STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF INGHAM

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

Plaintiffs,

Case No. 19-738-CZ

v

Honorable Wanda M. Stokes

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

Defendants.

George T. Sinas (P25643)
Stephen H. Sinas (P71039)
Thomas G. Sinas (P77223)
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PLAINTIFF'S MOTION FOR RECONSIDERATION

Plaintiffs, by and through their attorneys, Sinas, Dramis, Larkin, Graves & Waldman, P.C., seek reconsideration of the court's November 13, 2020 Opinion and Order for the following reasons:

1. Plaintiffs filed this action on October 3, 2019, alleging several challenges to legislative changes to Michigan's no-fault act that were passed in 2019.

2. Plaintiffs' complaint alleged that these legislative changes were in violation of several provisions of the Michigan Constitution, including the Contract Clause, the Equal Protection Clause, and the Due Process Clause.

3. On January 6, 2020, the defendants filed a motion for summary disposition pursuant to MCR 2.116(C)(8), claiming that plaintiffs' constitutional claims failed to state a claim for relief.

4. Plaintiffs filed a response to the defendants' motion for summary disposition on March 6, 2020.

5. In addition to responding to the legal arguments contained in defendants' motion, plaintiffs also requested the right to amend their complaint to state a claim other than the constitutional claims that were alleged in their original complaint on the basis of MCR 2.116(I)(5).

6. Plaintiffs request to amend their complaint was on the basis of *Lafontaine Saline, Inc v Chrysler Group, LLC,* 496 Mich 26 (2014), which stands for the proposition that if there is a statute that pertains to a contract between private parties, the statute, as is was at the time the contract was entered into, controls the rights and obligations of the

parties, and that later amendments to the statute cannot be interpreted to affect contracts that existed before the amendments were enacted. *Id.* at 34 – 35.

7. Specifically, in Plaintiffs' Brief in Opposition to the Motion to Dismiss Filed by Defendants, attached as ***Exhibit A***, Plaintiffs stated: "*Based on the reasoning expressed by the Supreme Court in* Lafontaine *and a number of prior decisions cited in that opinion, 496 Mich at 36, fn.18, plaintiffs request the right under MCR 2.116(I)(5) to amend their complaint to seek a declaration that it would constitute a breach of contract for the defendants to pay benefits differently after June 2021.*" p 18, fn 2.

8. The *Lafontaine* principle is of vital importance to plaintiffs' claims and deserves judicial analysis.

9. On November 13, 2020, the court issued an opinion granting the defendants' motion for summary disposition solely on the constitutional claims asserted in plaintiffs' complaint.

10. In its November 13, 2020 opinion, the court did not address plaintiffs' request to amend their complaint pursuant to MCR 2.116(I)(5) and did not in any way touch upon plaintiffs' arguments regarding the *Lafontaine* principle.

11. Under MCR 2.116(I)(5), where a motion for summary disposition is filed under MCR 2.116(C)(8), a court must give the nonmoving party the right to amend the complaint.

12. Based on MCR 2.116(I)(5), plaintiffs must be given the opportunity to file an amended complaint to allege a breach of contract claim under the *Lafontaine* standard, as requested in their Brief in Opposition to the Motion to Dismiss Filed by Defendants,

because the statute that existed at the time plaintiffs entered into their contractual relationships with defendants has consistently and repeatedly been interpreted by Michigan Appellate Courts to vest in plaintiffs certain specific rights regarding attendant care and medical expense reimbursement that the legislature subsequently attempted to substantially alter when it passed PA 21.

13. To further the relief requested in this motion, plaintiffs have, on this date, also filed a separate Motion to Amend Complaint under MCR 2.118, which has been scheduled for hearing on January 7, 2021 at 3:00 p.m., the contents of which are incorporated herein by reference.

14. Plaintiffs also request permission to make oral argument with respect to this motion, which plaintiffs suggest take place during the January 7, 2021 hearing on plaintiffs' Motion to Amend.

WHEREFORE, plaintiffs respectfully request that this Honorable Court grant their Motion for Reconsideration and, on reconsideration, allow plaintiffs to file an amended complaint.

Respectfully submitted:

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Dated: December 4, 2020

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Dated: December 4, 2020

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BRIEF IN SUPPORT OF PLAINTIFF'S MOTION FOR RECONSIDERATION

INTRODUCTION AND PROCEDURAL HISTORY

In June 2019, the Michigan Legislature enacted changes to this state's no-fault act. Included in those changes were provisions that limited in-home family provided attendant care to 56 hours per week, MCL 500.3135(10), and capped reimbursement for medical expenses that are not compensable by Medicare to 55% of what providers charged for those services as of January 1, 2019, MCL 500.3157(7).

On October 3, 2020, plaintiffs filed this case challenging these two provisions of the new no-fault act. The complaint that plaintiffs filed was limited exclusively to challenges based on the Michigan Constitution. Thus, in their complaint, plaintiffs alleged that these two amendments to the no fault act violated the Contract Clause of the Michigan Constitution, Const. 1963, art 1, §10, the Equal Protection Clause, Const. 1963, art 1, §2, and the Due Process Clause, Const. 1963, art 1, §17.

In January 2020 the defendants, in lieu of filing an answer, filed a motion for summary disposition under MCR 2.116(C)(8). In that motion, the defendants argued that plaintiffs' constitutional arguments failed to state a claim on which relief could be granted.

Plaintiffs filed their Brief in Opposition to the Motion to Dismiss Filed by Defendants on March 6, 2020. A copy of that brief is attached as ***Exhibit A*** to this motion. In addition to responding to the legal arguments that were made in the defendants' motion, plaintiffs' brief contained a discussion of the Michigan Supreme Court's decision in *Lafontaine Saline, Inc v Chrysler Group, LLC,* 496 Mich 26 (2014). *See* Plaintiffs' Plaintiffs' Brief in Opposition to the Motion to Dismiss Filed by Defendants (***Exhibit A***), at 16 - 18.

Based on the Supreme Court's decision in *Lafontaine,* plaintiffs requested in their response that they be allowed to amend their complaint to allege a breach of contract claim. ***Exhibit A*** at p 18, fn 2. Specifically, Plaintiffs stated: "*Based on the reasoning expressed by the Supreme Court in* Lafontaine *and a number of prior decisions cited in that opinion, 496 Mich at 36, fn.18, plaintiffs request the right under MCR 2.116(I)(5) to amend their complaint to seek a declaration that it would constitute a breach of contract for the defendants to pay benefits differently after June 2021.*" The basis for this request to amend was a Michigan court rule, MCR 2.116(I)(5).

On November 13, 2020, the Court issued an opinion addressed to the defendants' motion for summary disposition. In that opinion, the court determined that defendants were entitled to summary disposition on plaintiffs' constitutional claims. In dismissing these constitutional claims, the court did not address plaintiffs' request to amend their complaint to add a breach of contract claim or in any way touch upon plaintiffs arguments regarding the *Lafontaine* principle.

STANDARD OF REVIEW

MCR 2.116(I)(5) specifically provides that, where a party files a motion for summary disposition that is predicated on either MCR 2.116(C)(8), (9) or (10), "*the court shall give the parties an opportunity to amend their pleadings as provided by MCR 2.118.*" The language of MCR 2.116(I)(5) is mandatory in character; it provides that a court *shall* give the nonmoving party an opportunity to amend. *See Liggett Restaurant Group, Inc. v Pontiac,* 260 Mich App 127, 138; 676 NW2d 633 (2003). The Court of Appeals has recognized where a motion is filed under any of these provisions in MCR 2.116(C), "*the*

court must give the parties the opportunity to amend their pleadings . . ." Doyle v Hutzel Hospital, 241 Mich App 206, 212; 615 NW2d 759 (2000); *Yudashkin v Linzmeyer,* 247 Mich App 642,654; 637 NW2d 257 (2001)(*"the trial court was required pursuant to MCR 2.116(I)(5) to give plaintiff the opportunity to amend his complaint because it granted summary disposition at least in part, under MCR 2.116(C)(8)."*

LAW AND ARGUMENT

I. *Lafontaine* stands for the proposition that the no-fault act, as it existed at the time plaintiffs entered into their contracts for no-fault insurance, controls the rights and obligations of the parties to the contracts.

As is further explained in Plaintiffs' Brief in Opposition to the Motion to Dismiss Filed by Defendants, the case of *Lafontaine Saline, Inc v Chrysler Group, LLC,* 496 Mich 26; (2014) stands for the proposition that if there is a statute that pertains to a contract between private parties, the statute, as is was at the time the contract was entered into, controls the rights and obligations of the parties, and later amendments to the statute cannot be interpreted to affect contracts that existed before the amendments were enacted. *Id.* at 34 – 35. *Lafontaine* teaches that the contracts that plaintiffs entered into with their insurers prior to their accidents *must be read in conjunction with the law that existed at the time those contracts were entered. cf Rohlman,* 442 Mich at 525, fn. 3 (in construing a case based on the no-fault act, *"[t]he policy and the statutes relating thereto must be read and construed together as though the statutes were a part of the contract."*). This means that under the reasoning in *Lafontaine,* the policies that the plaintiffs entered into have to be read as incorporating the provisions of the no-fault act as of the date those contracts were entered into.

II. Michigan case law makes it abundantly clear that the no-fault statute at the time plaintiffs entered into their contracts provided for reimbursement for all reasonably necessary attendant care services and reimbursement for all reasonable charges for reasonably necessary products, services, and accommodations for plaintiffs care, recovery, or rehabilitation.

At the time plaintiffs entered into their respective contracts for no-fault insurance, the no-fault statute as it existed provided for, among other things: (1) all attendant care services that were reasonably necessary for plaintiffs' care, recovery, or rehabilitation, without regard to the identity of the caregiver provider or number of hours; and (2) reimbursement for all reasonably necessary products, services, and accommodations for plaintiffs' care, recovery, or rehabilitation without regard to any government imposed fee schedules or third-party payor reimbursement rates. Plaintiffs' right to these no-fault benefits vested as of the date of their respective motor vehicle accidents. When these insurers sold these contracts to plaintiffs prior to the 2019 legislation, they charged a premium to cover the risk they were underwriting with respect to their liability for these two types of unlimited benefits. The fact that a premium was charged by insurers to cover these benefits is obvious given the fact that the politicians who passed the 2019 law have touted the premium savings that would occur as a result of its passage.

Decades of Michigan case law make it abundantly clear that the no-fault statute, as it existed at the time plaintiffs entered into contracts with their insurers, provided for reimbursement for all reasonably necessary attendant care services, regardless of the identity of the caregiver and without any hourly limitation. In this regard, *Van Marter v American Fidelity Fire Ins Co,* 114 Mich App 171 (1982) stands for the proposition that a

stepmother was entitled to be compensated for the attendant care services that she provided to her stepson, regardless of the fact that she was a family member and she had no formal medical training. *Manley v DAIIE,* 425 Mich 140 (1986) reiterates the principle that family members are entitled to be compensated for all reasonably necessary attendant care services that they provide to an injured family member by holding that the parents of injured children are not precluded from recovering compensation for attendant care simply because they are legally obligated to support their minor children. (*See also Sharp v Preferred Risk Mutual Ins Co,* 142 Mich App 499 (1985) (holding that a mother was entitled to reimbursement for attendant care services she provided to her adult son; *Bonkowski v Allstate Ins Co,* 281 Mich App 154 (2008) (affirming a jury award of over $1 million for father's providing of 24/7 attendant care to son following son's motor vehicle accident); *Hardrick v Auto Club Ins Ass'n,* 294 Mich App 651 (2011) (holding that parents are entitled to compensation for attendant care they provided to their son and approving a jury instruction for attendant care cases that states: "*Plaintiff can recover benefits for care provided by member[s] of Plaintiff's family at its reasonable market value*"); *Brady v Home-Owners Ins Co,* unpublished per curiam opinion of the Court of Appeals, issued [June 21, 2016], (Docket No. 324864), attached as ***Exhibit B***, (holding that a mother was entitled to be compensated for attendant care services she provided to her son).

Case law has further confirmed that other family members, such as spouses, are entitled to be compensated for attendant care services they provide to an injured family member. *See, e.g. Booth v Auto-Owners Ins Co,* 224 Mich App 724 (1997) (holding that family members who rendered attendant care to their catastrophically injured relative

who was also entitled to receive attendant care under the workers compensation act, were entitled to recover compensation under §3107(1)(a) for attendant care rendered by the family above and beyond that which was compensable under the workers compensation statute. In other words, the workers compensation limitations on attendant care are not a cap on attendant care payable under the no-fault law); *Douglas v Allstate Ins Co*, 492 Mich 241 (2012) (holding that plaintiff's husband was entitled to compensation for attendant care services he provided to injured wife); *Attard v Citizens Ins Co of America*, 237 Mich App 311 (1999) (holding that plaintiff's wife could be compensated for attendant care services she provided to her husband); *Visconti v DAIIE*, 90 Mich App 477 (1979) (holding that plaintiff could recover benefits from his no-fault insurer for personal care services rendered by his wife who had quit her job to provide such care); *Richard v Allstate Ins Co*, unpublished per curiam opinion of the Court of Appeals, issued [June 21, 2012], (Docket No. 298650), attached as ***Exhibit C*** (holding that plaintiff's husband was entitled to be reimbursed for attendant care services he provided to his wife even though she did not bill him).

Similarly, years of Michigan case law have stood for the precedent 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, or rehabilitation. *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 220; 815 NW2d 412 (2012). Michigan courts have repeatedly confirmed that the only requirement to measure the compensability of charges under the system is that of "*reasonableness*." In *Auto Club Ins Assn v New York Life Ins*, 440 Mich 126 (1992), the Supreme Court stated:

> *"One way of containing those [health care] costs is for an insurer to place dollar limits upon the amounts it will pay to doctors and hospitals for particular services.* ***While health and accident carriers generally are free to establish such limits, a no fault insurer is not. Only the statutory qualification of reasonableness limits the amount that must be paid by a no-fault carrier for covered medical expenses."***
>
> *Id.* at 139 (emphasis added).

See also Advocacy Org for Patients and Providers v Auto Club Ins Ass'n, 257 Mich App 365 (2003) (holding that no-fault insurers are obligated to pay the reasonable and customary amount charged by medical providers for services rendered to a motor vehicle accident victim); *Hicks v Citizens Ins Co of America,* 204 Mich App 142 (1994) (holding that Citizens may not rely on an unenforceable agreement to avoid its obligations as the assigned insurer and is obligated to pay plaintiff the reasonable and customary charges incurred for her medical expenses); *Nassar v Auto Club Ins Ass'n,* 435 Mich 33 (1990) (holding that a no-fault insurer is liable for medical expenses that are a reasonable charge for reasonably necessary products, services, and accommodations); *Williams v Farm Bureau Ins Co,* unpublished per curiam opinion of the Court of Appeals, issued [August 28, 2001], (Docket No. 221119), attached as ***Exhibit D,*** (holding that a no-fault insurer is liable for reasonable and customary charges.)

In determining what constitutes a reasonable charge, Michigan courts have specifically held that fee schedules and amounts paid by Medicare, Medicaid, workers' compensation, and private health insurance ***cannot*** be used to determine what constitutes a reasonable charge. *See Johnson v Michigan Mutual Ins Co,* 180 Mich App 314 (1989) (where Court rejected the no-fault insurer's argument that it was only obligated to

pay hospital charges that would have been paid by Medicaid); *Botsford General Hospital and Noel v Citizens Ins Co,* 195 Mich App 127 (1992) (holding that a no-fault insurer is not entitled to limit reimbursement to a medical provider to only that which is paid by Medicaid); *Hicks v Citizens,* 204 Mich App 142 (1994) (again holding that a no-fault insurer cannot limit reimbursement to the amount that would be reimbursed by Medicaid); *Hofmann v Auto Club Ins Ass'n,* 211 Mich App 55 (1995) (where court rejected no-fault insurer's argument that a reasonable charge is the amount the provider would have received if private health insurance existed); *Munson Medical Center v Auto Club Ass'n,* 218 Mich App 375 (1996) (holding that an insurer could not apply the workers' compensation fee schedules to determine its liability to pay allowable medical expenses); *Mercy Mt Clemens Corp v Auto Club Ins Ass'n,* 219 Mich App 46 (1996) (holding that a no-fault insurer cannot use the amounts customarily paid by third party payors, such as workers' compensation, Medicare, Medicaid, Blue Cross Blue Shield, HMOs and PPOs to determine the no-fault insurer's liability).

III. Applying the 2019 no-fault amendments to plaintiffs results in a breach of contract and a fundamentally unfair and inequitable windfall to insurers that must be remedied.

