



Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS



Telephone: (517) 373-5383
Fax: (517) 373-1986

Senate Bill 248 (Substitute S-3 as passed by the Senate)
Senate Bill 249 (as passed by the Senate)
Sponsor: Senator Joe Hune
Committee: Insurance

Date Completed: 4-30-15

RATIONALE

Studies show that Michigan drivers pay some of the highest automobile insurance rates in the country. A recent study by Insure.com (which compared rates in every state for the same full-coverage policy for the same driver using average rates for the 20 best-selling vehicles in the U.S.) found that Michigan's rates were the highest of any state, and 88% higher than the nationwide average of \$1,311 per year. Another study, conducted in 2012 by the National Association of Insurance Commissioners, compared the average amount that residents of each state actually spent on auto insurance, regardless of what type of vehicle was insured or what type of coverage was purchased. That study found Michigan's residents paying the seventh-highest amount in the country, and 28% higher than average.

There are various explanations why insurance rates are so high in this State. Some believe that medical costs are a major component. Reportedly, medical costs make up 30% of the nationwide average cost for auto insurance. Providers' claims for reimbursement for medical care related to auto accidents evidently are 24% higher in Michigan than in other states, when holding the amount of care constant. Michigan has a unique requirement for all policyholders to purchase personal injury protection (PIP) insurance with unlimited lifetime benefits that cover all reasonable charges incurred for reasonably necessary products, services, and accommodations for the care, recovery, or rehabilitation of a person injured in an auto accident, regardless of who was at fault in the accident. Because of the nature of unlimited benefits, some believe that there is not sufficient incentive to contain the cost of care. For that reason, it has been suggested that mandatory cost controls be instituted. Some also believe that the State's unique insurance provisions make it a target for fraud, so the State should have a central agency to combat auto insurance fraud.

Another component of this State's approach to coverage is the Michigan Catastrophic Claims Association (MCCA), which reimburses an insurer if the cost of a medical claim exceeds a certain amount. Each insurer pays a fee to the MCCA each year based on the number of vehicles it insures. The current year assessment is \$186 per vehicle, and the cost is typically passed on to the consumer. Some are concerned about the perceived lack of transparency regarding the setting of the rate. At the same time, auto insurance companies in the State have complained that, since the liability for all claims rests with the insurer, regardless of reimbursement from the MCCA, they must underwrite for unlimited benefits, which increases the cost of premiums for policyholders. One suggestion is that the MCCA should assume liability for all claims for which it would normally reimburse insurers, which would limit insurers' potential medical claims, and could allow them to lower premiums.

CONTENT

Senate Bill 248 (S-3) would amend the Insurance Code to do the following:

- Describe when a rate for automobile insurance would be excessive, inadequate, or unfairly discriminatory, and prohibit such rates.**

- **Provide for the creation of an incorporated association to accept liability for ultimate loss sustained under personal protection insurance coverages above \$545,000, and require that amount to be adjusted biennially by changes in the Consumer Price Index.**
- **Provide for the dissolution of the existing Michigan Catastrophic Claims Association (which would be called the Michigan Legacy Claims Association once the incorporated association was issued a certificate of authority) after all liabilities had been paid.**
- **Set limits on the amount that could be paid by personal protection insurance benefits for attendant care.**
- **Limit the amount that an insurer or incorporated association could be required to pay a person or institution for products, services, and accommodations, to the average amount the person or institution customarily accepted from all sources, not including cases involving personal protection insurance, Medicaid, or Medicare.**
- **Appropriate \$150,000 from the General Fund to the Department of Insurance and Financial Services for it to compile a report on the effect of the changes made by the bill.**
- **Create the Michigan Automobile Insurance Fraud Authority within the Michigan Automobile Insurance Placement Facility, to provide financial support to law enforcement and prosecutorial agencies to combat auto insurance fraud.**
- **Authorize the board of the Facility, until December 31, 2020, to collect from participating members and self-insurers money paid at their discretion to cover costs of the proposed Authority and the Automobile Theft Prevention Authority.**
- **Terminate the proposed Authority on December 31, 2020, and require it to transfer its assets to the Department of State Police for the benefit of the Automobile Theft Prevention Authority.**

Senate Bill 249 would amend the Support and Parenting Time Enforcement Act to revise the citation to a section of the Insurance Code.

