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NO-FAULT AUTO INSURANCE AMENDMENTS – REVISED

House Bill 5013 as introduced
Sponsor: Rep. Lana Theis
Committee: Insurance
Complete to 10-3-17

BRIEF SUMMARY:

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

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

House Bill 5013 would do all of the following:

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

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

BRIEF FISCAL IMPACT - REVISED:

House bill 5013 could reduce state revenues by an estimated $20-$35 million per year and could create increased costs for Medicaid by an estimated $150 million per year after 10 years. The bill also could create additional indeterminate state department costs as well as local law enforcement and court costs. A more detailed fiscal impact follows in page 15.

DETAILED SUMMARY:

PIP Coverage Level Options

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

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

If an insured person did not make a coverage selection, done on a form approved by the director, then no maximum limit would apply to the policy. However, once a person makes a selection of a limited coverage policy, and does not select a different coverage level before renewing, the coverage level before the renewal would apply.

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

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

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

PIP Coverage Level Options, for a "Qualified Person"

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

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

The certification of a "qualified person", in addition to the PIP coverage selection of a qualified person, would be done through forms approved by the director. The form would have to disclose in a conspicuous manner that a qualified person is not obligated to purchase PIP coverage for the qualified person. If a person were at least 62 years of age and did not complete this form, the person would purchase insurance with PIP coverage in the normal manner.

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

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

PIP Premium Rate Reductions

The bill would require insurance companies that offer automobile insurance in Michigan to file premium rates for PIP coverage that take into account the bill's optional, lower coverage limits for policies effective after June 30, 2018, and before July 1, 2019. The rates filed, and any rates filed within the next 5 years for policies with PIP coverage that is subject to the coverage limits, would be required to "reflect savings expected from [the proposed bill]".

If the premium rates filed for PIP coverage under a policy that is subject to the $250,000 PIP coverage limit did not result in an average 40% reduction per vehicle from the PIP premium rates that were in effect for the insurer on October 1, 2017, the insurer would enter into a review process with the director. Such an insurer would be required to include the following with the rate filing:

- Premium rates for PIP coverage limits as near as practicable to the 40% reduction.
- A detailed explanation of the reasons for the insurer's failure to achieve the 40% reduction and a demonstration using accepted actuarial techniques that the 40% reduction is not justified because of any of the following:
    - Expected losses by the insurer.
    - Inflation.
    - A change in assessment by the MCCA or MAIPF.

The director would review all the filings for compliance with these requirements (that is, to both file rates for the $250,000 and $500,000 policies that "reflect savings" and file rates for the $250,000 policy that result in the 40% reduction). If a filing did not meet the rate reduction requirements, and if the failure to achieve the 40% reduction was not justified according to one of the factors listed, the director would be required to disapprove the filing.

If the director disapproved the filing, he or she would be required to determine what rate reduction the insurer could achieve (as close as possible to the average 40% reduction), and provide the insurer with a written explanation for the disapproval and determination of the practicable rate reduction. The insurer would then submit a revised filing with the director within 15 days of the disapproval that complies with the director's determination of the practicable rate reduction. This filing would again be subject to review.

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

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

Attendant Care and Allowable Expense Limits

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

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

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

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

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

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

Medical Provider Reimbursement Limits

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

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

- No more than 125% of the amount payable for the treatment, training, product, service, or accommodation under the federal Medicare program, for an "emergency medical condition" and "related emergency care".
- No more than 100% of the amount payable under Medicare, for all other circumstances and all other treatments, training, products, services, or accommodations.

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

- No more than the average amount accepted by the provider for the treatment, training, product, service, or accommodation during the preceding calendar year if Medicare does not provide an amount payable.

Medical Provider Reimbursement Limits, Regular Updates by Director

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

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

Medical Provider Reimbursement Limits, and Reporting Requirements

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

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

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

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

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

Finally, the bill would require DIFS to issue rules for hearings with medical providers regarding compliance with the medical reimbursement schedule. If after a hearing, DIFS determined that a medical provider engaged in a pattern or practice of conduct in violation of the reimbursement schedule or limitations, DIFS would be able to prohibit the medical provider from charging and receiving payment for any PIP benefits for a period of time, and would also be able to order a refund of amounts received in violation.

Utilization Review by Insurers

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

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

Any medical provider that knowingly submits false or misleading information to an insurer, the MCCA, or DIFS would be guilty of a misdemeanor, punishable by imprisonment up to one year or a fine of up to $1,000, or both.

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

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

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

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

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

Michigan Catastrophic Claims Association, Actuarial Examination

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

As noted above, beginning on July 1, 2018, the MCCA would be examined once every five years. The director would be required to engage one or more independent actuaries to

examine the MCCA's records, specifically as related to the premiums charged to members, adjustments to premiums for any excesses or deficiencies, and any rebates.

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

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

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

If a rebate were received, the MCCA member would then distribute the rebate to the person that it insures on a uniform basis per car in a manner and on the date or dates provided by the director in accordance with the order issued.

