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NO-FAULT AUTO INSURANCE AMENDMENTS

House Bill 5013 as reported from committee as (H-3)
Sponsor: Rep. Lana Theis
Committee: Insurance
Complete to 11-1-17

BRIEF SUMMARY:

House Bill 5013 would amend the Insurance Code (MCL 500.3101 et al.) by adding and amending sections and chapters that define the state's no-fault insurance system.

Except where noted otherwise, the bill's provisions would go into effect for automobile insurance policies issued or renewed after June 30, 2018.

House Bill 5013 would do all of the following:

- Allow an insured person to select one of three personal [injury] protection, or PIP, coverage levels: $250,000; $500,000; or no maximum limit.
- Allow a "qualified person"—a person who is at least 62 years old and has lifetime health benefits—to opt out of purchasing PIP coverage, and require an insurer to offer a reduced insurance premium rate for a person who opted out.
- Require, until July 1, 2023, insurers to file PIP premium rates for review with the director of the Department of Insurance and Financial Services (DIFS), and require that rates "reflect savings expected" from the proposed bill.
- Require insurers to file additional information with the director if the PIP premium rates do not, on average, result in the following specified reductions per vehicle from the PIP premium rate in effect for the company on October 1, 2017: 40% reduction for policies with a $250,000 coverage limit; 20% reduction for policies with a $500,000 coverage limit; and 10% reduction for policies with no coverage limit.
- Specify that an insurer is not required to provide coverage for the following: more than 56 hours of attendant care in the home per week, if provided by certain persons; ambulance care in an amount that exceeds the Medicare ambulance rate or 125% of the rate in emergency situations; and ground transportation (besides the ambulance care) in an amount that exceeds 300% of a suggested IRS rate.
- Set maximum reimbursement rates to medical providers for PIP benefits as follows: 125% of the Medicare rate for emergency services, 100% of the Medicare rate for all other services, and no more than the average amount received by the provider in the last year if Medicare does not provide a rate for the service.
- Require medical providers, after rendering treatment for PIP benefits, to provide relevant information to insurers, the Michigan Catastrophic Claims Association (MCCA), or DIFS for use in creating a "utilization review" to be used in assessing whether certain medical care is appropriate in a given instance.
- Allow the director to prohibit a medical provider from receiving payment for treatment provided under PIP coverage if the medical provider is found to engage in a pattern or practice of violating the reimbursement limits or other regulations.

- Prohibit an attorney from filing a lien for payment of a fee unless certain conditions are met, limit the look-back period in awarding some attorney fees, and prohibit the awarding of attorney fees in situations where the attorney had a financial interest in the person who provided medical treatment.
- Require an independent audit of the MCCA every 5 years, with the potential for a rebate if certain actuarial conditions are met.
- Revise the way in which the MCCA calculates its total premium and charges its member insurers, and require that if member insurers pass any portion of the MCCA premium to insureds, the amount passed on be equal to the portion of the MCCA premium attributable to the car insured.
- Allow the director, with support from the Department of Attorney General, to investigate potential fraudulent insurance acts.
- Create the Michigan Automobile Insurance Fraud Authority (MAIFA) within the Michigan Automobile Insurance Placement Facility (MAIPF), and provide for the governance, responsibilities, and powers of the MAIFA.

BRIEF FISCAL IMPACT:

House Bill 5013 could reduce state revenues by an estimated $11 million per year and could create increased costs for Medicaid by an estimated $80 million per year after 10 years. The bill also could create additional costs for state and local retirement systems that offer retiree health care benefits. The bill also could create additional indeterminate state department costs as well as local law enforcement and court costs. A more detailed fiscal impact follows on page 16.

DETAILED SUMMARY:

PIP Coverage Level Options

The bill would allow an insured person to select one of three PIP coverage levels:

- A limit of $250,000 per individual per loss occurrence; consisting of up to $225,000 for an "emergency medical condition" and "related emergency care", and up to $25,000 for all other allowable PIP benefits.
- A limit of $500,000 per individual per loss occurrence, for all allowable PIP benefits.
- No maximum limit per individual per loss occurrence, for all allowable PIP benefits.

If an insured person did not make a coverage selection, done on a form approved by the director, then no maximum limit would apply to the policy. However, once a person makes a selection of a limited coverage policy, if the person does not select a different coverage level before renewing, the coverage level before the renewal would apply. The form would be required to state the benefits and risks associated with each coverage level; provide a line for the person to sign, acknowledging he or she has read the form and understands the available options; and allow the person to make a coverage selection.

The $250,000 and $500,00 coverage limits would apply to PIP benefits payable under the policy to the insured person, the insured person's spouse, a relative of either domiciled in the same household, and any other person with a right to claim PIP benefits under the policy. The no maximum policy would apply to PIP benefits payable under the policy to the insured person,

the insured person's spouse, a relative of either domiciled in the same household, and any other resident of Michigan with a right to claim PIP benefits.

