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NAVIGATING THE CHAOS: THE NEW NO-FAULT LEGISLATION©

June 14, 2019
(1st Revision)

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INTRODUCTION

On May 25, 2019, the Michigan Legislature passed vast and sweeping changes to the Michigan No-Fault Insurance Law and the Michigan Insurance Code. Governor Whitmer signed these changes into law on May 30, 2019. This legislation is known as SB1. On June 4, 2019, the Michigan House and Senate passed the "*trailer bill,*" HB 4397, which included some revisions and clarifications to SB1. Both bills included language giving the legislation immediate effect. On June 11, 2019, Governor Whitmer signed HB 4397, and, on that date, both SB1 and HB 4397 were filed with the Michigan Secretary of State's Office of the Great Seal and assigned Public Act numbers 21 and 22, respectively. Therefore, except for those provisions that contain specific effective dates, this legislation is effective as of June 11, 2019.

This legislation fundamentally changes how the Michigan no-fault insurance system operates. Moreover, the number of people who will be covered with no-fault personal protection insurance (PIP) benefits will be significantly reduced. In addition, many people claiming PIP benefits will be subject to monetary caps.

The purpose of this outline is to summarize the content of this extensive and complex legislation. However, it should not be utilized as a substitute for the actual statutory text. To the extent there are discrepancies between the substance and citations of SB 1 and HB 4397, this outline and the citations it contains treats HB 4397 as the controlling authority.

1. PIP CHOICE OPTIONS, COORDINATION AND PIP OPT-OUTS

Beginning July 1, 2020, the legislation authorizes insurers to sell various types of no-fault PIP choice policies and opt-outs from PIP coverage that apply to allowable expense benefits payable under Section 3107(1)(a). These different PIP choice policies and PIP opt-outs are explained below.

A. THE $50,000 MEDICAID OPTION –

(1) **Those Eligible** – The $50,000 option is available to those persons who satisfy the following two conditions: 1) the person is covered under Medicaid; and 2) the person's spouse and all resident relatives are on Medicaid, have other health insurance, or have PIP coverage through a different policy. This level of choice applies to the person, the person's spouse, or any resident relatives. [Section 3107c(1)(a)].

(2) **Premium Reduction** – The premium rates offered by an insurer for this level of PIP coverage must result in an average reduction, as nearly as practicable, of "*an average 45% or greater per vehicle*."

Accordingly, the reduction is **not** based on a percentage reduction of the actual PIP insurance rates the specific individual consumer paid for PIP insurance on May 1, 2019. Rather, the rate reduction is based on the "*average reduction per vehicle from the premium rates for PIP insurance coverages that were in effect for the insurer on May 1, 2019.*" The statute does not provide any further specific guidance on how the reduction should calculated. These premium reductions are guaranteed through July 1, 2028. [Section 2111f(2)(a)].

B. THE $250,000 OPTION

(1) **Those Eligible** – A $250,000 option is available to any person, without limitation. [Section 3107c(1)(b)].

(2) **Premium Reduction** – The premium rates offered by an insurer for this level of PIP coverage must result in an average reduction, as nearly as practicable, of "*an average 35% or greater per vehicle*." This reduction is calculated under the same approach described in Section 1 A (2) of this outline. These premium reductions are guaranteed through July 1, 2028. [Section 2111f(2)(b)].

C. THE $500,000 OPTION

(1) **Those Eligible** - A $500,000 option is available to any person without limitation. [Section 3107c(1)(c)].

(2) **Premium Reduction** – The premium rates offered by an insurer for this level of PIP coverage must result in an average reduction, as nearly as practicable, of "*an average 20% or greater per vehicle*." This reduction is calculated under the same approach described in Section 1 A (2) of this outline. These premium reductions are guaranteed through July 1, 2028. [Section 2111f(2)(c)].

D. THE LIFETIME OPTION

(1) **Those Eligible** – The lifetime PIP option remains available to any person without limitation. [Section 3107c(1)(d)].

(2) **Premium Reduction** – The premium rates offered by an insurer for this level of PIP coverage must result in an average reduction, as nearly as practicable, in "*an average 10% or greater per vehicle*." This reduction is calculated under the same approach described in

Section 1 A (2) of this outline. These premium reductions are guaranteed through July 1, 2028. [Section 2111f(2)(d)].

E. **ATTENDANT CARE RIDER OPTION** - Insurers selling policies with limits of $50,000, $250,000, or $500,000 shall offer *"a rider that will provide coverage for attendant care in excess of the applicable limit."* This rider does not require the sale of attendant care coverage in excess of the 56 weekly hourly limitations set forth in Section 3157(10) and further discussed in Section 4 of this outline. [Section 3107c(8)].

F. **COORDINATION OF BENEFIT OPTIONS**

(1) **Basic Rule –** Insurers may continue to offer deductibles and exclusions reasonably related to other health and accident coverage (i.e., coordination of benefits). The option to purchase coordinated benefits coverage applies to the $250,000, $500,000, and lifetime options. [Section 3109a(1)]. Presumably, general coordination does not apply to those insured under a $50,000 Medicaid PIP choice policy, since Medicaid does not coordinate when there is no-fault coverage available.

(2) **Premium Reduction** - The statute removes the requirement that coordinated benefits coverage be sold at *"appropriately reduced premium rates."* Instead the statute states that coordination of benefits must be now offered at *"a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both."* [Section 3109a(1)].

G. **THE MEDICARE PIP OPT-OUT –**

(1) **Those Eligible** - A complete opt-out from no-fault allowable expense PIP benefits payable under Section 3107(1)(a) is available to a person who can satisfy the following two conditions: 1) the person is covered under Parts A and B of Medicare; and 2) the person's spouse and any resident relative has Medicare *"qualified health coverage,"* or has no-fault PIP coverage under a separate policy. [Section 3107d(1) & Section 3107d(8)(b)-(c)]. Notably, as explained in Section 5 of this outline regarding the Assigned Claims Plan (ACP), these people are not entitled to coverage through the ACP when injured as an occupant of a motor vehicle, but are likely entitled to ACP coverage when injured as an non-occupant of a motor vehicle and there is no other insurer in the line of priority from which to recover PIP benefits.

