Legislative Analysis

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NO-FAULT AUTOMOBILE INSURANCE REFORM

Senate Bill 1 as enrolled
Sponsor: Sen. Aric Nesbitt
House Committee: Select Committee on Reducing Car Insurance Rates
Senate Committee: Insurance and Banking
Complete to 5-29-19

SUMMARY:

Senate Bill 1 would amend the Insurance Code to make substantial changes to Michigan's no-fault automobile insurance system. Briefly, the bill would do the following:

- Create new personal injury protection (PIP) health benefit coverage level options for auto insurance plans, including a coverage limit of $50,000 for Medicaid enrollees; coverage limits of $250,000 and $500,000; an unlimited PIP option; and an option for individuals covered by Medicare to have no PIP health coverage.
- Allow an exclusion under the $250,000 PIP option for a person with other health or accident coverage to receive a reduction of 100% of the premium for PIP health benefits and be ineligible for any PIP benefits.
- Allow insurers to offer a managed care option for PIP benefits.
- Establish medical provider reimbursement limits for PIP health coverage benefits.
- Prohibit basing auto insurance rates on ZIP code, occupation, educational level, home ownership, or credit score.
- Mandate premium reductions based on PIP coverage levels.
- Increase required liability coverage limits.
- Require audits of the Michigan Catastrophic Claims Association (MCCA) every three years and require MCCA and insurers to make certain refunds.
- Codify the Anti-Fraud Unit created by Executive Order 2018-9.
- Increase fines for certain violations of the act.

Personal Injury Protection (PIP) Coverage Level Options

Beginning July 1, 2020, unlimited PIP health benefit coverage would no longer be mandatory in Michigan. A person obtaining or renewing auto insurance would have to select one of the following options for PIP health coverage for policies issued or renewed after July 1, 2020:

A. A PIP coverage limit of $50,000 for any PIP health benefits. To be eligible for this option, both of the following would have to apply:
   - The insured would have to be enrolled in Medicaid.
   - His or her spouse, and any relative living in the same household, would have to meet one of the following:
     - Be enrolled in Medicaid.
     - Have ***qualified health coverage*** (see below).
     - Have PIP health benefit coverage under another policy.

B. A PIP coverage limit of $250,000 for any PIP health benefits.
C. A PIP coverage limit of $500,000 for any PIP health benefits.
D. Unlimited PIP health benefit coverage.

The limits described above would be per person, per loss occurrence. The coverage level selected would apply to the insured, his or her spouse, and any relative living in the same household, as well as to any other person with a right to claim PIP benefits under the policies.

If a policy was issued or renewed without an indication of the desired level of coverage, but the applicant or insured paid a premium, the amount paid would be presumed to reflect the level of coverage desired. If no amount was paid, however, then option D above (unlimited PIP coverage) would be automatically applied.

For options A, B, and C above, insurers would have to offer a policy rider that would provide coverage for attendant care in excess of the applicable coverage limit. For option A, if benefits were payable under two or more insurance policies, the benefits would only be payable up to an aggregate limit equaling the highest available coverage under any one of the policies.

MCCA would not have liability for ultimate loss under policies with limited PIP coverage after July 1, 2020. It would have liability for 100% of ultimate loss for policies issued or renewed before July 2, 2020, and for policies issued under option D after that date. In calculating membership premiums, MCCA could only charge insurers for policies that continued to provide unlimited PIP coverage.

Special cases: The options above would apply for a transportation network company vehicle (e.g., one used by Uber or Lyft), but a transportation network company could select only option B, C, or D.[1] The options above would also apply to rental car companies certified as self-insurers under the act, which could allow customers to select option B, C, or D.

Option to Elect No PIP Coverage

After July 1, 2020, an individual could elect to not maintain coverage for PIP health benefits if the insured had Medicare coverage and if his or her spouse and any relative living in the same household either had ***qualified health coverage*** or had PIP health benefits under another policy. The applicant or insured would have to document required coverages when requesting issuance or renewal of the policy.

> ***Qualified health coverage*** would mean Medicare coverage or any other health or accident coverage that does not exclude or limit coverage for injuries related to motor vehicle accidents and that has a deductible of $6,000 or less per individual.
>
> ***Qualified person*** would mean a person with Medicare coverage. (Generally speaking, Medicare is available to people age 65 or older, younger people with disabilities, and people with permanent kidney failure.)[2]

The election to opt out would apply to the insured, his or her spouse, and any relative living in the same household, as well as to any other person who would have had a right to claim PIP benefits under the policy if the election had not been made.

[1] This provision would apply only to insurance purchased by a transportation network company, and not to insurance purchased by a transportation network company driver.

[2] See https://www.hhs.gov/answers/medicare-and-medicaid/who-is-elibible-for-medicare/index.html

If anyone required to have health coverage lost that coverage while a policy with an opt-out election was in effect, the insured would have 30 days to obtain insurance with PIP health benefit coverage. An insurer could not refuse to insure, limit coverage available to, charge a reinstatement fee to, or increase premiums for an ***eligible person***[3] solely because the person previously failed to obtain insurance providing PIP health benefits within 30 days. If the insured did not obtain PIP health coverage within 30 days and a person to whom the opt-out election applied was injured in a car accident, the injured person could claim benefits under the assigned claims plan (up to $2,000,000) but would not be entitled to PIP health benefits unless entitled to coverage under some other policy.

