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STATE OF MICHIGAN
IN THE SUPREME COURT

PORTIA WILLIAMSON, and LATESHA WILLIAMSON, as Personal Representatives for the Estate of CHARLES WILLIAMSON (deceased),

Plaintiffs-Appellees,

vs.

AAA-MICHIGAN,

Defendant-Appellant.
_____/

Supreme Court No. 165131

Court of Appeals No: 357070

Wayne County Circuit No. 19-014047-NF

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DEFENDANT-APPELLANT'S SUPPLEMENTAL BRIEF IN SUPPORT OF ITS APPLICATION FOR LEAVE TO APPEAL

ORAL ARGUMENT REQUESTED

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STATEMENT OF JURISDICTION

Pursuant to MCR 7.305(H)(1), on June 2, 2023, this Court issued an order directing the clerk to schedule oral argument on Defendant-Appellant's AAA of Michigan's Application for Leave to Appeal, which was timely filed with this Court on December 21, 2022. This Court further ordered the parties to "file supplemental briefs in accordance with MCR 7.312(E), addressing whether MCL 500.3173a(4), the statutory provision governing fraudulent insurance acts in the filing of a claim for no-fault benefits, applies to misrepresentations offered during discovery. See generally *Griffin v Trumbull Ins Co*, 509 Mich 484; 983 NW2d 760 (2022); *Haydaw v Farm Bureau Ins Co*, 332 Mich App 719 (2020); *Book-Gilbert v Greenleaf*, 302 Mich App 538 (2013)." (Appx. 2.)

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STATEMENT OF QUESTION PRESENTED

WHETHER MCL 500.3173A(4), THE STATUTORY PROVISION GOVERNING FRAUDULENT INSURANCE ACTS IN THE FILING OF A CLAIM FOR NO-FAULT BENEFITS, APPLIES TO MISREPRESENTATIONS OFFERED DURING DISCOVERY?

Plaintiffs-Appellees would answer:	No.
Defendant-Appellant answers:	Yes.
The Circuit Court would answer:	Yes.
The Court of Appeals would answer:	No.
This Court should answer:	Yes.

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SUMMARY OF ARGUMENT

AAA of Michigan ("AAA") seeks leave to appeal a published decision issued on September 22, 2022 by the Michigan Court of Appeals interpreting a key provision of the No-Fault Act governing claims made under the Michigan Assigned Claims Plan ("MACP"), MCL 500.3173a(4), which provides Michigan personal protection insurance ("PIP") benefits where there is no coverage under an insurance policy. By its unambiguous terms, Section 3173a(4) states that when a person makes a statement "as part of or in support of a claim" for benefits under the MACP, knowing the statement contains false information material to the claim, the claim is ineligible for payment of benefits under the MACP. MCL 500.3173a. This is the Legislature's chosen result for submitting false information in support of a claim for publicly-funded benefits under the MACP. Deterring abuse of the no-fault system is conducive to accomplishing the Act's stated purpose of providing affordable automobile insurance to the drivers of Michigan, who ultimately bear the burden of funding the MACP through their automobile insurance premiums.

Notwithstanding this clear language, the Court of Appeals engaged in the improper interpretation of an unambiguous statute as a means to invalidate Section 3173a(4) as it pertains to statements made in discovery in litigation. The lower court grafted an exception onto the statute and held that a fraudulent insurance act did not void a statutory claim for benefits against the MACP if the misrepresentation was made during the course of litigation. *Williamson v AAA of Mich*, ___Mich App___; ___NW2d___ (2022) (Appx. 12, Opinion.) The Court of Appeals' analysis hinges on its unnecessary and erroneous interpretation of the word "claim" to reach its conclusion that "[f]alse statements submitted during discovery, after an action for recovery has been filed, are not statements offered in support of a claim..." (*Id.* at 10..) This was error for the

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following reasons:

First, nothing in the plain language of the statute indicates the Legislature intended to give a free pass for a claimant to make a fraudulent statement in discovery and have that conduct be exempt from the scope of the disqualification set forth in MCL 500.3173a(4). The word "claim" is not ambiguous and its use in the statute does not somehow make a claim asserted through litigation something other than a "claim." Instead, the statute encompasses all statements, whether originally made in the submission as "part of" the claim or when pursuing that claim in litigation and providing the statement "in support of" that claim. Second, the fact that an "action" and a "claim" have different definitions does not somehow espouse an exception to Section 3173a(4) for "statement[s]" made "as part of or in support of a claim" merely because the statements are made in an "action." There is simply no statutory basis for the lower court's judicially-crafted exception. Third, the Court of Appeals' holding is inconsistent with the purposes of the Act and effectively endorses gaming the no-fault system in pursuit of publicly-funded benefits. Applying the rules of statutory interpretation requires reversal.

Fourth, the lower court's holding heavily relies on *Haydaw v Farm Bureau Ins Co*, 332 Mich App 719; 957 NW2d 858 (2020), where the Court of Appeals held that statements made during litigation after the insured's claim is denied do not constitute grounds to deny a claim under a contractual fraud provision in an insurance policy. *Haydaw* is inapplicable here because this case is about the proper interpretation of a statute. *Haydaw* and the cases from which it derives its holding, all pertain to insurance *contract* language. This distinction is vital because the fundamental premise on which the ruling in *Haydaw* and its underlying cases is based is the fact that a contract clause can be voided on the basis of public policy. But statutory language cannot be voided on the basis of public policy. Thus, the policy reasons justifying the holding in *Haydaw*

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cannot be used to invalidate Section 3173a(4) as it applies to statements made in discovery. Importantly, the right to claim benefits under the MACP is solely statutory in nature – it exists only at the will of the Legislature and is wholly governed by statute. See MCL 500.3171—3178. Moreover, the factual assumptions on which those policy considerations are based – that a claim has been denied prior to the initiation of litigation, the claims process has concluded, and the litigation is entirely focused on past conduct that occurred during the claims process – are inapposite to Michigan no-fault litigation.

In no-fault litigation, claimants routinely submit claims, for the first time, during litigation through discovery. The suits generally include claims for all allegedly incurred expenses prior to the litigation and all claims allegedly incurred during the course of litigation. Judgments (and settlements) in such suits are generally for benefits through the date of the judgment (or settlement). Thus, in the no-fault context, the litigation process is a means of making and asserting claims for benefits. Discovery answers are the primary vehicle in which such claims are made and by which statements and information supporting the claims are submitted. If discovery answers do not constitute statements made as part of or in support of claims, then insurers would not be obligated to treat them as such. It would be detrimental to an injured party if an insurer followed the Court of Appeals' reasoning, failing to recognize these as "claims" and failing to process such claims merely because they were submitted through discovery.

Put simply, by grafting such an exception into Section 3173a(4), the lower court created a troubling loophole in the law that incentivizes the filing of lawsuits to avoid statutory penalties for presenting false information in support of a claim for benefits under the MACP, which is entirely funded by Michigan's drivers, and encourages further abuse of the no-fault system, which is in direct contravention to the goals of the Act – providing affordable coverage and reducing lawsuits.

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For these reasons, Defendant-Appellant respectfully requests that this Court grant leave to appeal and, on appeal, reverse the Court of Appeals. Alternatively, the Court of Appeals decision should be reversed and the case remanded without the need for this Court to grant leave.

STATEMENT OF MATERIAL PROCEEDINGS AND FACTS

I. THE MICHIGAN AUTOMOBILE INSURANCE PLACEMENT FACILITY AND THE MICHIGAN ASSIGNED CLAIMS PLAN.

The Michigan Automobile Insurance Placement Facility ("MAIPF") is a statutorily-created association in which every insurer authorized to write automobile insurance in Michigan must participate. MCL 500.3301. The MAIPF administers the MACP, previously known as the Michigan Assigned Claims Facility, pursuant to MCL 500.3171 through MCL 500.3178, which is part of the Michigan No-Fault Act, MCL 500.3101 *et seq.*[1] The MACP program is designed to provide Michigan no-fault personal protection insurance ("PIP") benefits to persons otherwise eligible for coverage under the Act, MCL 500.3173, in the following circumstances:

> (a) No personal protection insurance is applicable to the injury.
>
> (b) No personal protection insurance applicable to the injury can be identified.
>
> (c) No personal protection insurance applicable to the injury can be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss.
>
> (d) The only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

MCL 500.3172(1). *Inter alia*, section 3172 sets forth requirements for making a claim for benefits

[1] Originally, the Michigan Secretary of State was charged with the organizing and maintaining an "assigned claims facility and plan." MCL 500.3171(1). However, 2012 PA 204 transferred administration of the assigned claims system from the Department of State to the MAIPF. See MCL 500.3171.

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under the MACP, including requiring a completed application, MCL 500.3172(3).

Through statute, the Legislature imposed specific obligations on the MAIPF. First, once a notice of a claim is received, the MAIPF makes an initial determination whether the claimant is eligible for benefits through the MACP. MCL 500.3174. See also MCL 500.3173a(1)-(2). The MAIPF "shall review a claim for personal protection insurance benefits under the assigned claims plan, shall make an initial determination of the eligibility for benefits under this chapter and the assigned claims plan, and shall deny a claim that the Michigan automobile insurance placement facility determines is ineligible under this chapter or the assigned claims plan." MCL 500.3173a.

If the person's claim is initially eligible, the MAIPF "shall promptly assign the claim in accordance with the plan and notify the claimant of the identity and address of the insurer to which the claim is assigned." MCL 500.3174. Once the claim is assigned, the Act provides that "[a]n insurer to whom claims have been assigned shall make prompt payment of loss in accordance with this act." MCL 500.3175. In other words, the assigned insurer adjusts the claim and pays all no-fault benefits available under the Act, including medical bills, attendant care, replacement services, and wage loss. See MCL 500.3107. However, the assigned insurer is reimbursed for that cost entirely from the MAIPF.

