STATE OF MICHIGAN

IN THE SUPREME COURT

PORSHA WILLIAMSON AND LATESHEA WILLIAMSON, as Co-Personal Representatives of the ESTATE OF CHARLES WILLIAMSON,

Plaintiffs-Appellees,

v

AAA OF MICHIGAN,

Defendant-Appellant,

Supreme Court: 165131

COA.: 357070

Wayne CC: 19-014047-NF

PLAINTIFFS-APPELLEE'S

SUPPLEMENTAL BRIEF

Kyle Kelly (P69863)
LIPTON LAW
18930 West 10 Mile Rd.
Southfield, MI 48075
(248) 557-1688/ (248) 557-6344 (Fax)
kyle@liptonlaw.com
Attorney for Plaintiffs/Appellees The Estate of Charles Williamson, Dec'd

Lori McAllister (P38501)
Erin Ann Sedmak (P78282)
201 Townsend Street, Suite 900
Lansing, MI 48933
(517) 374-9150/(855) 258-3519 (Fax)
lmcallister@dykema.com
esedmak@dykema.com
Attorneys for Defendant/Appellant AAA of Michigan

PLAINTIFF-APPELEE'S SUPPLEMENTAL RESPONSE IN OPPOSITION TO

DEFENDANT'S APPLICATION FOR LEAVE TO APPEAL

Oral Argument Requested

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes:

STATEMENT OF QUESTIONS ON APPEAL

1. **WHETHER MCL 500.3173A(4), THE STATUTORY PROVISION GOVERNING FRAUDULENT INSURANCE ACTS IN THE FILING OF A CLAIM FOR NOFAULT 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: No.

STATEMENT ON JURISDICTION

Plaintiff concurs with Defendant's Statement of Jurisdiction.

INDEX OF EXHIBITS

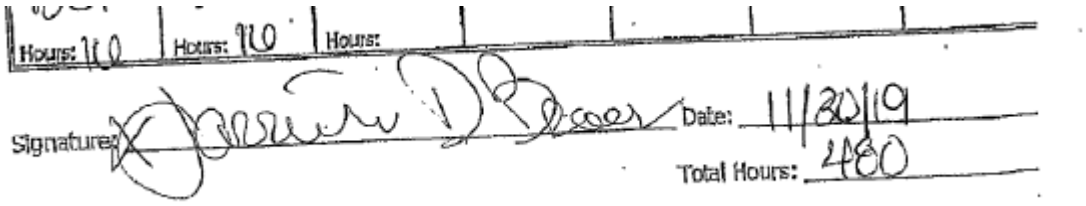
Plaintiff concurs with Defendant's Index of Exhibits and hereby adopts the same.

STATEMENT OF MATERIAL PROCEEDINGS AND FACTS

Plaintiff largely does not dispute AAA's recitation of the facts and procedural history of this case. However, in one significant example, AAA's facts contain a falsehood that is critical to the analysis in this case. At page 9 of their brief, AAA writes:

> 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.*)

The calendars are NOT signed and dated by Latesha Williamson. They are signed and dated by Lirrice Brown (who was also the care provider)[1]:

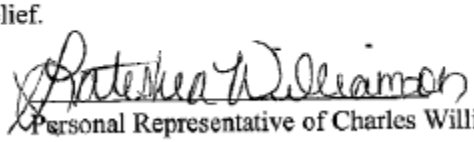


DEFENDANT-APPELLANT'S APPENDIX

Ms. Williamson did sign the interrogatories[2]:

[1] See Defendant's Appendix H. Plaintiff also concurs in Defendant's Appendix and will adopt, and cite to, that appendix.
[2] *Id.*

I have read the foregoing Answers to Interrogatories, and believe the same to be true to the best of my knowledge, information and belief.



Personal Representative of Charles Williamson

Subscribed and sworn to before me

These are very clearly different signatures and different people.

Thus, Ms. Williamson was not responsible for the creation of the erroneous calendars.

ARGUMENT

1. Standard of Review

A trial court's decision to grant or deny a motion for summary disposition is reviewed *de novo* on appeal. *Spiek v Dep 't of Transportation*, 456 Mich 331, 337, 572 NW2d 201 (1998). Issues of statutory interpretation also are reviewed *de novo* by the appellate courts in Michigan. *Griffith v State Farm Mut Auto Ins Co*, 472 Mich 521, 525-526, 697 NW2d 895 (2005).

