposes of calculating a personal protection insurance premium or premium rate under this section, the premium must include the catastrophic claims assessment imposed under section 3104.

(12) If subsection (2) or the application of subsection (2) to any insurer is found to be invalid by a court, the remaining portions of the amendatory act that added this section are not severable and shall be deemed invalid and inoperable.

(13) As used in this section:

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC report, including risk-based capital instructions adopted by the National Association of Insurance Commissioners and the director.

(b) "Company action level risk-based capital" means 2 times the insurer's authorized control level RBC.

(c) "RBC report" means the report of the insurer's RBC levels as required by the annual statement instructions.

Sec. 3009. (1) Subject to subsections (5) to (8), an automobile liability or motor vehicle liability policy that insures against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle must not be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless the liability coverage is subject to all of the following limits:

(a) Before July 2, 2020, a limit, exclusive of interest and costs, of not less than $20,000.00 because of bodily injury to or death of 1 person in any 1 accident, and after July 1, 2020, a limit, exclusive of interest and costs, of not less than $250,000.00 because of bodily injury to or death of 1 person in any 1 accident.

(b) Before July 2, 2020 and subject to the limit for 1 person in subdivision (a), a limit of not less than $40,000.00 because of bodily injury to or death of 2 or more persons in any 1 accident, and after July 1, 2020, and subject to the limit for 1 person in subdivision (a), a limit of not less than $500,000.00 because of bodily injury to or death of 2 or more persons in any 1 accident.

(c) A limit of not less than $10,000.00 because of injury to or destruction of property of others in any accident.

(2) If authorized by the insured, automobile liability or motor vehicle liability coverage may be excluded when a vehicle is operated by a named person. An exclusion under this subsection is not valid unless the following notice is on the face of the policy or the declaration page or certificate of the policy and on the certificate of insurance:

Warning—when a named excluded person operates a vehicle all liability coverage is void—no one is insured. Owners of the vehicle and others legally responsible for the acts of the named excluded person remain fully personally liable.

(3) A liability policy described in subsection (1) may exclude coverage for liability as provided in section 3017.

(4) If an insurer deletes coverages from an automobile insurance policy under section 3101, the insurer shall send documentary evidence of the deletion to the insured.

(5) After July 1, 2020, an applicant for or named insured in the automobile liability or motor vehicle liability policy described in subsection (1) may choose to purchase lower limits than required under subsection (1)(a) and (b), but not lower than $50,000.00 under subsection (1)(a) and $100,000.00 under subsection (1)(b). To exercise an option under this subsection, the person shall complete a form issued by the director and provided as required by section 3107e, that meets the requirements of subsection (7).

(6) After July 1, 2020, on application for the issuance of a new policy or renewal of an existing policy, an insurer shall do all of the following:

(a) Provide the applicant or named insured the liability options available under this section.

(b) Provide the applicant or named insured a price for each option available under this section.

(c) Offer the applicant or named insured the option and form under this subsection.

(7) The form required under subsection (5) must do all of the following:

(a) State, in a conspicuous manner, the risks of choosing liability limits lower than those required by subsection (1)(a) and (b).

(b) Provide a way for the person to mark the form to acknowledge that he or she has received a list of the liability options available under this section and the price for each option.

(c) Provide a way for the person to mark the form to acknowledge that he or she has read the form and understands the risks of choosing the lower liability limits.

(d) Allow the person to sign the form.

(8) After July 1, 2020, if an insurance policy is issued or renewed as described in subsection (1) and the person named in the policy has not made an effective choice under subsection (5), the limits under subsection (1)(a) and (b) apply to the policy.

Sec. 3107c. (1) Except as provided in sections 3107d and 3109a, and subject to subsection (5), for an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured shall, in a way required under section 3107e and on a form approved by the director, select 1 of the following coverage levels for personal protection insurance benefits under section 3107(1)(a):

(a) A limit of $50,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a). The selection of a limit under this subdivision is only available to an applicant or named insured if both of the following apply:

(*i*) The applicant or named insured is enrolled in Medicaid, as that term is defined in section 3157.

(*ii*) The applicant's or named insured's spouse and any relative of either who resides in the same household has qualified health coverage, as that term is defined in section 3107d, is enrolled in Medicaid, or has coverage for the payment of benefits under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(b) A limit of $250,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(c) A limit of $500,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(d) No limit for personal protection insurance benefits under section 3107(1)(a).

(2) The form required under subsection (1) must do all of the following:

(a) State, in a conspicuous manner, the benefits and risks associated with each coverage option.

(b) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands the options available.

(c) Allow the applicant or named insured to mark the form to make the selection of coverage level under subsection (1).

(d) Require the applicant or named insured to sign the form.

(3) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective selection under subsection (1) but a premium or premium installment has been paid, there is a rebuttable presumption that the amount of the premium or installment paid accurately reflects the level of coverage applicable to the policy under subsection (1).

(4) If an insurance policy is issued or renewed as described in subsection (1), the applicant or named insured has not made an effective selection under subsection (1), and a presumption under subsection (3) does not apply, subsection (1)(d) applies to the policy.

(5) The coverage level selected under subsection (1) applies to the named insured, the named insured's spouse, and a relative of either domiciled in the same household, and any other person with a right to claim personal protection insurance benefits under the policy.

(6) If benefits are payable under section 3107(1)(a) under 2 or more insurance policies, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any 1 of the policies.

(7) This section applies for a transportation network company vehicle, but an applicant or named insured that is a transportation network company shall only select limits under either subsection (1)(b), (c), or (d). As used in this subsection:

(a) "Transportation network company" means that term as defined in section 2 of the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2102.

(b) "Transportation network company vehicle" means that term as defined in section 3114.

(8) An insurer shall offer, for a policy that provides the security required under section 3101(1) to which a limit under subsection (1)(a) to (c) applies, a rider that will provide coverage for attendant care in excess of the applicable limit.

Sec. 3107d. (1) For an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured may, in a way required under section 3107e and on a form approved by the director, elect to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a) if the applicant or named insured is a qualified person, and if the applicant's or named insured's spouse and any relative of either that resides in the same household have qualified health coverage or have coverage for benefits payable under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(2) An applicant or named insured shall, when requesting issuance or renewal of a policy under subsection (1), provide to the insurer a document from the person that provides the qualified health coverage stating the names of all persons covered under the qualified health coverage.