It is fundamentally unfair and inequitable to retroactively apply the 2019 legislative limitations to plaintiffs. Plaintiffs purchased no-fault contracts that included reimbursement for all reasonably necessary attendant care services and reimbursement for all reasonable charges for necessary products, services, and accommodations for their care, recovery, or rehabilitation. Plaintiffs paid a premium based on the risk assessment

of the benefits that existed at the time the contracts were entered into. Plaintiffs right to these benefits vested at the time of their motor vehicle accidents.

Based on the above-referenced case law, it is clear that the statute as it existed at the time plaintiffs entered into contracts with their no-fault insurers did not contain any such limitations that the 2019 amendments are now attempting to impose. Retroactively applying the 2019 amendments to plaintiffs constitutes a breach of contract under *Lafonatine*. Furthermore, allowing insurers to retroactively change the benefits that plaintiffs are entitled to after their contractual rights have vested and after they have paid premiums for such benefits this results in an substantial windfall to insurers that must be remedied.

CONCLUSION

In the instant case, defendants filed a motion for summary disposition challenging only the constitutional claims asserted in plaintiffs' complaint. In responding to that motion, plaintiffs requested the right to amend their complaint to state a claim in addition to the constitutional claims they originally asserted based on *Lafontaine*, as discussed herein. On the basis of MCR 2.116(I)(5), the court was required to grant that request. The court did not address this issue in its November 13, 2020 order, nor touch upon plaintiffs' *Lafontaine* principle. Unless the court permits plaintiffs to amend their complaint to add this argument, this case will not have been fully adjudicated and plaintiffs' grievances will not have been fully addressed.

For these reasons, plaintiffs request that the court reconsider its November 13, 2020 decision dismissing plaintiffs' claims in their entirety and, on reconsideration, allow

plaintiffs the opportunity to amend their complaint, as is further discussed in plaintiffs' Motion to Amend Complaint, filed concurrently with this motion.

Respectfully submitted:

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Dated: December 4, 2020

EXHIBIT A

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PLAINTIFF'S BRIEF IN OPPOSITION TO THE MOTION TO DISMISS FILED BY DEFENDANTS

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STATEMENT OF FACTS

A. Ellen Andary

On December 5, 2014, Ellen Andary was a passenger in a motor vehicle which was struck head-on by a drunk driver. *Id.*, ¶9. As a result of that accident, Ms. Andary suffered severe injuries, including a catastrophic brain injury. *Id.*, ¶10. The injuries Ms. Andary sustained in the December 2014 accident have rendered her permanently disabled and incapable of caring for herself. *Id.*, ¶11. Many years before the December 5, 2014 accident, Ellen Andary and her husband, Dr. Michael T. Andary, purchased an automobile no-fault policy of insurance through USAA Casualty Insurance Company ("USAA"). At the time of the accident, Ms. Andary was insured under this USAA no-fault insurance policy. *Id.*, ¶17. In accordance with the allowable expense provision of the No-Fault Act, MCL 500.3107(1)(a), 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 schedule. *Id.*, ¶20. This policy further provided for all reasonable necessary attendant care services without any limitations as to the identity of her caregivers. *Id.*, ¶19. The premium that Ms. Andary paid for this policy was priced and sold based upon the fact that said policy entitled her to these benefits without regard to any limitations on the identity of her providers or any fee schedule. *Id.*, ¶21. Ms. Andary's right to these no-fault PIP benefits vested as of the date of her December 5, 2014 motor vehicle accident. *Id.*

Due to Ms. Andary's severe brain injury, doctors have prescribed 36-hours of in-home attendant care services. *Id.*, ¶12. 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. The care that Ms. Andary requires is very 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, she is prone to developing urinary tract infections so her in-home caregivers apply a vaginal cream to prevent these infections. Urinalysis tests must be regularly performed to check for these infections and other abnormalities.

While Ms. Andary has a severe brain injury, she is able to engage in superficial conversations. She enjoys being around her friends and family. Ms. Andary is aware of the care that is being provided to her and is further aware of the significant intrusions it imposes with regard to her sense of personal privacy. She has made comments that reflect that awareness. Consequently, she is more comfortable with the care rendered to her by family and friends as opposed to strangers.

B. **Philip Krueger And Eisenhower Center**

On March 10, 1990, Philip Krueger was involved in a motor vehicle accident while a passenger in a pickup truck. Complaint, ¶¶26-27. In that accident, Mr. Krueger sustained multiple injuries, including a severe traumatic brain injury which has left him permanently disabled and incapable of taking care of himself. *Id.*, ¶28. Prior to the March 10, 1990 accident, Philip Krueger's father, Ronald Krueger, purchased an automobile no-fault policy of insurance through Citizens Insurance Company of America ("Citizens"). At the time of the accident, Philip Krueger was 18-years old and resided with his father. *Id.*, ¶29. Accordingly, he was insured under the Citizens no-fault insurance policy as a resident relative of his father. In accordance with the allowable expense provision of the no-fault act, MCL 500.3107(1)(a), this policy provided for reimbursement of "all reasonable charges incurred for reasonably necessary products, services, and accommodations for [Philip Krueger's] care, recovery, or rehabilitation" without regard to any government imposed fee

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schedule. *Id.*, ¶31. The premium paid on behalf of Philip Krueger for this policy was priced and sold based upon the fact that said policy entitled Philip to these benefits without regard to any fee schedule. *Id.*, ¶32. Philip Krueger's right to these no-fault PIP benefits vested as of the date of his March 10, 1990 motor vehicle accident. *Id.* Mr. Krueger's right to these benefits vested as of the date of his March 1990 accident. *Id.*

In November 1997, Mr. Krueger became a resident of the Ann Arbor facility of the Eisenhower Center. *Id.*, ¶37. The Eisenhower Center is an entity that specializes in providing rehabilitative products and services for individuals who have suffered traumatic brain injuries. *Id.*, ¶33. 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.

When Mr. Krueger became a resident of Eisenhower Center, they entered into a contract under which Eisenhower Center agreed to provide the necessary services and accommodations for his recovery and rehabilitation. *Id.*, ¶38. At the time this contractual relationship was entered into and continuing through today, the funding for the services that Eisenhower Center provided to Mr. Krueger comes from Citizens by virtue of the insurance policy that was in effect at the time of his March 1990 accident and through the provisions of Michigan's no-fault act, MCL 500.3101, *et seq.*

Mr. Krueger represents a typical Eisenhower Center patient. The vast majority of Eisenhower Center's residential patients have suffered disabilities, and in particular brain injuries, as a result of motor vehicle accidents. *Id.*, ¶36. 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.

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Id. Most of the patients that the Eisenhower Center treats have severe behavioral issues as a result of brain injuries. Eisenhower Center is one of the few residential centers with the ability to treat such patients.

C. **Changes To The No-Fault Act**

On January 15, 2019, Senate Bill 1 (SB-1) to amend the insurance code of 1956 was introduced by Senator Aric Nesbitt and referred to the Committee on Insurance and Banking. The Committee held hearings prior to reporting out the Bill, but there were no opportunities for the general public to testify on the bill's subject matter. Stakeholders' testimony was by invitation of the chair only and was on certain specific policy issues and/or questions. On the morning of May 7, 2019, the Senate Committee on Insurance and Banking scheduled a meeting to take up SB-1. The Committee did not take any public testimony. The Committee quickly adopted a substitute for SB-1 (S-1), and reported it out of Committee. No copies of this substitute bill were made available to the public.

Typically, committee reports are laid over for a day or two prior to further deliberations on the Senate floor. However, SB-1 was quickly taken up during the regularly scheduled Senate session, which began at 10 a.m. the same day it was reported out of Committee. The rules were suspended to allow SB-1 to be placed on the General Orders Calendar. The Bill then moved to a Third Reading. Again, the rules were suspended and SB-1 was placed on immediate passage, which it did. SB-1 was transmitted to the House of Representatives that same day, May 7, 2019. SB-1 was read in and referred to the House Select Committee on Reducing Car Insurance Rates the next day, May 8, 2019. On May 15, 2019 the Select Committee met and reported out SB-1 (with a House Substitute H-1). Again, there was no public input at the hearing and no advance copies were made

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available to the public for review.

Back room discussions with the Governor, Speaker of the House, and Senate Majority Leader culminated in a deal reached in the late evening of May 23, 2019. In the early morning of May 24, 2019, Kevin McKinney, Legislative Coordinator for one of the interested groups, the Coalition Protecting Auto No-Fault (CPAN), was called into the Governor's office to be "briefed" on the overall agreement. At this time, the agreement was in outline form only and was not fully drafted.

Following this May 24, 2019 meeting, the House Democratic Caucus was briefed by the Governor's office on the compromise. At this time, the Legislative Service Bureau was still working on drafting the final agreement, so the Bill was still in outline form and the language was not shared during this briefing either.

Finally, copies of the Bill were made available and were online later that day. Some of the key changes included the imposition of the MCL 500.3157(7)'s fee schedule for non-Medicare compensable services. The Governor and Senate and House leadership took the position that this Bill was going to be passed that same day, and as such, no amendments would be supported. Therefore, most House members could not even offer corrective or clarifying amendments since they would be useless.

Later in the day on May 24, 2019, the House passed the Bill and gave it immediate effect. Following this, in the late afternoon of May 24, 2019, the Senate concurred with the House Substitute to SB-1 and the Bill was passed. The Bill was signed into law by Governor Whitmer and filed with the Secretary of State, becoming law on June 11, 2019.

As can be seen from this brief legislative history, this Bill was passed with enormous speed, behind closed doors, and with no public comment. Members of Legislature were not even given an

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opportunity to comment on the Bill and proposed changes.

Among the charges contained in the final version of the bill 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, regardless of whether or not this care is being provided through a licensed agency. *Id.*, ¶42. 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 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).[1]

The limitation on family-provided in-home attendant care does not go into effect until July 2021. But, as written, the new limitation contained in §3157(10) will apply to victims of motor vehicle accidents such as Ms. Andary, who were injured prior to the date the 2019 amendments to the act took effect. This means that, as of July 2021, Ms. Andary will presumably no longer be entitled to receive reimbursement for in-home family-provided attendant care beyond the 56-hours per week allowed by §3157(10). Accordingly, this limitation fundamentally changes Ms. Andary's rights under her policy of insurance with USAA in effect as of the date of her motor vehicle accident.

The 2019 amendments of the no-fault act have also dramatically limited the reimbursement for a provider of medical services to individuals injured in automobile accidents. The 2019 amendments have accomplished this through the creation of fee schedules. Complaint, ¶46. These fee schedules, which are contained in MCL 500.3157(2) and (7), set out maximum amounts that a physician, hospital, clinic or other person can charge for the care and treatment of accident-related

[1] The type of attendant care covered in MCL 500.3157(10) is hereinafter referred to in this brief as "in home family provided attendant care," even though the statute excludes more than just family members from providing such care.

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injuries. The fee schedules established by the 2019 amendments are divided into two categories. If the treatment or services being provided are covered by Medicare, the maximum amount that a provider can be reimbursed for the services it provides to motor vehicle accident victims after July 2021, is 200% of the amount payable under Medicare. MCL 500.3157(2). These reimbursement rates are further reduced to 195% in 2022 and 190% in 2023 and beyond. If Medicare does not provide coverage for a particular service, the maximum amount that the provider can be reimbursed for the services it provides to motor vehicle accident victims beginning in July 2021, is 55% of the amount that the provider charged for the treatment as of January 1, 2019. MCL 500.3157(7). This reimbursement rate is further reduced to 54% in 2022 and 52.5% in 2023 and beyond.

The fee schedule for non-Medicare compensable services addressed in §3157(7) fundamentally changes the rights of Ms. Andary and Mr. Kreuger under their policies of no-fault insurance that were in effect as of the date of their accidents. These fee schedules also fundamentally impair the rights of Eisenhower Center to be reimbursed for all reasonable charges it renders to motor vehicle accident victims that it has been treating before these fee schedules were enacted as well as patients it will treat in the future.

On October 3, 2019, plaintiffs Ellen Andary and Philip Krueger filed this action against their respective insurance companies, seeking a declaration that the limitation on in-home family-provided attendant care in MCL 500.3157(10) and the non-Medicare fee schedule limitations of MCL 500.3157(7) cannot be constitutionally enforced in derogation of the vested contractual rights the plaintiffs possess under the insurance policies defendants sold to them prior to the enactment of the 2019 legislation. Eisenhower Center further seeks a declaration that the non-Medicare fee schedule limitations of MCL 500.3157(7) cannot be enforced in derogation of its vested contractual rights

under an express or implied contract with Philip Krueger that has been in effect since Mr. Krueger first became a resident of Eisenhower Center. Plaintiffs have alleged that application of these amendments would be a violation of plaintiffs' constitutional rights under the Contract Clause of the Michigan Constitution, Const. 1963, art. 1, §10.

Ellen Andary and Philip Krueger further seek a declaration that MCL 500.3157(7) and (10) deprive them of their due process rights to privacy and bodily integrity in violation of article 1, §17 of the Michigan Constitution, by limiting their access to care and their ability to choose medical providers that render intimate and personal care. Eisenhower Center seeks a declaration that its due process right to property is violated by the imposition of oppressive, unsustainable price controls in the form of MCL 500.3157(7)'s fee schedules that will cause Eisenhower Center to go out of business.

Ms. Andary and Mr. Krueger seek a declaration that §3157(7) and (10) violate the Equal Protection Clause of the Michigan Constitution, Const. 1963, art. 1, §2. The attendant care limitation treats Ms. Andary differently than other similarly situated motor vehicle accident victims by limiting her right to access reasonably necessary attendant care provided by family members in contrast to other patients who receive reasonably necessary attendant care from commercial agencies. The complaint further asserts that the fee schedule limitations of §3135(7) violate the equal protection rights of Ms. Andary and Mr. Krueger, who both receive non-Medicare compensable services, by treating them differently than other motor vehicle accident victims who only receive Medicare compensable services.

Finally, Eisenhower Center also seeks a declaration that its equal protection rights are violated by §3157(7) by dramatically reducing its right to reimbursement as a provider of non-

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Medicare compensable services, in contrast to other providers that only render Medicare compensable services.

In lieu of filing an answer to plaintiffs' complaint, defendants have filed a motion to dismiss based on MCR 2.116(C)(8). For the reasons that follow, defendants' motion should be denied.

ARGUMENT

I. STANDARDS GOVERNING A MOTION FILED UNDER MCR 2.116(C)(8).

The defendants' motion to dismiss is predicated exclusively on MCR 2.116(C)(8). It has been filed at the very earliest stage of these proceedings, before any discovery has been conducted.

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). The Michigan Supreme Court in its recent decision in *El-Khalil vs Oakwood Healthcare, Inc*, 504 Mich 152; 934 NW2d 665 (2019), outlined the standards that govern a court's review of a motion filed under MCR 2.116(C)(8). In considering such a motion, "a trial court must accept all factual allegations as true, deciding the motion on the pleadings alone." 504 Mich at 160. The 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). In *El-Khalil*, the Court emphasized the difference between a motion filed under MCR 2.116(C)(8) and one that is based on MCR 2.116(C)(10): "A motion under MCR 2.116(C)(8) tests the *legal sufficiency* of a claim based on the factual allegations in the complaint. . . A motion under MCR 2.116(C)(10), on the other hand, tests the *factual sufficiency* of a claim." 504 Mich at 159-160 (emphasis in original). Thus, at this early stage in this litigation, the sole question presented to the court is whether the allegations in plaintiffs' complaint are legally sufficient, not whether there are sufficient facts to

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support these claims.

Dismissal under MCR 2.116(C)(8) is proper only if plaintiffs' claims are "so clearly unenforceable that no factual development could possibly justify recovery." *El-Khalil*, 504 Mich at 160. *Kuznar*, 481 Mich at 176; *Haynes v Neshewat*, 477 Mich 29, 34; 729 NW2d 488 (2012).

The standards governing a motion filed under MCR 2.116(C)(8) as described in these Supreme Court cases raise the first significant question that the court must address in defendants' MCR 2.116(C)(8) motion – whether further factual development of these constitutional issues should be allowed before the court addresses the significant constitutional issues raised in this case.

In considering whether the court should decline to address the constitutional questions raised in this case until the facts have been more fully developed, it is important to note that when the no-fault act was initially enacted in 1973, the constitutionality of that act was challenged. These constitutional challenges were ultimately decided by the Michigan Supreme Court in *Shavers v Attorney General*, 402 Mich 554; 267 NW2d 72 (1978). But, the constitutional challenges presented in *Shavers* only reached the Supreme Court after full development of the facts and a trial.