The cost to fund the MAIPF and MACP is substantial. The MAIPF is directed to use the funds paid by all insurers and self-insurers in Michigan to reimburse servicing insurers as described in the statute. See *id.*[2] The funds are collected through assessments to each Michigan automobile insurer and self-insurer and include an amount necessary to fund the operation of the MACP, including amounts to pay claims and administer claims. See MCL 500.3171(1) ("Costs

[2] "All insurers who write no-fault policies in Michigan receive a portion of MACP cases, allocated by market share." *Bazzi v Sentinel Ins Co*, 502 Mich 390, 419; 919 NW2d 20 (2018) (McCormack, J. dissenting).

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incurred in the operation of the facility and the plan shall be allocated fairly among insurers and self-insurers."); MCL 500.3171(2) ("Costs incurred in the administration of the assigned claims plan shall be allocated fairly among insurers and self-insurers."). In 2022, the annual assessment nearly reached $500 million dollars.[3]

The costs necessary to operate the MAIPF and MACP are ultimately borne from the driving public. See MCL 500.3176 ("Reasonable costs incurred in the handling and disposition of assigned claims, including amounts paid pursuant to assessments under section 3171, *shall be taken into account in making and regulating rates for automobile liability and personal protection insurance*.") (Emphasis added). Thus, the price of PIP benefits in every Michigan automobile insurance policy is based in part on the amount of funds required to operate the MACP. Put simply, every person who purchases a Michigan automobile-insurance policy pays the assessment fund the MACP. For that reason, "the Michigan Assigned Claims Plan (MACP) is the insurer of last resort." *Bazzi*, 502 Mich at 419 (McCormack, J. dissenting) (citing MCL 500.3171).

II. FACTUAL BACKGROUND

On October 30, 2018, Charles Williamson ("Plaintiff") walked into oncoming traffic and was struck by an unidentified vehicle. (Appx. 14-20, Police Report and Investigation.) Plaintiff sustained multiple injuries and was immediately transported to Providence Hospital, where he was reported to be in stable condition. (*Id.*) Plaintiff subsequently underwent surgery at St. Johns Hospital followed by rehabilitation at Lakeland Center for Rehabilitation. Plaintiff was discharged to home on December 26, 2018.

[3] The 2022 assessment was $499,873,833.81. Available at https://www.michacp.org/assessment.aspx (last accessed December 16, 2022).

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On December 14, 2018, Lakeland Center for Rehabilitation completed an Application for Benefits Through the Michigan Assigned Claims Plan on behalf of Plaintiff. (Appx. 22-26, Application for Benefits.) The application indicated Plaintiff was struck by an unidentified vehicle and, thus, no insurer in the order of priority could be identified, and Plaintiff did not maintain Michigan No-Fault automobile insurance of his own and was not otherwise entitled to claim benefits under the policy of a spouse or resident relative. (*Id.*) On January 8, 2019, the MAIPF assigned his claim to AAA Michigan, which promptly paid Plaintiff's benefits, consisting of medical bills for treatment.

III. PROCEDURAL BACKGROUND

A. Circuit Court Proceedings

Despite Plaintiff's claim not being disputed by AAA and all benefits submitted having been paid, on October 22, 2019, Plaintiff filed this action for first-party no-fault benefits against Defendant-Appellant Auto Club Insurance Association. (Appx. 28-33, Complaint.) It appears suit was filed to protect Plaintiff's rights under the "one-year-back rule" in MCL 500.3145, which is a fairly common practice in the Michigan no-fault world. (See *id.*, ¶¶ 4-6). Unfortunately, AAA learned that on October 23, 2019, Plaintiff passed away, following a second unrelated subsequent pedestrian-motor vehicle accident. (Appx. 35, Obituary.) Plaintiff's daughters, Porsha and Latesha Williamson, acquired Letters of Authority to proceed with this suit on January 8, 2020 on behalf of Mr. Williamson's estate (the "Estate"). (Appx. 37-40, Letters of Authority.)

During discovery, AAA served discovery on Plaintiff's Personal Representatives, inquiring into which specific no-fault benefits were being claimed by the Estate. The answers to AAA's interrogatories, dated February 10, 2020, indicated that the Estate was claiming replacement services and attendant care and specifically cited to attached documentation, consisting of fully completed replacement-service and attendant-care calendars detailing the dates

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on which services were provided and specified which services were performed on those days. (Appx. 42-78, Answers to Interrogatories). Specifically, the following answers to interrogatories were provided:

> 30. Do you claim any loss of services no-fault benefits in this lawsuit?
>
> **ANSWER:**
>
> 31. If your answer to Interrogatory 30 is yes, please provide the following information as to each person who has provided to you such services:
>
> a. The name, address and phone number of each person who has provided such services;
> b. The date or dates upon which said services were provided;
> c. Specify the services performed on each date;
> d. The amount of loss of services benefit you claim in regard to each person;
> e. The amount of money which you have paid to each person in regard to said services;
> f. The form of payment to each person, i.e., cash or check or by some other means;
> g. Do any documents exist in support of this claim? If yes, please describe and attach a copy of all such documents.
>
> **ANSWER:**
>
> **a-g** Lirrice Brown. See attached services forms
>
> * * *
>
> 57. Do you claim benefits for attendant care or nursing services in this lawsuit pursuant to MCL §500.3107(1)(a)? If so, please confirm what is the total amount of unpaid attendant care services claimed through the date you answer these Interrogatories.
>
> **ANSWER:**
>
> Yes. See attached
>
> 58. If you claim attendant care services pursuant to MCL §500.3107(1)(a), how many hours per day does Plaintiff claim to need attendant care services and for which inclusive dates? Where different numbers of hours were needed during different time frames, please break down your answer in that regard.

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ANSWER:

See attached

(*Id.*)

The calendars signed and dated by Lateshea Williamson for each month being claimed were attached to the interrogatories and presented to AAA to identify the benefits being claimed. Additionally, they indicated that Plaintiff received 16 hours per day of attendant care October 24 through 31, 2019 and every day of November and December of 2019, consisting of following services: general supervision, administering medications, and "night assistance/bathroom." (*Id.*) Moreover, the calendars indicated that Plaintiff received replacement services October 24 through 31, 2019 and every day of November and December of 2019, consisting of the following services: preparing meals, doing laundry, lifting and carrying groceries, and taking out garbage. (*Id.*) Lateshea Williamson signed and dated the answers to interrogatories, indicating that she read the Answers and believed them to be true to the best of her knowledge. (*Id.*)

As a result, AAA filed a Motion for Summary Disposition, arguing that Plaintiff's claim for benefits was precluded pursuant to MCL 500.3173a(4)[4], which states as follows:

[4] While Plaintiff's accident occurred prior to the 2019 amendments to the No-Fault Act, the misrepresentation at issue in this case occurred after the amendments were passed; thus, the amended version of MCL 500.3173a was applied, under which the material misrepresentation provision, at issue in this case, is found under MCL 500.3173a(4). Prior to the 2019 amendments, the material misrepresentation subsection of the statute was found under MCL 500.3173a(2). Despite the fact that one of the panel members in this case, Judge Douglas Shapiro, authored the Court of Appeals' majority opinion in *Andary v USAA Cas Ins Co*, ___ Mich App ___; ___NW2d___(2022) (holding that two amended provisions of the Act could not apply to claimants involved in accidents prior to their passage because it amounted to retroactive application of a statute because the subject accident occurred prior to the passage of the 2019 amendments), none of the panel members in this case questioned whether it was appropriate to apply MCL 500.3173a(4) as opposed to the pre-amendment MCL 500.3173a(2). Under this Court's analysis in *Andary v USAA Cas Ins Co*, ___ Mich ___; ___NW2d___(2023), because no contract rights are involved here, application of the amended statute is appropriate.

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> A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan automobile insurance placement facility, or to an insurer to which the claim is assigned under the assigned claims plan, for payment or another benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 that is subject to the penalties imposed under section 4511. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment of personal protection insurance benefits under the assigned claims plan.

MCL 500.3173a(4). (Appx. 80-138, Defendant's Motion for Summary Disposition.)

AAA argued that because Plaintiff was deceased in November and December of 2019, he could not have received replacement services and attendant care on those dates. As a result, under Section 3173a(4), the interrogatory answers were a fraudulent insurance act and Plaintiff's claim was rendered ineligible for payment of benefits under the MACP. (*Id.*)

Plaintiff[5] responded, arguing that the forms were not submitted in support of a claim for benefits and, instead, were merely documents in Plaintiff's possession and responsive to a discovery request. (Appx. 141, Plaintiff's Response to MSD.) Plaintiff argued that the forms were pre-dated and filled out prior to Plaintiff's death and any misrepresentation was unintentional. (*Id.*) Plaintiff further argued that the rule from *Haydaw* should be applied – "false statements made during discovery in the midst of litigation do not provide grounds to void an insurance policy" – and, inexplicably, argued that there was no fraud in the formation of the insurance contract. (*Id.* at 145.)

[5] While in reality it was counsel representing Plaintiff's Estate and Plaintiff's Personal Representatives who responded to the motion, for the sake of clarity, the term "Plaintiff" is used because ultimately Plaintiff's interest is the one being advanced.

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The Motion was granted on April 27, 2021. (Appx. 168-169, Order Granting Defendant's Motion.) The Order specifically noted that Plaintiff committed a fraudulent insurance act by knowingly presenting material misrepresentations in support of its claims for no-fault benefits, and, as a result, concluded that the claims are ineligible for payment or benefits pursuant to MCL 500.3173a. (*Id.*)

B. The Court of Appeals

Plaintiff appealed, making the same arguments made in the trial court. AAA responded, arguing that the facts of this case were virtually identical to *Candler v Farm Bureau Mut Ins Co of Michigan*, 321 Mich App 772; 910 NW2d 666 (2017), which leads to the same result – that the misrepresentation rendered the claim ineligible for benefits under the MACP (in *Candler*, the essential services calendars were also presented when the claim was in litigation). (Appx. 171-318, Defendant-Appellee's Brief on Appeal.) Defendant further argued that the correct analysis under the statute has no "intent" element; thus, required a different analysis than common-law fraud used to void the formation of a contract. (See *id.*) Plaintiff submitted a reply brief, arguing the misrepresentation was unintentional and the fraud defense was not plead with particularity.

