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STATE OF MICHIGAN

COURT OF APPEALS

SHAINA BREECE,

Plaintiff/Counterdefendant-Appellee,

v

MONIKA JOHNSON,

Defendant-Appellee,

and

CITIZENS INSURANCE COMPANY OF THE MIDWEST,

Defendant/Counterplaintiff/Third-Party Plaintiff-Appellant/Cross-Appellee,

and

TAMMY BREECE,

Third-Party Defendant-Appellee,

and

VHS OF MICHIGAN, INC, doing business as DETROIT MEDICAL CENTER,

Third-Party Defendant-Appellee/Cross-appellant.

UNPUBLISHED
June 24, 2021

No. 353759
Wayne Circuit Court
LC No. 18-011516-NI

Before: GLEICHER, P.J., and CAVANAGH and LETICA, JJ.

PER CURIAM.

After Shaina Breece was injured in a motor vehicle accident, Citizens Insurance Company determined that Shaina's mother, Tammy Breece, had misrepresented the vehicle's ownership when applying for coverage. Citizens refused payment and sought rescission of the insurance policy. The circuit court denied Citizens' motion for summary disposition on this issue and also declined to summarily decide the Detroit Medical Center's suit against Citizens. Questions of fact precluded summary disposition as to both claims. We affirm.

I. BACKGROUND

Tammy Breece secured no-fault insurance policies for her vehicles from Citizens Insurance Company through Custom Insurance Agency. On the application, Tammy responded "no" to the query, "are any vehicles for which insurance is requested not solely owned by and registered to the applicant." Tammy further indicated that the insured vehicles were kept at her address and that she was the only driver. On September 11, 2017, Tammy added a Pontiac G6 to her policy. This vehicle was actually co-owned by Tammy and her daughter, Shaina Breece, and was registered with Shaina's address, not Tammy's. Tammy did not advise Citizens of these facts.[1]

On February 22, 2018, Shaina was injured in a motor vehicle accident when another driver illegally turned in front of her. Sinai Grace Hospital, a Detroit Medical Center (DMC) facility, provided Shaina with $42,487.35 in medical services. Shaina and DMC sought first-party personal injury protection (PIP) benefits from Citizens. Rather than paying the claims, Citizens opened an investigation and discovered Tammy's misrepresentations.

Shaina filed suit against Citizens seeking first-party no-fault benefits. Citizens brought Tammy and DMC into the action by filing third-party complaints against them, and filed a countercomplaint against Shaina. Citizens sought rescission of the insurance policy and a declaration that Tammy's misrepresentations eliminated its contractual obligation to pay benefits. And DMC filed an intervening complaint against Citizens seeking recompense for the services it had provided Shaina.

Following discovery, Citizens and DMC filed motions for summary disposition. DMC argued that it was entitled to payment of $38,713.30 based on an audit by a third-party, Corvel Corporation, finding the requested amount reasonable. Citizens, countered that indisputable evidence established that Tammy secured the insurance policy for the G6 through fraud and misrepresentation, requiring rescission. The circuit court denied both motions. The court determined that there remained questions of fact regarding whether the services provided by DMC were reasonable and necessary. As to Shaina's PIP claims, the court concluded that questions of fact prevented a summary determination that Tammy had committed fraud. Even if Tammy had committed fraud, the court ruled, Shaina was an innocent third-party and equity weighed against rescission.

[1] Tammy listed two other vehicles in her policy that she co-owned with her mother and her son that also were not kept at her home.

Citizens filed an application for leave to appeal in this Court. In lieu of granting the application, this Court vacated the order denying Citizens' motion for summary disposition and remanded for further proceedings as follows:

> On this record, there is no genuine issue of material fact that the subject no-fault insurance policy was fraudulently induced by material misrepresentations in the insurance application. Thus, the defendant insurer, Citizens Insurance Company of the Midwest, is entitled to rescind the subject policy so long as the equities balance in favor of that result. See *Bazzi v Sentinel Ins Co*, 502 Mich 390, 410; 919 NW2d 20 (2018). In balancing the equities on remand, the trial court shall reconsider its previous analysis by utilizing the test adopted in *Pioneer State Mut Ins Co v Wright*, [331 Mich App 396, 410-411; 952 NW2d 586 (2020)]. [*Breece v Johnson*, unpublished order of the Court of Appeals, entered February 13, 2020 (Docket No. 351031).]