In *Shavers*, the Supreme Court considered due process and equal protection challenges to the no-fault act. The Court acknowledged that the act was cloaked with a rebuttable presumption of constitutionality and that judicial review of due process and equal protection challenges was deferential. 402 Mich at 613-614. Despite these considerations, the Court in *Shavers* 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*

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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 Supreme Court in *Shavers* then cited with favor the United States Supreme Court's decision in *Borden's Farm Products Co, Inc v Baldwin*, 293 US 194 (1934), which also emphasized the need for 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. The Supreme 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 when presented with a constitutional challenge, observed that "[t]o resolve these significant issues in such a vacuum would be imprudent where it appears that further

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factual development would substantially contribute to the proper disposition of the case. *Id.*, at 343.

Based on the Supreme Court's initial examination of the constitutionality of the no-fault act in *Shavers*, this Court should deny the defendants' motion without prejudice and allow for the full development of the factual record bearing on the constitutional issues raised in this case.

II. THE RECENTLY ENACTED AMENDMENTS TO THE NO-FAULT ACT VIOLATE THE VESTED CONTRACT RIGHTS OF PLAINTIFFS AND ARE UNCONSTITUTIONAL UNDER THE CONTRACT CLAUSE OF THE MICHIGAN CONSTITUTION.

Each of the plaintiffs has asserted claims based on the Contract Clause of the Michigan Constitution, Const. 1963, art 1, §10. 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." Const. 1963, art. 1, 10. *Health Care Ass'n Workers Comp Fund v Director of the Bureau of Workers Comp*, 265 Mich App 236, 240; 694 NW2d 761 (2005). "[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 765, 777; 527 NW2d 468 (1994) citing *Allied Structural Steel Co v Spannaus*, 438 US 234, 242 (1978). The Supreme 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 v Michigan Judges Retirement Board*, 378 Mich 169, 180; 143 NW2d 755 (1966); *In re Certified Question*, 447 Mich 765, 776; 527 NW2d 468 (1994) ("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

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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). Years of Michigan case law has confirmed that these benefits include all reasonably necessary attendant care services, regardless of the identity of the provider. Michigan case law has specifically confirmed that family members who provide in-home attendant care services are entitled to reimbursement for their services. In this regard, *Van Marter v American Fidelity Fire Ins Co,* 114 Mich App 171 (1982) stands for the proposition that a stepmother was entitled to be compensated for the attendant care services that she provided to her stepson, regardless of the fact that she was a family member and she had no formal medical training. *Manley v DAIIE,* 425 Mich 140 (1986) reiterates the principle that family members are entitled to be compensated for all reasonably necessary attendant care services that they provide to an injured family member by holding that the parents of injured children are not precluded from recovering compensation for attendant care simply because they are legally obligated to support their minor children. (*See also Sharp v Preferred Risk Mutual Ins Co,* 142 Mich App 499 (1985) (holding that a mother was entitled to reimbursement for attendant care services she provided to her adult son). Case law has further confirmed that a husband or wife is entitled to be compensated for attendant care services he or she provides to an injured spouse. *Douglas v Allstate Ins Co*, 492 Mich 241 (2012); *Attard v Citizens Ins Co of America,* 237 Mich App 311 (1999). Therefore, the long line of appellate decisions prior to the enactment of the 2019 reforms clearly establish that MCL 500.3017(1)(a) entitles an injured person to be reimbursed for every single hour of in home attendant care that was reasonably necessary, without regard to the identity of the care provider and without regard to any daily or weekly hour limitations.

Based on this case law, it is clear that under Ellen Andary's policy of no-fault insurance with

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USAA that was in effect at the time of her December 2014 accident, she had a clear unequivocal right to have all prescribed in-home attendant services provided her family members and friends be reimbursed, as long as those services were necessitated by accident-related injuries. Her right to all reasonably necessary in-home family-provided attendant care vested as of the date of her accident.

Similarly, years of Michigan case law have stood for the precedent 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, or rehabilitation. *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 220; 815 NW2d 412 (2012). In determining what constitutes a reasonable charge, Michigan courts have specifically held that fee schedules and amounts paid by Medicare, Medicaid, workers' compensation, and private health insurance ***cannot*** be used to determine what constitutes a reasonable charge. *See Johnson v Michigan Mutual Ins Co,* 180 Mich App 314 (1989) (where Court rejected the no-fault insurer's argument that it was only obligated to pay hospital charges that would have bee paid by Medicaid); *Hofmann v Auto Club Ins Ass'n,* 211 Mich App 55 (1995) (where Court rejected no-fault insurer's argument that a reasonable charge is the amount the provider would have received if private health insurance existed); *Munson Medical Center v Auto Club Ass'n*, 218 Mich App 375 (1996) (where Court held that an insurer could not apply the workers' compensation fee schedules to determine its liabiltiy to pay allowable medical expenses); *Mercy Mt Clemens Corp v Auto Club Ins Ass'n*, 219 Mich App 46 (1996) (where Court held that a no-fault insurer cannot use the amounts customarily paid by third party payors, such as workers' compensation, Medicare, Medicaid, Blue Cross Blue Shield, HMOs and PPOs to determine the no-fault insurer's liability).

Thus, when Ms. Andary and her husband purchased the insurance policy from USAA that

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was in effect at the time of her December 2014 accident, she had the unequivocal 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. Ms. Andary and Mr. Krueger paid premiums for their insurance policies to secure their unequivocal rights to have all "reasonable charges" reimbursed.

Finally, Eisenhower Center has contractual rights that are being violated by the recent amendments to §3135. 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. This right vested when Mr. Krueger became a resident of Eisenhower Center.

In their motion for summary disposition, defendants have first suggested that plaintiffs cannot establish the first essential component of a Contract Clause claim – the existence of enforceable contract-based rights. Relying on the Court of Appeals decision in *Bronson Health Care Group, Inc v State Auto Property & Casualty Ins Co*, ___ Mich App ___; ___ NW2d ___ (2019), defendants contend that the actual source of the benefits that plaintiffs are claiming in this case is *not* the contract that exists between Ms. Andary and USAA or between Mr. Krueger and Citizens. Rather, defendants contend on the basis of *Bronson Health* that it is the no-fault act itself that provides these

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benefits to the plaintiffs. Defs' Brf, at 30-31. This argument has no merit.

The short answer to this argument is that if there had been no auto insurance policy in existence 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 five 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 paid any of the no-fault benefits it has been obligated to pay for the last thirty years. Thus, contrary to defendants' contention, the existence of a contract between Ms. Andary and Mr. Kreuger and their insureds is absolutely essential to the benefits that they are claiming herein.

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 v Hawkeye-Security, Ins*, 442 Mich 520, 530, fn. 10; 502 NW2d 310 (1993). 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.

There is one other fundamental principle of contract law that comes into play in this case. This principle is demonstrated in the Michigan Supreme Court's decision in *Lafontaine Saline, Inc v Chrysler Group, LLC*, 496 Mich 26; 852 NW2d 78 (2014). In that case, the plaintiff was an authorized dealer of cars manufactured by Chrysler under a contract that the parties signed in 2007. At the time the contract was signed, a provision in the Motor Vehicle Dealer Act (MVDA), MCL 445.1566(1)(a), prohibited a vehicle manufacturer from contracting with another dealer to sell its vehicles within a six mile radius of an existing dealership. In 2010, the MVDA was amended and

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the distance between an existing dealership and a potential new dealership was extended to nine miles. Following the 2010 amendment of the MVDA, Chrysler sought to enter into an agreement with a new dealership that was to be located more than six miles from the plaintiff's dealership, but less than nine. Plaintiff 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.

The issue presented to the Supreme Court in *Lafontaine* was which version of the MVDA would apply to plaintiff's claim, the six-mile radius provided in the pre-2010 MVDA or the nine-mile radius provided by the statute in its amended form. The Supreme Court held in *Lafontaine* that the parties interests were governed by the contract that they entered into in 2007. The Supreme Court concluded that the six-mile radius in effect at the time the parties entered into that contract would control based on a principle that it characterized as "well settled":

> "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.
>
> 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).

Lafontaine teaches that the contracts that Ms. Andary and Mr. Krueger entered into with their insurers prior to their accidents *must be read in conjunction with the law that existed at the time those contracts were entered. cf Rohlman*, 442 Mich at 525, fn. 3 (in construing a case based on the no-fault act, "[t]he policy and the statutes relating thereto must be read and construed together as though the statutes were a part of the contract."). This means that under the reasoning in *Lafontaine*, the policies that the plaintiffs entered into have to be read as incorporating the provisions of the no-

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fault act as of the date those contracts were entered into.[2]

In assessing constitutional challenges based on the Contract Clause, Michigan Courts 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*, 265 Mich App at 241.

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*, 422 Mich at 21 ("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 §3135's 2019 amendments to the claims of Ms. Andary and Mr. Krueger would directly impact contractual rights that have vested for years. Where, as here, the legislative impairment of a contract is severe, "then 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

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2 Based on the reasoning expressed by the Supreme Court in *LaFontaine* and a number of prior decisions cited in that opinion, 496 Mich at 36, fn. 18, plaintiffs request the right under MCR 2.116(I)(5) to amend their complaint to seek a declaration that it would constitute a breach of contract for the defendants to pay benefits differently after June 2021.

related to the public purpose." *Health Care Ass'n Workers Comp Fund*, 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 next section of this brief will discuss the "rational basis" test that may be applied where due process and equal protection challenges are raised. It is important to note that the test for a Contract Clause claim differs substantially from this rational basis test. 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 on 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. The 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), the Supreme 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 aptly reflected in

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Michigan Supreme 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, 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

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(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. The defendants in *AFT Michigan* sought leave to appeal. The Michigan Supreme Court granted leave to appeal and, after further briefing and oral argument, the Court issued an order disposing of the case on December 20, 2017. *AFT Michigan v State of Michigan*, 501 Mich 939; 904 NW2d 417 (2017). In that order, the Supreme 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).

The Supreme 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 Supreme Court because the state failed to carry that burden.

For the same reasons expressed by the Michigan Supreme Court in *AFT Michigan*, the defendants' request to dismiss the Contract Clause claims must be denied because the defendants are unable to establish either that the 2019 amendments to MCL 500.3135 were "reasonable and necessary."

In addressing a motion filed under MCR 2.116(C)(8), the court is required to accept the allegations in the complaint as true. *El-Khalil*, 504 Mich at 160. Here, it is clear that plaintiffs have

alleged a substantial impairment of their contractual rights. As *LaFontaine* demonstrates, despite the fact that the 2019 amendments of the no-fault act at issue in this case do not take effect until June 2011, there is a decided "retroactive" component to the defendants' position in this case. They contend that the amendments that go into effect that month can reach back and retroactively affect the contract provisions that have been in effect since 2014 for Ms. Andary and since 1990 for Mr. Krueger. But, as the Supreme Court recognized in *Lafontaine*, "Retroactive application of legislation 'presents problems of unfairness ... because it can deprive citizens of legitimate expectations and upset settled transactions.'" *Id.* at 38-39. That is precisely the effect that application of the 2019 amendments would have on plaintiffs. *See Health Care Ass'n*, 265 Mich App at 244-246; *see also Minnesota Ass'n of Health Care Facilities, Inc v Dep't of Public Welfare*, 742 F2d 442, 450-451 (8th Cir 1984).

In support of their claim that plaintiffs' Contract Clause claim should be dismissed, defendants rely primarily on *Romein v General Motors Corp*, 436 Mich 515; 462 NW2d 555 (1990). *Romein* does not support their argument. *Romein* rejected the defendant auto manufacturers' constitutional challenges to 1987 amendments of the Workers' Disability Compensation Act, MCL 418.534(17)-(20), which prohibited the coordination of workers' compensation benefits for employees injured before its effective date and required the repayment plus interest of all benefits withheld as a result of coordinating benefits between 1982 and 1987 from disabled employees who were injured before 1982. 436 Mich at 520.

Although the Court rejected the defendants' constitutional challenge under the Contract Clause, it noted that "[o]ne factor in determining the extent of the impairment [of contract] is the degree of regulation in the industry the complaining party has entered," and, pointing to the fact that

"the legislative resolution in early 1982 purporting to interpret § 354 put the defendants on notice that the Legislature might seek to prevent the coordination of benefits for pre-1982 injuries if efforts to achieve this result failed in the courts," it determined that "[s]ince the [defendant] employer was aware of the likely alteration of the coordination of benefits provision, the [contractual] impairment cannot be deemed substantial." 436 Mich at 535.

In the instant case, plaintiffs did not have years of notice that the Legislature would, for the first time, severely diminish attendant-care benefits. As noted previously, the 2019 amendments to the no-fault act were passed swiftly, behind closed doors, and with no opportunity for public comment. Members of the Legislature were not even given the opportunity to comment on the bill and the proposed changes.

Furthermore, *Romein* is clearly distinguishable from the instant case. *Romein* involves workers' compensation benefits, which are not payable to accident victims pursuant to insurance policies that those victims purchased. Rather, worker's compensation benefits are paid statutorily based on policies bought by an employer, not the accident victim. An individual who is entitled to workers' compensation benefits does not have a contract with the workers' compensation insurer. Clearly, this type of insurance is distinguishable from no-fault insurance in which the injured individual has a contract for no-fault insurance with his or her no–fault insurer. Accordingly, defendants' reliance on *Romein* in the instant case is misplaced.

Eisenhower Center's Contract Clause Claim

The only case defendants cite in support of their argument that Eisenhower Center has no Contract Clause claim is *Romein*, which is addressed above. Again, defendants' reliance on *Romein* to support their argument is clearly misplaced.

III. PLAINTIFFS' DUE PROCESS AND EQUAL PROTECTION CLAIMS ARE NOT SUBJECT TO DISMISSAL ON A MOTION FILED UNDER MCR 2.116(C)(8).

The defendants also seek dismissal of the claims in plaintiffs' complaint based on the Michigan Constitution's Due Process Clause, Const. 1963, art. 1, sec. 17, and the Equal Protection Clause.

The Michigan Constitution's Equal Protection Clause is coextensive with the federal clause. *Doe v Dep't of Soc Servs*, 439 Mich 650, 670–71; 487 NW2d 166 (1992). Strict scrutiny applies to equal protection challenges when the challenged legislation creates a classification scheme that impinges upon the exercise of a fundamental right. *Id.*, at 662.

> [I]n two situations the equal protection guarantee is less tolerant of legislation that creates a classification scheme—when the classification is based upon suspect factors (such as race, national origin, or ethnicity), or when the legislation that creates the classification impinges upon the exercise of a fundamental right. *Plyler v. Doe*, 457 U.S. 202, 216–217, 102 S. Ct. 2382, 2394–2395, 72 L. Ed. 2d 786 (1982). In these situations, a higher standard of review, strict scrutiny, is applied. A statute reviewed under this strict standard will be upheld only if the state demonstrates that its classification scheme has been precisely tailored to serve a compelling governmental interest. *Id.*
>
> *Doe*, 439 Mich at 662.

Where the classification at issue is not based on suspect factors such as race, national origin, ethnicity, or a "fundamental right," or on such bases as illegitimacy and gender, rational basis review applies. *Phillips v Mirac, Inc*, 470 Mich 415, 432–33; 685 NW2d 174 (2004). "Under this test, 'courts will uphold legislation as long as that legislation is rationally related to a legitimate government purpose.'" *Id.* "This highly deferential standard of review requires a challenger to show that the legislation is arbitrary and wholly unrelated in a rational way to the objective of the statute." *Id.*

Count III of plaintiffs' complaint alleges that application of the attendant care limitations set out in §3157(10) to Ms. Andary violates her fundamental equal protection right to privacy and bodily integrity, as it forces her to bring strangers into her home to provide her with very personal and intimate care, such as bathing, dressing, and assisting with using the bathroom Complaint, ¶¶72, 75. Count III further alleges that §3157(10) creates two different classes of motor vehicle accident victims that require in-home attendant care: a) persons who receive in-home family provided attendant care and b) persons that receive in-home commercial attendant care, and discriminates against persons that receive in-home family provided attendant care, such as Ms. Andary, by putting a 56 hour per week cap on the amount of reimbursement, whereas persons who receive in-home commercial attendant care are not subject to any such limitation. *Id.*, ¶73. Count III alleges that the State of Michigan has no compelling interest to infringe upon Ellen Andary's fundamental right to privacy and bodily integrity and no compelling interest to treat her more harshly than other similarly situated motor vehicle accident victims by restricting her right to receive reasonably necessary in-home family provided attendant care. Complaint, ¶76.