On September 22, 2022, the Court of Appeals issued its opinion reversing the trial court, holding that "MCL 500.3173a(4), the statutory provision governing fraudulent insurance acts in this context, only applies to statements offered during the prelitigation insurance claims process and not to those offered during litigation." (Appx. 4, Opinion.) The court set forth the elements to establish ineligibility due to a material misrepresentation under MCL 500.3173a(4), as set forth in *Candler*, and noted that Plaintiff disputed the second element that requires the fraudulent statement "is part of or in support of a claim for no-fault benefits[.]" (*Id.* at 7,8.) The court stated "[t]his argument turns on the proper interpretation of the word 'claim' in MCL 500.3173a(4)."

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(*Id.* at 9.) The court concluded that the word "claim" refers only to the "prelitigation insurance claims process[.]" (*Id.* at 10.)

The court supported its conclusion by stating that the No-Fault Act must be "liberally construed in favor of the persons who are intended to benefit from it." (*Id.* at p. 6). The court relied on *Griffin v Trumbull Ins Co*, 509 Mich 484**;** 983 NW2d 760 (2022), which analyzed a priority statute, MCL 500.3114, which sets forth an order of priority of insurers (and the MACP in certain circumstances) from whom accident victims may "claim" no-fault benefits. "In this context, a claim for benefits is simply a demand to an insurer by its insured or a third party for payments that are believed to be due after a motor vehicle accident." (Appx. 9, Opinion) (quoting *Griffin, supra*, at 498). The court also noted that portions of the No-Fault Act specify where it refers only to a lawsuit and uses the terms "cause of action", "action for recovery", and "action by claimant[.]" (*Id.*) Because Section 3173a(4) did not specifically refer to an "action" and only used the term "claim", the court concluded that "[f]alse statements submitted during discovery, after an action for recovery has been filed, are not statements offered in support of a claim to the MAIPF or the assigned insurer." (*Id.* at 10.)

The court also relied on *Haydaw*, *supra*, in which the Court of Appeals "addressed 'whether statements made during litigation after the insured's claim is denied constitute grounds to void the policy under a fraud provision'" for its holding that "the fraudulent insurance act provision in MCL 500.3173a does not apply to statements made after litigation has ensued." (*Id.* at 11.) The court stated,

> [A] false statement made in a filing submitted during discovery is not a statement made to the MAIPF or to an assigned insurer. Rather, a false statement made during discovery is made to the court. See *Haydaw*, 332 Mich App at 728 ("[A]n insured's statements during discovery are made with the intention that the trier of fact, not the insurer, will act on them."). That is why the court rules authorize

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> courts to sanction discovery violations under specific circumstances. See MCR 2.313. Thus, an insurer may have recourse for a false statement made during discovery, but it is not dismissal of the claim under MCL 500.3173a.

(*Id.* at 12.) For those reasons, the court concluded that "[s]tatements made for the first time during discovery cannot form the basis of a fraudulent insurance act under MCL 500.3173a(4)." (*Id.*)

ARGUMENT

I. STANDARD OF REVIEW

This Court reviews *de novo* underlying issues of statutory interpretation. *Stanton v City of Battle Creek*, 466 Mich 611, 614; 647 NW2d 508 (2002). "This means that we review the issue independently, without any required deference to the lower court." *Lakeshore Group v Dep't of Environmental Quality*, 507 Mich 52, 62; 968 NW2d 251 (2021) citing *Millar v Constr Code Auth*, 501 Mich 233, 237; 912 NW2d 521 (2018). The granting of Defendants' motion to dismiss is also reviewed *de novo*. *Maiden v Rozwood*, 461 Mich 109; 597 NW2d 817 (1999).

II. MCL 500.3173a(4) APPLIES TO MISREPRESENTATIONS MADE DURING DISCOVERY.

A. There Is No Statutory Basis For Invalidating Section 3173a(4) As It Applies To Statements Made In Discovery.

This Court's well-settled precedent requires that, when interpreting a statute, courts must "follow the established rules of statutory construction, the foremost of which is to discern and give effect to the intent of the Legislature." *Kostadinovski v Harrington*, ___Mich___; ___NW3d___ (2023) quoting *Whitman v City of Burton*, 493 Mich 303, 311; 831 NW2d 223 (2013). Thus, courts "begin by examining the most reliable evidence of that intent, the language of the statute itself." *Whitman*, 493 Mich at 311. Courts "must read the statute as a whole and in its grammatical context, giving each and every word its plain and ordinary meaning unless otherwise defined." *Book-Gilbert v Greenleaf*, 302 Mich App 538, 541; 840 NW2d 743 (2013) citing *In re*

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Receivership of 11910 South Francis Road, 492 Mich 208, 222; 821 NW2d 503 (2012). "Effect must be given to every word, phrase, and clause in a statute, and the court must avoid a construction that would render part of the statute surplusage or nugatory." *Id.* citing *Johnson v Recca*, 492 Mich 169, 177; 821 NW2d 520 (2012). "If the language of the statute is unambiguous, the Legislature must have intended the meaning clearly expressed, and the statute must be enforced as written. No further judicial construction is required or permitted." *Kostadinovski*, *supra* quoting *Sun Valley Foods Co v Ward*, 460 Mich 230, 236; 596 NW2d 119 (1999). See also, *Whitman*, 493 Mich at 311. Only "if the statute's language is ambiguous, this Court 'may refer to the history of the legislation in order to determine the underlying intent of the Legislature.'" *Rouch World, LLC v Dep't of Civil Rights*, 510 Mich 398, 410; 987 NW2d 501 (2022) quoting *Luttrell v Dep't of Corrections*, 421 Mich 93, 103; 365 NW2d 74 (1984).

1. An Exception For Statements Made In Discovery Does Not Exist In The Plain Language Of MCL 500.3173a(4).

As with all questions of statutory interpretation, a court must begin its analysis with the plain language of the statute. *Ameritech Mich v PSC (In re MCI)*, 460 Mich 396, 411; 596 NW2d 164 (1999). Section 3173a(4) provides:

> A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan automobile insurance placement facility, or to an insurer to which the claim is assigned under the assigned claims plan, for payment or another benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 that is subject to the penalties imposed under section 4511. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment of personal protection insurance benefits under the assigned claims plan.

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MCL 500.3173a(4).[6] In an opinion authored by one of the panel members in this case, the Court of Appeals stated that the Legislature clearly evinced its intent that the conduct described in MCL 500.3173a(4) is grounds for a denial of a claim. *Williams v Farm Bureau Mut Ins Co*, 335 Mich App 574, 579 n 1; 967 NW2d 869 (2021) ("And notably, in MCL 500.3173a(4) the Legislature has demonstrated that it knows how to adopt legislation making grounds for denial of a claim. That statute provides that, as to claims filed with the Michigan automobile insurance placement facility, provision of material false information renders the claimant ineligible for benefits and classifies such an act as a fraudulent insurance act under MCL 500.4503.").

Nothing in the statute's plain language indicates an exception exists for statements in discovery made "as part of or in support of a claim to the Michigan automobile insurance placement facility, or to an insurer to which the claim is assigned under the assigned claims plan[.]" *Id.* Neither the words "discovery", "litigation", nor any other language is used to create some sort of subcategory of statements made "as part of or in support of a claim" that would be immune from the operation of MCL 500.3173a(4).

To reach its desired result, the lower court engaged in improper judicial construction of an unambiguous statute. The lower court's result requires inserting additional words into the statute as follows: "[A] person who presents...a statement…as part of or in support of a claim [except if that statement is made in an action]…." This is not what the statute says. "The courts may not read into the statute a requirement that the Legislature has seen fit to omit." *Book-Gilbert*, 302 Mich App at 542 citing *In re Hurd-Marvin Drain*, 331 Mich 504, 509; 50 NW2d 143 (1951) ("We may not read into the law a requirement that the lawmaking body has seen fit to omit."). See also

[6] Section 4503 defines fraudulent insurance acts. Section 4511 sets forth penalties for committing a fraudulent insurance act, which are not at issue in this case.

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Robinson v City of Lansing, 486 Mich 1, 15; 782 NW2d 171 (2010) (courts "may not read into the statute what is not within the Legislature's intent as derived from the language of the statute.") (cleaned up). Because the lower court failed to apply the plain language of the statute, it erred.

a. The Word "Claim" Is Unambiguous And Its Use In Section 3173a(4) Does Not Justify Grafting An Exception Into The Statute.

In this case, the Court of Appeals' analysis hinged on its unnecessary and erroneous interpretation of the word "claim", creating a dichotomy between "claim" and "action", to reach its conclusion that "[f]alse statements submitted during discovery, after an action for recovery has been filed, are not statements offered in support of a claim to the MAIPF or the assigned insurer." (Appx. 10, Opinion.) The panel's decision defies logic and the rules of statutory interpretation.

i. The Definition of "Claim."

"If a word in a statute is undefined, it must be given its plain and ordinary meaning, and it is proper to consult a dictionary for definitions." *Champine v DOT*, 509 Mich 447, 453; 983 NW2d 741 (2022) (cleaned up). "A court does not construe the meaning of statutory terms in a vacuum. Rather, [courts] interpret the words in their context and with a view to their place in the overall statutory scheme." *South Dearborn Environmental Improvement Ass'n, Inc v Dep't of Environmental Quality*, 502 Mich 349, 376; 917 NW2d 603 (2018).