2. MCL 500.3173a(4)

a. "Claim" vs "Action," Defined.

Defendant begins its entire analysis with a flawed argument: that "claim," in the context of the No-Fault Act, has not been defined. In a case the parties were directed to consider, *Book-Gilbert v Greenleaf*, 302 Mich App 538, 541; 840 NW2d 743 (2013), the Court of Appeals wrote, "When construing statutory language, [the court] 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*, at 541.

This Court has already defined "claim" in the No-Fault realm[3] in *Covenant Med. Ctr., Inc. v. State Farm Mut. Auto. Ins. Co.*, 500 Mich. 191, 895 N.W.2d 490 (2017), at fn 31:

[3] While *Covenant* focused on MCL 500.3112, we must consider "statute as a whole." *Book Gilbert*, at 541.

> Because the no-fault act does not define "claim," we may consult a dictionary definition. The relevant dictionary definitions of "claim" include "a demand for something due or believed to be due" and "a right to something." Therefore, to have a "claim" under the no-fault act, a provider must have a right to payment of PIP benefits from a no-fault insurer. Internal citations omitted.

While *Covenant* has been largely abrogated by the 2019 amendments, it has not been overruled and the logic holds: a "claim" encompasses the entire "right to payment." It does not mean a lawsuit. It involves the overall "right to payment of PIP benefits" in the generic plural, which are available under the statute. Not to any specific payment or amount of money, but the right to PIP payments in general. Once the "right to payment" has been determined, the claim has been made.

Next, the statue makes a clear distinction between a lawsuit and a claim. To initiate a "civil action," a party files a "complaint with a court[4]." Critically, and this is absolutely critical, the Court Rules use the word "action." "There is one form of action known as a "civil action[5]." Thus, an "action" is easily defined, and this Court has already done so: "An "action" is defined as a lawsuit brought in court; a formal complaint within the jurisdiction of a court of law." *Epps v 4 Quarters Restoration LLC*, 498 Mich 518, 522; 872 NW2d 412 (2015)

MCR 2.111(B)(1) simply requires a complaint to include a "statement of the facts, without repetition, on which the pleader relies in stating the cause of action, with the specific allegations necessary reasonably to inform the adverse party of the nature of the claims the adverse party is called on to defend[.]" The Court of Appeals has previously explained that this subrule is "consistent with a notice pleading environment" and that "the primary function of a pleading in Michigan is to give notice of the nature of the claim or defense sufficient to permit the opposite party to take a responsive position." *Dalley v Dykema Gossett*, PLLC, 287 Mich App 296, 305;

[4] MCR 2.101(B)
[5] MCR 2.101(A)

788 NW2d 679 (2010). Thus, an "action" is not a "claim," as an "action" does not create a right to anything, but only begins the litigation process.

This conclusion is bolstered by every single section of the statute. In the earlier subsections of §3173, the procedure for filing a "claim" to the MAIPF is outlined:

> The Michigan automobile insurance placement facility **shall review a claim** for personal protection insurance benefits under the assigned claims plan, **shall make an initial determination of the eligibility** for benefits under this chapter and the assigned claims plan, and shall deny a claim that the Michigan automobile insurance placement facility determines is ineligible under this chapter or the assigned claims plan. MCL 500.3173a.

Thus, we can see that a claim is the very first step in the process. A claim is made, the plan makes an "initial determination," and then determines eligibility for benefits under the Act. The Act does not call upon the MAPIF to review actions, nor could it. A lawsuit must be distinct from a "claim" because a lawsuit at this stage would be moot. A dispute is moot if no controversy exists and any judgment on the matter would lack practical legal effect. *People v Smith*, 502 Mich 624, 631; 918 NW2d 718 (2018).

Indeed, suppose an injured person were to file an action against the MAIPF before following the steps outlined in §3173, exactly what would the dispute be? No claim has been made. No determination has been made. No insurer has been assigned. There is nothing in controversy and there is no issue of law or fact a court can decide. In such an event, the trial court would surely dismiss the matter and require the plaintiff to actually make a claim so that the MAIPF can act (or not act) and potentially create a controversy.

