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TO: The Honorable Detroit City Council

FROM: David Whitaker, Director
Legislative Policy Division (LPD) Staff

DATE: June 10, 2019

RE: **State Senate Bill 1 No Fault Automobile Insurance Reform**

On February 19, 2019, Council President Jones requested that the Legislative Policy Division (LPD) provide a report regarding new proposed No Fault insurance reform legislation in the form of Senate Bill 1 – designated as the "auto insurance rate reduction plan". The proposed statute had been introduced on January 15, 2019. At that time the document stated simply that it was intended to enact cost controls to the No Fault system and rate relief for consumers, reduce the number of uninsured drivers, and incentivize more automobile insurers "to write business in this state". It was apparent from simply looking at the less than four page legislative proposal that it was surprisingly brief for such an extensive policy agenda, and indeed lacked any sufficient detail about how the law would be changed to accomplish anything like its stated ambitious policy agenda.

The subsequent history and development of the highly complex and technically ambitious legislation that eventually passed and was signed into law by the Governor on May 30, 2019, demonstrates dramatic departures from any open and transparent legislative process. That disturbing history is recounted in a lengthy procedural addendum at the end of this report.

In terms of the substance of the new legislation, it appears to represent a major concession to the auto insurance industry in the form of elimination of the mandatory lifetime medical care benefits¹ for auto injury victims, in exchange for much-needed, but only limited, rate relief on auto insurance premiums. This basic policy shift is accompanied by a host of administrative provisions that will have to be implemented by state government insurance regulators, insurers and consumers. From

¹ "Personal Injury Protection" or PIP benefits

the perspective of consumers, it may be difficult to determine what the best value received will be for newly available coverage options, and also difficult to comply with complex technical requirements for asserting and perfecting claims under the new law. The ultimate outcome of such significant alterations of the Michigan No Fault auto insurance law is impossible at this time to predict with confidence, because of the complex and significant changes made – without significant public debate or awareness of the legislative choices they embody - to a system that had been in existence (albeit with significant faults) for decades.

Amendments to Michigan No Fault Insurance Law

In general, SB1 trades reductions in available medical benefits under No Fault insurance policies for reduced premiums. The following significant changes have been made to the Michigan No Fault insurance law:

- **No-Fault PIP (Personal Injury Protection, or medical expenses covered by No Fault insurance):** Under the previous law, all drivers were required by law to purchase unlimited No-Fault PIP benefits. That core feature of the No Fault Law has often been publicly blamed for high premiums for auto insurance in Michigan, and especially in Detroit, although to LPD’s knowledge no independent study of the insurance industry’s books has ever substantiated that claim. After July 1, 2020, drivers will be able to choose from the following No-Fault medical benefit coverage levels: \$50,000 (if a driver is enrolled in Medicaid); \$250,000; \$500,000; or unlimited. Each benefit level then comes with an associated partial reduction of the premium for PIP benefits, as specified below.
- **Opt-Out of No-Fault PIP medical benefits:** Drivers with Medicare may “elect to not maintain coverage” for PIP medical benefits, under auto insurance policies issued or renewed after July 1, 2020. The lower levels of reimbursement for Medicare patients have potentially profound adverse implications for injured motorists, passengers, and pedestrians, as well as providers of costly, high-quality health care for such victims.
- **Savings for drivers:** For 8 years, after July 1, 2020 and until July 1, 2028, the new law promises 45% savings for drivers who opt for the \$50,000 cap on No-Fault PIP medical benefits; 35% savings for drivers who opt for the \$250,000 cap; 20% savings for drivers who choose the \$500,000 cap; and 10% savings for drivers who wish to have “no limit” and maintain their unlimited medical benefits. Drivers who opt-out of PIP medical benefits altogether will see 100% savings on the PIP portion of their auto insurance. All of these savings are limited only to the PIP portion of an auto insurance bill, not to the entire premium. The PIP portion generally averages between 35% and 44% of total auto insurance premiums. Drivers who currently find auto insurance to be unaffordable may or may not experience partial rate cuts to coverage under 35-44% of their premiums as a meaningful difference. This is only one aspect of the critique of the simple trade-off of reduced benefits for reduced premiums, and seems to be directly related to the almost complete lack of public debate of these legislative reforms, as more specifically detailed in the procedural addendum below.
- **Savings for auto insurance companies:** Insurers will be allowed to avoid reducing their premiums if they can demonstrate to the Insurance Commissioner that the new law’s mandatory