If a policy was issued or renewed as described above, and the applicant or named insured had not made an effective election to opt out of PIP coverage, then the policy would be considered to provide PIP benefits under option D (unlimited PIP coverage).

Health or Accident Coverage Exclusion

If a person selected option B ($250,000 PIP health benefit coverage limit), the insurer would have to offer an exclusion related to other health or accident coverage. All of the following would apply to the exclusion:

- If the insured, his or her spouse, and any relative living in the same household had health or accident coverage for injuries occurring as a result of a car accident, the premium for PIP health benefits payable under the policy would have to be reduced by 100%.
- If a member of the household covered by the policy had health or accident coverage for injuries occurring as a result of a car accident, but not all members of the household had that coverage, the insurer would have to offer a reduced premium reflecting reasonable anticipated reductions in losses or expenses. The share of the reduction attributable to any person with health or accident coverage would have to be 100%.
- A person subject to the exclusion would not be eligible for any PIP benefits under the policy.[4]

The amount of any premium reduction described above would have to be conspicuously displayed as a dollar amount or percentage on the policy declarations page.

If a person subject to an exclusion no longer had his or her required health or accident coverage, the insured would have to notify the insurer and would have 30 days to obtain insurance with PIP health benefit coverage. If the excluded person were injured in a car accident during that 30-day period, he or she would be entitled to claim benefits under the assigned claims plan (up to $2,000,000). If the insured did not obtain PIP health coverage within 30 days and the insured or any excluded person was injured in a car accident,[5] the injured person would not be entitled to PIP health benefits for an injury during the period of the exclusion unless entitled to coverage under some other policy. An insurer could not refuse to insure, limit coverage available to, charge a reinstatement fee to, or increase premiums for an eligible person solely because the person previously failed to obtain insurance providing PIP health benefits within 30 days.

[3] ***Eligible person*** is defined in section 2103 of the Insurance Code: http://legislature.mi.gov/doc.aspx?mcl-500-2103

[4] The premium reduction would be only for health-related PIP benefits (i.e., not a reduction of any premium for PIP benefits for work loss or replacement services), but the person to whom the exclusion applied would be ineligible for all PIP benefits (i.e., including work loss and replacement services).

[5] This would appear to apply to the insured regardless of whether the exclusion did.

Required Liability Coverage

The bill would increase the amount of liability coverage generally required, as follows:

- Increase from $20,000 to $250,000 the amount of liability coverage required for the injury or death of one person in any one accident.
- Increase from $40,000 to $500,000 the amount of liability coverage required for the injury or death of two or more people in any one accident.

However, a person could elect to purchase a policy with lower limits than those required above—but not less than $50,000 for the injury or death of one person or $100,000 for the injury or death of two or more people. Upon application for a policy, an insurer would have to provide the applicant with the liability options described above, giving a price for each option, and offer him or her a form for selecting an option. If a policy was issued or renewed without an effective election to purchase a lower limit of liability coverage, the $250,000 and $500,000 limits would apply to the policy.

Managed Care Option

The bill would add Chapter 31A to the Insurance Code to allow an automobile insurer to offer a ***managed care option*** to provide 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.

> ***Managed care option*** would mean an optional coverage elected by the insured at the time the policy is issued that includes at least the monitoring and adjudication of an injured person's care, the use of a preferred provider program or other network, or another similar option.

All of the following would apply to a managed care option:

- It would have to be uniformly offered in all areas where it is available.
- It would have to provide a discount based on expected reductions in losses or expenses.
- It would have to apply to the insured and any person claiming PIP benefits under the policy who lives in an area where the managed care option is available.
- It could provide for deductibles and/or co-pays.
- It could not apply to ***emergency care***.

> ***Emergency care*** would include at least the care necessary to bring a patient to the point where he or she can be physically transferred without its being likely that his or her condition will get materially worse during or because of the transfer.

A managed care option would have to provide for all of the following:

- That PIP benefits are primary and will not be coordinated with any other health or accident coverage on the individual claiming the managed care PIP benefits.
- That PIP benefits must be exhausted by the individual claiming those benefits before that individual may seek benefits from another health or accident coverage provider.
- That deductibles, co-pays, or similar sanctions will not be assessed or collected from other health or accident coverage providers for the individual claiming the managed care PIP benefits.

An insurer would have to get a signed acknowledgment from a person selecting the managed care option that he or she received either a written disclosure statement approved by the director of the Department of Insurance and Financial Services (DIFS) or a written disclosure statement that included all of the following:

- A summary of the managed care option's provisions.
- The estimated discount provided by the option, expressed as a percentage range.
- A general description of the differences between the managed care option and other PIP benefits, including procedural differences in seeking treatment and filing a claim.
- The consequences for violating any of the managed care option's provisions, including the possibility of having a claim denied, the payment of a deductible, and any additional out-of-pocket expenses that could be incurred.
- An explanation of whether the insurer offers a provision that would allow the insured to change from a managed care option to other PIP benefits, and any restrictions placed on the insured with regard to doing so.

The disclosure statement would also have to include a mailing address, and either a phone number or website address, for obtaining information on the managed care option.