Michigan Catastrophic Claims Association, Calculation of Premium

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

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

Additionally under the bill, a member may not be charged a premium for a car insured under a policy with either the $250,000 or $500,000 coverage limit, *except* for any portion

of the total premium attributable to an adjustment for a deficiency in a previous period.[2] The bill would state this provision again, as related to the calculation of average premium per car, by excluding those cars insured under a policy with a coverage limit from the calculation of the total written car years written by all members of the MCCA.

The bill would also require the MCCA to provide the director with a report regarding the new premium amount, and giving justification of any adjustment.

Michigan Catastrophic Claims Association, Plan of Operation

The bill would require the MCCA to amend its plan of operation. First, it would add that the plan of operations include procedures requiring that "any portion of the premium payable by a member of the [MCCA] passed on to an insured for a car" be equal to "the portion of the premium payable by the member attributable to that car, including any adjustments for excesses or deficiencies from previous periods."

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

Second, it would add that the plan of operations include "procedures for a rebate of a surplus to members of the association." This potential rebate would occur by an order of the director (see above), or as directed by the MCCA during any period in which the MCCA charges no premium because of excesses from previous periods. The MCCA could only direct such a rebate if it would not threaten the MCCA's ability to provide an effective reinsurance mechanism for PIP benefits based on generally accepted and reasonable actuarial techniques. The term "surplus" would be defined as any excesses from previous periods not reserved by the MCCA to cover the expected losses and expenses it will likely incur during the period for which a premium is applicable. Surplus would not include any excesses from previous periods adjusted over 5 years or more years.

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

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

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

Attorney Fee Changes

Currently under the act, an attorney is "entitled to" a reasonable fee for representing a claimant in an action for overdue PIP benefits. Also under the act, an insurer may be awarded a sum against a claimant for the insurer's attorney fees if the claim was "in some respect fraudulent or so excessive as to have to no reasonable foundation." The bill would revise these provisions.

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

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

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

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

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

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

- If a dispute were related to payment for allowable expenses of attendant care or nursing services, attorney fees could only be awarded for related expenses for the preceding 12 months of the date when the insurer is notified of the dispute. No attorney fees would be allowed to be awarded in relation to expenses paid after the date the insurer is notified of the dispute (even if future payments were ordered).
- A court would not be allowed to award an attorney fee for advising or representing a claimant for PIP benefits for treatment, services, training, or accommodation for the claimant in which the lawyer has (or had at time of treatment) a direct or indirect

financial interest in the person who provided the treatment, services, training, or accommodation.

- "direct or indirect financial interest" would exist if the person that provided the treatment, services, training, or accommodation makes a direct or indirect payment or provides a financial incentive to the attorney or a related person of the attorney relating to the treatment within 24 months before or after the treatment is provided.

Tort Liability

Currently under the Code, a person is subject to tort liability for noneconomic loss caused by his or her ownership or use of a motor vehicle if the injured person has suffered death, "serious impairment of body function", or permanent serious disfigurement. The "serious impairment of body function" is currently defined as an "objectively manifested impairment of an important bodily function that affects the person's general ability to lead his or her normal life."

The bill would state that the "serious impairment of body[ily] function" is fact-specific and determined on a case-by-case basis. It would also change the definition, and require the impairment to meet the following three criteria:

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

Michigan Automobile Insurance Fraud Authority

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

The changes to existing MAIPF would be as follows:

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

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

The MAIFA would be structured as follows:

- It is not a state agency, state authority, or political subdivision of Michigan. Money of the MAIFA is not state money. A record of the MAIFA is exempt from Michigan's Freedom of Information Act.

- Power and duties are vested in a 15-member board of directors, 8 who represent automobile insurers in Michigan, the director or designee, the director of the Michigan State Policy (MSP) or designee, 2 who represent law enforcement, one who represents prosecuting attorneys, a resident of the state's largest city (Detroit), and one member of the general public.
- The board members representing automobile insurers are elected by the authorized automobile insurers in Michigan.
- The governor appoints the 2 members representing law enforcement, the member representing prosecuting attorneys, the member representing the state's largest city, and the member representing the general public.
- Members serve for 4 years or until a successor is elected or appointed, with staggered terms for the initial board. They serve without compensation, except for necessary travel and expense reimbursements.
- The board must elect a chairperson and meet at the call of the chair, or as provided in the bylaws of the authority. Meetings are open to the public, must be posted at least 10 days in advance, and minutes and other information regarding the authority's operation must be posted online. The board may meet in closed session for specific purposes.

The responsibilities of the MAIFA would be the following:

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

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

The board would have the following powers:

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

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

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

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

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

Insurance Fraud Changes

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

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

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

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

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

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

Additional Changes

The bill provides that within a 3-year window after being enacted into law, an insurance producer, including a producing agent, or an employee or agent of an insurance producer would not be liable for damages caused by the conduct of the producer, employee, or agent as related to obtaining or providing information, or the choice of PIP benefits by an insured.

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

New Definitions

The bill would create multiple new definitions within Chapter 31 of the Insurance Code. They are highlighted above, and defined below.