MCL 500.3173(2) further illustrates the distinction between an action and a claim perfectly:

> A claimant or a person making a claim through or on behalf of a claimant shall cooperate with the Michigan automobile insurance placement facility in its determination of eligibility and the settlement or defense of **any claim or suit**,

> including, but not limited to, submitting to an examination under oath and compliance with sections 3151 to 3153. MCL 500.3173a(2)

The statute clearly makes a distinction between a "claim" **OR** a "suit[6]." The two words must have different meanings because they are used independently and separated by an "or."

Next, §3173(3) states:

> The Michigan automobile insurance placement facility may perform its functions and responsibilities under this section and the assigned claims plan directly or through an insurer assigned by the Michigan automobile insurance placement facility to **administer the claim on behalf** of the Michigan automobile insurance placement facility. **The assignment of a claim** by the Michigan automobile insurance placement facility to an insurer is not a determination of eligibility under this chapter or the assigned claims plan, and a claim assigned to an insurer by the Michigan automobile insurance placement facility may later be denied if the claim is not eligible under this chapter or the assigned claims plan. MCL 500.3173a(3)

Here again is the distinction between a claim and an action displayed. The MAIPF assigns a "claim." Once the claim has been assigned, the claim has been made. A lawsuit cannot be "assigned," or "administered." If the MAIPF is sued, it cannot simply step aside after it assigns the claim; it must participate in the litigation and answer the complaint[7].

Finally, this Court has reached the same conclusion. In a footnote to *Griffin v Trumbull Ins Co*, 509 Mich 484; 983 NW2d 760 (2022), this Court wrote (the Court of Appeals in this cased cited to the same footnote):

> *The point is that making a claim for insurance benefits is not the same as filing a lawsuit*. This commonsense, contextual understanding is also consistent with how an insurance claim is understood within the insurance industry. *Griffin*, at fn 5. Emphasis in original.

[6] Suit is obviously shorthand for lawsuit, which we have seen, is analogous to "action." *Epps,* supra.
[7] There is no shortage of examples of litigation proceeding directly against the MAIPF, for example see *Mich Head & Spine Institute, PC v Mich Assigned Claims Plan*, 331 Mich App 262; 951 NW2d 731 (2019).

Thus, we can see, contrary to Defendant's argument, that there is a clear dichotomy between a "claim" and an "action" in the text of the No-Fault Act, and this dichotomy is obvious from the plain language of the act, and in numerous cases from this Court interpreting it.

b. "Claim" vs "Action," In Practice

We can also see that that dichotomy is not only present, but highly important. Defendant attempts to conflate the entire concept of a claim with an action. Indeed, Defendant seeks to fully blur the lines between the concepts, essentially arguing that everything that happens in a lawsuit is also necessarily a claim as used in §3173a(4). There is no basis for this argument. Aside from the fact that these two words have been fully defined by This Court and are clearly differentiated in the No-Fault Act as explained above, simple logic demonstrates just how different they are.

When taken as a whole, §3173a outlines the process to determine the eligibility for benefits under the Assigned Claims Plan. It requires the MAPIF to "review a claim," gives criteria to "deny a claim," and mandates the cooperation of a person "making a claim" in the "determination of eligibility" to No-Fault Benefits. The "claim" here is the "a right to payment of PIP benefits" under this portion of the statute. In other words, the "claim" in MCL 500.3171 *et seq*, is the eligibility to receive PIP from the MAIPF provisions of the Act.

This analysis is bolstered by *Candler v Farm Bureau Mut Ins Co*, 321 Mich App 772; 910 NW2d 666 (2017). In *Candler*, the Court of Appeals held that incorrect submissions to the MAIPF triggered the fraud provision in §3173a[8]. However, in footnote 4, the Court of Appeals explained the interaction between a "claim" to the MAIPF and an "application" to the MAIPF:

> Accordingly, while there is a reason to use the terms "claim" and "application" in MCL 500.4503, there is no reason to use both terms in MCL 500.3173a because the request/application to the MAIPF is nevertheless a claim for owed benefits. The MACP Plan of Operations, § 5.1.A states that "[**a] claim for personal protection insurance benefits under the Plan must be made on an application prescribed**

[8] As Defendant correctly points out, at the time, the fraud provisions were found in §3173a(2) and now it is (4).