Rates and Plan Filings

The Insurance Code currently prohibits insurers from establishing or maintaining rates or rating classifications for auto insurance based on sex or marital status. Beginning July 1, 2020, the bill would additionally prohibit insurers from setting rates or rating classifications based on the following:

- Home ownership
- Educational level attained
- Occupation
- The ZIP code in which the insured resides
- ***Credit score***

Credit score would mean the numerical score ranging from 300 to 850 assigned by a consumer reporting agency to measure credit risk and would include a FICO credit score.[6]

Further, a filing would have to specify that the insurer will not refuse to insure, refuse to continue to insure, or limit the amount of coverage available based on the location of the risk, a practice known as redlining. The bill would prohibit insurers from engaging in redlining.

The bill would require auto insurance manuals or plans filed with the director of DIFS to remain on file for a waiting period of 90 days before becoming effective. The director could not extend this waiting period, and the period would apply regardless of whether the director required supporting information from the insurer. However, upon written application by the insurer, the director could authorize a reviewed filing to become effective before the end of the period.

[6] The bill would allow an insurer to use any other measure of credit risk or a credit score that is not written on a scale ranging from 300 to 850.

Mandated Premium Rate Reductions

The bill would require auto insurers to file, before July 1, 2020, premium rates for PIP coverage for policies effective after July 1, 2020. The rates filed—and any subsequent rates filed by the insurer for policies effective before July 1, 2028—would have to result in the following minimum average reductions per vehicle from the premium rates for PIP coverage that were in effect for the insurer on May 1, 2019:

- 45% for policies with a $50,000 PIP health benefit coverage limit (option A).
- 35% for policies with a $250,000 PIP health benefit coverage limit (option B).
- 20% for policies with a $500,000 PIP health benefit coverage limit (option C).
- 10% for policies with unlimited PIP health benefit coverage (option D).

For policies for which an election was made to not maintain PIP health benefit coverage or to which a health or accident coverage exclusion applied, the premium rates would have to result in no premium charge for PIP health benefit coverage.

The director of DIFS would have to review the filings for compliance with the above provisions and disapprove a filing that did not result in the required premium reductions. Within 15 days after a disapproval, the insurer would have to submit a revised premium rate filing, which would be subject to the same review.

Insurers could apply to the director for an exemption from the mandated reductions or for approval to file higher rates, and the director would have to approve the application, if the rates otherwise complied with the act and if complying with the mandated reductions would result in any of the following:

- The insurer reaching the company action level risk-based capital (meaning that the mandated reductions result in rates that are lower than the minimum rates an insurer can offer while remaining in business).[7]
- A violation of the insurer's Fourteenth Amendment rights. (This would not apply after July 1, 2023.)
- A violation of section 17 of Article I of the State Constitution regarding the deprivation of property without due process. (This would not apply after July 1, 2023.)

In these filings, insurers would have to pass on savings realized from the application of the provider reimbursement limits for medical treatment given to individuals who were injured in a car accident occurring before the effective date of the bill. After July 1, 2022, the director of DIFS would have to review all applicable rate filings for compliance with this provision. An insurer would have to provide the director with any information necessary to evaluate compliance.

After July 1, 2020, and before July 1, 2028, an insurer could not issue or renew an auto insurance policy in Michigan unless the premium rates filed by the insurer for PIP coverage were approved as described above. For policies issued or renewed in the year beginning July 1, 2024, and in the year beginning July 1, 2026, automobile insurers would have to make filings to demonstrate compliance with the above provisions.

[7] Specifically under the bill, ***company action level risk based capital*** would mean two times the number determined under the risk-based capital formula in accordance with the report of the insurer's risk-based capital levels as required by the annual statement instructions, including risk-based capital instructions adopted by the National Association of Insurance Commissioners and the director of DIFS.

For the purpose of calculating premium rates under the above provisions, the premium would include the catastrophic claims assessment. The above provisions would not prohibit an insurer from increasing any individual insurance policy premium using approved rating factors.

Provider Reimbursement Limits

The bill would establish reimbursement limits for treatment (including products, services, accommodations, and rehabilitative occupational training) provided to an injured person for an injury covered by PIP.

> [Note: In the descriptions below, the percentage of "the amount the provider charged for the treatment on January 1, 2019" would apply only if Medicare does not have an amount payable for the treatment in question, and "the amount the provider charged for the treatment on January 1, 2019" refers to the amount payable for the treatment on the provider's ***charge description master***[8] on that date or, if the provider did not have a charge description master, to the average amount that the provider charged for the treatment on that date. These 2019 amounts would be adjusted annually for inflation based on the medical care component of the Consumer Price Index for Michigan for the year preceding the adjustment.]

Under the bill, unless the medical provider qualified for higher reimbursements as described below, a medical provider that rendered treatment to an injured person for an injury covered by PIP would be eligible for reimbursement for up to the following:

- For treatment rendered after July 1, 2021, and before July 2, 2022:
  - 200% of the amount payable for the treatment under Medicare.
  - 55% of the amount the provider charged for the treatment on January 1, 2019.
- For treatment rendered after July 1, 2022, and before July 2, 2023:
  - 195% of the amount payable for the treatment under Medicare.
  - 54% of the amount the provider charged for the treatment on January 1, 2019.
- For treatment rendered after July 1, 2023:
  - 190% of the amount payable for the treatment under Medicare.
  - 52.5% of the amount the provider charged for the treatment on January 1, 2019.

