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

BILL ANALYSIS

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

Senate Bill 530 (Substitute S-4 as passed by the Senate)
Senate Bill 531 (Substitute S-2 as passed by the Senate)
Senate Bill 575 (as passed by the Senate)
Sponsor: Senator Mary Cavanagh (S.B. 530)
Senator Sarah Anthony (S.B. 531)
Senator Jeremy Moss (S.B. 575)
Committee: Finance, Insurance, and Consumer Protection

Date Completed: 7-26-24

RATIONALE

Public Act (PA) 21 of 2019 significantly restructured the State's no-fault driver insurance system. Previously, Michigan drivers were required to possess unlimited personal injury protection (PIP) coverage. The PA introduced three additional PIP coverage levels that Michigan drivers could choose from beginning July 1, 2020: 1) $50,000, if the person were enrolled in Medicaid; 2) $250,000; and 3) $500,000. The PA also specified reimbursement rates for Medicare and non-Medicare services. The legislation was meant to lower the cost of auto insurance in the State.[1]

However, according to testimony before the Senate Committee on Finance, Insurance, and Consumer Protection, PA 21 had unintended consequences. Some people claim that its modifications to eligible medical expenses and reimbursement rates resulted in limited access to care for auto accident survivors requiring specialized care and unsustainable reimbursement for providers. Accordingly, it has been suggested that reimbursement structures be modified to make these healthcare services accessible to auto accident survivors with catastrophic injuries.

CONTENT

Senate Bill 530 (S-4) would amend Chapter 31 (Motor Vehicle Personal and Property Protection) of the Insurance Code to do the following:

- **Modify how providers would be reimbursed for the treatment of an individual covered by PIP for an accidental bodily injury.**
- **Modify the percentages for which providers could be reimbursed for treating or training an individual covered by PIP following an accidental bodily injury.**
- **Specify the amounts that a provider would have to be reimbursed if Medicare did not provide an amount payable for treatment or rehabilitation of an individual covered by PIP for an accidental bodily injury.**
- **Specify reimbursement amounts for caregivers and chiropractors for the treatment of an individual covered by PIP for an accidental bodily injury.**
- **Require the proposed reimbursement amounts to adjust annually at the rate of the Consumer Price Index (CPI).**
- **Require a provider that rendered home care or residential services to be accredited to be eligible for reimbursement.**

[1] Gibbons, Lauren, "Michigan lawmakers eye tweaks to auto insurance reform that has cut rates", *Bridge Michigan*, December 5, 2023.

-- Specify how an insurer would have to pay benefits to a personal caregiver.
Senate Bill 531 (S-2) would amend the Insurance Code to modify Michigan Complied Law (MCL) references to reflect changes proposed by Senate Bill 530 (S-4).

Senate Bill 575 would amend the Insurance Code to modify MCL references to reflect the changes proposed in Senate Bill 530 (S-4).

Senate Bill 530 and Senate Bill 531 are tie-barred. Senate Bill 530 is described in greater detail below.

Senate Bill 530 (S-4)

Generally, all drivers in the State must have PIP, and an insurer issuing PIP is liable for accidental bodily injury involving a motor vehicle. These benefits under PIP are due regardless of fault in the motor vehicle accident that caused the bodily injury. Among other things, Chapter 31 prescribes the reimbursement rates discussed below, rates at which insurers issuing PIP must pay providers for treatment of an injured person involved in a motor vehicle accident and covered by PIP.

Reasonable Cost for Treatment

The Code allows a provider to charge a reasonable amount for providing treatment or rehabilitative occupational training to an injured individual for accidental bodily injury covered by PIP. The charge may not exceed the amount the provider customarily charges for similar treatment or training in cases where insurance is not involved.

Reimbursement for Treatment or Training

Generally, a provider that treats or provides rehabilitative occupational training to an injured person covered by PIP for an accidental bodily injury is not eligible for payment or reimbursement for more than the following:

-- For treatment or training rendered after July 1, 2021, and before July 2, 2022, 200% of the amount payable to the person for that treatment or training under Medicare.
-- For treatment or training rendered after July 1, 2022, and before July 2, 2023, 195% of the amount payable to the person for that treatment or training under Medicare.
-- For treatment or training rendered after July 1, 2023, 190% of the amount payable to the person for the treatment or training under Medicare.

The bill would sunset the latter provision on July 1, 2024. After that date, the bill would require a provider to be reimbursed *in an amount equal to* 200% of the amount payable to the person for the treatment or training under Medicare.