On remand, the circuit court balanced the equities in accordance with the five factors set out in *Pioneer*, 331 Mich App at 411:

> (1) the extent to which the insurer could have uncovered the subject matter of the fraud before the innocent third party was injured; (2) the relationship between the fraudulent insured and the innocent third party to determine if the third party had some knowledge of the fraud; (3) the nature of the innocent third party's conduct, whether reckless or negligent, in the injury-causing event; (4) the availability of an alternate avenue for recovery if the insurance policy is not enforced; and (5) a determination of whether policy enforcement only serves to relieve the fraudulent insured of what would otherwise be the fraudulent insured's personal liability to the innocent third party. [Citations omitted.]

The parties agreed that the fifth factor did not apply to this case and the court found that the remaining factors weighed in Shaina's favor. The circuit court denied rescission.

Citizens filed another application for leave to appeal, which this Court granted. *Breece v Johnson*, unpublished order of the Court of Appeals, entered August 31, 2020 (Docket No. 353759). And DMC filed a cross-appeal challenging the denial of its summary disposition motion.[2]

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[2] Citizens argues that this Court lacks jurisdiction of DMC's cross-appeal because (1) the cross-appeal was untimely filed 11 months after entry of the order denying DMC's summary disposition motion, (2) the cross-appeal is beyond the limited scope of appeal granted by this Court, and (3) DMC did not attempt to seek review of the circuit court's denial of its summary disposition motion in Citizens' first appeal. We have jurisdiction of DMC's cross-appeal. Under MCR 7.207(A)(1), a cross-appeal must be filed within 21 days of the clerk certifying the order granting leave to appeal, and DMC's cross-appeal was filed within that time. The Court Rules do not require that DMC separately seek of the denial of its motion, and permit cross-appellants to challenge rulings

II. CITIZENS' APPEAL

Citizens argues that the circuit court erred in denying its motion for summary disposition because the *Pioneer* factors weighed in favor of rescinding the insurance policy. We review de novo the lower court's summary disposition ruling. *Richardson v Allstate Ins Co*, 328 Mich App 468, 471; 938 NW2d 749 (2019).

> A motion under MCR 2.116(C)(10) tests the factual support of a plaintiff's claim. Summary disposition is appropriate under MCR 2.116(C)(10) if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law. In reviewing a motion under MCR 2.116(C)(10), this Court considers the pleadings, admissions, affidavits, and other relevant documentary evidence of record in the light most favorable to the nonmoving party to determine whether any genuine issue of material fact exists to warrant a trial. A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds might differ. [*Zaher v Miotke*, 300 Mich App 132, 139-140; 832 NW2d 266 (2013) (cleaned up).]

Rescission is an equitable remedy.

> The remedy of rescission is granted only in the sound discretion of the court. An abuse of discretion occurs when the decision falls outside the range of reasonable and principled outcomes. An abuse of discretion necessarily occurs when the trial court makes an error of law. The trial court's factual findings are reviewed for clear error, and a finding is clearly erroneous if the reviewing court is left with a definite and firm conviction that a mistake has been made. [*Pioneer*, 331 Mich App at 405 (cleaned up).]

"Generally, fraud in the inducement to enter a contract renders the contract *voidable* at the option of the defrauded party. For that reason, an insurance policy procured by fraud may be declared void ab initio at the option of the insurer." *Bazzi*, 502 Mich at 408 (cleaned up). But fraud does not give an insurer an absolute right to rescission; rather, rescission is an equitable remedy within the discretion of the court. *Id*. at 409. " '[W]hen two equally innocent parties are affected,' the trial court 'must balance the equities to determine whether' the insurer is entitled to rescind an insurance policy." *Pioneer*, 331 Mich App at 407, quoting *Bazzi*, 502 Mich at 410.

