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Senate Bill 1 (Substitute S-1)  
Sponsor: Senator Aric Nesbitt  
Committee: Insurance and Banking

Date Completed: 5-7-19

## **CONTENT**

**The bill would amend the Insurance Code to do the following:**

- **Allow an insured person to select one of two personal injury protection (PIP) coverage levels: \$250,000; or \$50,000, plus \$200,000 for medically necessary treatment rendered at an acute care unit or trauma center of a hospital immediately after the accidental bodily injury.**
- **Allow an insurer to offer unlimited PIP coverage, beginning on the bill's effective date.**
- **Allow a qualified person to elect not to maintain coverage for PIP benefits, for insurance policies issued on or after the bill's effective date, and provide the definition of a "qualified person".**
- **Require the Director of the Department of Insurance and Financial Services (DIFS) to approve forms for the selection of PIP benefits and for the election not to maintain PIP coverage.**
- **Specify that the Michigan Catastrophic Claims Association (MCCA) would not have liability for a loss under PIP coverage for a motor vehicle accident policy issued or renewed after [date unspecified].**
- **Require the MCCA's plan of operation to include a dissolution plan for the eventual payment of all claims remaining against the MCCA, the MCCA's dissolution, and the distribution of any proceeds from the dissolution.**
- **Require the Director to engage one or more independent actuaries to examine the MCCA's affairs and records, beginning July 1, 2019, and every third year after that.**
- **Require the Director to order the MCCA to issue a rebate, if the actuarial examination showed that the MCCA's assets exceed 120% of its liabilities.**
- **Require the MCCA to prepare and submit to the Legislature and post on its website, by September 1 of each year, an annual consumer statement containing certain information.**
- **Require a person entitled to claim PIP benefits through the assigned claims plan to file a completed application on a claim form provided by the Michigan Automobile Insurance Placement Facility (MAIPF) and provide reasonable proof of loss to the MAIPF.**
- **Require the MAIPF to review a claim for PIP benefits under the assigned claims plans, make an initial determination of a claimant's eligibility for benefits, and deny a claim it determined was ineligible.**
- **Limit reimbursement to medical providers based on schedules for maximum fees for worker's compensation.**

- **Require a medical provider to submit necessary records and other information concerning treatment, products, services, or accommodations provided for utilization review.**
- **Require DIFS to promulgate rules to establish criteria or standards for utilization review.**
- **Specify that an insurer would be required to pay attendant care only up to 56 hours per week if the care were provided by the employee's spouse, brother, sister, child, parent, or any combination of those individuals.**
- **Allow an insurer to contract to pay benefits for attendant care for more than the 56-hour limitation.**
- **Modify the statute of limitations for filing an action to enforce rights to indemnify or reimbursement against a third party.**
- **Modify the order of priority for claiming PIP benefits from insurers with regard to an occupant of a motor vehicle, operator or passenger of a motorcycle, and a nonoccupant.**
- **Create the Automobile Insurance Fraud Task Force within the Michigan State Police (MSP).**
- **Require the Task Force to investigate automobile insurance fraud and pursue the prosecution of persons that commit automobile insurance fraud.**
- **Require the Task Force to prepare and publish an annual report to the Legislature detailing automobile insurance fraud by medical providers, attorneys, or other people and unfair claims practices of insurance companies, and the impact the fraud and unfair claims practices had on rate charges for automobile insurance.**
- **Create the "Automobile Insurance Fraud Fund".**

Section 3112, which the bill would amend, would apply to products, services, or accommodations provided after the bill's effective date.

#### PIP Benefits

The Code specifies that PIP benefits are payable for accidental bodily injury suffered in an accident occurring in the State, if the accident occurred within the United States, its territories and possession, or Canada, and the person whose injury is the basis of the claim was at the time of the accident a named insured under the no-fault insurance policy, the spouse of the named insured, a relative of either domiciled in the same household, or the occupant of a vehicle involved in the accident, if the owner or registrant was insured under a no-fault policy.

Under the bill, PIP benefits would be payable to an occupant if the owner or registrant of the were insured under a no-fault policy *or* if the occupant were a resident of the State.

A person is not entitled to PIP benefits for accidental bodily injury if at the time of the accident certain circumstances prescribed in the Code existed, including if the person was not a resident of the State, was an occupant of a motor vehicle or motorcycle not registered in the State, and the motor vehicle or motorcycle was not insured by an insurer that had filed a certificate of compliance.

The bill would refer only to a person who was not a resident of the State.

#### PIP Choice

The Code requires the owner or a registrant of a motor vehicle required to be registered in Michigan to maintain security for payment of benefits under "no-fault" insurance, which includes PIP, property protection insurance, and residual liability insurance.

Under the bill, except as otherwise provided, for an insurance policy that provided no-fault insurance and was issued on or after the bill's effective date, the person named or to be named in the policy, in the manner required under the bill and on a form approved by the Director, would have to select one of the following coverage levels for PIP benefits:

- A limit per person per loss occurrence consisting of both of the following: a \$50,000 limit for PIP benefits, and an additional \$200,000 for medically-necessary treatment rendered at an acute care unit or trauma center of a hospital immediately after the accidental bodily injury and until the patient was stable.
- A \$250,000 limit per individual per loss occurrence for PIP benefits.

The PIP benefits selection form described above would have to do all of the following:

- State, in a conspicuous manner, the benefits and risks associated with each coverage option.
- Provide a way for the person to mark the form to acknowledge that he or she had read the form and understood the options available.
- Allow the insured person to mark the form and make the selection of coverage level.
- Require the person to sign the form.

If an insurance policy were issued or renewed and the person named in the policy had not made an effective PIP benefits selection, but a premium or portion of a premium had been paid, there would be a rebuttable presumption that the amount of the premium accurately reflected level of coverage applicable to the policy.

If an insurance policy were issued or renewed as described above, the person named in the policy had not made an effective PIP benefits selection, and a rebuttable presumption did not apply, the \$50,000 PIP coverage, plus \$200,000 for medically-necessary treatment limit would apply to the policy.

The coverage level selected would apply to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, and any other person with a right to claim PIP benefits under the policy.

If benefits were payable for allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation under two or more insurance policies, the benefits would be payable only up to an aggregate coverage limit for both or all of the policy that equaled the highest available coverage limit under any one of the policies.

After the bill's effective date, an insurer could offer an insurance policy that provided coverage for PIP benefits without any limit.