Currently, if Medicare does not provide an amount payable for a treatment or training described above, the provider is not eligible for payment or reimbursement of more than the applicable percentage of the amount payable for the treatment or training under the individual's charge description master,[2] or, if there was no charge description master, between 52.5% and 55% of the amount that was charged based on the date of treatment. The bill would delete these reimbursement rates.

[2] "Charge description master" means a uniform schedule of charges represented by the person as its gross billed charge for a given service or item, regardless of payer type.

After July 1, 2021, a provider who is a freestanding rehabilitation facility[3] or whose clientele meets specified indigent standards established by the Department of Health and Human Services (DHHS) that renders treatment or rehabilitative occupational training to an injured person for accidental bodily injury covered by personal protection insurance is eligible for payment or reimbursement of no more than the following:

-- For treatment or training rendered after July 1, 2021, and before July 2, 2022, 230% of the amount payable to the person for the treatment under Medicare.
-- For treatment or training rendered after July 1, 2022, and before July 2, 2023, 225% of the amount payable to the person for treatment or training under Medicare.
-- For treatment or training rendered after July 1, 2023, 220% of the amount payable to the person for the treatment or training under Medicare.

The bill would sunset the latter provision on July 1, 2024. After that date, a provider who was a freestanding rehabilitation facility or whose clientele met specified indigent standards established by the DHHS that rendered treatment or training to an injured person for accidental bodily injury covered by personal protection insurance would have to be reimbursed *in an amount equal to* 230% of the amount payable to the person for the treatment or training under Medicare.

Additionally, the bill would modify the indigent standards a provider is required to meet to receive the reimbursement described above. Currently, on July 1 of the year in which the provider renders treatment or training, the provider must have 20% or more, but less than 30%, indigent volume determined using the methodology also used by the DHHS in determining inpatient medical/surgical factors used in measuring eligibility for Medicaid disproportionate share payments. Under the bill, indigent volume would be calculated using the three-year average of that methodology, which first would be calculated on July 1, 2024, and every third year after.

Currently, the Director of the Department of Insurance and Financial Services (DIFS) must annually review documents and information to determine whether a provider whose clientele meets specified indigent standards qualifies for payment and reimbursement. The bill would make this a triennial requirement.

If Medicare does not provide an amount payable for a treatment or training described above, the provider is not eligible for payment or reimbursement of more than the applicable percentage of the amount payable for the treatment or training under the individual's charge description master or, if there were no charge description master, the provider will be reimbursed between 66.58% and 70% of the amount that was charged for the service based on the date of treatment. If Medicare does not provide an amount payable for a treatment or training described above and the provider is a freestanding rehabilitation facility or has clientele that meets specified indigent standards, the provider is not eligible for payment or reimbursement of more 78% of the amount payable for the treatment or training under the individual's charge description master or if the person did not have a charge description master, 78% of the average amount based on the date. The bill deletes these reimbursement rates.

[3] A freestanding rehabilitation facility is an acute care hospital that was in existence on May 1, 2019, and meets certain requirements. Among other things, a freestanding rehabilitation facility must assist catastrophically injured patients to achieve excellent rehabilitation outcomes, possess sophisticated technology and specialized facilities, participate in rehabilitation research and clinical education, and be accredited by one or more third party, independent organizations focused on quality.

The Code sets the following maximum payment levels for Level I and Level II trauma centers providing emergency treatment to an injured individual covered by PIP before the individual is stabilized and transferred:

-- For treatment rendered after July 1, 2021, and before July 2, 2022, 240% of the amount payable to the hospital for the treatment under Medicare.
-- For treatment rendered after July 1, 2022, and before July 2, 2023, 235% of the amount payable to the hospital for the treatment under Medicare.
-- For treatment rendered after July 1, 2023, 230% of the amount payable to the hospital for the treatment under Medicare.

The bill would sunset the latter provision on July 1, 2024. For treatment or training rendered after July 1, 2024, the bill would set the maximum payment level at 240% of the amount payable to the person for the treatment or training under Medicare.

If Medicare does not provide an amount payable for a treatment or training described above the provider is not eligible for payment or reimbursement of more the applicable percentage of the amount payable for the treatment or training under the individual's charge description master or, if there were no charge description master, the provider will be reimbursed between 71% and 75% of the amount that was charged for the service, based on the date of treatment. The bill deletes these reimbursement rates.

For any increase in an amount payable under Medicare that occurs after June 11, 2019, the change must be applied to the amount allowed for payment or reimbursement. The bill would delete a provision prohibiting the amount allowed from exceeding the average amount charged by a provider on January 1, 2019.