As an initial matter, the word "claim" is not defined by statute. Looking to its dictionary definitions, a "claim" is "a demand for something due or believed to be due." Merriam-Webster Collegiate Dictionary (11th ed). See also Black's Law Dictionary (11th ed) (defining a "claim" to mean "[t]he assertion of an existing right; any right to payment or to an equitable remedy, even if contingent or provisional"). Nothing in the ordinary definition of "claim" would indicate that claims (assertion of rights or demand for something) pursued through litigation are not claims. Likewise, nothing in the plain or ordinary meaning of the word "claim" somehow transforms an

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insurance claim into something other than a claim merely because a claimant[7] pursues the claim through litigation.

Next, the statute does not use the word "claim" in a vacuum. Instead, it indicates that it is a claim made to the MAIPF or an assigned insurer and that it is a claim "for payment or another benefit[.]" MCL 500.3173a(4); *Candler*, 321 Mich App at 781. Thus, in the context of Section 3173a(4), "claim" means "*a demand for, or an assertion of rights to*" payment or another benefit that is made to the MAIPF or an assigned insurer, without any further qualifications. Again, nothing about the word "claim" as used in the context of the statute transforms a claim into something other than a claim merely because it is asserted in litigation. The statute does not differentiate between a claim for payment of benefits made outside of litigation and one asserted through litigation. Courts may not create an ambiguity where none exists in a statute. *Lantz v Banks*, 245 Mich App 621, 626; 628 NW2d 583 (2001).

ii. *Griffin v Trumbull.*

The lower court's reliance on *Griffin v Trumbull Ins Co* to support the false dichotomy between an "action" and a "claim" is also misplaced. In *Griffin*, this Court analyzed the language of MCL 500.3114, which directs persons injured in motor vehicle accidents to claim no-fault benefits "from insurers according to the listed order of priority." *Griffin*, 509 Mich at 498. Analyzing MCL 500.3114, this Court stated,

> *In this context*, a claim for benefits is simply a demand to an insurer by its insured or a third party for payments that are believed to be due after a motor vehicle accident…. [T]o 'claim' PIP benefits *in this context* can be reasonably understood to mean that one must put potential insurers on notice and submit insurance claims stating an entitlement to benefits and requesting payment.

[7] Consistent with the definition of "claim", a "claimant" is "one that asserts a right or title[.]" https://www.merriam-webster.com/dictionary/claimant.

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Id. at 498, 500 (emphasis added).

This Court's statements in *Griffin* are perfectly consistent with AAA's position in this case. First, nothing in *Griffin* changes the definition of the word "claim[.]" To the contrary, this Court cited additional definitions derived from insurance-industry sources that are also entirely consistent with the dictionary definitions of "claim" set forth above as follows: "defining 'claim' as 'a request made by the insured for insurer remittance of payment due to loss incurred and covered under the policy agreement'… defining 'claim' as '[a]ny request or demand for payment under the terms of the insurance policy'…'Claim — used in reference to insurance, a claim may be a demand by an individual or corporation to recover, under a policy of insurance, for loss that may come within that policy.'" *Id.* at 498 n 5. Thus, within the insurance industry, a "claim" is a request or demand for payment or benefits due under an insurance policy. Again, nothing in these definitions indicates that filing suit as a means to pursue a claim for benefits fundamentally transforms the nature of a "claim" so that it is no longer a demand for payment or benefits due. It would be a very dangerous precedent to set to ignore claims for payment made during litigation based on the erroneous interpretation by the *Williamson* Court.

Second, this Court was clear that its statements regarding the meaning of the word "claim" were specifically in the context of MCL 500.3114 – which is limited to making the initial demand of benefits to an insurer highest in the order of priority. This Court did not limit the definition of "claim" in the entire No-Fault Act to mean only the act of "put[ting] potential insurers on notice and submit[ting] insurance *claims* stating an entitlement to benefits and requesting payment." *Id.* at 500 (emphasis added). Regardless, as stated above, this definition is consistent with AAA's position in this case.

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Third, while this Court in *Griffin* correctly noted that making a claim is not the same thing as filing a lawsuit, nothing in *Griffin* suggests that a lawsuit cannot be a means to pursue a claim. In *Griffin*, this Court found, *inter alia*, that a claimant complied with MCL 500.3114 because he filed a claim against all "insurers in the order of priority who were identifiable prior to the expiration of the limitations period" and he was not required to file a lawsuit to obtain subpoena power to identify a higher-priority insurer under the circumstances. *Id.* at 491. Thus, *Griffin* simply stands for the proposition that MCL 500.3114 merely requires a claimant to make a "good-faith" effort to claim benefits from the highest-priority insurer and that does not necessarily require filing suit to obtain subpoena power. *Id*. at 11. *Griffin* does not stand for the proposition that filing suit makes a claim something other than a claim. *Griffin* does not stand for the proposition that a claim cannot be pursued through litigation. Indeed, the Act itself contemplates filing an "action" as a means of making a "claim" for the first time. Under MCL 500.3145:

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

MCL 500.3145(1). In other words, where a claimant has *not* yet provided an insurer "a demand … for payments that are believed to be due after a motor vehicle accident" or "put [the] potential insurer[] on notice [or] submit[ted] insurance claims" to the insurer; *Griffin*, 509 Mich at 498, 500; the claimant may assert its claim by commencing an "action." Simply put, under the Act, claims may be pursued through actions. A claim and an action are not mutually exclusive. Thus, nothing in the Act nor *Griffin* justifies a judicially-crated exception to MCL 500.3173a(4) for misrepresentations made in discovery.

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iii. The Lower Court Created A Meaningless Dichotomy Between "Action" And "Claim."

To reach its holding, the Court of Appeals invented a dichotomy between claims made in the prelitigation insurance claims process versus pursuing a claim for benefits through litigation that simply does not exist in the No-Fault Act. The court bases this conclusion, in part, on its argument that the Act uses both the word "action" and the word "claim", thus, they must have different meanings, and, as a result, a statement made in an "action" is not a statement made in support of a "claim." (See Appx. 9-10, Opinion.) This is faulty reasoning. "Action" and "claim" *do* have different meanings because they are two different words but, the fact that two different words are used in the Act does not mean that a "claim" pursued in an "action" is not a "claim."

The lower court first relies on the Act's use of the phrase "cause of action for damages" in MCL 500.3135(2), which sets forth rules for a lawsuit over an automobile-negligence claim, such as making the issue of threshold injury a question of law for a court to decide in certain circumstances and rules for assessing damages in such a lawsuit. Thus, the use of the phrase "cause of action for damages" is logical here because the statute sets forth rules for auto-negligence *lawsuits*. It would not make sense to use the word "claim" here. The language doesn't govern insurance claims. It governs issues relevant only to litigation—whether a court could decide an issue as a question of law or how a jury may assess damages. Likewise, MCL 500.3145, on which the lower court relied, repeatedly uses the word "action" to describe when a *lawsuit* to recover PIP benefits or property-protection benefits must or may be filed. Again, the use of the word "claim" here would not make sense, as those specific sentences set forth deadlines relevant specifically only to *lawsuits*, as it is a statute of limitation. Finally, the lower court relied on the use of the terms "claim" and "action" in MCL 500.3174, which states as follows:

> A person claiming through the assigned claims plan shall notify the Michigan automobile insurance placement facility of his or her

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> claim within 1 year after the date of the accident. On an initial determination of a claimant's eligibility for benefits through the assigned claims plan, the Michigan automobile insurance placement facility shall promptly assign the claim in accordance with the plan and notify the claimant of the identity and address of the insurer to which the claim is assigned. An action by a claimant must be commenced as provided in section 3145.

MCL 500.3174.

Again, the use of the terms "claim" and "action" are perfectly consistent with their meanings and the use is logical. The word "claim" refers to the claimant's demand for, or assertion of right to, benefits under the MACP and sets forth rules for notifying the MAIPF of the claim, for the MAIPF to make an initial determination of eligibility of the claim, and for the assignment of the claim to a servicing insurer. See *id.* However, where the statute addresses when a *lawsuit* may be filed, it logically uses the word "action." *Id.* But nothing in MCL 500.3174, or any other statute that uses the term "action" in the Act, indicates that a claim for benefits is not a claim where it is asserted through litigation.

In sum, where the Act prescribes requirements only specifically applicable to *lawsuits*, it uses the term "action." Where the Act addresses a demand for, or an assertion of right to, benefits, it uses the word "claim[.]" Recognizing that the words "action" and "claim" have different meanings does not render the word "claim" ambiguous. Nor does it require that Section 3173a(4) be interpreted as being inapplicable to statements made in support of claims for benefits made during litigation.

Moreover, the lower court's reasoning that a claim pursued through litigation is an "action" and not a claim yields an absurd result when applied in other parts of the Act. Statutes should be construed to avoid absurd results. *Barrow v Detroit Election Comm*, 301 Mich App 404, 416; 836 NW2d 498 (2013). For example, MCL 500.3104 uses the word "claim" to refer to an assertion of right for benefits by a claimant, arising out of an accident, including all amounts sought during the

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lifetime of the claim. Section 3104 governs the Michigan Catastrophic Claims Association ("MCCA"), which reimburses member insurers for 100% of the "ultimate loss" a member insurer sustains under PIP coverage above a statutory threshold. MCL 500.3104(2). "Ultimate loss" is defined as "the actual loss amounts that a member is obligated to pay and that are paid or payable by the member, and do not include claim expenses" – in other words all amounts due for the lifetime of a claim. MCL 500.3104(28)(g). Annually, the MCCA must prepare an annual statement regarding MCCA-retention level claims (those meeting the statutory threshold) and that report must include:

> (a) The number of *claims* opened during the preceding 12 months, the amount expended on the *claims*, and the future anticipated costs of the *claims*.
> (b) For each of the preceding 10 years, the total number of open *claims*, the amount expended on the *claims*, and the anticipated future costs of the *claims*.
> (c) For each of the preceding 10 years, the total number of *claims* closed and the amount expended on the *claims*.
> (d) For each of the preceding 10 years, the ratio of *claims* opened to *claims* closed.
> (e) For each of the preceding 10 years, the average length of open *claims*.
>
> ***
>
> (o) For each of the preceding 10 years, an injury type summary, categorizing the injuries suffered by *claimants* the payment of whose *claims* are being reimbursed by the association, by brain injuries, injuries resulting in quadriplegia, injuries resulting in paraplegia, burn injuries, and other injuries.