rate reductions would violate their constitutional rights and/or leave them at risk of having too little capital. The issue of lack of transparency of insurance companies' profits has long been a point of contention in debates over No Fault reform. Whether or not insurers will be able to convince state regulators to exempt them from rate reductions, and whether or not enhanced regulation of the insurance industry envisioned by provisions of SB1 will in fact occur, are unknown at this time.

- **Michigan Catastrophic Claims Association (MCCA):** The MCCA would remain liable for catastrophic injury benefits payable under policies issued or renewed before July 2, 2020, and for subsequently issued policies where drivers have opted to maintain unlimited PIP benefits. Drivers who decide to cap their PIP benefits or opt-out altogether could still be required to pay annual MCCA assessments to cover any deficits. MCCA will pay refunds to drivers if its assets exceed 120% of liabilities. The refund will be the difference between the excess and 120% of liabilities.

- **Medical-provider fee schedule:** A fee schedule based on the Medicare fee schedule will limit reimbursement to providers for auto accident victims. Depending on the type and level of care provided by a facility, reimbursement will range from 190% to 250% of the amount payable under Medicare. The new Medicare-based fee schedule will apply to treatment rendered after July 1, 2021.

- **Passing along savings from medical-provider fee:** The savings that auto insurance companies realize as a result of the fee schedule must be passed along to drivers in form of lower premiums. Auto insurers will be required to document these savings in their rate filings to the Director of the Department of Insurance and Financial Services (DIFS). However, until after July 1, 2022, Michigan's Insurance Commissioner will not be required to start checking to ensure that insurers are passing along their savings to drivers.

- **Insurance premium pricing factors that cannot be considered:** Auto insurers cannot base premium rates on such non-driving factors as: sex, marital status, home ownership, education level attained, occupation, the postal zone in which the insured resides or credit score. The prohibition against these non-driving factors begins July 1, 2020. "Redlining" is explicitly condemned, as refusal to insure or limiting coverage "because of the location of the risk". However, premiums will apparently still be allowed to rely on risks "grouped by territory". And while use of "credit score" to calculate premiums is prohibited, no such prohibition applies to defined terms "credit information" or "credit report". Again, whether or not future regulation of the insurance industry will effectively prevent abuses of such powers must be considered an open question.

- **Mini Tort:** The Michigan mini tort law's maximum recovery limit will immediately increase from \$1,000 to \$3,000.

- **Tolling² of the one-year-back rule:** Under the previous No-Fault law, when a car accident victim was denied or cut-off from benefits, they “may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.” (MCL 500.3145(1)) The new law provides that this “limitation . . . is tolled from the date the person claiming the benefits makes a specific claim for the benefits until the date the insurer formally denies the claim.” Tolling does not apply if the claimant “fails to pursue the claim with reasonable diligence.”

- **Independent Medical Examinations (IMEs):** IMEs of car accident victims will be conducted under new rules by doctors hired by insurance companies: (1) The IME doctors must be licensed in Michigan; (2) The examining IME doctor must be a licensed, board certified, or board eligible physician qualified to practice in the area of medicine appropriate to treat the condition; (3) During the year before an IME, the IME doctor must have devoted a majority of professional time to clinical practice of medicine/specialty or teaching in an accredited medical school. It is expected that these rules will take immediate effect.

- **Attendant Care:** After July 1, 2021, auto insurers are not required to pay for more than 56 hours per week of in-home attendant care provided by a family member.

- **Anti-Fraud Unit:** The new law will create an Anti-Fraud Unit to investigate all “criminal and fraudulent activities in the insurance market.” This will take effect immediately.

