Legislative Analysis

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NO-FAULT AUTO INSURANCE AMENDMENTS

House Bill 4612 (Substitute H-1)
Sponsor: Rep. Pete Lund
Committee: Insurance

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A SUMMARY OF HOUSE BILL 4612 (SUBSTITUTE H-1) AS REPORTED FROM HOUSE COMMITTEE

The bill would make numerous amendments to the No-Fault Automobile Insurance statute within the Insurance Code. Key provisions include the following:

$1 Million Cap

- No-fault policies would no longer automatically cover "unlimited" lifetime medical and rehabilitation benefits for injured persons. Instead, for personal (injury) protection, or PIP, benefits, there would be a maximum of $1 million per injured person. This new limit would apply to loss occurrences under auto insurance policies issued or renewed after December 31, 2013.

From "Reasonably Necessary" to "Medically Appropriate"

- The current language of the act provides for allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation.

  The bill instead specifies that benefits would be payable for allowable expenses consisting of all reasonable charges, up to $1 million per injured person, for medically appropriate products, services, and accommodations for the injured person's care, recovery, and rehabilitation. This new standard would apply to loss occurrences under auto insurance policies issued or renewed after December 31, 2013. A further explanation of this and similar terms is provided later in the summary.

Additional Cost Containment Provisions

- The bill would impose new limits on provider reimbursement criteria and limits on allowable expenses, including those for attendant care and home and vehicle modifications. These limits are discussed in greater detail later in the summary.

  Generally speaking, the new limits on provider reimbursement that would be imposed would apply both to the ongoing treatment of injured persons and to the treatment of those injured after the bill takes effect; this would include payments to those providing attendant care. Other limits on certain "allowable expenses," including for attendant care and home and vehicle modification would apply only

to loss occurrences under auto insurance policies issued or renewed after December 31, 2013.

Premium Reduction

- By December 31, 2013, each no-fault insurer would have to file rates that result in a per-vehicle reduction in the annual premium "to reflect the savings expected as a result of the changes made" by the bill. The reduction would have to equal at least the sum of the initial new catastrophic claims fee plus $125. The reduction would be from rates in effect for the insurer on the date the bill was enacted into law and would apply to policies issued or renewed after December 31, 2013. Further, rates for PIP coverage could not be increased before January 1, 2015.

MCCA Has No Liability for Future Claims

- The Michigan Catastrophic Claims Association (MCCA), which currently covers medical and rehabilitation claims once they exceed $500,000, would cease to have liability for losses under motor vehicle accident policies issued or renewed after December 31, 2013. It would continue in existence until all previous liabilities are paid. Within 90 days of the bill taking effect, the MCCA would have to adjust the premium charge to its members (auto insurance companies) by an amount sufficient to reflect changes made by the bill.

New Corporation for Catastrophic Claims

- A new organization—to be called the Michigan Catastrophic Claims Corporation or MC3—would be created. This new entity would essentially take the place of the MCCA. It would provide personal (injury) protection benefits when they exceed the limit that auto insurers must provide. That limit would be $530,000 as of January 1, 2014, and would be adjusted for inflation in 2015 and then biennially. The corporation would provide PIP benefits beyond that amount, up to $1 million.

  [Note that the limit on insurance company liability is adjusted periodically upward while the overall limit appears to be fixed; this would suggest that over time the two will become closer together and that, unless the cap were later adjusted upward by legislation, there would eventually be no liability for the catastrophic corporation.]

- The new Catastrophic Claims Corporation would be a nonprofit "charitable and benevolent institution for the public benefit" and would be exempt from state and local taxes. The MC3 would have a seven-member board of directors appointed by the governor with the advice and consent of the State Senate. Business of the board would have to be conducted at meetings that were open to the public and be held in the state at a place available to the general public (although closed sessions would be allowed for certain specified reasons). The board would have to provide notice of its meetings. The MC3 would be subject to supervision by the director of the Department of Insurance and Financial Services as specified in the bill. The director could examine the affairs of the corporation and the

corporation would be required to provide the director access to all the corporation's records.

MC3 Per-Vehicle Fee

- The new corporation would annually determine a per-motor vehicle catastrophic claims fee, with the total fees imposed "sufficient to cover the expected losses and expenses that the corporation will likely incur during the period during which the fees are applicable." The required calculation is contained in the bill. The fee could be adjusted for any excess or deficient amounts from previous periods. The amount of the first fee would be set by the Director of the Department of Insurance and Financial Services, to cover policies issued in 2014.

  Unlike the MCCA assessment, which is levied on auto insurance companies on a per vehicle basis and then passed through to no-fault customers, the MC3 assessment would be imposed directly on the owner or registrant of each motor vehicle that carries no-fault coverage. (This does not include motorcycles, which apparently would not pay the fee.) The bill says that the fee is a charge imposed by the corporation and is not a part of an insurance company's premium. However, the fee would be collected by insurance companies when they collect their premiums. (A historic vehicle would be charged 20% of the normal fee, as now.)

$25 Health Insurance Claims Assessment

- Until December 31, 2019, a $25 charge would be added to the catastrophic claims fee. The corporation would pay the charges to the Department of Treasury, which would use the proceeds to finance expenditures of the Medicaid managed care organizations under the Health Insurance Claims Assessment Act. The estimated amount of funds generated by the $25 charge would be approximately $175.5 million per year. (See ***Fiscal Impact*** for additional information.)