(2) **Premium Reduction** - The premium for this opt-out must result in no premium charge for PIP benefit coverage for PIP benefits payable under Section 3107(1)(a). [Section 2111f(3)].

H. THE $250K PIP EXCLUSION OPT-OUT –

(1) **Basic Concept –** If a person selects the $250,000 PIP level of coverage, and if that person, his or her spouse, and all resident relatives have other health and accident coverage that extends to auto-related injuries, then the insurer must offer an exclusion that would apply to all allowable expense benefits payable under Section 3107(1)(a). Persons selecting this exclusion will hereinafter be referred to as *"$250K PIP excluders."* However, the language pertaining to the $250K PIP exclusion states, *"a person subject to an exclusion under this subsection is not eligible for personal protection benefits under the insurance policy."* [Section 3109a(2)(c)]. This language is so broad that it could be interpreted to mean that an exclusion sold under this section bars payment of any and all PIP benefits, not merely allowable expenses under Section 3107(1)(a). On the other hand, other language in this section seems to suggest that the $250K PIP exclusion is only intended to apply to allowable expense benefits under Section 3107(1)(a). For example, the legislation provides that, for $250K excluders, the *"premium for personal protection insurance benefits payable under Section 3107(1)(a) under the policy must be reduced by 100%."* [Section 3109a(2)(a)].

(2) **The ACP and $250K Excluders -** As explained in Section 5 of this outline regarding the ACP, people who select the $250K PIP exclusion are not entitled to coverage through the ACP if they are injured while an occupant of a motor vehicle. However, these $250K excluders may very well be entitled to coverage if injured while a non-occupant of a motor vehicle and there is no other insurer in the line of priority from which PIP benefits would be payable. This situation is further discussed in Section 5 of this outline.

(3) **Rules for Lapses in Health or Accident Coverages –** If a $250K PIP excluder has a lapse in their other health and accident coverage, the person is obligated to notify their no-fault insurer within 30 days of the lapse and must purchase uncoordinated coverage. [Section 3109a(2)(d)]. If such a person is injured during this 30-day time period, the statute provides that the person will claim benefits through the ACP. [Section 3109a(2)(d)(ii)]. Individuals claiming benefits through the ACP in this situation will be capped at

$2,000,000. [Section 3172(7)(b)]. However, it is not clear if this is the case when the person has properly purchased the uncoordinated coverage within the 30-day window. Presumably, in such a situation, the person would claim benefits under the newly purchased uncoordinated no-fault policy, but the law does not expressly confirm this conclusion.

I. GENERAL RULES APPLICABLE TO PIP CHOICE OPTIONS AND OPT-OUTS

(1) **PIP Benefits Subject to the Cap –** With the possible exception of the $250K PIP excluders referenced above, it would appear that all of the PIP choice options and PIP benefit opt-outs apply only to allowable expense benefits payable under Section 3107(1)(a). In other words, persons selecting such options and opt-outs would not be diminishing wage loss benefits under Section 3107(1)(b) and Section 3107a, replacement service expenses under Section 3107(1)(c), or survivor's loss benefits under Section 3108. This conclusion is supported by the fact that only allowable expenses payable under Section 3107(1)(a) are referenced in the PIP choice and opt-out provisions contained in Section 3107c and Section 3107d.

(2) **Basic Rules Regarding Priorities and Coverage Limits** – With the exception of vehicle occupants and non-occupants who have no PIP coverage, and motorcyclists in certain scenarios, the basic rules of priority previously existing have not been changed by this legislation. Subject to the provisions discussed above, any PIP benefit option or opt-out selected by a person will apply to the person, the person's spouse, any resident relative, or any other person with the right to claim PIP benefits under the policy. [Section 3107c(5)]. The legislation further provides that the selected PIP choice limit is not a household limit. Rather, it is a limit that would apply to each individual claiming benefits under a PIP policy in relation to a given accident. [Section 3107c(1)(a)-(c)]. If there are two or more PIP policies in a household and a resident relative is injured and does not have their own PIP policy, then this resident relative would be entitled to claim PIP benefits up to the highest level of coverage under any single PIP policy in the household. [Section 3107c(6)].

(3) **Employer Vehicle and Motorcycle Accidents –** If the injured person is occupying an employer-provided vehicle and is drawing PIP benefits under the employer's policy, pursuant to the priority

provisions of Section 3114(3), the PIP coverage limits selected by the employer will apply to the claim regardless of whether the injured person purchased higher limits. A similar result applies to motorcyclists in certain situations as explained in Section 6, of this outline. For further information regarding the issue of priorities and ACP claimants, see Section 5 of this outline.

(4) **Required Forms** – For any PIP benefit option or opt-out, a person must be presented with form documents promulgated by the Department of Insurance and Financial Services (DIFS) that explain the "*benefits and risks*" of selecting any level of PIP coverage or opt-out. [Section 3107c(2)].

(5) **Coverage Presumptions** - Certain presumptions apply if the applicant's option choice is not clear. If a premium has been paid, the presumption is that the choice is commensurate with the premium paid. [Section 3107c(3)]. If no premium has been paid, the presumption is that the person bought lifetime coverage. [Section 3107c(4)].

(6) **Uncovered Medical Expenses** – Auto-related medical expenses not covered because of options and opt-outs may be recovered in a tort claim against an at-fault driver under Section 3135. See Section 13 of this outline for further details.

J. THE MANAGED CARE OPTION

(1) **Concept** – The legislation allows insurers to offer "*managed care options*" at the time a policy is issued. This option "*includes, but is not limited to, the monitoring and adjudication of an injured person's care, the use of a preferred provider program or other network, or other similar option.*"[Section 3181].

(2) **Availability** - All no-fault insurers are allowed to offer managed care plan options. [Section 3182].

(3) **Non-Managed Care Plans** - Insurers who offer managed care options must also offer non-managed care options. [Section 3184].

(4) **Emergency Medical Care** - The managed care cannot apply to the emergency medical care, which is defined as including, but not limited to, "*all care necessary to the point where no material deterioration*

of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient." [Section 3183(c)].