- **Insurance Commissioner remedies when insurers refuse to pay benefits:** The Insurance Commissioner is required to create a page on the Department of Insurance and Financial Services (DIFS) website describing how the Insurance Commissioner “may be able to assist a person who believes that an automobile insurer is not paying benefits, not making timely payments, or otherwise not performing as it is obligated to do under an insurance policy.” Additionally, the Insurance Commissioner would be required to create a web site page that “allows a person to report insurance fraud and unfair settlement and claims practices.” These requirements will take effect immediately.

- **Higher liability limits:** Liability limits refer to coverage for liability protection if the insured causes an accident and injures someone else. Drivers were previously required to carry a minimum of \$20,000 for bodily injury or death to one person in one accident, or \$40,000 for two or more persons in one accident. The new law will increase those minimum limits to \$50,000 and \$100,000 respectively. A new “default” residual bodily injury limit of \$250,000 and \$500,000 will be offered, with the ability to purchase either more or less coverage, but not less than \$50,000/\$100,000.³

² “Tolling” is a legal term of art that refers to a legally required pause in the running of the limitations period on bringing claims. The result is that the statute of limitations does not “run” toward the time when bringing the claim would expire, while it is “tolled”, thereby lengthening the limitations period allowed for bringing legal claims.

³ The effective date for this provision was reportedly changed on June 4, to avoid a windfall to insurance companies who would be allowed to charge higher premiums immediately for the

- **Suing for excess medical benefits:** Under the new law, a person injured in a car accident can sue for excess medical costs and economic expenses, i.e., those medical costs and expenses that will exceed the dollar amount of the new PIP cap amount they have selected. Michigan now becomes like most other states in this regard, and the amount of third party liability coverage available under the insurance policy liability limits of the other driver who negligently causes an accident becomes much more important. Suing for excess medical benefits may, or may not, become a much more hotly contested issue in Michigan courts after the new PIP Choice levels become available July 1, 2020.⁴

- **Serious Impairment of Body Function threshold for pain and suffering compensation:** Under the new law, a car accident victim will still be required to satisfy the definition of a “serious impairment of body function” in order to be able to sue a driver for pain and suffering compensation, under a restrictive standard articulated in a 2010 Michigan Supreme Court decision. Specifically, the new law defines a “serious impairment of body function” is an “impairment” that: “is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person”; “is an impairment of an important body function, which is a body function of great value, significance or consequence to the injured person”; and “affects the injured person’s general ability to lead his or her normal life”, meaning it has significantly reduced the person’s capacity to live in their normal manner of living. Although temporal considerations may be relevant, there is no specific requirement for how long such an impairment must last. This examination is inherently fact- and circumstance-specific to each injured person. It must be conducted on a case-by-case basis, and requires comparison of the injured person’s life before and after the incident. This new definition of “serious impairment of body function” will take effect immediately. The new law states that its definition of “serious impairment of body function” is intended to codify and give full effect to the opinion of the Michigan Supreme Court in *McCormick v. Carrier*, 487 Mich 180 (2010).

additional required third party coverage, if it applied immediately. The legislature wanted to avoid such an immediate premium increase for obvious reasons.

⁴ Because a requirement for bringing suit for an automobile accident injury is the restrictive, high standard of “significant impairment” injuries, a third-party lawsuit against a negligent driver to recover excess medical benefits will likely exhaust that party’s liability coverage. Such actions would therefore likely only be able to recover for medical care cost liens, with little or no recovery for the victim’s pain and suffering, or other damages usually allowed under tort law as a result of these severe injuries. For persons who elect not to purchase unlimited PIP benefits coverage, and are severely injured in an auto accident - requiring extensive and very costly medical care - their inability to recover additional damages from negligent drivers will be a major disincentive to even pursuing such claims, likely providing a windfall to insurance companies who probably will not have to defend and pay for many such claims that would otherwise be filed, because the injured victim has no real motive to pursue money for the benefit of their treating medical providers and insurer.