Motorcycle PIP Limit

- Individuals injured on a motorcycle involved in an accident with a motor vehicle could claim PIP benefits only up to a maximum of $250,000. PIP benefits would not be payable to the extent that benefits covering the same loss were available from other sources, regardless of the nature and number of benefit sources available and regardless of the nature or form of the benefits. (This applies to loss occurrences under policies issued or renewed after December 31, 2013.)

  (Individuals injured on a motorcycle involved in an accident with a motor vehicle claim PIP benefits in the following order of priority: the insurer of the owner or registrant of the motor vehicle; the insurer of the operator of the motor vehicle; the motor vehicle insurer of the operator of the motorcycle; and, finally, the motor vehicle insurer of the owner or registrant of the motorcycle.)

Nonresidents in Accidents

- PIP benefits payable to a nonresident would be limited to $50,000 per individual per loss occurrence. PIP benefits are not payable to a nonresident injured in an accident occurring outside the state to the extent that benefits covering the same loss are available from other sources, regardless of the nature and number of benefit sources available and regardless of the nature or form of the benefits. (This applies to loss occurrences under policies issued or renewed after December 31, 2013.)

"Medically Appropriate" Further Defined

- Medically appropriate products, services, and accommodations rendered or prescribed by a health care facility, agency, or provider would be those that are medically necessary and would not include those that would have been needed or used by the injured person or a member of the person's household regardless of the loss occurrence. An insurance company would not be required to provide coverage for a product, service, or accommodation that is not medically necessary for an injured person's care, recovery, and rehabilitation or not reasonably likely to result in meaningful and measurable lasting improvement in the injured person's functional status.

  If reimbursement is initially rejected in whole or in part as not medically necessary, the no-fault insurer, at the provider's request, must have the decision reexamined by a provider with the same license, certification, or registration as the appealing provider or one who has a license, registration, or certification with a scope of practice that includes the same scope of practice as the appealing provider. A company would have to designate a person with whom providers could discuss the company's determinations regarding what is medically appropriate or medically necessary.

  (These provisions apply to loss occurrences under policies issued or renewed after December 31, 2013.)

Attendant Care Limits

- The bill would provide limits on allowable expenses for attendant care provided in the home by a family or household member. Payment would be limited to a total of 56 hours per week, regardless of the level of care provided, and payment would be limited to $15 per hour, regardless of the level of care provided. (Payment amounts would be adjusted every three years based on inflation.) These limitations apply whether or not the family or household member is licensed or otherwise authorized to render the attendant care under the Public Health Code, or is employed by, under contract with, or in any way connected with an individual or agency licensed or authorized to render the care.

- The bill would also impose limits on allowable expenses for attendant care provided by someone other than a family or household member. Payment would be limited to a total of 24 hours per day for services performed by one or more

individuals. Payment for the first 30 days of attendant care would not be subject to a copay, but after 30 days, payment would be subject to a copay of 20%, up to a maximum of $200 per month. Payment for attendant care would be cumulatively limited to 24 hours per day.

- However, the bill would allow an insurance company or the catastrophic claims corporation to contract to provide attendant care as an allowable expense at any rate and for any number of hours per week.
  These provisions would apply to ongoing care and new cases as of the effective date of the bill.

Attorney Fees for Attendant Care

- In a dispute over payment for allowable expenses for attendant care, attorney fees could only be awarded for services rendered in the 12-month period immediately preceding the date the insurance company was notified of the dispute.

Home Modification Limits

- The bill specifies that allowable expenses for home modifications are for charges directly necessitated by and related to the injured person's injuries if the accommodations are functionally necessary to meet the injured person's treatment, rehabilitation, maintenance, and daily living needs. (This applies to loss occurrences under policies issued or renewed after December 31, 2013.)

Motor Vehicle Modification Limits

- Expenses for a special motor vehicle or motor vehicle modifications directly necessitated by and related to an injured person's injuries would not be allowable more than once every seven years. (This applies to loss occurrences under policies issued or renewed after December 31, 2013.)

Other "Allowable Expense" Criteria

- A product, service, or accommodation for an injured person's care, recovery, or rehabilitation would be an allowable expense if it were provided for medical or rehabilitative reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider.

- A product, service, or accommodation would be an allowable expense if it were provided in the most appropriate location where the service could, for practical purposes, be safely and effectively provided.

- Allowable expenses would not include experimental treatment or participation in research projects.

- Expenses for medically appropriate rehabilitation services that are reasonably likely to produce significant rehabilitation would have to be reimbursed for a fixed-duration period of not more than 52 weeks. The services could be extended for an additional 52 weeks, and a 52-week or 104-week period could be extended

if it was reasonably likely that longer treatment could produce significant measurable improvement.

(These provisions apply to loss occurrences under policies issued or renewed after December 31, 2013.)

Reimbursement Limits (Section 3157)

- The No-Fault statute currently says that a physician, hospital, clinic, etc. lawfully rendering treatment for an accidental bodily injury covered by PIP coverage, and a person or institution providing rehabilitative occupational training following an injury, may charge a reasonable amount for the products, services, and accommodations rendered. The charge cannot exceed the amount the provider customarily "charges" for like products, services, and accommodations in cases not involving insurance.