The bills are tie-barred and, except as provided in Senate Bill 248 (S-3), would take effect 90 days after being signed into law. Amendments to various sections of the Insurance Code, as well as the proposed chapter concerning the Michigan Automobile Insurance Fraud Authority, would take effect on January 1, 2016.

Senate Bill 248 (S-3)

Rates for Automobile Insurance

The bill would prohibit rates for automobile insurance from being excessive, inadequate, or unfairly discriminatory. A rate would be excessive if it were likely to produce a profit that was unreasonably high in relation to the risk involved or if the cost of the insurance were unreasonably high in relation to services rendered. A rate would be inadequate if it were clearly insufficient (when combined with the investment income attributable to the rate) to sustain projected losses and expense, or if allowed discounts or credits to the premium charged exceeded a reasonable reflection of expense savings and reasonably expected loss experience from the risk. A rate would be unfairly discriminatory as to a risk if the application of premium discounts, credits, or surcharges to the risk did not bear a reasonable relationship to the expected loss and expense experience.

MCCA/Legacy Association; Incorporated Association

The Michigan Catastrophic Claims Association was created as an unincorporated, nonprofit association under the Insurance Code. The MCCA has a five-member board of directors appointed by the Director of the Department of Insurance and Financial Services (DIFS). The board is composed of individuals from Association members. All automobile insurers are required to be members of the MCCA and to pay premiums to the Association so that it may provide indemnification for ultimate loss sustained under personal protection insurance coverages for the payment of claims that exceed specified amounts

The bill would allow two or more voting directors of the "unincorporated association" (the existing MCCA) to form an incorporated association by filing articles of incorporation with the DIFS Director. The Director could not certify more than one incorporated association to be active and operate in the State at a time. Within 90 days after the DIFS Director certified the articles of incorporation, the incorporated association would have to file with the Director an application for a certificate of authority. If the Director were satisfied that the incorporated association could comply with applicable law, the Director would have to issue it a certificate of authority to commence claims activities. At that time, the Director would have to establish the initial catastrophic claims assessment to be assessed by the incorporated association.

The new incorporated association would have a seven-member board appointed by the Governor with the advice and consent of the Senate. An employee or officer of an insurer would not be eligible to serve as a director. The new association would be subject to an annual audit by an independent public accountant, and would have to comply with the Freedom of Information Act (FOIA). The board of the incorporated association would have to conduct its business at a meeting that was open to the public. The bill specifies that the State would not be liable for obligations of the association, and any debt of the association would not be a debt of the State.

The new incorporated association would collect the catastrophic claims assessment from drivers, instead of collecting premiums from insurers as the MCCA does. The assessment would still be collected with the insured's regular premium payment, but would not be part of an insurer's premium and would have to be listed separately on the invoice. If an insurer received a refund from the incorporated association for a portion of an assessment paid because of the cancellation of a policy, it would have to refund that portion to the owner or registrant.

The bill states that neither the unincorporated association nor the incorporated association would be an insurer, and neither would be subject to any Michigan laws with respect to insurers. Also, the incorporated association would not be required to participate in a pool or fund in which an insurer is required to participate.

The unincorporated association would continue to reimburse insurers for ultimate loss above \$530,000 (as provided by current law) until June 30, 2015. Beginning July 1, 2015, the amount would increase to \$545,000. The legacy unincorporated association would not be liable to reimburse for claims under policies issued (and would be prohibited from collecting premiums from member insurers) after the first June 30 after the DIFS Director issued a certificate of authority to the new association. The MCCA would be called the Michigan Legacy Claims Association if an incorporated association were issued a certificate of authority. After all existing liabilities were paid, the Legacy Claims Association would have to transmit any remaining money to the incorporated association and the legacy association would be dissolved.

The new incorporated association would be responsible for 100% of all liability for ultimate loss sustained within the scope of personal protection insurance coverages and claims expenses in excess of \$545,000 for policies issued after the first June 30 after the DIFS Director issued a certificate of authority to the new association. Rather than reimbursing member insurers for claims, the incorporated association would take over the administration and payment of claims for which it was liable.

The \$545,000 amount, and each subsequent adjusted amount, would have to be adjusted biennially on the second July 1 after the prior adjustment, by the lesser of 6% or the cumulative change in the Consumer Price Index for the 24 months before the July 1 effective date of the adjustment, and rounded to the nearest \$5,000. An adjusted amount would apply to motor vehicle accident policies issued or renewed on or after the effective date of the adjustment and before July 1 of the second following year.