Under the Code, for care rendered in an injured person's home, the insurer is only required to pay benefits for attendant care up to certain hourly limitations. Additionally, the Code specifies the eligibility requirements for the attendant care. The insurer may contract to pay benefits for attendant care for more than the hourly limitation. The bill deletes these provisions. It also deletes a provision which states that neurological rehabilitation clinics are not entitled to payment or reimbursement for treatment, training, product, service, or accommodation unless the clinic has certain accreditation.

Proposed Reimbursement Rates for Treatment or Training

Under the bill, if Medicare did not provide an amount payable for a treatment or rehabilitative occupational training to an injured person for accidental bodily injury that occurred after June 10, 2019, and that individual was covered by PIP, the provider would have to be reimbursed in the manner described below:

Service	Metro Detroit	Rest of State
HHA/CNA Supervision Level Services, using code S9122 with modifier 01.	$32.78/hour	$32.92/hour
HHA/CNA Basic Care Level Services, using code S9122 with modifier 02.	$36.57/hour	$34.97/hour
HHA/CNA High-Tech Care Level Services using code S 9122 with modifier 03.	$40.37/hour	$38.60/hour
Licensed Practical Nurse Home Health Care Level Services, using code S9124.	$77.50/hour	$74.50/hour
Licensed Practical Nurse Home Health Care Level Services, using code T1031.	$181.15/visit	$178.95/visit

Service	Metro Detroit	Rest of State
Registered Nurse Home Health Care Level Services, using code S9123.	$86.56/hour	$82.76/hour
Registered Nurse Home Health Care Level Services, using code T1030.	$220.88/visit	$211.19/visit
Residential Services Level 1, using code T2048 with modifier 01.	$454.65/day	$434.71/day
Residential Services Level 2, using code T2048 with modifier 02.	$599.62/day	$573.32/day
Residential Services Level 3, using code T2048 with modifier 03.	$754.46/day	$721.37/day
Residential Services Bed Hold, using code T2048 with modifier 04.	55% daily rate per care level	
One-on-One Staffing: Aide Services, using code S5125.	$9.66/15 minutes	$9.24/15 minutes
Day Treatment: Half Day, using code H2001 with modifier 01.	$216.77/day	$207.26/day
Day Treatment: Full Day, using code H2001 with modifier 02.	$433.96/day	$414.93/day
Day Treatment: 15 minutes, using code H2032.	$18.36/15 minutes	$17.81/15 minutes
Home- and Community-Based Therapies, using codes 97535, 97110, 97530, 97537, 92507, 97129, or 97130, with Place of Service codes 12 or 99.	$82.23/15 minutes	$78.63/15 minutes
In-Home Occupational Therapy, using code S9129.	$269.55/visit	$256.07/visit
In-Home Physical Therapy, using code S9131.	$267.71/visit	$254.32/visit
In-Home Speech Language Pathology, using code S9128.	$291.00/visit	$274.45/visit
Job Development/Job Placement, using code H2015.	$45.03/15 minutes	$43.06/15 minutes
Job Coaching, using code H2025.	$21.44/15 minutes	$20.50/15 minutes
Enclave Work Site – Group, using code H2023.	$17.25/15 minutes	$16.49/15 minutes
Case Management, using code T1016.	$42.90/15 minutes	$41.01/15 minutes
Pharmacy – Generic Drugs, Dispensing Fee, using an unidentified code.	$6.36/ Prescription	$6.53/ Prescription
Pharmacy – Generic Drugs, Drug Payment, using an unidentified code.	12% discount to average wholesale price.	
Pharmacy – Name Brand Drugs, Dispensing Fee, using an unidentified code.	$4.05/prescription	
Pharmacy – Name Brand Drugs, Drug Payment, using an unidentified code.	12% discount to average wholesale price.	
Pharmacy – Custom Compounds, Dispensing Fee, using an unidentified code.	$14.45/prescription	
Pharmacy – Custom Compounds, Drug Payment, using an unidentified code.	12% discount to average wholesale price.	
Pharmacy – Commercially Manufactured Topicals, Dispensing Fee.	$9.83/prescription	
Nonemergency Medical Transport – Charge per Mile while Rider Is in the Vehicle, using code S0215,	$3.47/mile	

Service	Metro Detroit	Rest of State
Nonemergency Medical Transport – Wheelchair Van Pickup Fee – Weekday, using code A0130 with modifier 01.	$39.30/pick up	
Nonemergency Medical Transport – Nonwheelchair Van Pickup Fee – Weekday, using code A0100 with modifier 01.	$36.61/pick up	
Nonemergency Medical Transport – Wheelchair Van Pickup Fee – Weekend, using code A0130 with modifier 02.	$45.37/pick up	
Nonemergency Medical Transport – Nonwheelchair Van Pickup Fee – Weekend, using code A0100 with modifier 02.	$40.46/pick up	
Nonemergency Medical Transport – Wait Time, using code T2007.	$8.45/15 minutes	

These reimbursements also would apply to a service with a substantially similar code or modifier.