  The bill would make this provision say: "the charge shall not exceed the amount the person or institution customarily receives for like products, services, and accommodations in cases that do not involve personal protection insurance [PIP], the program for medical assistance for the medically indigent [Medicaid] . . . or the federal Medicare program." (Underlining added)

  This appears to mean that charges are not to exceed those customarily received from health insurance companies, including Blue Cross and Blue Shield.

  These provisions apply to loss occurrences that occurred both before and after the bill's effective date; in other words, they apply to treatment of injured persons ongoing at the time the bill takes effect as well as future cases.

- Any information needed by an insurer or the catastrophic claims corporation to determine the appropriate reimbursement would have to be provided by the person providing the treatment or rehabilitative or occupational training. If an insurer or corporation needs information and the information is not available or not provided or is not sufficient to determine the appropriate reimbursement, the insurer or corporation would pay the amount based on the Workers Compensation's schedule of maximum fees.

No Duplicate Benefits

- Regardless of the number of motor vehicles insured or insurance companies providing security, or the provisions of any other law providing for direct benefits without regard to fault for vehicle accidents, a person could not recover duplicate benefits for the same expenses or losses incurred. Coverage for allowable expenses for two or more motor vehicles under one policy or for two or more policies could not be added together, combined, or stacked to determine the limit of insurance coverage available for each injured person covered under the policy. (This applies to loss occurrences under policies issued or renewed after December 31, 2013.)

Assigned Claims

- The bill would specify that an injured person claiming benefits under the Assigned Claims Plan would be limited to reasonable charges incurred up to a maximum of $250,000.

  The Assigned Claims Plan is a program aimed at providing assistance to individuals entitled to claim benefits for injuries arising out a motor vehicle accident in Michigan where PIP coverage is not available because no PIP insurance is applicable or no PIP coverage can be identified (for example, a pedestrian without coverage in his or her household injured by a hit-and-run driver); the applicable coverage cannot be ascertained because of a dispute between insurance companies; or the applicable coverage is inadequate because of the financial inability of insurers to provide benefits.

Fraud Authority

- The bill would create a new Insurance Fraud Authority. The authority would be supported by up to $21 million in annual assessments from automobile insurance companies and self-insured entities in years 2014 through 2018. The authority would be required to provide financial support to state or local law enforcement agencies and to state and local prosecutorial agencies, in both cases for programs designed to reduce the incidence of automobile insurance fraud. A more detailed explanation is found later in the summary. The new authority also could provide financial support to law enforcement, prosecutorial, insurance, education, and training *associations* for programs designed to reduce the incidence of automobile insurance fraud and theft. The authority would be dissolved on January 1, 2019, and prior to dissolution would transfer all assets to the Department of State Police for the benefit of the Automobile Theft Prevention Authority.

- The new authority would be created within the Michigan Automobile Insurance Placement Facility, and the staff of that facility would provide staff for the new authority. That "facility" is a statutorily-created insurer of last resort sponsored by the auto insurance industry and intended for drivers who cannot get coverage in the regular marketplace.

- The Fraud Authority would not be a state agency, and the money of the authority would not be state money. A record of the authority would be exempt from disclosure under the Freedom of Information Act.

Theft Prevention Authority Funding

- At least $6.25 million of the money received by the new Fraud Authority would be paid to the Automobile Theft Prevention Fund. Currently, the anti-theft authority is supported by its own assessment, which is specified in statute as equal to $1 multiplied by an insurance company's total earned car years (and this is typically passed along on customers' insurance bills). The current assessment would be suspended from January 1, 2014, to December 31, 2018, and this

funding would replace it. The anti-theft authority is housed within the Department of State Police but operates independently.

Additional Information on the Fraud Authority

Each insurance company authorized to transact insurance in the state would be required, as a condition of its authority to transact insurance, to report automobile insurance fraud data to the new authority using the format and procedures established by the authority board. The Department of State Police would be required to cooperate with the authority and would have to provide available motor vehicle fraud and theft statistics to the authority on request.

Board of Directors

The Fraud and Theft Authority would have a 15-member board of directors. Of those, eight would represent auto insurance companies and would be elected by the companies from a list of nominees proposed by the board of governors of the Placement Facility (who would solicit the names from insurance companies). The other members would be, the Director of the Department of Insurance and Financial Services or a designee; the Attorney General or a designee; the Director of the Department of State Police or a designee; two members representing law enforcement; one member representing prosecuting attorneys; and one member representing the general public. The members representing law enforcement, prosecutors, and the general public would be appointed by the governor. Terms would be for four years (although initial terms would be staggered).

Members would serve without compensation except reimbursement for travel and expenses. A majority of the members would constitute a quorum, notwithstanding any vacancies. Action could be taken in person or through amplified telephonic equipment, if authorized in the board's bylaws or plan of operation. Meetings would be held at the call of the chair or as provided in the bylaws, and meetings could be held anywhere in the state. The board would adopt a plan of operation, and that plan would describe how board vacancies are to be filled.

Appointment Requirements

Of the eight insurance members on the board, at least two would represent insurer groups with 350,000 or more car years; at least two would represent insurer groups with between 100,000 and 350,000 car years; and at least one would represent insurer groups with less than 100,000 car years. ("Car years" is a measure of the amount of mandatory no-fault coverage a company has written in Michigan.)