For an insurance policy that provided no-fault insurance, and was issued or renewed after the bill's effective date, the person named or to be named on the policy who was a qualified person could, in the manner required under the bill and on a form approved by the Director, elect not to maintain coverage for PIP benefits.

"Qualified person" would mean a person who has qualified health coverage. "Qualified health coverage" would mean either of the following:

- Other health or accident coverage that did not exclude or limit coverage for injuries related to motor vehicle accidents.

- Medicare coverage.
- Medicaid coverage.

The person named in the policy, when requesting issuance or renewal of the policy, would have to provide to the insurer a document that the person provided the qualified health coverage stating that the person named in the policy had qualified health coverage.

The form to elect not to maintain coverage for PIP benefits would have to do all of the following:

- Require the person named or to be named in the policy to mark the form to certify whether he or she was a qualified individual.
- Disclose in a conspicuous manner that a qualified person was not obligated to but could purchase coverage for PIP benefits.
- State, in a conspicuous manner, the coverage levels available under the bill.
- State, in a conspicuous manner, the benefits and risks associated with not maintaining coverage.
- State, in a conspicuous manner, that if during the term of the policy the person ceased to have qualified health insurance, he or she would have 14 days to notify the insurer or he or she would be excluded from PIP benefits.
- Provide a way for the person named or to be named in the policy to mark the form to acknowledge that he or she had read the form and understood it, and that he or she understood that option available to him or her.
- Provide the person a way to mark the form to elect not to maintain coverage, if the person named or to be named on the policy were a qualified person.
- Require the person to sign the form.

If an insurance policy were issued or renewed and the person named in the policy had not made an effective election for PIP benefits but a premium or portion of a premium had been paid, there would be a rebuttable presumption that the amount of the premium accurately reflected whether the person elected to maintain coverage for personal protection benefits.

If an insurance policy were issued or renewed as described above, the person named in the policy had not made an effective personal protection insurance selection, and a rebuttable presumption did not apply, the \$50,000 PIP coverage, plus \$200,000 for medically necessary treatment limit would apply to the policy.

An election not to maintain PIP benefits would apply to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, and any other person with a right to claim PIP benefits under the policy but for the election.

If a person named in an insurance policy under which coverage for PIP benefits were not maintained ceased, during the term of the policy, to be covered under qualified health coverage, the person, within 14 days, would have to notify the insurer that the person no longer was a qualified person. All of the following would apply:

- During the 14-day period, if a person to whom the election not to maintain PIP benefits applied suffered accidental bodily injury arising from a motor vehicle accident, the person would be entitled to claim benefits under the assigned claims plan.
- If the person named in the insurance policy notified the insurer within the 14-day period, the person would have to obtain insurance that provided PIP benefits that included the coverage that was not maintained.

- If the person named in the policy did not notify the insurer within the 14-day period and a person to whom the election applied suffered accidental bodily injury arising from a motor vehicle accident, unless the injured person was entitled to coverage under some other policy, the injury person would not be entitled to PIP benefits for the injury.

A PIP benefits selection form or a form to elect not to maintain PIP benefits would have to be delivered to the person insured or to be insured under the policy using one of the following methods:

- Personal delivery.
- First-class mail, postage prepaid.
- Electronic delivery in accordance with those methods specified under the Code.

A person would have make a PIP benefits selection or an election not to maintain PIP benefits in one of the following ways:

- Marking and signing a paper form.
- Giving verbal instructions, in person or telephonically, that the form be marked and signed in behalf of the person.
- Electronically marking the form and providing an electronic signature.

#### Michigan Catastrophic Claims Association

The Code establishes the Michigan Catastrophic Claims Association, an unincorporated, nonprofit association. Each insurer engaged in writing insurance coverages that provides no-fault insurance in the State, as a condition of its authority to transact insurance in the State, must be a member of the MCCA. An insurer engaged in writing coverage that provide the no-fault insurance in the State, as a condition of its authority to transact insurance in the State, is considered to be a member of the MCCA. The bill would refer to insurers that provide the required no-fault insurance six months after the bill's effective date.

The MCCA must provide and each member must accept indemnification for 100% of the amount of ultimate loss sustained under PIP coverages in excess of certain amounts in each loss occurrence. Under the bill, this provision would apply only to a motor vehicle accident policy issued or renewed before six months after the bill's effective date. The MCCA would not have liability for an ultimate loss under PIP coverage for a motor vehicle accident policy issued or renewed after [date unspecified].

The MCCA reimburses a company for the amount of PIP losses over a certain amount, which is currently \$555,000. Under the bill, for a motor vehicle accident policy issued or renewed during the following periods, the MCCA would provide PIP coverages in excess in the following amount in each loss occurrence:

- \$555,000 for July 1, 2017, to June 30, 2019.
- \$580,000 for July 1, 2019, to six months after the bill's effective date.

The bill would delete a provision requiring the amount to be increased biennially on July 1 of each odd-numbered year, by the lesser of 6.0% or the Consumer Price Index, and rounded to the nearest \$5,000.

Each member of the MCCA must be charged an amount equal to that member's total written car years of insurance providing no-fault insurance, or both, written in the State during the period to which the premium applies multiplied by the average premium per car. Under the

bill, the average premium per car would have to be multiplied by the total written car years of insurance.

The average premium per car is the total premium divided by the total written car years of insurance providing no-fault insurance. Under the bill, the total premium would have to be adjusted for any excess or deficiencies.

MCCA Responsibilities. Under the Code, in a manner provided for in the plan of operation, the MCCA must calculate and charge to its members a total premium sufficient to cover the MCCA's expected losses and expenses that it likely will incur during the period for which the premium is applicable. Under the bill, the premium charged to members would have to be less any money payable by insurers under the rate-making procedures (described below). Total premium must include an amount to cover incurred but not reported losses for the period and may be adjusted for any excess or deficient premium from previous periods. Under the bill, the premium would have to be adjusted for any excess or deficient premium from previously periods, *including any period previous to the MCCA's dissolution.*

In addition to the above requirement and other requirements prescribed in the Code, the bill would require the MCCA to do the following:

- Provide any records necessary or requested by the Director for an actuarial examination described below.
- Obey an order of the Director for a rebate.

Plan of Operation. The Code requires the MCCA's board of directors to operate the Association consistent with the plan of operation and the Code. The plan of operation must provide for certain requirements specified in the Code, including procedures to be used in charging premiums, including adjustments for excess or deficient premiums for prior periods. The bill would require the plan of operation to require that any deficiency from a prior period be amortized over at least 15 years.