In *Pioneer*, this Court noted that *Bazzi* "did not provide trial courts with a clear-cut framework for balancing the equities because 'an absolute approach would unduly hamper and constrain the proper functioning of' an equitable remedy." *Pioneer*, 331 Mich App at 410, quoting *Bazzi*, 502 Mich at 411. The *Pioneer* Court adopted the "nonexclusive list of factors" offered as

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other than those underlying the primary appeal. See *Costa v Community Emergency Med Servs, Inc*, 263 Mich App 572, 584; 689 NW2d 712 (2004) ("The language of MCR 7.207 does not restrict a cross-appellant from challenging whatever legal rulings or other perceived improprieties occurred during the trial court proceedings.").

guidance by Justice MARKMAN in his concurrence in *Farm Bureau Gen Ins Co of Mich v ACE American Ins Co*, 503 Mich 903, 906-907; 919 NW2d 394 (2018). *Pioneer*, 331 Mich App at 411. As a reminder, the five factors to be considered are:

> (1) the extent to which the insurer could have uncovered the subject matter of the fraud before the innocent third party was injured; (2) the relationship between the fraudulent insured and the innocent third party to determine if the third party had some knowledge of the fraud; (3) the nature of the innocent third party's conduct, whether reckless or negligent, in the injury-causing event; (4) the availability of an alternate avenue for recovery if the insurance policy is not enforced; and (5) a determination of whether policy enforcement only serves to relieve the fraudulent insured of what would otherwise be the fraudulent insured's personal liability to the innocent third party. [*Pioneer*, 331 Mich App at 411, citing *Farm Bureau*, 503 Mich at 906-907 (MARKMAN, J., concurring).]

The first factor—"the extent to which the insurer could have uncovered the subject matter of the fraud before the innocent third party was injured"—does not weigh in either party's favor. DMC, Shaina, and Tammy contend that Citizens could have easily discovered Tammy's misrepresentations had it reviewed the publicly available vehicle registration information, and the circuit court agreed. As Justice MARKMAN stated in *Farm Bureau*, "If the insurer could have with reasonable effort obtained information indicating that the insured had committed fraud in procuring the insurance policy, equity may weigh against rescission because the insurer may be deemed to have acted without adequate professional diligence in issuing and maintaining the policy." *Farm Bureau*, 503 Mich at 906 (MARKMAN, J., concurring). Citizens argues that it had no duty to investigate the veracity of Tammy's statements in her insurance application.

The "reasonable effort" approach to the first *Pioneer* factor seems to conflict with the Supreme Court's holding in another case written by Justice MARKMAN, *Titan Ins Co v Hyten*, 491 Mich 547, 570; 817 NW2d 562 (2012), that "an insurer an insurer has no duty to investigate or verify the representations of a potential insured." In *Pioneer*, this Court reconciled the apparent contradiction as follows: "The first factor does not impose a duty to investigate upon insurers, . . . but merely addresses the process of procurement of insurance and any information disclosed." *Pioneer*, 331 Mich App at 412 n 6. In that case we determined that the first factor did "not truly weigh in either party's favor" because "[t]here is no evidence to suggest that there could or could not have been a more diligent effort on Pioneer's part to discover contradictions or omissions in Wright's application any earlier." *Pioneer*, 331 Mich App at 412. Similarly, there is no indication that Citizens could have done more to uncover the misrepresentations other than searching outside sources. No evidence supports that Citizens was on notice of potential fraud before the accident occurred. Accordingly, this factor does not weigh in favor of either party.

The circuit court correctly weighed in Shaina's favor the second *Pioneer* factor—"the relationship between the fraudulent insured and the innocent third party to determine if the third party had some knowledge of the fraud." Citizens contends that Shaina actually or likely knew of the fraud because she had a close relationship with Tammy and she was closely associated with the fraud as the co-owner, registrant, and driver of the subject vehicle. Citizens urges that Shaina should not be permitted to benefit from a fraud she was likely a party to. No direct evidence supports that Shaina was involved in the fraudulent conduct or had any knowledge of Tammy's

statements to Custom or Citizens. Mother and daughter did not live in the same household and the Custom agent testified that he never spoke to Shaina. Unsubstantiated speculation does not satisfy this factor.

The circuit court also did not clearly err by weighing the third factor—"the nature of the innocent third party's conduct, whether reckless or negligent, in the injury-causing event"—in Shaina's favor and against rescission. This factor asks whether the innocent third party played some role in the event as a whole or whether the innocent third party could have been more prudent in preventing injury: "Where the innocent third party acted recklessly or even negligently in the course of the injury-causing event, equity may weigh in favor of rescission because the innocent third party could have avoided the injury by acting more prudently." *Farm Bureau*, 503 Mich at 906-907 (MARKMAN, J., concurring).

