Legislative Analysis

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NO-FAULT AUTO INSURANCE AMENDMENTS

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

Complete to 5-17-13

A PRELIMINARY SUMMARY OF HOUSE BILL 4612 (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:

No-Fault Impact

House Bill 4612 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 is dependent on the growth in the amounts paid in excess of $1.0 million for claims exceeding $1.0 million which 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; and whether HB 4612 would result in drivers who are currently uninsured purchasing automobile insurance.

A detailed description of the potential fiscal impact of the bill will be available in the near future.

Health Insurance Claims Assessment (HICA)

HB 4612 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 01/01/2014 to 12/31/2019, and the funds generated by the $25 charge would be used to finance expenditures of Medicaid managed care organizations 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.