> **by the MAIPF."** MACP, Plan of Operations, **although the initial document to the MAIPF is called an application, it nevertheless is a claim for benefits**, and the Legislature's failure to use the term "application" in MCL 500.3173a is neither surprising nor determinative. *Candler* at 778 n 4. (website link to Plan of Operations removed as the link is now broken).

Thus, the *Candler* Court has equated the initial application to the MAIPF, which is a requirement taken directly MAIPF's (the former MACP) own Plan of Operations, to the "claim" for benefits specified in the MAPIF sections of the Act, including §3173(a)(4[9]). In other words, the application to the MAIPF, which determines eligibility, necessarily is the claim for benefits. When statements are presented to the MAIPF ("or to an insurer to which the claim is assigned under the assigned claims plan," as the statute now reads) in support of the "claim," the fraud provision in the statute can be triggered. However, it is ONLY these submissions in support of a "claim" that trigger, and as the Plan of Operations dictates, "[a] claim for personal protection insurance benefits under the Plan must be made on an application prescribed by the MAIPF."

Plaintiff anticipates that Defendant will argue in reply that, since §3173a(4) now includes the additional language, "or to an insurer to which the claim is assigned under the assigned claims plan," that the "claim" discussed in *Candler* and in the amended statute now indicates an ongoing process beyond the initial application. First, this is without basis, as the MAIPF, through its Plan of Operations, has explained what it means by "claim, and it clearly mandates ("must be made") that the claim be made on a prescribed application form. Second, this argument accomplishes nothing other than to demonstrate why *Candler* is no longer persuasive given the amendments to §3173a. The entire analysis in *Candler* is predicated on the idea that:

> Contrary to plaintiff's suggestion, the prepositional phrase "to the [MAIPF]" modifies the antecedent noun "claim," not "statement." Therefore, a person commits a fraudulent insurance act under this statute when (1) the person presents or causes to be presented an oral or written statement, (2) the statement is part of or

[9] Again, in *Candler*, subsection (4) was subsection (2).

> in support of a claim for no-fault benefits, and (3) the claim for benefits was submitted to the MAIPF. *Candler* at 779-80.

Since the operative word here is "claim," and a claim "must be made on an application prescribed by the MAIPF," it does not matter to whom the statement was made, as long as the "claim" was made to the MAIPF. Therefore, the only statements implicated by the fraud provision are statements made as part of the initial claim within the application for benefits.

The statute itself supports this conclusion. §3173a(3) provides:

> The Michigan automobile insurance placement facility may perform its functions and responsibilities under this section and the assigned claims plan directly or through an insurer assigned by the Michigan automobile insurance placement facility to administer the claim on behalf of the Michigan automobile insurance placement facility. **The assignment of a claim by the Michigan automobile insurance placement facility to an insurer is not a determination of eligibility under this chapter or the assigned claims plan, and a claim assigned to an insurer by the Michigan automobile insurance placement facility may later be denied if the claim is not eligible under this chapter or the assigned claims plan**.

Thus, the application process does not end when an insurer is assigned if there is an eligibility question later. This means that "an insurer to which the claim is assigned" may receive "statements" as part of an eligibility investigation (i.e., the "claim") and, if justified, "a claim assigned to an insurer by the Michigan automobile insurance placement facility may later be denied if the claim is not eligible under this chapter or the assigned claims plan." Essentially, a claim is made, eligibility is initially determined, and if new information about that claim is received, the eligibility determination can be revisited.

In this case, the discovery responses were not submitted to the MAIPF and were not submitted to AAA in furtherance of the "claim." The claim, as in the eligibility of Mr. Williamson to receive benefits, had been made and completed. While, in theory, AAA could have obtained "statements" that changed the eligibility analysis, it did not. Nothing about these attendant care logs, or discovery answers in general, affect Mr. Williamson's entitlement to MAIPF-provided

benefits under §3172. Thus, nothing about the discovery responses impacts the "claim." AAA obtained only discovery responses in litigation, submitted from one attorney to another pursuant to the Court Rules, that had no bearing upon the "claim" or the analysis of whether that "claim" should be denied as ineligible.

