House
Legislative
Analysis
Section

Olds Plaza Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

AMENDMENTS TO NO-FAULT LAW

House Bill 4156 as passed by the House
Second Analysis (5-2-93)

Sponsor: Rep. Michael J. Griffin
House Committee: Insurance
Senate Committee: Commerce

THE APPARENT PROBLEM:

Michigan's no-fault auto insurance system took effect on October 1, 1973, and it is regularly cited as one of the best, if not the best, of its kind in operation. Under a no-fault system, motorists look to their own insurance policies for benefits in case of accidents and injuries and can only sue another motorist in extraordinary circumstances. The promise of no-fault is that by giving up the traditional right to sue, claims will be settled more predictably and without as much dispute and delay, compensation will more closely match losses, and more of the customers' premium dollars will be spent on the payment of claims and less on administration and transaction costs, such as legal fees. It is still possible to sue a negligent driver under most no-fault systems when injuries go beyond a certain "threshold", expressed either in a dollar amount or in a "verbal" description.

Auto insurance is compulsory in Michigan; drivers must buy certain coverages to operate a vehicle. The compulsory coverages are personal injury protection (PIP), which includes medical and rehabilitation costs, lost earnings, replacement for personal services, and survivors' benefits; property protection insurance (PPI), for damage done to the property of others; and residual liability insurance, which covers the policyholder if he or she is sued. Collision coverage, which pays for damage to the policyholder's car due to an accident, and comprehensive coverage, which pays if a car is stolen or damaged in some way other than a collision (e.g., vandalism, fire, falling objects) are optional coverages, but in many cases drivers are compelled to purchase them by the terms of a car loan or by common sense. (Obviously, the older and less valuable a vehicle, the less need for collision or comprehensive coverages.) Drivers can also purchase uninsured motorist insurance, which pays for excess wage loss and noneconomic (pain and suffering) damages if a person is injured by an uninsured motorist or a hit-and-run driver.

The most striking feature of Michigan's no-fault system is that, apparently alone among the no-fault states, it provides unlimited lifetime medical and rehabilitation benefits. Once a claim exceeds $250,000, the costs are picked up from the original insurer by the Michigan Catastrophic Claims Associations (MCCA), a statutorily mandated organization supported financially by the auto insurance industry. The MCCA assessment, which every insurance customer must pay, is $118.56 per vehicle as of January 1993. This reflects the estimated cost of lifetime care for people catastrophically injured in auto accidents. Over 90 percent of the MCCA cases are said to involve injury to the brain and/or spinal cord, which can result in coma, paralysis, loss of reasoning ability and memory, and other permanently disabling conditions.

Michigan's law also features a relatively stiff threshold for lawsuits. Lawsuits are only permitted for economic losses beyond those covered by insurance and for non-economic ("pain and suffering") losses in cases of "death, serious impairment of body function, or permanent serious disfigurement." The phrase "serious impairment of body function" has twice been interpreted by the state supreme court, the second decision more or less repudiating the first. In 1982 in what is called the Cassidy decision, the court imposed a quite strict interpretation, saying basically that whether the "serious impairment of body function" threshold had been met in a given case was a matter of statutory construction for a trial court (i.e., a judge not a jury) to decide and that the phrase referred to "important" body functions. The decision also said an injury should be "objectively manifested" (e.g., by x-ray). The Cassidy court's ruling said the legislature had not intended to raise two significant obstacles to lawsuits (death and permanent serious disfigurement) and one quite insignificant one (serious impairment of body function). Nor had it intended that the threshold vary jury by jury or

community by community. But in 1986 in the DeFranco ruling, the court rejected the earlier decision, putting the question of whether a person had suffered a serious impairment of body function in the hands of the "trier of fact;" that is, a jury (when there is one). The court said the threshold is "a significant, but not extraordinarily high, obstacle" to recovering damages and that "the impairment need not be of the entire body function or of an important body function," and it "need not be permanent." Predictably, insurance companies see this decision as an unwarranted liberalization of the no-fault law (and a significant increase in costs), while the trial lawyers view it more as a restoration of plaintiffs' rights and the acknowledgment by the court of a the need to end a failed experiment.

Although the no-fault system's combination of generous mandatory benefits, restrictions on lawsuits, and competitive (file and use) pricing has evoked generally favorable reviews, the system does have its critics and controversies. Some consumer organizations have argued that rates are too high due to excessive profits, reserves, and administrative overhead by insurance companies. Industry critics have also suggested that there has been an increase in "first-party" benefit disputes, meaning that companies have unfairly resisted paying some claims because there are no penalties for delay. Legislation has been proposed to put in place tighter state regulation of insurance rates and to eliminate antitrust protections that allow companies to share information. Industry officials, for their part, have resisted efforts to roll back their rates and have argued, among other things, for a means of controlling health care costs and auto repair costs, and ways of reducing "pain and suffering" lawsuits. They point out that costs get shifted to them from other health care payers because they lack the statutory authority to effectively control what they pay out in medical benefits to health care providers.