(3) The form required under subsection (1) must do all of the following:

(a) Require the applicant or named insured to mark the form to certify whether all persons required to be qualified persons under subsection (1) are qualified persons.

(b) Disclose in a conspicuous manner that qualified persons are not obligated to but may purchase coverage for personal protection insurance coverage benefits payable under section 3107(1)(a).

(c) State, in a conspicuous manner, the coverage levels available under section 3107c.

(d) State, in a conspicuous manner, the benefits and risks associated with not maintaining the coverage.

(e) State, in a conspicuous manner, that if during the term of the policy the qualified health coverage ceases, the person has 30 days after the effective date of the termination of qualified health coverage to obtain insurance that provides coverage under section 3107(1)(a) or the person will be excluded from all personal protection insurance coverage benefits under section 3107(1)(a) during the period in which coverage under this section was not maintained.

(f) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands it and that he or she understands the options available to him or her.

(g) If all persons required to be qualified persons under subsection (1) are qualified persons, provide the person a way to mark the form to elect to not maintain the coverage.

(h) Require the applicant or named insured to sign the form.

(4) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective election under subsection (1), the policy is considered to provide personal protection benefits under section 3107c(1)(d).

(5) An election under this section applies to the applicant or named insured, the applicant or named insured's spouse, a relative of either domiciled in the same household, and any other person who would have had a right to claim personal protection insurance benefits under the policy but for the election.

(6) If, during the term of an insurance policy under which coverage for personal protection insurance benefits payable under section 3107(1)(a) are not maintained under this section, the persons required to have qualified health coverage under subsection (1) cease to have qualified health coverage, all of the following apply under this subsection:

(a) Within 30 days after the effective date of the termination of qualified health coverage, the named insured shall obtain insurance that includes coverage under section 3107(1)(a).

(b) An insurer that issues policies that provide the security required by section 3101(1) shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee to, or increase the insurance premiums for a person who is an eligible person, as that term is defined in section 2103, solely because the person previously failed to obtain insurance that provides coverage for benefits under section 3107(1)(a) in the time required under subdivision (a).

(c) If the applicant or named insured does not obtain insurance as required under subdivision (a) and a person to whom the election under this section applies as described in subsection (5) suffers accidental bodily injury arising from a motor vehicle accident within the 30-day period, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury but is entitled to claim benefits under the assigned claims plan.

(7) As used in this section:

(a) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(b) "Qualified health coverage" means either of the following:

(*i*) Other health or accident coverage to which both of the following apply:

(A) The coverage does not exclude or limit coverage for injuries related to motor vehicle accidents.

(B) Any annual deductible for the coverage is $6,000.00 or less per individual. The director shall adjust the amount in this sub-subparagraph on July 1 of each year by the percentage change in the medical component of the Consumer Price Index for the preceding calendar year. However, the director shall not make the adjustment unless the adjustment, or the total of the adjustment and previous unadded adjustments, is $500.00 or more.

(*ii*) Coverage under parts A and B of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(c) "Qualified person" means a person who has qualified health coverage under subdivision (b)(*ii*).

Sec. 3109a. (1) An insurer that provides personal protection insurance benefits under this chapter may offer deductibles and exclusions reasonably related to other health and accident coverage on the insured. Any deductibles and exclusions offered under this section must be offered at a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both, are subject to prior approval by the director, and must apply only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

(2) For an insurance policy issued or renewed after July 1, 2020, the insurer shall offer to an applicant or named insured that selects a personal protection benefit limit under section 3107c(1)(b) an exclusion related to qualified health coverage. All of the following apply to that exclusion:

(a) If the named insured has qualified health coverage as defined in section 3107d(7)(b)(*i*) that will cover injuries that occur as the result of a motor vehicle accident and if the named insured's spouse and any relatives of either the named insured or the spouse domiciled in the same household have qualified health coverage that will cover injuries that occur as the result of a motor vehicle accident, the premium for the personal protection insurance benefits payable under section 3107(1)(a) under the policy must be reduced by 100%.

(b) If a member, but not all members, of the household covered by the insurance policy has qualified health coverage that will cover injuries that occur as the result of a motor vehicle accident, the insurer shall offer a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both. The reduction must be in addition to the rate rollback required by section 2111f and the share of the premium reduction for the policy attributable to any person with qualified health coverage must be 100%.

(c) Subject to subdivision (d), a person subject to an exclusion under this subsection is not eligible for personal protection benefits under the insurance policy.

(d) If a person subject to an exclusion under this subsection is no longer covered by the qualified health coverage, the named insured shall notify the insurer that the named insured or resident relative is no longer eligible for an exclusion. All of the following apply under this subdivision:

(*i*) The named insured shall, within 30 days after the effective date of the termination of the qualified health coverage, obtain insurance that provides the security required under section 3101(1) that includes coverage that was excluded under this subsection.

(*ii*) During the period described in subparagraph (*i*), if any person excluded suffers accidental bodily injury arising from a motor vehicle accident, the person is entitled to claim benefits under the assigned claims plan.

(e) If the named insured does not obtain insurance that provides the security required under section 3101(1) that includes the coverage excluded under this subsection during the period described in subdivision (d)(*i*) and the named insured or any person excluded under the policy suffers accidental bodily injury arising from a motor vehicle accident, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury that occurred during the period in which coverage under this section was excluded.

(3) An automobile insurer shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance for an eligible person, as that term is defined in section 2103, solely because the person previously failed to obtain insurance that provides the security required under section 3101(1) in the time period provided under subsection (2)(d)(*i*).

(4) The amount of a premium reduction under subsection (1) must appear in a conspicuous manner in the declarations for the policy, and be expressed as a dollar amount or a percentage.

(5) As used in this section, "qualified health coverage" means that term as defined in section 3107d.

Sec. 3111. Personal protection insurance benefits are payable for accidental bodily injury suffered in an accident occurring out of this state, if the accident occurs within the United States, its territories and possessions, or Canada, and the person whose injury is the basis of the claim was at the time of the accident a named insured under a personal protection insurance policy, the spouse of a named insured, a relative of either domiciled in the same household, or an occupant of a vehicle involved in the accident, if the occupant was a resident of this state or if the owner or registrant of the vehicle was insured under a personal protection insurance policy or provided security approved by the secretary of state under section 3101(5).