Procedural Addendum

The language of the original proposed S-1 statute was clearly deficient on its face for a statutory law. The first proposed policy reform set forth as “Sec. 3107” stated “IT IS THE INTENT OF THE LEGISLATURE TO ALLOW SENIORS AND OTHER INDIVIDUALS OVER 62 YEARS OF AGE⁵ WITH LIFETIME HEALTH CARE BENEFITS TO ENJOY SAVINGS ON THEIR AUTOMOBILE INSURANCE PREMIUMS BY CHOOSING TO NOT CARRY PERSONAL INJURY PROTECTION INSURANCE WHEN THEY EFFECTIVELY ALREADY HAVE COVERAGE FOR INJURIES IN AUTOMOBILE ACCIDENTS.”

It is readily apparent that this provision constitutes a cursory argument in favor of a particular position, rather than a cognizable legal rule suitable for statutory enactment. The whole initial version of SB 1 suffered from this defect, making effective analysis and meaningful debate of the reforms it promised impossible.

LPD understands, as referenced by Council President Jones’ referral memo, that it appears to have been the intent of this draft provision to exempt senior citizens over the age of 62 (presumably because they qualify for federal social security, although they would not qualify for Medicare until age 65), from the mandatory requirement of carrying Personal Protection Insurance (PIP) under their No Fault Automobile Insurance policies. However, this language did not actually enact that policy. On its face, it simply summarized “the intent” to do so.

Similarly, the next initial provision designated “Sec. 3109B”, was also a statement of general policy preference, without any actual, cognizable legislative rule: “IT IS THE INTENT OF THE LEGISLATURE THAT AN INDIVIDUAL WHO PURCHASES AN AUTOMOBILE INSURANCE POLICY IN THIS STATE HAVE THE ABILITY TO CHOOSE AN AMOUNT OF PERSONAL INJURY PROTECTION COVERAGE THAT SUITS THE INDIVIDUAL’S NEEDS, LIFESTYLE, AND BUDGET. THE LEGISLATURE FURTHER INTENDS WHEN AN INDIVIDUAL SELECTS A COVERAGE LEVEL FOR PERSONAL INJURY PROTECTION BENEFITS FROM THOSE ENUMERATED IN STATUTE, THE INDIVIDUAL WILL ENJOY A CORRESPONDING SAVINGS ON HIS OR HER AUTOMOBILE INSURANCE PREMIUM THAT CORRESPONDS WITH THE CHOSEN BENEFIT LEVEL.”

The above language leaves so many questions unanswered that it was nearly impossible to envision it being passed as written by the State legislature, and hard to imagine how even in that unlikely event, it could be implemented as written. How would the automobile insurance consumer exercise “the ability to choose” any particular amount of coverage? What amounts of coverage suit individuals’ needs, lifestyle and budget? How is that determined? By whom? How would it be implemented and enforced? How can one know whether or not a chosen “coverage level” will result in “a corresponding savings on their premium”? In cases of inevitable disputes about what such general language means in particular cases, who decides and by what standards what the premiums, and the benefits, will be? In the absence of so many basic details, the original

⁵ Persons over 62 years of age would be seniors, so what persons older than 62 would be “other” than seniors? The particular language of the original Senate Bill appeared to be less than half baked.

placeholder text of SB 1 did not appear, in LPD's judgment, to be a realistic or appropriate legislative proposal.

The original language of the next provision, "Sec. 3157", as well as a subsequent one, "Sec. 3148", merely changed the word "shall" to the word "MUST", which is merely changing a word without changing the meaning or substantive intent of these provisions at all.

The original version of Subparagraph 2 of Sec. 3157 further stated another general policy preference without sufficient detail to effect legislation: "IT IS THE INTENT OF THE LEGISLATURE, IN SEEKING TO REDUCE MEDICAL COST INFLATION IN THIS STATE RELATED TO NO-FAULT INSURANCE CLAIMS THAT IS 90% HIGHER THAN NORMAL HEALTH CARE INFLATION, THAT A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER PERSON OR INSTITUTION THAT RENDERS A TREATMENT, TRAINING, PRODUCT, SERVICE, OR ACCOMMODATION TO AN INJURED PERSON FOR AN ACCIDENTAL BODILY INJURY NOT BE ELIGIBLE FOR PAYMENT OR REIMBURSEMENT UNDER THIS CHAPTER OF MORE THAN A STATUTORILY DETERMINED AMOUNT THAT IS A REASONABLE PAYMENT FOR THE TREATMENT OR SERVICE RENDERED".