Simply put, Judge Garrett got this one right. The Court of Appeals in this case held:

> Here, the Estate argues that its submission of inaccurate service forms during discovery was not "in support of a claim to the [MAIPF], or to an insurer to which the claim is assigned under the assigned claims plan." MCL 500.3173a(4). We agree. False 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. The no-fault act recognizes a distinction between the prelitigation insurance claims process and the initiation of litigation through an action for recovery. Had the Legislature intended for MCL 500.3173a(4) to apply to statements made during litigation, the Legislature would have drafted the statute differently to apply, for example, to statements offered "in support of an action for recovery." Because the Legislature did not do so, we give "claim" its intended meaning. *Williamson v AAA of Mich*, ___NW2d___; 2022 Mich. App. LEXIS 5684, at *12-13 (Ct App, Sep. 22, 2022).

This conclusion is sound.

c. A Party's Answers in Discovery

Documents or answers provided in discovery are not part of the "claim" to the MAIPF or the assigned insurer. The claim has already been made. "The right to payment" has already been initially determined and the MAPIF Plan of Operations procedure is complete. Nowhere does AAA or the MAIPF argue that Mr. Williamson was not eligible for benefits under MCL 500.3172(1). The distinction between "claim" and "action," which clearly exists, and the MAIPF mandatory requirements for "claim" submission, necessarily creates a separation between "statements" in furtherance of the prescribed claim process and discovery responses in lawsuits.

Indeed, to find the opposite would mean that the entire "claim" process under the MAIPF is never ending, since theoretically a lawsuit can be filed decades after an injury occurred if

benefits become unpaid. It defies common sense that a "claim" to the MAIPF is still being made when a lawsuit is filed, and discovery is conducted, 20 or 30 years after the motor vehicle accident. The only logical conclusion, which is the holding of the Curt of Appeals in this case, is that the "statute to appl[ies] to the prelitigation claims process." *Williamson*, at 13. Anything that occurs during a lawsuit becomes subject to the discovery rules in the Court Rules.

Defendant also argues that the Legislature did not include any "narrowing language" in §3173a(4), but it did: it specifies a "claim." Other paragraphs of §3173a reference a "suit" when the legislature intended a lawsuit or action, but subsection (4) says only "claim." Defendant's entire argument fails because it does not distinguish a MAIPF "claim" and an "action," while both the Court of Appeals panel and the rest of the No Fault Act do.

Judge Garrett wrote:

> This distinction between a "claim" for benefits submitted to the MAIPF or the MACP-assigned insurer and a lawsuit filed for a wrongful denial of that claim is further highlighted by the plain language of the no-fault act. *Williamson v AAA of Mich*, ___NW2d___; 2022 Mich. App. LEXIS 5684, at *11 (Ct App, Sep. 22, 2022)

This hits the nail on the head. The "claim" is the submission of required paperwork (via a "prescribed application") to obtain, and determine eligibility to receive, benefits; the "action" is the legal proceeding that follows a denial of the claim. They are distinct. The No-Fault Act treats them distinctly, as does the Case Law.

Finally, and interestingly, Defendant argues[10] that the Court of Appeals inserted words into the statute, but the opposite is true. The Court of Appeals had no need to insert "[except if the statement is made in an action][11]" because it simply omitted that requirement and did not specify anything about actions at all. It spoke of claims, not actions. Put another way: in this context,

[10] See page 15 of AAA's brief.
[11] Id.

omitting a requirement is the same as negating that requirement. On the contrary, Defendant proposes to insert the word “action” into MCL 500.3173(a)(4), which for the law cited in AAA’s brief, is not appropriate.

d. Haydaw

The reasoning in the Court of Appeals opinion falls squarely within the logic of *Haydaw v Farm Bureau Ins Co*, 332 Mich App 719; 957 NW2d 858 (2020). Defendant correctly points out that *Haydaw* considers an anti-fraud provision within an insurance policy, but the same reasoning applies to a statutory analysis. Judge Shapiro wrote:

> False statements made during discovery do not provide grounds to void the policy because, by that time, the claim has been denied and the parties are adversaries in litigation. Once suit is brought, what is truth and what is false are matters for a jury or a judge acting as fact-finder. And if it can be shown that a party intentionally testified falsely, it is up to the court to determine what, if any, sanction is proper. Indeed, defendant is essentially seeking dismissal of plaintiff's claim on the basis of alleged discovery misconduct. Given that questions of credibility and intent are generally left to the trier of fact, "[i]t is . . . doubtful whether dismissal for intentionally false deposition testimony is ever appropriate." *Haydaw v. Farm Bureau Ins. Co*., 332 Mich. App. 719, 726-727 (2020). Internal Citations Omitted.