The evidence supports that Shaina did not cause the motor vehicle accident. However, Shaina violated the law by failing to wear a seatbelt. And MCL 257.710e(8) provides that "[f]ailure to wear a safety belt in violation of this section may be considered evidence of negligence." Had Shaina been restrained, her injuries might have been less severe and her medical bills potentially lower. Although Shaina could have acted more prudently, Pioneer presented no competent evidence supporting that her negligence in failing to wear her seatbelt was the cause of her injuries, or that but for her seatbelt abstention, she would have avoided injury. Although we might have weighed this factor differently, the circuit court's assessment was not outside the range of reasonable and principled outcomes.

The court properly weighed in Shaina's favor the fourth factor—"the availability of an alternate avenue for recovery if the insurance policy is not enforced." The circuit court reasoned that Shaina did not have an alternate source of PIP benefits "and though she may be able to obtain medical coverage, that is insufficient because [she] also seeks wage loss benefits." Citizens contends that the circuit court erred by failing to consider that Shaina had the alternative option of coverage under the Michigan Assigned Claims Plan (MACP) or Medicaid. In providing guidance for this factor, Justice MARKMAN stated, "[s]uch an avenue for recovery may include, for example, the assigned claims plan or health insurance. Where the innocent third party possesses an alternative means of recovery, equity may weigh in favor of rescission because the insurer need not suffer loss because of the fraud." *Farm Bureau*, 503 Mich at 906-907 (MARKMAN, J., concurring).

Recovery through the MACP likely was not an option because of the one-year back rule, which is "designed to limit the amount of benefits recoverable under the no-fault act to those losses occurring no more than one year before an action is brought." *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 203; 815 NW2d 412 (2012). In *Pioneer*, this Court acknowledged that the one-year back rule would prevent the innocent third party from recovering from the MACP if the insurance company rescinded the policy, and noted, "[r]egardless, the fourth factor considers the present situation, not whether an injured party could have done something different to have more options in the future." *Pioneer*, 331 Mich App at 413-414. And although Shaina had health insurance through Tammy until January 2019 and then qualified for Medicaid, health insurance does not provide a wage loss benefit. Accordingly, the circuit court did not err in weighing this factor.

The parties do not challenge the circuit court's conclusion that the fifth *Pioneer* factor does not apply in this case. Overall, however, one factor weighed in favor of neither party, and three weighed in favor of insurance coverage. As the majority of factors were either neutral or weighed in favor of coverage for Shaina, the circuit court did not abuse its discretion in denying Citizens' summary attempts at rescission and we have no ground to interfere with the court's denial of the insurer's motion for summary disposition.

III. DMC'S CROSS-APPEAL

DMC also challenges the circuit court's denial of its motion for summary disposition. DMC contends that its medical bills were already audited and reduced by an independent auditor hired by Citizens, establishing that DMC requested reasonable fees for services that it describes as necessary.

The no-fault act states that "an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle." MCL 500.3105(1). This includes "allowable expenses"—"reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." MCL 500.3107(1)(a). A PIP claimant must prove the following *four* requirements before recovering benefits for allowable expenses under MCL 500.3107(1)(a): "(1) the expense must be for an injured person's care, recovery, or rehabilitation, (2) the expense must be reasonably necessary, (3) the expense must be incurred, and (4) the charge must be reasonable." *Douglas v Allstate Ins Co*, 492 Mich 241, 259; 821 NW2d 472 (2012). Reasonableness of cost and necessity of the service are *both* required as to each expense. *Nasser v Auto Club Ins Ass'n*, 435 Mich 33, 50; 457 NW2d 637 (1990); *Advocacy Org for Patient & Providers v Auto Club Ins Ass'n*, 257 Mich App 365, 374; 670 NW2d 569 (2003) (*AOPP*). This is generally a question of fact for the jury, unless "it could be said with certainty that an expense was both reasonable and necessary" as a matter of law. *Nasser*, 435 Mich at 55.

At this point in the proceedings, no one has disputed that the emergency medical services Shaina received at Sinai Grace after the accident were "for an injured person's care, recovery, or rehabilitation." We will assume for the sake of argument that this element was established. There also is no real dispute that the expenses were actually incurred. DMC presented the bill for services rendered and Citizens has not challenged the services actually were rendered to Shaina.

But contrary to DMC's assertions, the reasonableness of the charges remains at issue. As noted, Citizens hired Corvel to conduct an independent audit of the bill presented by DMC. Corvel compared the bill to "prevailing billing practices for healthcare providers within" the geographic area and slightly reduced the amount requested. The circuit court determined that summary disposition was not warranted because the repricing of charged expenses alone does not establish reasonableness of rates and reasonable minds may differ as to whether the charges were reasonable and necessary.

