

STATE OF MICHIGAN
IN THE SUPREME COURT

RANDY BURRIS,

Plaintiff-Appellee,

v.

ALLSTATE INSURANCE COMPANY,

Defendant-Appellant,

Supreme Court No.: 132949

Court of Appeals No.: 261505

Lower Court Case No.: 02-208320-NF

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**DEFENDANT-APPELLANT'S SUPPLEMENTAL
BRIEF TO ITS APPLICATION FOR LEAVE TO APPEAL**

ORAL ARGUMENT REQUESTED

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**DEFENDANT-APPELLANT'S SUPPLEMENTAL
BRIEF TO ITS APPLICATION FOR LEAVE TO APPEAL**

LEGAL ARGUMENT

I. FAMILY PROVIDED ATTENDANT CARE SHOULD NOT BE TREATED DIFFERENTLY THAN ANY OTHER ALLOWABLE EXPENSE PAYABLE PURSUANT TO MCL 500.3107

In *Proudfoot v State Farm Mutual Insurance Co*, 469 Mich 476; 673 NW2d 739 (2003), this Court discussed what constitutes "incurred" under MCL 500.3107. This Court ruled: "To 'incur' means to become liable or subject to, especially because of one's own actions." *Proudfoot*, at 484. The Court of Appeals has created a situation whereby family members are not required to invoice or bill their injured relatives to prove that the benefit has been incurred. Unfortunately, these opinions have now been construed to mean that family members need provide no proof of services in order to be paid. In fact, Plaintiff has stated to this Court that the only proof he must present is the prescription or order for attendant care in order to receive that benefit.

The case causing the most confusion is *Booth v Auto Owners Insurance Company*, 224 Mich App 724, 569 NW2d 903 (1997). In *Booth*, the Plaintiff sought PIP benefits for attendant care services provided by the plaintiff's parents. *Id.* The trial court granted summary judgment in favor of the insurance carrier and ruled that the plaintiff failed to show that the uncharged expenses for attendant care services provided by her parents had actually been "incurred". *Id.* The Court of Appeals reversed the trial court's decision and ruled that even though the Plaintiff was not billed by her family members for attendant care services, the expenses had been incurred, essentially, because they had been provided. *Id.*

The thrust of the *Booth* decision was that “charges” or “expenses” may be “incurred” without requiring that the insured actually be billed by, or pay, family members providing services. *Id.* at 730. The *Booth* Court stated that its ruling was based on its determination that this legal precept was *implicit* from the rulings in *Visconti v DAIIIE*, 90 Mich App 477; 282 NW2d 360 (1979), *Van Marter v American Fidelity Fire Insurance Company*, 114 Mich App 171; 318 NW2d 679 (1982), *Reed v Citizens Insurance Company of America*, 198 Mich App 443; 499 NW2d 22 (1993), and *Botsford General Hospital v Citizens Insurance Company of America*, 195 Mich App 127; 489 NW2d 137 (1992), and stated;

We decline to create such a requirement [that the insured actually be billed by family members,] in this case. 224 Mich App at 730.

However, none of the decisions, including *Booth*, stated that family members are relieved of the requirement to provide reasonable proof that their services were rendered to the injured party. The Court did not state, in any of the above-referenced cases, that the family member, or the injured party, does not have to notify the insurer and provide verification to receive such benefits. Without such a request, the insurance company has no way of knowing that the family members are seeking benefits. Simply stated, the holding in *Booth* requires clarification and further analysis.

It is unclear from the *Booth* decision as to when Ms. Booth submitted her request for PIP attendant care benefits for care provided by her mother and father. The obvious difference between the *Booth* case and the instant case is that Christine Booth lived with her parents so that she could be provided with 24-hour attendant care, while Randy Burreis lived on his own most of the time, except for the period that he was married to and living

with his then wife, Diane Vermette. In fact, Mr. Burris was self-sufficient enough to operate a motor vehicle on his own and to babysit his minor child, with no other adults present. (See Trial Transcript, January 14, 2004, p.66 and 71.)

Contrary to Plaintiff's assertions, Defendant is not requesting that family members be required to enter negotiated contracts with the injured parties for attendant care services in order to be paid. In order to carry out the intent of the Michigan No-Fault Act, the family members providing attendant care should be held to the same requirements as other providers of allowable expenses. It is not unreasonable to require that family members submit reasonable proof as to who is performing services, what services are being performed on what days and for what duration.