For many years, reformers focused on the intertwined problems of availability and affordability of auto insurance in urban areas, particularly the inner city. The use of territorial rating (where prices are based on where a car is garaged) by insurance companies means that drivers in Detroit, for example, pay far more for the same insurance coverage than outstate drivers. The problem is made worse because many insurers don't have agents to sell their products in Detroit and some other urban areas, and so consumers there do not have the same opportunity to shop around for the best prices. A law that took effect in 1981, known as the Essential Insurance Act, attempted to reduce the impact of the use of an insured's place of residence on insurance rates. It limited the ratio between the highest territory-based rate and the lowest, restricted how much difference there could be between adjacent territories, and set a maximum number of rates that could be based on territory. These restrictions were suspended in 1986 at the behest of those insurance companies writing most of the business in Detroit, on the grounds it put them at a competitive disadvantage. However, a cap on how fast rates could increase in Detroit was imposed.) The 1986 legislation, however, carried a five-year sunset, and after several extensions, the restrictions went back into effect in 1992.

The Essential Insurance Act also created what could be termed a "modified take-all-comers" approach to marketing insurance. Insurers cannot refuse to cover motorists who meet certain eligibility standards. Drivers become ineligible based mostly on driving record and vehicle characteristics. (There is a special association, known as the placement facility, where "ineligible" drivers can get insurance if they cannot buy it in the voluntary market. However, many drivers insured through the facility are "eligible drivers" under the law and are there for other reasons.) The act also, among other things, restricted the factors insurance companies can use in setting rates, generally to factors within the control of the insureds, and required insurers to adopt merit rating plans. A "file and use" rating system was put in place, whereby rates could be used by companies as soon as they were filed with the insurance commissioner and without the commissioner's approval.

The legislature had been struggling for some time with many of the concerns that led to the passage of the Essential Insurance Act, but significant impetus was provided by a Michigan Supreme Court decision (known as the Shavers decision) in June of 1978. That decision declared the no-fault law "constitutionally inadequate to assure that coverage is available at fair and equitable rates" and gave the legislature 18 months to repair the defects. The court said, among other things, that the legislature had to give "substantial meaning to the statutory standards [that] 'rates shall not be excessive, inadequate, or unfairly discriminatory.'" The ruling also said people need to be made aware of how rates are computed, be allowed to protest the rates,

and to be able to protest a company's refusal to issue a policy or cancellation of a policy. The Shavers decision noted that the compulsory auto insurance scheme makes the registration and operation of a motor vehicle dependent on the availability of coverage at fair and equitable rates and concluded that "Michigan motorists are constitutionally entitled to have no-fault insurance made available on a fair and equitable basis."

For many, the overriding problem now for Michigan's insurance system is its cost. While Michigan's rates may not be out of line when compared with those in other states (with rankings of 19th and 17th in recent years despite unlimited medical benefits), auto insurance is expensive and may be unaffordable for an increasing number of motorists. It is not uncommon for families to pay well over $1,000 annually for auto insurance, and premiums can be three times that in Detroit. There is concern that the courts (following the Shavers reasoning) could strike down the state's insurance system if people cannot afford coverage. Even if the courts did not do so, the system could not long withstand the existence of a large number of uninsured drivers.

The legislature has been debating conflicting insurance proposals for several years. In fact, legislation containing a 15 percent rate reduction passed both houses in the 1991-92 legislative session but was vetoed by Governor Engler on the grounds that there were not sufficient cost savings in the bill to justify the rate cut. In November of 1992, AAA Michigan (also known as Triple A and the Auto Club) put a proposition on the ballot, Proposal D, to reduce auto insurance costs, principally by eliminating unlimited medical and rehabilitation benefits and establishing instead a minimum benefit of $250,000. The proposal was defeated, and new legislative attempts were begun to amend the state's auto insurance system.

THE CONTENT OF THE BILL:

The bill would amend various sections of the Insurance Code (MCL 500.2103 et al.) dealing with no-fault automobile insurance. Following is a brief description of major provisions.

Rate Reduction

** Insurance companies would have 120 days to reduce auto insurance rates by an average of at least 16 percent from those in effect on November 1, 1992. (That reduction assumes a driver chooses the lowest allowed medical benefits and wage loss coverages.) The bill says that companies' new rates would have to reflect savings from this legislation in personal injury protection, residual liability, uninsured motorist, and collision and comprehensive coverages. Rate reductions for individual drivers would vary. (The reduction, says the bill, would be for "the overall average rate for all coverages.")