In the absence of such a "statutorily determined amount", which was not provided by the original version of SB 1, this language was also too vague to implement or enforce. How SB 1 would actually reduce costs by reducing medical charges was unexplained, other than general principles that could be applied in many different ways.

Continuing in this same vein of the initial text's facial insufficiency, the next draft provision, designated "Sec. 3157A", originally stated: "IT IS THE INTENT OF THE LEGISLATURE, IN SEEKING TO REDUCE OVERUTILIZATION OF MEDICAL TREATMENTS, PRODUCTS, AND SERVICES RELATED TO NO-FAULT INSURANCE CLAIMS IN THIS STATE, THAT AN ANNUAL UTILIZATION REVIEW BE CONDUCTED BY AN INDEPENDENT PARTY TO IDENTIFY UTILIZATION ABOVE THE USUAL RANGE FOR THE TREATMENT BASED ON MEDICALLY ACCEPTED STANDARDS, WITH CONSEQUENCES FOR PROVIDERS THAT KNOWINGLY PROVIDE FALSE OR MISLEADING INFORMATION."

The impressive number of undefined terms in this provision, which would have to be defined in order for this to take on the form of a statute, include "overutilization"; "utilization review"; "independent party"; "the usual range for the treatment"; "medically accepted standards"; "consequences"; and "false or misleading information". As with the other initial provisions of SB 1, the intent of the proposed statute as originally published was reasonable clear; the means of achieving the desired ends were almost totally unclear.

The final provision of the original SB 1, "Sec. 3148(3)", stated: "IT IS THE INTENT OF THE LEGISLATURE TO REDUCE FRAUD AND CONFLICTS OF INTEREST IN THE NO-FAULT SYSTEM BY PROVIDING FOR RESTRICTIONS ON THE COMMON OWNERSHIP OF, AND REFERRALS BETWEEN AND AMONG, ENTITIES THAT PROVIDE LEGAL, MEDICAL, AND TRANSPORTATION SERVICES".

While the lack of definition of the key terms means LPD is unsure what specific “common ownership and referrals” this referred to, it seems reasonably clear that actual “fraud and conflicts of interest in the no-fault system” are already illegal.

As of May 7, 2019, the Republican majority in the State Senate introduced the first “real” version of SB1, which was passed within hours and sent on to the State House of Representatives. The State House passed its version on May 24, 2019. By May 30, 2019, the actual version of Enrolled Senate Bill 1, representing, upon information and belief, a negotiated compromise between the Republican State Legislature and the new Democratic Governor, was signed into law by the Governor. How the legislation was developed from the initial placeholder to the statute ultimately enacted was not contemporaneously available to the general public, as far as LPD can discern.

From the above partial chronology, it is clear that this No Fault Insurance reform legislation was passed without any adequate public debate of its actual provisions. Rather a placeholder statute was introduced, stating broad policy goals but lacking adequate legislative language to achieve them. Some six (6) weeks later an actual legislative product was finally unveiled, then rushed through both the legislature and the Governor’s office to enact the reforms they wanted, regardless of how Michigan residents and automobile insurance consumers feel about the matter or how we could be affected. What was accomplished, by whom and how, before January 15, 2019, and between that date and the introduction of a first draft of actual statutory reform language some (6) six weeks later in early May, would presumably be useful information for anyone seeking to understand exactly who was behind this statute and how it was orchestrated, in lieu of transparency and normal legislative process. The possibility of some unintended consequences, resulting from such a rushed, closed-door process for passing a law with such potentially vast and expensive social impacts, should probably be kept in mind as we move forward under the new, modified no-fault insurance rules. Moreover, the apparent desire to bypass public debate and keep the public uninformed until it was too late to do anything about the proposed legislation, in order to achieve such a political compromise, is extremely worrisome if it becomes a new norm for State government.

If Council has any other questions or concerns regarding this subject, LPD will be happy to provide further research and analysis upon request.