The law enforcement members of the board would be appointed from input solicited from various law enforcement associations in the state, and the two members appointed could not be from the same type of law enforcement agency. Further, the governor could not appoint a member representing the same law enforcement agency to more than two consecutive terms. The prosecuting attorney representative would be appointed based on input solicited from various prosecuting attorney associations. The public member could

not be employed by or under contract with any state or local unit of government or any insurance company.

Assessments
The assessments on insurance companies and self-insured entities would be determined by the plan of operation and would be based on the ratio of car years written to the statewide total car years written (meaning, essentially, that the assessments are made on the proportion of company's or entity's no-fault business).

Annual Financial Report & Report to Legislature
The authority would have to prepare and publish an annual financial report, as well as an annual report to the Legislature on its efforts to prevent automobile insurance fraud and cost savings. The annual report to the Legislature would have to detail the automobile insurance fraud occurring in the state during the previous year, assess the impact of the fraud on auto insurance rates, summarize prevention programs, and outline allocations made by the authority, among other things. The report would have to be submitted to the standing committees of the House of Representatives and Senate with primary jurisdiction over insurance issues.

FISCAL IMPACT:

House Bill 4612 (H-1) would have a significant, yet indeterminate, fiscal impact on the state budget, primarily on the state's Medicaid program. The extent of that fiscal impact depend on the growth in the amounts paid in excess of $1.0 million for claims exceeding $1.0 million that are the result of automobile accidents, the limitations on coverage and differences in the amounts paid for health care services between private automobile insurers and the state's Medicaid program, whether HB 4612 would result in uninsured drivers purchasing automobile insurance, and the amount collected from charges on automobile insurance policies to finance expenditures of Medicaid.

HB 4612 (H-1) would provide an annual charge of $25 per insured motor vehicle in addition to the catastrophic claims fee. The estimated amount of funds generated by the $25 charge would be approximately $175.5 million per year. The $25 would be charged from 2014 through 2019, and the funds generated by the $25 charge would be used to finance expenditures of Medicaid as defined by the Health Insurance Claims Assessment Act, 2011 PA 142.

<u>Michigan Catastrophic Claims Associations Financial Data</u>

Before analyzing the fiscal impact that HB 4612 (H-1) would have on the state's Medicaid program, it is necessary to ascertain the financial liability of the Michigan Catastrophic Claims Association (MCCA) under current law.

Exhibit #1 presents the number of MCCA's total paid claims and the total amounts paid, both below and exceeding a $1.0 million threshold, since the MCCA's inception in 1978.[1] From 1981, the first year that the MCCA began reimbursing insurance companies, to 2012, the MCCA paid a total of $9.9 billion on 12,836 claims.

Exhibit #1

MCCA Paid Amounts for Claims Below and Exceeding $1.0 Million
Fiscal Years 1981-2012, as of June 30, 2012

Paid Claims	Number of Claims Paid	Paid Amounts Below $1.0 Million	Paid Amounts Exceeding $1.0 Million	Total Paid Amounts
Claims Under $1.0 Million	8,487	$1,731,319,996	$0	$1,731,319,996
Claims Exceeding $1.0 Million	4,349	$3,068,643,142	$5,124,122,810	$8,192,765,952
Total Paid Claims and Amounts	**12,836**	**$4,799,963,137**	**$5,124,122,810**	**$9,924,085,947**

NOTE: Claim amounts used to calculate $1.0 million loss threshold include PIP benefits paid by original auto insurer and those reimbursed by the MCCA. Paid amounts include only those losses reimbursed by the MCCA.
SOURCE: Data provided to HFA via email communication with the MCCA in early May, 2013.

Given that HB 4612 (H-1) would establish a $1.0 million limit in PIP benefits per injured individual, this analysis will concentrate on the amounts paid by the MCCA's in excess of $1.0 million for claims exceeding $1.0 million, since these are the amounts that would no longer be indemnified by automobile insurers (or reinsured via the MCCA/Michigan Catastrophic Claims Corporation (MC3)) if HB 4612 is enacted as reported by the House Insurance Committee. Between 1981 and 2012, the MCCA paid a total of $5.1 billion on 4,349 claims exceeding $1.0 million.[2]

Exhibit #2 presents the annual number of claims and amounts paid by the MCCA, both below and exceeding a $1.0 million threshold, since the inception of the MCCA. In fiscal year 2012, the MCCA paid $639.1 million in excess of $1.0 million for 3,345 claims exceeding $1.0 million.

[1] Claim amounts used to calculate $1.0 million loss threshold include PIP benefits paid by original auto insurer and those reimbursed by the MCCA. Paid amounts include only those losses reimbursed by the MCCA.
[2] The phrase "amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million" appears frequently throughout this analysis; while the two conditions may seem redundant, the phrase is technically necessary as it 1) specifically includes the amounts paid by the MCCA in excess of $1.0 million only for those claims that exceed the $1.0 million limit that would be established if HB 4612 is enacted as reported by the House Insurance Committee, and 2) excludes amounts paid by the MCCA between the reinsurance retention limit ($500,000 in 2012) and the $1.0 million limit that would be established if HB 4612 is enacted as reported by the House Insurance Committee.