MCL 500.3104(25) (emphasis added). (See also, Appx. 320-330, MCCA Amicus Brf, discussing cost of MCCA-retention level claims.) Additionally, member insurers are required to report to the MCCA "each claim" that may require MCCA involvement (a claim that may or has reached the statutory threshold). MCL 500.3104(7). "The member shall also advise the association of

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subsequent developments likely to materially affect the interest of the association in the claim." *Id.*

It is axiomatic that over the lifetime of these claims, many are in litigation at various times but the fact that such claims are asserted in an "action" neither exempts them from inclusion in the MCCA's annual reports nor relieves member insurers of their reporting requirements to the MCCA. However, if the lower court's reasoning applied, once these "claims" were asserted in litigation, they would be "actions" and not subject to any statute under the Act that referred to them as "claims." The lower court's premise for its holding is patently incorrect.

b. Section 3173a(4)'s Plain Language Encompasses Statements Made In Discovery.

The Legislature intended the statute to apply broadly to all statements "as part of or in support of a claim" for payment of benefits, regardless whether made before litigation or in discovery during litigation. This is evident because the Legislature did not include any narrowing language. The Legislature is not required to specify that there are no exceptions to a statute or affirmatively specify that certain categories are not exempt from statute. Because MCL 500.3173a(4) is absent of "textual indications to the contrary", there is no "clearer sign" that the Legislature did not intend an exemption for statements made in discovery. See *People v Wafer*, 509 Mich 31, 42; 983 NW2d 315 (2022). Where a statute is broad in its scope as written, it must, likewise, be applied broad in scope. *Ionia Pub Sch v Ionia Ed Ass'n*, 311 Mich App 479, 493; 875 NW2d 756 (2015).

To foreclose any doubt regarding the Legislature's intent, Section 3173a(4) expressly encompasses statements made "as part of *or* in support of a claim…" MCL 500.3173a(4) (emphasis added). The use of the word "or" is important here because "[t]he word 'or' generally refers to a choice or alternative between two or more things." *Auto-Owners Ins Co v Budkis*, 227

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Mich App 45, 50; 575 NW2d 79 (1997). "[T]he words 'and' and 'or' are not interchangeable and their strict meaning should be followed when their accurate reading does not render the sense dubious and there is no clear legislative intent to have the words or clauses read in the conjunctive." *In re AGD*, 327 Mich App 332, 348; 933 NW2d 751 (2019). Thus, a statement made "as part of" a claim is not the same as a statement made "in support of" a claim.

Moreover, the fact that the statute differentiates between a statement made "as part of" versus "in support of" a claim is meaningful. The Legislature is presumed to have acted intentionally and the difference in words selected must be given effect. *Robertson v DaimlerChrysler Corp*, 465 Mich 732, 759; 641 NW2d 567 (2002). "[C]ourts must give effect to every word, phrase, and clause in the statute and avoid an interpretation that renders any part of the statute nugatory or surplusage." *Mason v City of Menominee*, 282 Mich App 525, 536; 766 NW2d 888 (2009). "'Part' is defined as 'a portion or division of a whole that is separate or distinct; piece, fraction, or section.'" *People v Kloosterman*, 295 Mich App 68, 70; 810 NW2d 917 (2011). Thus, a statement that is "part of" a claim is a statement that forms a portion of the claim itself – in other words – statements made as part of the insurance claims process. "Dictionary definitions of 'support' include 'to provide with substantiation,' 'corroborate,' 'assist,' or 'help.'" *Sullivan v State*, 328 Mich App 74, 83; 935 NW2d 413 (2019). Thus, a statement made "in support of a claim" is any statement that substantiates, corroborates, assists, or helps validate that the claim is entitled to be paid. In sum, MCL 500.3173a(4) is applicable to statements made as part of the insurance claims process and statements made for the purpose of substantiating, corroborating, assisting, or helping to validate a claim. There is simply nothing about the phrase "in support of"

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that would exclude statements in litigation that aid in proving that the claimant is statutorily entitled to benefits under the MACP.[8]

The lower court erroneously reasoned that "a false statement made in a filing submitted during discovery is not a statement made to the MAIPF or to an assigned insurer. Rather, a false statement made during discovery is made to the court." (Appx. 12, Opinion) (citing *Haydaw*, 332 Mich App at 728 ("[A]n insured's statements during discovery are made with the intention that the trier of fact, not the insurer, will act on them.")). As an initial matter, *to whom* a false statement is made is immaterial because section 3173a(4) does not specify to whom the false statement must be made in order for the statute to render the claim ineligible. It is enough that it is a statement made "as part of or in support of" a claim for benefits to the MAIPF or an assigned insurer. *Candler*, 321 Mich App at 780; *Bakeman v Citizens Ins Co*, ___Mich App___; ___NW2d___ (2022) ("The statute does not require the false statement to be submitted to any particular person or entity so long as it supports a claim to the MAIPF). The language of the statute controls and the Court of Appeals here was not at liberty to read in requirements not set forth in the statute.

[8] It is axiomatic that where a claimant files a lawsuit to compel payment of benefits under the MACP, statements made in litigation are "in support of" the claim for benefits, as that is precisely what is being sought by a plaintiff in litigation. There is no meaningful difference between a pre-litigation claim and a claim asserted through litigation. The right to receive PIP benefits through the MACP is purely statutory in nature as there is no insurance policy applicable to claims for benefits through the MACP. MCL 500.3172. See also, *Andary v USAA Cas Ins Co*, ___Mich___, n 30; ___NW3d___ (2023) (recognizing "purely statutory claim[s]" for PIP benefits). Thus, the "cause of action" available to a claimant is a claim for payment of benefits pursuant to the statute. Whether the claim is made to the MAIPF, an assigned insurer, or asserted in litigation, the claimant must prove that his or her "claim" is eligible for payment of benefits under the Act. See MCL 500.3172—MCL 500.3174. See also, *Mich Head & Spine Institute, PC v Mich Assigned Claims Plan*, 331 Mich App 262, 274; 951 NW2d 731 (2019) (holding that a cause of action for payment of benefits exists against the MAIPF and a claimant is not limited to filing an action for "declaratory relief seeking to require MAIPF to assign an insurer"). Accordingly, regardless whether the claim is asserted in litigation, the claimant would be required to show eligibility under the Act which necessarily involves the submission of statements "made as part of or in support of" the claim.

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Mich Ed Ass'n v Secretary of State, 489 Mich 194, 217-18; 801 NW2d 35 (2011) ("Courts may not speculate regarding legislative intent beyond the words expressed in a statute. Hence, nothing may be read into a statute that is not within the manifest intent of the Legislature as derived from the act itself."). Thus, whether a statement is made to the MAIPF, an assigned insurer, a court, or a jury is entirely inconsequential.

Next, discovery answers are not "made to the court" simply because court rules govern discovery and evidence exchanged in discovery may be used at trial. Discovery answers are served on the party who served the interrogatories or discovery requests. See MCR 2.309(B)(4), 2.310(C)(2), 2.312(B)(1). They are not filed with the court and the judge does not review them unless they are attached to another filing as documentary support or presented to the jury at trial. Discovery is exchanged to allow the parties to evaluate the claims and defenses asserted and obtain all relevant evidence regarding the same. "The purpose of discovery is to simplify and clarify the contested issues, which is necessarily accomplished by the open discovery of all relevant facts and circumstances related to the controversy." *Hamed v Wayne Co*, 271 Mich App 106, 109; 719 NW2d 612 (2006). Here, it defies logic to maintain that Plaintiff's interrogatory answers here were not statements made to AAA, as they were in response to AAA's inquiries and submitted to AAA's counsel for the purposes of notifying AAA of the expenses being claimed and to proffer statements in support of those claims.

More importantly, Plaintiff's discovery answers were unquestionably made "as part of or in support of" Plaintiff's claim for benefits. MCL 500.3173a(4). Plaintiff filed a lawsuit in an attempt to compel AAA to pay benefits under the MACP. Lateshea Williamson, on behalf of Plaintiff, presented AAA, an assigned insurer, with answers to interrogatories, which inquired into the type and amount of benefits being demanded in the lawsuit. Interrogatory 30 asked "Do you

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claim any loss of services no-fault benefits *in this lawsuit*?"[9] (Appx. 44, Pl. Interrogatory Answer, no. 30) (emphasis added). As the Court of Appeals recognized, while this question was not answered, the answer to interrogatory no. 31 indicated that replacement services were being claimed in the lawsuit. (See Appx. 6 n.3, Ex A, Opinion.) Interrogatory no. 31 asked for details regarding the claim for replacement services, such as, *inter alia*, the dates such services were provided and the services performed. (Appx. 44-45, Pl. Interrogatory Answers, no. 31). The answer to this interrogatory stated "See attached services forms[.]" (*Id.*) Likewise, interrogatory no. 57 asked "Do you *claim* benefits for attendant care or nursing services *in this lawsuit* pursuant to MCL §500.3107(1)(a)? If so, please confirm what is the total amount of unpaid attendant care services *claimed* through the date you answer these Interrogatories." (*Id.* at 56, no. 57) (emphasis added). This was answered in the affirmative and again directed AAA to the attached documentation (attendant care calendars). Stated simply, Plaintiff was "claiming" entitlement to payment of replacement services and attendant care benefits in the "lawsuit." The answers to interrogatories were written statements "made in support of" a claim for benefits under the MACP. Such statements plainly fall within the purview of MCL 500.3173a(4).