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BILL ANALYSIS

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Senate Bill 1 (Substitute H-3 as passed by the House)

Sponsor: Senator Aric Nesbitt

Senate Committee: Insurance and Banking

House Committee: Select Committee on Reducing Car Insurance Rates

CONTENT

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

- Require all automobile insurance policies offered in the State to include benefits for personal injury protection (PIP), property protection insurance, and residual liability insurance.
- Allow an insured person to select, beginning July 1, 2020, one of four PIP coverage levels: 1) \$50,000, if the person were enrolled in Medicaid, or if the person's spouse and any resident relative had qualified health insurance, Medicaid, or insurance that provided PIP benefits, 2) \$250,000; 3) \$500,000; or 4) unlimited.
- Allow a qualified person to elect not to maintain coverage for PIP benefits, for insurance policies issued on or after the bill's effective date, if the person's spouse and any resident relative had qualified health insurance or PIP coverage, and provide the definition of a "qualified person".
- Require any premium rates filed by an insurer for PIP coverage under automobile insurance policies effective before July 1, 2028, to result, as nearly as practicable, in an average reduction per vehicle from the premium rates for PIP coverage that were in effect for the insurer on May 1, 2019, as follows: 1) an average 45% or greater reduction per vehicle for policies with a \$50,000 PIP coverage limit, 2) an average 35% or greater reduction per vehicle for policies with a \$250,000 PIP coverage limit, 3) an average 20% or greater reduction per vehicle for policies with a \$500,000 PIP coverage limit, and 4) an average 10% or greater reduction per vehicle for policies with unlimited PIP coverage.
- Require the Director of the Department of Insurance and Financial Services (DIFS) to review a filing submitted by an insurer, and disapprove a rate filing that the Director determined did not result in the premium reductions required by the bill.
- Require an insurer to submit a revised premium rate filing to the Director within 15 days after the Director disapproved a filing.
- Require an insurer to file, before July 1, 2020, premium rates for PIP coverage for automobile insurance policies effective after July 1, 2020.
- Allow an insurer to apply to the Director for approval to file rates that would result in a lower premium reduction level or an exemption from the bill's requirements, and require the Director to approve the application under certain circumstances.
- Prohibit an insurer from establishing or maintaining rates or rating classification for automobile insurance based on home ownership, educational level attained, occupation, the postal zone in which the insured resided, and credit score.
- Require a rate filing to specify that the insurer would not refuse to insure, refuse to continue to insure, or limit the amount of coverage available because of the location of the risk, and that the insurer recognized those practices to constitute redlining.
- Specify that the Michigan Catastrophic Claims Association (MCCA) would not have liability for a loss under PIP coverage for a motor vehicle accident policy to which the \$50,000, \$250,000, and \$500,000 PIP coverage limits applied after July 1, 2020.
- Require the Director to order the MCCA to issue a rebate, if the actuarial examination showed that the MCCA's assets exceeded 120% of its liabilities.

- Require the MCCA to prepare and submit to the Legislature and post on its website, by September 1 of each year, an annual consumer statement containing certain information.
- Require the MCCA's plan of operation to provide for procedures for a refund to MCCA members, for distribution to insureds, and require the procedures to provide for a distribution of a refund attributable to a historic vehicle equal to 20% of the refund for a car that was not a historic vehicle.
- Require a person entitled to claim PIP benefits through the assigned claims plan to file a completed application on a claim form provided by the Michigan Automobile Insurance Placement Facility (MAIPF) and provide reasonable proof of loss to the MAIPF.
- Require the MAIPF to review a claim for PIP benefits under the assigned claims plan, make an initial determination of a claimant's eligibility for benefits, and deny a claim if determined was ineligible.
- Specify that the MAIPF would be required to provide PIP benefits only up to \$250,000; or \$2.0 million, if the person were entitled to claim benefits under the assigned claims plan.
- Specify that a medical provider would not be eligible for reimbursement for certain services for more than certain specified amounts.
- Require a medical provider to submit necessary records and other information concerning treatment, products, services, or accommodations provided for utilization review.
- Require DIFS to promulgate rules to establish criteria or standards for utilization review.
- Specify that an insurer would be required to pay attendant care only up to 56 hours per week if the care were provided by the injured person's relative, a person domiciled in the injured person's household, or a person with whom the injured person had a business or social relationship before the injury.
- Allow an insurer to contract to pay benefits for attendant care for more than the 56-hour limitation.
- Reduce, from 67% to 55%, the amount of revenue derived from a regulatory fee that could be used for the regulation of financial conduct of people regulated under the Director's authority and for the regulation of people regulated under the Director's authority engaged in the business of health care and health insurance in the State.
- Require DIFS to maintain on its website a page that, among other things, advised that the Department could assist a person who believed that an automobile insurer was not paying benefits, not making timely payments, or otherwise not performing as it was obligated to do under a policy; and a page that advised consumers about the changes to automobile insurance made by the bill.
- Modify certain liability coverage limits for an automobile liability or motor vehicle liability policy that insured against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle.
- Require the Director to engage one or more independent actuaries to examine the MCCA's affairs and records, beginning July 1, 2022, and every third year after that.
- Require an insurer to offer to an applicant or named insured that selected a PIP coverage limit an exclusion related to other health or accident coverage, if certain conditions applied.
- Increase, from \$1,000 to \$3,000, the threshold for which tort liability arising from the ownership, maintenance, or use within the State of a motor vehicle would apply to damages to a motor vehicle, to the extent the damage were not covered by insurance.