The bill would stipulate that the current coverage limit of $500,000 for out-of-state residents would apply if the nonresident is not the insured name in the policy, the insured person's spouse, or a relative of either domiciled in the same household; however, if the $250,000 policy were in effect, that limit would apply instead. Additionally, individuals injured on a motorcycle involved in an accident with a motor vehicle could claim PIP benefits only up to the coverage level limit of the vehicle involved in the accident.

The PIP coverage limit in effect would apply on a per occurrence, per loss basis, regardless of the number of policies applicable to the occurrence or loss.

PIP Coverage Level Options, for a "Qualified Person"

Under the bill, if a person is at least 62 years of age and has "qualified health coverage" (termed a "qualified person" in the bill), the person would not be entitled to PIP benefits unless the person affirmatively elected to purchase PIP coverage. If a "qualified person" opted out of PIP coverage, the insurer would be required to offer a reduced premium rate, and the insurer would be discharged from any liability for PIP benefits.

- The person would be required to certify that he or she has "qualified health coverage", meaning health insurance or benefits that are provided under a private or public retirement program for the remainder of the person's life and that include coverage for accidental bodily injury arising from the ownership or use of a motor vehicle.

The certification of a "qualified person", in addition to the PIP coverage selection of a qualified person, would be done through forms approved by the director. The form would have to disclose in a conspicuous manner that a qualified person is not obligated to purchase PIP coverage for the qualified person, but provide the person with the option to do so. As above, the form would also be required to include a statement of benefits and risks associated with each coverage option, and to provide a line for the person to sign, acknowledging that he or she has read the form and understands the available options. If a person were at least 62 years of age and did not complete this form, the person would purchase insurance with PIP coverage in the normal manner.

Even if a "qualified person" did not choose to purchase PIP benefits, the insurance policy would be required to include up to the $250,000 coverage level for other persons who would have a right to claim PIP benefits under the policy.

Finally, the statutory requirement for the owner or registrant of a motor vehicle registered in Michigan to maintain security for PIP benefits would be rewritten so that any of the above choices (coverage limits or "qualified person" opt-out) would satisfy the requirement.

PIP Premium Rate Reductions

The bill would require insurance companies that offer auto insurance to file premium rates for PIP insurance coverage for policies effective after June 30, 2018 and before July 1, 2019. The rates filed, and any rates filed within the next 5 years for all policies, would be required to "reflect savings expected from [the bill]".

If the premium rates filed for PIP coverage did not result in specific PIP premium rate reductions from rates in effect on October 1, 2017 (40% or greater for the $250,000 policy, 20% or greater for the $500,000 policy, or 10% or greater for the no-coverage-limit policy), the insurer would enter into a review process with the director. Such an insurer would be required to include the following with the rate filing:

- Premium rates for PIP coverage limits as near as practicable to those reductions.
- A detailed explanation of the reasons for the insurer's failure to achieve the required reductions and a demonstration, using accepted actuarial techniques, that the required reductions are not justified because of any of the following:
    - Expected losses by the insurer from auto insurance.
    - Inflation.
    - A change in assessment by the MCCA or MAIPF.

The director would review all the filings for compliance with these requirements (that is, to both file rates that "reflect savings" and file rates that result in the specific required reductions). If a filing did not meet the rate reduction requirements, and if the failure to achieve the reductions was not justified according to one of the factors listed, the director would be required to disapprove the filing.

If the director disapproved the filing, he or she would be required to determine what rate reduction the insurer could achieve as near as practicable to the average per vehicle reductions required, and to provide the insurer with a written explanation for the disapproval and determination of the practicable rate reduction. The insurer would then submit a revised filing with the director within 15 days of the disapproval that complies with the director's determination of the practicable rate reduction. This filing would again be subject to review.

A premium rate filed that is not disapproved by the director within 30 days would be considered approved; however, the director would be able to extend the review period to 60 days so long as he or she gave the insurer written notice and the reasons for extension.

Between June 30, 2018, and July 1, 2023, an insurer would not be able to issue or renew an automobile insurance policy in Michigan unless the insurer’s PIP premium rates were approved by the director in the above manner. Finally, the bill would stipulate that the PIP premium or premium rate does include the MCCA assessment.

Attendant Care and Allowable Expense Limits

Currently under the Code, PIP benefits are payable for allowable expenses consisting of reasonable charges for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation. The bill would keep this provision, but make changes to allowable expenses.

The bill would stipulate that PIP benefits are payable up to any coverage limit chosen by the insured, and that any charge that is not related to or necessitated by the injury is not an allowable expense.

The bill would list items and activities that an insurer is not required to provide coverage for. These items and activities would include:

- Attendant care over 56 hours per week, if the care is provided directly, or indirectly through another person, by a "related person" of the injured person, a person domiciled in the household of the injured person, or a person with whom the injured person had a business or social relationship before the injury. (However, the bill would not prohibit an insurer from paying PIP benefits for attendant care for more than 56 hours per week when provided by one of these individuals.)
- Ambulance services, including, but not limited to, air ambulance services, in an amount that exceeds the amount that would be allowable under the ambulance fee schedule under the federal Medicare program. However, if the ambulance services were for an "emergency medical condition" or "related emergency care", the limitation would be 125% of the allowable rate.
- Ground transportation services (other than the ambulance services) in an amount that exceeds 300% of the optional standard mileage rate provided by the Internal Revenue Service under 26 USC 213.[1]

Additionally, the bill would require claims for ground transportation or ambulance services to identify the service provider, the locations where the injured person was picked up and dropped off, the mileage between each location, and the total mileage for each day for which a claim is made.