The bill also would require the plan of operation to include the following:

- A dissolution plan for the eventual payment of all claims remaining against the MCCA, the MCCA's dissolution, and the distribution of any proceeds from the dissolution, including money held by the MCCA.
- Procedures for a rebate to MCCA members, for distribution to insureds, as ordered by the Director.

The procedures for rebate would have to provide for a distribution of a rebate attributable to a historic vehicle equal to 20% of the rebate for a car that is not a historic vehicle.

Under the bill, the rate-making procedures for insurance rates for an insurer engaged in writing insurance coverage that provided no-fault insurance in the State that did not write those coverages before six months after the bill's effective date would have to recognize a portion of the MCCA's expected losses and expenses that it likely would incur during the applicable period, adjusted for any excesses or deficiencies from any previous periods (described above). The portion to be recognized in rates for an insurer would have to be determined by multiplying the insurer's total written car years of insurance providing no-fault insurance, or both, by the average premium per car. An insurer would have to pay to the MCCA all money received from its insureds.

Actuarial Examination. The Code specifies that the Director or his or her authorized representative may visit the MCCA at any time and examine all of its affairs. Under the bill, beginning July 1, 2019, and every third year after 2019, the Director would have to engage one or more independent actuaries to examine the MCCA's affairs and records for the previous three years. The actuarial examination would have to be conducted using sound actuarial principles consistent with the applicable statements of principles and the Code of Professional conduct adopted by the Casualty Actuarial Society. By September 1, 2019, and by September 1 of every third year after that, the Director would have to provide to the Legislature a report on the results of the audit.

Rebate. If the actuarial examination showed that the MCCA's assets exceeded 120% of its liabilities, including incurred but not reported liabilities, and if the rebate would not threaten the MCCA's ongoing ability to provide reimbursements for PIP benefits based on sound actuarial principles consistent with applicable statements of principles and the Code of Professional Conduct adopted by the Casualty Actuarial Society, the Director would have to order the MCCA to rebate an amount equal to the difference between the total excess and 120% of the MCCA's liabilities, including incurred but not reported liabilities, and order the MCCA's members to distribute the rebates (described below).

Within 30 days after receiving an order from the Director to issue a rebate, the MCCA could request a hearing to review the order by filing a written request with the Director. The Department would have to conduct the review as a contested case under the Administrative Procedures Act.

A member of the MCCA would have to distribute any rebate it received to the people that it insured under policies that provided no-fault insurance or first-party medical benefits to motorcycle owners or registrants, or both, and that were subject to a premium charged by the MCCA on a uniform basis per car and historic vehicle in a manner and in a date or date provided by the Director. A rebate attributable to a historic vehicle would have to be equal to 20% of the rebate for a car that was not a historic vehicle.

Annual Consumer Statement. By September 1 of each year, the MCCA would have to prepare, submit to the House and Senate committees with jurisdiction over insurance matters, and post on its website, an annual consumer statement, written in a manner intended for the general public. The statement would have to include all of the following:

- The number of claims opened during the preceding 12 months, the amount spent on the claims, and the future anticipated costs of the claims.
- For each of the preceding 10 years, the total number of open claims, the amount spent on the claims, and the anticipated future costs of the claims.
- For each of the preceding 10 years, the total number of claims closed and the amount spent on the claims.
- For each of the preceding 10 years, the ratio of claims opened to claims closed.
- For each of the preceding 10 years, the average length of open claims.
- A statement of the MCCA's current financial condition and the reasons for any deficit or surplus in collected assessments compared to losses.
- A list of the MCCA's assets sorted by category or type of asset, and the expected return of each asset.
- The total amount of the MCCA's discounted and undiscounted liabilities and a description and explanation of the liabilities, including an explanation of the MCCA's definition of the terms "discounted" and "undiscounted".
- Measures taken by the MCCA's to contain costs.

- A statement explaining what portion of the assessment to insureds as recognized in premium rates was attributable to claims occurring in the previous 12 months, administrative costs, and the amount, if any, to adjust for past deficits.
- A statement explaining any qualifications identified by the independent auditors in the most recent audit report.
- A loss payment summary for each of the preceding years by category.
- For each of the preceding 10 years, an injury type summary, categorizing the injuries suffered by claimants the payment of whose claims were being reimbursed by the MCCA.
- A summary of investment returns over the preceding 10 years showing the investment balance, the investment gain, and the percentage return on the investment balance.
- A summary of the mortality assumptions used in making cost projections.
- A summary of any financial practices that differed from those found in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.
- A statement of the assumptions, methodology, and data used to make revenue and cost projections.

"Revenue" would mean return on investments.

Annual Report of the MCCA. By September of each year, the MCCA would have to prepare and provide to the House and Senate committees with jurisdiction over insurance matters an annual report containing all of the following:

- An executive summary.
- A discussion of the mortality assumptions it used in making costs projections.
- An evaluation of the accuracy of its actuarial assumptions over the preceding five years.
- A discussion of the MCCA's progress in developing a dissolution plan and, when it was developed, the plan of dissolution, which would have to include any anticipated dissolution date for the MCCA.
- The annual consumer statement.
- Anything else the MCCA determined was necessary to advise the Legislature about the its operations.

### Medical Care Reimbursement

Section 3157 of the Code specifies that a physician, hospital, clinic, or other person or institution that lawfully renders treatment to an injured person for an accidental bodily injury covered by PIP benefits, or that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services, and accommodations rendered. The charge may not exceed the amount the person customarily charges for like products, services, and accommodations in cases that did not involve PIP benefits. The bill would refer to treatment, *products, services, or accommodations* rendered to an injured person. Also, the bill would allow a provider to charge a reasonable amount for the *treatment, training, products, services, and accommodations*.

A person that rendered a treatment, training, product, service, or accommodation to an injured person for an accidental bodily injury would not be eligible for payment or reimbursement of more than the amount payable for the treatment, training, product, service or accommodation under Rules 418.10101 to 418.104503 of the Michigan Administrative Code or schedules of maximum fees for worker's compensation developed under those rules, in effect on the bill's effective date. The Director would have to review any changes to Rules 418.10101 to 418.104503 or schedules of fees developed under those rules. If the Director determined that the changes were reasonable and appropriate to assure affordable automobile insurance in the State, the changes would apply for purposes of the bill, and the

Director would have to issue an order to that effect. This provision would apply to a treatment, training, product, service, or accommodation rendered after the bill's effective date, regardless of when the accidental bodily injury occurred. It also would apply regardless of whether indemnification for the charge was being made by the MCCA.