Exhibit #2

MCCA Annual Paid Amounts for Claims Below and Exceeding $1.0 Million Annually for Fiscal Years 1981-2012, as of June 30, 2012

Fiscal Year	Total Number of Claims Paid	Number of Claims Exceeding $1.0 Million Paid	Paid Amounts Below $1.0 Million for All Claims	Paid Amounts Exceeding $1.0 Million for Claims Exceeding $1.0 Million	Total Paid Amounts for All Claims
1981	3	0	$100,797	$0	$100,797
1982	13	0	$448,120	$0	$448,120
1983	21	0	$859,265	$0	$859,265
1984	46	0	$2,144,136	$0	$2,144,136
1985	72	0	$4,826,250	$0	$4,826,250
1986	251	6	$33,806,123	$859,608	$34,665,732
1987	373	11	$27,145,256	$1,612,338	$28,757,594
1988	509	16	$39,237,349	$2,788,450	$42,025,798
1989	714	29	$63,185,718	$4,880,308	$68,066,026
1990	963	52	$83,394,390	$8,379,136	$91,773,526
1991	1,202	90	$91,561,540	$12,999,533	$104,561,072
1992	1,524	141	$107,183,633	$20,613,402	$127,797,035
1993	1,753	201	$105,134,430	$26,373,702	$131,508,132
1994	1,993	276	$112,152,581	$38,889,273	$151,041,854
1995	2,226	352	$118,657,523	$45,636,988	$164,294,511
1996	2,486	431	$126,630,717	$59,084,038	$185,714,754
1997	2,672	517	$127,328,650	$70,378,936	$197,707,586
1998	2,869	587	$138,471,684	$77,554,578	$216,026,262
1999	3,243	685	$163,441,342	$98,809,816	$262,251,157
2000	3,463	801	$173,800,205	$110,171,732	$283,971,937
2001	3,852	935	$189,910,873	$137,379,995	$327,290,868
2002	4,185	1,117	$218,650,833	$176,503,682	$395,154,516
2003	4,601	1,278	$236,265,093	$221,429,082	$457,694,176
2004	5,072	1,497	$281,879,455	$258,547,873	$540,427,328
2005	5,572	1,675	$291,082,225	$308,429,322	$599,511,548
2006	6,066	1,921	$296,702,091	$350,600,663	$647,302,754
2007	6,383	2,135	$284,721,148	$384,242,585	$668,963,733
2008	6,679	2,374	$276,315,236	$434,264,364	$710,579,600
2009	6,986	2,569	$282,213,168	$482,996,676	$765,209,844
2010	7,475	2,840	$293,522,209	$523,387,549	$816,909,758
2011	7,879	3,087	$336,577,960	$628,232,606	$964,810,566
2012	8,183	3,345	$292,613,137	$639,076,576	$931,689,712
Total (1981-2012)			**$4,799,963,137**	**$5,124,122,810**	**$9,924,085,947**

NOTE: Claim amounts used to calculate $1.0 million loss threshold include PIP benefits paid by original

auto insurer and those reimbursed by the MCCA. Paid amounts include only those losses reimbursed by the MCCA.
SOURCE: Data provided to HFA via email communication with the MCCA in early May, 2013.

Between 2003 and 2012, the number of paid claims exceeding $1.0 million increased by 2,067, a 162% increase over 2003. During this period, the average annual year-over-year increase in the number of paid claims exceeding $1.0 million was 223 per year, an average increase of 11.6% per year. The amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million increased by $417.6 million over the decade between 2003 and 2012, a 189% increase. Annual MCCA amounts paid in excess of $1.0 million for claims exceeding $1.0 million increased by an average of $46.3 million year-over-year, an average increase of 13.9% per year.

In fiscal year 2012, claims exceeding $1.0 million constituted 40.8% of the total paid claims by the MCCA, and the amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million constituted 68.6% of the total amounts paid by the MCCA for all claims. Because the MCCA continues to make payments on claims initiated soon after its inception while new claims are added each year, the number of paid claims exceeding $1.0 million and the amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million are, under current law, expected to continually increase into the foreseeable future. Between 2003 and 2012, the proportion of paid claims exceeding $1.0 million to total paid claims increased by 47.2% and the proportion of the amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million to the total amounts paid by the MCCA for all claims increased by 41.8%.

Exhibit #3 presents the number of claimants within paid claims exceeding $1.0 million for fiscal year 2012 and the amounts paid by the MCCA in excess of $1.0 million, classified by the type and severity of their injury.[3,4] In 2012, the MCCA paid $639.4 million in excess of $1.0 million for a total of 3,558 claimants within paid claims exceeding $1.0 million, thus the average amount paid per claimant was $179,715.[5]

The 2,354 paid claims exceeding $1.0 million for Traumatic Brain Injuries of varying severity constitute the greatest proportion of amounts paid by the MCCA in excess of $1.0 million and cumulatively constitute 64.2% of such payments, totaling $410.3 million

[3] A claim paid by the MCCA may include multiple claimants (e.g. a single car accident with two passengers would count a single claim but each injured passenger could be a claimant).