Additionally, a personal caregiver who rendered home care services to an injured person for accidental bodily injury that occurred after June 10, 2019, and was covered by PIP would have to be reimbursed as follows:

Service	Metro Detroit	Rest of State
HHA/CNA Supervision Level Services.	$19.67/hour	$19.37/hour
HHA/CNA Basic Care Level Services.	$21.94/hour	$20.98/hour
HHA/CNA High-Tech Care Level Services.	$24.22/hour	$23.16/hour
Licensed Practical Nurse Home Health Care Level Services.	$46.50/hour	$44.70/hour
Registered Nurse Home Health Care Level Services.	$51.94/hour	$49.66/hour

A chiropractic provider that rendered home care services to an injured person for accidental bodily injury that occurred after June 10, 2019, and was covered by PIP would have to be reimbursed as follows:

Service	Metro Detroit	Rest of State
Low-level laser treatment using code S8948	$25.24/15 minutes	$24.61/15 minutes
Vertebral axial decompression using code S9090	$48.63/hour	$47.41/hour

An amount applied as proposed above would have to be adjusted by the percentage change in the medical care component of the of the CPI for the year preceding the adjustment.

Under the bill, for treatment and training provided to an injured person for accidental bodily injury that occurred after June 10, 2019, and the treatment or training was covered by PIP but the provisions described above did not apply, reimbursement would have to be issued in accordance with Section 3107(1)(a) and the provider would have to charge a reasonable amount for the treatment or training where the charge could not exceed the amount the provider customarily charged for similar treatment or training in cases without insurance.

(Generally, Section 3107(1)(a) specifies the allowable expenses for reasonable charges incurred for necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation.)

A provider that rendered home care or residential services would not be entitled to payment for a treatment or training unless the provider was accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Community Health Accreditation Partner Program, the Accreditation Commission for Health Care, or a similar organization recognized for accreditation by the DIFS Director. This provision would not apply to a provider that was in or was beginning the process of accreditation, as verified by the accrediting body, within one year after the bill's effective date, unless three years had passed, and the provider was still not accredited.

The accreditation requirement would not apply to a personal caregiver. For care rendered by a personal caregiver, the insurer would only be required to pay benefits for a maximum of 16 hours per day per individual but could contract to pay more. A personal caregiver could not seek payment from an insurer for care rendered to more than two injured persons at the same time.

For all treatment or training provided to an injured person for accidental bodily injury that occurred before June 11, 2019, and that was covered by PIP, the reimbursement would have to be issued in accordance with Section 3107(1)(a) and the provider would have to charge a reasonable amount for the treatment or training where the charge could not exceed the amount the provider customarily charged for similar treatment or training in cases without insurance.

Definitions

"BADLs" would mean basic activities of daily living and may include bathing, dressing, grooming, toileting, personal hygiene, feeding, and other basic self-care activities.

"Case management" would mean services provided by a case manager with a health professional degree and current license or national certification in a health or human services profession. The term would include, assessing, planning, implementing, coordinating, monitoring, and evaluating the options and services required to meet the injured person's health and human service needs.

"Day treatment" would mean daytime programs that provide educational, prevocational, or vocational or therapeutic activity services and that are supervised by paraprofessional staff with program design and oversight by health care professionals.

"Day treatment – 15 minute" would mean day treatment for which 15-minute units are used and reimbursed for services rendered that are not otherwise covered by full day or half day codes.

"Day treatment – Full Day" would mean treatment provided for five to seven hours per day.

"Day treatment – Half Day" would mean treatment provided for two and a half to three and a half hours per day.

"Enclave Work Site – Group" would mean a community-based work site of a competitive employer external to a residential services program where a group of injured persons work under the supervision of staff from the program.

"HHA/CNA Basic Care Level Services" would mean services generally performed at the care level of a home health aide or certified nursing assistant for the purpose of providing personal care or assisting an injured person with the performance of BADLs or IADLs in the home or other place of residence.

HHA/CNA High-Tech Care Level Services" would mean services generally performed at the care level of a home health aide or certified nursing assistant for the purpose of providing personal care, assisting with the performance of BADLs and IADLs, and providing additional interventions for an injured person, including, but not limited to, basic bowel and bladder program management, complex transfers, basic behavior and cognitive management, vital sign monitoring, orthopedic brace care, basic skin integrity care, pediatric patient care, and other forms of monitoring and care that do not require direct care or oversight by a licensed nurse, in the home or other place of residence.