Candler illustrates that claims pursued in litigation are subject to MCL 500.3173a(4). Thus, the lower court's holding is inconsistent with *Candler*. In *Candler*, the plaintiff submitted calendars supporting his claim for replacement services, for the first time, in litigation. The calendars indicated his brother provided such services in August, September, and October, 2015. *Candler*, 321 Mich App at 776. Plaintiff filed suit in August, 2015. (Appx. 332-334, *Candler* Register of Actions.) Thus, at a minimum, the September and October calendars must have been

[9] The use of the words "claim" and "lawsuit" in the interrogatories further demonstrates that while the words have different meanings, the "claim" is a demand for, or assertion of right to, benefits and the "lawsuit" is a means of compelling payment of the claim.

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submitted during litigation, as it is axiomatic that there is no obligation to pay benefits until allowable expenses are actually incurred. *Douglas v Allstate Ins Co*, 492 Mich 241, 267; 821 NW2d 472 (2012) (there is no liability to pay PIP benefits unless an expense is actually incurred). However, the plaintiff's brother had stopped providing such services in July, 2015. *Candler*, 321 Mich App at 776. Like in this case, the plaintiff in *Candler* submitted forms supporting claims for services that were never actually rendered. *Id.* at 781. The Court of Appeals held the plaintiff's claim was ineligible for benefits under Section 3173a(4)[10] because he knowingly made false statements in his replacement service calendars in support of his claim for benefits under the MACP. *Id.* at 782.

In this case, the panel found its holding "consistent with the circumstances in *Candler*" because, in *Candler*, "although the fraudulent act was discovered after litigation had commenced, it related to statements made in support of the plaintiff's claim to the assigned insurer." (Appx. 10 n.7, Opinion.) Apparently, the panel was unaware such statements were received for the first time during litigation.

In sum, there is simply neither any textual nor practical basis for carving out an exception for misrepresentations made in discovery from MCL 500.3173a(4).

2. <u>The Lower Court's Holding Contravenes The Policy Goals Of The Act.</u>

The Court of Appeals grasped at straws to reach a decision that benefits only untruthful plaintiffs in lawsuits and ignored the interests of the millions of Michigan citizens who bear the

[10] At the time of *Candler*, the fraudulent misrepresentation provision was MCL 500.3173a(2). As a result of the 2019 amendments to the No-Fault Act, the provision was placed under subsection (4). Additionally, two textual changes were made. First, the amended statute clarified, consistent with the holding in *Candler*, that the claim must be a claim for payment or benefits to the MAIPF or an assigned insurer. MCL 500.3173a(4). Second, the amended provision clarified that where a fraudulent misrepresentation is made as part of or in support of a claim, the claim is ineligible for payment of "personal protection insurance benefits" under the MACP. *Id.*

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burden of funding the operation of MACP, which includes the cost to pay claims and litigation costs. Where a court interprets a statute, it "reads the statutory language in the light of history and common sense and in the light of previously-established and recognized rules of the common law. *Soaring Pine Capital Real Estate & Debt Fund II, LLC v Park Street Group Realty Servs*, LLC, ___Mich___; ___NW3d___(2023). When interpreting statutes, courts must "determine and effectuate the intent of the Legislature through reasonable construction in consideration of the purpose of the statute and the object sought to be accomplished." *Frankenmuth Mut Ins Co v Marlette Homes*, 456 Mich 511, 515; 573 NW2d 611 (1998).

"More than 50 years ago, Michigan's no-fault act, 1972 PA 294, was enacted by the Legislature as 'an innovative social and legal response to the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or 'fault') liability system." *Andary v USAA Cas Ins Co*, ___Mich___;___NW3d___ (2023) quoting *Shavers v Attorney General*, 402 Mich 554, 578; 267 NW2d 72 (1978). The Legislature believed these goals could be most effectively achieved through a system of compulsory insurance. MCL 500.3101. The goal of the Act is provision of an equitable and prompt method of redressing injuries in a way which makes mandatory insurance coverage affordable to all motorists. *Tebo v Havlik*, 418 Mich 350, 360; 408 NW2d 181 (1984). However, "[t]he no-fault act was as concerned with the rising cost of health care as it was with providing an efficient system of automobile insurance." *Dean v Auto Club Ins Ass'n*, 139 Mich App 266, 273; 362 NW2d 247 (1984), *appeal denied*, 422 Mich 921 (1985). For that reason, "the proper interpretation" of a statute within the Act "comports both with the plain language of the statute and the legislative purpose of keeping insurance premiums at affordable rates while providing victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses." *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 217-18; 815 NW2d

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412 (2012).

Unfortunately, keeping the cost of Michigan's auto insurance has not always been effectively accomplished. Indeed, City of Detroit Mayor Duggan filed a federal lawsuit arguing that the cost of insurance had escalated so high that it was no longer affordable to Detroiters. *Duggan v Patrick McPharlin*, Docket No. 2:18-cv-12639 (ED Mich, 2018). It is no secret that that the primary driver of costs is the high cost of medical care provided under PIP coverage.[11] It is also no secret that abuse of the no-fault system is an epidemic further driving the high cost of premiums.[12]

In 2019, the Legislature made widespread reforms to the No-Fault Act in an effort "to drive down premiums for all operators of automobiles in Michigan and to curb what had been portrayed as exploitative billing by medical providers." *Andary*, *supra*. "In fact, the Legislature included in the title of 2019 PA 21 and 2019 PA 22 a statement that one purpose was 'to provide for the continued availability and affordability of automobile insurance . . . in this state and to facilitate

[11] See 2019 Senate Journal 441 (No. 43, May 7, 2019), quoting Senator Nesbitt ("This legislation will put an end to the bloated costs of health care within the system. The cost of the exact same medical procedures should not cost any more simply because [it] happens in a car accident. By leveling the playing field and bringing down the cost of auto insurance, we will have lower rates, provide choice, *crack down on fraud and end lawsuit abuse*…. The current system in unaffordable it's failing the people, the families of Michigan, so we have an obligation to fix this system. The bill will provide consumers with significant savings, while still offering the highest minimum coverage of any state. Passage of this bill will result in lower rates, provide unlimited options, and offer the highest minimum coverage.") (emphasis added).

[12] For example, Ira Demery billed Auto Club Insurance Company (ACIA) for attendant care she allegedly provided to her husband, Michael, who had sustained a below the elbow amputation and, allegedly, a traumatic brain injury, in a motor vehicle accident. After paying for such care, ACIA learned that Michael had actually spent time in jail and fathered a child with another woman, all while supposedly receiving 24/7 care from his wife. See *Demery v Auto Club Ins Ass'n*, No. 11-117189-NF, 2015 Mich Cir LEXIS 803, at *1 (Oakland Cty Cir Ct, Sept 21, 2015) (cited in the MCCA's Amicus brief to the Court of Appeals in *Andary*, *supra*, for the purpose of illustrating abuse on the no-fault system) (Appx. 327).

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the purchase of that insurance by all residents of this state at fair and reasonable rates[.]'" *Id.*

Consistent with these goals, the Legislature has taken a hard line with respect to false statements made as part of or in support of claims for benefits under the publicly-funded MACP. See MCL 500.3173a. While the MACP provides a limited safety net for accident victims with no other means for coverage, it does not come without a cost. The money used to fund the MACP comes from assessments made on every insurer authorized to write automobile insurance in Michigan and self-insurers. See MCL 500.3171(1); MCL 500.3171(2) ("Costs incurred in the administration of the assigned claims plan shall be allocated fairly among insurers and self-insurers."). The insurers, in turn, are required to take these costs into account when setting their automobile rates. MCL 500.3176. As a result, the funds to operate the MACP are ultimately borne from Michigan's driving public, who already bears the burden for paying for the most expensive auto insurance in the nation.[13]

The Court of Appeals erred when it apparently found its duty was to interpret Section 3173a(4) in a manner that best serves the interests of plaintiffs suing for payment of no-fault benefits under the MACP because the No-Fault Act is remedial.[14] (See Appx. 9, Opinion.) First, as this Court recently recognized, the Act was not designed only to benefit claimants but to benefit Michigan drivers. *Andary, supra* (the no-fault system was intended to "remedy the perceived flaws of a fault-based tort system of post-accident recovery" and to make "automobile insurance more

[13] See 2019 Senate Journal 588 (No. 52, May 24, 2019) (Senator Theis, the Chair of the Senate Insurance and Banking Committee stating that no-fault reform would relieve "Michiganders" from bearing the cost of "the most expensive car insurance in the country.").

[14] Remedial legislation is that which is "designed to correct an existing law, redress an existing grievance, or introduce regulations conducive to the public good." *Rookledge v Garwood*, 340 Mich 444, 453; 65 NW2d 785 (1954), quoting *In re School Dist No 6, Paris & Wyoming Twps*, 284 Mich 132; 278 NW 792 (1938).

affordable for Michiganders and combat[] bad actors.") Here, Section 3173a(4) is consistent with making insurance more affordable for Michigan drivers specifically by penalizing bad actors. A statute that disincentivizes gaming the no-fault system and aids in containing the cost of the MACP – which is ultimately funded by Michigan's drivers – is clearly conducive to the public good and consistent with the goals of making automobile insurance more affordable.

Second, the Court of Appeals' holding frustrates the "no-fault act's purpose of reducing litigation." *Devillers v Auto Club Ins Ass'n*, 473 Mich 562, 565; 702 NW2d 539 (2005). All a claimant has to do to avoid Section 3173a(4) is file a lawsuit. The Court of Appeals' holding shields untruthful plaintiffs from the statute's penalty and, in effect, rewards the filing of lawsuits.