For the PIP benefits for attendant care in the home, ground transportation services, and ambulance services, an insurer would only be required to pay reasonable charges incurred for reasonable necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation related to the injury, up to the policy coverage limits or the limits noted elsewhere.

Medical Provider Reimbursement Limits

Currently under the Code, any institution rendering treatment to an injured person covered by PIP insurance can charge a "reasonable amount" for services rendered. The charge "shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance." The bill would make numerous changes to this provision.

The bill would provide for specific reimbursement amounts to providers and stipulate that an institution that received such a reimbursement would not be allowed to charge the injured person any remaining balance. The reimbursement amounts would be as follows:

- No more than 125% of the amount payable for the treatment, training, product, service, or accommodation under the federal Medicare program, for an "emergency medical condition" and "related emergency care".
- No more than 100% of the amount payable under Medicare for all other circumstances and all other treatments, training, products, services, or accommodations.
- No more than the average amount accepted by the provider for the treatment, training, product, service, or accommodation during the preceding calendar year in cases that do not involve PIP insurance if Medicare does not provide an amount payable.

[1] See Section 213, "Medical, dental, etc., expenses." In US Code. Available online at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title26-section213&num=0&edition=prelim

The bill would stipulate that these limitations only limit the amount that a medical provider may be paid or reimbursed for a treatment, product, service, accommodation, or training. The limitations would not be limitations on the scope or duration of care an injured person could receive.

Medical Provider Reimbursement Limits, Regular Updates by Director

Every 2 years after December 31, 2020, the director would be required to review the optional standard mileage rate provided by the IRS for medical ground transportation and the Medicare rate for ambulance services. If the director determined any changes provided by the IRS and Medicare were reasonable and appropriate for purposes of assuring affordable automobile insurance in Michigan, the changes would apply to the reimbursements rates for PIP benefits and the director would issue an order to that effect.

For Medicare amounts payable for an "emergency medical condition", "related emergency care", and all other treatments, the director would be required to review the amounts every year. As above, if any changes were found reasonable and appropriate, the director would issue an order to that effect.

Medical Provider Reimbursement Limits and Reporting Requirements

Any medical provider rendering treatment for accidental bodily injury covered by PIP benefits would be considered to agree to submit to the insurer, MCCA, or DIFS all information related to treatment for a person under PIP coverage and all information related to the average amount accepted for a treatment, including, but not limited to, the following:

- Diagnoses; scans and x-rays; notes of physicians, nurses, and other providers; progress, psychiatric, or other notes; reports and records relating to consultations, operations, and other procedures; incident, triage, and pharmacy reports and records; documentation related to therapy; documents related to billing and charges; and a determination of an "emergency medical condition" or "related medical care."

A medical provider would not be eligible for reimbursement for any of the following:

- A request for payment for a treatment if the request is based on false or misleading information.
- A treatment that is not usually associated with, and is longer in duration than, is more frequent than, or extends over a greater time period than is usually required for, a patient with the diagnosis or condition of the injured person if there is no supporting documentation to justify the necessity of the treatment.
- A treatment where evidence is provided to the institution rendering the treatment to indicate that the treatment was not medically necessary for the injured person.

If a person paid or reimbursed an amount not authorized under the above guidelines, the person would be able to request a refund of the amount paid. If the unauthorized amount paid were not returned within 30 days, interest of 1% per month would apply to the amount. Additionally, the person would be able to recover court costs and attorney fees in seeking the amount owed.

Finally, the bill would require DIFS to issue rules for hearings with medical providers regarding compliance with the medical reimbursement schedule. If, after a hearing, DIFS determined that a medical provider engaged in a pattern or practice of conduct in violation of the reimbursement schedule or limitations, DIFS would be able to prohibit the medical provider

from charging and receiving payment for any PIP benefits for a period of time, and would also be able to order a refund of amounts received in violation.

Utilization Review by Insurers

By rendering treatment to an injured person covered by PIP insurance, a medical provider would be considered to have agreed to do the following:

- Submit necessary records and other information concerning treatments, products, services, or accommodations for "utilization review".
- Comply with any DIFS decision (see above).

Any medical provider that knowingly submitted false or misleading information to an insurer, the MCCA, or DIFS would be guilty of a misdemeanor, punishable by imprisonment for up to one year or a fine of up to $1,000, or both. Any proprietary information or sensitive personal information submitted to DIFS would be exempt from disclosure under the Freedom of Information Act.