Of course, the payment of the benefits also anticipates that the money will be paid to the provider/family member.

According to Plaintiff-Appellee's argument, attendant care, unlike all of the other allowable expenses paid as benefits under the No-Fault Act, requires no submission of proofs of services rendered for the insurance carrier to pay said benefits. That is clearly not what the drafters of the Michigan No-Fault Act intended. An insured and his caregivers must submit some sort of request for benefits and verifications of services provided in order for a carrier to properly evaluate the claim and pay benefits as warranted.

Under the Michigan No-Fault Act, in order for physicians, hospitals and clinics to receive payment for treatment and medical services rendered for an injured party, they must submit invoices itemizing the services provided and the dates on which they were provided for the insurer to pay for the injured party's medical expenses. Similarly, in order for an insured to receive payment for wage loss under personal injury protection benefits,

the insured must submit a statement of earnings to verify his or her earnings and wage loss. Moreover, household services are paid based on services performed on certain days and dates, after the insured or the persons providing said household services submit documentation and request for payment. There is no reason to treat the claims of family members differently from those of other providers of allowable expenses.

In contrast to the cases cited by Plaintiff, a rather similar case, which precedes the recent case law, is *Schaible v Michigan Mutual Insurance Company*, 116 Mich App 116; 321 NW2d 860 (1982). In *Schaible*, the insured filed an action against his carrier to recover no-fault benefits due to the death of his wife in an automobile accident. *Id.* Among other damages, the insured sought replacement cost services, of \$14,400.00. *Id.* However, prior to trial, the insurer paid \$7,200.00 (one half of replacement services claimed) to the insured, which was never paid to the service providers. *Id.*

The issues at trial in *Schaible* were whether the insured was entitled to an additional payment for replacement cost services, and the jury awarded the Plaintiff an additional \$7,200.00 for said services. *Id.* The Court of Appeals reversed the jury's verdict and award of damages and held that the award of \$7,200.00 for replacement services was proper only if the plaintiff expended that amount or *became liable to pay* that amount in addition to the \$7,200.00 the insured was paid prior to trial. *Id.* The Court of Appeals determined that the plaintiff failed to meet his burden of proof on that matter and ruled that "The award was improper, and the trial court erred in denying the defendant's motion for directed verdict on this issue." *Id.* at 117.

The Court of Appeals properly discussed this issue as follows:

Plaintiff testified that family members performed various household tasks for him after his wife died. However, *he was unable to state with certainty how much time the relatives had spent on his behalf. In addition, he stated that he had agreed to compensate them if he prevailed in this lawsuit, but he was unable to state how much he had agreed to pay them.* Finally, on cross-examination, plaintiff testified that although defendant had paid plaintiff \$7,200.00 for replacement services prior to trial, plaintiff had not paid any of that money to the relatives who had performed the replacement services. Plaintiff did offer the testimony of an expert to show that, in general, replacement services of a household nature are worth from \$4 to \$6 an hour.

Since plaintiff did not offer proof that he expended money or became liable to pay for replacement services, the trial court's denial of defendant's motion for a directed verdict was error and the jury's award of \$7,200.00 for replacement services is reversed. (*Emphasis added.*) *Id.* at 122.

This case is similar to the *Schaible* case. In *Schaible*, the insured was unable to state with reasonable certainty how much time relatives spent performing replacement services on his behalf and, therefore, the Court of Appeals determined that the expense for services were not "incurred" and thus, the insured did not "become liable" for those services. *Id.*

Similarly the caregivers in this case did not and could not provide specific dates and hours of services provided, most likely because they never expected or intended to receive payment for same. Allstate did pay for attendant care services purportedly performed by Randy Burris' ex-wife, Diane Vermette, based on affidavits and documentation of dates and hours she allegedly provided care, which is now questionable based on her testimony at Trial. But, much like Mr. Schaible who never paid his relatives out of the \$7,200.00 he received from the insurer for replacement services, Randy Burris never paid Diane

Vermette out of the monies he received from Allstate for her alleged attendant care services.