Third, the Court of Appeals' holding is also in contravention of the Act's goal of providing prompt reparation for injuries. See *Hardrick v Auto Club Ins Ass'n*, 294 Mich App 651, 694; 819 NW2d 28 (2011) ("The basic goal of the no-fault insurance system is to provide individuals injured in motor vehicle accidents assured, adequate and prompt reparation for certain economic losses at the lowest cost to the individual and the system."). If the lower court's holding that statements in discovery are not statements "made as part of or in support of" claims for benefits stands, then claims submitted for payment in the course of litigation need not be paid within 30 days. See MCL 500.3142 (payment of benefits are due within 30 days of a claimant presenting reasonable proof of the "claim"). Simply put, claims incurred by a plaintiff during the course of litigation could not be included as part of the plaintiff's claim in the litigation because it would not trigger an insurer's duty to pay the claim within 30 days. This would certainly be a surprise to the hundreds of no-fault plaintiffs with cases pending throughout the state. Moreover, this would further frustrate the goal of reducing lawsuits because a plaintiff would have to file additional lawsuits to pursue benefits accrued during the pendency of litigation.

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Likewise, any information provided to insurers intended to establish "reasonable proof" of a claim would not need to be considered when determining whether a claim way payable because such information would not be "statements in support of" a claim for benefits. See MCL 500.3142. Simply put, the lower court's holding contravenes the Act's policy goals.

B. *Haydaw* Does Not Provide Support For the Lower Court's Holding.

The lower court further rationalized its holding by relying on *Haydaw*. But *Haydaw* is wholly inapplicable to this case for two reasons: (1) it is based on contractual provisions and not statute, which is a fundamental distinction because the rule and reasoning in *Haydaw* is premised on the idea that a court can invalidate contractual language based on public policy, but a similar rule does not exist with respect to statutory language; and (2) it analyzed a rule developed through caselaw that used reasoning applicable only to circumstances that are fundamentally dissimilar to this case and all litigation involving Michigan PIP benefits.

1. *Haydaw* Pertains To Fraud Clauses In Insurance Policies.

The issue in *Haydaw* was "whether statements made during litigation *after the insured's claim is denied* constitute grounds to void the policy *under a fraud provision*." (Appx. 11, Opinion) (quoting *Haydaw*, 332 Mich App at 723) (emphasis added). This was an issue of first impression in Michigan and the Court of Appeals held that statements made during litigation do not implicate a fraud or false-swearing clause in an insurance policy. *Haydaw*, 332 Mich App at 726. The Court adopted this holding based on the reasoning of extra jurisdictional cases that addressed fraud or false-swearing clauses in property insurance contracts. *Id.* at 724-726.

As an initial matter, unlike *Haydaw*, this case does not involve a fraud or false swearing clause in an insurance policy. Section 3173a(4) is statutory; thus, caselaw regarding a contractual

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fraud provision is irrelevant.[15] Here, there is no insurance policy applicable to Plaintiff's claim for benefits. "Although the word 'fraudulent' might have other connotations in other contexts, where a statute provides its own definition of a word, the statute's definition alone must be applied." *Bakeman, supra* (citing *Tryc v Mich Veterans' Facility*, 451 Mich 129, 135-136; 545 NW2d 642 (1996); *Candler*, 321 Mich App at 780 n 6). The elements of fraud and a "fraudulent insurance act" differ substantively. Fraud requires proof of falsity, intent, reasonable reliance, and damages. Proof of a "fraudulent insurance act" requires none of those elements. *Candler*, 321 Mich App at 779-780. While the Court of Appeals recognized this point, it stated "much of the rationale from *Haydaw* is persuasive to the circumstances before us, and most importantly, applying *Haydaw's* holding in this context is consistent with the plain language of MCL 500.3173a(4)." A closer examination of *Haydaw* demonstrates this is false.

Haydaw relies on *American Paint Serv v Home Ins Co*, 246 F2d 91 (CA 3, 1957), a case arising out of a claim for business-interruption losses caused by a fire, in which an insurer asserted a defense under the fraud or false swearing clause of its insurance policy. The Third Circuit held that in-court testimony could not be the basis of the insurer's contract defense. *Id.* at 94. The court

[15] "Fraud" is both a common-law cause of action and a defense. The cause of action requires pleading and proving of the following elements: (1) the defendant made a material representation; (2) the representation was false; (3) the defendant knew, or should have known, that the representation was false when making it; (4) the defendant made the representation with the intent that the plaintiff act upon it; (5) the plaintiff acted on the representation and reasonably relied on defendant's false representations; and (6) the plaintiff incurred damages as a result. *Roberts v Saffell*, 280 Mich App 397, 403; 760 NW2d 715 (2008); *Foreman v Foreman*, 266 Mich App 132, 141-142; 701 NW2d 167 (2005). At common-law, "this avoidance defense is typically used when a contract is obtained as a result of fraud or misrepresentation[.]" *Stein v Home-Owners Ins Co*, 303 Mich App 382, 388; 843 NW2d 780 (2013) (quotation marks omitted). However, the contract defense of fraud can also be an affirmative defense available to an insurer where an insurance policy (a contract) contains a provision that voids the policy if the insured engages in fraudulent conduct. *Id.* at 384, 387.

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reasoned that a fraud or false swearing clause is meant to incentivize cooperation with the insurer for the adjustment and settlement of a claim but, by the time suit is filed, the claim has already been denied. Thus, if the insurer's pre-suit denial of the claim was based on some fraud or false swearing, it must have occurred prior to the filing of suit. "It is at the trial that the insurer must display, not manufacture, its case." *Id.* The purpose of a trial is for the jury to determine whether the claim should have been paid or whether the defense was properly asserted. See *id.* Thus, evidence relevant to an insurer's defense under such a contract clause would logically pertain to proofs and statements submitted to the insurer pre-litigation. Once litigation ensues, the parties are adversaries and the terms of the policy no longer govern the parties' conduct. See *id.*; *Ocean-Clear, Inc v Continental Cas Co*, 94 AD2d 717, 718; 462 NYS2d 251 (NY App Div, 1983) (discussing *American Paint*, stating "once an insurer repudiates liability, however, the assured is excused from any of its obligations under the policy").

Many of the cases cited in *Haydaw* as support for its holding rely on *American Paint* or its same reasoning. See *Dodson Aviation, Inc v Rollins, Burdick, Hunter, Inc*, 15 Kan App 2d 314, 325; 807 P2d 1319 (Kan Ct App, 1991) (case arising from property damage caused by a hail storm); *Ocean-Clear, Inc*, 94 AD2d 717 (case arising from property damage caused by a fire); *Mercantile Trust Co v NY Underwriters Ins Co*, 376 F2d 502, 504 n 2 (CA 7, 1967) (case arising from property damage caused by a fire); *Third Nat'l Bank v Yorkshire Ins Co*, 218 Mo App 660, 673; 267 SW 445 (Mo Ct App, 1924) (case arising from a loss that occurred when property was stolen and burned).[16]

[16] In the Court of Appeals' decision in this case, it acknowledged that its holding in *Haydaw* that "fraud provisions in no-fault insurance policies do not provide grounds for rescission based upon false statements made by the insured during first-party litigation", *Haydaw*, 332 Mich App at 721, was clarified by the Court of Appeals in a subsequent opinion, which limited its scope. (Appx. 11, Opinion.)

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Importantly, the holding in *American Paint* was a policy decision by the court, based on its contention that if insurers could rely on statements made in litigation, it would incentivize denying claims, forcing litigation, and then allowing an insurer to later manufacture a defense through litigation. See *American Paint*, 246 F2d at 94. The rule set forth in *American Paint* applies regardless of the language of the contract clause at issue, some of which are broad and not expressly limited to statements made in the pre-litigation claims process. See e.g. *Dodson Aviation, Inc*, 15 Kan App 2d at 322; *Third Nat'l Bank*, 218 Mo App at 669. Thus, contract clauses are not applied as written under the rule, which is supported by policy considerations. In other words, it is fundamental to the holding in *Haydaw* that contracts that violate public policy may not be enforced. *Rory v Continental Ins Co*, 473 Mich 457, 491; 703 NW2d 23 (2005).

2. Statutory Language Cannot Be Invalidated On The Basis Of Public Policy Absent A Basis In The Language Of The Statute.

There is no rule of law in Michigan that allows a court to invalidate a statute on the basis of public policy as it could a contractual provision. The Legislature, not the courts, decide issues of public policy. *Woodman v Kera LLC*, 486 Mich 228, 245; 785 NW2d 1 (2010). This concept is rooted in the separation of power doctrine. "The Legislature has no duty to satisfy us that its

> Having reviewed the parties' supplemental briefs, we conclude that *Haydaw* has no impact on the outcome of this case. We read *Haydaw* as standing for the unremarkable proposition that an insurer cannot assert that it denied a claim because of fraud that occurred after litigation began; the fraud must have occurred before the commencement of legal proceedings. This recognizes the reality that a plaintiff-insured only commences suit after the defendant-insurer denies the plaintiff's claim and that the denial cannot possibly be based on an event that has not yet taken place. This does not mean that a defendant cannot rely on evidence of fraud obtained after litigation commences. It simply means that the evidence must relate to fraud that took place before the proceedings began.

Butross Dawood Fashho v Liberty Mut Ins Co, 333 Mich App 612, 619; 963 NW2d 695 (2020).

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legislative enactment is a 'good' one. Legislation must be constitutional; this alone is enough." *People v Gardner*, 482 Mich 41, 65; 753 NW2d 78 (2008). The courts' judicial role "precludes [them from] imposing different policy choices than those selected by the Legislature." *Johnson*, 492 Mich at 187. Courts are not permitted to rewrite statutes. Such decisions belong to the branch of our government that the people empowered to make the desired change: the Legislature. See *Karaczewski v Farbman Stein & Co*, 478 Mich 28, 42-43; 732 NW2d 56 (2007), overruled in part on other grounds by *Bezeau v Palace Sports & Entertainment, Inc*, 487 Mich 455; 795 NW2d 797 (2010). "It is not within the province of th[e] Court[s] to usurp the functions of the legislature and amend the act or its title by judicial interpretation in the absence of clear and express language which dictates such an interpretation." *Croff v Lake Foundry & Machine Co*, 320 Mich 581, 595; 31 NW2d 728 (1948).