** Rate filings could not be modified, changed, or altered for six months, unless the a change resulted in an overall premium reduction for those affected. Also, customers would have to be given at least 30 days' notice of a premium increase when a policy was being renewed.

** Insurance companies could, however, petition the insurance commissioner for relief from some or all of the rate reductions. This could be done no sooner than 150 days and no later than 210 days after the bill's effective date. A company would have to demonstrate that, based on its book of business, the savings resulting from this bill would not justify the required rate reduction because it would result in underwriting profits below the statewide average underwriting profit for all auto insurers for the years 1989 through 1992. The company would have to specify the reduction it could afford. The insurance commissioner would have 60 days to deny the request or grant the request, either in the amount requested or some other amount. A company aggrieved by the insurance commissioner's decision could request a hearing under the Administrative Procedures Act.

Limits on PIP Coverage

** No-fault policies would no longer automatically contain unlimited medical and rehabilitation benefits. The mandatory minimum medical and rehabilitation benefits under personal injury protection (PIP) coverage would be $1 million. Companies would have to offer coverage of $2 million, $3 million, $4 million, and $5 million; and could offer coverage in any amount above that. The PIP premium for an insured who selected $5 million in coverage could not be increased beyond that in place for unlimited PIP coverage on November 1, 1992. The $1 million figure would be adjusted each year so that 99 percent of benefit claims were covered. Only the minimum amount of benefits would be available to 1) a person who was not a

named insured in a policy, the insured's spouse, or a relative of either domiciled in the same household; 2) a non-resident involved in an accident in Michigan; or 3) a non-resident injured in an accident outside the state. Benefits would not be payable at all in the third case to the extent the injured person recovered benefits under any other policy.

** Currently, personal injury protection (PIP) benefits are 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." The bill would refer to "allowable expenses incurred for medically appropriate products, services, and accommodations." The bill specifies that this would refer to products, services, and accommodations that are medically necessary and would not include those that would have been needed or used by the injured person or a member of the injured person's household if the accident had not occurred. Insurance companies could not be required to provide coverage for products, services, or accommodations that were not medically appropriate or medically necessary or that were not "reasonably likely to provide continued effectiveness with regard to the injured person's care, recovery, or rehabilitation." A company that initially rejected reimbursement for a product, service, or accommodation provided or prescribed would, at the provider's request, have to get the decision reexamined by a provider with the same credentials or credentials that encompassed the same scope of practice. Further, each company would have to designate a person with whom providers could discuss company determinations of what was medically appropriate and medically necessary. Disputes over what were reasonable charges and what things were and were not medically appropriate and medically necessary would be questions of law to be decided by the court (i.e., a judge).

** Other limitations also would be placed on personal injury protection benefits. PIP benefits would not cover experimental treatment or participation in research projects. Expenses for attendant care services and skilled home care services provided by a home health agency would be limited to the reasonable and customary charge for the appropriate skill level and time intensity. Attendant care services, including those provided by household members, would be limited to the customary wage an individual would have received if working for a home health agency commensurate with the person's qualifications. Expenses for attendant care services or skilled care services by members of the same household would not be covered in excess of 16 hours per day. Attendant care for more than six months could be limited to persons with quadriplegic spinal cord injuries, brain injuries, and similar injuries. Psychological services would only be provided if they were reasonably likely to produce significant improvement and if prescribed by a physician or a licensed psychologist. They would be for a fixed-duration time period not to exceed 26 weeks with one additional 26-week extension possible. The periods could be extended if it was reasonably likely that treatment of a longer duration, which could be intermittent, could produce significant measurable improvement. Vocational rehabilitation services would be for a fixed-duration time period not to exceed 52 weeks, with one additional extension of 52 weeks possible if the services were reasonably likely to produce significant rehabilitation and would cease once the injured person had acquired employment skills. Expenses for home modification could not exceed $50,000 (with the amount to be adjusted annually to reflect the cost of living.) Expenses for motor vehicle modifications or special vehicles would be limited to $50,000 every seven years. The bill says the limitations should not be interpreted to exclude any health care provider providing services within the scope of his or her license, certification, or registration.

** The bill specifies that a person could not recover duplicate PIP benefits for the same expenses or losses and that, regardless of the number of vehicles insured, in no event could the limit of liability for two or more vehicles or two or more policies be added together, combined, or stacked to determine the limit of insurance coverage available to each injured person covered under a policy.