DIFS would be required to issue rules to establish criteria or standards for utilization review. The utilization review would be the initial evaluation by an insurer or the MCCA of the appropriateness of the level and quality of treatment provided by PIP coverage, based on medically accepted standards. The criteria or standards would identify the utilization of treatments under PIP insurance above the usual range of utilization for the treatment based on medically accepted standards.

DIFS would also be required to establish procedures for utilization review related to the following:

- Collecting necessary records and bills concerning the treatments provided.
- Allowing an insurer to request an explanation for and requiring a medical provider to explain the necessity of, treatments provided.
- Appealing determinations.

If an insurer or the MCCA determined that a medical provider improperly over utilized or otherwise rendered inappropriate treatment, the medical provider would be able to appeal under the DIFS procedures.

Finally, if DIFS determined that an insurer complied with the criteria and standards for utilization review, it would be required to certify the insurer.

Michigan Catastrophic Claims Association, Actuarial Examination

Currently under the Code, the [insurance] commissioner, or any authorized representative of the commissioner, may visit the MCCA at any time and examine any and all of the MCCA's affairs. The bill would add to this provision.

As noted above, beginning on July 1, 2018, the MCCA would be examined once every 5 years. The director would be required to engage one or more independent actuaries to examine the MCCA's records, specifically as related to the premiums charged to members, adjustments to premiums for any excesses or deficiencies, and any rebates. The examination would be conducted using sound actuarial principles consistent with the applicable statement of principles and the code of professional conduct adopted by the Casualty Actuarial Society.

Following an actuarial examination, by December 31, 2018, and every 5 years thereafter, the director would be required to report to the Governor and the House and Senate Insurance Committees all of the following relating to the 5-year period ending the previous June 30:

- The MCCA's compliance with the statutory requirements and its plan of operation, specifically relating to [the proposed bill's] calculation of premiums charged and any adjustments for excesses or deficiencies from previous periods.
- The expectations used by the MCCA for medical cost inflation, economic conditions, investment returns, and the number of claims presented.
- The MCCA's compliance with [the proposed bill's] requirements to amend the MCCA plan of operation to provide for the procedures of a rebate.
- The MCCA's compliance with sound actuarial principles.
- The effect of any rebate and distribution of the rebate [under the proposed bill] on the MCCA's ongoing ability to provide an effective reinsurance mechanism for PIP benefits, based on sound actuarial principles.

If this actuarial examination found that the assets of the MCCA exceeded 120% of its liabilities, including incurred but not reported liabilities, the director would be required to order the MCCA to rebate the difference between the total excess and 120% of the liabilities to its members. If this order were received, the MCCA could request a hearing to review the order by filing a written request within 30 days. DIFS would then conduct a review as a contested case under the Administrative Procedures Act.

If a rebate were received, the MCCA member would then distribute the rebate to the person that it insures and that is subject to a premium on a uniform basis per car (and historic vehicle) in a manner and on the date or dates provided by the director in accordance with the order issued. A rebate for a historic vehicle would be equal to 20% of the rebate for a car.

Michigan Catastrophic Claims Association, Calculation of Premium

The bill would make changes to the manner in which the MCCA calculates its total premium, that is, the premium sufficient to cover the expected losses and expenses that the MCCA will likely incur during the time period for which the premium is applicable.

The bill would require the total MCCA premium to be adjusted for any excess or deficient premiums from previous periods, and would require these excesses or deficiencies to be either adjusted in a single period or over several periods. (Under current law, the MCCA premium may be adjusted for any excess or deficient premiums from previous periods.) The bill would also insert this "adjustment for any excesses or deficiencies" into the calculation used to determine the average premium per car.

Additionally under the bill, a member may not be charged a premium for a car insured under a policy with either the $250,000 or $500,000 coverage limit, *except* for any portion of the total premium attributable to an adjustment for a deficiency in a previous period.[2] The bill would state this provision again, as related to the calculation of average premium per car, by excluding

[2] For reference, member insurers are currently charged $170.00 per vehicle for the MCCA premium. This represents $143.33 to cover anticipated new claims, and $26.27 to address an existing deficiency. See "MCCA sets 2017 – 2018 Insurance Company Assessment." Available online at: http://michigancatastrophic.com/Portals/71/Final%20MCCA%20Assessment%20Press%20Release%20March%202017%20with%20Exhibits.pdf

those cars insured under a policy with a coverage limit from the calculation of the total written car years written by all members of the MCCA.

The bill would stipulate that if any member of the MCCA passed on any portion of the total premium to an insured, the amount passed on must equal the portion of the premium payable by the member attributable to the car (or historic vehicle) insured, including any adjustments for excesses or deficiencies from a previous period.

That is, an insurer could only pass on to the insured the portion of the MCCA premium attributable to that car. (Presumably, since MCCA members cannot be charged a premium for a car insured with a $250,000 or $500,000 coverage limit, and since they are only allowed to pass on to the insured the cost attributable to that insured's car, the new MCCA premium would be passed on only to insureds who selected the no-coverage-limit plan, *except* for adjustments or deficiencies from previous periods that could be passed on to all insureds.)