[4] The data provided by the MCCA is arranged either below or exceeding a threshold of $1.0 million per *claim*. HB 4612 would establish a $1.0 million limit in PIP benefits per injured individual (i.e. per *claimant*). There were 3,345 paid claims exceeding $1.0 million in 2012 and 3,558 claimants within these claims; thus there were 213 claimants who were counted within claims with multiple claimants. While this analysis assumes that paid amounts exceeding $1.0 million per claim would no longer be indemnified by automobile insurers (or reinsured via the MCCA/MC3), HB 4612 actually would provide indemnification by automobile insurers (partially reinsured via the MC3) up to $1.0 million per injured individuals (i.e. claimant). This deficiency in the analysis, due to limitations in available data, results in marginally greater amounts that are presumed to no longer be indemnified by automobile insurers (or reinsured via the MCCA/MC3).

[5] The nominal discrepancy between the paid amounts in excess of $1.0 million for claims exceeding $1.0 million during the fiscal year 2012 presented in Exhibit #2 and Exhibit #3 is due to variation in the data provided by the MCCA.

and an average paid amount of $183,309 per claimant in 2012. Amounts paid by the MCCA in excess of $1.0 million for the 469 paid claims exceeding $1.0 million for quadriplegia of varying severity totaled $135.0 million, an average of $393,402 per claimant, constituting a cumulative 21.1% of such payments in 2012.

Exhibit #3

MCCA Claims Exceeding $1.0 Million by Injury and Severity
For Fiscal Year 2012, as of June 30, 2012

Type of Injury	Degree of Severity	Number of Claimants	Paid Amounts Exceeding $1.0 Million	Percent of Paid Amounts	Average Paid per Claimant
Brain	Minimum	140	$5,151,953	0.81%	$36,800
Brain	Moderate	1,649	$261,067,354	40.83%	$158,319
Brain	Permanent Vegetative State	34	$9,693,306	1.52%	$285,097
Brain	Severe	531	$134,353,072	21.01%	$253,019
Burn	N/A	8	$189,606	0.03%	$23,701
Miscellaneous	Amputation	82	$9,120,802	1.43%	$111,229
Miscellaneous	Back & Neck	83	$8,156,046	1.28%	$98,266
Miscellaneous	Multiple Fractures	241	$21,597,515	3.38%	$89,616
Miscellaneous	Other	52	$5,210,554	0.81%	$100,203
Paraplegic	Complete	208	$41,257,444	6.45%	$198,353
Paraplegic	Incomplete	57	$8,583,475	1.34%	$150,587
Quadriplegic	Complete	261	$71,496,112	11.18%	$273,931
Quadriplegic	Incomplete	171	$38,293,402	5.99%	$223,938
Quadriplegic	Ventilator Dependent	37	$25,246,464	3.95%	$682,337
Non-Probable Lifetime Care	N/A	4	$9,286	0.00%	$2,322
Total (2012)		**3,558**	**$639,426,391**	**100.00%**	**$179,715**

NOTE: Claim amounts used to calculate $1.0 million loss threshold include PIP benefits paid by original auto insurer and those reimbursed by the MCCA. Paid amounts include only those losses reimbursed by the MCCA.
SOURCE: Data provided to HFA via email communication with the MCCA in early May, 2013.

As a counterfactual, if HB 4612 (H-1), with its PIP benefit cap, had been in effect during fiscal year 2012, all other things being equal, the $639.4 million in paid amounts in excess of $1.0 million for claimants within claims exceeding $1.0 million for injuries of all types and severities would not have been indemnified by the MCCA under the no-fault system.[6] This amount is illustrative of the potential magnitude of future cost-shifting from the MCCA to other private and/or public health insurance providers under HB 4612,

[6] However, under HB 4612 (H-1), individuals injured in motor vehicle accidents occurring under automobile insurance policies issued or renewed prior to January 1, 2014 would remain indemnified under the MCCA if their claims exceeded the statutory retention limit and the MCCA would continue to pay such claims until all previous liabilities are paid.

subject to coverage limitations and cost containments that would be expected to reduce loss payments made by other private and/or public health insurance providers.

While the foregoing analysis described that the amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million has increased in previous years and, under current law, is expected to increase in prospective years, this does not entail that the trend for these paid amounts would necessarily remain unaffected if HB 4612 (H-1) is enacted. Private health insurers, Medicaid, and Medicare impose numerous limitations on coverage and enforce various cost controls for the products, services, and accommodations available to individuals who may become indemnified or eligible for enrollment if HB 4612 (H-1) is enacted. Specifically, Medicaid coverage limitations and cost containments are discussed in further detail below.

Exhibit #4 presents the utilizations of the various products, services, and accommodations by claimants within paid claims exceeding $1.0 million and the amounts paid by the MCCA in excess of $1.0 million for such products, services, and accommodations during fiscal year 2012.