PIP Fee Schedule

** The Insurance Commissioner would be required to establish a schedule of fees that would determine the reimbursement levels for treatment of an injured person under an auto insurance policy by a physician, hospital, clinic, or other person or institution. Beginning 90 days after the bill's effective date and until the commissioner's schedule

was official, an interim arrangement would be in place that would limit payments to either, as chosen by the provider, (1) the schedule of maximum fees for worker's compensation or (2) for providers, 110 percent of amounts paid to participating providers by Blue Cross and Blue Shield of Michigan (BCBSM) and, for facilities, 113 percent of the ratio of costs to charges for the prior calendar year as used in the development of BCBSM reimbursement multiplied by the prior calendar year's charges for specific automobile accident injury treatments, services, accommodations, and medicines. For facilities in plans where BCBSM pays controlled charges, auto insurers would pay controlled charges. BCBSM would not be required to reveal any participating provider plans; information necessary for auto insurer reimbursements would have to come from health care facilities and providers.

The commissioner would establish the subsequent fee schedule through the rules process. Rules would have to be submitted to a public hearing by 21 months after the bill's effective date. The commissioner would have to appoint an advisory committee to help the bureau establish the fee schedule. Health care facilities and providers would be required to accept the amount reimbursed as established by the commissioner's fee schedule and the interim fee schedule as payment in full. Nothing would require a health care facility or provider to accept a payment at a rate lower than the interim or commissioner's fee schedule, and an insurance company would not be required to pay more than a facility's usual and customary charge. Further, nothing in the bill would preclude facilities and providers from contracting with insurers for reimbursement levels that varied from those provided elsewhere in the bill.

** Insurance companies also would be required to implement utilization review systems, unless a company could demonstrate to the insurance commissioner's satisfaction that it would not be cost effective. A company would have to report to the commissioner each year the results of the system. Companies would be prohibited from using a utilization review system in bad faith and from delaying payments of legitimate claims unduly and harassing or discriminating against medical providers or automobile accident victims.

Catastrophic Claims

** The Michigan Catastrophic Claims Association (MCCA) currently pays for medical and rehabilitation claims when they exceed $250,000. Under the bill, that "attachment point" would be $250,000 for a policy issued or renewed before 300 days after the bill's effective date; $300,000 for a policy issued or renewed 300 days to and including 665 days after the bill's effective date; $400,000 for a policy issued or renewed 666 days to and including 1031 days after the effective date; and $500,000 for a policy issued or renewed on and after 1032 days after the effective date. The last amount would be adjusted annually every October 1 by the lesser of five percent or the consumer price index and rounded up to the nearest $25,000.

** The bill would require the MCCA to maintain two separate accounts. One, known as the MCCA account, would indemnify for losses arising under policies issued or renewed before 120 days after the bill's effective date. The second, known as the excess PIP account, would indemnify for later policies. Each account would be self-supporting and there could be no transfer of assets or liabilities between accounts. (This would, essentially, "seal off" the current MCCA fund.) The association would be authorized to assess members to recoup a deficiency existing in the MCCA account up to certain limits. Companies could be assessed annually the full amount of the deficiency if it was less than $100 million. If the deficit was $100 million or higher, companies could be assessed the greater of $100 million or 12 percent of the deficiency. However, if the assessment was not sufficient to permit the MCCA to meet its payments, the assessment would be increased in an amount sufficient to meet the payments.

** Beginning 120 days after the bill's effective date, an insurance company would be prohibited from separating the premium paid to either association account from the PIP premium stated on a declaration page.

** A personal injury protection task force would be created to prepare a plan to reduce costs associated with catastrophic claims. The members would be appointed by the insurance commissioner. The task force would consider, among other things, structured settlements; the use of managed care, case management, treatment protocols, and utilization review; standards for assessing injuries

and prognoses, making treatment goals, and implementing treatment; cost-shifting and other suspected abuses, including home and vehicle modification abuses; and the use of qualified review and independent medical examinations. The task force would be funded by the auto insurance industry and would have 18 months to report to the governor and legislature.

** An insurer would be required to make use of a "clinical care manager" for insureds whose benefits were expected to exceed the catastrophic threshold (and could engage such a manager in other cases). The insured would be allowed to select the manager, and the insurance company could appoint one if the insured did not do so. A manager would develop a written plan for six months of treatment setting forth the products, services, and accommodations for an injured person's care, treatment, recovery, and rehabilitation. A plan could be revised at the request of the injured person, his or her representative, or a health care provider. A manager would have to be a licensed allopathic or osteopathic physician, a physiatrist, psychologist, nurse, social worker, or physical or occupational therapist who provided the type of care needed. An insurer could not contract with itself, an entity in which it had a financial interest, or another auto insurer to provide clinical care management.

