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NO-FAULT AUTOMOBILE INSURANCE REFORM

Senate Bill 1 (H-1) as reported from House committee
Sponsor: Rep. Jason Sheppard
House Committee: Select Committee on Reducing Car Insurance Rates
Senate Committee: Insurance and Banking
Complete to 5-15-19

SUMMARY:

Senate Bill 1 would amend the Insurance Code to make substantial changes to Michigan's no-fault automobile insurance system, including creating new personal injury protection (PIP) coverage options on auto insurance plans, mandating certain premium reductions, creating fee schedules for medical expenses when treating injuries from automobile accidents, creating new guidelines and restrictions for insurers in regard to producing policies and setting rates, mandating an annual audit for the Michigan Catastrophic Claims Association (MCCA), requiring the Department of Insurance and Financial Services (DIFS) to provide new information to the public, and creating the Automobile Insurance Fraud Task Force and the Automobile Insurance Fraud Fund.

PIP Coverage Revisions

Automobile insurance policies issued six months after the effective date of the bill would have to offer the following options for PIP benefits:

A. A PIP coverage limit consisting of a $50,000 limit for any PIP benefits and an additional $200,000 for medically necessary emergency treatment.
B. A PIP coverage limit of $250,000 for any PIP benefits.
C. A PIP coverage limit of $500,000 for any PIP benefits.
D. Unlimited PIP coverage.

The coverage limits above are per person per loss occurrence.

Insurers would also have to offer a rider that would provide coverage for attendant care in excess of the limits in options A, B, and C above.

One more option could be made available after the effective date of the bill, but an insurer would not be required to provide it:

E. No PIP coverage, provided that the policyholder has ***qualified health coverage*** and can present documentation proving that this is the case.

Qualified health coverage would mean health or accident coverage that does not exclude or limit coverage for injuries related to motor vehicle accidents, including Medicaid and Medicare coverage. The bill refers to a person who has qualified health coverage as a ***qualified person***.

A policyholder who lost his or her health coverage while a policy under option E above was in effect would have 14 days to notify his or her insurer and, if he or she did so, could choose one of the other PIP coverage options. During those 14 days, the policyholder could still claim

benefits under his or her assigned plan in the case of an accident. If after the 14 days the policyholder has failed to notify his or her insurer, however, the policyholder could no longer claim benefits under the former policy even in the case of an accident.

If a policyholder renewed a policy without indicating a desired level of coverage, but paid the premium, the amount paid would be presumed to reflect the level of coverage desired. If no amount was paid, however, then option A above would be automatically applied.

For those who remained on unlimited PIP coverage plans, Senate Bill 1 would adjust the amount that an insurer would pay before MCCA coverage began as follows:

- $530,000 for policies issued or renewed between July 1, 2013, and June 30, 2015.
- $545,000 for policies issued or renewed between July 1, 2015, and June 30, 2017.
- $555,000 for policies issued or renewed between July 1, 2017, and June 30, 2019.
- $580,000 for policies issued or renewed between July 1, 2019, and June 30, 2021.
- Beginning July 1, 2021, this $580,000 amount would be increased biennially by the lesser of 6% or the Consumer Price Index and rounded to the nearest $5,000.

In calculating membership premiums, MCCA could only charge its members for policies that continued to provide unlimited PIP coverage. After the effective date of the bill, MCCA would not have liability for ultimate loss under policies with limited PIP coverage.

For one year after the effective date of the bill, 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.

Coverage Selection/Election Forms

The director of DIFS would have to approve forms for use by policyholders or applicants for insurance to select a PIP coverage level or elect to not maintain PIP coverage.

The form for making a coverage selection would have to include a conspicuous statement of the coverage levels available, and of the benefits and risks associated with each option, and provide a way for the person to indicate that he or she has read the form and understands the options, a way to indicate his or her selection, and a requirement that he or she sign the form.