Personal injury protection benefits are payable to or for the benefit of an injured person or, in the case of his or her death, to or for the benefits of his or her dependents. Under the bill, a health care provider listed in Section 3157 could make a claim and assert a direct cause of action against an insurer, or under the assigned claims plan, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person.

#### Utilization Review

Under the bill, by rendering any treatment, products, services, or accommodations to one or more injured people for an accidental bodily injured covered by personal protection insurance after the bill's effective date, a physician, hospital, clinic, or other person would be considered to have agreed to do both of the following:

- Submit necessary records and other information concerning treatment, products, services, or accommodations provided for utilization review.
- Comply with any decision of the Department.

A physician, hospital, clinic, or other person or institution that knowingly submitted false or misleading records or other information to an insurer, the MCCA, or the Department would be guilty of a misdemeanor punishable by imprisonment up to one year or a fine of up to \$1,000, or both.

If a physician, hospital, clinic, or other person provided treatment, products, services, or accommodations that were not usually associated with, were longer in duration than, were more frequent than, or extended over a greater number of days than the treatment, products, services, or accommodations usually required for the diagnosis or condition for which the patient was being treated, the insurer or the MCCA created could require the physician, hospital, clinic, or other person to explain the necessity or indication for the treatment, products, services, or accommodations in writing under the procedures related to utilization review.

The Department would have to promulgate rules to establish criteria or standards for utilization review that identified utilization of treatment, products, services, or accommodations above the usual range of utilization for the treatment, products, services, or accommodations based on medically-accepted standards.

"Utilization review" would mean the initial evaluation by an insurer or the MCCA of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided based on medically accepted standards.

The Department also would have to promulgate rules to provide procedures related to utilization review including procedures for all of the following:

- Acquiring necessary records, medical bills, and other information concerning the treatment, products, services, or accommodations provided.
- Allowing an insurer to request an explanation for and requiring a physician, hospital, clinic, or other person to explain the necessity or indication for treatment, products, services, or accommodations provided.

-- Appealing determination.

If an insurer or the MCCA determined that a physician, hospital, clinic, or other person improperly overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate, the physician, hospital, clinic, or other person could appeal the determination to the Department.

If the Department determined that an insurer complied with the criteria or standards of utilization review, it could certify the insurer.

Any proprietary information or sensitive personally identifiable information regarding a patient that was submitted to the Department under Section 3157a would be exempt from disclosure under the Freedom of Information Act.

### Attendant Care

The bill specifies that for attendant care rendered in an injured person's home, an insurer would be required to pay only benefits for attendant care up to the hourly limitation in Section 315 of the Worker's Disability Compensation Act. This provision would apply if the attendant care were provided directly, or indirectly through another person, by any of the following:

- An individual who was related to the injured person.
- An individual who was domiciled in the same household of the injured person.
- An individual with whom the injured person had a business or social relationship before the injury.

(Under Section 315, attendant care may not be ordered in excess of 56 hours per week if the care is provided by the employee's spouse, brother, sister, child, parent, or any combination of these persons).

The insurer could contract to pay benefits for attendant care for more than the hourly limitation.

If Rules 418.10101 to 418.101503 or schedules of maximum fees for worker's compensation developed under those rules, in effect on the bill's effective date, including any changes the Director made to those rules, did not provide an amount payable for treatment, training, product, service, or accommodation rendered to an injured person for accidental bodily injury covered by personal protection insurance or rehabilitative occupational training to the injured person following the injury, the person that rendered the treatment, training, product, service, or accommodation would not be eligible for payment or reimbursement for more than the average amount accepted by the person as payment or reimbursement in full for the training, product, service, or accommodation during the preceding calendar year in cases that did not involve personal protection insurance.

These provisions would apply to a treatment, training, product, service, or accommodation rendered after the bill's effective date, regardless of when the accidental bodily injury occurred. They also would apply regardless of whether indemnification for the charge was being made by the MCCA.

An insurer would have to offer, for a policy that provided PIP benefits, a rider that would provide coverage for attendant care in excess of the limits applicable to the policy.

## Assigned Claims Plan

The Code specifies that a person is entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle in Michigan may claim PIP benefits through the assigned claims plan under certain circumstances.

Under the bill, a person entitled to claim PIP benefits through the assigned claims plan would have to file a completed application on a claim form provided by the MAIPF and provide reasonable proof of loss to the MAIPF. The MAIPF or an insurer assigned to administer a claim on behalf of the MAIPF under the assigned claims plan would have to specify in writing the materials that constituted a reasonable proof of loss within 60 days after it received an application.

The MAIPF or an insurer assigned to administer a claim on behalf of the MAIPF under the assigned claims plan would not be required to pay an interest penalty in connection with a claim for any period of time during which the claim was reasonably in dispute.

The MAIPF and the insurer to whom a claim was assigned by the MAIPF would be required to provide only personal protection insurance benefits up to the limits provided in the bill.

Under the Code, the MAIPF must make an initial determination of a claimant's eligibility for benefits under the assigned claims plan and must deny an obviously ineligible claim. Instead, the bill would require the MAIPF to review a claim for PIP benefits under the assigned claims plan, make an initial determination of a claimant's eligibility for benefits under the assigned claims plan, and deny a claim the MAIPF determined was ineligible. If a claimant or person making a claim through or on behalf of a claimant failed to cooperate with it, the MAIPF would have to suspend benefits to the claimant under the assigned claims plan. A suspension of benefits would not be an irrevocable denial of benefits, and would have to continue only until the MAIPF determined that the claimant or person making a claim through or on behalf of a claimant cooperated or resumed cooperation with the MAIPF.

The Code also requires the MAIPF to promptly notify in writing a claimant of a denial and the reasons for the denial. Under the bill, it also would have to promptly notify in writing any person that submitted a claim through or on behalf of a claimant for a denial and the reasons for the denial.

A claimant or a person making a claim through or on behalf of a claimant would have to cooperate with the MAIPF in its determination of eligibility and the settlement or defense of any claim or suit, including submitting to an examination under oath and compliance with the Code's provisions to mental or physical examinations. There would be a rebuttable presumption that a person had satisfied the duty to cooperate if all of the following applied:

- The person submitted a claim for PIP benefits under the assigned claims plan by submitting to the MAIPF a complete application in accordance with the assigned claims plan.
- The person provided reasonable proof of loss under the assigned claims plan.
- If required to submit to an examination under oath, the person submitted to the examination, subject to all of the following: a) the person was provided at least 21 days' notice of the examination; b) the examination was conducted in a location reasonably convenient for the person; and c) any reasonable request by the person to reschedule the date, time, or location of the examination was accommodated.