Tort Threshold/Contingency Fees

** There would be additional restrictions on lawsuits. Now, lawsuits for non-economic damages ("pain and suffering") require that the injured person suffer death, permanent serious disfigurement, or serious impairment of body function. A state supreme court ruling has interpreted this last expression for lower courts to follow; it is not now further defined in statute. Under the bill, a person would not have suffered "serious impairment of body function" unless he or she had suffered "an objectively manifested impairment of an important body function that affects his or her general ability to lead his or her normal life." The determination under the bill would be "a question of law for the court." This means, generally, it would be a question for a judge rather than a jury. Currently, the question is decided by a jury. In general, the bill's provisions present a higher standard for lawsuits than the governing court opinion. Further, a person more than 50 percent at fault could not collect damages. Nor could a person who at the time of the accident did not carry required insurance coverages. The bill would permit a court, after a jury verdict, to concur with an award, review the award and determine the appropriate amount, or grant a new trial solely on the issue of damages.

Territorial Rating/Marketing Plans

** Current restrictions on how insurers may use geographical territories in rating (including some suspended in 1986 and revived in 1992) would be eliminated. So would restrictions on how much auto insurance rates can increase in Detroit. The bill would require that each territory used by an insurer contain at least 60,000 registered automobiles and consist of a single contiguous area. A territory that included any portion of a city would have to include the entire city. However, any portion of a city that contained 60,000 or more registered vehicles could be a separate territory if the remainder of the city also contained that many vehicles. If a portion of a city was made a separate territory, dividing lines would have to consist of roadways that are state trunklines, county primary, or municipal major streets. The bill would also require that the loss ratios on an average basis over a three-year period be substantially uniform among territories.

** Auto insurance companies with a volume of business that puts them in the top 85 percent of the market would be required to maintain at least one agent who was physically located and actively writing business in each rating territory in its rating plan. Companies also would be required to implement a market assistance plan by 120 days after the bill's effective date. The plan would be subject to the insurance commissioner's approval and would involve the maintenance of a statewide, toll-free telephone line to dispense comparative rate information, buyer's guides, company telephone numbers, and consumer rights information. The buyer's guide would be prepared semiannually by the commissioner and would compare rates among a reasonable representation of at least 50 automobile insurers. Beginning April 1, 1996, the guide would also contain comparative complaint information. The guide would be available through the Insurance Bureau and branch offices of the secretary of state. The customer's certificate of insurance would have to contain the number of the toll-free telephone line.

Dispute Resolution Conferences

** A person who had reason to believe an auto insurer had improperly denied a claim for benefits would be entitled to a private, informal, managerial-level conference and to a conciliation conference with the insurance commissioner if the conference with the company did not resolve the dispute. A legal action for recovery of personal injury benefits could not be commenced unless the claimant had gone through the informal dispute resolution process.

Anti-Fraud Plans/Provisions

** Each insurance company would be required to establish and maintain an anti-fraud plan to be filed with the insurance commissioner. Companies could establish and maintain plans jointly. Plans would have to be filed no later than 300 days after the bill's effective date. The commissioner would be required to establish a motor vehicle insurance fraud office. Each company would have to report each year to the commissioner on actions taken under the plan to prevent and combat insurance fraud. The plan and reports would not be subject to the Freedom of Information Act. The bill also would require the reporting of suspected fraud by insurers, agents, adjusters, and others. Also, companies would be required to verify the existence of automobiles they insured, obtain vehicle identification numbers for each vehicle insured, and be a paying member of the National Insurance Crime Bureau.

** Insurers could impose in their policies a $500 deductible to a theft loss or a ten percent reduction in recovery under theft loss for cases where an automobile was unattended when stolen with the keys in the passenger compartment. If an insurer included one or both of these provisions in a policy, it would have to include them in all policies.

Placement Facility

** The automobile insurance placement facility, which is available as an alternative to the voluntary auto insurance market, would be required to establish rates designed to be self-supporting for eligible private passenger non-fleet insurance, ineligible private passenger non-fleet insurance, and all other auto insurance. The facility's rates would have to conform to the requirements for the voluntary market. Special rating provisions in the code would be eliminated. Commissions for agents placing eligible drivers (those who the voluntary market must take and who theoretically need not be placed in the facility) in the placement facility could not exceed five percent, effective 300 days after the bill's effective date.

Collision Repairs

** Insurance companies would be permitted to establish direct repair programs. A company that did so would have to make participation criteria available to all repair facilities. Any repair facility that met the criteria would be eligible to participate in the program. An insurance company could not prohibit an eligible repair facility from participating in a direct repair program and could not limit the number of participating repair facilities. The bill also would specify that an insured could use any repair facility for an estimate or for covered repair services.

** The insurance commissioner would be required to prepare reports that provide damageability and repairability ratings for the most recent available model year of vehicles. The ratings would have to be based on credible information provided by recognized auto damage and repair experts from government and other institutions. The first report would be due October 1, 1993, and then annually thereafter. The report would be made available to the public upon request, would be given to the governor and legislature, and summaries distributed to the media. The cost of the report would be covered by assessing insurance companies.