A ***freestanding rehabilitation facility***[9] or a medical provider that had 20% but less than 30% ***indigent volume***[10] on July 1 of the year the treatment was rendered would be eligible for reimbursement for up to the following:

- For treatment rendered after July 1, 2021, and before July 2, 2022:
  - 230% of the amount payable for the treatment under Medicare.
  - 70% of the amount the provider charged for the treatment on January 1, 2019.

[8] ***Charge description master*** would mean a uniform schedule of charges represented by the provider as its gross billed charge for a given service or item, regardless of payer type.

[9] ***Freestanding rehabilitation facility*** would mean an acute care hospital that serves the rehabilitation needs of catastrophically injured patients in Michigan and meets other requirements detailed in the bill. Each year the director of DIFS would designate up to two facilities to qualify for payments under this provision for that year.

[10] ***Indigent volume*** would be determined using the methodology used by the Department of Health and Human Services in determining inpatient medical/surgical factors used in measuring eligibility for Medicaid disproportionate share payments. The director of DIFS would determine and certify which providers qualify using this measure and provide a list of qualifying providers to insurers.

- For treatment rendered after July 1, 2022, and before July 2, 2023:
  - 225% of the amount payable for the treatment under Medicare.
  - 68% of the amount the provider charged for the treatment on January 1, 2019.
- For treatment rendered after July 1, 2023:
  - 220% of the amount payable for the treatment under Medicare.
  - 66.5% of the amount the provider charged for the treatment on January 1, 2019.

A medical provider that had 30% or more ***indigent volume*** on July 1 of the year the treatment was rendered would be eligible for reimbursement of 250% of the amount payable for the treatment under Medicare or 78% of the amount the provider charged for the treatment on January 1, 2019.

A hospital that is a ***Level I or Level II trauma center***[11] that rendered treatment for an emergency medical condition before the patient was stabilized and transferred[12] would be eligible for reimbursement for up to the following:

- For treatment rendered after July 1, 2021, and before July 2, 2022:
  - 240% of the amount payable for the treatment under Medicare.
  - 75% of the amount the provider charged for the treatment on January 1, 2019.
- For treatment rendered after July 1, 2022, and before July 2, 2023:
  - 235% of the amount payable for the treatment under Medicare.
  - 73% of the amount the provider charged for the treatment on January 1, 2019.
- For treatment rendered after July 1, 2023:
  - 230% of the amount payable for the treatment under Medicare.
  - 71% of the amount the provider charged for the treatment on January 1, 2019.

A ***neurological rehabilitation clinic*** (a person that provides post-acute brain and spinal rehabilitation care) would not be entitled to payment or reimbursement for services rendered unless the clinic were accredited by the Commission on Accreditation of Rehabilitation Facilities or a similar organization recognized by the director of DIFS. This restriction would not apply to a clinic that was in the process of becoming accredited on July 1, 2021, unless the clinic still was not accredited three years or more after beginning the accreditation process.

Reimbursement for attendant care rendered in an injured person's home by his or her relative or housemate or a person with whom he or she had a social or business relationship would be limited to 56 hours per week. However, an insurer could contract to pay benefits for attendant care for more than the 56-hour limitation.

The above limitations would not apply to emergency medical services (EMS) rendered by an ambulance operation as defined in the Public Health Code.

[11] As verified by the American College of Surgeons Committee on Trauma.

[12] For applicable definitions of ***emergency medical condition***, ***stabilized***, and ***transferred***, see section 1395dd of the Social Welfare Act: https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partE-sec1395dd.pdf

Utilization Review

A medical provider providing treatment for an injury covered by PIP after July 1, 2020, would be considered to have agreed to submit necessary records and other information concerning the treatment for ***utilization review*** and to comply with any decision by DIFS. Any submitted proprietary information or sensitive personally identifying information regarding a patient would be exempt from disclosure under the Freedom of Information Act (FOIA).

> ***Utilization review*** would mean the initial evaluation by an insurer or MCCA of the appropriateness, based on medically accepted standards, of the level and the quality of treatment, products, services, or accommodations provided under PIP.

An insurer or MCCA could require a provider to explain the necessity or indication for treatment that is not usually associated with the condition for which the patient is being treated or that has a greater frequency or duration than usually required. A provider could appeal to DIFS if an insurer or MCCA determined that the provider improperly overutilized or otherwise rendered a treatment that was inappropriate or inappropriately expensive.

DIFS would have to promulgate rules to do the following:

- Establish criteria or standards for utilization review that identify, based on medically accepted standards, utilization of care under PIP above the usual range of utilization for that care.
- Provide utilization review procedures, including procedures for all of the following:
    - Acquiring necessary and relevant records, medical bills, and other information.
    - Allowing an insurer to request an explanation for treatment provided, and requiring a provider to explain the necessity or indication for that treatment.
    - Appealing determinations.

A medical provider that knowingly submitted false or misleading records or information to an insurer, MCCA, or DIFS would be committing a fraudulent insurance act under section 4503 of the Insurance Code, which is a felony punishable by imprisonment for up to four years or a fine of up to $50,000, or both.

PIP Claim Priority

The Insurance Code currently indicates the order of priority for which insurers must pay benefits to an individual who suffers accidental bodily harm in a motor vehicle accident. The bill would specify that, if PIP benefits were payable under two or more insurance policies in the same order of priority, then the benefits would only be payable up to an aggregate limit equaling the highest available coverage under any one of the policies. Holders of policies with no PIP coverage could claim benefits only under other policies in the same order of priority allowed for those with policies that do contain PIP coverage or, if the chain of priority was exhausted, under the assigned claims plan.