The bill also would enact Chapter 31A (Managed Care) of the Code to do the following:

- Allow an automobile insurer to offer a managed care option that provided for allowable expenses, if certain conditions were met.
- Require an automobile insurer that offered a managed care option also to offer PIP benefits that were not subject to the managed care option.
- Require a managed care option to provide for all of the following: 1) that PIP benefits would be primary and would not be coordinated with other health and accident coverage, 2) that PIP benefits would have to be exhausted by the individual claiming benefits under the managed care option before he or she could seek benefits from another health or accident

coverage provider, and 3) that deductibles, copays, or other similar sanctions would not be assessed or collected for the individual claiming IPP benefits under the managed care option.

Additionally, the bill would enact Chapter 63 (Anti-Fraud Unit) of the Code to do the following:

- Establish an anti-fraud unit as a criminal justice agency within DIFS.
- Allow the anti-fraud unit to conduct criminal background checks on applicants for licenses and current licensees, collect and maintain claims of criminal and fraudulent activities in the insurance industry and investigate claims of criminal and fraudulent activity in the insurance market, among other things.
- Allow the Director to share and receive certain documents, materials, or information.
- Require the anti-fraud unit to prepare and publish to the Legislature, beginning July 1 of the year after the bill's effective date, a report on the anti-fraud unit's efforts to prevent automobile fraud.

Section 3112, which the bill would amend, would apply to products, services, or accommodations provided after the bill's effective date. The bill also states that Section 3135, which the bill would amend, is intended to codify and give full effect to the opinion of the Michigan Supreme Court in *McCormick v. Carrier*, 487 Mich 180 (2010).

MCL 500.150 et al.

Legislative Analyst: Stephen Jackson

FISCAL IMPACT

Medicaid Costs

Enactment of the proposed bill would lead to a gradual increase in Medicaid costs that would depend on the availability of and public interest in unlimited PIP coverage. The bill would mandate that unlimited PIP coverage be available so an indeterminate number of individuals would opt to maintain unlimited coverage.

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

The bill would create four levels of PIP coverage, including unlimited, \$500,000, \$250,000, and a \$50,000 option available only to those enrolled in Medicaid. Individuals who were eligible for Medicare or other qualified health coverage could opt out of PIP coverage entirely.

Because of the uncertainty about the interest in unlimited PIP coverage, it is difficult to provide a precise estimate of the potential increase in Medicaid costs. Based on the available data and the assumptions outlined below, the Senate Fiscal Agency (SFA) projects costs similar to those projected in the previous analysis of Senate Bill 1: that enactment of the legislation would cause Medicaid costs to increase gradually over a ten-year period by \$70.0 million General Fund/General Purpose (GF/GP). In other words, Medicaid costs ten years after enactment would be \$70.0 million GF/GP greater, which equates to about a 1.3% increase over a ten-year period, or a 0.13% per year increase in the State share of Medicaid spending. This figure would depend on the interest in unlimited PIP coverage. If more people purchased unlimited PIP coverage, Medicaid costs would be lower. If there were less interest in unlimited PIP coverage, then the increase in Medicaid costs would be greater.