** Companies would have to provide to customers who called them about collision claims the telephone numbers of the Better Business Bureau, the Bureau of Automotive Regulation, and, if applicable, the consumer affairs division of the local unit of government.

Rate Determinations

** Companies could offer premium discounts based on the length of time the insured had been a customer and based on how long a customer had been free of substantially at-fault accidents with the insurer. Such discounts, if offered, would have to be offered uniformly and applied to all customers.

** Insurers would have to establish premium discount plans no later than 300 days after the bill's

effective date based on safety features in a motor vehicle, including anti-lacerative glass, air bags, antilock brakes, enhanced sidewall protection, special bumpers, and other passive safety features.

** Companies are required to have merit rating plans under which surcharges are imposed for certain kinds of driving-related conduct. The bill would require that surcharges be flat dollar surcharges (not percentages). Further, certain other factors would be added to those on which surcharges could be based, including having a suspended driver license, operating with a suspended or revoked license, violating a license restriction, or similar violations in this or other states. The bill also would permit companies not to surcharge its insureds under a merit rating plan beginning 300 days after the bill's effective date. (This would have to be uniformly applied to customers.)

** In establishing rates, insurance companies would be required to give consideration to investment income earned on loss reserves, on unearned premium reserves, and on the portion of capital and surplus attributable to auto insurance.

Standard Forms

** The insurance commissioner would be required to develop several standard forms by October 1, 1993. One would be a standard application form in plain English, listing what coverages were mandatory and what were not and how to obtain consumer assistance materials. Insurers would have to accept the standard form by December 1, 1993, and use one substantially similar to it by April 1, 1994. Copies of the standard form would be available through the Insurance Bureau and secretary of state's offices, and a customer could submit a standard form (or a company's own application form) when applying to an agent for coverage. A model declarations page in plain English would also have to be developed and by December 1, 1993, companies would have to use a declarations page substantially similar to it. The model declarations page would have to contain a warning that comprehensive and collision coverages reimburse insureds only for the current value of a motor vehicle. Finally, the commissioner would have to develop a standard rate filing form for companies to use when filing auto insurance rates. With each rate filing, a company would have to complete and submit a buyer's guide rate survey on a commissioner-prepared form.

New Penalties

The bill would add new penalties for violations of Chapter 21 (essential insurance provisions regarding underwriting and rating for home and auto coverage). If the commissioner found a person or organization had committed a violation, he or she could impose a civil fine of not more than $5,000 for each violation and, for a willful violation, a civil fine of not more than $25,000 per violation; a cease and desist order; an order to comply; or a refund of any overcharges with interest and penalties. Further, the commissioner could suspend the authority of a rating organization or an insurance company that failed to comply with an order (provided the time for an appeal had expired or an order that had been appealed had subsequently been affirmed). A civil fine could not be imposed and authority to do business suspended or revoked except upon a written order of the commissioner subsequent to a hearing on the matter. A civil fine could not exceed $50,000. The commissioner would have to report annually to the legislature on the amount of fines collected.

FISCAL IMPLICATIONS:

There is no specific information at this time about the effect of the bill on the state budget. It is generally acknowledged, however, that the limitation of no-fault medical benefits could result in people catastrophically injured in auto accidents being shifted to Medicaid (a federal-state program) from the no-fault system.

ARGUMENTS:

For:

This bill offers realistic and meaningful rate relief for insurance consumers. It promises an average 16 percent rate cut by offering customers an opportunity to choose lower medical and rehabilitation benefits and by reducing insurance companies' costs. The only way to lower the cost of automobile insurance is to lower the cost of the things insurance pays for. Higher insurance rates are a reflection of the increasing cost of medical care, legal expenses, car repairs, and cars themselves. Representatives of insurance agents say that while from 1987 to 1992 payouts for all auto insurance coverages increased at the same rate as

the consumer price index (22 percent), payouts for bodily injury liability coverage (from lawsuits) increased 52 percent and payouts for personal injury protection coverage (for medical and rehabilitation benefits) increased 60 percent.

This bill addresses the costs of the insurance system. It replaces unlimited medical and rehabilitation benefits with a minimum $1 million of coverage. It puts a cap on certain kinds of benefits where none exists now. It requires health care providers and facilities to accept a schedule of fees, which will help stop the cost-shifting that now makes auto insurers pay more than other third-party payers. (During the debate over Proposal D, Triple A claimed that auto insurers reimburse hospitals 133 percent of costs while the uninsured pay 45 percent, Medicaid and Medicare about 80 percent, and Blue Cross-Blue Shield 103 percent.) It employs a new standard to ensure that the benefits provided are "medically appropriate," which gives insurance companies greater ability to control costs. It requires insurers to use "clinical care management" to make sure treatment is appropriate and cost effective. It places additional restrictions on lawsuits, putting into the hands of judges the question of whether the tort threshold has been reached. And in the long run there could be savings from the work of a special task force to investigate reducing the cost of catastrophic care and from mandated anti-fraud plans.