In the instant case, Judge Garrett came to nearly the same conclusion:

> Here, the attendant care and replacement service forms were not submitted in support of Williamson's claim for no-fault benefits that he submitted to the MAIPF or to AAA. Rather, the forms were disclosed during discovery—after the claim was submitted to the MAIPF, assigned to AAA, denied by AAA, and litigation had ensued. MCL 500.3173a(4) asks whether the allegedly false statement was "part of or in support of a claim to the [MAIPF], or to an insurer to which the claim is assigned under the assigned claims plan." But 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. *Williamson v AAA of Mich*, ___NW2d___; 2022 Mich. App. LEXIS 5684, at *16-17 (Ct App, Sep. 22, 2022).

The reasoning is sound. Discovery is the information gathering process in a lawsuit. “Because the purpose of discovery is to simplify and clarify issues … in an effort to facilitate trial preparation and to further the ends of justice." *Spine Specialists of Mich., P.C. v. State Farm Mut. Auto. Ins.*

Co., 317 Mich. App. 497, 501 (2016). Discovery is not intended to be a claim process to the MAIPF. Defendant's argument that discovery is necessarily ALSO a mechanism for submitting claims is without foundation or authority, especially considering *Candler* and how a MAIPF claim is linked to the application for benefits.

Discovery responses are not made "as part of or in support of a claim." They are made pursuant to the Court Rules. There is nothing in the No-Fault Act that penalizes violation of the Court Rules, just as there is nothing in the Court Rules that overwrites the No-Fault Act. Any argument that "in support of" means anything beyond what is specifically outlined in the Act is baseless. For example, §3173a(2)(a) mandates that:

> The person submitted a claim for personal protection insurance benefits under the assigned claims plan by submitting to the Michigan automobile insurance placement facility a complete application on a form provided by the Michigan automobile insurance placement facility in accordance with the assigned claims plan.

This is documentation required "as part of or in support of a claim." Subsection (4) would clearly apply to the application submitted, because that is an essential component of a "claim," as well as any "statements" made as part of that application, per *Candler*. However, nowhere does the Act require anything regarding discovery.

Defendant's arguments that "statements made in litigation are "in support of" the claim for benefits[12]" is belied by the reality of litigation. Not all materials obtained in discovery are submitted to the jury. Nor is there any requirement that a plaintiff pursue every single PIP benefit to jury verdict. It is routine for plaintiffs to amend complaints on the eve of trial or to even drop entire categories of damages from an "action."

[12] See Defendant's Brief, page 25, fn 8.

Finally, Defendant attempts to differentiate the reasoning of *Haydaw* and the instant case by claiming that *Haydaw* is premised on a policy argument. This is a curious statement. This is incorrect. *Haydaw* is primary based on an analysis of how other jurisdictions apply fraud provisions, and the ultimate conclusion – bringing Michigan into the majority rule bracket that "statements made during litigation do not implicate a fraud or false-swearing clause[13]" – is hardly a policy argument. Indeed, the only policy statement in *Haydaw* is equally applicable to the instant case because it discusses the policy behind discovery, and not contracts:

> We are also mindful that allowing insurers to void a policy for false statements made during litigation would create a perverse incentive. For example, an insurer with full knowledge of the insured's medical history could seek to bait or lead the insured into making an inaccurate statement at deposition and then seek summary disposition on those grounds. Such tactics are directly at odds with the purpose of discovery. *Haydaw* at 728.

The same idea applies here, and the same kind of trap discussed by Judge Shapiro will be discussed next.

3. Public Policy

Defendant makes the argument that, if the provision in §3173a(4) were to cover every single piece of information produced during discovery in a lawsuit, it would be in furtherance of the No-Fault Act. Nothing could be further from the truth. The public policy of the No-Fault Act is in favor of providing coverage. "Given the remedial nature of the no-fault act, courts must liberally construe its provisions in favor of the persons who are its intended beneficiaries." *Frierson v West American Ins, Co*, 261 Mich App 732, 734; 683 NW2d 695 (2004).