The form for a ***qualified person*** to elect not to maintain PIP coverage would have to include, in addition to the above, a requirement that the applicant certify whether he or she is a qualified person; a conspicuous disclosure that a qualified person is not obligated to purchase PIP coverage but may choose to do so; a notice that, if the policyholder ceases to have qualified health coverage while holding the policy, he or she has 14 days to notify the insurer before being excluded from PIP coverage benefits; and a way for a qualified person to mark the form to elect not to maintain the coverage.

A form described above would 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.

Mandated Premium Rate Reductions

Within six months after the effective date of the bill, insurers that offer auto insurance in Michigan would have to file premium rates for PIP coverage that would be effective between six months and eighteen months after the bill's effective date. The premium rates filed—along with any subsequent premium rates effective before five years and six months after the bill's effective date—would have to result, as nearly as practicable, in an average reduction per vehicle from the premium PIP coverage rates that were in effect for the insurer on May 1, 2019, as follows:

- An 80% or greater reduction for policies with a PIP coverage limit consisting of a $50,000 limit for any PIP benefits and an additional $200,000 for medically necessary emergency treatment (described as option A above).
- A 60% or greater reduction for policies with a PIP coverage limit of $250,000 for any PIP benefits (described as option B above).
- A 30% or greater reduction for policies with a PIP coverage limit of $500,000 for any PIP benefits (described as option C above).
- A 10% or greater reduction for policies with unlimited PIP coverage (described as option D above).

Policies for which an election was made to not maintain PIP coverage would have to result in no premium charge for PIP coverage for policies effective within five years and six months after the bill's effective date.

The director of DIFS would have to review premium rates filed by insurers and disapprove filings that do not comply with the mandated reductions. If the director disapproved a filing, the insurer would be required to submit a revised premium rate filing to the director within 15 days. The revised filing would be subject to review in the same manner. An insurer could not issue or renew a policy that did not match the approved premium rates listed above between six months and five years and six months after the effective date of the bill.

For the purpose of calculating premium rates under the above provisions, the premium would include the catastrophic claims assessment imposed under the Insurance Code.

Rates and Plan Filings

The Insurance Code currently prohibits insurers from establishing or maintaining rates or rating factors for auto insurance based on sex or marital status. The bill would further prohibit setting or maintaining rates or rating classifications based on a ***nondriving factor***.

> A ***nondriving factor*** would mean any factor for which there is no rational correlation between the factor and insurance losses. The director of DIFS would be responsible for promulgating rules to establish nondriving factors. After the rules were promulgated, an insurer could not use a factor in those rules to establish a rate.

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.

Further, the bill would provide that any filing must 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, and the bill would prohibit insurers from engaging in redlining.

Provider Reimbursement Limits

The bill would limit reimbursement to medical providers providing treatment, products, services, or accommodations (hereafter "treatment") to the amount payable for that treatment under the administrative rules governing worker's compensation health services or schedules of maximum fees developed under those rules, as in effect on the effective date of the bill. If a treatment was not covered by the rules or schedule, the provider would not be eligible for reimbursement that exceeded the average amount the provider received over the previous calendar year for providing that treatment in cases not involving PIP. The director of DIFS would have to review any changes to those rules or schedules and, if the director determined that they were reasonable and appropriate for assuring affordable automobile insurance in the state, issue an order applying the changes to these provisions.

Reimbursement for attendant care rendered in the 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.

A neurological rehabilitation clinic 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 when the bill took effect, unless the clinic still was not accredited three years of more after beginning the accreditation process.

The above limitations would apply to a treatment rendered after the bill's effective date, regardless of when the accident happened, and regardless of whether indemnification for the charge is being made by the MCCA. However, the above limitations would not apply to emergency medical services (EMS) rendered by an ambulance operation as defined in the Public Health Code.

Utilization Review

A medical provider providing treatment for an injury covered by PIP after the bill's effective date 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.