Tort Liability and Other Actions

The bill would modify the grounds on which a nonresident may pursue tort liability in the case of an accident. The nonresident would now need to have suffered death, serious impairment of body function, or permanent serious disfigurement to recover damages for economic loss.

The bill would increase, from $1,000 to $3,000, the amount that can be recovered in an action for damages to a motor vehicle that are not covered by insurance.

Currently, PIP benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained. SB 1 would also provide that if a bill was not provided to the insurer within 90 days after the treatment was rendered, the insurer would have 60 days in addition to the 30 days described above before the benefits would be overdue. A health care provider could make a claim and assert a direct cause of action against an insurer or under the assigned claims plan to recover overdue benefits payable for treatment provided after the effective date of the bill to an injured person.

Currently, a legal action to recover PIP benefits must be taken within one year after the accident took place unless notice of the injury was given to the insurer within one year after the accident or the insurer made a payment of PIP benefits for the injury. If notice was given or payment was made, the action may be commenced within one year after the most recent loss covered by PIP benefits was incurred, except that a claimant cannot recover benefits for loss incurred more than one year before the date of the action. Under the bill, the latter one-year period would be tolled from the date of a specific claim for payment of benefits until the date the insurer formally denied the claim. However, the tolling of the time period would not apply if the claimant failed to pursue his or her claim with reasonable diligence.

An attorney advising or representing an injured person concerning PIP benefits could not claim, file, or serve a lien for payment of any fees for his or her services unless a payment for the claim was both authorized under the act and overdue under the act.

Currently, the court may award an insurer a reasonable amount against a claimant as an attorney fee for the insurer's attorney in defending against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation. The bill would also allow such an award in defending against a claim for which the client was solicited by the attorney in violation of state law or the Michigan Rules of Professional Conduct.

In a dispute over the payment of allowable expenses for attendant care or nursing services, attorney fees could not be awarded in relation to future payments ordered more than three years after the trial court judgment or order was entered. If attendant care or nursing services were subsequently suspended or terminated, attorney fees on future payments could be again awarded for not more than three years after a new trial court judgment or order is entered.

A court could not award fees to an attorney representing or advising an injured person in an action concerning PIP benefits if the attorney or a person related to the attorney had a direct or indirect financial interest in the provider of the treatment the PIP benefits would have paid for. (This would include a payment or financial incentive from the treatment provider to the attorney or attorney's relative within two years before, or two years after, the treatment.)

Currently, if the mental or physical condition of an individual is material to a claim for PIP benefits, he or she must be examined by physicians. Under the bill, the individual would have to do so only at the request of an insurer. The bill would add that a physician conducting a mental or physical examination must be licensed in Michigan or another state and must meet the following criteria, as applicable:

- He or she must be a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the person's condition.
- During the year preceding the examination, he or she must have devoted a majority of his or her professional time to either or both of the following:
    - The active clinical practice of medicine and, if applicable, the active clinical practice relative to the relevant specialty.
    - The instruction of students in an accredited medical school or residency or clinical research program and, if applicable, the instruction of students in the relevant specialty.

Assigned Claims Plan

The Michigan Automobile Insurance Placement Facility (MAIPF) currently makes an initial determination of PIP claimants' eligibility for benefits under the assigned claims plan and denies obviously ineligible claims with a written notice of the denial and the reasoning behind it.

The bill would require a person entitled to claim PIP benefits to file a completed application on a claim form provided by MAIPF and provide reasonable proof of loss. MAIPF or an insurer assigned to administer a claim on its behalf would have to specify in writing what materials constitute a reasonable proof of loss within 60 days after MAIPF's receipt of the application. MAIPF or the insurer acting on its behalf would not have to pay an interest penalty in connection with a claim for any period of time during which the claim was reasonably in dispute. MAIPF and the insurer would only be required to provide PIP benefits up to a limit of $250,000 or, for a person entitled to claim benefits under the assigned claims plan as described above in **Option to Elect No PIP Coverage** and **Health or Accident Coverage Exclusion**, $2,000,000.

The bill would also require a claimant or person acting on the claimant's behalf to cooperate with MAIPF in determining the claim's eligibility and the settlement or defense of any claim or suit, including submitting to examination under oath and any mental or physical examinations required under the act. A person would be rebuttably presumed to have cooperated if the person did all of the following:

- Submitted a PIP claim under the assigned claims plan on a complete MAIPF application form in accordance with the plan.
- Provided reasonable proof of loss under the plan.
- Submitted to any required examination under oath. (The bill would require that the person be given at least 21 days' notice of an examination and that the examination be held in a place reasonably convenient for the person, with accommodation for any reasonable request to reschedule its date, time, or place.)

MAIPF would have to suspend benefits to a claimant under the assigned claims plan if the claimant or person making a claim on the claimant's behalf failed to cooperate with MAIPF as

described above. The suspension would not be a denial of benefits and would last only as long as the claimant's noncooperation.

MAIPF could perform its functions and duties directly or through an insurer assigned by MAIPF to administer a claim on its behalf. Assignment of a claim to an insurer would not be a determination of eligibility, and an assigned claim could be later denied if found to be ineligible. An insurer assigned a claim, or another person authorized to act on behalf of the assigned claims plan, could bring an action on behalf of MAIPF for reimbursement and indemnification of the claim. MAIPF could also contract with other persons for all or a portion of the goods and services necessary for operating and maintaining the assigned claims plan.