Limits on Payments

The bill would limit the amount that would be paid for attendant care by personal protection insurance benefits. For attendant care provided in the home by a family or household member,

payment would be limited to \$15 per hour, regardless of the level of care. Beginning three years after the bill's effective date, and every three years thereafter, the DIFS Director would have to adjust the amount by the aggregate percentage change in the United States Consumer Price Index, rounded to the nearest 10 cents. The limitation would apply regardless of whether the family or household member was licensed or otherwise authorized to provide attendant care, or was employed by, or under contract with, or in any way connected with an individual or agency licensed or authorized to render the care.

For attendant care provided in the home by someone other than a family or household member, payment would be limited to a total of 24 hours per day for services performed by one or more individuals. Payment for attendant care provided by a family or household member and someone other than a family or household member would be cumulatively limited to 24 hours per day.

Notwithstanding these limits, an insurer or the incorporated association could contract to provide for attendant care at any rate and for any number of hours per week. Also, an injured person or that person's representative would be allowed to request a medical review to determine the care and treatment requirements of the patient. If the review determined that the patient required more attendant care than was allowable under the bill, the additional care would be considered an allowable expense.

The bill would allow an insurer or the incorporated association to negotiate reimbursement amounts for products, services, and accommodations, if the insurer or association did not agree with the amount charged by a person or institution providing treatment to an injured person. If the parties were unable to reach an agreement, the insurer or association would not be required to pay an amount that exceeded the average amount the person or institution customarily accepted from all sources for like products, services, and accommodations in cases not involving personal protection insurance, Medicaid, or Medicare.

Report to Standing Committees; Appropriation

Before July 1, 2017, the Director of the Department would have to report to the standing committees of the Senate and the House of Representatives with primary jurisdiction over insurance matters. The report would have to detail the effect of the changes to the Insurance Code made by the bill, and contain any recommendation of the Director for changes to be made.

For the 2015-16 fiscal year, the bill would appropriate \$150,000 from the General Fund to DIFS to create the report, including hiring an additional full-time employee to prepare the report.

Automobile Insurance Fraud Authority

The bill would create the Michigan Automobile Insurance Fraud Authority within the Michigan Automobile Insurance Placement Facility. Before March 1, 2016, the facility's board of governors would have to amend its plan of operation to establish procedures necessary to make assessments for and to carry out the administrative duties and functions of the Authority. The bill specifies that the Authority would not be a State agency; however, the Authority would have to comply with the FOIA and conduct its business at meetings that were open to the public.

Until December 31, 2020, the board of the Facility could collect from participating members and self-insurers money paid at their discretion to cover costs of the proposed Authority and the Automobile Theft Prevention Authority. Any money paid to the proposed Authority could not come from premium revenue, but would have to be paid from other earnings or investments. A member or self-insurer would be prohibited from considering the payment of money to the Authority when calculating a premium rate.

The duties and powers of the Automobile Insurance Fraud Authority would have to be carried out by a 15-member board of directors, which would consist of members specified in the bill. Board members would have to serve without compensation but the board would have to reimburse a member for necessary travel and expenses. The board would be dissolved on January 1, 2021.

The bill also would require automobile insurers to report automobile insurance fraud data to the Authority. In addition, the Department of State Police would have to provide available motor vehicle fraud and theft statistics to the Authority on request.

The Authority would be required to provide financial support to State or local law enforcement and prosecutorial agencies for programs designed to reduce the incidence of auto insurance fraud.

The Authority also would have to prepare and publish an annual financial report, as well as an annual report to the Legislature on the Authority's efforts to prevent auto insurance fraud and the cost savings that resulted from those efforts. The reports would have to detail insurance fraud occurring in the State for the previous year, assess the impact of the fraud on rates charged for automobile insurance, summarize prevention programs, and outline allocations made by the Authority. The Authority also would have to evaluate the impact auto insurance fraud had on the residents of the State and the costs they incurred through insurance, police enforcement, prosecution, and incarceration due to that fraud.

The Authority would be dissolved on January 1, 2021. It would have to transfer all assets to the Department of State Police for the benefit of the Automobile Theft Prevention Authority before that date.