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. (The bill would allow an insurer or MCCA to require a provider to explain the necessity or indication for treatment that is not usually associated with the diagnosis or condition for which the patient is being treated or that has a greater frequency or duration.)
    - Appealing determinations. (The bill would allow a provider to appeal to DIFS is an insurer or MCCA determined that the provider improperly overutilized or otherwise rendered a treatment that was inappropriate or inappropriately expensive.)

A medical provider that knowingly submitted false or misleading records or information to an insurer, 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.

Michigan Automobile Insurance Placement Facility (MAIPF)

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 the PIP coverage limit chosen on the claimant's insurance policy.

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 by relevant sections of the Insurance Code. 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 under these provisions and the assigned claims plan 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 expressly 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 allow commencement of a claim within one year after the date the responsible third party was identified.

The bill would also expressly 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 against them for costs related to an accident involving that vehicle. (Under current law and installment agreement would be made with the Secretary of State.) The bill would specify that the owner or registrant or his or her estate is responsible for any expenses or fees for the suspension, revocation, or reinstatement of a motor vehicle registration or license.

The bill would require the Secretary of State to provide information on auto insurance policies issued in the 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 bill. Such 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.

PIP Claim Priority

The Insurance Code currently includes a chain of priority for who pays out benefits to an individual who suffers accidental bodily harm in a motor vehicle accident. The bill would stipulate that holders of policies with no PIP coverage can only collect benefits on other policies according to the same chain of priority allowed for those with policies that do contain PIP coverage or, if the chain of priority is exhausted, under an assigned claims plan. 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 coverage limit for both or all of the policies that equals the highest available coverage limit under any one of the policies.

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 allow a health care provider to 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 to an injured person.

The bill would also provide that, for PIP benefits, payment for a treatment is not overdue if the bill for the treatment was not provided to the insurer within 90 days after the treatment was rendered.

Currently, with some exceptions, a legal action to recover PIP benefits must be taken within one year after the accident took place. Under the bill, that time period would be tolled from the date the claimant made a specific claim for PIP benefits until his or her insurer formally denied the claim. However, the tolling of the time period 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 from could not claim, file, or serve a lien for payment of any fees for their services unless all of the following conditions were met:

- A payment for the claim was authorized under the Insurance Code.
- A payment for the claim was overdue under the Insurance Code.
- The attorney notified the resident agent of the insurer in writing that the payment for the claim was overdue.
- Within 30 days after the insurer received the notice, it did not either provide reasonable proof that the insurer was not responsible for the payment or take remedial action.

If an action involved several claims, then the court would have to reduce the attorney's fee in the proportion that the number of claims that were not determined to have been unreasonably refused or delayed bears to the total number of claims presented in the action.

If an attorney claimed, filed, served, or enforced a lien as prohibited above, the insurer or other person aggrieved by the lien could recover court costs and reasonable attorney fees related to their opposition to the lien.

Currently, the Insurance Code allows the court to 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 either the following:

- A claim for benefits for a treatment 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 the law of this state or its rules of professional conduct.

In a dispute over the payment of allowable expenses for attendant care or nursing services, the bill would allow attorney fees to be rewarded in relation to expenses recovered for the 12 months preceding the date the insurer was notified of the dispute, including any future payments ordered after the judgment was entered.

The bill would prohibit a court from awarding fees to an attorney in an action concerning PIP benefits if the attorney or a person related to the attorney turned out to have a direct or indirect

financial interest in the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation that the benefits would have paid for.

Michigan Catastrophic Claims Association (MCCA)

Beginning July 1, 2019, and for every third year afterward, the bill would require the director of DIFS to engage one or more independent actuaries to audit MCCA for the previous three years. The audit would have to be conducted using sound actuarial principles consistent with those of the Casualty Actuarial Society. By September 1, 2019, and every third year thereafter, 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, then the director would have to order MCCA to rebate the excess to its members, provided that doing so does not threaten MCCA's ongoing ability to provide reimbursements for PIP benefits. MCCA could request a hearing to review the order by filing a written request with the director within 30 days after receiving the order. Insurers would be required to pass the rebate along to their insured customers in a manner and time determined by the director. (Any rebate attributable to a historic vehicle would have to be equal to 20% of the rebate for an ordinary car.)