Sec. 3116. (1) A subtraction from personal protection insurance benefits must not be made because of the value of a claim in tort based on the same accidental bodily injury.

(2) A subtraction from or reimbursement for personal protection insurance benefits paid or payable under this chapter may be made only if recovery is realized on a tort claim arising from an accident that occurred outside this state, a tort claim brought in this state against the owner or operator of a motor vehicle with respect to which the security required by section 3101 was not in effect, or a tort claim brought in this state based on intentionally caused harm to persons or property, and may be made only to the extent that the recovery realized by the claimant is for damages for which the claimant has received or would otherwise be entitled to receive personal protection insurance benefits. A subtraction may be made only to the extent of the recovery, exclusive of reasonable attorney fees and other reasonable expenses incurred in effecting the recovery. If personal protection insurance benefits have already been received, the claimant shall repay to the insurers out of the recovery an amount equal to the benefits received, but not more than the recovery exclusive of reasonable attorney fees and other reasonable expenses incurred in effecting the recovery. The insurer has a lien on the recovery to this extent. A recovery by an injured person or his or her estate for loss suffered by the person may not be subtracted in calculating benefits due a dependent after the death and a recovery by a dependent for loss suffered by the dependent after the death may not be subtracted in calculating benefits due the injured person.

(3) A personal protection insurer with a right of reimbursement under subsection (1), if suffering loss from inability to collect reimbursement out of a payment received by a claimant on a tort claim, is entitled to indemnity from a person who, with notice of the insurer's interest, made the payment to the claimant without making the claimant and the insurer joint payees as their interests may appear or without obtaining the insurer's consent to a different method of payment.

(4) A subtraction or reimbursement is not due the claimant's insurer from that portion of any recovery to the extent that recovery is realized for noneconomic loss as provided in section 3135(1) and (2)(b) or for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110 in excess of the amount recovered by the claimant from his or her insurer.

Sec. 3135. (1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

(2) For a cause of action for damages under subsection (1) or (3)(d), all of the following apply:

(a) The issues of whether the injured person has suffered serious impairment of body function or permanent serious disfigurement are questions of law for the court if the court finds either of the following:

(*i*) There is no factual dispute concerning the nature and extent of the person's injuries.

(*ii*) There is a factual dispute concerning the nature and extent of the person's injuries, but the dispute is not material to the determination whether the person has suffered a serious impairment of body function or permanent serious disfigurement. However, for a closed-head injury, a question of fact for the jury is created if a licensed allopathic or osteopathic physician who regularly diagnoses or treats closed-head injuries testifies under oath that there may be a serious neurological injury.

(b) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(c) Damages must not be assessed in favor of a party who was operating his or her own vehicle at the time the injury occurred and did not have in effect for that motor vehicle the security required by section 3101(1) at the time the injury occurred.

(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:

(a) Intentionally caused harm to persons or property. Even though a person knows that harm to persons or property is substantially certain to be caused by his or her act or omission, the person does not cause or suffer that harm intentionally if he or she acts or refrains from acting for the purpose of averting injury to any person, including himself or herself, or for the purpose of averting damage to tangible property.

(b) Damages for noneconomic loss as provided and limited in subsections (1) and (2).

(c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies. The party liable for damages is entitled to an exemption reducing his or her liability by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

(d) Damages for economic loss by a nonresident. However, to recover under this subdivision, the nonresident must have suffered death, serious impairment of body function, or permanent serious disfigurement.

(e) Damages up to $1,000.00 to a motor vehicle or, for motor vehicle accidents that occur after July 1, 2020, up to $3,000.00 to a motor vehicle, to the extent that the damages are not covered by insurance. An action for damages under this subdivision must be conducted as provided in subsection (4).

(4) All of the following apply to an action for damages under subsection (3)(e):

(a) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(b) Liability is not a component of residual liability, as prescribed in section 3131, for which maintenance of security is required by this act.

(c) The action must be commenced, whenever legally possible, in the small claims division of the district court or the municipal court. If the defendant or plaintiff removes the action to a higher court and does not prevail, the judge may assess costs.

(d) A decision of the court is not res judicata in any proceeding to determine any other liability arising from the same circumstances that gave rise to the action.

(e) Damages must not be assessed if the damaged motor vehicle was being operated at the time of the damage without the security required by section 3101(1).

(5) As used in this section, "serious impairment of body function" means an impairment that satisfies all of the following requirements:

(a) It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.

(b) It is an impairment of an important body function, which is a body function of great value, significance, or consequence to the injured person.

(c) It affects the injured person's general ability to lead his or her normal life, meaning it has had an influence on some of the person's capacity to live in his or her normal manner of living. Although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last. This examination is inherently fact and circumstance specific to each injured person, must be conducted on a case-by-case basis, and requires comparison of the injured person's life before and after the incident.

Sec. 3151. (1) If the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, at the request of an insurer the person shall submit to mental or physical examination by physicians. A personal protection insurer may include reasonable provisions that are in accord with this section in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits.

(2) A physician who conducts a mental or physical examination under this section must be licensed as a physician in this state or another state and meet the following criteria, as applicable:

(a) If care is being provided to the person to be examined by a specialist, the examining physician must specialize in the same specialty as the physician providing the care, and if the physician providing the care is board certified in the specialty, the examining physician must be board certified in that specialty.

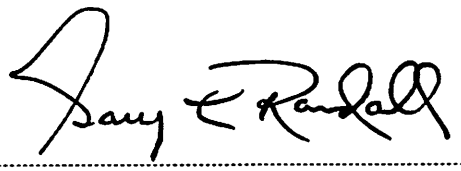
(b) During the year immediately preceding the examination, the examining physician must have devoted a majority of his or her professional time to either or both of the following:

(*i*) The active clinical practice of medicine and, if subdivision (a) applies, the active clinical practice relevant to the specialty.

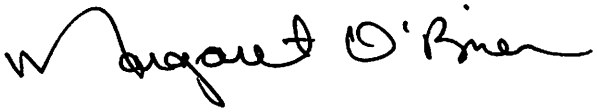
(*ii*) The instruction of students in an accredited medical school or in an accredited residency or clinical research program for physicians and, if subdivision (a) applies, the instruction of students is in the specialty.