Currently, an action to enforce rights to indemnity or reimbursement against a third party cannot be commenced more than the later of two years after the assignment of the claim to the insurer or one year after the date of the last payment to the claimant. The bill would additionally allow commencement of a claim within one year after the date the responsible third party was identified.

The bill would also allow MAIPF to make a written agreement with the owner or registrant of an uninsured vehicle, or his or her estate, permitting payment in installments of a judgment for costs related to an accident involving that vehicle. (Under current law an installment agreement would be made with the Secretary of State.) The owner or registrant or his or her estate would be responsible for any expenses or fees for the suspension, revocation, or reinstatement of a motor vehicle registration or license.

The Secretary of State would have to provide information on auto insurance policies issued in this state—including the name of the insured and the insurer, the insured's address, the vehicle identification number for each vehicle listed on the policy, and the policy number—to MAIPF as required for MAIPF to comply with the act. This information would not be subject to FOIA. MAIPF could use the information only to administer the assigned claims plan and could not disclose the information to any person, except to administer the plan or to comply with a court order in connection with a fraud investigation or prosecution.

Michigan Catastrophic Claims Association (MCCA) Audits and Refunds

Beginning July 1, 2022, and every three years afterward, the director of DIFS would have to engage one or more independent actuaries to audit MCCA for the previous three years, using actuarial principles consistent with those of the Casualty Actuarial Society. By September 1, 2022, and every three years afterward, the director would have to provide a report of the audit to the legislature. MCCA would be required to provide any records necessary or requested by the director for the audit.

If the audit showed that the assets of MCCA exceeded 120% of its liabilities, the director would have to order MCCA to refund the excess to its members as long as doing so would not threaten MCCA's ongoing ability to provide reimbursements for PIP benefits. MCCA could file a request for a hearing to review the order within 30 days after receiving it. Insurers would have to pass the refund along to their insured customers in a manner and time determined by the director. (Any refund attributable to a historic vehicle would be equal to 20% of the refund for an ordinary car.)

By September 1 of each year, MCCA would have to submit an annual consumer statement to the House and Senate committees with jurisdiction over insurance matters and post the statement on the MCCA website. The statement would have to be written for the general public and contain information, detailed in the bill, concerning such things as the MCCA's assets, liabilities, claims history, revenue projections, mortality assumptions, and cost-containment measures. MCCA would also have to provide to the House and Senate committees with jurisdiction over insurance matters an annual report containing all of the following:

- An executive summary.
- A discussion of the mortality assumptions used by MCCA in making cost projections.
- An evaluation of the accuracy of MCCA's actuarial assumptions over the preceding five years.
- The annual consumer statement.
- Anything else MCCA determined necessary to advise the legislature about its operations.

Anti-Fraud Unit

The bill would add Chapter 63 to the Insurance Code, which largely codifies in statute Executive Order No. 2018-9,[13] which created an Anti-Fraud Unit in DIFS.

The Anti-Fraud Unit has full access to criminal justice information and criminal justice information systems. The unit investigates persons subject to the regulatory authority of DIFS, consumers, insureds, and anyone else allegedly engaged in criminal and fraudulent activities in the insurance market, and it can investigate criminal and fraudulent activity related to any matter under the jurisdiction and authority of DIFS.

The Anti-Fraud Unit can do any of the following:

- Conduct criminal background checks on license applicants and current licensees.
- Collect and maintain claims of criminal and fraudulent activity in the insurance industry.
- Investigate claims of criminal or criminally fraudulent activity in the insurance market.
- Maintain records of criminal investigations.
- Share records of its investigations with other criminal justice agencies.
- Review information from other criminal justice agencies to assist in its enforcement and investigation activities.
- Conduct outreach and coordination efforts with law enforcement and regulatory agencies at all levels of government to promote investigation and prosecution of insurance crimes and insurance fraud.

Under the bill, material (e.g., documents or information) related to an Anti-Fraud Unit investigation would be confidential and would not be subject to FOIA, subject to subpoena, or subject to discovery or admissible in any private civil action. The director of DIFS, or any person who received confidential material while acting on behalf of the unit, could not testify in any private civil action concerning the material. The director could use the material in any supervisory activity or a legal action brought as part of his or her duties. The director could also share material with, and receive it from, other state, federal, and international regulatory and law enforcement agencies, or any other person the director considered necessary. The

[13] https://www.michigan.gov/documents/snyder/EO_2018-9_632697_7.pdf

director would have to maintain as confidential any confidential material received, and the sharing of confidential material would not waive the claim of confidentiality in that material.

Beginning July 1 of the year after the bill's effective date, the unit would have to prepare and publish an annual report on its efforts to prevent automobile insurance fraud. The report would be submitted to the director of DIFS and the House and Senate committees with jurisdiction over insurance matters.

Department of Insurance and Financial Services (DIFS) Website and Report

DIFS would have to maintain on its website a page that does all of the following:

- Informs a visitor that it may be able to assist a person who believes that an auto insurer is not performing as obligated by an insurance policy, such as not paying benefits or not making timely payments.
- Advises the person of rights under the Insurance Code that relate to auto insurers and the payment of insurance benefits.
- Allows the person to submit a ticket informing DIFS of his or her problems with an auto insurer.
- Allows the person to submit—electronically or on paper—any documentation to support the facts of his or her case.
- Explains the steps that DIFS will take and that may be taken after the person submits a ticket.