Count VI alleges that Ellen Andary's fundamental equal protection rights to privacy and bodily integrity are violated by the fee schedule limitations of MCL 500.3157(2) and (7) in that they treat similarly situated motor vehicle accident victims in a dissimilar manner, thereby imposing a substantial disadvantage on those who receive reasonably necessary products, services, and accommodations for their care, recovery, or rehabilitation that are not compensable by Medicare, such as Ms. Andary. *Id.*, ¶¶91, 93. Count VI alleges that the State of Michigan has no compelling interest to infringe upon Ms. Andary's fundamental right to privacy and bodily integrity and no compelling interest to treat her more harshly than other similarly situated motor vehicle accident

victims with respect to provider reimbursement rates for reasonably necessary products, services, and accommodations under MCL 500.3157(7). Complaint, ¶94.

Count IX alleges the same violations as Count VI, but as to Mr. Krueger. *Id.*, ¶¶109-113.

Count XII alleges that application of the fee schedule limitations of §§3157(2) and (7) discriminates against medical providers, such as Eisenhower Center, that render reasonably necessary products, etc., to motor vehicle accident victims that are not compensable under the Medicare laws, i.e., it is reimbursed at a rate of 52.5% - 55% of the amount charged for those products, etc., on January 1, 2019, whereas medical providers that render reasonably necessary products, etc., that would be compensable under the Medicare laws are reimbursed at a rate of 190% - 200% of the amount compensable by Medicare. *Id.*, ¶ 128. MCL 500.3157(2) and (7) create two classes and treat similarly situated Michigan medical providers in a dissimilar manner. Complaint, ¶129. Count XII further alleges that the State of Michigan has no rational basis for treating plaintiff Eisenhower Center more harshly than medical providers that render reasonably necessary products, etc., that are compensable by Medicare. *Id.*, ¶130.

Counts III, VI and IX assert violations of Ms. Andary's and Mr. Krueger's fundamental right to privacy and bodily integrity. Plaintiffs acknowledge that none of their equal protection claims implicate a suspect classification. However, plaintiffs have alleged that these claims do involve fundamental rights – the right to privacy and bodily integrity. Strict scrutiny is required in an equal protection claim that involves *either* suspect classification *or* a fundamental right. *Doe*, 439 Mich at 662. Accordingly, plaintiffs' claim that their equal protection rights are being violated by the infringement upon their fundamental rights, which will be discussed further in the next section of this brief, must be analyzed under strict scrutiny.

But, even if the Court were to ultimately determine that rational basis applies to plaintiffs' equal protection and due process claims, summary disposition on the basis of MCR 2.116(C)(8) should not be ordered at this stage. Again, in addressing such a motion, all well-pleaded factual allegations in plaintiffs' complaint must be accepted as true. *El-Khalil*, 504 Mich at 160. Under the rational basis standard, the constitutionality of a statute will be upheld where it is "rationally related to a legitimate government purpose." *Phillips*, 470 Mich at 432. But, as the Supreme Court recognized in *Shavers*, "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.'" 402 Mich at 615.

Judicial inquiry into whether the 2019 amendments to the no-fault act are "rationally related to a legitimate government purpose" is particularly important in this case in light of the process by which these amendments came to be. These amendments were adopted with extraordinary speed, without deliberation into the implications of the changes being made and without public input.[3] This case presents the unique situation where it can be said in light of the manner in which the 2019 amendments to the no-fault act took place that the Legislature had no time to acknowledge whether the changes they were making were "rationally related to a legitimate government purpose." Since the Legislature failed to do so, it is particularly important that this Court perform the role that the *Shavers* Court outlined and allow factual development of the plaintiffs' equal protection and due process claims, under a rational basis test.

[3] Judicial deference to legislative judgments is in part based on recognition of the fact that "the Legislature possesses superior tools and means for gathering facts, data, and opinion and assessing the will of the public." *Wells Fargo Bank NA v Cherryland Mall Ltd Partnership*, 300 Mich App 361, 375; 835 NW2d 593 (2013). The deliberative resources available to the Legislature, however, had no role to play in the passage of the 2019 legislation at issue in this case.

Indeed, the defendants' own analysis of the equal protection arguments appears to emphasize the lack of reasoned support for the choices made by the Legislature in passing the 2019 amendments. Defendants assert that the rational basis test is satisfied on two grounds; the Legislature acted to either cut the cost of automobile insurance or to remove fraud from the no-fault system. The suggestion that cutting the cost of insurance could serve as a rationale for the limitation on in-home family-provided attendant care is difficult to sustain since the professional care that would replace family members would likely be more expensive than that provided by family and friends. Defendants seem to grasp this fact when the best they can offer is that "[t]here is certainly *a possibility*" that reducing funding provided attendant care "could reduce the cost of insurance and its abuse." Defs' Brf., at 13 (emphasis added).

The defendants are similarly less-than-assured that the other rationale for the 2019 changes to the act that they offer – cutting the cost of medicare care covered by the no-fault act – will be achieved. At another point in their brief they acknowledge that this long-term goal "cannot yet be fully assessed . . ." Defs' Brf., at 17.

Thus, even if plaintiffs' allegations of fundamental rights were disregarded, and their equal protection and due process challenges were governed solely under the rational basis test, the defendants are still not entitled to the dismissal of those claims at this early stage in the litigation.

IV. PLAINTIFFS' FUNDAMENTAL RIGHTS TO PRIVACY AND TO BODILY INTEGRITY HAVE BEEN VIOLATED (Counts II, V, VIII)

Count II alleges that the in-home attendant-care limitation of MCL 500.3157(10) violate Ms. Andary's "fundamental right to privacy and bodily integrity, as it forces her to bring strangers into her home to provide her with very personal and intimate care, such as bathing, dressing, and assisting with using the bathroom." Complaint, ¶68.

Count V alleges that application of the fee schedule limitations of MCL 500.3157(7) violate Ms. Andary's fundamental due process right to privacy and bodily integrity, Complaint, ¶84. Count V further alleges that the "reimbursement rates set forth in §3157(7) are unsustainable for many Michigan medical providers. Therefore, those providers will be unable or unwilling to treat Ellen M. Andary at such dramatically reduced reimbursement rates, thereby impairing her access to reasonably necessary products, services, and accommodations for her care, recovery, or rehabilitation. Complaint, ¶87.

Count VIII alleges that the fee schedule limitations set forth in MCL 500.3157(7) "interfere with Philip Krueger's fundamental right to privacy and bodily integrity . . . in his ability to access reasonably necessary products, services, and accommodations for this care, recovery, or rehabilitation." Complaint, ¶104. "The reimbursement rates under the fee schedules . . . are unsustainable for Plaintiff Eisenhower Center. Therefore, Plaintiff Eisenhower Center will be unable or unwilling to treat Philip Krueger at such dramatically reduced reimbursement rates, thereby impairing his access to reasonably necessary products, services, and accommodations for his care, recovery, and rehabilitation." Complaint, ¶104. Count VIII further alleges that the State of Michigan "has no compelling interest to infringe upon Philip Krueger's fundamental right to privacy and bodily integrity and his liberty interest by the imposition of price fixing rules, applicable to private insurance contracts, that interfere with his ability to access reasonably necessary products, services, and accommodations for his care, recovery, or rehabilitation." Complaint, ¶106.

A. Substantive Due Process and Right to Privacy.

"The substantive due process clause protects two types of privacy rights." *Jenkins v Rock Hill Local Sch Dist*, 513 F3d 580, 590 (6th Cir. 2008) (citing *Whalen v Roe*, 429 US 589, 599–600;

97 S Ct 869; 51 L Ed 2d 64 (1977)). A "fundamental" privacy right is an "individual's right to make 'personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education.'" *Id.*, quoting *Lawrence v Texas*, 539 US 558, 574 (2003); *People v Jensen*, 231 Mich App 439, 457; 586 NW2d 748 (1998). The second type of privacy right is "an individual's 'interest in avoiding disclosure of personal matters.'" *Jenkins*, 513 F3d at 590 (quoting *Whalen*, 429 US at 599). Only the first type of privacy right is at issue here, specifically, the fundamental privacy right of Ellen and Michael Andary to make personal decisions relating to family relationships in the context of the in-home attendant care provided Ellen Andary by family members as opposed to strangers.

Courts are required "to exercise reasoned judgment in identifying interests of the person so fundamental that the State must accord them its respect." *Obergefell v Hodges*, ___ US ___; 135 S Ct 2584, 2598 (2015). In *Obergefell*, a substantive due process and equal protection challenge to Michigan's prohibition of same sex marriages, the Supreme Court overruled prior decisions and held that the right to marry is a fundamental right inherent in the liberty of the person, and that under the Fourteenth Amendment's Due Process and Equal Protection Clauses, couples of the same-sex may not be deprived of that right and that liberty. *Id.*, 135 S Ct at 2604-2605.

A plaintiff alleging a substantive due process claim under the Michigan Constitution must show that the deprivation of a fundamental right is so arbitrary that it shocks the conscience. *Mettler Walloon, LLC v Melrose Twp*, 281 Mich App 184, 201; 761 NW2d 293, 306 (2008); citing *Landon Holdings, Inc v Grattan Twp*, 257 Mich App 154, 176; 667 NW2d 93 (2003).

Defendants' motion does not discuss the seminal cases addressing fundamental substantive due process rights in family relationships. These seminal cases include *Troxel v Granville*, 530 US

57 (2000), in which the United States Supreme Court held that the state of Washington's nonparent visitation statute was unconstitutional because it allowed the trial court to order visitation without granting deference to the parents' decisions, contrary to the parents' fundamental right and liberty interest in managing the care, custody, and control of their children. *Id.*, at 70–74. Another significant case in this area is *Moore v City of East Cleveland*, 431 U.S. 494 (1977), in which the Supreme Court held that a local zoning ordinance violated fundamental rights to family relationships by prohibiting a grandmother from residing with two grandsons who were cousins.

In *Brinkley v Brinkley*, 277 Mich App 23; 742 NW2d 629 (2007), the Court of Appeals addressed whether a statute that denied the plaintiff grandparents' rights to visitation with their grandchild, where the parents of the child did not consent, violated their fundamental substantive due process right to maintain a familial relationship. The court held that strict scrutiny did not apply because the statute "does not authorize governmental interference into a family relationship. Instead, it restricts a court's authority to interfere with parental decisions concerning grandparenting time." *Id.*, at 29-31.

In the instant case, Count II of plaintiffs' complaint clearly states a viable claim that the attendant-care limitations imposed by §3157(10) constitute governmental interference in the Andarys' familial relationship rights by capping at 56 hours per week family members may provide Ms. Andary in in-home attendant care. Complaint, ¶¶21, 41, 42-45, 67-70.

Defendants are not entitled to judgment as a matter of law on Counts II, V, and VIII. These Counts state viable claims that plaintiffs' substantive due process rights to privacy are burdened by the 2019 attendant-care limitation amendment, §3157(10), and the amendments to reimbursement rates, §3157(7).

This court should deny defendants' MCR 2.116(C)(8) motion and allow discovery to proceed on plaintiffs' substantive due process claims alleging that their fundamental right to maintain family relationships is subject to governmental interference under MCL 500.3157(10), the novel and unprecedented amendment limiting in home attendant care by family members to 56 hours per week.

Because it is undisputed that the amendments to the no-fault act plaintiffs challenge are novel and important, this court should deny defendants' motion to dismiss and allow this case to proceed to discovery, *Shavers*, 402 Mich at 614–15, particularly given the Legislature's rush to judgment in enacting the challenged amendments.

B. Substantive Due Process – Right to Bodily Integrity.

Defendants' motion argues that plaintiffs have failed to establish that any right to bodily integrity is implicated in this case. Defendants are incorrect, as Counts II and VIII allege viable substantive due process violations of the right to bodily integrity of Ms. Andary and Mr. Krueger.

Count II alleges that the in-home attendant-care limitation of MCL 500.3157(10) violates Ms. Andary's "fundamental right to privacy and bodily integrity, as it forces her to bring strangers into her home to provide her with very personal and intimate care, such as bathing, dressing, and assisting with using the bathroom." Complaint, ¶¶66, 68, 69.

Count VIII alleges that the fee schedule limitations set forth in MCL 500.3157(7) "interfere with Philip Krueger's fundamental right to privacy and bodily integrity . . . in his ability to access reasonably necessary products, services, and accommodations for this care, recovery, or rehabilitation." Complaint, ¶104. "The reimbursement rates under the fee schedules . . . are unsustainable for Plaintiff Eisenhower Center. Therefore, Eisenhower Center will be unable or unwilling to treat Philip Krueger at such dramatically reduced reimbursement rates, thereby

impairing his access to reasonably necessary products, services, and accommodations for his care, recovery, and rehabilitation." Complaint, ¶104. Count VIII further alleges that the State of Michigan "has no compelling interest to infringe upon Philip Krueger's fundamental right to privacy and bodily integrity . . . by the imposition of price fixing rules, applicable to private insurance contracts, that interfere with his ability to access reasonably necessary products, services, and accommodations for his care, recovery, or rehabilitation." Complaint, ¶106.

In *Mays v Snyder*, 323 Mich App 1; 916 NW2d 227 (2018), *appeal granted sub nom Mays v Governor of Michigan*, 503 Mich 1030; 926 NW2d 803 (2019), the Court of Appeals recognized a cause of action for a constitutional violation of a plaintiff's substantive due process right to bodily integrity, and held that the plaintiffs "alleged facts sufficient to support a constitutional violation by defendants of plaintiffs' right to bodily integrity." 323 Mich App at 58-61.

MCL 500.3157(10) provides that no-fault benefits are not payable for in-home family provided attendant care services that exceed 56 hours per week (8 hours per day). Complaint, ¶42. Although this attendant-care limitation does not go into effect until July 1, 2021, this limitation will supposedly apply to seriously injured motor vehicle accident victims like Ellen Andary, who were injured prior to June 11, 2019. Complaint, ¶43. Ellen Andary will presumably no longer be entitled to receive reimbursement for in-home family provided attendant care rendered to her in excess of 56 hours per week (8 hours per day), Complaint, ¶44, and thus will be denied the full benefits under her insurance policy with defendant USAA, which was purchased and was in full force and effect on the date of her December 5, 2014 accident. Complaint, ¶45.

MCL 500.3157(2) and (7) enacted unprecedented "fee schedules that dramatically limit a no-fault insurer's obligation to reimburse expenses for reasonably necessary products, services, and

accommodations rendered for the care, recovery, or rehabilitation of motor vehicle accident victims." Complaint, ¶46. The fee schedule amendments provide that medical providers such as plaintiff Eisenhower Center, which has housed plaintiff Philip Krueger since 1997, will be reimbursed under § 3157(7) only at a rate of 52.5% - 55% of the amount these providers charged for those products, services, and accommodations on January 1, 2019. Complaint, ¶110. Although the fee schedules in §§ 3157(2) and (7) do not apply until July 1, 2021, these schedules will presumably apply to motor vehicle accident victims like Philip Krueger who was catastrophically injured in a motor vehicle accident prior to June 11, 2019. Complaint, ¶47.

This court must accept as true these allegations in plaintiffs' complaint and construe them in the light most favorable to plaintiffs. *Kuznar*, 481 Mich at 176; Mich at 119. The effect of the attendant-care limitation challenged here will be to force Ms. Andary to submit to in-home attendant care by strangers rather than by her family members. Whether that "involves an egregious, nonconsensual entry into the body" presents a novel question unaddressed by any precedent plaintiffs could find. But, as is obvious, for strangers to provide intimate care to Ms. Andary, including with bathing and assisting her in urination and defecation, certainly implicates the "nonconsensual entry" into her body contemplated by the precedent discussed above.

Under the fee schedule limitations of MCL 500.3157(7), Mr. Krueger will be ejected from Eisenhower Center, where he has resided since 1997, because the reimbursement rates as amended will be unsustainable for Eisenhower Center. Complaint, ¶104. Since Mr. Krueger is totally and permanently disabled and incapable of caring for himself, he will thus be subject to intimate physical care by strangers. As is obvious, for strangers to provide intimate care to completely disabled and incapacitated Philip Krueger will involve "nonconsensual entry" into his body.

If this court is not persuaded that these allegations state a viable claim of violation of the substantive due process right to bodily integrity of Ellen Andary and Philip Krueger, however, plaintiffs request that, rather than dismiss this claim, this court should defer ruling on the substantive due process right to bodily integrity claims because the Michigan Supreme Court in *Mays* granted leave to appeal on issues including "whether the Court of Appeals erred in recognizing a constitutional tort for violation of bodily integrity under Const. 1963, art. 1, § 17, and, if not, whether the plaintiffs properly alleged such a violation." *Mays*, 503 Mich 1030.