Exhibit #4

MCCA Claims Exceeding $1.0 Million by Payment Category
For Fiscal Year 2012, as of June 30, 2012

Payment Category	Claimant Utilization Count	Paid Amounts Exceeding $1.0 Million	Percent of Paid Amounts	Average Paid per Utilization
Uncoded	18	$122,000	0.02%	$6,778
Attendant Care Agency	1,192	$132,310,745	20.69%	$110,999
Attendant Care Family	1,973	$142,631,025	22.31%	$72,291
Bill Review Fee	23	$206	0.00%	$9
Case Management	1,681	$10,031,665	1.57%	$5,968
Doctors/Labs	3,178	$27,666,518	4.33%	$8,706
Equipment	475	$4,364,771	0.68%	$9,189
Home Purchase\Modification	239	$5,768,112	0.90%	$24,134
Hospitalization	1,068	$40,094,842	6.27%	$37,542
Other	1,313	$11,693,152	1.83%	$8,906
Prosthesis	93	$1,216,268	0.19%	$13,078
Rehabilitation	2,026	$42,565,010	6.66%	$21,009
Residential Care	1,173	$148,330,513	23.20%	$126,454
Prescription	3,082	$50,707,059	7.93%	$16,453
Replacement Services	126	$351,195	0.05%	$2,787
Transportation	1,933	$15,153,462	2.37%	$7,839
Van Purchase/Modification	167	$5,212,235	0.82%	$31,211
Wage Loss/Survivor's Loss	95	$1,207,612	0.19%	$12,712
Total (2012)	**19,855**	**$639,426,391**	**100.00%**	**$32,205**

NOTE: Claim amounts used to calculate $1.0 million loss threshold include PIP benefits paid by original auto insurer and those reimbursed by the MCCA. Paid amounts include only those losses reimbursed by the MCCA.
SOURCE: Data provided to HFA via email communication with the MCCA in early May, 2013.

Michigan's Medicaid Program Fiscal Impact

Having presented data pertaining to the MCCA's paid amounts exceeding $1.0 million for claims exceeding $1.0 million, the remainder of the analysis will concentrate on the potential fiscal impact to the state's Medicaid program if HB 4612 is enacted as reported by the House Insurance Committee.

Potential Cost Shift to Medicaid

HB 4612 would have a fiscal impact on the state's Medicaid program to the extent that it would shift health care costs from private automobile insurers (partially reinsured via the MCCA/MC3) to the state's Medicaid program.

This cost shift would occur to the extent that the PIP benefit claims of individuals injured in automobile accidents exceeded the $1.0 million limit in PIP benefits per injured individual established by HB 4612 and the injured individuals were not otherwise indemnified by private health insurance. If an injured individual was determined to be disabled as defined by the U.S. Social Security Administration, (s)he would become eligible for either Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), administered by the U.S. Social Security Administration, depending on program eligibility requirements.[7]

In order to be eligible for Supplemental Security Income (SSI), individuals must have low income, few resources, and be either older than 65, blind, or disabled.[8] The 2013 monthly wage income limit for individuals in Michigan is $1,505 ($18,060 annually) and the assets limit (excluding house and automobile, among other assets) is $2,000 ($3,000 if married). Individuals receiving SSI benefit payments are automatically eligible for enrollment in the state's Medicaid program (individuals in the process of applying for SSI benefits may also be eligible for enrollment in state's Medicaid program).

Individuals injured in automobile accidents whose PIP benefit claims exceeded the $1.0 million limit in PIP benefits per injured individual established by HB 4612 and who are eligible for SSI benefits would engender a cost shift from private automobile insurance companies (reimbursed via the MCCA/MC3) to the state (paying 33.86% of Medicaid costs) and federal (paying 66.14% of Medicaid costs) governments.
In order to be eligible for Social Security Disability Insurance (SSDI), individuals must satisfy both: (1) a "recent work" test based on the individuals age at the time they became disabled, and (2) a "duration of work" test to show that individuals worked long enough

[7] The SSA defines "disability" based on individuals inability to work, specifically: 1) individuals are unable to perform the work they did before, 2) cannot adjust to other work because of their medical condition(s), and 3) the disability has lasted or is expected to last for at least one year or result in death.
[8] For more information pertaining to SSI benefits, see: http://www.ssa.gov/pubs/EN-05-11000.pdf.

under Social Security.[9] SSDI benefits begin six months after the disability began and disabled individuals are automatically entitled to Medicare coverage after receiving disability benefits for two years. Individuals injured in automobile accidents whose PIP benefit claims exceeded the $1.0 million limit in PIP benefits per injured individual established by HB 4612 and who are eligible for SSDI benefits would engender a cost shift from private automobile insurance companies (reimbursed via the MCCA/MC3) the federal government (paying 100% of Medicare cost).

Medicare provides coverage for hospital and hospice care, limited skilled nursing facility and limited nursing home care, and limited home health services, in addition to medically necessary services and prescription drugs. However, Medicare does not provide coverage for long-term custodial care or in-home attendant care, such care would potentially be covered under the state's Medicaid program (see Medicaid cost sharing information above), if the injured individual was eligible.

Difference in Coverages between No-Fault and Medicaid

No-fault automobile insurance under current law includes coverage for several products, services, and accommodations which are not covered under the state's Medicaid program. Specifically, as categorized by Exhibit #4, the state's Medicaid program does not provide coverage for bill review, home purchase or modification, replacement services, van purchase or modification, wage loss or survivor's loss, and various other products, services, and accommodations covered under the current no-fault law (e.g. telecommunication charges, college tuition, funeral benefits, home repairs, homeowners insurance, property taxes, rent, utilities, tutoring, etc.).

Cumulatively, these products, services, and accommodations were utilized in 1,963 instances by claimants within claims exceeding $1.0 million, and the amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million for these products, services, and accommodations totaled $24.2 million during fiscal year 2012.