(5) **Covered Area** - Managed care option plans must be "*uniformly offered in all areas where the managed care option is available."* However, there is no further definition of "*areas*." [Section 3183(a)].

(6) **Discounted Premium –** Insurers offering managed care plans must do so at a discounted premium that *"reflects reasonably anticipated reductions in losses or expenses or both."* [Section 3183(b)].

(7) **Household Application** - The managed care option applies to the insured who selects the managed care option and any person who resides in an area where the managed care option is available and who is claiming PIP benefits under the managed care policy. [Section 3185].

(8) **Primary Coverage** - Managed care plans must be primary and cannot be coordinated with other health and accident coverage on a person claiming PIP benefits under the plan. [Section 3187(a)].

(9) **Exhaustion of PIP Benefits** - PIP benefits under a managed care plan must be exhausted before a person can seek benefits from another health or accident coverage provider. [Section 3187(b)].

(10) **Date of Effect –** Insurers may begin selling the managed care option beginning on June 11, 2019.

K. **DATE OF EFFECT** - The above PIP choice policies and opt-out options must be offered on July 1, 2020 and will apply to any accident occurring thereafter.

2. FEE SCHEDULES

A. **DEFAULT FEE SCHEDULE RULE –** Subject to the exceptions referenced below, a physician, hospital, clinic, or other person that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is not eligible to be paid more than the following:

(1) 200% of the amount payable under Medicare for treatment or training rendered after July 1, 2021 and before July 2, 2022. [Section 3157(2)(a)].

(2) 195% of the amount payable under Medicare for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(2)(b)].

(3) 190% of the amount payable under Medicare for treatment or training rendered after July 1, 2023. [Section 3157(2)(c)].

(4) If Medicare does not provide an amount payable for a particular treatment, the provider is eligible to be paid certain percentages of amounts payable under the provider's *"charge description master"* that was in effect on January 1, 2019. If the provider did not have a *"charge description master"* in effect on that date, the provider is eligible to be paid the same percentages based on the average amount the provider charged for the treatment on January 1, 2019. These specific percentages are as follows:

(a) 55% for treatment or training rendered after July 1, 2021 and before July 2, 2022. [Section 3157(7)(a)(i)].

(b) 54% for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(7)(a)(ii)].

(c) 52.5% for treatment or training rendered after July 1, 2023. [Section 3157(7)(a)(iii)].

B. TIER I MEDICAID PROVIDERS - Any physician, hospital, clinic, or other person having more than 20%, but less than 30% of *"indigent volume"* for *"measuring eligibility for Medicaid disproportionate share payments"* is not eligible to be paid more than the following:

(1) 230% of the amount payable for treatment or training under Medicare for treatment rendered after July 1, 2021 and before July 2, 2022. [Section 3157(3)(a)].

(2) 225% of the amount payable for treatment or training under Medicare for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(3)(b)].

(3) 220% of the amount payable for treatment or training under Medicare for treatment or training rendered after July 1, 2023. [Section 3157(3)(c)].

(4) For these providers, if Medicare does not provide an amount payable for a particular treatment, the provider is eligible to be paid certain percentages of amounts payable under the provider's "*charge description master*" that was in effect on January 1, 2019. If the provider did not have a "*charge description master*" in effect on that date, the provider is eligible to be paid the same percentages based on the average amount the provider charged for the treatment on January 1, 2019. These specific percentages are as follows:

(a) 70% for treatment or training rendered after July 1, 2021 and before July 2, 2022. [Section 3157(7)(b)(i)].

(b) 68% for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(7)(b)(ii)].

(c) 66.5% for treatment or training rendered after July 1, 2023. [Section 3157(7)(b)(ii)].

C. TIER II MEDICAID PROVIDERS - Any physician, hospital, clinic, or other person "*that provides more than 30% on average of its total treatment or training*" for "*indigent volume*" for "*measuring eligibility for Medicaid disproportionate share payments*" is not eligible to be paid more than 250% of the amount payable for treatment or training under Medicare. [Section 3157(5)]. For these providers, if Medicare does not provide an amount payable for a particular treatment, the provider is eligible to be paid 78% of the provider's "*charge description master*" that was in effect on January 1, 2019. If the provider did not have a "*charge description master*" in effect on that date, the provider is eligible to be paid 78% of the average amount the provider charged for the treatment on January 1, 2019. [Section 3157(7)(c)]. Notably, the legislation does not provide any further increases or decreases in the payment amount allowed for these Tier II Medicaid providers.

D. FREESTANDING REHABILITATION FACILITIES – The legislation designates a fee schedule for providers known as "*freestanding rehabilitation facilities.*" These facilities are defined as an acute care hospital to which all of the following apply: the hospital has staff with specialized and demonstrated rehabilitation medicine expertise; the hospital possesses sophisticated technology and specialized facilities; the hospital participates in rehabilitation research and clinical education; the hospital assists patients to achieve excellent rehabilitation outcomes; the hospital coordinates necessary post-discharge services; the hospital is accredited by 1 or more third-party, independent organizations focused on quality; the hospital serves the rehabilitation needs of catastrophically injured patients in this

state; and the hospital was in existence on May 1, 2019. [Section 3157(4)(b)(i-viii)]. Furthermore, the state may not designate more than two of these facilities to receive payment under this designated fee schedule. Under this designated fee schedule, these facilities are not eligible to be paid more than the following:

(1) 230% of the amount payable under Medicare for treatment or training rendered after July 1, 2021 and before July 2, 2022. [Section 3157(3)(a)].

(2) 225% of the amount payable under Medicare for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(3)(b)].

(3) 220% of the amount payable under Medicare for treatment or training rendered after July 1, 2023. [Section 3157(3)(c)].

(4) For these providers, if Medicare does not provide an amount payable for a particular treatment, the provider is eligible to be paid certain percentages of amounts payable under the provider's *"charge description master"* that was in effect on January 1, 2019. If the provider did not have a *"charge description master"* in effect on that date, the provider is eligible to be paid the same percentages based on the average amount the provider charged for the treatment on January 1, 2019. These specific percentages are as follows:

   (a) 70% for treatment or training rendered after July 1, 2021 and before July 2, 2022. [Section 3157(7)(b)(i)].