Senate Bill 249

The Support and Parenting Time Enforcement Act exempts payments made for benefits under personal property insurance from a lien against real and personal property for the purpose of collecting past due support. The bill would amend this provision to change the citation to a section of the Insurance Code that Senate Bill 248 (S-3) would amend.

MCL 500.2109 et al. (S.B. 248)
552.625a (S.B. 249)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Senate Bill 248 (S-3) could bring down insurance costs. Those savings could be passed on to consumers in the form of lower premiums because of competition in the auto insurance market. Michigan auto insurance costs are among the highest in the country, in part because all policyholders in the State are required to purchase generous PIP benefits. While the bill would not reduce the unlimited lifetime benefits, it would implement various cost control measures. The two principal cost savers would be a "fee schedule" (explained below) for reimbursement paid to providers and limitations on attendant care.

Auto insurance companies pay more to hospitals and other providers for products, services, and accommodations than is paid by Medicare and Medicaid, worker's compensation insurers, and private health insurers. This is partly because the Insurance Code has been interpreted to require that PIP benefits reimburse providers for the amount customarily charged, not necessarily the amount customarily received. That interpretation evidently prevents no-fault insurers from negotiating rates, as health insurance companies can do. Even if the auto insurers could negotiate, these types of claims represent a relatively small percentage of total health claims, so the auto insurance companies lack the market power to negotiate strong discounts. The bill would mitigate the problem by specifically allowing no-fault auto insurers to negotiate rates for reimbursements, and providing that they would not be required to pay more than the average amount the provider customarily accepts for like products, services, and accommodations for cases not involving PIP, Medicare, or Medicaid. (When a provider bills for services, it uses Current Procedural Terminology (CPT) codes to describe the services rendered. Since the bill would limit the maximum that an auto insurer would be required to pay for any particular code, it essentially would create a list of allowable charges, or a fee schedule, for all services.)

In addition, there are currently no limits in the statute for the amount that must be paid for attendant care. The Insurance Code states that benefits are payable for "all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation". Almost 18% of the MCCA premium cost in fiscal year 2013-14 was for family-provided attendant care. Overall attendant care costs accounted for more than 39% of premiums. The bill would help to reduce these costs by limiting payment to family members to \$15 per hour and providing that insurers would not have to pay for more than 24 hours of care per day, unless a medical review determined that an injured person required more than that.

Supporting Argument

The new incorporated association would be more transparent than the MCCA, since it would be subject to Freedom of Information Act requests and would be required to hold meetings open to the public. This would allow anyone to view the process through which the annual assessment was determined. The new incorporated association also would assume 100% liability for all claims that exceeded the threshold in the bill, rather than simply reimbursing insurers for the costs above that amount. This would enable the insurers to remove the liability from their books. Under the current system, auto insurers retain that liability, even though they are reimbursed for the costs. Removing the liability could improve the financial strength ratings of the insurers, which could lead to lower borrowing costs. These lower costs then could lead to lower premium charges to Michigan consumers.

Response: There is concern about the welfare of the victims of catastrophic injuries if the new association became insolvent. Under the current system, the auto insurance companies retain liability for claims, so they would still have to pay for claims if the MCCA became insolvent. Since the new incorporated association would accept 100% liability for all claims, and the bill specifies that its obligations would not be obligations of the State, there would be no source to pay claims if the new association became insolvent. Even if injured parties had health insurance, it would not necessarily pay for all costs since many catastrophically injured people require facility and attendant care, which is typically not covered by health insurance. These people would likely have to exhaust their personal resources to pay for care, and if those assets were not enough, they would have to enroll in Medicaid.

Supporting Argument

The Michigan Automobile Insurance Fraud Authority could lower costs by reducing the rate of insurance fraud. More than 40 other states have some type of coordinated system to combat insurance fraud. According to data from the National Insurance Crime Bureau, questionable medical claims in Michigan have increased by more than 200% since 2009, the highest rate in the country. Medical insurance fraud can involve overzealous solicitation of patients, upcoding (billing for more expensive procedures than what were actually performed), or other abuses. It is estimated that fraudulent auto claims in Michigan cost about \$400.0 million annually. The proposed Authority could provide funding to law enforcement and prosecutors to combat this fraud. Reportedly, states such as Ohio, Pennsylvania, and Texas have seen success with an approach similar to what is being proposed.