The state's Medicaid program does provide coverage for the remaining products, services, and accommodations categorized by Exhibit #4. However, several particular products, services, and accommodations within the categories of Exhibit #4 are not covered under the state's Medicaid program, specifically, but not limited to: acupuncture, massage therapy, music therapy, personal trainers, gym memberships, recreational therapy, vocational rehabilitation, driving evaluations, vehicle insurance, vehicle repairs, etc. Significantly, those particular products, services, and accommodations which are covered under the state's Medicaid program are subject to numerous limitations and various cost controls and may not be equivalent to coverage under the current no-fault automobile insurance law.[10]

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[9] For more information pertaining to the SSDI benefits, see: http://www.ssa.gov/pubs/EN-05-10029.pdf.

[10] Comparing the amount paid by dissimilar private automobile and health insurers as well as public social insurance programs for health care products, services, and accommodations is exceptionally problematic. This is due to the realities that 1) medical billing codes are exceedingly complex, 2) the amounts charged by health care providers (i.e. "chargemaster" prices) vary extensively with little discernible rationality, 3) the negotiated final amounts paid by private insurers are typically proprietary, and 4) Medicare and Medicaid revise their payment schedules frequently.

For instance, the amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million for the 1,173 claimant utilizations of residential care was $148.3 million during 2012, an average of $126,454 per claimant utilization. In contrast, the average annual cost to state's Medicaid program for long-term care was $68,167 per individual during 2012.

Additionally, amounts paid by the MCCA in excess of $1.0 million for claims exceeding $1.0 million for the 1,192 claimant utilizations of attendant care provided by professional agencies and 1,973 claimant utilization of attendant care provided by family or household members was $132.3 million and $142.6 during 2012, an average of $110,999 and $72,291 per claimant utilization, respectively. Whereas, the average annual cost to the state's Medicaid program for home and community based health care services for the disabled provided through the MIChoice waiver, with a goal of allowing individuals who are eligible for long-term care to remain in their homes, was $32,836 per individual during 2012.

Possible Medicaid Reductions if Uninsured Drivers Become Insured

Lastly, in testimony delivered by the Director of the Department of Insurance and Financial Services (DIFS) to the House Insurance Committee on April 25, 2013, the Director stated that HB 4612 could result in reductions to costs for the state's Medicaid program if HB 4612, by reducing the overall MCCA and MC3 assessments, reduces automobile insurance premiums for insurance customers who cannot afford to purchase automobile insurance under current law. Reduced vehicle insurance premiums are expected to induce some number of currently uninsured drivers to purchase insurance. Currently, if a low-income uninsured driver is injured in a vehicle accident and is currently enrolled in Medicaid, or becomes eligible for Medicaid, the cost of their medical treatment is incurred by the state (33.86%) and federal (66.14%) governments. The magnitude of cost reductions, if any, for the state's Medicaid program depends on how many currently uninsured drivers are enrolled in Medicaid, or become eligible for Medicaid subsequent to an automobile accident, and the costs of their coverage under the state's Medicaid program. Divergent

Health Insurance Claims Assessment (HICA)

Since 2002 Michigan has established several health care provider assessment programs as a means to implement Medicaid rate increases for hospitals, nursing homes, health maintenance organizations (HMOs), and specialty prepaid inpatient health plans (PIHPs) for Medicaid mental health services. These assessments leverage additional federal Medicaid matching funds. These initiatives are also referred to as quality assurance assessment programs (QAAPs).

For HMOs the State transitioned from the QAAP, to the Use Tax, to the HICA as a means of generating matchable revenue. This was done due to anticipated disallowances by the federal Centers for Medicare and Medicaid Offices. The establishment of HICA

As a result, a comprehensive comparison of the amounts paid for health care products, services, and accommodations is beyond the scope of this analysis.

through PA 141 of 2011 is considered a broad-based tax which satisfies the federal government as a replacement for the Use Tax model.

Revenue projections for HICA put forth by the Executive were based on an estimate of total taxable health care claims of $40.0 billion, with a 1% tax generating $400.0 million annually. The House and Senate Fiscal Agencies projections were slightly lower, but as discussions progressed both the insurance industry and the State acknowledged corrections may be necessary, with some industry spokespeople fearing that too much would be collected.

The Executive budget proposal for FY 2013-14 proposes changes to PA 141 of 2011, the Health Insurance Claims Assessment Act, by replacing on January 1, 2014, the 1% current assessment with a levied rate that would generate revenue not greater than $400.0 million in the immediate preceding year. The most recent estimate is that HICA revenues are short $134.0 million in FY 2012-13.

HB 4612 would provide an annual charge of $25 per insured motor vehicle in addition to the catastrophic claims fee. The $25 would be charged from 01/01/2014 to 12/31/2019 and the funds generated by the $25 charge would be used to finance expenditures of Medicaid as defined by the Health Insurance Claims Assessment Act, 2011 PA 142. The purpose of the $25 charge would be to offset the shortfall of HICA revenue. According to the Michigan Catastrophic Claim Association, there were a total of 7,019,000 motor vehicles insured in Michigan during 2012. Thus, the estimated amount of funds generated by the $25 charge would be approximately $175.5 million per year, based on the number of motor vehicles insured in 2012. If the number of motor vehicle insured in Michigan remains at approximately the 2012 level, the total amount of funds generated from 2014 through 2019 would be $1.1 billion.

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.