The MAIPF could perform its functions and responsibilities and the assigned claims plan directly or through an insurer assigned by the MAIPF to administer the claim on its behalf.

The assignment of a claim by the MAIPF to an insurer would not be a determination of eligibility and a claim assigned to an insurer by the MAIPF could later be denied if the claim were not eligible.

Under the Code, a person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the MAIPF for payment or another benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under Section 4503 that is subject to the penalties imposed under Section 4511. (Section 4503 specifies that particular acts or omissions committed by a person knowingly, and with intent to injure, defraud, or deceive, are designated fraudulent insurance acts. Under Section 4511, a person who commits a fraudulent insurance act under Section 4503 is guilty of a felony, punishable by up to four years' imprisonment or a fine of up to \$50,000, or both, and must pay restitution. A person who enters into an agreement or conspiracy to commit a fraudulent act under Section 4503 is guilty of a felony, punishable by up to 10 years' imprisonment or a fine of up to \$50,000, or both, and must pay restitution.)

Under the bill, a person who presented or caused to be presented an oral or written statement to an insurer to which the claim was assigned under the assigned claims plan for payment or another benefit knowing that the statement contained false information concerning a fact or thing material to the claim also would commit a fraudulent insurance act.

The bill would allow the MAIPF to contract with other people for all or a portion of the goods and services necessary for operating and maintaining the assigned claims plan.

The Code requires a person claiming through the assigned claims plan to notify the MAIPF of his or her claim within the time that would have been allowed for filing an action for personal protection insurance benefits if identifiable coverage applicable to the claim had been in effect. Instead, under the bill, a person claiming through the assigned claims plan would have to notify the MAIPF of his or her claim within one year after the date of the accident.

The Code also requires the MAIPF to promptly assign the claim in accordance with the plan and notify the claimant of the identity and address of the insurer to which the claim is assigned. Under the bill, this provision would apply on an initial determination of a claimant's eligibility for benefits through the assigned claims plan.

Under the Code, an action by a claimant may not be commenced more than 30 days after receiving notice of the assignment or the last date on which the action could have been commenced against an insurer of identifiable coverage applicable to the claim, which is later. Instead, the bill specifies that an action by a claimant would have to be commenced as provided in Section 3145. (That section specifies that an action to recover PIP benefits payable for accidental bodily injury may not be commenced later than one year after the date of the accident causing the injury unless written notice of the injury has been given to the insurer within one year after the accident or unless the insurer has previously made a payment of PIP benefits for the injury. If the notice has been given or a payment has been made, the action may be commenced at any time within one year after the most recent allowable expense, work loss, or survivor's loss has been incurred.)

#### Indemnification & Reimbursement by the MAIPF

The bill would allow an insurer assigned a claim by the MAIPF under the assigned claims plan or a person authorized to act on behalf of the plan to bring an action for reimbursement and indemnification of the claim on behalf of the MAIPF.

Under the Code, the insurer to which a claim has been assigned must preserve and enforce rights to indemnify or reimbursement against third parties and account to the MAIPF for rights and must assign the rights to the MAIPF on reimbursement by the MAIPF.

An action to enforce rights to indemnity or reimbursement against a third party may not be commenced after the later of the following:

- Two years after the assignment of the claim to the insurer.
- One year after the date of the last payment to the claimant.

Instead, under the bill, an action to enforce rights to indemnify or reimbursement against a third party could not be commenced after the later of the following:

- Two years after the assignment of the claim to the insurer.
- One year after the date of the last payment to the claimant.
- One year the date the responsible third party is identified.

#### Order of Priority

Occupant. Except as otherwise provided, a person who suffers accidental bodily injury arising from a motor vehicle accident while an occupant of a motor vehicle must claim PIP benefits from insurers in the following order of priority:

- The insurer of the owner or registrant of the motor vehicle occupied.
- The Insurer of the operator of the motor vehicle occupied.

Instead, under the bill, a person who suffered accidental bodily injury while an occupant of a motor vehicle who was not covered under a policy providing PIP benefits would have to claim PIP benefits under the assigned claims plan.

Motorcycle. A person who suffers accidental bodily injury arising from a motor vehicle accident that shows evidence of the involvement of a motor vehicle while an operator or passenger of a motorcycle must claim PIP benefits from insurers in a certain order or priority prescribed in the Code.

Under the bill, if an applicable insurance policy in an order of priority for a motorcycle operator or passenger were a policy for which the person named in the policy had elected not to maintain coverage for PIP benefits, the injured person would have to claim benefits only under other policies in the same order of priority for which no such election had been made. If there were no other policies for which an election had been made, the injured person would have to claim benefits under the next order of priority or, if there were not a next order or priority, under the assigned claims plan.

If PIP benefits were payable to a motorcycle operator or passenger under two or more insurance policies in the same order of priority, the benefits would be payable only up to an aggregate coverage limit for both or all of the policies that equaled the highest available coverage limit under any one of the policies.

Nonoccupant. Except as otherwise provided, a person who suffers accidental bodily injury while not an occupant of a motor vehicle must claim PIP benefits from insurers in the following order of priority:

- Insurers of owners or registrants of motor vehicles involved in the accident.
- Insurers of operators of motor vehicles involved in the accident.

Instead, under the bill, except as otherwise provided, a person who suffered accidental bodily injury while not an occupant of a motor vehicle would have to claim PIP benefits under the assigned claims plan.

The Code specifies that when two or more insurers are in the same order of priority to provide PIP benefits an insurer paying benefits due is entitled to partial recoupment from the other insurers in the same order of priority, together with a reasonable amount of partial recoupment of the expense of proceeding the claim, in order to accomplish equitable distribution of the loss among such insurers. A limit on the amount of PIP benefits available because of accidental bodily injury to one person arising from one motor vehicle accident must be determined without regard to the number of policies applicable to the accident. The bill would delete these provisions.

#### DIFS Website

The bill would require DIFS to maintain on its website a page that did all of the following:

- Advised that the Department could be able to assist a person who believed that an automobile insurer was not paying benefits, not making timely payment, or otherwise not performing as it is obligated to do under an insurance policy.
- Advised the person of selected important rights that the person had under Chapter 20 (Unfair and Prohibited Trade Practices and Frauds) that specifically related to automobile insurers and the payment of benefits by insurers.
- Allowed the person to submit an explanation of the facts of the person's problems with the automobile insurer.
- Allowed the person to submit electronically, or instructed the person how to provide paper copies of, any documentation to support the facts submitted.
- Explained to the person the steps that the Department would take and that could be taken after information was submitted.
- Anything else that the Director determined to be important.