The bill would also require the MCCA, at least 60 days before a change in the total premium is effective, to provide the director with a report regarding the new premium amount, and giving justification for any adjustment.

Michigan Catastrophic Claims Association, Plan of Operation

The bill would require the MCCA to amend its plan of operation. It would add that the plan of operations must include "procedures for a rebate of a surplus to members of the association." This potential rebate would occur by an order of the director (see above), or as directed by the MCCA during any period in which the MCCA charges no premium because of excesses from previous periods. The MCCA could only direct such a rebate if it would not threaten the MCCA's ability to provide an effective reinsurance mechanism for PIP benefits based on sound actuarial principles consistent with the applicable statement of principles and the code of professional conduct adopted by the Casualty Actuarial Society. The procedures for a rebate would be required to include the distribution of a rebate to a historic vehicle.

The term "surplus" would be defined as any excesses from previous periods not required to cover the expected losses, expenses, or other liabilities of the MCCA. Surplus would not include any excesses from previous periods adjusted over 5 or more years.

The bill would revise language regarding the board of directors, and would eliminate two subsections of the MCCA statute that relate to the initial organizational meeting of the board and the initial approval of the plan of operation. Finally, as related to amendments to the plan of operation, the bill would specifically reference the above required adjustments for excesses or deficiencies, as well as the additional requirement for the plan of operation.

Finally, the bill would stipulate that after June 30, 2018, the MCCA does not have liability for an ultimate loss under PIP coverage for a motor vehicle accident policy if a coverage limit is in effect for the policy at the time of the ultimate loss. The effective date of PIP coverage would be the date that a motor vehicle accident policy is issued or renewed.

Attorney Fee Changes

Currently under the act, an attorney is "entitled to" a reasonable fee for representing a claimant in an action for overdue PIP benefits. Also under the act, an insurer may be awarded a sum

against a claimant for the insurer's attorney fees if the claim was "in some respect fraudulent or so excessive as to have no reasonable foundation." The bill would revise these provisions.

The bill would provide that an attorney "may be awarded" a reasonable fee, rather than "is entitled to." Additionally, an attorney would not be able to claim, file, or serve a lien for payment of a fee until the following conditions were met:

- A payment for the claim is authorized.
- A payment for the claim is overdue.
- The attorney notifies the resident agent of the insurer in writing that the payment is overdue.
- Within 30 days after the insurer receives the written notice, the insurer does not provide reasonable proof that the insurer is not responsible for the payment or take remedial action.

If an attorney claimed, filed, or enforced a lien in a manner prohibited by this new provision, an insurer or other person aggrieved by the lien would be entitled to court costs and attorney fees related to opposing the lien.

The bill would also add to the claims for which an insurer could be awarded attorney fees (and would retain the "in some respect fraudulent…" language). These would include:

- A claim for benefits for a treatment, product, service, rehabilitative occupational training, or accommodation that was not medically necessary or that was for an excessive amount.
- A claim for which the client was solicited by the attorney in violation of Michigan law or the Michigan rules of professional conduct.

The bill would make the following additional changes to provisions regarding attorney fees:

- If a dispute were related to payment for allowable expenses of attendant care or nursing services, attorney fees could only be awarded for related expenses for the 12 months preceding the date when the insurer is notified of the dispute. No attorney fees would be allowed to be awarded in relation to expenses paid after the date the insurer is notified of the dispute (even if future payments were ordered).
- A court would not be allowed to award an attorney fee for advising or representing a claimant for PIP benefits for treatment, services, training, or accommodation for the claimant if the attorney has (or had at time of treatment) a direct or indirect financial interest in the person who provided the treatment, services, training, or accommodation.
    - "Direct or indirect financial interest" would exist if the person that provided the treatment, services, training, or accommodation makes a direct or indirect payment or provides a financial incentive to the attorney or a related person of the attorney relating to the treatment within 24 months before or after the treatment is provided.

Tort Liability

Currently under the Code, a person is subject to tort liability for noneconomic loss caused by his or her ownership or use of a motor vehicle if the injured person has suffered death, "serious impairment of body function", or permanent serious disfigurement. "Serious impairment of

body function" is currently defined as an "objectively manifested impairment of an important body function that affects the person's general ability to lead his or her normal life."

The bill would state that whether an impairment is an "impairment of an important body function" is inherently subjective and must be decided on a case-by-case basis. Further, it would stipulate that the issue of whether an impairment affects an injured person's "general ability to lead his or her normal life" is a subjective, person- and fact-specific inquiry that must be decided on a case-by-case basis and requires a comparison of the injured person's life before and after the person's injury.

The bill would redefine "serious impairment of body function" to mean an impairment that satisfies all of the following:

- It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.
- It is an impairment of an important body function, which is a body function of great value, significance, or consequence to the injured person.
- It affects the injured person's general ability to lead a normal life, meaning it influences the injured person's power, skill, or capacity to live or pass life in his or her normal manner of living.