"HHA/CNA Supervision Level Services" would mean services generally performed at the care level of a home health aide or certified nursing assistant for the purpose of providing direct supervision to ensure the health and safety of an injured person in the home or other place of residence.

"Home- and Community-Based Therapies" would mean those services that are performed by licensed, registered, or certified professionals, using current procedural terminology codes within their scope of practice, and performing services in the home or community setting, as an extension of an outpatient rehabilitation program or community-based private practice model.

"Home care" would mean home health aide, nursing, and other similar services provided to an injured person in the home or place of residence, other than in a hospital, nursing home, or county medical facility, unless ordered by a physician for safety reasons.

"In-Home Occupational Therapy" would mean occupational therapy services performed in the home or other place of residence.

"In-Home Physical Therapy" would mean physical therapy services performed in the home or other place of residence.

"In-Home Speech Language Pathology" would mean speech language pathology services performed in the home or other place of residence.

"IADLs" would mean instrumental activities of daily living and may include health and medication management, money and financial management, menu planning, grocery shopping, cooking, cleaning, laundry, transportation, community mobility or access, planning and organization, and other similar activities.

"Job Coaching" would mean services performed to assist an injured person with learning, accommodating, or performing specific job tasks and developing interpersonal and other employment-related skills.

"Job Development/Job Placement" would mean services performed by an individual with a bachelor's degree or higher with additional vocational training for the purpose of assisting an injured person with job placement and development of interpersonal and other employment-related skills.

"Licensed Practical Nurse Home Health Care Level Services" would mean skilled nursing services performed at the care level of a licensed practical nurse in the home or place of residence.

Currently "Medicare" means the fee for service payments under Part A, B, or D of the Federal Medicare Program without regard to the limitations unrelated to the rates and fee schedule

such as limitations or supplemental payments related to unitization, readmissions, recaptures, bad debt adjustments, or sequestration.

Under the bill, "Medicare" would mean, the fee for service payments under Parts A, B, or D of the Federal Medicare Program. The term would not include adjustments related to readmissions, bad debt adjustments, or sequestration. The term would include payments to providers, reimbursed under a prospective payment system, including the inpatient acute, inpatient psychiatric, inpatient rehabilitation, long-term acute care, skilled nursing, hospice, and outpatient prospective payment systems and any other hospital payment system designated by the United States Department of Health and Human Services. Additionally, the term would include all facility adjustments, including adjustments for acuity, area wage index, capital, direct and indirect graduate medical education, disproportionate share components, new technology, low volume, organ acquisition cost, routine and ancillary cost for allied health programs, and outlier. For sole community hospitals, rural referral centers, rural emergency hospitals, and critical access hospitals, Medicare means the equivalent hospital-specific payment for providing inpatient or outpatient services to Medicare beneficiaries.

"Metro Detroit" would mean services provided in the county of Wayne, Washtenaw, Oakland, or Macomb.

"One-on-One Staffing – Aide Services" would mean direct supervision of a single injured person by an aide or other caregiver to ensure the injured person's health, safety, or adherence to medical recommendations or to enable the injured person to participate in therapeutic activities or other treatment.

"Personal caregiver" would mean an individual who is any of the following:

-- An individual who is related to the injured person.
-- An individual who is domiciled in the household of the injured person.
-- An individual with whom the injured person had a business or social relationship before the injury.
-- An individual who is employed or contracted to perform home care services directly by an injured person or the injured person's legal representative.
-- An individual who is not employed or contracted to perform home care services by an agency or other organization.

"Provider" would mean a physician, hospital, clinic or other person that renders treatment or training to an injured person.

"Registered Nurse Home Health Care Level Services" would mean skilled nursing services generally performed at the level of a registered nurse, in the home or other place of residence.

"Residential services" would mean post-acute brain or spinal cord rehabilitation treatment or training rendered in an accredited residential program that may include direct assistance with BADLs or IADLs on a continual or intermittent basis, direct supervision for health and safety, and medical or behavioral oversight or intervention. The term would not include one-on-one staffing or supervision beyond program-level supervision, nursing treatment or intervention, medical supplies, durable medical equipment, individualized interventions, and therapeutic services, individual or group therapy services, vocational services and supports, day programs, or transportation to appointments or activities not sponsored by the program.

"Residential Services Bed Hold" would mean a temporary leave of absence for an injured person from the accredited residential program in which the injured person permanently resides. The first two consecutive days of any leave of absence would have to be reimbursed

at the applicable residential services level rate, and any consecutive day or days of leave after the first two days would have to be reimbursed at the Residential Services Bed Hold Rate.