Even with the changes, Michigan's system will remain the best and most generous in the country. (Plus customers will have the option of purchasing additional medical benefits coverage beyond $1 million.) Proponents of the bill point out that many of those who oppose the changes made to benefits in this bill would be fighting strenuously to make such benefit levels available in other states.

For:

Michigan's basic auto insurance policy is often called "generous" because of its unlimited medical and rehabilitation benefits and other benefit features. But the system is not generous to those who cannot afford to buy insurance. Some people claim that one in six drivers is uninsured. The compulsory insurance system cannot survive if basic auto insurance becomes unaffordable for more and more drivers. This bill will make auto insurance more affordable for the driving public and allows drivers more choice over their level of coverage.

Response:

As one critic of this bill has pointed out, a driver who cannot afford auto insurance because it costs $2,000 is not likely to buy it because its price has been reduced to $1,680. Besides, it is not clear that the number of uninsured drivers is directly related to the cost of insurance. Some states with much higher rates have fewer uninsured motorists, and states with lower rates have more uninsureds. Critics of this bill claim that insurance expenditures today take up a lower percentage of the family budget that they did ten years ago. Households reportedly spend less on auto insurance that on alcohol and tobacco.

For:

There are a great many other advantageous features for consumers in this bill besides the reduction in costs. A great deal more information will be made available through buyer's guides, reports on damageability and repairability of vehicles by model and year, and mandatory market assistance plans with toll-free telephone numbers. An alternative dispute resolution system would be created to solve disputes between insurance companies and customers, involving conferences first with company managers and then with state regulators. The bill also calls for standardized applications forms and standardized declaration pages (the page that explains coverages and their costs on an insurance bill) in plain English. For urban residents, particularly those in Detroit, the requirement that companies put agents in all their rating territories will improve access to insurance and make shopping around easier.

Against:

This bill has been described as a warmed-over Proposal D, the ballot proposal resoundingly defeated by the voters just months ago. Why would anyone believe the public would support this proposal when the voters have already expressed their unwillingness to trade their medical benefits and their rights to sue at-fault drivers for what amounts to a temporary reduction in rates? Rates would only have to be reduced for six months under this bill. Nothing would prevent companies from raising them after that. Indeed, the bill, like Proposal D, allows companies to avoid the rate reduction entirely if they can prove hardship. In which case, customers would get their benefits cut, health care providers and facilities would see their revenues decline, catastrophically injured motorists would be abandoned, the victims of irresponsible

drivers would lose access to the courts, and all for nothing. Further, customers who want to buy far more than the minimum coverage in order to have a policy approximating the insurance policy they have now will likely see their premiums go up.

Response:

Regardless of what one thought of Proposal D (and it had many supporters), it is not fair to say that this bill is merely a new version. There are many differences, most notably the minimum PIP coverage in this bill of $1 million, compared to $250,000 in Proposal D. Also this bill does not make residual liability coverage optional. This bill should be judged on its own merits and not be simplemindedly and unfairly equated with a defeated ballot proposal. It also should be noted, for those concerned about how much it would cost to keep current coverages, that the bill says $5 million in PIP coverage could not cost more than the unlimited PIP benefits available now.

Against:

The combination of lower medical benefits, mandatory fee schedules for health care providers and facilities, higher deductibles, and limits on treatment could lead to many victims of auto accidents receiving inadequate or second-rate care and to many catastrophically injured victims not receiving the care they desperately need. Doctors, hospitals, ambulances, head injury networks, and others say the fee schedules proposed are inadequate. And, they say, the $1 million dollar minimum will not be sufficient to provide the quality and duration of care necessary to give the catastrophically injured a chance at living a productive life. A person who chooses the lower levels of benefits and then is injured catastrophically will no longer have the kind of treatment, rehabilitation, and long-term care that no-fault benefits provide now. And shifting such cases over to Medicaid will mean that taxpayers must pay for the care. Further, brain injury professionals say that Medicaid reimbursement levels are insufficient and that the system is already overburdened. The reduction in no-fault benefits puts brain injury networks in jeopardy because they depend on that revenue. The bill would also allow insurance companies to decide what products, services, and care are "medically appropriate" and would require patients and providers to go to court to dispute those determinations.

Moreover, the young people most likely to suffer catastrophic injuries are also the most likely to choose the lower coverage amounts to save a few dollars. Head injury providers warn that they then could become a burden on the state for many, many years, leading to greater state expenditures. In the long run, it would be better to provide these people the care and services they need through the auto insurance system.