   (b) 68% for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(7)(b)(ii)].

   (c) 66.5% for treatment or training rendered after July 1, 2023. [Section 3157(7)(b)(iii)].

E. LEVEL I AND II HOSPITAL TRAUMA CENTERS – A hospital that is a level I or II trauma center has a designated fee schedule. The legislation defines level I or II trauma centers as a *"hospital that is verified as a level I or level II trauma center by the American College of Surgeons Committee on Trauma."* [Section 3157(15)(d)]. A level I or II trauma center is not eligible to be paid more than the following:

(1) 240% of amount payable under Medicare for treatment or training rendered after July 1, 2021 and before July 2, 2022. [Section 3157(6)(a)].

(2) 235% of amount payable under Medicare for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(6)(b)].

(3) 230% of amount payable under Medicare for treatment or training rendered after July 1, 2023. [Section 3157(6)(c)].

(4) For these providers, if Medicare does not provide an amount payable for a particular treatment, the provider is eligible to be paid certain percentages of amounts payable under the provider's *"charge description master"* that was in effect on January 1, 2019. If the provider did not have a *"charge description master"* in effect on that date, the provider is eligible to be paid the same percentages based on the average amount the provider charged for the treatment on January 1, 2019. These specific percentages are as follows:

(a) 75% for treatment or training rendered after July 1, 2021 and before July 2, 2022. [Section 3157(7)(d)(i)].

(b) 73% for treatment or training rendered after July 1, 2022 and before July 2, 2023. [Section 3157(7)(d)(ii)].

(c) 71% for treatment or training rendered after July 1, 2023. [Section 3157(7)(d)(iii)].

F. NO PAYMENT TO NON-ACCREDITED *"NEUROLOGICAL REHABILITATION CLINICS"* – A neurological rehabilitation clinic cannot be paid for services and accommodations under the legislation, unless the neurological rehabilitation center is *"accredited by the Commission on Accreditation of Rehabilitation Facilities or a similar organization recognized by the director for purposes of accreditation under this subsection."* [Section 3157(12)]. The legislation defines *"neurological rehabilitation clinic"* as *"a person that provides post-acute brain and spinal rehabilitation care."* [Section 3157(15)(g)]. Query: Is this language so broad that it could be interpreted to apply to ***any*** person or business providing care to brain injury and spinal cord injury patients, rather than being limited only to entities commonly understood to be *"clinics?"* There is an exception to this nonpayment rule if the neurological rehabilitation clinic is *"in the process of becoming accredited as required under this subsection on July 1, 2021, unless three*

years have passed since the beginning of that process and the neurological rehabilitation clinic is still not accredited." [Section 3157(12)]. Finally, it is interesting to note that the prohibitory language of this section is so broad that it could be read to mean that unaccredited facilities cannot charge ***anyone*** for their services, not only no-fault insurers.

G. **CHARGES IN EXCESS OF FEE SCHEDULES –** There appears to be some uncertainty in the language of the legislation as to whether a provider can pursue a patient directly for payment of provider charges that exceed the new fee schedules. The fee schedule provisions of Section 3157(2), (3), (6), and (7), all state that the providers who are subject to each of these provisions are "*not eligible for payment or reimbursement* ***under this chapter***," for more than the fee schedule amount. Does this language allow the provider to argue that a contractual relationship exists between the provider and the patient, permitting the provider to pursue the patient under *contract law*, rather than "*under this chapter?"* If so, the question then becomes whether those provider charges in excess of the new fee schedules can be recovered by the patient in a tort case against the at-fault driver. See Section 13 of this outline for further information regarding that issue.

H. **DATE OF EFFECT -** The above fee schedules and the rules regarding unaccredited neurological clinics all go into effect on July 1, 2021. Furthermore, it appears these fee schedules will apply to claimants injured prior to June 11, 2019. However, an insurer is required to pass along savings from application of the fee schedules to those persons who were injured in auto accidents before July 2, 2021.

3. UTILIZATION REVIEW

A. **DEFINITION** – The statute imposes a mandatory utilization review process for any provider rendering products, services or accommodations to an injured person covered by PIP. Utilization review is defined as "*the initial evaluation by an insurer or the association created under section 3104 of the appropriateness in terms of both the level and the quality of treatment, products, services, or accommodations provided under this chapter based on medically accepted standards."* [Section 3157a(6)].

B. **DEPARTMENT INVOLVEMENT** – DIFS will promulgate rules and establish criteria or standards to implement the utilization review process. This includes establishing procedures for gathering records and information regarding the products, services, or accommodations being rendered. In addition, the rules and standards will address the right of an insurer to request a written explanation from the provider regarding the necessity or

indication for the treatment, products services, or accommodations that are being provided by the provider. [Section 3157a(3)].

C. PROVIDER OBLIGATIONS – The utilization review process will obligate providers to do a number of things, including the following:

(1) provide treatment and billing records regarding their patients;

(2) justify the rendition of products, services or accommodation that *"are not usually associated with, are longer in duration than, are more frequent than, or extend over a greater number of days than the treatment, products, services, or accommodations usually require[d] for the diagnosis or condition for which the patient is being treated."* [Section 3157a(4)].

D. SANCTIONS & PENALTIES - The statute references certain things that will operate to subject providers to penalties and sanctions. For example, a provider that knowingly submits a false or misleading record or other information, has committed a fraudulent insurance act. [Section 3157a(2)]. In addition, over utilization will subject providers to unspecified consequences by DIFS.

E. APPEAL PROCESS – The statute contemplates that DIFS shall promulgate rules for appealing *"determinations,"* but there is no specific indication as to what can be appealed, the process that should be followed, or the consequences of any decision after an appeal. [Section 3157a(3)(iii)].

F. DATE OF EFFECT – These provisions appear to apply to treatment, products, services, or accommodations rendered after July 1, 2020. Furthermore, it appears these standards, when they go into effect, will apply to auto accident victims injured prior to June 11, 2019.

4. ATTENDANT CARE LIMITATIONS

A. GENERAL RULE – The legislation restricts payment of certain noncommercial attendant care rendered in the patient's home to those amounts payable under the Michigan workers' compensation law, which limits payment of such noncommercial attendant care to 56 hours per week. This new limitation applies to attendant care provided in the patient's home by the patient's relative, someone who lives with the patient, or any person who had *"a business or social relationship"* with the patient before the injury. [Section 3157(10)].