The bill would also require MCCA to submit an annual consumer statement to the Senate and House committees with jurisdiction over insurance matters by September 1 of each year. The statement would also have to be posted on the MCCA website. The statement would have to be written in a manner intended for the general public and would have to contain information specified by the bill concerning such things as the MCCA's assets, liabilities, claims history, revenue projections, mortality assumptions, cost-containment measures, and the like.

By September 1 of each year, MCCA would also have to provide a report to the Senate and House 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 itself.
- Anything else MCCA determined necessary to advise the legislature about its operations.

Automobile Insurance Task Force and Automobile Insurance Fraud Fund

The bill would add Chapter 63 to the Insurance Code to create the Automobile Insurance Task Force in the Department of State Police (MSP). The task force would consist of the following members:

- Five officers of MSP, appointed by the MSP director.
- One MSP employee, appointed by the MSP director.
- One representative of MCCA, appointed by the MCCA Board.
- One employee of MAIPF who is involved in the operation of the assigned claims plan created under section 3171, appointed by MAIPF.
- One employee of the Department of the Attorney General, appointed by the attorney general.

Members of the task force would perform their duties under the direction of the MSP director. Members would serve at the pleasure of the person who appointed them. Vacancies would be filled in the same manner as the original appointment.

The task force would have to do the following:

- Receive records from the Anti-Fraud Unit created in DIFS by Executive Order No. 2018-9.[1] (This unit would be required to transfer its records of claims and investigations of auto insurance fraud within 60 days after the effective date of the bill, and would then be dissolved.)
- Collect and maintain claims of automobile insurance fraud.
- Investigate claims of automobile insurance fraud.
- Maintain records of its investigations.
- Pursue the criminal or civil prosecution of persons who commit automobile insurance fraud.

The task force could also share records of its investigations with other law enforcement agencies and state departments and agencies, review their records to assist in its investigation and enforcement activities, and conduct outreach and coordination efforts with them to promote investigation and prosecution of automobile insurance fraud. The task force could also do anything else it determined necessary to investigate and prosecute automobile insurance fraud.

Automobile insurers would have to report to the task force data regarding automobile insurance fraud by medical providers, attorneys, or other persons. DIFS would have to cooperate with the task force and upon request provide all available statistics on automobile fraud and unfair claims practices.

Beginning July 1 of the year after the bill's effective date, the task force would have to prepare and publish an annual report on its efforts to prevent automobile insurance fraud by medical providers, attorneys, or other persons, unfair claims practices of insurance companies, and cost savings that have resulted from those efforts. The report would be submitted to the director of DIFS and the standing committees of both houses with primary jurisdiction over insurance issues. The report would have to detail automobile insurance fraud and unfair claims practices for the previous year, assess their impact on rates charged for automobile insurance, evaluate their impact on the citizens of this state and on costs incurred by those citizens, and outline any expenditures made by the task force. The director would have to cooperate in developing the report as requested by the task force and make available to the task force records and statistics concerning automobile insurance fraud and unfair claims practices.

The bill would also create the Automobile Insurance Fraud Fund within the state treasury. The state treasurer could receive assets from any source for deposit into the fund, would direct the fund's investment, and would credit to the fund interest and earnings from its investments. Money in the fund at the close of the fiscal year would remain in the fund and not lapse to the general fund.

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

Until five years after the bill's effective date, MSP would disburse money from the fund, upon appropriation, to MSP, DIFS, MCCA, MAIPF, and the Department of the Attorney General, in proportion to the number of officers, employees, or representatives each has on the task force, for the operation of the task force. Beginning five years after the bill's effective date, MSP would expend money from the fund, upon appropriation, for the operation of the task force.

Department of Insurance and Financial Services (DIFS) Website

The bill would require DIFS to update its website with 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 Chapter 20 of 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—either 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.
- Anything else that the director of DIFS determines to be important as it relates to the above.