Enacting section 1. Section 3135 of the insurance code of 1956, 1956 PA 218, MCL 500.3135, as amended by this amendatory act, is intended to codify and give full effect to the opinion of the Michigan supreme court in *McCormick v Carrier*, 487 Mich 180 (2010).

This act is ordered to take immediate effect.



Clerk of the House of Representatives



Secretary of the Senate

Approved .....

.....
Governor

EXHIBIT C

SUBSTITUTE FOR

SENATE BILL NO. 1

As amended May 7, 2019

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 150, 2105, 2108, 2118, 2120, 3101, 3101a, 3104, 3107,

3111, 3112, 3113, 3114, 3115, 3135, 3142, 3148, 3157, 3163, 3172,

3173a, 3174, 3175, and 3177 (MCL 500.150, MCL 500.2105, MCL 500.2108, 500.2118, 500.2120,

500.3101, 500.3101a, 500.3104, 500.3107, 500.3111, 500.3112,

500.3113, 500.3114, 500.3115, 500.3135, 500.3142, 500.3148,

500.3157, 500.3163, 500.3172, 500.3173a, 500.3174, 500.3175, and

500.3177), section 150 as amended by 1992 PA 182, section 2108 as amended by 2015 PA 141, sections 2118 and

2120 as amended by 2007 PA 35, section 3101 as amended by 2017 PA

140, section 3101a as amended by 2018 PA 510, section 3104 as

amended by 2002 PA 662, section 3107 as amended by 2012 PA 542,

section 3113 as amended by 2016 PA 346, section 3114 as amended by

2016 PA 347, section 3135 as amended by 2012 PA 158, section 3163

Sec. 3157. (1) ~~A~~ **SUBJECT TO SUBSECTIONS (2), (3), AND (5), A PERSON, INCLUDING, BUT NOT LIMITED TO, A** physician, hospital, clinic, or other ~~person or~~ institution, **THAT** lawfully ~~rendering~~ **RENDERS** treatment, **PRODUCTS, SERVICES, OR ACCOMMODATIONS** to an injured person for an accidental bodily injury covered by personal protection insurance, ~~and a person or institution providing~~ **OR THAT PROVIDES** rehabilitative occupational training **TO THE INJURED PERSON** following the injury, may charge a reasonable amount for the **TREATMENT, TRAINING,** products, services, and accommodations. ~~rendered.~~ The charge ~~shall~~ **MUST** not exceed the amount the person ~~or institution~~ customarily charges for like **TREATMENT, TRAINING,** products, services, and accommodations in cases ~~not involving~~ **THAT DO NOT INVOLVE PERSONAL PROTECTION** insurance.

(2) A PERSON THAT RENDERS A TREATMENT, TRAINING, PRODUCT, SERVICE, OR ACCOMMODATION TO AN INJURED PERSON FOR AN ACCIDENTAL BODILY INJURY IS NOT ELIGIBLE FOR PAYMENT OR REIMBURSEMENT UNDER THIS CHAPTER OF MORE THAN THE AMOUNT PAYABLE FOR THE TREATMENT, TRAINING, PRODUCT, SERVICE, OR ACCOMMODATION UNDER R 418.10101 TO R 418.101503 OF THE MICHIGAN ADMINISTRATIVE CODE OR SCHEDULES OF MAXIMUM FEES FOR WORKER'S COMPENSATION DEVELOPED UNDER THOSE RULES, IN EFFECT ON THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION. THE DIRECTOR SHALL REVIEW ANY CHANGES TO R 418.10101 TO R 418.101503 OF THE MICHIGAN ADMINISTRATIVE CODE OR SCHEDULES OF MAXIMUM FEES FOR WORKER'S COMPENSATION DEVELOPED UNDER THOSE RULES. IF THE DIRECTOR DETERMINES THAT THE CHANGES ARE REASONABLE AND APPROPRIATE FOR PURPOSES OF ASSURING AFFORDABLE AUTOMOBILE INSURANCE IN THIS STATE, THE CHANGES APPLY FOR PURPOSES

OF THIS SUBSECTION AND THE DIRECTOR SHALL ISSUE AN ORDER TO THAT EFFECT.

(3) FOR ATTENDANT CARE RENDERED IN THE INJURED PERSON'S HOME, AN INSURER IS ONLY REQUIRED TO PAY BENEFITS FOR ATTENDANT CARE UP TO THE HOURLY LIMITATION IN SECTION 315 OF THE WORKER'S DISABILITY COMPENSATION ACT OF 1969, 1969 PA 317, MCL 418.315. THIS SUBSECTION APPLIES IF THE ATTENDANT CARE IS PROVIDED DIRECTLY, OR INDIRECTLY THROUGH ANOTHER PERSON, BY ANY OF THE FOLLOWING:

(A) AN INDIVIDUAL WHO IS RELATED TO THE INJURED PERSON.

(B) AN INDIVIDUAL WHO IS DOMICILED IN THE HOUSEHOLD OF THE INJURED PERSON.

(C) AN INDIVIDUAL WITH WHOM THE INJURED PERSON HAD A BUSINESS OR SOCIAL RELATIONSHIP BEFORE THE INJURY.

(4) AN INSURER MAY CONTRACT TO PAY BENEFITS FOR ATTENDANT CARE FOR MORE THAN THE HOURLY LIMITATION UNDER SUBSECTION (3).

(5) IF R 418.10101 TO R 418.101503 OF THE MICHIGAN ADMINISTRATIVE CODE OR SCHEDULES OF MAXIMUM FEES FOR WORKER'S COMPENSATION DEVELOPED UNDER THOSE RULES, IN EFFECT ON THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION, INCLUDING ANY CHANGES APPLICABLE UNDER SUBSECTION (2), DO NOT PROVIDE AN AMOUNT PAYABLE FOR TREATMENT, TRAINING, PRODUCT, SERVICE, OR ACCOMMODATION RENDERED TO AN INJURED PERSON FOR ACCIDENTAL BODILY INJURY COVERED BY PERSONAL PROTECTION INSURANCE OR REHABILITATIVE OCCUPATIONAL TRAINING TO THE INJURED PERSON FOLLOWING THE INJURY, THE PERSON THAT RENDERS THE TREATMENT, PRODUCT, SERVICE, OR ACCOMMODATION IS NOT ELIGIBLE FOR PAYMENT OR REIMBURSEMENT UNDER THIS CHAPTER OF MORE THAN THE AVERAGE AMOUNT

ACCEPTED BY THE PERSON AS PAYMENT OR REIMBURSEMENT IN FULL FOR THE TREATMENT, TRAINING, PRODUCT, SERVICE, OR ACCOMMODATION DURING THE PRECEDING CALENDAR YEAR IN CASES THAT DO NOT INVOLVE PERSONAL PROTECTION INSURANCE.