V. THE COURT SHOULD DENY DEFENDANTS' MOTION TO DISMISS COUNTS II, V AND VIII REGARDING PLAINTIFFS' SUBSTANTIVE DUE PROCESS CLAIMS BECAUSE PLAINTIFFS HAVE ALLEGED SUFFICIENT FACTS TO SHOW THAT THEIR DUE PROCESS RIGHTS HAVE BEEN VIOLATED.

Defendants take issue with plaintiffs' allegations of liberty interests under their substantive due process claims, specifically Count II's allegation that §3157(10) violates Ms. Andary's "liberty interests, as it restricts her right to be able to choose the in-home caregivers that she or her Guardian selects, and who provide the care that is most efficacious and beneficial for her," Complaint, ¶68; Count V's allegation that application of the fee schedule limitations of MCL 500.3157(7) violate Ms. Andary's liberty interest "in being able to make personal medical decisions and in being free from governmental interference with the ability to access reasonably necessary products, services, and accommodations for her recovery, or rehabilitation by limiting the amount her providers can be reimbursed by her insurer under a private insurance contract," Complaint, ¶85; Count VIII's allegation that Philip Krueger has a substantive due process liberty interest in being able to make personal medical decisions and in being free from governmental interference with his ability to access reasonably necessary products, services, and accommodations for his care, recovery, or

rehabilitation by limiting the amount his providers, such as plaintiff Eisenhower Center, can be reimbursed by his insurer under a private contract, Complaint, ¶103, and a liberty interest in his ability to access reasonably necessary products, services, and accommodations for his care, recovery, or rehabilitation, Complaint, ¶104. Motion to Dismiss at 22 n 11. Defendants argue that plaintiffs' "alleged liberty interest in having their insurer pay medical providers any fee amount without limitation is not a proper subject of state constitutional protection under the doctrine of substantive due process." Motion to Dismiss at 22. They further argue that the "fee schedule and limits on family provided attendant care are directed at the providers and the insurers, which only indirectly affects the patients," Motion to Dismiss at 24.

Plaintiffs have alleged claims of substantive due process based on their rights to privacy and bodily integrity. As discussed previously, these are viable claims. Even if the Court were to ultimately determine that a substantive due process claim cannot be proved, that is not a proper inquiry at this stage in the litigation. Since the Court must at this stage accept all of plaintiffs' well pleaded allegations true, defendants' arguments for the dismissal of these substantive due process claims should be denied. Clearly, additional factual development is necessary before the Court can make a determination that plaintiffs' allegations are without merit.

VI. DEFENDANTS ARE NOT ENTITLED TO DISMISSAL UNDER MCR 2.116(C)(8) ON THE CLAIMS ASSERTED BY EISENHOWER CENTER.

Count XI of the Complaint alleges that Eisenhower Center has a property interest in the survival of its business and the perpetuation of its financial operations without government interference in the form of oppressive price controls that threaten its survival. Complaint, ¶120. Again, Plaintiffs have pled sufficient facts to state a viable claim on behalf of Eisenhower Center.

Dismissal of this claim under MCR 2.116(C)(8) would be improper.

VII. PLAINTIFFS HAVE PLED ALLEGATIONS THAT ARE SUFFICIENT TO GIVE PLAINTIFFS STANDING TO RAISE THE CLAIMS ASSERTED IN COUNTS XIII THROUGH XVIII OF THEIR COMPLAINT.

The final argument that defendants raise in their motion to dismiss is addressed to Counts XIII through XVIII of plaintiffs' complaint, in which plaintiffs have alleged that the future application of the attendant care limitations imposed in §3135(10) and the fee schedules of §3135(7) should be found unconstitutional under the various constitutional provisions that the plaintiffs have named in this case. The defendants contend that plaintiffs lack standing to raise these issues.

MCR 2.605 governs declaratory judgments and provides that a court may grant declaratory relief "in a case of actual controversy within its jurisdiction . . . whether or not other relief is or could be sought or granted." MCR 2.605(A). "The existence of an actual controversy is a condition precedent to invocation of declaratory relief and this requirement prevents a court from deciding hypothetical issues." *Detroit v Michigan*, 262 Mich App 542, 550; 686 NW2d 514 (2004).

The Michigan Supreme Court defined the test for standing in *Lansing Schools Education Association v Lansing Board of Education*, 487 Mich 349; 729 NW2d 686 (2010). Prior to its decision in *Lansing Schools*, the Court had issued two decisions that interpreted the concept of standing rigidly and vested that doctrine with a constitutional component. *See Lee v Macomb County Board of Commissioners*, 464 Mich 726; 629 NW2d 900 (2001); *Nat'l Wildlife Federation v Cleveland Cliffs Iron Co*, 471 Mich 608; 684 NW2d 800 (2004). In *Lansing Schools*, the Supreme Court overruled *Lee* and *Cleveland Cliffs*, and restored the standing to its traditional "limited, prudential approach." 487 Mich at 355.

The Supreme Court explained in *Lansing Schools* that the purpose of the standing

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requirement is "to assess whether the litigant's interest in the issue is sufficient to 'assure sincere and vigorous advocacy." *Id.*, quoting *Detroit Fire Fighters Ass'n v Detroit*, 449 Mich 629, 633; 537 NW2d 436 (1995). In returning standing to its prudential, as opposed to constitutional, roots, the Court in *Lansing Schools* emphasized that the traditional application of this doctrines was "one of discretion and not of law." 487 Mich at 355. The Court in *Lansing Schools* reached the following holding with respect to standing:

> We hold that Michigan standing jurisprudence should be restored to a limited, prudential doctrine that is consistent with Michigan's long-standing historical approach to standing. Under this approach, a litigant has standing whenever there is a legal cause of action. Further, whenever a litigant meets the requirements of MCR 2.605, it is sufficient to establish standing to seek a declaratory judgment. Where a cause of action is not provided at law, then a court should, in its discretion, determine whether a litigant has standing. A litigant may have standing in this context if the litigant has a special injury or right, or substantial interest, that will be detrimentally affected in a manner different from the citizenry at large or if the statutory scheme implies that the Legislature intended to confer standing on the litigant.
>
> *Id.* at 372.

Plaintiffs can satisfy the standing requirements outlined in *Lansing Schools* to bring the claims stated in the last six counts of their complaint. There is, without question, a "legal cause of action," raised in these counts premised on the claims that application of the 2019 amendments to §3135(7) and (10) violate various provisions of the Michigan Constitution. Moreover, plaintiffs have an interest in these issues that is distinct from the "category at large."

Under the limited, prudential approach to standing adopted by the Supreme Court in *Lansing Schools*, the defendants' request to discuss the last Counts XIII through XVIII of the complaint should be denied.

CONCLUSION

Based on the foregoing, plaintiffs, 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, request that defendants' motion to dismiss be denied in its entirety.

MARK GRANZOTTO, P.C.

Mark Granzotto/w/permission

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Dated: **March 6, 2020.**

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF INGHAM

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,

-vs-

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

Defendants.

Case No. 19-738-CZ

Hon. Wanda M. Stokes

/

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PROOF OF SERVICE

Nancy Jo Gibson states that on **March 6, 2020**, a copy of **PLAINTIFFS' BRIEF IN OPPOSITION TO THE MOTION TO DISMISS FILED BY DEFENDANTS**, filed in said cause on or about **March 6, 2020**, was served on **Lori McAllister, Attorney for Defendants, 201 Townsend Street, Suite 900, Lansing, MI 48933,** via email at lmcallister@dykema.com and by hand-delivering the same to her office and leaving it with a person in charge thereof.

Nancy Jo Gibson

Nancy Jo Gibson

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EXHIBIT B

STATE OF MICHIGAN

COURT OF APPEALS

DIANE BRADY, as Guardian of THOMAS ROBERT MIDDLETON,

Plaintiff-Appellant,

v

HOME-OWNERS INSURANCE COMPANY,

Defendant-Appellee.

UNPUBLISHED
June 21, 2016

No. 324864
Oakland Circuit Court
LC No. 2012-128435-NF

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

PER CURIAM.

Plaintiff, as guardian of her son, Thomas Robert Middleton, brought this action for recovery of 24-hour attendant care no-fault benefits. Following a trial, a jury concluded that plaintiff was entitled to a reasonable hourly daytime rate of $11.44, the rate then paid by defendant, Home-Owners Insurance Company, but found that the hourly nightly rate of $7.40 paid by defendant was unreasonable, and awarded a reasonable hourly nighttime rate of $11.44. The difference in the nighttime rates between October 2011 and May 31, 2014, resulted in a judgment of $27,317.69 in favor of plaintiff. At trial, plaintiff asserted that $30 an hour was the reasonable rate for the 24-hour attendant care services provided to her son in light of his behavioral and cognitive injuries caused by a traumatic brain injury sustained in an automobile accident. Plaintiff now appeals as of right. We affirm in part, reverse in part, and remand for a new trial consistent with this opinion.

I. FACTS AND PROCEEDINGS

In August 2011, 18-year-old Thomas Middleton ("Tommy") suffered a traumatic brain injury in an automobile accident. Before the accident, Tommy had been diagnosed with Asperger's syndrome and attention deficit/hyperactivity disorder (ADHD). Following the accident, Tommy required an extensive stay in both a hospital and rehabilitation facility. Doctors determined that a home setting was more beneficial than an institutional setting. Tommy was ultimately discharged to plaintiff's home, but his doctor prescribed 24-hour attendant care. Plaintiff established a corporate entity that employed family members and a close friend to care for Tommy. Tommy's cognitive deficits also caused anger management, impulse, and safety issues, and triggers for those issues included alteration in scheduling and unfamiliar

events. Consequently, the caregivers had to recognize Tommy's triggers and act accordingly. Tommy's home care was supplemented by various therapies that occurred outside the home.

Because the 24-hour attendant care prescription did not contain specific direction, defendant's representative determined that it was the lowest level of supervision required and could be fulfilled by a home health aide. Thus, the rate for the service was paid at $11.44 for daytime hours and $7.40 for nighttime hours.

Although Tommy had a case manager, plaintiff was a registered nurse and she performed some of the functions of a case manager. She attended all of Tommy's doctor appointments and scheduled, coordinated, and provided direction to all of Tommy's caregivers. The home business plaintiff established managed the appropriate deductions and payroll for Tommy's caregivers. The caregivers were paid $10.00 an hour because that was all plaintiff could afford and did not include any payment to plaintiff. However, plaintiff did not submit a request for payment as a case manager, registered nurse, or business to defendant.

After this action was filed, Tommy's doctor altered the prescription for 24-hour attendant care to provide that he needed a behavioral technician or life skills trainer, not a home health aide. Although plaintiff presented evidence that supported a range of hourly rates for the position, she requested $30 an hour at trial. Defendant disputed that a change in rate was warranted, particularly because Tommy's caregivers did not have specialized medical training, and plaintiff acknowledged that the behavioral training therapy was paid for by defendant outside the home setting. Ultimately, the jury concluded that $11.44 was a reasonable rate for the attendant care on a 24-hour basis.

II. ANALYSIS

Plaintiff first argues that the trial court erred by instructing the jury that agency rates for similar attendant care services were not relevant and by failing to instruct the jury that comparable agency rates was an appropriate consideration. A claim of instructional error is reviewed de novo, but the trial court's determination whether a jury instruction is applicable and accurate is reviewed for an abuse of discretion. *Alfieri v Bertorelli*, 295 Mich App 189, 197; 813 NW2d 772 (2012). Whether a supplemental jury instruction is warranted is also reviewed for an abuse of discretion. *Guerrero v Smith*, 280 Mich App 647, 660; 761 NW2d 723 (2008). An abuse of discretion occurs when the trial court's decision falls outside the range of reasonable and principled outcomes. *Nelson v Dubose*, 291 Mich App 496, 500; 806 NW2d 333 (2011).

"Jury instructions are reviewed in their entirety to determine whether they accurately and fairly presented the applicable law and the parties' theories." *Guerrero*, 280 Mich App at 660. The instructions should not omit material issues, defenses, or theories that are warranted by the evidence. *Ward v Consol Rail Corp*, 472 Mich 77, 83-84; 693 NW2d 366 (2005). "When the standard jury instructions do not adequately cover an area, the trial court is obligated to give additional instructions when requested, if the supplemental instructions properly inform the jury of the applicable law and are supported by the evidence." *Bouverette v Westinghouse Electric Corp*, 245 Mich App 391, 401-402; 628 NW2d 86 (2001). A supplemental instruction must be modeled as nearly as possible to the style of the standard jury instructions and must be "concise, understandable, conversational, unslanted, and nonargumentative." *Id.* at 402.

A no-fault claim requires an insured to establish that he or she is entitled to benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle. *Cooper v Auto Club Ins Ass'n*, 481 Mich 399, 407; 751 NW2d 443 (2008). Personal injury protection benefits are payable for allowable expenses incurred for reasonably necessary products, services, and accommodations for the injured person's care, recovery, or rehabilitation. MCL 500.3107(1)(a). The plaintiff must prove that the charge for the service was reasonable, the expense was reasonably necessary, and it was incurred. *Williams v AAA Mich*, 250 Mich App 249, 258; 646 NW2d 476 (2002).

Attendant care services need not be performed by trained medical personnel. *Van Marter v American Fidelity Fire Ins Co*, 114 Mich App 171, 180; 318 NW2d 679 (1982). In *Hardrick v Auto Club Ins Ass'n*, 294 Mich App 651, 665; 819 NW2d 28 (2011), this Court held that "the market rate for agency-provided attendant-care services bears relevance to establishing a rate for family-provided services." In *Douglas v Allstate Ins Co*, 492 Mich 241, 276; 821 NW2d 472 (2012), our Supreme Court concluded that a fact-finder should focus on the individual's compensation, holding "that a fact-finder may base the hourly rate for a family member's provision of attendant care services on what health care agencies compensate their employees, but what health care agencies charge their patients is too attenuated from the appropriate hourly rate for a family member's services to be controlling." Although the *Douglas* Court recognized that it was not addressing an admissibility issue, *id.*, at 276 n 79, it nonetheless acknowledged that admission of an agency rate may be helpful in calculating a rate, though it could not be uncritically adopted. *Id.* at 276. Importantly, the Court stated that an agency rate may be relevant particularly when "the individual caregiver has overhead and administrative costs similar to those of a commercial agency." *Id.*

Plaintiff requested a jury instruction that allowed the jury to consider agency rates as evidence of an appropriate rate for the family members' care for Tommy. However, contrary to the holding in *Hardrick* and the statements in *Douglas*, the trial court precluded the jury from considering any evidence of rates charged by agencies:

> "Reference to rates charged by agencies to insurers or other entities (with regard to similar attendant care services as those being provided to Middleton) are irrelevant and should not be considered as part of your decision on an appropriate hourly rate (for such care)."

This instruction was provided, despite the fact that *Hardrick* stated that agency rates are at least a minimally relevant factor for a jury to consider in a home attendant care situation, and *Douglas*'s specific reference to admissibility of agency rates when a party (as plaintiff testified to at trial) has overhead costs similar to that of a commercial agency. As defendant acknowledges on appeal[1], this was error. Hence, as to the issue of the appropriate rate for family members

[1] "The trial record admittedly contains some evidence from which the jury could have concluded that 'the individual caregiver has overhead and administrative costs similar to those of a commercial agency.' *Id.* Thus, Defendant concedes that Plaintiff's 'agency rates' instruction would have been permissible."

providing home attendant care services to Tommy, the trial court erred in instructing the jury that agency rates were *irrelevant*[2] and not to be considered, and in refusing to instruct as plaintiff requested on that issue.

Defendant argues that this instructional error was harmless because "the jury unmistakably rejected Plaintiff's home business theory." We cannot accept that argument because it would have been very difficult—if not impossible—for the jury to accept plaintiff's theory when the court instructed it not to consider the exact evidence that would have allowed plaintiff to succeed on that theory. Nor do we agree with defendant that plaintiff's alleged failure to request reimbursement from defendant for these business related expenses bars these claims. Plaintiff is not seeking reimbursement of those specific costs, but is instead seeking a higher rate for attendant care services, in part because of those business costs. And obtaining a higher rate for attendant care is exactly what was at issue. We therefore reverse and remand for a new trial only on the issue of the appropriate rate for Tommy's attendant care services.[3] We now turn to several evidentiary issues that may arise again at trial.