"Residential Services Level 1" would mean residential services provided to an injured person who generally requires at least one of the following:

-- Minimal assistance on a routine basis to perform some BADLs.
-- Minimal to moderate assistance to perform at least some IADLs.
-- Ongoing supervision in a structured living environment.
-- Minimal assistance on a routine basis to manage one or more medical conditions.
-- Intermittent support to manage mood or promote behavioral stability.

"Residential Services Level 2" would mean residential services provided to an injured person who may require any Residential Level 1 Services and who generally requires at least one of the following:

-- Minimal to moderate assistance or supervision to perform most BADLs.
-- Minimal to moderate assistance for functional mobility.
-- Moderate to maximum assistance to perform most IADLs.
-- Direct care on a routine basis to monitor and manage one or more medical condition.
-- One or more impromptu specialized interventions to address behavioral concerns, including mild to moderate aggression.

"Residential Services Level 3" would mean residential services provided to an injured person who may require any Residential Level 1 or Level 2 Services and who generally requires at least one of the following:

-- Maximum to total assistance to perform more BADLs.
-- Maximum to total assistance for functional mobility.
-- Moderate to maximum assistance to perform most IADLs.
-- Daily direct care and/or oversight by a licensed health care professional to manage one or more medical conditions.
-- One or more impromptu specialized interventions or individual behavioral plans for consistent therapeutic response to address behavioral or mental health concerns, including verbal or physical aggression.

"Rest of State" would mean services provided in any location, including a location in or outside of the State, other than in the counties of Wayne, Washtenaw, Oakland, and Macomb in the State.

MCL 500.3157 (S.B. 530)
500.2111f (S.B. 531)
500.3107c (S.B. 575)

BACKGROUND

Prior to the passage of PA 21 of 2019, Michigan's auto insurance system charged the highest premiums in the United States.[4] Michigan was the only state in the country that required every driver to have unlimited PIP medical coverage in the case of severe injury.[5] Michigan

[4] Cooney, Patrick, *et al.*, University of Michigan Poverty Solutions, "*Auto Insurance and Economic Mobility in Michigan*", March 2019.
[5] Nothaft, Amanda, *et al.*, University of Michigan Poverty Solutions, "*Building on Michigan's Auto Insurance Reform Law*", December 2021.

also did not impose a medical fee schedule (a complete listing of fees used to pay healthcare providers) on procedures covered by auto insurance, which may have resulted in healthcare providers charging inflated rates to auto insurers.[6] These two policies increased the number of claims in Michigan, which also drove up insurance rates.[7] In addition, Michigan allowed the use of non-driving factors to determine auto insurance, which disproportionally affected some residents.[8] The codification of PA 21 gave three options for PIP coverage to Michigan residents instead of one, imposed a medical fee schedule on services, and barred insurance companies from using some non-driving factors to calculate rates.

In addition to these measures, PA 21 reduced costs in other areas. For services with a Medicare code (a medical classification system that identifies all the items and services covered under Medicare), such as visits to a healthcare provider or home health care, insurance companies may pay up to 190% of what Medicare pays.[9] For services without a code, such as custodial care performed by family, insurance companies pay 55% of what they paid in 2019.[10] Additionally, starting on July 1, 2021, auto insurance companies have not been obligated to pay for more than 56 hours per week of in-home, family-provided attendant care for Michigan car accident victims.

ARGUMENTS

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

Supporting Argument

The bills would secure access to life-saving rehabilitative care for many victims of auto accidents with catastrophic injuries. In many cases, due to the specialized and consistent care that victims need, the pay cut to healthcare providers enacted by PA 21 of 2019 has resulted in providers giving care to victims of auto accidents with catastrophic injuries at a financial loss. Specifically, PA 21 reduced the reimbursement rate that auto insurance payers paid for services without a Medicare code by up to 45% of what they previously paid before 2019. These reduced fee caps do not cover labor costs for providers, much less the typical agency overhead of payroll, insurance, retirement accounts, computers, supplies, and more.