Enacting section 1 of the bill states that the above proposed amendments to the Code are "intended to codify and give full effect to the opinion of the Michigan supreme court in *McCormick v Carrier*, 487 Mich 180 (2010)."

Currently, tort liability arising from the ownership, maintenance, or use of a motor vehicle is abolished except as to (among other damages) "damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110 in excess of the daily, monthly, and 3-year limitations contained in those sections." The bill would remove "allowable expenses" from this provision.

Michigan Automobile Insurance Fraud Authority

The bill would make changes to the existing MAIPF, then create the MAIFA in a new chapter—Chapter 63—of the Insurance Code.

The changes to the existing MAIPF would be as follows:

- Require the board of governors to assess and collect from all participating members and self-insurers money based on participation ratios to cover costs of the MAIFA. The amount and duration of the assessment must be approved by at least 5 of the 7 elected governors.
- Require the board of governors to amend the plan of operation to account for this assessment and to carry out the administrative duties and functions of the MAIFA. This must be done prior to January 2, 2018.

As noted, the bill would create the MAIFA within the placement facility. The facility would be required to provide staff for the authority and carry out its administrative duties.

The MAIFA would be structured as follows:

- It is not a state agency, state authority, or political subdivision of Michigan. Money of the MAIFA is not state money. A record of the MAIFA is exempt from Michigan's Freedom of Information Act.
- Power and duties are vested in a 15-member board of directors, 8 who represent automobile insurers in Michigan, the director or designee, the director of the Michigan State Police (MSP) or designee, 2 who represent law enforcement, one who represents prosecuting attorneys, a resident of the state's largest city (Detroit), and one member of the general public.
- The board members representing automobile insurers are elected by the authorized automobile insurers in Michigan.
- The governor appoints the 2 members representing law enforcement, the member representing prosecuting attorneys, the member representing the state's largest city, and the member representing the general public.
- Members serve for 4 years or until a successor is elected or appointed, with staggered terms for the initial board. They serve without compensation, except for necessary travel and expense reimbursements.
- The board must elect a chairperson and meet at the call of the chair, or as provided in the bylaws of the authority. Meetings are open to the public and must be posted at least 10 days in advance, and minutes and other information regarding the authority's operation must be posted online. The board may meet in closed session for specific purposes.

The responsibilities of the MAIFA would be the following:

- Provide financial support to state or local law enforcement agencies, or to state or local prosecutorial agencies, for programs designed to reduce the incidence of automobile insurance fraud and theft.
- Approve and disapprove programs that seek to meet this goal.

The MAIFA would be able to provide financial support for an active fraud prevention program in the state's largest city (Detroit), and any joint fraud prevention task forces that include local, state, and federal agencies.

The board would have the following powers:

- To sue and be sued; solicit and accept gifts, grants, and loans; make grants and investments; procure insurance; invest any money held in reserve; contract for goods and services as necessary; and other acts that are not inconsistent with the plan of operation.
- To examine persons under oath, compel the testimony of witnesses and the production of any documents, and authorize subpoenas as related to automobile insurance fraud.

The MAIFA would be funded by the assessment imposed by the MAIPF (described above). This money could be expended by the MAIFA only as directed by the board.

The MAIFA would require data reporting regarding automobile insurance fraud from the authorized insurers, in a format and procedure adopted by the board. The MSP and local law enforcement agencies would be required to cooperate with the board and provide available motor vehicle fraud and theft statistics to the MAIFA. With this data, the board would be

required to create performance metrics and use the metrics to evaluate applications for funding considerations and to renew funding for existing programs.

Beginning January 1, 2019, the MAIFA would be required to publish an annual financial report, and beginning July 1, 2019, an annual report to the legislature on the efforts to prevent automobile insurance fraud and the cost savings that have resulted. The annual report would have to include details on the amount of automobile insurance fraud occurring and the impact of the fraud on automobile insurance rates. In creating the report, members of the board, insurers, and the director would be required to work together and share statistics needed to complete the report. The MAIFA would be required to evaluate the impact and costs of automobile insurance fraud on Michigan citizens. The MAIFA would then submit the report to the Senate and House Insurance Committees.

Insurance Fraud Changes

The bill would make amendments in Chapter 45 of the Code—Insurance Fraud—to account for the creation and operation of the MAIFA. The bill would add the MAIFA to a list of "authorized agencies" under the Chapter.

Currently, the chapter defines "fraudulent insurance act" as including, but not being limited to, a variety of acts or omissions committed by a person knowingly and with an intent to injure, defraud, or deceive.

The bill would make changes as to what constitutes a fraudulent insurance act to include when a person presents or assists in presenting, with knowledge that it will be presented to an insurer, false information concerning a fact that is material to various ratings, premiums, payments, financial conditions, issuances, or reinstatements of an insurance policy or reinsurance contract. A fraudulent insurance act would also occur when a person transacts insurance in violation of the laws requiring a license, certificate, or legal authority to transact insurance.