II. FOR AN ATTENDANT CARE PROVIDER TO BE COMPENSATED UNDER SECTION 3107 OF THE MICHIGAN NO-FAULT ACT, A REQUEST FOR COMPENSATION MUST BE SUBMITTED TO THE NO-FAULT INSURER PRIOR TO LITIGATION.

While a family member may not be required to bill an insured for his or her attendant care services, there should be some sort of written request for payment for services rendered submitted to the insurance company prior to litigation. While the Court of Appeals noted that an insured's entitlement to collect the value of services and the determination of value of said services are issues properly left for a jury to decide, attendant care providers and insureds must be required to submit their requests to the insurance company short of litigation, otherwise, it defeats the purpose of the No-Fault Act to efficiently, effectively and promptly pay claims that are reasonable, reasonably necessary, and incurred. See MCL 500.3107; and *Davis v Citizens Insurance Company of America*, 195 Mich App 323; 489 NW2d 214 (1992).

The purpose of the Michigan No-Fault Insurance Act, as quoted by Plaintiff-Appellee is: "To provide accident victims with assured, adequate and prompt reparations at the lowest cost to both the individuals and the no-fault system." *Williams v AAA Michigan*, 250 Mich App 249, 257; 646 NW2d 476 (2002).

In order for the insurance carriers of Michigan to effectively and efficiently administer claims, and properly pay claims, claims for benefits must be submitted to the insurance company. In the instant case, the insured, Randy Burris' ex-wife, submitted attendant care forms for services purportedly rendered, even though it was later revealed that not all

services were performed by Ms. Vermette as claimed. Allstate Insurance Company issued remittance payable to Diane Vermette and Randy Burris (the insured) for said services.

However, with regard to the insured's father, Richard Burris, his brother, Ryan Burris, and his friend, Christopher Marcott, neither the insured nor the caregivers submitted a claim for compensation for the attendant care services. In fact, it was not until the time of Trial, that these individuals testified as to the attendant care services provided. They further testified that they were not seeking compensation or expecting to be compensated for the care provided to Randy Burris.

Plaintiff-Appellee argues that a doctor's prescription for 24-hour attendant care is the only submission of proof required for an insured to be paid for attendant care, regardless of whether anyone actually provided attendant care to the injured insured. This cannot be the intention of the No-Fault Act. The Plaintiff's proposition in this regard would mean that, if a surgeon prescribed a surgery related to an accident, the insurer would have to pay on the basis of that order, regardless of whether the surgery was performed. It is not the order or prescription which creates the obligation to pay; it is the submission of reasonable proof that the services have actually been performed.

If family members are not required to submit proof of their claims, insurers will be required to file suit for declaratory relief, or for discovery under section 3159, on every attendant care claim submitted in order to ascertain the nature and extent of the claim.

Not only does Plaintiff-Appellee's argument that an insured need not submit a request or verification for attendant care expenses prior to the time of trial defeat the purpose of the No-Fault Act and go against all logic, it would also prevent an insured from bringing a breach of contract action. That is, how can a plaintiff allege that an insurance

company has breached the insurance contract if, in fact, the insured has never submitted a claim under the policy of insurance?

This argument is even more absurd when a plaintiff is requesting Section 3142 interest penalties, Section 3148 attorneys' fees and case evaluation sanctions in his lawsuit. The purpose of MCL 500.3142 is to penalize an insurer for failing to timely pay benefits which an insured has requested and is entitled to. But, if a request is never made, and reasonable proof of a claim is not submitted, how can the clock begin to run for interest under Section 3142?

CONCLUSION

If insureds are not required to notify the insurer and provide reasonable proof of their claims prior to litigation, insurers will have to resort to lawsuits to determine every aspect of an attendant care claim. This defeats the purpose of the No-Fault Act, and defies logic.

Family or friends providing attendant care should be treated the same as any other provider of allowable expense services when submitting their claims for benefits. Likewise, there should be some intent to pay the attendant care providers, and that those providers intend to be paid.

RELIEF REQUESTED

WHEREFORE, for the foregoing reasons, Defendant-Appellee, Allstate Insurance Company respectfully requests that this Honorable Court grant Leave to Appeal, reverse the Court of Appeals' decision and reinstate the trial court's Order of Final Judgment granting JNOV for Allstate with regard to attendant care services.

Respectfully submitted,

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