According to testimony before the Senate Committee on Finance, Insurance, and Consumer Protection, some providers have denied care to three times as many victims of auto accidents with catastrophic injuries than they did before 2019 because of these reimbursement cuts. Lower payments to healthcare providers that care for victims of auto accidents with catastrophic injuries have led providers to reduce services or close down entirely, which has further burdened victims of auto accidents with catastrophic injuries. For example, 35% of brain injury service providers claimed that they could not accept new patients with auto insurance funding due to the pay cut, 11% of providers had to discharge patients, and 8% had to close operations completely.[11] Testimony also indicates that the reduced reimbursement cap has resulted in thousands of jobs being lost in the healthcare sector. Physicians' salaries have decreased 26% in the last 22 years when compared to inflation and many healthcare providers who work with victims of auto accidents with catastrophic injuries have not seen raises recently. The rates proposed by the bill would support healthcare

---

[6] *Id*.
[7] *Id*.
[8] *Id*.
[9] Centers for Medicare and Medicaid Services, "*What Medicare covers*", 2024.
[10] Centers for Medicare and Medicaid Services, Medicare Learning Network, "*Items and Services Not Covered Under Medicare*", June 2022.
[11] Michigan Public Health Institute, Brain Injury Association of Michigan, "*Phase I: Provider Survey Results from a Study Tracking Impact of Fee Changes in No-Fault Auto Insurance Reform*", December 2021.

providers in their care for victims of auto accidents with catastrophic injuries and support financial solvency and jobs in the healthcare industry.

Supporting Argument

Under current law, family caregivers only receive reimbursement for up to 56 hours per week for their services to victims of auto accidents with catastrophic injuries. According to testimony before the Senate Committee on Finance, Insurance, and Consumer Protection, providing care to catastrophically injured victims often requires more work than 56 hours per week, forcing family members who already forfeit other sources of income in becoming family caregivers to receive compensation for only a portion of their time. The economic value of the work of unpaid family caregivers was estimated nationally at $600.0 billion in 2021.[12] Family caregivers should be compensated for their work because their work generates economic value and improves the care of victims of auto accidents with catastrophic injuries. In addition, family members who provide care to their loved ones at home deserve to be paid more because they improve patient outcomes and efficiency at hospitals.[13] The bill would standardize wages for family caregivers and remove the 56 hour per week cap on compensation for their care.

Supporting Argument

According to testimony before the Senate Committee on Finance, Insurance, and Consumer Protection, prior to the 2019 bills, there was a quiet campaign to discredit family caregivers. Before PA 21 was enacted, many individuals perpetuated the narrative that family healthcare providers exploited Detroit drivers who got into auto accidents by charging them expensive fees for simple procedures.[14] Additionally, individuals perpetuating this narrative at the time also spoke about extensive fraud from family care providers. Reducing auto insurance fraud was one of PA 21's proponents' primary objectives to ultimately reduce costs to Michigan residents.[15] In their efforts to accomplish this, PA 21 lowered the amount insurance companies were obligated to pay family care providers; however, testimony indicates that DIFS' fraud reports from 2019 to 2023 list only three fraud cases perpetrated by family care providers, totaling less than $60,000. These statistics do not indicate undue rates for services or extensive fraud on the part of family care providers and increasing compensation for family care providers would not increase fraud.

Response: Prior to PA 21's reforms, some healthcare workers charged rates that were considerably higher than what other healthcare workers charged. According to testimony before the Senate Committee on Finance, Insurance, and Consumer Protection, it was common for trial attorneys to send victims of auto accidents who suffered minor injuries to medical facilities that charged inflated rates.[16] Then, a portion of these inflated payments for medical costs from the auto insurance provider would be paid to the trial attorney, incentivizing them to continue sending patients to facilities that charged inflated rates.[17] This raised the costs of auto insurance policies and premiums, especially in the City of Detroit, and so reimbursement rates should not be changed.[18]

---

[12] Horovitz, Bruce, AARP, "*New AARP Report Finds Family Caregivers Provide $600 Billion in Unpaid Care Across the U.S.*", March 2023.

[13] Schulz, R., et al, "*Family Caregivers' Interactions with Health Care and Long-Term Services and Supports*", November 2016.

[14] J.C. Reindl, Detroit Free Press, "*How aggressive lawyers, costly lawsuits and runaway medical bills make Detroit car insurance unaffordable*", May 2017.

[15] Senate Journal No. 43, May 7, 2019., p. 441.

[16] J.C. Reindl, Detroit Free Press, "*How aggressive lawyers, costly lawsuits and runaway medical bills make Detroit car insurance unaffordable*", May 2017.

[17] *Id*.

[18] *Id.*

Supporting Argument

The expected relief from auto insurance rates for Michigan residents never came as a result of the reforms enacted by PA 21. While rates have decreased by 18% since the PA's enactment, Michigan auto insurance rates are still among the highest in the country.[19] Individual policyholders save relatively small amounts in exchange for lesser and sometimes insufficient care for auto accident victims with catastrophic injuries. The tradeoff is not worthwhile, and the bill would restore access to healthcare for auto accident victims with catastrophic injuries.

Response: Public Acts 21's reforms resulted in PIP insurance rates decreasing by 18%, resulting in $5.0 billion in savings to drivers. As a consequence of these savings, 200,000 more Michigan residents now have car insurance. These savings to Michigan residents are not insignificant.