Here, Plaintiff's right to benefits is solely statutory –"[h]is right then…. sprang from the kindness and grace of the legislature." *Rookledge*, 340 Mich at 457. Thus, the statute dictates the parameters of those rights, including what actions constitute a "fraudulent insurance act" and render a claim for benefits ineligible for payment under the MACP. See e.g., MCL 500.3173a(4). "[T]he statute is the 'rule-book' for deciding the issues involved in questions regarding awarding [PIP] benefits." *Bronson Health Care Group, Inc v State Auto Prop & Cas Ins Co*, 330 Mich App 338, 343; 948 NW2d 115 (2019).

By applying the reasoning in *Haydaw* to justify excluding statements made in litigation from the operation of Section 3173a(4), the Court of Appeals made a policy decision. This is improper. As explained above, nothing in the statute itself indicates the Legislature intended for the statute to be inapplicable to a particular class of statements "made as part of or in support of" a claim based on whether the claim is asserted in litigation. While the panel may have found it

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unfair or an overly harsh result to deem Plaintiff's claim ineligible as a result of the false statements asserted in interrogatory answers, the panel was not at liberty to carve out a judicial exception to the unambiguous statute.[17] Ineligibility is the Legislature's chosen remedy. "It is well settled that when a statute provides a remedy, a court should enforce the legislative remedy rather than one the court prefers." *City of South Haven v Van Buren Co Bd of Comm'rs*, 478 Mich 518, 528; 734 NW2d 533 (2007).

"[T]he judicial branch cannot amend the no-fault act to make it 'better.' That is an authority reserved solely to the Legislature." *Johnson*, 492 Mich at 187. "Whether or not a statute is productive of injustice, inconvenience, is unnecessary, or otherwise, are questions with which courts . . . have no concern." *Id.* "Regardless of how unjust [a] statutory penalty might seem to this Court, it is not our place to create an equitable remedy for a hardship created by an unambiguous, validly enacted, legislative decree." *Stokes v Millen Roofing Co*, 466 Mich 660, 672; 649 NW2d 371 (2002) (quotation marks and citation omitted). "Statutes lose their meaning if an aggrieved party need only convince a willing judge to rewrite the statute under the name of equity." *Trentadue v Buckler Lawn Sprinkler*, 479 Mich 378, 407; 738 NW2d 664 (2007) (quotation marks and citation omitted).

Because this case involves a statute and not a contractual provision, the public policy reasoning in *Haydaw* cannot be applied to justify invalidating Section 3173a(4) to statements made in discovery.

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[17] During oral argument in the Court of Appeals, Judge Rick indicated that mistakes happen and she felt as if barring the claim as a result of an error in paperwork wasn't just. The error was characterized as a typo. Judge Garret questioned whether the statute should carry an intent requirement closer to that of common-law fraud. Courts are not at liberty to refuse to apply statutes as written or rewrite statutes. *Sun Valley Foods Co*, 460 Mich at 236; *Book-Gilbert*, 302 Mich App at 542.

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3. *Haydaw* And Its Underlying Cases Are Premised On Circumstances Inapposite To No-Fault Litigation, Making Their Reasoning Inapplicable Here.

The cases on which *Haydaw* is based simply have no applicability here. First, *Haydaw* indicates that the issue of whether statements in litigation can form the basis of a defense under a fraud or false swearing clause was first addressed in *Republic Fire Ins Co of North America v Weides*, 81 US 375; 14 Wall 375 (1871). In that case, the plaintiffs' statements made in proofs of claim and during an examination under oath during the initial claims process materially differed from their statements made while testifying in court. *Id.* at 382-83. The insurer defendant argued a fraud or false swearing provision in the policy voided the claim. The argument was rejected because the clause expressly applied only to information the insureds agreed to submit in the claims process. See *id.* at 382. This point is crucial to the court's holding in *Weides* that the existence of the clause alone did not require judgment in favor of the insurer. *Id.* at 383. The Court reasoned that there was still a question of fact as to which statements were false – the statements made during the claims process– to which the fraud or false swearing clause applied – or the testimony – to which the clause did not apply. That was a question of fact for the jury. *Id.* at 383.

Weides is readily distinguishable from the facts here because, unlike the fraud or false swearing provision in the insurance policy at issue in *Weides*, Section 3173a does not expressly apply only to statements made in certain documents or during certain claims processes. As explained above, the statute unambiguously applies to all statements "made as part of *or* in support of" a claim for benefits without any express exceptions. MCL 500.3173a(4) (emphasis added). Nothing in *Ins Cos v Weides* compels a different reading of the statute. To find that section 3173a(4) does not apply to statements made in discovery based on *Weides* is the tail wagging the dog.

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Second, neither *American Paint* nor any of the cases based on its same reasoning provide justification for exempting statements made in discovery from operation of Section 3173a(4). *American Paint* and its progeny arise from property-damage claims and assume that the insurer denied the claim following an investigation, the claims process was concluded, and the litigation was focused solely on past conduct to determine whether or not the insurer's denial was wrongful. Accordingly, it would be illogical to allow statements made in litigation to form the basis of a defense to coverage where the litigation was solely focused on what occurred during the claims process. While the reasoning in *American Paint*, appears to be logical in the context of a claim for damages caused by a fire, it is inapplicable to a suit for Michigan no-fault PIP benefits.

Here, the lower court, quoting *Haydaw*, reasoned that "[a]n insured's statements during discovery are made with the intention that the trier of fact, not the insurer, will act on them." (Appx. 12, Opinion.) However, the lower court's opinion omitted the next sentence in *Haydaw* that states, "[t]o the extent that the insurer acts on those statements, it is through counsel for purposes of litigation strategy *rather than processing the claim under the policy's terms*." *Haydaw*, 332 Mich App at 728 (emphasis added). But in no-fault litigation, an insurer *is* relying on the information submitted in discovery to process the claim.

Michigan no-fault cases are fundamentally different than cases for breach of contract arising from a property-damage claim. [18] In no-fault cases, the claims process is not concluded when litigation ensues. Litigation is merely a vehicle for asserting claims. While an accident may

[18] A property-damage claim arises out of an occurrence resulting in damage of property and, relevant to *American Paint*, sometimes resulting losses, such as lost business the insured would have conducted but for the loss of use of the property damaged or destroyed. The property-damage claims process largely involves the valuation of such damages, resulting in a final determination of the extent of its liability by the insurer. If the claim is denied and suit is filed, the claims process has concluded and the trial is focused on pre-litigation events.

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trigger a claimant's right to coverage under MCL 500.3105, a claimant's actual "claim" is comprised of allowable expenses as they are incurred over time. MCL 500.3107 (benefits payable only for "reasonable charges incurred"); MCL 500.3110(4) ("benefits payable…as the allowable expense… is incurred"); *Douglas*, 492 Mich at 267 (no obligation to pay for an expense until it is actually incurred). The Act requires expenses be paid within 30 days of "reasonable proof" of the incurred allowable expense being submitted. MCL 500.3142. Thus, the Act's system creates a continual claims process where claims for allowable expenses are submitted piecemeal over time and comprise the claimant's overall claim for benefits. See MCL 500.3104 (referring to "claims" as the totality of what is paid over the lifetime of a claim).

As a result, plaintiffs in no-fault cases continue to assert claims for PIP benefits incurred during the pendency of litigation in the litigation itself, for the first time in litigation, by submitting such claims to an insurer's counsel before there has even been an opportunity for a breach of contract. Adjusters continue to adjust PIP claims in litigation. It is axiomatic that, in many cases, claims are submitted ***for the first time*** in litigation in initial disclosures or answers to discovery. Indeed, that was the case here.

In the trial court, Plaintiff argued that the calendars were not meant to be in support of a claim but were merely documents in Plaintiff's possession that were responsive to document requests, indicating they were never previously sent to AAA. (Appx. 141, Pl. Resp. to MSD.) However, AAA was paying Plaintiff's claim and it appears suit was filed to protect Plaintiff's rights under MCL 500.3145. (See Appx. 28-33, Complaint.) Thus, there had not yet been a denial of any benefits. AAA's discovery requests, as is common in PIP litigation, were served for the purpose of *learning* what benefits were being claimed. This is remarkably different from a property-damage case where all claims and proofs have already been submitted to, investigated

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by, and a coverage determination has been made by an insurer. Even where a specific allowable expense was previously submitted and denied, nothing prevents a plaintiff in no-fault litigation from submitting additional documents or other statements "in support of" that claim in litigation, and if that additional information constitutes "reasonable proof" of the claim, it triggers the 30-day deadline to pay under MCL 500.3142. See e.g., *Hartman v Ins Co of North America*, 106 Mich App 731, 747; 308 NW 2d 625 (1981) (penalty interest allowed to begin 30 days after reasonable proof of the fact and amount of loss was introduced at trial). Thus, the reasoning in *American Paint* is inapplicable because "[s]tatements made for the first time during discovery" are "part of or in support of" the claim for PIP benefits. (Appx. 12, Opinion); MCL 500.3173a(4). Stated another way, when it comes to Michigan PIP, litigation often *is* the claims process. Accordingly, the lower court's reliance on *Haydaw* is misplaced and is error.

CONCLUSION AND REQUEST FOR RELIEF

WHEREFORE, Defendant-Appellant respectfully request that this Honorable Court grant its Application for Leave to Appeal and reverse the Court of Appeals' decision.

Respectfully submitted,

Dated: August 16, 2023

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CERTIFICATE OF COMPLIANCE

I certify that the Defendant-Appellant's Supplemental Brief complies with the type-volume limitation set forth in MCR 7.212(B). This brief uses a 12-point proportional font (Times New Roman), and the word count, based on the word count of the word-processing system used to produce this document, for this brief is 14,263.

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