B. **OPTION TO CONTRACT** – An insurer may contract to pay benefits for attendant care that is more than the statutory hourly limitations. [Section 3157(11)].

C. **THE ATTENDANT CARE RIDER** – Based on the language of Section 3107c(8) and Section 3157(10), it is clear that a person who purchases an attendant care rider will only be able to claim family-provided attendant within the 56 hour weekly limit. The rider does not enlarge the 56 hour weekly cap. Rather, it only adds dollar cap space to pay for that attendant care.

D. **DATE OF EFFECT** – The attendant care limitations applies to care provided after July 1, 2021. [Section 3157(14)]. Furthermore, beginning on that date, it appears these limitations will apply to auto accident victims injured prior to June 11, 2019.

5. ASSIGNED CLAIMS PLAN (ACP)

A. **THE $250,000 CAP** – Unless subject to an exception, the legislation provides that a $250,000 cap applies to all persons claiming benefits through the ACP. However, it is not clear if this cap applies to all PIP benefits, or only allowable expense benefits payable under section 3107(1)(a). In this regard, Section 3172(7)(a) states, "*the [ACP] and the insurer to whom a claim is assigned by the [ACP] are only required to provide personal protection insurance benefits under section 3107(1)(a) up to . . . [$250,000].*" This suggests that perhaps other PIP benefits are not subject to this cap.

B. **THE EXCEPTION TO THE $250,000 CAP** - The only exception to the $250,000 cap is if the injured person claims benefits through the ACP when, pursuant to Section 3017d or 3019a(2), the person is injured during the 30-day window in which the person had a lapse in qualified health insurance or other health and accident coverages. In that case, the capped amount would total $2,000,000. [Section 3172(7)(b)].

C. **EXCLUDED CLAIMANTS**

(1) **Medicare Opt-Outers Occupying Motor Vehicles** - Those persons who are described as Medicare opt-outers, and who are injured while occupying a motor vehicle, are not entitled to claim PIP benefits through the ACP. [Section 3114(4)]. The only exception is if these persons are injured during the previously mentioned 30-day health coverage lapse window, in which case the ACP will pay benefits up to $2,000,000. [Section 3172(7)(b)].

(2) **$250K Excluders Occupying Motor Vehicles** – Those persons who were previously described as $250K excluders and who are injured while occupying a motor vehicle are not entitled to claim PIP benefits through the ACP. [Section 3114(4)]. The only exception is if these persons are injured during the previously mentioned 30-day health coverage lapse window, in which case the ACP will pay PIP benefits up to $2,000,000. [Section 3172(7)(b)].

(3) **The Unanswered Question** – What happens to Medicare opt-outers and $250k excluders who are injured ***as non-occupants*** of a motor vehicle? These persons will likely be entitled to claim PIP benefits through the ACP up to the $250,000 cap, because the exclusionary language contained in the occupant priority provisions, Section 3114(4), is not contained in the non-occupant priority provisions of Section 3115(1).

D. **ALTERED PRIORITY RULES PERTAINING TO ACP CLAIMS** – The legislative changes to the operation of the ACP have resulted in alterations of certain priority rules that existed under previous law. In this regard, the following should be noted:

(1) Vehicle occupants not otherwise insured with PIP coverage and who are not Medicare opt-outers or $250K excluders will draw benefits from the ACP, not from the vehicles occupied. [Section 3114(4)].

(2) A pedestrian or bicyclist not otherwise insured with PIP coverage, draws benefits from the ACP, not from the involved vehicle. This appears to be true even if the pedestrian or bicyclist is a Medicare opt-outer or a $250K excluder. [Section 3115(1)].

(3) Motorcyclists can claim PIP benefits through the ACP when any of the vehicles in the listed order of priorities had no insurance or where the applicable insurance policy was a Medicare opt-out or a $250K exclusionary policy. As explained in Section 6 A of this outline, a motorcyclist may be able to draw benefits from the ACP even when the motorcyclist was a Medicare opt-outer or a $250K excluder. [Section 3114(6)].

E. **NEW ACP CLAIM PROCEDURES** – The ACP claim making process will become much more complicated under this legislation in several ways, including, but not limited to, the following:

(1) Claims must be made on a special form provided by the ACP. [Section 3172(3)].

(2) The claimant must provide *"reasonable proof of loss."* The ACP must specify in writing the materials that constitute reasonable proof of loss within 60 days after receipt of an application. There is no limitation on how the ACP can define this requirement. [Section 3172(3)].

(3) Benefits may be suspended if a claimant *"fails to cooperate"* with the ACP in one or more of the ways specified in the legislation, including failing to submit to an examination under oath. [Section 3173a(1)].

(4) A person making a claim through the ACP must do so within 1 year from the date of accident. [Section 3174].

F. DATE OF EFFECT – The new rules for ACP claimants are effective immediately for any accident occurring after June 11, 2019, except as to those claimants whose ACP eligibility will be affected by the new PIP choice policies that will be sold beginning July 1, 2020.

6. MOTORCYCLISTS

A. BASIC RULE – Motorcyclists draw PIP benefits pursuant to the same order of priority as they did under previous law, i.e., primarily from insurers of the motor vehicle involved in the accident. If a motorcyclist is in accident involving another motor vehicle that has a limited no-fault policy, the motorcyclist will receive no-fault benefits under that limited no-fault policy, even if the motorcyclist purchased a no-fault policy on their own motor vehicle with higher limits or lifetime coverage. If any policy in the order of priority was written so that PIP coverage was excluded under that policy, then the motorcyclist moves down to the next level of priority that is not so excluded. [Section 3114(6)]. Furthermore, it appears that if a Medicare PIP opt-outer or a $250K PIP excluder is injured as motorcyclist in an accident involving a motor vehicle, such a person would be entitled to PIP coverage in the same manner as any other person. In this regard, while the legislation is clear that Medicare PIP opt-outers and $250K excluders are not eligible for PIP benefits under their own auto policy, there is nothing in the legislation that makes these persons ineligible for PIP benefits under the rules that apply to any other motorcyclists. [Section 3114(6)].