The bill would create a new section, section 4505, within Chapter 45. The section would allow the director to investigate fraudulent insurance acts and persons engaged in suspected acts. The Department of Attorney General would be required to provide DIFS with technical assistance, as requested by DIFS. The director would also be allowed to allocate resources of DIFS to prosecute alleged fraudulent acts.

The section would also require an insurer or agent who has knowledge of fraudulent acts to report the information to the director, in a form prescribed by the director. Similarly, any other person with knowledge of fraudulent acts would be able to provide the information to the director.

Finally, the section would provide that any DIFS investigations would not preempt the authority of any other authorized government entity to investigate illegal activity, and that any insurer or employee who provides DIFS with the information described above would be immune from civil or criminal liability for providing the information.

Additional Changes

The bill provides that within a 3-year window after being enacted into law, an insurance producer, including a producing agent, or an employee or agent of an insurance producer would

not be liable for damages caused by the conduct of the producer, employee, or agent as related to obtaining or providing information or the choice of PIP benefits by an insured.

The bill's title would be edited to eliminate references to the "state accident fund" and "nonprofit malpractice insurance fund", and to allow for the creation of "one or more authorities to reduce insurance fraud…"

New Definitions

The bill would create multiple new definitions within Chapter 31 of the Insurance Code (Motor Vehicle Personal and Property Protection). They are highlighted above, and defined below.

"Emergency medical condition" means the "term as defined in section 1395dd of the Social Security Act, 42 USC 1395dd, as determined and documented by a qualified health professional."[3]

"Related emergency care" means "a reasonably necessary in-patient treatment, product, service, or accommodation related to, immediately following, and necessitated by an emergency medical condition as determined and documented by a qualified medical professional."

"Qualified medical professional" means any of the following:

- A physician, as defined in the Public Health Code as "an individual who is licensed under [the Code] to engage in the practice of medicine" or "an individual who is licensed under [the Code] to engage in the practice of osteopathic medicine and surgery".
- A physician's assistant, licensed under Article 15 of the Public Health Code "under that health profession subfield of the practice of medicine or the practice of osteopathic medicine and surgery."
- A dentist, as defined in the Public Health Code as, "an individual licensed under [the Code] to engage in the practice of dentistry".
- An advanced practice registered nurse, defined in the Public Health Code as a registered professional nurse who has been granted a specialty certification under section 17210 in one of the following health profession specialty fields: nurse midwifery, nurse practitioner, clinical nurse specialist.

"Household" means "a house, an apartment, a mobile home, or any other structure or part of a structure intended for residential occupancy as separate living quarters."

"Related person" means "the spouse, a child, or a relative who is related to the person within the seventh degree of consanguinity, as computed by the civil law method."

"Ultimate loss" means "the actual loss amounts paid or payable by a member of the [MCCA]. Ultimate loss does not include claim expenses."

[3] See Section 1395dd, "Examination and treatment for emergency medical conditions and women in labor" in US Code. Online at: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1395dd%20edition:prelim)

DETAILED FISCAL IMPACT:

House Bill 5013 would reduce state revenues and create increased costs for Medicaid and public retirement systems along with other indeterminate state department costs. The bill also could create additional local law enforcement and court costs.

State Revenues:
Domestic and foreign insurers pay an insurance premiums tax under the corporate income tax, the base of which is 1.25% of gross direct premiums written in Michigan. Foreign insurers also pay a retaliatory assessment to the extent that the policies written would be more expensive in the state in which they're incorporated.

Because of the mandated decreases in PIP premium costs (depending on the level of coverage chosen), it is expected that auto insurance policy premiums will decline and therefore reduce revenue from the premiums tax paid by insurance companies. Unfortunately, there is no way to know in advance which levels of coverage will be chosen, and what the overall impacts will be on total auto insurance policy premiums paid. However, using revised information provided by the Department of Insurance and Financial services, HFA calculations estimate that total auto insurance policy premiums will decline by roughly 14%.

Based on this estimate, revenue from the insurance company premiums tax would decline by slightly more than $11 million, the entire impact of which would be borne by the state's General Fund.

Medicaid:
The state Medicaid program costs would increase to the extent that the bill would shift health care costs from private automobile insurers to Medicaid. Using information received from the Michigan Catastrophic Claims Association including the number and cost of claims paid annually by accident date, HFA's estimates indicate this bill would increase state costs by $500,000 in the first year and would steadily grow to approximately $80.0 million in annual state costs within 10 years. The annual cost growth would slow thereafter.

The primary Medicaid cost driver from the bill would be the added cost as more individuals receive Medicaid-funded long-term care services instead of private automobile insurance-funded long-term care services. Medicaid is a joint state/federal health care program where the federal government provides reimbursement funding for part of the total program cost. The current federal Medicaid match rate is 64.78%, meaning the state has to pay for 35.22% of the program's cost.