DIFS would also have to maintain a page advising consumers about the changes made to Michigan auto insurance by Senate Bill 1, including how to shop for insurance, as well as a page allowing people to report insurance fraud and unfair settlement and claims practices.

By December 31, 2022, and annually thereafter through December 31, 2030, DIFS would have to review the effect of the health care provider reimbursement changes made by Senate Bill 1 and provide a report of its findings to the legislature.

Regulatory Fee Revenue

Currently, at least 67% of the revenue derived from the regulatory fee collected from insurers under section 224 of the Insurance Code must be used to regulate the financial conduct of persons subject to the regulatory authority of the DIFS director and to regulate persons subject to that authority that are engaged in the business of health care and health insurance. The bill would amend this to provide that at least 55% of that revenue may be used for those purposes.[14]

[14] This change would eliminate the requirement that any specific amount be used for the specified purposes. As amended, nothing in the provision would prevent more than 55% of the revenue from being spent for those purposes, and nothing would prevent less than 55% from being spent for them.

Civil Fines and Monetary Penalties

The bill would double the amount of fines and monetary penalties that can be ordered under the following sections of the Insurance Code:

- Section 150, concerning violations of the act for which no other penalty is specified:
  - Civil fine of up to $1,000 per violation (currently up to $500).
  - Civil fine of up to $5,000 per violation committed knowingly (currently up to $2,500).
  - Total limit of $50,000 in civil fines per each order of the DIFS director (currently $25,000).
  - Civil fine of $20,000 for each knowing violation of a cease and desist order (currently $10,000).

- Section 1244, concerning violations of Chapter 12 of the Insurance Code:
  - Civil fine of up to $1,000 per violation (currently up to $500).
  - Civil fine of up to $5,000 per violation committed knowingly (currently up to $2,500).
  - Total limit of $50,000 in civil fines per each order of the DIFS director (currently $25,000).
  - Civil fine of up to $20,000 for each knowing violation of a cease and desist order (currently up to $10,000), up to a total limit of $100,000 (currently $50,000) per each order of the DIFS director.

- Section 2038, concerning prohibited methods of competition or unfair or deceptive acts or practices:
  - Monetary penalty of up to $1,000 for each violation (currently up to $500), to a total limit of $10,000 (currently $5,000).
  - Monetary penalty of up to $5,000 for each knowing violation (currently up to $2,500), to a total limit of $50,000 for all violations committed in a six-month period (currently $25,000).

- Section 2040, concerning violation of a cease and desist order regarding a prohibited method of competition or unfair or deceptive act or practice:
  - Monetary penalty of up to $20,000 per violation (currently up to $10,000).

- Section 2069, concerning misrepresentation of the terms of a policy, its benefits, or its future dividends:
  - Fine of up to $2,000 per violation (currently up to $1,000).

Sections 150 and 1244 currently allow the director of DIFS to apply to the Ingham County circuit court for an order enjoining a violation of the act. The bill would change this to the Court of Claims.

Coverage Selection/Election Forms

The director of DIFS would have to approve forms for selecting a PIP health benefit coverage level or electing to not maintain PIP coverage and would have to issue forms for indicating a liability coverage choice. Generally speaking, each form would have to include a conspicuous statement of the benefits and risks associated with the applicable coverage options and provide a way for the person to indicate that he or she has read the form and understands those options and risks, a way to indicate his or her selection, and either a requirement that he or she sign the

form or a way for him or her to do so. The form for a ***qualified person*** to elect to not maintain PIP coverage would also require that the applicant or insured certify the qualified person status of everyone required to be a qualified person and include a description of what happens if qualified health coverage ceases during the term of the policy.

A form could be delivered to an applicant or policyholder electronically, by personal delivery, or by first-class mail, postage prepaid. A person could make his or her selection or election electronically, on paper, or by giving verbal instructions that the form be marked and signed in the person's behalf. To be effective, verbal instructions would have to be recorded, and the recording maintained, by the person to whom they were given. In a dispute over a selection or election made verbally, the insurer would have the burden of rebutting with the recording a presumption that the selection or election was not effective. Failure of an insurer to comply with provisions described in this paragraph would be an unfair method of competition and an unfair or deceptive act or practice in the business of insurance.

Miscellaneous Provisions

Beginning July 1, 2020, with respect to applications made before January 1, 2022, an insurer could not refuse to insure or continue to insure, limit available coverage, charge a reinstatement fee for, or increase the auto insurance premiums of an eligible person applying for auto insurance solely because the person previously failed to maintain auto insurance for a vehicle the person owned.

The bill would require a person who suffered accidental bodily injury while not an occupant of a motor vehicle (e.g., a pedestrian) to claim PIP benefits under the assigned claims plan rather than from the insurers of owners or operators of motor vehicles involved in the accident.

The bill would modify the definition of ***serious impairment of body function*** as used in section 3135 of the Insurance Code with the expressed intent of codifying and giving full effect to the opinion of the Michigan Supreme Court in *McCormick v Carrier*, 487 Mich 180 (2010).[15]

Nonseverability

Finally, the bill stipulates that if the rate reductions described in the first paragraph of **Mandated Premium Rate Reductions**, above, or their application to any insurer, were found by a court to be invalid, the "remaining portions" of Senate Bill 1 would not be severable and would "be deemed invalid and inoperable."