Opposing Argument

The bill would cancel out savings for Michigan residents achieved by PA 21's reforms. According to testimony before the Senate Committee on Finance, Insurance, and Consumer Protection, passing the bill would result in at least $1.2 billion of additional PIP premiums annually that would need to be collected to cover higher costs. The bill also would result in an increase to the Michigan Catastrophic Claims Association (MCCA) per-vehicle fee, which has dropped 66% since PA 21's enactment. The MCCA is a non-profit association of which every insurance company that sells automobile or motorcycle coverage in Michigan is required to be a member. The MCCA manages the Catastrophic Care Fund used to reimburse auto insurers once an accident victim's medical bills exceed $635,000. Each year, the MCCA determines the amount needed to cover the lifetime claims of all people catastrophically injured in a car accident for the coming year.[20] This amount is gathered through a per-vehicle fee charged to each insurance company in Michigan and is based primarily on the number of vehicles that company insures.[21] The per-vehicle fee has decreased since 2019 primarily due to the medical fee schedule and utilization review process imposed by PA 21.[22]

Finally, the bill would more quickly exhaust the PIP medical coverage limits of the individual policyholders that chose to decrease their coverage levels after PA 21's enactment. The faster those coverage limits are exhausted, the more likely it would be that victims of auto accidents would seek excess medical costs under the at-fault driver's Bodily Injury (BI) insurance, which covers the at-fault driver during a car accident resulting in someone else's injury or death. Bodily injury insurance coverage pays for pain and suffering compensation, excess medical benefits, lost wages, and other economic damages the driver owes to the injured party.[23] The more insurance is used, the more insurance companies will charge to cover costs; therefore, using BI insurance would lead to increased BI rates. Overall, this would increase already expensive auto insurance costs for Michigan residents.

Opposing Argument

Increased auto insurance rates would likely lead to more uninsured drivers and less competition in the insurance marketplace through insurance company closures, which could further increase auto insurance rates. According to testimony before the Senate Committee on Finance, Insurance, and Consumer Protection, with these higher rates, more drivers may find themselves unable to afford their premiums and may take the risk of going without

---

[19] Amanda Nothaft, et al, University of Michigan Poverty Solutions, "*Building on Michigan's Auto Insurance Reform Law*", December 2021.

[20] Department of Insurance and Financial Services, "*Michigan Catastrophic Claims Association (MCCA)*", April 2019.

[21] *Id*.

[22] Erhardt, Joseph, Michigan Catastrophic Claims Association, "*MCCA Sets 2024-2025 Insurance Company Assessment*", December 2023.

[23] Michigan Auto Law, "*Michigan Bodily Injury Liability Insurance: What You Need To Know*", 2024.

insurance, potentially leaving them without coverage for medical bills or vehicle repairs in the event of an accident.

Opposing Argument

A narrower solution is needed to avoid overcharging Michigan residents to pay healthcare providers. The way the bill is currently written, no additional benefits would occur for most consumers after the bill's increase in healthcare provider payouts; instead, the bill would increase the profits of healthcare providers since the increase to the reimbursement rate would apply to payments covering all victims of auto accidents, not just payments covering victims of auto accidents with catastrophic injuries. For healthcare providers who do not issue care to victims of auto accidents with catastrophic injuries, a reimbursement rate of 190% of Medicare is good enough. The bill should be amended to increase reimbursement rates only for healthcare providers providing services to victims of auto accidents with catastrophic injuries to fix this issue without sacrificing the savings to Michigan residents gained by PA 21.

Legislative Analyst: Nathan Leaman

FISCAL IMPACT

The bill would not have a significant fiscal impact on DIFS and would have no fiscal impact on local units of government. Existing appropriations and staff likely would be sufficient to manage implementation activities resulting from the bill.

There would be no direct fiscal impact to the Medicaid program under the changes proposed in the bill. The proposed changes in the provider reimbursement limits and the defined fee schedule are applicable to treatment and training for accidental bodily injury covered by PIP. As the bill does not modify the existing PIP tiers that permit qualified individuals enrolled in Medicaid to purchase a PIP coverage of $50,000, there is not likely to be any changes in insurance coverage behavior. As the State Medicaid program negotiates a fee schedule for Medicaid fee-for-service individuals and Medicaid managed care health plans negotiate rates on behalf of the Medicaid managed care enrollees, the bill would have no direct change in underlying Medicaid payments made to providers of Medicaid services.

Fiscal Analysts: John P. Maxwell
Elizabeth Raczkowski

SAS\S2324\s530a