B. **ASSIGNED CLAIMS ELIGIBILITY** – If there is no coverage available under the basic motorcycle rules discussed above, motorcyclists will claim PIP benefits through the ACP, which claims will be limited to $250,000. [Section 3114(6)].

C. **DATE OF EFFECT** - These changes regarding motorcycle claimants are effective immediately for any accident occurring after June 11, 2019, except as to those motorcyclists whose PIP eligibility will be affected by the PIP choice policies that will be sold beginning July 1, 2020.

7. OUT-OF-STATE RESIDENTS

A. **BASIC RULE** – Out-of-state residents are no longer entitled to PIP coverage for injuries sustained in Michigan, unless the out-of-state resident is an owner of a vehicle that is both ***registered and insured*** in Michigan, regardless of whether the out-of-state resident was insured under an out-of-state policy issued by an insurer authorized to sell auto insurance in Michigan, or otherwise known under the previous law as a "*Section 3163 certified insurer.*" [Section 3113(c)].

B. **POTENTIAL PROBLEM FOR OUT-OF-STATE RESIDENTS** – The legislation preserves the current legal requirement under Section 3102 that out-of-state residents who operate motor vehicles in Michigan for more than 30 days must buy a no-fault policy. However, purchasing such a policy may not be enough, because the new legislation disqualifies the out-of-state resident unless the vehicle is also ***registered*** in Michigan. [Section 3113(c)].

C. **TORT RECOVERY** – The medical expenses of an out-of-state resident may be recovered in tort against the negligent driver without monetary limitation. However, these expenses are only recoverable if the out-of-state person sustains a threshold injury (i.e., death, serious impairment of body function, permanent serious disfigurement) as set forth under Section 3135. [Section 3135(3)(d). Furthermore, all economic and noneconomic damages an out-of-state resident plaintiff can recover in tort are subject to the "*51% comparative negligence rule,*" which holds that damages are not recoverable by a plaintiff who is found to be more than 50% at fault. [Section 3135(2)(b)].

D. **DATE OF EFFECT** - These changes to out-of-state resident claimants are effective immediately for any accident occurring after June 11, 2019.

8. MCCA

A. MCCA COVERAGE - MCCA coverage does not apply to any injured person claiming PIP benefits under a capped no-fault PIP choice policy. Rather, MCCA coverage will be available only to those persons who select lifetime PIP coverage. Those who sustain injury before July 2, 2020, will continue to be eligible for coverage through the MCCA. [Section 3104(2)].

B. MCCA ANNUAL ASSESSMENT – An annual assessment can only be made with respect to lifetime PIP policies, except that all insurance policies can be assessed a charge for that portion of the total premium attributable to an adjustment for a deficiency in a previous period. Therefore, even those policy holders who will never have a claim reach the MCCA, are required to pay for projected deficiencies attributable to previous claims. [Section 3104(d)].

C. MCCA DISCLOSURE REQUIREMENTS – The legislation requires the MCCA to disclose various items of information including, financial condition of the association, open claims data, actuarial assumptions, asset and liability data, cost containment data, etc. [Section 3104(25)].

D. MCCA REFUND – DIFS is given power to order a refund of any surplus. The refund is ultimately to be passed on to insured persons as reimbursement for amounts paid for MCCA assessments, including any assessments related to excesses or deficiencies. [Section 3104 (22) & (24)]. However, it is not clear if the refund is to only be paid to those persons who are currently paying for lifetime PIP coverage, or whether it includes everyone who has or is currently paying any form of MCCA assessment. Furthermore, after surplus money is distributed to insured persons to cover their assessment fees, it is not clear to whom any remaining surplus money will be distributed—insurers or ratepayers?

E. DATE OF EFFECT – The MCCA coverage limitations apply to any policies sold after July 1, 2020. The other administrative and operational provisions apply as of June 11, 2019.

9. INDEPENDENT MEDICAL EVALUATION

A. THE NEW SPECIALIZATION RULE – The legislation requires that medical evaluations performed at the request of insurance companies be performed by a physician with specializations similar to those of the injured person's treating physicians. Specifically, the statute states: "*If care is being provided*

to the person to be examined by a specialist, the examining physician must specialize in the same specialty as the physician providing the care, and if the physician providing the care is board certified in the specialty, the examining physician must be board certified in that specialty." [Section 3151(2)(a)].

B. **GENERAL QUALIFICATION RULE** – In all cases, an examining physician, during the year prior to the evaluation, must have devoted a majority of his or her time to the active clinical practice of medicine or to teaching in a medical school, or in an accredited residency or clinic research program for physicians. [Section 3151(2)(b)].

C. **DATE OF EFFECT** – The general qualification and the new specialization rules discussed above are effective as of June 11, 2019.

10. STATUTE OF LIMITATIONS

A. **NEW TOLLING RULE** – The time to commence a legal action and the time limitation to recover benefits *"is tolled from the date a specific claim for payment of the benefits until the date the insurer formally denies the claim."* [Section 3145(3)].

B. **EXCEPTION TO THE TOLLING RULE** – This subsection does not apply if the person claiming the benefits *"fails to pursue the claim with reasonable diligence."* [Section 3145(3)].

C. **DATE OF EFFECT** - These change will be effective as of June 11, 2019.

11. PENALTY INTEREST & ATTORNEY FEE SANCTIONS

A. **REVISED DEFINITION OF *"OVERDUE"*** - The legislation redefines when a benefit is deemed to be "*overdue.* In this regard, the legislation states that if a bill is not provided to an insurer within 90 days after a product, service, accommodation, or training was provided, the insurer has 60 additional days to the basic 30 days to issue payment before the payment is deemed to be "*overdue."* [Section 3142(3)].

B. **RULES REGARDING ATTORNEY FEE LIENS ON PIP BENEFITS** – The legislation states that an attorney advising or representing an injured person concerning a claim for payment of personal protection insurance benefits from an insurer "*shall not claim, file, or serve a lien for payment of a fee or fees until both of the following apply: (a) a payment for the claim is authorized*

under this chapter; and (b) a payment for the claim is overdue under this chapter." [Section 3148(1)(a)-(b)].