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

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

"Qualified medical professional" means any of the following:

- A physician, as defined in the Public Health Code as, "an individual who is licensed under [the Code] to engage in the practice of medicine," or "an individual who is licensed under [the Code] to engage in the practice of osteopathic medicine and surgery".
- A physician's assistant, licensed under Article 15 of the Public Health Code, "under that health profession subfield of the practice of medicine or the practice of osteopathic medicine and surgery."
- A dentist, as defined in the Public Health Code as, "an individual licensed under [the Code] to engage in the practice of dentistry".
- An advanced practice registered nurse, defined in the Public Health Code as, "a registered professional nurse who has been granted a specialty under section 17210 in one of the following health profession specialty fields: nurse midwifery, nurse practitioner, clinical nurse specialist."
- Related emergency care (in the context of the allowable medical costs described above) is defined as "a reasonable necessary in-patient treatment, product, service, or accommodation related to, immediately following, and necessitated by an emergency medical condition as determined and documented by a qualified medical professional."

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

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

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

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

DETAILED FISCAL IMPACT - REVISED:

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

State Revenues:
Domestic and foreign insurers pay an insurance premiums tax under the corporate income tax, the base of which is 1.25% of gross direct premiums written in Michigan. Foreign insurers also pay a retaliatory assessment to the extent that the policies written would be more expensive in the state in which they're incorporated. Because it is expected that premiums will decline, depending on the level of coverage chosen, revenue from insurance companies would also decline accordingly. Unfortunately, that actual decrease in gross premiums written in Michigan that will result from the legislation cannot be determined in advance, which complicates the estimation process. However, using available data on average premiums in Michigan along with the number of registered vehicles, average premiums, the percentage of drivers that are currently uninsured, and other factors, and assuming an approximate premium reduction of 25%, the annual revenue reduction is expected to fall somewhere in the $20 million to $35 million range and would be borne by the state's General Fund. To the extent the assumptions vary from the eventual outcome, the estimated revenue reduction will likewise vary.

Medicaid:
The Medicaid program costs would increase to the extent that the bill would shift health care costs from private automobile insurers to Medicaid. Preliminary estimates indicate this bill would increase state costs by $10.0 million in the first year and would steadily grow to approximately $150.0 million in annual state costs within 10 years. The primary Medicaid cost driver from the bill would be the added cost as more individuals receive Medicaid-funded long-term care services instead of private automobile insurance-funded long-term care services. Medicaid is a joint state/federal health care program where the federal government provides reimbursement funding for part of the total program cost. The current federal Medicaid match rate is 64.78%, meaning the state has to pay for 35.22% of the program's cost.

There are 3 primary benefits PIP covers that commercial health insurance does not: long-term nursing home services, home help (or attendant) services, and loss of income from injury. Medicaid, however, does cover long-term nursing home services and attendant care services, so this estimate assumes 100% of Medicaid beneficiaries would select a capped PIP limit. Therefore, a catastrophic injury to a Medicaid beneficiary would be covered by Medicaid after the limit is exhausted. The new state Medicaid costs for these acute health care costs would range from $10.0 million to $13.0 million GF/GP.

The other, more significant, Medicaid cost from the bill would be the added costs to Medicaid long-term care services. Medicaid would be responsible for chronic nursing home and attendant care costs for both of the following: 1) Medicaid beneficiaries who selected a capped PIP limit and 2) individuals who selected a capped PIP limit and have both exhausted any long-term care benefits provided through commercial insurance or Medicare, and have spent down their financial resources to become Medicaid eligible. These added costs for long-term care services would not have an immediate impact to the state, but would increase to approximately $12.0 million GF/GP within 3 years and would increase to $140.0 million GF/GP within 10 years as the number of affected individuals grows. The percentage of non-Medicaid eligible individuals who would select a capped PIP is unknown, so this estimate assumes a mid-point of 50%, meaning the actual impact may be greater or less than this estimate depending on the extent to which that population chooses a capped plan.

Department of Insurance and Financial Services

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

Department of Attorney General

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

Michigan State Police and Local Enforcement

HB 5013 would likely increase revenues, by an unknown amount, for the Department of State Police (MSP) and local law enforcement agencies. The bill would require the Michigan Automobile Insurance Fraud Authority to "provide financial support to state or local law enforcement agencies" in order to mitigate automobile insurance fraud and theft. Currently, the Auto Theft Prevention Authority provides grants to the MSP from the Auto

Theft Prevention Fund, to support auto theft prevention operations – such as those of the Southeast Auto Theft Team. This fund is established by 1956 PA 218 and is supported by a $1 per non-commercial vehicle assessment paid annually by automobile insurers operating with the State. A total of $7.7 million is appropriated from the Auto Theft Prevention Fund in the FY 2017-18 MSP budget.

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

Department of Corrections and State and Local Courts

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

Legislative Analyst: Patrick Morris
Fiscal Analysts: Jim Stansell
Kevin Koorstra
Marcus Coffin
Michael Cnossen
Kent Dell
Robin Risko

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

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