MCL 500.150 et seq.

[15] http://publicdocs.courts.mi.gov/OPINIONS/FINAL/SCT/20100731_S136738_79_mccormick-op.pdf

FISCAL INFORMATION:

State Revenues

Domestic (in-state) and foreign (out-of-state) 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 are 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, therefore reducing 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 by drivers and what the overall impacts will be on total auto insurance policy premiums paid. However, using information provided by DIFS, HFA calculations suggest that total PIP premiums could decline by as much as 50% and total auto insurance policy premiums would decline by roughly 23%.

Based on this estimate, revenue from the insurance company premiums tax would decline by about $15.0 million to $20.0 million, the entire impact of which would be borne by the state's general fund. To the extent that the number of drivers opting for reduced PIP coverage increased, the revenue decline would grow larger. At the upper bound, if all drivers opted out of PIP coverage, the revenue loss would likely exceed $35.0 million.

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. HFA's estimates indicate that this bill would increase state costs by $2.5 million in the first year and would steadily grow to approximately $72.0 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 64.45%, meaning the state has to pay for 35.55% of the program's cost.

There are three 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 that 75% of Medicaid beneficiaries would select a capped PIP limit under the bill. Therefore, a moderate to 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 $2.5 million GF/GP in the first year and would increase to $14.0 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 and home- and community-based 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 either a capped PIP limit or no PIP coverage 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 on the state, but would increase to approximately $8.0 million GF/GP annually within two years and would increase to $58.0 million GF/GP within 10 years as the number of affected individuals grew. The percentage of non-Medicaid-eligible individuals who would select a capped PIP, or no PIP, is unknown, so this estimate assumes a mid-point of 50%, meaning that the actual impact may be greater or less than this estimate, depending on the extent to which that population chooses a capped plan.

Department of Insurance and Financial Services (DIFS)

Senate Bill 1 would have significant fiscal implications for DIFS, including cost increases of indeterminate magnitude. The net fiscal impact is presently indeterminate, as it is unclear whether costs for implementing the bill's provisions would be sufficiently offset by existing revenues and staff and present departmental appropriations.

The bill would lower a statutory floor for how much revenue collected from assessments deposited to the Insurance Bureau Fund may be used for regulation of financial conduct of persons regulated under the DIFS director's authority, from 67% to 55%. The bill would lead to additional departmental administrative burdens associated with the following: rulemaking authority, rate filing review, document creation and form approval, oversight of the MCCA refund process, review of reimbursement schedules for medical treatment, and other miscellaneous responsibilities. DIFS would have rulemaking authority to promulgate rules establishing criteria and standards for utilization review. It is unclear whether additional staff would be required to fulfill these responsibilities.

The department would likely experience indeterminate cost increases for information technology (IT) costs associated with creating and maintaining functionality on the department's webpage that would be required under the bill. IT costs related to the bill would be dependent on a variety of factors and are presently indeterminate.

Beginning July 1, 2022, and every third year thereafter, the bill would require DIFS to engage with an independent actuary to examine the affairs and records of MCCA. Costs associated with the required actuarial examinations would be variable and would presumably be contractually determined between the vendor and the department.

The bill would statutorily codify the Anti-Fraud Unit (created by Executive Order 2018-9) and its responsibilities within DIFS. Funding has not yet been appropriated for the unit, but the Executive Budget Recommendation for Fiscal Year 2019-20 includes approximately $500,000 in funding and authorization for 6.0 FTE positions for the unit.

Department of Corrections and State and Local Courts

For Corrections and the Judiciary, Senate Bill 1 would have an indeterminate fiscal impact on the state and on local units of government. The fiscal impact would depend on the number of offenders who would be assigned civil fines or convicted of misdemeanors or felonies.

Under the bill, an individual who supplies false information to the Secretary of State or who issues or uses an altered, fraudulent, or counterfeit certificate of insurance would be guilty of a misdemeanor. Also, a physician, hospital, clinic, or other person or institution that knowingly submits false or misleading records or other information to an insurer, MCCA, or DIFS would commit a fraudulent insurance act, which is a felony punishable by imprisonment, a fine, or both. New misdemeanor convictions would increase costs related to county jails and/or local misdemeanor probation supervision. The costs of local incarceration in a county jail and local misdemeanor probation supervision, and how the costs are financed, vary by jurisdiction. New felony convictions would result in increased costs related to state prisons and state probation supervision. In fiscal year 2018, the average cost of prison incarceration in a state facility was roughly $38,000 per prisoner, a figure that includes various fixed administrative and operational costs. State costs for parole and felony probation supervision averaged about $3,700 per supervised offender in the same year. Those costs are financed with state general fund/general purpose revenue. An increase in penal fine revenue would increase funding for local libraries, which are the constitutionally designated recipients of those revenues.

For insurance fraud and for violations of the law for which a specific penalty is not listed, the director of DIFS could order payment of civil fines. Civil fine revenue would be paid to the state and credited to the general fund.

The fiscal impact on local court systems would depend on how provisions of the bill affected caseloads and related administrative costs. Increased costs could be offset, to some degree, depending on the amount of additional court-imposed fee revenue generated.

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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.