There are 3 primary benefits PIP covers that commercial health insurance does not: long-term nursing home services, home help (or attendant) services, and loss of income from injury. Medicaid, however, does cover long-term nursing home services and attendant care services, so this estimate assumes 100% of Medicaid beneficiaries would select a capped PIP limit. Therefore, a catastrophic injury to a Medicaid beneficiary would be covered by Medicaid after the limit is exhausted. The new state Medicaid costs for these acute health care costs would range from $500,000 GF/GP in the first year and would increase to $12.0 million GF/GP within 10 years.

The other, more significant, Medicaid cost from the bill would be the added costs to Medicaid long-term care services. Medicaid would be responsible for chronic nursing home and attendant care costs for both of the following: 1) Medicaid beneficiaries who selected a capped PIP limit and 2) individuals who selected a capped PIP limit and have both exhausted any long-term care benefits provided through commercial insurance or Medicare, and have spent down their financial resources to become Medicaid-eligible. These added, annual costs for long-term care services would not have an immediate impact to the state, but would increase to approximately $9.0 million GF/GP annually within 2 years and would increase to $68.0 million GF/GP within 10 years as the number of affected individuals grows. The percentage of non-Medicaid-eligible individuals who would select a capped PIP is unknown, so this estimate assumes a mid-point of 50%, meaning the actual impact may be greater or less than this estimate depending on the extent to which that population chooses a capped plan.

State and Local Retirement Plans

The bill would increase costs, by an unknown but likely minimal magnitude, for state and local retirement plans to the extent that retirees 62 or older choose a capped plan or opt out of PIP coverage altogether. There is not enough data available to estimate the potential impact. The shift would be related to medical benefits as the shift in long-term residential care costs would be accounted for in the Medicaid cost estimate above. The state's active and pension health plans are coordinated policies and are already primary in the case of an automobile accident for people up to age 65, and so would experience an increase related only to the portion of costs that would have been covered by MCCA for people ages 62-64. However, after age 65 when the state plans are coordinated with Medicare, auto insurance is primary. The bill's PIP opt-out provision could shift those costs related to medical care from PIP to the retirement system's health care benefits; however, Medicare would incur the majority of these costs. Currently state retirement system actuarial estimates assume that Medicare payments will offset between 67% and 75% of future retiree health liabilities.

Department of Insurance and Financial Services

HB 5013 would likely cause an increase in costs–of unknown magnitude–for DIFS. The department would experience additional costs for any additional staff required related to the following bill requirements: interpretation of statutory changes, actuarial examinations of the MCCA, promulgation of rules, review of reimbursement schedules for services provided during the treatment of insured persons, participation in contested cases, and other administrative responsibilities. Increased costs would most likely be borne by existing departmental resources. Generally, DIFS finances these types of expenditures with appropriations from several restricted funds which receive revenues generated from regulatory fees levied on individuals and entities within the insurance industry.

Department of Attorney General

The bill would have an indeterminate cost to the Department of the Attorney General. The cost would depend on whether the work load demand associated with providing assistance with investigating fraudulent insurance acts would require one or more additional investigators. This work load demand is not yet known. The cost of an additional FTE for an investigator is $110,000 a year.

Michigan State Police and Local Enforcement

HB 5013 would likely increase revenues, by an unknown amount, for the Department of State Police (MSP) and local law enforcement agencies. The bill would require the Michigan

Automobile Insurance Fraud Authority to "provide financial support to state or local law enforcement agencies" in order to mitigate automobile insurance fraud. Currently, the Auto Theft Prevention Authority (ATPA) housed within the auspices of the MSP provides grants to the MSP, local law enforcement agencies, prosecuting attorney's offices, and non-profit organizations from the Auto Theft Prevention Fund, to support auto theft prevention operations This fund is established by 1956 PA 218 and is funded by an annual assessment on automobile insurance companies at a rate of $1 per motor vehicle including private passenger and commercial motor vehicles. A total of $7.7 million is appropriated from the Auto Theft Prevention Fund in the FY 2017-18 ATPA budget.

The automobile fraud and theft statistics reporting requirement in this bill could create minor administrative costs for the MSP and local law enforcement agencies. However, the MSP and many local law enforcement agencies participate in the Federal Bureau of Investigation Uniform Crime Reporting program and likely already have much of these data readily available, and in many cases, published in on a publicly accessible website.[4]

Department of Corrections and State and Local Courts

For Corrections and Judiciary, HB 5013 would have an indeterminate fiscal impact on the state and on local units of government. Information is not available on the number of persons that might be convicted under provisions of the bill. New misdemeanor convictions would increase costs related to county jails and/or local misdemeanor probation supervision. Costs of local incarceration in a county jail and local misdemeanor probation supervision vary by jurisdiction. Any increase in penal fine revenues would increase funding for local libraries, which are the constitutionally designated recipients of those revenues. Also, the bill would have an indeterminate fiscal impact on the judiciary and local court funding units. The fiscal impact would depend on how provisions of the bill affected court caseloads and related administrative costs.

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

[4] For example, the MSP reports that there were 832 motor vehicle theft incidents and 107 motor vehicle fraud incidents in Wayne County, in 2016. www.micrstats.state.mi.us; accessed September 29, 2017.