We should consider the business end of Defendant's proposed interpretation of the law. If all discovery responses are to be considered, in essence, claim submissions, this creates a trap for any person who dares to file a lawsuit to collect benefits. Say, for example, a plaintiff in a lawsuit

[13] *Haydaw*, at 726.

appears for a deposition duces tecum and brings his entire file of paperwork pursuant to the deposition notice. Being (presumably) injured and suffering from those health maladies, the plaintiff is perhaps not the best organizer of paper and simply brings everything he has in a banker's box. Suppose now the insurance attorney asks to see the paperwork and admits it as an exhibit to the deposition. And the paperwork contains some calendars, either for attendant care or replacement services, that are dated in advance.

The deposition continues and the testimony reveals that the plaintiff, not having an abundance of time or patience due to his injuries, has partially completed some forms in advance. He has not submitted them, of course, because the services described have not been performed. But to save time, he has placed his name on them and signed them and maybe even checked off some services that he has consistently required, hoping to save himself some time down the road when it comes time to submit those forms. Under AAA's proposed rules, the plaintiff in this hypothetical has committed fraud, simply because some documents, which were **NEVER SUBMITTED** to the insurance company for payment[14], were provided to the insurance attorney during the course of discovery.

This cannot be justice, this cannot be remedial, and there is nothing about this proposal that is "in favor" of intended beneficiaries. This is nothing other than a trap to spring so that insurance industry can deny claims. Indeed, if AAA's analysis prevails, there is nothing stopping insurers from demanding every single piece of paper in a plaintiff's possession, without any regard to whether that document was intended to be sent (or was sent at all) as part of the claim submissions, in the hope of finding a single bit of erroneous information.

[14] In the instant case, Plaintiff did not ever seek payment for the incorrect forms, and Plaintiff's case evaluation summary did not include them. See Defendant's Exhibit J.

Indeed, even a very old claim could trigger the provision. If the plaintiff had a very old attendant care calendar from 1995 (for example) in his box of paper, that turned out to be inaccurate, it would be considered a fraud if the document were to find its way into the insurer's possession via discovery, despite the fact that the calendar was never submitted and it is old enough to drink or rent a car. This would be nonsensical.

Further, tying all discovery submissions to a MAIPF "claim" imperils the law firms representing the plaintiffs themselves. An attorney must answer a discovery request pursuant to the Court Rules and must answer it timely and accurately or else be exposed to sanctions. Adding a requirement that all discovery submissions must also comport with §3173a(4) is an easy way for a clerical error to invalidate an injured person's entire PIP claim.

Take the example above, except the plaintiff has turned his box of paper over to his attorney. In answering interrogatories, the plaintiff and the attorney types in the answers and submits the relevant documents. However, an assistant, or perhaps a law clerk, inadvertently sends ALL the attendant care calendars as an attachment, and not just the calendars for incurred services. That simple mistake, which is not even the fault of the plaintiff, can now effectively render them uninsured. Surely every litigator has accidentally attached the wrong file to an email, or not deleted every page from a PDF bundle that they intended to delete. These clerical errors are common, especially now that more offices are paperless, and software becomes more confusing by the year.

This is exactly why the discovery process is treated differently, and should be treated differently, from claim submission. Discovery has its own rules and its own methods of determining what is material or intentional and what is not. It has its own remedies, such as jury instructions or orders to strike or compel. It has the rules of evidence to ensure only relevant,

authenticated, and foundational evidence is considered by the factfinder. It has judicial discretion to ensure that, during a lawsuit, due process and fairness prevail.

To give another example, a plaintiff lying in discovery has technically committed perjury. However, few, if any, courts will ever contact the prosecutor and demand that criminal charges be brought. Instead, other sanctions will be imposed, such as penalty fees or the striking of evidence. If the conduct is severe enough, adverse instructions can be given or even a default entered (or a case dismissed). However, Plaintiff's Counsel cannot find a single example of criminal charges being brought for a discovery violation, even when that violation is technically also a violation of the perjury statute. It is simply not the way discovery is handled in the American court system. AAA is essentially arguing for a mandatory perjury charge and jail time for every single time a PIP litigant makes an erroneous statement in discovery.

The complete invalidation of a PIP claim, resulting the full loss of all benefits forever, for any discovery infraction big or small, intentional or unintentional, and without concern with who actually made the mistake, is simply not justice.