Plaintiff argues that the trial court erred by excluding evidence of plaintiff's earnings as a registered nurse when her training was an integral part of Tommy's care, recovery, and rehabilitation. A trial court's decision to exclude evidence is reviewed for an abuse of discretion, but any preliminary questions of law are reviewed de novo. *Barnett v Hidalgo*, 478 Mich 151, 158-159; 732 NW2d 472 (2007). An abuse of discretion occurs when the decision falls outside the range of reasonable and principled outcomes. *Id.* at 158.

Although plaintiff did not specifically raise in the final pretrial order the issue that nursing services were required and that the $30 an hour sought was consistent with the wage of a nurse, *Wilhelm v Mustafa*, 243 Mich App 478, 485; 624 NW2d 435 (2000), even if she did through several broad statements about attendant care and reference to her part-time nursing job, we nonetheless find no abuse of discretion in the trial court's ruling. For one, the trial court did not abuse its discretion by holding that the evidence of plaintiff's wage as a nurse was not relevant, MRE 401; MRE 402; *Omian v Chrysler Group LLC*, 309 Mich App 297, 308; 869 NW2d 625 (2015), because the issue for trial was essentially whether Tommy's attendant care providers should be paid at the rate of a home health aide or the higher rate of a life skills trainer or behavioral technician.

---

[2] Though this evidence should have been presented to the jury, it does not, of course, have to be accepted by the jury.

[3] This holding does not apply to plaintiff's argument on appeal regarding compensation for case management services, for as defendant argues, those expenses were not at issue in this case. In plaintiff's complaint, the joint final pretrial order, and in plaintiff's opening statement, all that is placed at issue is the appropriate rate for Tommy's attendant care services. Additionally, it was undisputed that Tommy had a case manager regardless of the role plaintiff voluntarily took in her child's care.

Even if it was an abuse of discretion, it was harmless, because the jury was aware of plaintiff's employment and she argued that her nursing skills were necessary to Tommy's proper care. Plaintiff testified that she was a registered nurse, continued to work on a part-time basis, and delineated her extensive involvement with Tommy's care. Defendant, of course, argued that Tommy's attendant care did not require a nursing degree, and so a higher rate was not necessitated simply because plaintiff was also a practicing nurse. As a result, the jury had evidence on this issue such that it could have provided a higher rate if it determined such was need for Tommy's care. It did not. Under the circumstances, no error requiring reversal exists on this issue.

Plaintiff next argues that the trial court erred in using defendant's modified verdict form at trial. Whether a special verdict form may be submitted to the jury is within the trial court's discretion. *In re Portus*, 142 Mich App 799, 803-804; 371 NW2d 871 (1985). An abuse of discretion occurs when the trial court's decision falls outside the range of reasonable and principled outcomes. *D'Alessandro Contracting Group, LLC v Wright*, 308 Mich App 71, 76; 862 NW2d 466 (2014).

Plaintiff requested that the following verdict form be submitted to the jury:

> We, the jury, make the following answers to the questions submitted by the Court:
>
> ALLOWABLE EXPENSES
>
> QUESTION NO. 1: What is the amount of allowable expenses owed to the plaintiff (include only expenses not already paid by the defendant from August 24, 2011, through the present)?
>
> $_____.
>
> INTEREST
>
> QUESTION NO. 2: Was payment for any of the expenses or losses to which the plaintiff was entitled overdue?
>
> (Payment for an expense or loss is overdue if it is not paid within 30 days after the defendant receives reasonable proof of the fact and the amount of the claim. An overdue claim bears interest at the rate of 12 percent per annum from the date the expense or loss became overdue.)
>
> A. Answer: ___(yes or no)
>
> B. If your answer is "yes", what is the amount of interest owed to the plaintiff on overdue benefits (include only interest not already paid by the defendant)? $_____.

Defendant requested the following verdict form, which the circuit court concluded was more applicable to the evidence presented at trial, and thus gave it to the jury:

We, the jury, make the following answers to the questions submitted by the Court:

ALLOWABLE EXPENSES

(Allowable expenses consist of all reasonable charges for reasonably necessary products, services, and accommodations for the plaintiff's care, recovery, or rehabilitation.)

QUESTION NO. 1: Beginning in October, 2011 through May 31, 2014 is the daytime hourly rate that has been paid by Home-Owners for attendant care services being provided to and for the benefit of Thomas Middleton reasonable?

A. Answer: ___(yes or no)

B. If your answer is "yes", go on to Question No. 2. If your answer is "no", what is the reasonable daytime hourly rate for the attendant care services being provided to and for the benefit of Thomas Middleton?

$_____.

QUESTION NO. 2: Beginning in October, 2011 through May 31, 2014 is the nighttime hourly rate that has been paid by Home-Owners for attendant care services being provided to and for the benefit of Thomas Middleton reasonable?

A. Answer: ___(yes or no)

B. If your answer is "yes", go on to Question No. 3. If your answer is "no", what is the reasonable nighttime hourly rate for the attendant care services being provided to and for the benefit of Thomas Middleton.

$_____.

INTEREST

(Payment for an expense or loss is overdue if it is not paid within 30 days after the defendant receives reasonable proof of the fact and the amount of the claim. An overdue claim bears interest at the rate of 12 percent per annum from the date the expense or loss became overdue.)

QUESTION NO. 3: Was payment for any of the expenses or losses to which the plaintiff was entitled overdue?

A. Answer: ___(yes or no)

B. If your answer is "yes," what is the amount of interest owed to the plaintiff on overdue benefits (include only interest not already paid by the defendant)?

$\_\_\_\_\_$

The standard jury form, MI Civ JI 67.01 sets forth the allowable expenses and interest inquiry as set forth by plaintiff, but also addressed benefits that were not at issue, such as work loss, replacement service expenses, and survivor's loss that both parties had omitted from their respective verdict forms. The use note accompanying the jury verdict form provides, in pertinent part:

> Omit any questions that are not at issue, such as whether the injuries arose out of the ownership, operation, maintenance, or use of a motor vehicle, and any benefits that are not claimed by the plaintiff.
>
> *This Special Verdict Form may have to be modified where there are* questions involving coordination of benefits, governmental setoffs, or *other issues arising under the no-fault statutes that are not specifically addressed by the format set forth.* [Emphasis added.]

MCR 2.515 governs special verdicts and provides, in relevant part:

> (A) Use of Special Verdicts; Form. The court may require the jury to return a special verdict in the form of a written finding on each issue of fact, rather than a general verdict. If a special verdict is required, the court shall, in advance of argument and in the absence of the jury, advise the attorneys of this fact and, on the record or in writing, settle the form of the verdict. The court may submit to the jury:
>
> (1) written questions that may be answered categorically and briefly;
>
> (2) written forms of the several special findings that might properly be made under the pleadings and evidence; or
>
> (3) the issues by another method, and require the written findings it deems most appropriate.
>
> The court shall give to the jury the necessary explanation and instruction concerning the matter submitted to enable the jury to make its findings on each issue.

A general verdict form does not delineate the facts, the law, or the application of the law to the facts. *Sahr v Bierd*, 354 Mich 353, 364; 92 NW2d 467 (1958). Conversely,

> [t]he special verdict form compels detailed consideration. But above all it enables the public, the parties and the court to see what the jury really has done. The general verdict is either all wrong or all right, because it is an inseparable and inscrutable unit. A single error completely destroys it. But the special verdict enables errors to be localized so that the sound portions of the verdict may be saved and only the unsound portions be subject to redetermination through a new trial. [*Id.* at 365 (citation omitted).]

A special verdict form is not warranted when the case is not so complex that there would be a necessity to submit special findings of fact. *Danaher v Partridge Creek Country Club*, 116 Mich App 305, 320; 323 NW2d 376 (1982).

Here, the parties submitted competing verdict forms. Plaintiff's form mirrored the language of the jury verdict form contained in the civil jury instructions. However, defendant's proposed form was narrowly focused on whether the rates already provided were reasonable. Pursuant to MCR 2.515 and *In re Portus*, 142 Mich App at 803-804, the trial court had the discretion to provide a special verdict form to the jury. Although a close call due to the narrow questions contained in the special verdict form, we cannot conclude that the trial court abused its discretion in using that form at the original trial. Defendant's modification merely acknowledged that there existed separate day and nighttime rates. It is possible that the language contained in the special verdict form addressing the different rates reminded the jury of this fact and allowed the jury to make its award in the bifurcated way rates had been determined.

Because we are vacating the award and remanding for a new trial as specified in this opinion, we need not address plaintiff's final argument that the trial court erred in denying her request for a new trial on the basis that the jury's verdict was contrary to the great weight of the evidence.

Affirmed in part, reversed in part, and remanded for a new trial consistent with this opinion. No costs, neither party having prevailed in full. MCR 7.219(A). We do not retain jurisdiction.

/s/ Christopher M. Murray
/s/ Cynthia Diane Stephens
/s/ Michael J. Riordan

EXHIBIT C

STATE OF MICHIGAN

COURT OF APPEALS

TRINA RICHARD,

Plaintiff-Appellee/Cross-Appellant,

and

TBCI P.C.,

Intervening Plaintiff,

v

ALLSTATE INSURANCE COMPANY,

Defendant-Appellant/Cross-Appellee.

UNPUBLISHED
June 21, 2012

No. 298650
Wayne Circuit Court
LC No. 06-613557-NF

Before: WILDER, P.J., and CAVANAGH and DONOFRIO, JJ.

PER CURIAM.

Defendant appeals by delayed leave granted a $51,809.17[1] judgment in favor of plaintiff, Trina Richard, that was entered after a jury trial. The lawsuit was initiated for the recovery of first-party no-fault personal injury protection ("PIP") benefits. Plaintiff cross-appeals from the same judgment. We affirm.

I. BASIC FACTS

On October 1, 1991, plaintiff, then a 16-year old high school student, was hit by a vehicle while she was walking across a street in Detroit. The impact of the collision tossed plaintiff into the air, which resulted in her head hitting the ground when she landed. She had a "huge," "thick," "gigantic" knot on her head. Plaintiff was transported to Henry Ford Hospital, where she was treated and released later that same day. The hospital records show that plaintiff

[1] The $51,809.17 was broken down as follows: $40,704.20 for allowable expenses; $4,884.50 for statutory interest, MCL 500.3142; and $6,220.47 for post-filing judgment interest, MCL 600.6013(8).

suffered a large hematoma on her right forehead and abrasions on the right side of her chin and face. Additionally, she was diagnosed with a closed-head injury. Plaintiff returned to school some weeks after the accident.

After the October 1, 1991, accident, plaintiff's parents filed a claim with defendant for $420 for replacement services, which was paid. The medical bills presumably were paid by plaintiff's health insurance carrier.

At trial, plaintiff complained of having neck and back pain virtually every day since the accident. However, from 1993 until 2005, plaintiff received no treatment for any head, neck, or back injuries related to the accident. In fact, she never even mentioned any such injuries during her many doctor visits throughout this time.

In 2005, plaintiff met with Lawrence Gamby, a certified rehabilitation counselor and case manager, who had started Gamby, Kageff[2] & Associates ("GK&A"). GK&A provided services to plaintiff totaling $16,000, which defendant has not paid.[3] Gamby testified that these services were reasonably necessary for plaintiff's care and treatment stemming from the October 1, 1991, accident.

GK&A initially referred plaintiff to Dr. Thomas Park, a psychiatrist, at TBCI P.C.[4] Dr. Park then referred plaintiff to Dr. Woo Kim, a physical medicine physician, for care of her neck and back pain; to Dr. Renee Applebaum, a neuropsychologist, for neuropsychological evaluation; and back to GK&A for case-management services. GK&A also utilized Health Care Unlimited, another company owned by Gamby, which provided transportation for plaintiff. Gamby claimed that Health Care Unlimited was owed $13,000 for these transportation services, which also were reasonably necessary charges that defendant denied.

Dr. Applebaum first evaluated plaintiff in March 2006. Dr. Applebaum found that there was no indication of malingering[5] and concluded that plaintiff was moderately impaired. Dr. Applebaum also concluded that plaintiff had a cognitive disorder and organic personality syndrome, which were all attributable to the October 1, 1991, car accident. Dr. Applebaum testified that she incurred $5,150 in charges for her services.

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[2] The trial transcript spelled this name as "Caga," but the parties' briefs on appeal spell it "Kageff." We assume the parties' briefs are correct and will use the "Kageff" spelling.

[3] Gamby later formed "Gamby & Associates," but that entity did not provide any services to plaintiff.

[4] TBCI P.C. had intervened in the lawsuit and successfully petitioned the court to bifurcate the trial, with its issues being tried separately. However, TBCI P.C. was ultimately dismissed by stipulated order on February 1, 2010.

[5] "Malingering" is defined as the "intentional production of false or grossly exaggerated physical or psychological symptoms." Medscape Reference, Malingering, <http://emedicine.medscape.com/article/293206-overview> (accessed September 2, 2011).

In 2005, defendant received a bill for the treatment plaintiff received. Ruth Billiau was the claims adjuster at Allstate that was assigned to the claim. Billiau was skeptical that the current treatment was related to the 1991 accident since there had been no treatment or issues during the previous 12 years. Accordingly, defendant requested authorizations from plaintiff for her medical records. But plaintiff never returned the authorizations. Contemporaneous to this, Billiau sent plaintiff to be evaluated by Dr. Clifford Fergison, a neuropsychologist. But because Billiau never received any authorizations, she did not have access to, and could not provide Dr. Fergison with, any of plaintiff's medical records that spanned from 1993 through 2005.

Dr. Fergison evaluated plaintiff on November 30, 2005, and gave a report of his findings. Dr. Fergison concluded that "there was significant evidence of symptom exaggeration based on symptom validity testing," which made it impossible for him "to arrive at any clear diagnosis or treatment recommendations." On cross-examination, Dr. Fergison clarified that, even though plaintiff's testing results were consistent with symptom exaggeration, malingering, and pre-existing impairment, he could not conclude that plaintiff actually was exaggerating, malingering, or had a pre-existing impairment.

After reading Dr. Fergison's report, Billiau denied plaintiff's claims for benefits. Billiau explained that, while she also had Dr. Applebaum's conflicting report, she based her decision solely on Dr. Fergison's report.

Plaintiff filed suit on May 10, 2006. Before trial, plaintiff, in a motion in limine, sought to have any evidence of plaintiff's prior abortion excluded from trial. Plaintiff argued that such evidence was irrelevant to any of the contested issues at trial and, even if the abortion was somewhat relevant, any relevance would have been substantially outweighed by undue prejudice, making it inadmissible pursuant to MRE 403. The trial court granted the motion but noted that defendant would be allowed to make a subsequent offer of proof at trial if it wished. There is nothing on the record to suggest that defendant ever made such an offer of proof.

After a six-day trial, a jury returned a verdict in favor of plaintiff in the amount of $40,704.20 for allowable expenses and $4,884.50 for statutory interest.

On May 27, 2009, defendant filed a motion with the trial court to settle the record, or in the alternative, to have a new trial. Defendant noted that the entire transcript from August 13, 2008, was missing. The missing testimony supposedly included part of the direct testimony (and possibly a portion of the cross-examination) of plaintiff's father, Cornell Richard; all of the testimony of plaintiff's husband, Anthony Montgomery; and Dr. Park's direct-examination (and possibly a portion of the cross-examination).

On January 15, 2010, defendant provided a proposed record of the testimony of Cornell but stated that Dr. Park's settled record of testimony was to be supplied by plaintiff.[6] A few days later, plaintiff submitted her proposed record for the testimony of Cornell and Dr. Park.

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[6] Anthony Montgomery's testimony was not a concern because, since it was introduced via deposition, the testimony was still available.

Plaintiff's version of Cornell's testimony was not substantively different than defendant's version except for a few instances. Even though defendant disagreed with the additions that plaintiff proposed related to Cornell's testimony, the trial court ordered that both sides' proposed facts would encompass the settled record.

II. EVIDENCE OF ABORTION

Defendant argues that the trial court abused its discretion when it excluded evidence that plaintiff had an abortion. We disagree. A trial court's decision to admit or exclude evidence is reviewed for an abuse of discretion. *In re Kramek Estate*, 268 Mich App 565, 573; 710 NW2d 753 (2005). "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006).

Generally, relevant evidence is admissible. MRE 402. Evidence is relevant if it has a tendency to make the existence of a fact of consequence more probable or less probable than it would be without the evidence. MRE 401; *Waknin v Chamberlain*, 467 Mich 329, 333; 653 NW2d 176 (2002). Defendant argued at the trial court that the fact that plaintiff got an abortion was "relevant because it is part of what made her into the person she is today. . . . These sort of incidents very much flavor and create the person we have here today and going to be testifying at trial. . . . In this case it is relevant and the testimony will support that." In other words, defendant maintained that plaintiff's abortion was a cause of at least some of her impairments. However, this was sheer speculation on defendant's part. There was nothing in the record that suggested that the abortion did cause any such impairment. Thus, the trial court correctly excluded the evidence on a relevance basis.