C. ATTORNEY FEE SANCTIONS FOR SOLICITED CLIENTS - The legislation provides that a court may award an insurer *"a reasonable amount against a claimant's attorney as an attorney fee for defending against a claim for which the client was solicited by the attorney in violation of the laws of this state or the Michigan rules of professional conduct."* [Section 3148(2)].

D. LIMITATIONS ON COURT-ORDERED ATTORNEY FEE

(1) A court cannot order payment of attorney fees *"in relation to future payment"* of attendant care or nursing services *"ordered more than 3 years after the trial court judgment or order is entered."* [Section 3148(4)].

(2) A court cannot order payment of attorney fees when the attorney or a related person of the attorney has or had, *"a direct or indirect financial interest in the person that provided the treatment, product, service, rehabilitative occupation training, or accommodation."* The legislation defines a direct or indirect financial interest as including, but not limited to, *"the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation making a direct or indirect payment or granting a financial incentive to the attorney or a related person of the attorney relating to the treatment, product, service, rehabilitative occupational training, or accommodation within 24 months before or after the treatment, product, service, rehabilitative occupational training, or accommodation is provided."* [Section 3145(5)].

E. DATE OF EFFECT - These changes will be effective as of June 11, 2019.

12. PROVIDER DIRECT CAUSE OF ACTION

A. QUALIFIED REVERSAL OF THE *COVENANT* DECISION – The legislation conditionally restores a medical provider's independent cause of action against a no-fault insurer for nonpayment of charges, which right was eliminated by the Michigan Supreme Court's decision in *Covenant v State Farm*, 500 Mich. 191 (2011). In this regard, the legislation states that a *"health care provider listed in section 3157 may make a claim and assert a direct cause of action against an insurer, or under the assigned claims plan under section 3171 or 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person."* [Section 3112].

B. **ACCRUAL CAUSE OF ACTION** – A provider's independent cause of action does not accrue until after a benefit is *"overdue."* The legislation revises the definition of when a benefit is overdue, as discussed in Section 10 of this outline.

C. **DATE OF EFFECT** – This restored cause of action applies to products, services, or accommodations provided after June 11, 2019.

13. TORT CLAIMS & LIABILITY INSURANCE LIMITS

A. ***MCCORMICK*** **THRESHOLD CODIFICATION** – The legislation codifies the Michigan Supreme Court's definition of the serious impairment of body function threshold set forth in the case of *McCormick v Carrier,* 487 Mich. 180 (2010), which must be satisfied in order to recover noneconomic damages from an at-fault driver. This threshold standard requires that the injured person prove the following elements:

(1) The impairment is objectively manifested in that it is *"observable or perceivable from actual symptoms or conditions by someone other than the injured person."* [Section 3135(5)(a)].

(2) The impairment is of an important body function, which is *"a body function of great value, significance, or consequence to the injured person."* [Section 3135(5)(b)].

(3) The impairment affects the injured person's general ability to lead his or her normal life in that it *"has had an influence on some of the person's capacity to live in his or her normal manner of living."* Furthermore, this element is fact specific and *"although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last."* [Section 3135(5)(c)].

B. **NEW LIABILITY FOR EXCESS ECONOMIC LOSS CLAIMS** – Accident victims are now entitled to recover in tort *"damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusions under section 3109a(2) applies."* [Section 3135(3)(c)]. Accordingly, seriously injured persons who chose capped no-fault coverage, or who have opted-out, will be able to sue any at-fault driver to recover their uncovered medical expenses and work loss.

C. EXCESS ECONOMIC LOSS CLAIMS BY ACP CLAIMANTS – There is a question as to whether ACP claimants who are subject to the $250,000 and $2,000,000 caps can maintain excess economic loss tort claims against at-fault drivers for uncovered medical expenses. The excess tort claim provisions of Section 3135(3)(c), quoted above, refer only to tort claims for expenses in excess of those limited under Section 3107 to 3110. The cap on ACP claimants is found in Section 3172(7). However, that section of the legislation specifically references expenses payable under Section 3107c(1)(b). Therefore, this cross-reference might fairly be read to permit excess economic loss tort claims by ACP claimants.

D. EXCESS ECONOMIC LOSS CLAIMS FOR AMOUNTS EXCEEDING FEE SCHEDULES – Section 2 G of this outline raises the question of whether a medical provider can pursue a patient for the provider's charges that exceed those payable under the fee schedules referenced in Section 2 of this outline. If the patient is liable to the provider for such excess amounts, can the patient recover those excess amounts in a tort claim against the at-fault driver? The answer is not clear from the text of this legislation. As indicated in the previous paragraph, the excess economic loss tort claim created by Section 3135(3)(c) references only expenses in excess of those limited under Section 3107 to 3110. The new fee schedule limitations are found only in Section 3157. Therefore, this could present a situation where a patient may be financially liable for provider charges in excess of the new fee schedules, but might not be able to recover those excess expenses from the at-fault driver.

E. PURE COMPARATIVE NEGLIGENCE FOR EXCESS MEDICAL EXPENSE CLAIMS - The legislation makes it clear that principles of pure comparative negligence will apply to the payment of excess medical expenses. In this regard, a defendant's percentage of fault will be the only portion that the defendant's insurer will be required to pay fora plaintiff's excess medical expenses. [Section 3135(2)(b)]. This comparative negligence allocation will often require tort litigation to resolve.

F. INCREASE IN RESIDUAL LIABILITY INSURANCE LIMIT – The legislation provides that the default minimum liability insurance limits are $250,000 per individual and $500,000 per occurrence. However, utilizing a special form document, to be approved by DIFS, a person can opt out of this new minimum and can purchase a policy with liability insurance limits of only $50,000 per individual and $100,000 per occurrence. [Section 3009].