Response: As defined by the bill, automobile insurance fraud would include only acts committed by a person to defraud an insurance company or the Department. Fraud also should include acts by insurance companies to unlawfully deny or delay claims. That activity can deprive injured people of the care they need or the benefits to which they are legally entitled.

Opposing Argument

The limits on payment for attendant care would be too harsh. If an injured person needed around-the-clock care by at least one person, plus any amount of care by one or more people, the insurance company or incorporated association would not be required to pay for all of the care, unless the patient obtained a medical review and it was deemed necessary, because total attendant care would be limited to 24 hours per day. It is not clear who would perform the review or whether the physician would be chosen by the insurance company or the patient. Attendant care already must be ordered by a physician if it is to be covered by no-fault, so it is unclear why a separate medical review would be necessary. If that physician ordered attendant care greater than the limits provided in the bill, the additional care should be an allowable expense.

In addition, the payment limit of \$15 per hour for home attendant care provided by a family or household member would be unreasonable. The bill does not define who would be considered a family or household member. It also specifies that the limit would apply regardless of the type of care or the qualifications of the caregiver. Some catastrophically injured people require very specialized care, and it is often more cost effective for the insurance company to have a family member trained to provide the care, rather than hiring an LPN or RN to provide it. The wage limit could actually force insurance companies to hire outside providers in more cases, thus increasing the cost of care. The same limit would apply even if the family member were a trained and certified caregiver. It is unclear why that family member should be allowed to be paid a market rate to provide care to a stranger, but not be paid the same amount to provide the same care to a family member.

Response: The bill would allow an insurer or the incorporated association to contract for attendant care as an allowable expense at any rate and for any number of hours per week. In situations in which it was cost effective to train a family member to care for an individual, the insurer would be allowed to pay more than \$15 per hour.

Opposing Argument

The lower reimbursement rates that would result from the bill would reduce revenue for care providers and could drive some providers out of business. That means less care would be available for patients and fewer jobs would be available in the State. Catastrophic auto claims are different and require different care than most health claims. For instance, while approximately 1.2% of patients covered by general medical insurance are suffering from a brain injury, 51% of the population covered by the MCCA has a brain or spinal cord injury. The average cost of care for this population is higher than the cost for the general treatment population. Although the medical reimbursement codes may be the same, the cost of providing care to an auto accident victim may be higher. An hour of physical therapy, for example, may require more people and special equipment for an auto accident victim, but with a fee schedule, the reimbursement amount would be the same as the average paid to a general insurance company for an hour of physical therapy. Also, since the language in the bill is unclear regarding what would constitute negotiation between parties or how the average rate would be calculated, there could be considerable delays in payments to providers.

Response: No-fault claims account for 4% to 5% of hospital revenue, so a reduction in reimbursement would be unlikely to drive providers out of business. There are thousands of CPT codes for providers to describe the care they have provided for an accident victim. If the level of care for two patients is different, the providers will code the care differently. Therefore, different patient needs should not explain different reimbursement rates for the same CPT codes, depending on the type of insurer that is paying for the coverage.

Opposing Argument

The Michigan Legacy Claims Association would not be transparent under the bill. Senate Bill 248 (S-3) would require the new incorporated association to comply with FOIA requests and hold its meetings in a place open to the public, but it would not extend those requirements to the former association (the current MCCA). The legacy association still would not be required to share data or allow the public to see its rate-setting process.

Response: There is a pending court case regarding whether the MCCA is subject to FOIA disclosure. Requirements concerning the existing association should not be changed until that case is resolved.

Opposing Argument

None of the language in Senate Bill 248 (S-3) would require auto insurance companies to lower rates for policy holders. It is possible that lower costs would lead to higher profits for the insurers, rather than lower payments for drivers.

Response: Michigan has many auto insurers operating within the State. The marketplace is competitive, and the main concern for many potential customers is the premium. It is in the insurance companies' best interests to offer premiums at the lowest level that is actuarially sound in order to attract more customers.

Legislative Analyst: Ryan M. Bergan

FISCAL IMPACT

The bill would appropriate \$150,000 General Fund to the Department of Insurance and Financial Services for the purpose of producing a report on the effects of the bill. The bill would have no fiscal impact at the local level.

Fiscal Analyst: Glenn Steffens

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.