(6) SUBSECTIONS (2) TO (5) APPLY TO A TREATMENT, TRAINING, PRODUCT, SERVICE, OR ACCOMMODATION RENDERED AFTER THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION, REGARDLESS OF WHEN THE ACCIDENTAL BODILY INJURY OCCURRED. SUBSECTIONS (2) TO (5) APPLY REGARDLESS OF WHETHER INDEMNIFICATION FOR THE CHARGE IS BEING MADE BY THE CATASTROPHIC CLAIMS ASSOCIATION UNDER SECTION 3104.

SEC. 3157A. (1) BY RENDERING ANY TREATMENT, PRODUCTS, SERVICES, OR ACCOMMODATIONS TO 1 OR MORE INJURED PERSONS FOR AN ACCIDENTAL BODILY INJURY COVERED BY PERSONAL PROTECTION INSURANCE UNDER THIS CHAPTER AFTER THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SECTION, A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON IS CONSIDERED TO HAVE AGREED TO DO BOTH OF THE FOLLOWING:

(A) SUBMIT NECESSARY RECORDS AND OTHER INFORMATION CONCERNING TREATMENT, PRODUCTS, SERVICES, OR ACCOMMODATIONS PROVIDED FOR UTILIZATION REVIEW UNDER THIS SECTION.

(B) COMPLY WITH ANY DECISION OF THE DEPARTMENT UNDER THIS SECTION.

(2) A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON OR INSTITUTION THAT KNOWINGLY SUBMITS FALSE OR MISLEADING RECORDS OR OTHER INFORMATION TO AN INSURER, THE ASSOCIATION CREATED UNDER SECTION 3104, OR THE DEPARTMENT UNDER THIS SECTION IS GUILTY OF A MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR NOT MORE THAN 1 YEAR OR

EXHIBIT D

HOUSE SUBSTITUTE FOR

SENATE BILL NO. 1

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 150, 224, 1244, 2038, 2040, 2069, 2105, 2106, 2108, 2111, 2118, 2120, 2151, 3009, 3101, 3101a, 3104, 3107, 3109a, 3111, 3112, 3113, 3114, 3115, 3135, 3142, 3145, 3148, 3151, 3157, 3163, 3172, 3173a, 3174, 3175, and 3177 (MCL 500.150, 500.224, 500.1244, 500.2038, 500.2040, 500.2069, 500.2105, 500.2106, 500.2108, 500.2111, 500.2118, 500.2120, 500.2151, 500.3009, 500.3101, 500.3101a, 500.3104, 500.3107, 500.3109a, 500.3111, 500.3112, 500.3113, 500.3114, 500.3115, 500.3135, 500.3142, 500.3145, 500.3148, 500.3151, 500.3157, 500.3163, 500.3172, 500.3173a, 500.3174, 500.3175, and 500.3177), section 150 as amended by 1992 PA 182, section 224 as amended by 2007 PA 187, section 1244 as amended by 2001 PA 228, section 2069 as amended by

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(B) DURING THE YEAR IMMEDIATELY PRECEDING THE EXAMINATION, THE EXAMINING PHYSICIAN MUST HAVE DEVOTED A MAJORITY OF HIS OR HER PROFESSIONAL TIME TO EITHER OR BOTH OF THE FOLLOWING:

(*i*) THE ACTIVE CLINICAL PRACTICE OF MEDICINE AND, IF SUBDIVISION (A) APPLIES, THE ACTIVE CLINICAL PRACTICE [RELEVANT TO] THE SPECIALTY.

(*ii*) THE INSTRUCTION OF STUDENTS IN AN ACCREDITED MEDICAL SCHOOL OR IN AN ACCREDITED RESIDENCY OR CLINICAL RESEARCH PROGRAM FOR PHYSICIANS AND, IF SUBDIVISION (A) APPLIES, THE INSTRUCTION OF STUDENTS IS IN THE SPECIALTY.

Sec. 3157. **(1)** ~~A~~ **SUBJECT TO SUBSECTIONS (2) TO (14), A** physician, hospital, clinic, or other person ~~or institution~~ **THAT** lawfully ~~rendering~~ **RENDERS** treatment to an injured person for an accidental bodily injury covered by personal protection insurance, ~~and~~ **OR** a person ~~or institution providing~~ **THAT PROVIDES** rehabilitative occupational training following the injury, may charge a reasonable amount for the ~~products, services and accommodations rendered.~~ **TREATMENT OR TRAINING.** The charge ~~shall~~ **MUST** not exceed the amount the person ~~or institution~~ customarily charges for like ~~products, services and accommodations~~ **TREATMENT OR TRAINING** in cases **THAT DO** not ~~involving~~ **INVOLVE** insurance.

(2) SUBJECT TO SUBSECTIONS (3) TO (14), A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON THAT RENDERS TREATMENT OR REHABILITATIVE OCCUPATIONAL TRAINING TO AN INJURED PERSON FOR AN ACCIDENTAL BODILY INJURY COVERED BY PERSONAL PROTECTION INSURANCE IS NOT ELIGIBLE FOR

PAYMENT OR REIMBURSEMENT UNDER THIS CHAPTER FOR MORE THAN THE FOLLOWING:

(A) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2021 AND BEFORE JULY 2, 2022, 200% OF THE AMOUNT PAYABLE TO THE PERSON FOR THE TREATMENT OR TRAINING UNDER MEDICARE.

(B) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2022 AND BEFORE JULY 2, 2023, 195% OF THE AMOUNT PAYABLE TO THE PERSON FOR THE TREATMENT OR TRAINING UNDER MEDICARE.

(C) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2023, 190% OF THE AMOUNT PAYABLE TO THE PERSON FOR THE TREATMENT OR TRAINING UNDER MEDICARE.