The Department also would have to maintain on its website a page that advised consumers about the changes the bill would make to automobile insurance in the State, including, among any other information that the Director determined to be important, ways to shop competitively for insurance.

Additionally, the Department would have to maintain on its website a page that allowed a person to report insurance fraud and unfair settlement and claims practices to the Department.

#### Automotive Insurance Fraud Task Force

The bill would create the Automobile Insurance Fraud Task Force within the Michigan State Police. Members of the Task Force would have to perform their duties on the under the direction of the MSP Director.

Membership. The Task Force would consist of the following members:

- Five MSP officers, appointed by the MSP Director.
- One DIFS employee, appointed by the Director of DIFS.

- One representative of the MCCA, appointed by the MCCA Board.
- One employee of the MAIPF who was involved in the operation of the assigned claims plan, appointed by the MAIPF.
- One employee of the Department of Attorney General, appointed by the Attorney General.

A member of the Task Force would have to serve at the pleasure of the person that appointed the member. If a vacancy occurred on the Task Force, the person with the power to appoint a member to the vacant position would have to make an appointment in the same manner as the original appointment.

Responsibilities. The Task Force would have to do all of the following:

- Receive records from the anti-fraud unit created under Executive Order 2018-9.
- Collect, maintain, and investigate claims of automobile insurance fraud.
- Maintain records of its investigations.
- Pursue the prosecution, whether criminal or civil, of persons that commit automobile insurance fraud.

"Automobile insurance fraud" would mean a fraudulent insurance act as described in Section 4503 that is committed in connection with automobile insurance, including an application for automobile insurance, regardless of whether the act constitutes a crime or another violation of law.

The Task Force could do one or more of the following:

- Share records of its investigations with other law enforcement agencies and Michigan departments and agencies.
- Review records of other law enforcement agencies and Michigan departments and agencies to assist in the investigation of automobile insurance fraud and enforcement of laws relating to automobile insurance fraud.
- Conduct outreach and coordination efforts with local and State law enforcement agencies and Michigan departments and agencies to promote investigation and prosecution of automobile insurance fraud.
- Anything else that it determined was necessary to investigate and prosecute automobile insurance fraud in the State.

Within 60 days after the bill's effective date, the anti-fraud unit created under Executive Order 2018-9 would have to transfer all records regarding claims of automobile insurance fraud and investigation of claims of fraud in its possession to the Task Force. After the anti-fraud unit had transferred the records, the anti-fraud unit would be dissolved.

Insurance Fraud Reporting. An insurer authorized to transact automobile insurance in the State would have to report data regarding automobile insurance fraud by medical providers, attorneys, or other people to the task force.

The Department of Insurance and Financial Services would have to cooperate with the Task Force and would have to provide all available statistics on automobile fraud and unfair claims practices to the Task Force on request.

Report. Beginning July 1 of the year after the bill's effective date, the Task Force would have to prepare and publish an annual report to the Legislature on its efforts to prevent automobile insurance fraud by medical providers, attorneys, or other people, unfair claims practices of insurance companies, and cost savings that had resulted from those efforts.

The report would have to detail the automobile insurance fraud by medical providers, attorneys, or other people and unfair claims practices of insurance companies occurring in the State for the previous year, assess the impact of the fraud and unfair claims practices on rates charges for automobile insurance, and outline expenditures made by the Task Force. The Director would have to cooperate in developing the report as requested by the Task Force and would have to make available to it records and statistics concerning automobile insurance fraud by medical providers, attorneys, or other people, unfair claims practices, including the number of instances of suspected and confirmed automobile insurance fraud, number of prosecutions and convictions involving automobile insurance fraud, automobile insurance fraud recidivism, unfair settlement practices and claims practices, including those reported to the Department, reimbursement rate practices, timeliness of claims practices, and the use of independent medical examiners.

The Task Force would have to evaluate the impact automobile insurance fraud by medical providers, attorneys, or other people had on Michigan residents and the costs incurred by the residents through insurance, police enforcement, prosecution, and incarceration because of automobile insurance fraud.

The Task Force would have to evaluate the impact unfair claims practices by insurers had on Michigan residents and would have to determine the costs incurred by the residents through unnecessary litigation and bad-faith practices.

The Task Force would have to submit the report to the House and Senate standing committees with primary jurisdiction over insurance issues and the Director.

#### Automobile Insurance Fraud Fund

The bill would create the Automobile Insurance Fraud Fund within the State Treasury. The State Treasurer could receive money or other assets from any source for deposit into the Fund. The State Treasurer would have to direct the investment of the Fund and credit to it interest and earning from Fund investments. Money in the Fund at the close of a fiscal year would have to remain in the Fund and not lapse to the General Fund.

The Michigan State Police would be the administrator of the Automobile Insurance Fraud Fund for auditing purposes.

The MSP would have to disburse money from the Fund as follows:

- Until five years after the bill's effective date, money in the Fund would have to be disbursed to the MSP, DIFS, the MCCA, the Michigan Automobile Insurance Placement Facility, and the Attorney General in proportion to the number of officers, employees, or representatives each of those had on the Task Force.
- Beginning five years after the bill's effective date, the MSP would have to spend money from the Fund for the operation of the Task Force.

#### Attorney Fees

The Code allows an attorney to be awarded a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits that are overdue. The attorney's fee is a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment.

Under the bill, an attorney advising or representing an injured person concerning a claim for payment of PIP benefits from an insurer could not claim, file, or serve a lien for payment of a fee until all of the following applied:

- A payment for the claim was authorized.
- A payment for the claim was overdue.
- 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 that payment was overdue, the insurer did not either provide reasonable proof that the insurer was not responsible for the payment or take remedial action.

If an attorney claimed, filed, served, or enforced a lien in a manner prohibited by the Code, an insurer or other person aggrieved by the lien would be entitled to court costs and reasonable attorney fees related to opposition of the imposition of the lien.

If an action involved a number of claims, 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.

The Code allows a 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.