The circuit court's ruling is supported by this Court's opinion in *Spectrum Health Hosp v Farm Bureau Mut Ins Co of Mich*, ___ Mich App ___, ___; ___ NW2d ___ (2020) (Docket No. 348440). In *Spectrum*, ___ Mich App at ___, slip op at 12, this Court explained that "[t]he amount

that a healthcare provider can 'charge' for products and services is . . . described in MCL 500.3157[(1)]" as follows:

> (1) [A] physician, hospital, clinic, or other person that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, *may charge a reasonable amount* for the treatment or training. The charge must not exceed the amount the person *customarily charges* for like treatment or training in cases that do not involve insurance. [Emphasis added.]

Under this statute, "a provider's 'customary' charge functions as 'the cap on what health-care providers can charge,' but it is 'not, automatically, a 'reasonable' charge requiring full reimbursement . . . .' " *Spectrum*, ___ Mich App at ___; slip op at 13, quoting *AOPP*, 257 Mich App at 377. The no-fault act leaves "open the questions of (1) what constitutes a reasonable charge, (2) who decides what is a reasonable charge, and (3) what criteria may be used to determine what is reasonable." *Spectrum*, ___ Mich App at ___; slip op at 14 (cleaned up). This Court further explained:

> For instance, in terms of who decides what is a reasonable charge, this Court has explained that healthcare providers necessarily make the initial determination of reasonableness by charging the insured for the services. Once they charge the insured, the insurer then makes its own determination regarding what is reasonable and pays that amount to plaintiffs. If the no-fault insurer does not pay all of the charges, a healthcare provider may file suit to challenge the failure to fully pay the bills. It is the healthcare provider's burden to establish the reasonableness of the charges by a preponderance of the evidence. And a hospital's itemized bills and records do not, standing alone, satisfy the reasonableness requirement. Whether the amount charged is reasonable is ultimately a question of fact for a jury. [*Id*. (cleaned up).]

Therefore, "[a]lthough it is clear who determines reasonableness, the answers to the questions (1) what constitutes a reasonable charge and (2) what criteria may be used to make this determination are somewhat less certain." *Id*.

The *Spectrum* Court further noted that this Court has "approved consideration of some specific factors when determining reasonableness," as illustrated for example, by *AOPP*, in which "the panel concluded that the no-fault act did not prohibit consideration of charges by other healthcare providers for the same services for purposes of assessing reasonableness." *Id*. However, when the reasonableness of a charge is at issue, "the charges alone—even if customary and even if comparable to the charges of other healthcare providers—cannot be absolutely dispositive of their reasonableness." *Id*. at 25.

> To limit assessing the reasonableness of provider charges solely to a comparison of such charges among similar providers would be to leave the determination of reasonableness solely in the hands of providers, as a collective group, and would abrogate the cost-policing function of no-fault insurers, contrary to the intention of the Legislature. [*Id*. (cleaned up).]

The burden for proving the reasonableness of the fees lies with the party seeking recompense for those fees. *Bronson Methodist Hosp v Auto-Owners Ins Co*, 295 Mich App 431, 455; 814 NW2d 670 (2012). DMC's evidence was insufficient to support the requested fees' reasonableness.

DMC submitted a medical bill to Corvel listing 22 services it had provided to Shaina. Corvel reviewed and repriced 19 of the line items. The amount determined to be compensable by Corvel was relevant evidence of reasonableness, but was not dispositive of the issue. Although DMC claims that Citizens' representative Michelle Nowak told a DMC representative that the insurer would have issued a payment for $38,713.30 to DMC but for the fact that it was seeking rescission, this discussion was undocumented.

Whether the medical services were reasonably necessary, "must be assessed by using an objective standard." *Douglas*, 492 Mich at 264 (cleaned up). In support of its claim that the expenses were reasonably necessarily, DMC argues that the medical care provided was mandated under the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, which required that the DMC provide Shaina with necessary stabilizing treatment. This does not support that each of the 22 specific services rendered were objectively and reasonably necessary. Although this issue may eventually resolve in DMC's favor, the evidence was insufficient to support summary disposition.

We affirm.

/s/ Elizabeth L. Gleicher
/s/ Mark J. Cavanagh
/s/ Anica Letica