(3) SUBJECT TO SUBSECTIONS (5) TO (14), A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON IDENTIFIED IN SUBSECTION (4) THAT RENDERS TREATMENT OR REHABILITATIVE OCCUPATIONAL TRAINING TO AN INJURED PERSON FOR AN ACCIDENTAL BODILY INJURY COVERED BY PERSONAL PROTECTION INSURANCE IS ELIGIBLE FOR PAYMENT OR REIMBURSEMENT UNDER THIS CHAPTER OF NOT MORE THAN THE FOLLOWING:

(A) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2021 AND BEFORE JULY 2, 2022, 230% OF THE AMOUNT PAYABLE TO THE PERSON FOR THE TREATMENT OR TRAINING UNDER MEDICARE.

(B) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2022 AND BEFORE JULY 2, 2023, 225% OF THE AMOUNT PAYABLE TO THE PERSON FOR THE TREATMENT OR TRAINING UNDER MEDICARE.

(C) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2023, 220% OF THE AMOUNT PAYABLE TO THE PERSON FOR THE TREATMENT OR TRAINING UNDER MEDICARE.

(4) SUBJECT TO SUBSECTION (5), SUBSECTION (3) ONLY APPLIES TO

A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON IF EITHER OF THE FOLLOWING APPLIES TO THE PERSON RENDERING THE TREATMENT OR TRAINING:

(A) ON JULY 1 OF THE YEAR IN WHICH THE PERSON RENDERS THE TREATMENT OR TRAINING, THE PERSON HAS 20% OR MORE, BUT LESS THAN 30%, INDIGENT VOLUME DETERMINED PURSUANT TO THE METHODOLOGY USED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IN DETERMINING INPATIENT MEDICAL/SURGICAL FACTORS USED IN MEASURING ELIGIBILITY FOR MEDICAID DISPROPORTIONATE SHARE PAYMENTS.

(B) THE PERSON IS A FREESTANDING REHABILITATION FACILITY. EACH YEAR THE DIRECTOR SHALL DESIGNATE NOT MORE THAN 2 FREESTANDING REHABILITATION FACILITIES TO QUALIFY FOR PAYMENTS UNDER SUBSECTION (3) FOR THAT YEAR. AS USED IN THIS SUBDIVISION, "FREESTANDING REHABILITATION FACILITY" MEANS AN ACUTE CARE HOSPITAL TO WHICH ALL OF THE FOLLOWING APPLY:

(*i*) THE HOSPITAL HAS STAFF WITH SPECIALIZED AND DEMONSTRATED REHABILITATION MEDICINE EXPERTISE.

(*ii*) THE HOSPITAL POSSESSES SOPHISTICATED TECHNOLOGY AND SPECIALIZED FACILITIES.

(*iii*) THE HOSPITAL PARTICIPATES IN REHABILITATION RESEARCH AND CLINICAL EDUCATION.

(*iv*) THE HOSPITAL ASSISTS PATIENTS TO ACHIEVE EXCELLENT REHABILITATION OUTCOMES.

(*v*) THE HOSPITAL COORDINATES NECESSARY POST-DISCHARGE SERVICES.

(*vi*) THE HOSPITAL IS ACCREDITED BY 1 OR MORE THIRD-PARTY, INDEPENDENT ORGANIZATIONS FOCUSED ON QUALITY.

(*vii*) THE HOSPITAL SERVES THE REHABILITATION NEEDS OF CATASTROPHICALLY INJURED PATIENTS IN THIS STATE.

(*viii*) THE HOSPITAL WAS IN EXISTENCE ON MAY 1, 2019.

(5) TO QUALIFY FOR A PAYMENT UNDER SUBSECTION (4)(A) [ ], A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON SHALL PROVIDE THE DIRECTOR WITH ALL DOCUMENTS AND INFORMATION REQUESTED BY THE DIRECTOR THAT THE DIRECTOR DETERMINES ARE NECESSARY TO ALLOW THE DIRECTOR TO DETERMINE WHETHER THE PERSON QUALIFIES. THE DIRECTOR SHALL ANNUALLY REVIEW DOCUMENTS AND INFORMATION PROVIDED UNDER THIS SUBSECTION AND, IF THE PERSON QUALIFIES UNDER SUBSECTION (4)(A) [ ], SHALL CERTIFY THE PERSON AS QUALIFYING AND PROVIDE A LIST OF QUALIFYING PERSONS TO INSURERS AND OTHER PERSONS THAT PROVIDE THE SECURITY REQUIRED UNDER SECTION 3101(1). A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON THAT PROVIDES 30% OR MORE OF ITS TOTAL TREATMENT OR TRAINING AS DESCRIBED UNDER SUBSECTION (4)(A) [ ] IS ENTITLED TO RECEIVE, INSTEAD OF AN APPLICABLE PERCENTAGE UNDER SUBSECTION (3), 250% OF THE AMOUNT PAYABLE TO THE PERSON FOR THE TREATMENT OR TRAINING UNDER MEDICARE.

(6) SUBJECT TO SUBSECTIONS (7) TO (14), A HOSPITAL THAT IS A LEVEL I OR LEVEL II TRAUMA CENTER THAT RENDERS TREATMENT TO AN INJURED PERSON FOR AN ACCIDENTAL BODILY INJURY COVERED BY PERSONAL PROTECTION INSURANCE, IF THE TREATMENT IS FOR AN EMERGENCY MEDICAL CONDITION AND RENDERED BEFORE THE PATIENT IS STABILIZED AND TRANSFERRED, IS NOT ELIGIBLE FOR PAYMENT OR REIMBURSEMENT UNDER THIS CHAPTER OF MORE THAN THE FOLLOWING:

(A) FOR TREATMENT RENDERED AFTER JULY 1, 2021 AND BEFORE JULY 2, 2022, 240% OF THE AMOUNT PAYABLE TO THE HOSPITAL FOR THE

TREATMENT UNDER MEDICARE.

(B) FOR TREATMENT RENDERED AFTER JULY 1, 2022 AND BEFORE JULY 2, 2023, 235% OF THE AMOUNT PAYABLE TO THE HOSPITAL FOR THE TREATMENT UNDER MEDICARE.