On appeal, defendant argues that the expert testimony of Dr. Elliot Wagenheim was sufficient to show that the abortion was relevant. However, there are two significant flaws with this assertion. First and foremost, Dr. Wagenheim's testimony came towards the end of trial and, thus, was not available to the trial court at the time it granted plaintiff's motion in limine. Therefore, it can have no bearing on whether the trial court erred at the time it granted the motion. Second, Dr. Wagenheim never testified about an abortion specifically. Instead, defendant relies on Dr. Wagenheim's testimony that a person who had "been abused physically, emotional[ly], [or] sexually tend[s] to develop certain personality traits and certain patterns." Defendant did not introduce expert testimony, however, to establish that having an abortion, while likely emotionally and physically traumatic, is the equivalent of being physically, emotionally, or sexually abused. Thus, the jury would have had to speculate to reach such a conclusion.

Even assuming, arguendo, that plaintiff's abortion was relevant, the evidence was still inadmissible pursuant to MRE 403. Under MRE 403, even relevant evidence is inadmissible if its probative value is substantially outweighed by the danger of unfair prejudice. *Detroit v Detroit Plaza Ltd P'ship*, 273 Mich App 260, 272; 730 NW2d 523 (2006). "Evidence is unfairly prejudicial when there exists a danger that marginally probative evidence will be given undue or preemptive weight by the jury." *Waknin*, 467 Mich at 334 n 3. Here, the probative value was minimal since any link between plaintiff having an abortion and her mental state years after the fact is tenuous at best. Conversely, the danger of jurors giving undue weight to this fact is clear.

This Court noted in 1979 that "[t]he existing strong and opposing attitudes concerning the issue of abortion clearly make any reference thereto potentially very prejudicial." *People v Morris*, 92 Mich App 747, 751; 285 NW2d 446 (1979). This rationale is no less valid in 2011. Thus, given the limited probative value of the evidence, it would have been reasonable for the trial court to have concluded that the probative value was substantially outweighed by the potential of unfair prejudice. Moreover, reviewing courts should generally defer to a trial court's contemporaneous judgment of probative value and potential unfair prejudice under MRE 403. *People v Bahoda*, 448 Mich 261, 291; 531 NW2d 659 (1995). Accordingly, the trial court did not abuse its discretion when it excluded evidence of plaintiff's abortion.

III. DIRECTED VERDICT

Defendant next argues that the trial court erred when it denied its motions for directed verdict with respect to the separate issues of attendant-care benefits and benefits supplied by GK&A. We disagree.

A lower court's decision on a motion for directed verdict is reviewed de novo. *King v Reed*, 278 Mich App 504, 520; 751 NW2d 525 (2008). The evidence presented up to the time of the motion is viewed in a light most favorable to the nonmoving party to determine whether a question of fact existed. *Silberstein v Pro-Golf of America, Inc*, 278 Mich App 446, 455; 750 NW2d 615 (2008). If reasonable jurors could honestly have reached different conclusions, then the motion is properly denied. *Id.*

A. ATTENDANT-CARE BENEFITS

Under Michigan's No-Fault Act, MCL 500.3101 et seq., PIP benefits are payable for "[a]llowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." MCL 500.3107(1)(a). A plaintiff must prove that "(1) the charge for the service was reasonable, (2) the expense was reasonably necessary and (3) the expense was incurred." *Williams v AAA Mich*, 250 Mich App 249, 258; 646 NW2d 476 (2002).

"Care" includes attendant care, even if the provider does not have medical training. *Van Marter v American Fidelity Fire Ins Co*, 114 Mich App 171, 180; 318 NW2d 679 (1982). But attendant care, like all other compensable services, must be reasonably necessary and actually rendered. *Williams*, 250 Mich App at 258; *Moghis v Citizens Ins Co*, 187 Mich App 245, 247; 466 NW2d 290 (1990).

Defendant maintains that there was insufficient evidence to show that plaintiff actually received any attendant-care services. However, defendant's brief on appeal fails to reference the testimony of plaintiff's husband, Anthony Montgomery, which was introduced via deposition. Montgomery recounted providing care to plaintiff related to her condition, which included cooking, caring for their child, leaving daily reminders, and helping her with her medication. Therefore, viewing this evidence in a light most favorable to plaintiff, the nonmoving party, a jury could have concluded that Montgomery actually provided attendant-care services to plaintiff.

Defendant also contends that, even if attendant-care services were provided, plaintiff never "incurred" any expense. Defendant relies on *Manley v DAIIE*, 425 Mich 140; 388 NW2d 216 (1986), in arguing that an insurer is not obligated to pay unless there is a bill presented. However, this reliance is misplaced. In *Manley*, the Court stated that "*insofar as nurse's aides are concerned* [the insurer] is not obligated to pay any amount except upon submission of evidence that servicers were actually rendered and of the actual cost expended." *Id.* at 159 (emphasis added). Defendant provides the above quote minus the emphasized portion. Thus, it is clear that this statement is in the context of nonfamily members providing care. There is nothing to suggest in *Manley* that this requirement extends to immediate family members. In fact, the Supreme Court recently has explained that "incurring" an expense simply means that "the attendant care providers expected compensation for their services." *Burris v Allstate Ins Co*, 480 Mich 1081, 1081; 745 NW2d 101 (2008). Justice Corrigan, in a concurring opinion, explained that

> the term "incur" does not mean that an insured must necessarily enter contracts with the care provider to be entitled to reimbursement for attendant-care expenses. . . . Nor does it mean that an insured must necessarily present a formal bill establishing that the attendant-care services were provided. It merely means that the insured must have an obligation to pay the attendant-care-service providers for their services. [*Id.* at 1084-1085, (Corrigan, J., concurring).]

Therefore, defendant's position that attendant-care services must be billed in order to be recoverable is not supported by case law. As the *Burris* Court explained, all that is necessary is that the providers expected to be compensated. *Id.* at 1081. Here, plaintiff testified that she communicated with the caregivers that she intended to compensate them. Furthermore, Montgomery testified that, although no specific dollar amounts were discussed, he talked to plaintiff about getting paid at the prevailing rate. Hence, when viewing plaintiff's testimony and Montgomery's testimony in a light most favorable to plaintiff, a jury could have inferred that at least some caregivers expected to be compensated for their services.

We note that defendant's criticism of the verdict form is not pertinent to whether the trial court properly denied the motion for directed verdict. Instead, whether the verdict form was deficient is an entirely separate legal issue. Moreover, it appears from the record that defendant wrote and submitted the proposed verdict form and never objected to it at trial. As a result, defendant has either waived the issue by offering the form itself or has forfeited the issue by not objecting to it. See *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 69; 642 NW2d 663 (2002). Moreover, given that the trial court did not err in denying the motion for directed verdict, defendant's argument regarding the verdict form is moot.

B. EXPENSES FOR GK&A

Defendant also claims that, because GK&A was no longer in business and did not have a current assumed-name certificate under MCL 445.1, GK&A could not collect from plaintiff for any services it rendered, which in turn means that defendant cannot be obligated to pay plaintiff for those services. We disagree.

MCL 445.1 requires a person who conducts business under an assumed name to file a certificate in the county in which the person conducts the business. Failure to comply with this requirement bars the person from filing suit. MCL 445.5.[7] However, MCL 445.1 also provides that this filing requirement only is applicable when the assumed name is "other than the real name of the person owning, conducting, or transacting that business."

Here, the assumed name in question is "Gamby, Kageff & Associates," and the name of the person conducting the business was "Gamby." Thus, by the plain language of the statute, it is clear that Gamby was not required to file any certificate under MCL 445.1 because the assumed name encompassed his and his partner's real names. This is wholly distinguishable from the case that defendant relies on, *Krager v Hedler Storage*, 7 Mich App 644; 152 NW2d 708 (1967). In *Krager*, the plaintiff, Herman Krager, operated the "Casnovia Milling Company" but never filed an assumed-name certificate in Newaygo County. *Id.* at 646. This failure to file was fatal to the plaintiff's case, because it was evident that "Casnovia," under which business was transacted, was not Krager's real name. More analogous to the present case is *June v Vibra Screw Feeders, Inc*, 6 Mich App 484; 149 NW2d 480 (1967). In *June*, the plaintiff "used his own surname, June, as part of the name of the company he operated and in so doing, was not subject to the filing requirements of the assumed name filing statute." *Id.* at 492-493. Just as the plaintiff in *June* was not required to file an assumed-name certificate because he used his own name in the company's name, Gamby was not required to file an assumed-name certificate because he used his name in his company's name.

Therefore, Gamby was not required to file an assumed name certificate, and his failure to do so, does not invoke any of the limitations of MCL 445.5. As a result, the trial court did not err by denying defendant's motion for directed verdict on this issue.

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[7] MCL 445.5, in pertinent part: "Any person or persons owning, carrying on or conducting or transacting business as aforesaid, who shall fail to comply with the provisions of this act, shall be guilty of a misdemeanor . . . . [H]owever, the fact that a penalty is provided herein for noncompliance with the provisions of this act shall not be construed to avoid contracts; but any person or persons failing to file the certificate required by [MCL 445.1 and MCL 445.1a] shall be prohibited from bringing any suit, action or proceeding in any of the courts of this state, in relation to any contract or other matter made or done by such person or persons under an assumed or fictitious name, until after full compliance with the provisions of this act; but no person or persons doing business under a fictitious name or as the assignee or assignees thereof shall maintain or prosecute any action, nor shall any order, judgment, or decree be made in any action heretofore or hereafter commenced in any court of this state upon or on account of any contract or contracts made or transactions had under such fictitious name after August 14, 1919, if the conduct of such business under such fictitious name has ceased, or if it is still conducted under such fictitious name, then until after full compliance with the provisions of this act."

IV. ATTORNEY FEES – MCL 500.3148(2)

Defendant argues that the trial court abused its discretion when it denied its request for attorney fees. We disagree.

A trial court's decision regarding the granting of attorney fees is reviewed for an abuse of discretion. *Peterson v Fertel*, 283 Mich App 232, 235; 770 NW2d 47 (2009). "An abuse of discretion occurs when the decision results in an outcome falling outside the principled range of outcomes." *Woodard*, 476 Mich at 557. A trial court's findings regarding the fraudulent, excessive, or unreasonable nature of a claim are reviewed for clear error. *Beach v State Farm Mut Auto Ins Co*, 216 Mich App 612, 627; 550 NW2d 580 (1996). "A finding of fact is clearly erroneous if the reviewing court has a definite and firm conviction that a mistake has been committed, giving due regard to the trial court's special opportunity to observe the witnesses." *In re BZ*, 264 Mich App 286, 296-697; 690 NW2d 505 (2004).

Generally, attorney fees are not recoverable unless a statute, court rule, or common-law exception exists. *Dessart v Burak*, 470 Mich 37, 42; 678 NW2d 615 (2004). Here, defendant requested attorney fees pursuant to MCL 500.3148(2), which provides, in relevant part, the following:

> An insurer may be allowed by a court an award of a reasonable sum against a claimant as an attorney's fee for the insurer's attorney in defense against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation.

Defendant argues, as it did at the trial court, that the fact that plaintiff was only awarded $40,704.20 when plaintiff sought much more before trial is conclusive that plaintiff's claim was, in part, fraudulent or excessive. Specifically, defendant noted that plaintiff initially requested $6 million during case evaluation and lowered that request to $463,000 during discovery. The trial court denied defendant's request and stated that "[j]ust because the plaintiff didn't get everything [she] wanted, doesn't make it automatic fraudulent or excessive." We are not left with a definite and firm conviction that the trial court's conclusion was incorrect.

The mere fact that an ultimate jury award is much less than what a plaintiff claims can be relevant to whether the initial claim was fraudulent or excessive, but it is not dispositive. Defendant relies on *Robinson v Allstate Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued May 11, 2004 (Docket Nos. 244824 & 245363). Of course, unpublished opinions are only persuasive authority and are not binding on this panel. MCR 7.215(C)(1). In fact, we disagree with the analysis employed in *Robinson*. The *Robinson* Court agreed with the defendant that a $4,000 verdict on an $82,000 claim "is evidence" that the jury found that plaintiff's claim was in some respect fraudulent or so excessive as to have no reasonable foundation. *Robinson*, unpub op at 1. The Court then, without any further analysis, remanded for an award of a reasonable amount of attorney fees. *Id.*

We find that simply remanding without any further analysis was not appropriate because that action did not give the proper deference to the trial court's findings of fact. Specifically, the *Robinson* panel never considered whether this "evidence" was of such a nature that it left them

with a definite and firm conviction that the trial court erred in its conclusion. We do not disagree that a disparity in the amount ultimately awarded and the amount initially sought is *evidence* that the initial claim may have been excessive. But that is entirely different from holding that a disparity *conclusively establishes* that a claim was excessive or fraudulent, necessitating an award of attorney fees. As a result, we do not find *Robinson* persuasive.

Defendant also claims that the trial court applied the incorrect legal standard when it made the following statement at the hearing:

> I think merely the fact plaintiff prevailed does not trigger this statutory requirement, at least in this case, and I think that each case has to be looked at individually. Although I was not expecting [defendant] to request attorney fees, I think the same standard applies to [defendant]. Just because the plaintiff didn't get everything they wanted, doesn't make it automatic fraudulent or excessive.
>
> So your request is denied.

Defendant's position is without merit. While the trial court did use the words "I think the same standard applies to [defendant]," it is clear that the court did not actually apply the same legal standard. In fact, the court clearly identified the correct standard as being whether plaintiffs claim was "fraudulent or excessive."[8] The trial court was merely making an analogy between plaintiff's claim for attorney fees and defendant's claim for attorney fees. Plaintiff claimed she was owed the fees on the sole basis that the jury awarded penalty interest, pursuant to MCL 500.3142. The court was explaining that this fact was not dispositive for awarding plaintiff attorney fees just as the fact that plaintiff received a lot less than what she was requesting was not dispositive to defendant's claim of fees.

V. MOTION FOR NEW TRIAL

Defendant argues that the trial court erred when it did not order a new trial because of the missing transcript for the second day of trial. We disagree.

Defendant has waived this issue. Defendant's motion at the trial court was a "Motion to Settle the Record, or, in the Alternative, for a New Trial." Hence, defendant asked for one of two particular remedies. The trial court granted one of those remedies when it entered an order to settle the record. Thus, defendant cannot now complain that the trial court did what it was specifically requested to do. See *Marshall Lasser, PC v George*, 252 Mich App 104, 109; 651 NW2d 158 (2002) ("A party is not allowed to assign as error on appeal something which his or her own counsel deemed proper at trial since to do so would permit the party to harbor error as an appellate parachute.").

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[8] The fact that the trial court abbreviated the standard as being "fraudulent or excessive" instead of "in some respect fraudulent or so excessive as to have no reasonable foundation" while conversing in open court is of no consequence. The trial court clearly was referring to the standard set in MCL 500.3148(2) and not MCL 500.3148(1).

We note that the only question before this Court is whether the trial court erred in not granting a new trial. To the extent that defendant also argues on appeal that the *method* the court used to settle the record was inadequate, that particular issue is not listed in defendant's statement of the questions presented as required by MCR 7.212(C)(5) and, therefore, is abandoned. *Mettler Walloon, LLC v Melrose Twp*, 281 Mich App 184, 221; 761 NW2d 293 (2008).

VI. ATTORNEY FEES – MCL 500.3148(1)

Plaintiff, on cross-appeal, argues that the trial court erred when it denied her request for attorney fees under MCL 500.3148(1). We disagree.

"The trial court's decision about whether the insurer acted reasonably involves a mixed question of law and fact. What constitutes reasonableness is a question of law, but whether the defendant's denial of benefits is reasonable under particular facts of the case is a question of fact." *Ross v Auto Club Group*, 481 Mich 1, 7; 748 NW2d 552 (2008). Questions of law are reviewed de novo, and questions of fact are reviewed for clear error. *Id.* "A decision is clearly erroneous when the reviewing court is left with a definite and firm conviction that a mistake has been made." *Id.* (internal quotations omitted). Moreover, a trial court's ultimate decision regarding the granting of attorney fees is reviewed for an abuse of discretion. *Peterson*, 283 Mich App at 235.

The award of attorney fees in this instance is governed by MCL 500.3148(1), which states,

> An attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue. The attorney's fee shall be 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.