DIFS would also have to maintain a page that advises consumers about the changes made to auto insurance in Michigan by SB 1, including how to shop competitively for insurance and whatever else the director considers important.

The DIFS site would also have to include a page that allows people to report insurance fraud and unfair settlement and claims practices.

Civil Fines

Currently, section 150 of the Insurance Code allows the director of DIFS to order payment of a civil fine for a violation of the act for which no other penalty is specified. The fines are in an amount of up to $500 for each violation of the act a person is found to have committed, or up to $2,500 for each violation the person committed knowingly, to a total limit of $50,000 per order of the director. Violation of a cease and desist order can be subject to a civil fine of $10,000 for each violation.

The bill would allow the director to order civil fines for violation of the Insurance Code's insurance fraud provisions. Those fines could be ordered in addition to, rather than instead of, payment of a penalty or restitution. The fines would be credited to the Automobile Insurance Fraud Fund, as would any civil fines ordered for violating a cease and desist order relating to insurance fraud. (Civil fines under section 150 are otherwise credited to the general fund.)

MCL 500.150 et seq.

FISCAL IMPACT:

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'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 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 auto insurance policy premiums would decline by roughly 30%.

Based on this estimate, revenue from the insurance company premiums tax would decline by about $26.0 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 increases, 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 or would select no PIP coverage, as Medicaid would be considered a "qualified health coverage" under the bill. Therefore, a catastrophic injury to a Medicaid beneficiary would be covered by Medicaid after the limit is exhausted. Any injury costs to a Medicaid beneficiary that selected no PIP coverage would be covered by Medicaid. 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 either a capped PIP limit or no PIP coverage 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 grows. 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 present departmental appropriations.

The bill would lead to an additional departmental administrative burden associated with the following: rulemaking authority, rate submission review, document creation and form approval, oversight of the MCCA rebate process, review of reimbursement schedules for medical treatment, and other miscellaneous responsibilities. The department would have authority to promulgate rules delineating nondriving factors that could no longer be used to establish auto insurance rates and to establish criteria and standards for utilization review. It is unclear whether additional staff would be required to fulfill these responsibilities.

DIFS 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 intermediate.

Beginning July 1, 2019, and every third year thereafter, the bill would require DIFS to engage with independent actuaries to examine the affairs and records of the 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 dissolve the Anti-Fraud Unit created within DIFS by Executive Order 2018-9, after the unit transfers any records to the Automobile Insurance Fraud Task Force created under the bill. 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 State Police (MSP)

Senate Bill 1 would create the Automobile Insurance Fraud Task Force within MSP. Generally speaking, the purpose of the task force would be to collect and investigate claims of automobile insurance fraud and to pursue prosecution of individuals who commit automobile insurance fraud.

The bill would designate MSP as the administrator of the Automobile Insurance Fraud Fund and would require the proportional distribution of funds to MSP, DIFS, MCCA, MAIPF, and the Department of the Attorney General for operation of the Automobile Insurance Fraud Task Force for five years after the effective date of the bill. After five years, MSP would expend money for the operation of the task force. The task force would be required to submit an annual report to the legislature detailing auto insurance fraud, assessing the impact of fraud and unfair claims practices on rates, and outlining task force expenditures. Costs for MSP's responsibilities under the bill are presently indeterminate.

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 and/or convicted of misdemeanors.

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 be guilty of a misdemeanor. 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. An increase in misdemeanor convictions would mean an increase in penal fine revenues. Any increase in penal fine revenues 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. In some instances, civil fine revenue would be paid to the state and credited to the general fund. In other instances specified in the bill, civil fine revenue would be credited to the Automobile Insurance Fraud Fund created under the bill.

Any fiscal impact on the judiciary and local court systems would depend on how the bill affected caseloads and related administrative costs.

POSITIONS:

The following entities indicated opposition to the bill (5-15-19):

- Concerned Association of Patients and Providers
- Citizens for Affordable No-Fault
- Hope Network

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