4. Intent

The Court of Appeals did not consider the intent of the Plaintiff:

> Given our holding, we need not address the Estate's alternative arguments that AAA failed to satisfy the intent and materiality prongs for a fraudulent insurance act under MCL 500.3173a(4). *Williamson v AAA of Mich*, ___NW2d___; 2022 Mich. App. LEXIS 5684, at *18 (Ct App, Sep. 22, 2022).

However, the issue was clearly raised and preserved, and since Defendant is seeking to overturn the Court of Appeals decision, it should be considered now. In order to establish fraud, defendant must show:

> (1) that [plaintiff] made a material representation; (2) that it was false; (3) that [plaintiff] made the representation knowing that it was false or made it recklessly without knowledge of its truth; (4) that [plaintiff] intended that [defendant] would

> act on the representation; (5) that [defendant] relied on the representation; and (6) that [defendant] suffered injury as a result of having relied on the representation. *Lucas v Awaad*, 299 Mich App 345, 363; 830 NW2d 141 (2013).

Here, Ms. Williamson did not sign the erroneous forms herself; it was Mr. Brown who signed them. The Plaintiff in the instant case did not make a misrepresentation, material or otherwise. Further, Plaintiff never submitted these forms to AAA, so AAA never relied on them, and AAA did not suffer injury as a result of the forms because they never paid out any benefits because of the forms. AAA simply cannot sustain a claim of fraud here.

A similar situation was addressed in *Bakeman v Citizens Ins Co*, ___NW2d___; 2022 Mich. App. LEXIS 6798 (Ct App, Nov. 10, 2022). In that case, the injured gentleman, Mr. Bakeman, signed some attendant care forms which he later admitted contained inaccurate information. Mr. Bakeman admitted[15] he signed the forms, but denied knowing their content, and denied knowing the content was incorrect. The Court of Appeals explained:

> Regarding the former argument, "the law is clear that one who signs an agreement, in the absence of coercion, mistake, or fraud, is presumed to know the nature of the document and to understand its contents, even if he or she has not read the agreement." Plaintiff testified that the forms were filled out by Watson at the direction of Awada. He did not testify that he was induced to sign the forms on the basis of coercion, mistake, or fraud. Therefore, if plaintiff signed the forms, he cannot rely upon a lack of knowledge of the forms' contents. **In other words, if plaintiff signed the attendant care forms, then he committed a fraudulent insurance act.** *Bakeman v Citizens Ins Co*, ___NW2d___; 2022 Mich. App. LEXIS 6798, at *8-9 (Ct App, Nov. 10, 2022)

Here, there is no evidence that Plaintiff (either Mr. Williamson the deceased, or the Personal Representative Ms. Williamson) signed the forms, as Lirrice Brown signed the forms. Thus, there is no evidence that Plaintiff committed a fraudulent insurance act.

[15] There were actually conflicting statements as to whether Bakeman signed the forms, but in the end, the Court of Appeals accepted as fact that he did.

CONCLUSION

For these reasons, Plaintiff respectfully requests that the Court of Appeals opinion be AFFIRMED.

/s/ Kyle Kelly
Kyle Kelly (P69863)
Lipton Law
18930 W. 10 Mile Road
Southfield, MI 48075
(248) 557-1688/(248) 557-6344 (Fax)
kyle@liptonlaw.com
Attorney for Plaintiffs/Appellees The Estate of Charles Williamson, Dec'd

Dated: October 18, 2023

CERTIFICATE OF COMPLIANCE

I certify that the Plaintiff-Appellee'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 6,236.

*/s/ Kyle Kelly*_____

Kyle Kelly (P69863)
Lipton Law
18930 W. 10 Mile Road
Southfield, MI 48075
(248) 557-1688/(248) 557-6344 (Fax)
kyle@liptonlaw.com
Attorney for Plaintiffs/Appellees The Estate of Charles Williamson, Dec'd

Dated: October 18, 2023

CERTIFICATE OF SERVICE

I hereby certify that on October 18, 2023, I electronically served the foregoing document via the Court's electronic filing systems which will provide notice to all attorneys of record.

*/s/ Kyle Kelly*_____

Kyle Kelly (P69863)
Lipton Law
18930 W. 10 Mile Road
Southfield, MI 48075
(248) 557-1688/(248) 557-6344 (Fax)
kyle@liptonlaw.com
Attorney for Plaintiffs/Appellees The Estate of Charles Williamson, Dec'd

Dated: October 18, 2023