(C) FOR TREATMENT RENDERED AFTER JULY 1, 2023, 230% OF THE AMOUNT PAYABLE TO THE HOSPITAL FOR THE TREATMENT UNDER MEDICARE.

(7) IF MEDICARE DOES NOT PROVIDE AN AMOUNT PAYABLE FOR A TREATMENT OR REHABILITATIVE OCCUPATIONAL TRAINING UNDER SUBSECTION (2), (3),[(5),] OR (6), THE PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON THAT RENDERS THE TREATMENT OR TRAINING IS NOT ELIGIBLE FOR PAYMENT OR REIMBURSEMENT UNDER THIS CHAPTER OF MORE THAN THE FOLLOWING, AS APPLICABLE:

(A) FOR A PERSON TO WHICH SUBSECTION (2) APPLIES, THE APPLICABLE FOLLOWING PERCENTAGE OF THE AMOUNT PAYABLE FOR THE TREATMENT OR TRAINING UNDER THE PERSON'S CHARGE DESCRIPTION MASTER IN EFFECT ON JANUARY 1, 2019 OR, IF THE PERSON DID NOT HAVE A CHARGE DESCRIPTION MASTER ON THAT DATE, THE APPLICABLE FOLLOWING PERCENTAGE OF THE AVERAGE AMOUNT THE PERSON CHARGED FOR THE TREATMENT ON JANUARY 1, 2019:

(*i*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2021 AND BEFORE JULY 2, 2022, 55%.

(*ii*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2022 AND BEFORE JULY 2, 2023, 54%.

(*iii*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2023, 52.5%.

(B) FOR A PERSON TO WHICH SUBSECTION (3) APPLIES, THE APPLICABLE FOLLOWING PERCENTAGE OF THE AMOUNT PAYABLE FOR THE

TREATMENT OR TRAINING UNDER THE PERSON'S CHARGE DESCRIPTION MASTER IN EFFECT ON JANUARY 1, 2019 OR, IF THE PERSON DID NOT HAVE A CHARGE DESCRIPTION MASTER ON THAT DATE, THE APPLICABLE FOLLOWING PERCENTAGE OF THE AVERAGE AMOUNT THE PERSON CHARGED FOR THE TREATMENT OR TRAINING ON JANUARY 1, 2019:

(*i*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2021 AND BEFORE JULY 2, 2022, 70%.

(*ii*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2022 AND BEFORE JULY 2, 2023, 68%.

(*iii*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2023, 66.5%.

(C) FOR A PERSON TO WHICH SUBSECTION (5) APPLIES, 78% OF THE AMOUNT PAYABLE FOR THE TREATMENT OR TRAINING UNDER THE PERSON'S CHARGE DESCRIPTION MASTER IN EFFECT ON JANUARY 1, 2019 OR, IF THE PERSON DID NOT HAVE A CHARGE DESCRIPTION MASTER ON THAT DATE, 78% OF THE AVERAGE AMOUNT THE PERSON CHARGED FOR THE TREATMENT ON JANUARY 1, 2019.

(D) FOR A PERSON TO WHICH SUBSECTION (6) APPLIES, THE APPLICABLE FOLLOWING PERCENTAGE OF THE AMOUNT PAYABLE FOR THE TREATMENT UNDER THE PERSON'S CHARGE DESCRIPTION MASTER IN EFFECT ON JANUARY 1, 2019 OR, IF THE PERSON DID NOT HAVE A CHARGE DESCRIPTION MASTER ON THAT DATE, THE APPLICABLE FOLLOWING PERCENTAGE OF THE AVERAGE AMOUNT THE PERSON CHARGED FOR THE TREATMENT ON JANUARY 1, 2019:

(*i*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2021 AND BEFORE JULY 2, 2022, 75%.

(*ii*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2022 AND

BEFORE JULY 2, 2023, 73%.

(*iii*) FOR TREATMENT OR TRAINING RENDERED AFTER JULY 1, 2023, 71%.

(8) FOR ANY CHANGE TO AN AMOUNT PAYABLE UNDER MEDICARE AS PROVIDED IN SUBSECTION (2), (3), (5), OR (6) THAT OCCURS AFTER THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBSECTION, THE CHANGE MUST BE APPLIED TO THE AMOUNT ALLOWED FOR PAYMENT OR REIMBURSEMENT UNDER THAT SUBSECTION. HOWEVER, AN AMOUNT ALLOWED FOR PAYMENT OR REIMBURSEMENT UNDER SUBSECTION (2), (3), (5), OR (6) MUST NOT EXCEED THE AVERAGE AMOUNT CHARGED BY THE PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON FOR THE TREATMENT OR TRAINING ON JANUARY 1, 2019.

(9) AN AMOUNT THAT IS TO BE APPLIED UNDER SUBSECTION (7) OR (8), THAT WAS IN EFFECT ON JANUARY 1, 2019, INCLUDING ANY PRIOR ADJUSTMENTS TO THE AMOUNT MADE UNDER THIS SUBSECTION, MUST BE ADJUSTED ANNUALLY BY THE PERCENTAGE CHANGE IN THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX FOR THE YEAR PRECEDING THE ADJUSTMENT.

(10) FOR ATTENDANT CARE RENDERED IN THE INJURED PERSON'S HOME, AN INSURER IS ONLY REQUIRED TO PAY BENEFITS FOR ATTENDANT CARE UP TO THE HOURLY LIMITATION IN SECTION 315 OF THE WORKER'S DISABILITY COMPENSATION ACT OF 1969, 1969 PA 317, MCL 418.315. THIS SUBSECTION ONLY APPLIES IF THE ATTENDANT CARE IS PROVIDED DIRECTLY, OR INDIRECTLY THROUGH ANOTHER PERSON, BY ANY OF THE FOLLOWING:

(A) AN INDIVIDUAL WHO IS RELATED TO THE INJURED PERSON.

(B) AN INDIVIDUAL WHO IS DOMICILED IN THE HOUSEHOLD OF THE INJURED PERSON.

(C) AN INDIVIDUAL WITH WHOM THE INJURED PERSON HAD A BUSINESS OR SOCIAL RELATIONSHIP BEFORE THE INJURY.

(11) AN INSURER MAY CONTRACT TO PAY BENEFITS FOR ATTENDANT CARE FOR MORE THAN THE HOURLY LIMITATION UNDER SUBSECTION (10).