Response:

As mentioned above, the no-fault system is now paying far more than its fair share to health care providers. If people cannot afford insurance, they will have no benefits at all. At least under this bill they will be able to purchase $1 million in medical benefits, which will take care of the overwhelming number of cases. Plus, people can buy up to $5 million in coverage (and more), which is an extraordinarily high amount. (Reportedly, no case has yet reached that figure.) Keep in mind that people injured in other ways do not get unlimited medical and rehabilitation benefits. It is only when people are injured in automobile accidents that these unlimited benefits are supposed to be available. This is increasingly an unrealistic expectation.

Against:

When no-fault was enacted, citizens gave up many of their rights to sue negligent drivers in exchange for unlimited benefits. This proposal not only reneges on the unlimited benefits, it further restricts the right of those injured in auto accidents to sue drunk drivers and other negligent motorists. The bill would put into statute language governing lawsuits that the state supreme court rejected as unworkable and unfair for a great many reasons in 1986. The definition of "serious impairment of body function" in the bill is from the Cassidy decision of 1982, which the supreme court repudiated in 1986. That definition, the court said, gave few plaintiffs the opportunity to collect non-economic ("pain and suffering") damages. This language, combined with the provision that does not allow someone more than 50 percent at fault from collecting damages, will deprive seriously injured auto accident victims from going to court to collect damages for their genuine suffering. This is unjust. It will lead to clogged court dockets for judges and the potential that no-fault cases will get short-shrift. Moreover, it will not contribute greatly to reducing insurance premiums because the cost of lawsuits is not that great a contributor to overall insurance costs. Consumers will also be hurt by having to go through the conciliation and mediation process in arguments over first party benefits before going to court. This

process will likely find the consumer on a very uneven playing field. It will stretch out the process of getting benefits consumers are owed by insurers.

Response:

The provision defining the tort threshold will still allow the seriously injured to recover noneconomic damages. It sets a higher standard, it is true, but all it requires is that a judge be convinced that the tort threshold has been reached by objective evidence of an injury that has a serious effect on a person's life.

Against:

The bill fails to address adequately one of the most important problems on the insurance system: the high cost of insurance in the inner city due to territorial rating. The Essential Insurance Act over ten years ago limited the use companies could make of geographic territories in setting prices. A 1986 law suspended those restrictions for five years, but they are now at least temporarily back in effect. This bill would eliminate the restrictions entirely, including caps on rate increases in Detroit, and would allow insurance companies pretty much free rein in how they establish territories, how many they use, and how rates can vary from one to another. While it would require a certain number of vehicles per territory, the bill does not go far enough. What is needed is legislation to reduce the impact of territories, for example, by requiring that they be much larger and, thus, spread risks over more drivers. More needs to be done also to make sure insurance is available in Detroit and other urban areas.

Response:

The bill does require that a territory have at least 60,000 registered vehicles, which prevents most cities from being divided up into more than one territory. And it does require that the largest ten or twelve companies have an agent in each of their territories, which should increase the ability of urban consumers to shop around. Market assistance plans are also required. Insurance companies argue against restrictions on territorial rating because they believe it results in subsidies among drivers. Rates based on territory, insurers argue, accurately predict the loss experience of those geographic areas.

Against:

Cutting prices for insurance (or for other commodities and services) through legislation is simply a bad idea. While some people may think of their insurance premiums as a kind of tax and some may think of insurance companies as like public utilities (like the power company), insurance is not a tax and insurance companies are not public utilities. The prices for auto insurance should be set in the competitive marketplace and not on the floor of the legislature. It is one thing to pass legislation that cuts some of the costs out of the auto insurance system, but it is stretching things to predict in advance how much rates can be reduced, and absurd to mandate the same size rate cut for all companies prospectively. Further, the rate reduction called for in the bill is not justified by the savings it would create. In fact, the bill imposes numerous new requirements on insurance companies.

The across-the-industry rate cut mandated by the proposal penalizes the most efficient companies, whose rates are kept low by good management practices and low administrative overhead. It treats all companies alike even though they are not: they have different "books of business" or mix of customers and different marketing systems (e.g., independent agents versus one-company agents), among other things. For example, a company that does not sell much insurance in heavily populated urban areas may not see as much savings from anticipated reductions in "pain and suffering lawsuits" as a company that does a lot of business in Wayne County or other metropolitan areas, where there is more litigation and higher jury awards.

Against:

Some industry critics remain convinced that insurance rates can be reduced without the kind of sacrifice of the rights of accident victims or without the sizeable loss of benefits contained in this proposal. What they urge is reform of the rate regulation process and the elimination of antitrust protections, which together would work to make insurance more affordable and companies more competitive. Rates could be reduced by making companies eliminate excessive profits, excessive administrative costs, and excessive estimates of future losses, which lead to far too much set aside in reserves. While there may be a need to control other underlying costs, this should not be done without also addressing the finances of insurance companies.