Under the bill, a court also could award an insurer a reasonable amount against a claimant as an attorney fee for the insurer's attorney in defending against the following:

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

For a dispute over payment for allowable expenses under Section 3107(1)(a) for attendant care or nursing services, attorney fees could be awarded in relation to expenses recovered for the 12 months preceding the date the insurer was notified of the dispute. Attorney fees could not be awarded in relation to expenses paid after the date the insurer was notified of the dispute, including any future payments ordered after the judgment was entered.

A court could not award a fee to an attorney for advising or representing a claimant in an action for personal or property protection insurance benefits for a treatment, product, service, rehabilitative occupational training, or accommodation provided to the claimant if the attorney or a related person of the attorney had, or had at the time the treatment, product, service, rehabilitative occupational training, or accommodation was provided, a direct or indirect financial interest in the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation. For purposes of this provision, a direct or indirect financial interest would exist if the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation made a direct or indirect payment or granted a financial incentive to the attorney or a related person of the attorney relating to the treatment, product, service, rehabilitative occupational training, or accommodation within 24 months before or after the treatment, product, service, rehabilitative occupational training, or accommodation was provided.

## Tort Liability

Notwithstanding any other provision of law, tort liability arising from ownership, maintenance, or use within the State of a motor vehicle with respect to which no-fault insurance was in effect is abolished except under certain circumstances, including the damages for economic loss by a nonresident in excess of the \$500,000 limit on PIP benefits provided by an insurer of an out-of-State resident required to provide benefits to that out-of-State resident for bodily injury for an accident in which the out-of-State resident was not an occupant of a motor vehicle registered in Michigan.

Damages for economic loss by a nonresident are not recoverable to the extent that benefits covering the same loss are available from other sources, regardless of the nature or number of benefit sources available and regardless of the nature or form of the benefits. Under the bill, the exception to tort liability would apply to damages for economic loss by a nonresident, however, in order to recover, the nonresident would have to have suffered death, serious impairment of a body function, or permanent serious disfigurement.

Under the Code, tort liability also is not abolished for damages for allowable expenses, work loss, and survivor's loss in excess of the daily, monthly, and three-year limitation contained in those provisions. Instead, under the bill, tort liability would not be abolished for damages for allowable expenses, work loss, and survivor's loss in excess of any applicable PIP benefits limit under the bill or the daily, monthly, and three-year limitation contained in those provisions, or without limit for allowable expenses if an election to not maintain PIP coverage were made.

## Civil Penalties

Any person who violates any provision of the Insurance Code for which a specific penalty is not provided under any other provision of the Code or of other laws applicable to the violation must be afforded an opportunity for a hearing before the Director of the Department of Insurance and Financial Services under the Administrative Procedures Act. If the Director finds that a violation of the Code has occurred, he or she must issue a written decision on his or her findings and an order requiring the person to cease and desist from the violation. In addition, the Director may order the suspension, limitation, or revocation of the person's license or certificate or authority, or payment of a civil fine of up to \$500. However, if the person knew or reasonably should have known that he or she was in violation of the Code, the Director may order the payment of a civil fine of up to \$2,500 for each violation.

Under the bill, with respect to a fraudulent insurance act described in Section 4503, a fine could be ordered in addition to and not instead of a penalty of restitution.

The Code specifies that an order of the Director may not require the payment of a civil fine exceeding \$25,000. The bill would refer to \$50,000, instead of \$25,000.

If a person knowingly violates a cease and desist order and has been given notice and opportunity for a hearing, the Director may order a civil fine of \$10,000 for each violation, or a suspension, limitation, or revocation of the person's license, or both.

A fine collected pursuant to an order of the Director or for violating a cease and desist order must be turned over to the State Treasurer and credited the General Fund. Under the bill, a fine collected for a fraudulent insurance act described in Section 4503 would have to be credited to the Automobile Insurance Fraud Fund.

### Certificate of Insurance

An insurer, in conjunction with the issuance of an automobile insurance policy, must provide to the insured one certificate of insurance for each insured vehicle and for private passenger nonfleet automobiles listed on the policy must supply the SOS the automobile insurer's name, the name of the named insured, the named insured's address, the vehicle identification number for each vehicle listed on the policy, and the policy number.

The bill would require the Secretary of State to provide the policy information described above to the Michigan Automobile Insurance Placement Facility as required for the MAIPF to comply with the Code. Information received by the MAIPF would be confidential and would not be subject to the Freedom of Information Act. The MAIPF could use the information only for purposes of administering the information to any person unless it was for the purpose of administering the assigned claims plan or in compliance with an order by a court of competent jurisdiction in connection with a fraud investigation or prosecution.

### Insurance Producer Liability

Under the bill, an insurance producer, including a producing agency 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 related to obtaining or providing information, or the choice of or election not to maintain PIP benefits.

This provision would not apply with respect to a policy issued or renewed after 18 months after the bill's effective date.

### Refusal to Insure

The bill would prohibit an automobile insurer from refusing to insure, refusing to continue to insure, limiting coverage available to, charging a reinstatement fee for, or increasing the premiums for automobile insurance for an eligible person solely because the person previously failed to maintain no-fault insurance for a vehicle owned by the person.

This provision would apply only to an eligible person that applied for automobile insurance within one year after the bill's effective date.

### Overdue Payment of PIP Benefits

Currently, PIP benefits are payable as loss accrues. Personal injury protection benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained.

Under the bill, for PIP benefits for allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation, payment for a product, service, or accommodation would not be overdue if a bill was not provided to the insurer within 90 days after the product, service, or accommodation was provided.

MCL 500.150 et al.

Legislative Analyst: Stephen Jackson

## **FISCAL IMPACT**

### Medicaid Costs

Enactment of the proposed bill would lead to a gradual increase in Medicaid costs that would depend on the availability of and public interest in unlimited PIP coverage. The bill would not mandate that unlimited PIP coverage be available but would allow insurance companies to offer unlimited coverage as an option.

At present, individuals with automobile insurance in Michigan have unlimited coverage for medical and other costs tied to automobile accidents. If the legislation were enacted, people would have the requirement to purchase limited coverage with the possibility of purchasing unlimited coverage. Some of the costs faced by those in accidents who did not have unlimited coverage would shift to other insurers, including their current primary insurer (whether that is commercial insurance, Medicare, or Medicaid). In many severe injury cases (in which the accident victim became dependent on long-term care) costs would shift to Medicaid as most people do not have long term care coverage beyond the limited coverage provided to Medicare recipients.