Thus, "attorney fees are payable only on overdue benefits for which the insurer has unreasonably refused to pay or unreasonably delayed in paying." *Moore v Secura Ins*, 482 Mich 507, 517; 759 NW2d 833 (2008), citing *Proudfoot v State Farm Mut Ins Co*, 469 Mich 476, 485; 673 NW2d 739 (2003)

Hence, the fundamental question on appeal is whether defendant's refusal to pay was unreasonable. When answering this question, the inquiry is not dependent on whether the insurer was ultimately held responsible for the benefits, but whether its *initial* refusal to pay was reasonable. *Ross*, 481 Mich at 11. Furthermore, a refusal to pay is not unreasonable if it is based on a bona fide factual uncertainty. *Moore*, 482 Mich at 520.

Here, plaintiff contends that defendant was unreasonable when it failed to clarify Dr. Fergison's report. In doing so, plaintiff relies on *Tinnin v Farmers Ins Exch*, 287 Mich App 511; 791 NW2d 747 (2010). In *Tinnin*, the insurer failed to clarify the results of its physician report that did not specifically address whether it was reasonable for the insured to obtain the treatment in question. *Id.* at 516. In fact, that physician testified that he believed it *was reasonable* for the insured to continue to receive the treatment on an as-needed basis. *Id.* at 516-517. However,

that situation is distinguishable from the instant case. Dr. Fergison never testified that plaintiff's condition was caused by the 1991 car accident, nor did Dr. Fergison ever testify that plaintiff required the at-issue medical and attendant care. Plaintiff, instead, refers to Dr. Fergison's testimony, where he states that he could not form *any* opinion with regard to plaintiff's condition. While this is true, this inability to form a definitive opinion was based on Dr. Fergison's view that plaintiff was exhibiting characteristics consistent with one who was exaggerating her symptoms, malingering, or having a pre-existing condition. The exchange went as follows:

> *Q.* Do you – when you mention those things previously, you weren't suggesting that my client was malingering, were you?
>
> *A.* What I was reporting on was that she performed in the ranges that would be considered in the symptom exaggerated, malingering, or represent preexisting impairment.
>
> *Q.* Okay. And just so that the jury's clear, you're not offering an opinion that my client was exaggerating, correct?
>
> *A.* That is correct.
>
> *Q.* And you're not offering an opinion that she was malingering?
>
> *A.* That is correct.
>
> *Q.* And you're not offering an opinion that there was a preexisting condition, right?
>
> *A.* Correct.

The fact that Dr. Fergison could not state with certainty that he knew plaintiff was exaggerating does not change his underlying findings that plaintiff's testing was *consistent* with one who was exaggerating. As a result, Dr. Fergison said that because of this characteristic, it was impossible for him to give an evaluation of plaintiff's condition.

Contrary to plaintiff's assertion, Dr. Fergison's true opinion was not "the opposite" of what the claims adjuster thought the report read. Essentially, the claims adjuster interpreted the report as stating that plaintiff *was* exaggerating, malingering, or had a pre-existing condition, while Dr. Fergison merely stated that plaintiff's results were *consistent* with one who was exaggerating, malingering, or had a pre-existing condition. The difference between these two views is slight. Therefore, *Tinnin* is not persuasive for plaintiff's position.

It is important to note that defendant was skeptical of plaintiff's claim for benefits because this claim came after a 12-year period in which plaintiff had no claims whatsoever related to the accident. Thus, when the claims adjuster saw Dr. Fergison's report, it reinforced the belief that plaintiff's current claim was not related to the 1991 accident.

Plaintiff also contends that defendant acted unreasonably when it failed to provide medical records to Dr. Fergison. However, it was impossible for defendant to forward the records because the claim file was lost years earlier. While the loss of the claim file was the sole fault of defendant and not plaintiff, defendant cannot be said to have been unreasonable in not providing records it could not access.

Also noteworthy is that defendant sent a request for an authorization for medical records to plaintiff, but plaintiff never returned the signed form. Thus, defendant was prohibited from getting plaintiff's medical records and could not forward those records to Dr. Fergison.

But plaintiff also maintains that Billiau had access to a report written by Dr. Park and should have forwarded it to Dr. Fergison. Plaintiff again relies on unpublished cases to support her position. In *Clack v Allstate Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued January 23, 1998 (Docket No. 192420), this Court affirmed the lower court's award of attorney fees to the plaintiff. This Court did so because it found that the independent medical evaluation ("IME") reports the insurer possessed *confirmed* that plaintiff had jaw, back, and neck injuries, making its refusal to pay for those injuries unreasonable. Furthermore, the Court found that at the time the insurer denied benefits, it only had a single IME report that concluded that the plaintiff was not disabled. However, that report was prepared without seeing an MRI of the plaintiff's knee, and when the physician saw the MRI at trial, he admitted that "the MRI did show an internal derangement of the right knee." Thus, it is easy to see why the *Clack* panel found that the trial court did not clearly err. But that situation is distinguishable from the instant case because (1) none of the reports generated by defendant confirmed any diagnosis offered by plaintiff, and (2) Dr. Fergison never admitted that seeing Dr. Park's report would have changed anything. We also note that seeing someone's *conclusions* is vastly different than seeing actual *testing results*, such as an MRI. The inherent value of objective *results* is much greater than someone else's subjective *opinions*.

Also, plaintiff's reliance on *Spencer v State Farm Mut Auto Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued January 24, 2008 (Docket No. 271702), is greatly misplaced. The principle that *Spencer* espoused, that an insurer is unreasonable when it fails to attempt to reconcile conflicting opinions or make an inquiry beyond its own IME opinion, has been explicitly overruled by our Supreme Court in *Moore*, 482 Mich at 521.

Last, plaintiff maintains that any reliance on Dr. Fergison's report was conclusively unreasonable because Dr. Fergison was a psychologist, not a physician. Plaintiff relies on MCL 500.3151 as support for her view. MCL 500.3151 provides, in pertinent part:

> When 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, the person shall submit to mental or physical examination by physicians.

However, plaintiff is reading more into the statute than there is. The purpose of the statute is apparent from the plain and ordinary meaning of the words. The statute simply mandates that a person who seeks PIP benefits "shall submit to mental or physical examination by physicians." This statute does not speak to or limit which evaluations an insurer can rely on in making its determinations. Thus, under MCL 500.3151, plaintiff may have been rightfully

able to decline the examination with Dr. Fergison since he was not a physician. See *People v Beckley*, 434 Mich 691, 728; 456 NW2d 391 (1990) (recognizing that psychologists are different than physicians), citing *People v LaLone*, 432 Mich 103, 109; 437 NW2d 611 (1989); see also MCL 600.2157 (identifying physician-patient privilege) and MCL 333.18237 (identifying psychologist-patient privilege). However, plaintiff did not object and instead proceeded with the examination. There is nothing inherently unreasonable about relying on a psychological report when the insured is complaining of psychological problems. In fact, plaintiff relied on an evaluation and report done by Dr. Applebaum, also a psychologist, in support of her case.

In sum, the trial court did not clearly err when it determined that defendant's denial of plaintiff's claim was reasonable under the circumstances. Defendant was presented with a claim for benefits for an accident that occurred 14 years earlier, when there were no other claims during this intervening period. Then, after defendant requested that plaintiff submit to an examination, defendant was informed by Dr. Fergison that plaintiff's results were consistent with one who was exaggerating her symptoms. All of these facts combined with the fact that plaintiff never provided a signed medical record authorization created a bona fide factual uncertainty regarding the authenticity of the claim. Thus, we are not left with a definite and firm conviction that the trial court erred. Consequently, the trial court did not abuse its discretion when it denied plaintiff's request for attorney fees.

Affirmed. No costs are taxable pursuant to MCR 7.219, neither party having prevailed in full.

/s/ Kurtis T. Wilder
/s/ Mark J. Cavanagh
/s/ Pat M. Donofrio

EXHIBIT D

STATE OF MICHIGAN

COURT OF APPEALS

JUDY F. WILLIAMS and BOBBY G. WILLIAMS,

Plaintiffs-Appellees,

v

FARM BUREAU INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED
August 28, 2001

No. 221119
Wayne Circuit Court
LC No. 97-734353-NZ

Before: Jansen, P.J., and Collins and Cooper, JJ.

PER CURIAM.

Defendant appeals as of right from a judgment following a jury verdict awarding plaintiffs reimbursement of medical expenses and work loss. We affirm.

Plaintiffs, who are married, were both injured in a serious automobile accident that occurred on October 16, 1996. Plaintiffs subsequently treated at the Stroia Chiropractic Clinic under the care of Thomas Pinson, D. O. Plaintiffs were able to resume work with their tree service a few months after the accident, but were not able to work full time because of their injuries, and had to turn down approximately forty to fifty jobs. On March 14, 1997, after being examined by a doctor at defendant's request, plaintiffs received a letter from defendant stating that it would not reimburse them for their medical expenses because of the doctor's findings.

Plaintiffs sued defendant for reimbursement of medical expenses and work loss. At trial, defendant moved for a directed verdict on two bases: (1) that there was evidence that the chiropractic clinic that treated plaintiffs charged insured patients more than uninsured patients in violation of MCL 500.3157, and (2) that there was no evidence that plaintiffs suffered any wage loss from the accident. The trial court denied defendant's motion. The jury awarded plaintiffs $39,501.50 in medical expenses and $18,000 for Mr. Williams' work loss.[1] The trial court subsequently entered a judgment on the verdict awarding plaintiffs $87,392.94, including costs, interest, attorney fees, and mediation sanctions.

[1] The jury determined that Mrs. Williams had not suffered a loss of income as a result of the accident.

We review de novo a trial court's ruling on a motion for a directed verdict. *Thomas v McGinnis*, 239 Mich App 636, 643; 609 NW2d 222 (2000). "In reviewing the trial court's ruling, this Court views the evidence presented up to the time of the motion in the light most favorable to the nonmoving party, grants that party every reasonable interference, and resolves any conflict in the evidence in that party's favor to decide whether a question of fact existed." *Id.* at 643-644. If reasonable jurors could honestly have reached different conclusions, this Court may not substitute its judgment for that of the jury. *Hunt v Freeman*, 217 Mich App 92, 99; 550 NW2d 817 (1996).

Defendant first argues that the trial court erred in denying defendant's motion for a directed verdict on the basis that the medical charges incurred for services provided by the Stroia Clinic were unreasonable because the medical charges violated MCL 500.3157. Under personal protection insurance, an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, or use of a motor vehicle. MCL 500.3105(1). Personal protection insurance benefits are payable 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." MCL 500.3107(1)(a). An insurer may not be held liable for an expense that is not both reasonable and necessary. *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55, 94; 535 NW2d 529 (1995).

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance. [MCL 500.3157.]

A no-fault insurer is not liable for the amount of any charge that exceeds the health care provider's customary charge for a like product, service, or accommodation in a case not involving insurance. *Hofmann, supra* at 103. "Customary charge" means the standard amount the physician, hospital, or clinic bills on behalf of every patient treated, as opposed to the amount of payment it accepts on behalf of the patient. *Munson Medical Center v Auto Club Ins Ass'n*, 218 Mich App 375, 382-383; 554 NW2d 49 (1996). Whether there has been an overcharge impermissible under MCL 500.3157 is determined by looking to the provider's customary charge in cases not involving insurance. *Hofmann, supra* at 104. A provider cannot avoid committing an overcharge violation simply by claiming that the amount charged in a no-fault case is a "customary charge," when in fact the provider customarily charges a lesser amount in cases not involving insurance. *Id.* at 104-105.

In the present case, the evidence adduced at trial showed that the Stroia Clinic charged every patient the same amount for the same procedures, but that special consideration was given to patients who had special situations, such as being short of money. There were some situations where the Stroia Clinic would reduce the bill when the patient signed an affidavit of indigency stating an inability to pay. If a patient did not have automobile insurance, that would constitute a hardship that would justify a lower rate for treatment. When patients did not have insurance,

they would sign a form stating that they had limited funds to pay for the service and then would receive a lower rate.

The trial court did not err in denying defendant's motion for a directed verdict because, viewing the testimony and all legitimate inferences from the testimony in a light most favorable to plaintiffs, there is a factual question with regard to whether the Stroia Clinic customarily charged patients less in cases not involving insurance. The evidence adduced at trial shows that the Stroia Clinic may have charged patients without insurance less than it charged patients with insurance, but there is no evidence that the Stroia Clinic customarily charged uninsured patients less *because they were uninsured.* Instead, there is evidence that the Stroia Clinic charged uninsured patients less *only when they signed an affidavit of indigency stating that they could not afford the standard charge.* This evidence tends to show that the Stroia Clinic's basis for the lower charge was the patients' inability to pay the customary charge, rather than the patients' lack of reimbursable insurance. Cf. *Hofmann, supra* at 104-107 (MCL 500.3157 was violated where patients were billed less based on whether they had reimburseable insurance, not whether they could afford to pay for the services). Therefore, viewing the evidence in a light most favorable to plaintiffs, reasonable jurors could disagree in regarding to whether the Stroia Clinic customarily charged less in cases not involving insurance.

Defendant next argues that the trial court erred in denying defendant's motion for a directed verdict on the basis that plaintiffs presented no evidence of a loss of income from the accident. In addition to other personal protection insurance benefits that may be due from an insurer for accidental bodily injury, MCL 500.3107(1)(b), in part, requires payment for:

> 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. [MCL 500.3107(1)(b); *Marquis v Hartford Accident & Indemnity (After Remand)*, 444 Mich 638, 643; 513 NW2d 799 (1994).]

MCL 500.3107(1)(b) compensates an injured person for income he would have received but for the accident. *Marquis, supra* at 645. The statute compensates an injured person for lost income that he *would* have earned rather than what he *could* have earned. *Id.* at 648. "Work loss" under the statute covers only actual loss of earnings as contrasted to loss of earning capacity. *Id.* at 647. Work loss includes not only lost wages, but also lost profit that is attributable to personal effort and self-employment. *Kirksey v The Manitoba Public Ins Corp*, 191 Mich App 12, 17; 477 NW2d 442 (1991). In all cases, claimants bear the burden of proving the amount they would have earned had they not been injured in the accident. *Anton v State Farm Mutual Automobile Ins Co*, 238 Mich App 673, 684; 607 NW2d 123 (1999).

The evidence at trial indicated that Mr. Williams resumed doing tree service about a month or two after the accident, but he could no longer do heavy work because of his injuries. After the accident, he had to wear a back brace while he was working in order to alleviate the pain in his lower back. He testified that, after the accident, he turned down approximately forty or fifty tree service jobs because of his injuries from the accident. In 1996, when Mr. Williams was still working as a millwright, plaintiffs' expenses exceeded their revenues by $10,892 for their tree service business. In 1997, however, after Mr. Williams retired from his millwright job, plaintiffs had a profit of $9,337 from their tree service business. In 1998, plaintiffs had a net gain

of $33,078.01. At trial, plaintiffs' accountant, Alton Schroeder, projected that plaintiffs' income would have been approximately $4,375 a month if they had not been injured. Schroeder arrived at this figure by taking plaintiffs' earnings in June through August 1998 and averaging those earnings. Schroeder then projected this figure over the period between November 1, 1996, and August 31, 1998, and concluded that plaintiffs would have earned $144,474 if they had not been injured. Because plaintiffs actually earned $49,317, Schroeder concluded that plaintiffs had a loss of $95,157.

Defendant argues that plaintiffs did not present any evidence that Mr. Williams made any income from the tree service before the accident or that he lost profits that he would have made but for the accident. Although plaintiffs did not present any evidence that Mr. Williams made a profit from the tree service before the accident, he was working full time as a millwright before the accident and did not have the opportunity to work full time on his tree service until he retired from being a millwright after the accident. This Court has held that there may be a question of fact with regard to whether an injured person would have received income even when the injured person did not have an income before the accident. *Swartout v State Farm Mutual Automobile Ins Co*, 156 Mich App 350, 353-355; 401 NW2d 364 (1986).

Here, there is evidence that Mr. Williams was in the process of buying equipment so that he could work full time after he retired from his job as a millwright. Plaintiffs presented evidence that Mr. Williams had to refuse jobs because of his accident and that he lost $95,157 in profits as a result of his injury. Whether Mr. Williams actually would have earned these profits was a question of fact for the jury. *Id.* at 353-355. We find that reasonable minds could differ regarding whether Mr. Williams would have earned these profits from the tree service if he had not been injured. Therefore, the trial court did not err in denying defendant's motion for directed verdict with regard to the award of wage loss.

Affirmed.

/s/ Kathleen Jansen
/s/ Jeffrey G. Collins
/s/ Jessica R. Cooper