G. **MEDICAL EXPENSE CLAIMS OF OUT-OF-STATE RESIDENTS** - The medical expenses of an out-of-state resident may be recovered in tort against the negligent driver without limitation. However, these expenses are only recoverable if the out-of-state person sustains ***a threshold injury*** (i.e., death, serious impairment of body function or permanent serious disfigurement), as set forth under Section 3135. [Section 3135(3)(d)]. Furthermore, all economic loss and noneconomic loss damage claims of out-of-state residents are subject to the 51% comparative negligence rule, which means that no damages are recoverable by an out-of-state plaintiff who is found to be more than 50% at fault. [Section 3135(2)(b)].

H. **MINI-TORT INCREASE** – The mini-tort property damage provisions of Section 3135(3)(e) have been amended to increase the amount recoverable from $1,000 to $3,000.

I. **DATE OF EFFECT** – The provisions regarding bodily injury tort claims apply to any accident occurring on or after June 11, 2019. The mini-tort provisions will be effective for accidents occurring after July 1, 2020. The increased mandatory minimum bodily injury liability insurance limits will be effective after July 1, 2020.

14. CONSUMER PROTECTIONS

A. **WEBSITE FOR CONSUMER COMPLAINTS** – The department of insurance is required to maintain a page on its website that provides assistance to persons who believe an insurer is not properly paying benefits. The page must also advise such persons of their available rights and how information can be provided to the department. It must also inform the person about what the department can do to offer assistance. The webpage must also allow people to report cases of fraud. [Section 261(3)].

B. **WEBSITE FOR LAW CHANGES** – The department must also maintain a page on its website informing the public about recent changes in the law. [Section 261(2)].

C. **UNFAIR TRADE PRACTICES** – The statute specifies that the failure of an insurer to comply with the coverage selection and disclosure provisions of the act is deemed to constitute an unfair method of competition and an unfair or deceptive act in the business of insurance. [Section 2013a]. However, it should be noted that, under existing law, there is no private cause of action against an insurance company for its fraudulent or deceptive practices.

D. **DATE OF EFFECT –** These consumer protection provisions become effective June 11, 2019.

15. ANTI-FRAUD UNIT

A. **BASIC CONCEPT –** A newly enacted Chapter 63 creates an "*anti-fraud unit,*" which is *"established as a criminal justice agency in the department, dedicated to prevention and investigation of criminal and fraudulent activities in the insurance market."* [Section 6301(1)].

B. **SCOPE OF AUTHORITY –** The newly created anti-fraud unit *"is a criminal justice agency with full access to criminal justice information and criminal justice information systems."* Furthermore, the anti-fraud unit, "*may investigate all persons, including, but not limited to, persons subject to the department's regulatory authority, consumers, insureds, and any other persons allegedly engaged in criminal and fraudulent activities in the insurance market."* The legislation also authorizes pursuing activities referenced in Governor Snyder's Executive Order No-2013-1, MCL 550.991. [Section 6301(2)].

C. **TESTIMONIAL LIMITATION IN CIVIL CASES –** Any person involved with, or acting on behalf of, the anti-fraud unit, is not permitted *"and may not be required to testify in any private civil action concerning any confidential documents, materials"* or to disclose other information collected by the unit. [Section 6302].

D. **ANNUAL REPORT –** The anti-fraud unit is required to submit an annual report to the legislature regarding *"the anti-fraud unit's efforts to prevent automobile insurance fraud."* [Section 6303].

E. **DATE OF EFFECT –** The anti-fraud provisions become effective on June 11, 2019.

16. RATE MAKING RULES

A. **PIP PREMIUM REDUCTIONS –** The premium reductions for the various PIP benefit level options were summarized in Section 1 of this outline. There are, however, a few additional points worth mentioning:

(1) The premium reductions apply only to PIP policies issued before July 1, 2028. [Section 2111f(2)]. The legislation does not mandate PIP premium reductions for automobile insurance policies issued after July 1, 2018.

(2) Even during the period of mandatory PIP premium reduction, the legislation permits insurers to apply to DIFS for an exemption from the mandatory reductions. [Section 2111f(7)].

(3) The mandatory reductions apply only to the premiums charged for PIP benefits, and the legislation does not require mandatory reductions in automobile insurance premiums as a whole. Specifically, the legislation states that it "*does not prohibit an increase for any individual insurance policy premium*" so long as the increase results from application of the new rating factors. [Section 2111f(9)].

B. **NON-DRIVING RATING FACTORS** – The legislation prohibits insurers from using certain factors in setting rates for automobile insurance premiums. These non-driving rating factors include sex, marital status, home ownership, education level attained, occupation, the postal zone in which the insured resides, and credit score. [Section 2111(4)]. The legislation also prohibits, as of January 1, 2022, an insurer from refusing to offer, charging a reinstatement fee, or increasing premiums to those people who previously failed to maintain automobile insurance. [Section 2116b]. However, there are significant limitations on the prohibition of using non-driving rating factors. For example, the legislation states that "*automobile insurance risks may be grouped by territory*." [Section 2111(5)]. In addition, "*credit score*" is defined as "*the numerical score ranging from 300 to 850 assigned by a consumer reporting agency to measure credit risk and includes a FICO credit score*." [Section 2151(e)]. Thus, any underlying credit data or credit information that does not include a FICO score can still be used by insurers to set automobile insurance premiums.

C. **FILE AND APPROVE** - The legislation provides that an insurer shall file rates with DIFS for approval in compliance with the act. [Section 2108(1)]. The legislations also states that any rates filed with DIFS must remain on file for a waiting period of 90 days before they become effective. [Section 2108(6)]. That waiting period may not be extended by DIFS and it applies "*regardless of whether the supporting information is required by the director under section 2406(1),*" i.e., the section that addresses information insurers need to submit to support their rate filings. The rates filed do not require prior specific approval by DIFS. Rather, rates become effective unless DIFS disapproves.

Therefore, there appears to be no substantive difference between this approach and the prior file and use systems.

17. RETROACTIVITY ISSUES

A. **GENERAL RULE** – As previously referenced above, this legislation will apply, in certain circumstances, to claimants who were injured prior to June 11, 2019. For example, the fee schedules, the weekly hourly limits on attendant care, and the utilization review provisions all apply to those injured before June 11, 2019. Such retroactive application potentially raises significant constitutional and other legal challenges. One basis for such a challenge is the fact that insurers sold policies priced on risks they underwrote but are no longer required to insure.

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June 14, 2019

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