(12) A NEUROLOGICAL REHABILITATION CLINIC IS NOT ENTITLED TO PAYMENT OR REIMBURSEMENT FOR A TREATMENT, TRAINING, PRODUCT, SERVICE, OR ACCOMMODATION UNLESS THE NEUROLOGICAL REHABILITATION CLINIC IS ACCREDITED BY THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES OR A SIMILAR ORGANIZATION RECOGNIZED BY THE DIRECTOR FOR PURPOSES OF ACCREDITATION UNDER THIS SUBSECTION. THIS SUBSECTION DOES NOT APPLY TO A NEUROLOGICAL REHABILITATION CLINIC THAT IS IN THE PROCESS OF BECOMING ACCREDITED AS REQUIRED UNDER THIS SUBSECTION ON JULY 1, 2021, UNLESS 3 YEARS HAVE PASSED SINCE THE BEGINNING OF THAT PROCESS AND THE NEUROLOGICAL REHABILITATION CLINIC IS STILL NOT ACCREDITED.

(13) SUBSECTIONS (2) TO (12) DO NOT APPLY TO EMERGENCY MEDICAL SERVICES RENDERED BY AN AMBULANCE OPERATION. AS USED IN THIS SUBSECTION:

(A) "AMBULANCE OPERATION" MEANS THAT TERM AS DEFINED IN SECTION 20902 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.20902.

(B) "EMERGENCY MEDICAL SERVICES" MEANS THAT TERM AS DEFINED IN SECTION 20904 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.20904.

(14) SUBSECTIONS (2) TO (13) APPLY TO TREATMENT OR REHABILITATIVE OCCUPATIONAL TRAINING RENDERED AFTER JULY 1, 2021.

(15) AS USED IN THIS SECTION:

(A) "CHARGE DESCRIPTION MASTER" MEANS A UNIFORM SCHEDULE OF CHARGES REPRESENTED BY THE PERSON AS ITS GROSS BILLED CHARGE FOR A GIVEN SERVICE OR ITEM, REGARDLESS OF PAYER TYPE.

(B) "CONSUMER PRICE INDEX" MEANS THE MOST COMPREHENSIVE INDEX OF CONSUMER PRICES AVAILABLE FOR THIS STATE FROM THE UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS.

(C) "EMERGENCY MEDICAL CONDITION" MEANS THAT TERM AS DEFINED IN SECTION 1395DD OF THE SOCIAL SECURITY ACT, 42 USC 1395DD.

(D) "LEVEL I OR LEVEL II TRAUMA CENTER" MEANS A HOSPITAL THAT IS VERIFIED AS A LEVEL I OR LEVEL II TRAUMA CENTER BY THE AMERICAN COLLEGE OF SURGEONS COMMITTEE ON TRAUMA.

(E) "MEDICAID" MEANS A PROGRAM FOR MEDICAL ASSISTANCE ESTABLISHED UNDER SUBCHAPTER XIX OF THE SOCIAL SECURITY ACT, 42 USC 1396 TO 1396W-5.

(F) "MEDICARE" MEANS FEE FOR SERVICE PAYMENTS UNDER PART A, B, OR D OF THE FEDERAL MEDICARE PROGRAM ESTABLISHED UNDER SUBCHAPTER XVIII OF THE SOCIAL SECURITY ACT, 42 USC 1395 TO 1395*lll*, WITHOUT REGARD TO THE LIMITATIONS UNRELATED TO THE RATES IN THE FEE SCHEDULE SUCH AS LIMITATION OR SUPPLEMENTAL PAYMENTS RELATED TO UTILIZATION, READMISSIONS, RECAPTURES, BAD DEBT ADJUSTMENTS, OR SEQUESTRATION.

(G) "NEUROLOGICAL REHABILITATION CLINIC" MEANS A PERSON THAT PROVIDES POST-ACUTE BRAIN AND SPINAL REHABILITATION CARE.

(H) "PERSON", AS PROVIDED IN SECTION 114, INCLUDES, BUT IS NOT LIMITED TO, AN INSTITUTION.

(I) "STABILIZED" MEANS THAT TERM AS DEFINED IN SECTION 1395DD OF THE SOCIAL SECURITY ACT, 42 USC 1395DD.

(J) "TRANSFER" MEANS THAT TERM AS DEFINED IN SECTION 1395DD OF THE SOCIAL SECURITY ACT, 42 USC 1395DD.

(K) "TREATMENT" INCLUDES, BUT IS NOT LIMITED TO, PRODUCTS, SERVICES, AND ACCOMMODATIONS.

SEC. 3157A. (1) BY RENDERING ANY TREATMENT, PRODUCTS, SERVICES, OR ACCOMMODATIONS TO 1 OR MORE INJURED PERSONS FOR AN ACCIDENTAL BODILY INJURY COVERED BY PERSONAL PROTECTION INSURANCE UNDER THIS CHAPTER AFTER JULY 1, 2020, A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON IS CONSIDERED TO HAVE AGREED TO DO BOTH OF THE FOLLOWING:

(A) SUBMIT NECESSARY RECORDS AND OTHER INFORMATION CONCERNING TREATMENT, PRODUCTS, SERVICES, OR ACCOMMODATIONS PROVIDED FOR UTILIZATION REVIEW UNDER THIS SECTION.

(B) COMPLY WITH ANY DECISION OF THE DEPARTMENT UNDER THIS SECTION.

(2) A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON OR INSTITUTION THAT KNOWINGLY SUBMITS UNDER THIS SECTION FALSE OR MISLEADING RECORDS OR OTHER INFORMATION TO AN INSURER, THE ASSOCIATION CREATED UNDER SECTION 3104, OR THE DEPARTMENT COMMITS A FRAUDULENT INSURANCE ACT UNDER SECTION 4503.

(3) THE DEPARTMENT SHALL PROMULGATE RULES UNDER THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328, TO DO BOTH OF THE FOLLOWING:

(A) ESTABLISH CRITERIA OR STANDARDS FOR UTILIZATION REVIEW THAT IDENTIFY UTILIZATION OF TREATMENT, PRODUCTS, SERVICES, OR ACCOMMODATIONS UNDER THIS CHAPTER ABOVE THE USUAL RANGE OF UTILIZATION FOR THE TREATMENT, PRODUCTS, SERVICES, OR