Because of the uncertainty about the widespread availability of unlimited PIP coverage, it is difficult to provide a precise estimate of the potential increase in Medicaid costs. Based on the available data and the assumptions outlined below, the Senate Fiscal Agency (SFA) estimates that enactment of the legislation would cause Medicaid costs to increase gradually over a ten-year period by \$65.9 million General Fund/General Purpose (GF/GP). In other words, Medicaid costs ten years after enactment would be \$65.9 million GF/GP greater, which equates to about a 1.2% increase over a ten-year period, or a 0.12% per year increase in the State share of Medicaid spending. This figure would depend on the interest in and availability of unlimited PIP coverage. The more available unlimited PIP coverage was, the lower the Medicaid costs would be, as more people would potentially purchase unlimited PIP coverage. If unlimited PIP coverage were not generally available, then the increase in Medicaid costs would be greater.

The SFA notes that costs would grow gradually year to year and the rate of growth would slowly decline to the point that, after ten years, the post ten-year annual cost growth would be less than \$3.0 million GF/GP per year. This long-term annual cost increase would be about 0.05% of overall State Medicaid costs.

There were multiple assumptions made in the derivation of this estimate. The SFA used MCCA data from 2017 to model expenditures for cases going back 40 years. To provide the most useful comparison, the SFA made its estimates in 2019 dollars. The SFA used age and insurance provider data to model the insurance status of the population currently receiving MCCA services. The SFA assumed that Medicaid nursing home and pharmaceutical costs would be similar to MCCA costs for those services, but that Medicaid attendant care, hospital, and physician care costs would be two-thirds of MCCA costs. The SFA assumed 3.0% medical inflation in order to update the cost estimate from the 2017 data to 2019. The SFA assumed that the \$250,000 limit on the PIP options outlined in the legislation would lead to some shifting of non-MCCA costs away from auto insurance coverage as the \$250,000 PIP limit would be less than the MCCA limit.

### Insurance Premiums Tax Revenue

The reduction in the cost of insurance also would reduce the tax base for the 1.25% insurance premium tax. The exact reduction in revenue would depend on the change in the cost of insurance itself, which is partially dependent on the unlimited PIP take-up rate noted above.

The SFA estimates that the longer-term reduction in revenue would be in the range of \$10.0 million to \$15.0 million per year.

#### Department of Insurance and Financial Services

The bill would have an unknown, but likely negative, fiscal impact on the Department of Insurance and Financial Services.

The additional responsibilities that would be assigned to DIFS by the bill likely would result in increased administrative costs for the Department. It is possible that an additional FTE would be required to perform some of these responsibilities, but this would depend on current distribution of duties among existing staff, as well as the volume of information processing, records management, and appeals-related activity generated by the bill. The cost of an additional FTE is estimated at \$120,000 per year. Some responsibilities described in the bill likely would be sufficiently funded by existing appropriations.

The bill would require DIFS to engage at least one independent actuary to examine the MCCA's records and affairs every three years, beginning in July 2019. This cost likely would total less than \$100,000 per engagement.

The Department would receive funds from the Automobile Insurance Fraud Fund until five years after the bill's effective date. Approximately 11% of the Fund would be distributed to DIFS for expenses related to the operation of the Automobile Insurance Fraud Task Force.

The Department also would experience cost savings due to the transfer and dissolution of the Anti-Fraud Unit. Appropriations for this unit were first proposed for fiscal year 2019-20. The Governor, the Senate Appropriations Committee, and the House Appropriations Subcommittee Recommendations each proposed an appropriation of \$499,300 in restricted funding for its operations and administration.

#### Department of Treasury

The bill would have no fiscal impact on the Department of Treasury. Based on the level of estimated revenue within the Automobile Insurance Fraud Fund, the ongoing costs associated with administering and investing the Fund would be less than \$100, which would be within current appropriations.

#### Department of State Police

The bill would create the Automobile Insurance Fraud Task Force within the MSP, which would consist of a member from DIFS, a member from the MCCA, a member from the Michigan Automobile Insurance Placement Facility, a member from the Department of Attorney General, and five members from the MSP. The Task Force would have to receive records from the anti-fraud unit created under Executive Order 2018-9, collect and maintain claims of insurance fraud, investigate and pursue prosecution of those who commit automobile insurance fraud, work with other law enforcement agencies to outreach and assist in prosecutions, and prepare an annual report to the Legislature.

As for the annual costs of operating the Task Force, it is difficult to estimate to the extent to which the responsibilities and time commitments of appointed members from the Department of Insurance and Financial Services, the Catastrophic Claims Association, the Michigan Automobile Insurance Placement Facility, and the Attorney General would increase as members of the Task Force. Accordingly, that makes estimating the costs for those members

difficult. Under the Consumer Protection Practice Bureau, the Department of Attorney General currently has a functioning Health Care Fraud Division. The Department of State Police, which would be charged with directing the Task Force, currently has a Fraud Investigation Unit within its Special Investigations Division, but it mostly focuses on automobile theft and other types of fraud using five teams throughout the State. To fully address the responsibilities under the proposed Task Force and to work with the Department of Insurance and Financial Services and the Department of Attorney General to investigate and prosecute cases, it is estimated that the MSP would require 6.0 new FTEs, which would include five uniformed officers and an analyst, along with travel, fleet, and contractual services, supplies and materials costs. Payroll costs would be approximately \$1,125,000 each year, along with \$155,000 for other costs, for an annual budget of \$1,280,000.

The bill would require the Task Force to prepare an extensive annual report for submission to the Legislature. This could result in additional costs, but that amount cannot be determined at this time.

As discussed above, the bill would create the Automobile Insurance Fraud Fund, from which money would be disbursed to the various organizations that make up the Task Force. For the first five years, money would be disbursed for the costs of Task Force operations in proportion to those entities' representation. After that, the MSP would spend money from the Fund for Task Force operations. The bill would include no GF/GP appropriations, but does specify that a fine collected for a fraudulent insurance act committed in violation of Section 5403 of the Code would have to be credited to the Automobile Insurance Fraud Fund. The amount of revenue generated from the fine cannot be determined at this time.

#### Department of Corrections

The bill specifies that a physician, hospital, clinic, or other person or institution that knowingly submitted false or misleading records or other information to an insurer, the MCCA, or the Department would be guilty of a misdemeanor punishable by imprisonment for up to one year or a fine of up to \$1,000, or both.

This proposed offense would have a negative, but likely minor, fiscal impact on local government, and no impact on State government. An increase in misdemeanor arrests and convictions could increase resource demands on local court systems, law enforcement, and jails. Any associated increase in fine revenue would be dedicated to public libraries.

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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.