The SFA notes that costs would grow gradually year to year and the rate of growth would slowly decline to the point that, after ten years, the post ten-year annual cost growth would

be less than \$3.0 million GF/GP per year. This long-term annual cost increase would be about 0.05% of overall State Medicaid costs.

This estimate is slightly higher than the estimate included in the SFA analysis of Senate Bill 1 (S-1) and House Bill 4397 (H-1) but that is largely due to the effective date being three months before the start of FY 2020-21, so the original estimate was updated for anticipated medical inflation.

The complete opt-out option for Medicare recipients would lead to an indeterminate number of Medicare-eligible individuals completely opting out. While Medicare-eligible individuals who completely opted out would be fully covered for hospital, pharmaceutical, and physician services, they would have limited coverage for long-term care (up to 100 days under certain circumstances) and attendant care, so those costs would be shifted to Medicaid for those Medicare recipients who were injured in accidents, required long term or attendant care, and spent down to Medicaid eligibility.

Similarly, Medicaid recipients who opted for the \$50,000 coverage level and required extensive care after automobile accidents would see their medical costs shifted from automobile insurance and the MCCA to Medicaid. Over time, the largest component of this cost shift would be nursing home and attendant care.

Other individuals could choose \$250,000, \$500,000, or unlimited PIP coverage. If individuals who chose \$250,000 or \$500,000 in coverage faced large costs from auto accidents, in particular long-term care and attendant care costs, many of them would end up spending down to Medicaid eligibility and that would lead to a cost shift as well.

There were multiple assumptions made in the derivation of this estimate. The SFA used MCCA data from 2017 to model expenditures for cases going back 40 years. To provide the most useful comparison, the SFA made its estimates in 2021 dollars as the legislation would take effect on July 1, 2020, three months before the start of FY 2020-21. The SFA used age and insurance provider data to model the insurance status of the population currently receiving MCCA services. The SFA assumed that Medicaid nursing home and pharmaceutical costs would be similar to MCCA costs for those services, but that Medicaid attendant care, hospital, and physician care costs would be two-thirds of MCCA costs. The SFA assumed 3.0% medical inflation in order to update the cost estimate from the 2017 data.

Insurance Premiums Tax Revenue

The reduction in the cost of insurance also would reduce the tax base for the 1.25% insurance premium tax. The exact reduction in revenue would depend on the change in the cost of insurance itself, which would depend partially on the PIP options selected.

The SFA estimates that the longer-term reduction in revenue would be in the range of \$15.0 million to \$20.0 million per year.

Department of Insurance and Financial Services

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

The bill would require DIFS to engage at least one independent actuary to examine the MCCA's records and affairs every three years, beginning in July 2022. This cost likely would total less

than \$100,000 per engagement. The director would be required to prepare a report to the Legislature on the audit's findings.

The bill would revise current law to reduce the amount of revenue derived from the regulatory fee on insurers, which may be used for the regulation of financial conduct and health care and health insurance activities under the purview of the director, from 67% to 55%.

The bill also would establish the anti-fraud unit within the Department to prevent and investigate criminal and fraudulent activities in the insurance industry, as established under Executive Order 2018-9. Under that authority, the anti-fraud unit would work with the Department of State Police to have full access to criminal justice information and criminal justice information systems and to conduct criminal background check on applicants for licenses and current licensees, collect and maintain claims of criminal and fraudulent activities, investigate claims of criminal and fraudulent activity, maintain records of investigations, share records of investigations of with other criminal justice agencies, review information from other agencies and work with those agencies to promote investigation and prosecution of criminal and fraudulent activities in the insurance market, and prepare an annual report to the Legislature.

As for the annual costs of operating the anti-fraud unit, appropriations for this unit were first proposed for fiscal year 2019-20. The Governor, the Senate Appropriations Committee, and the House Appropriations Committee recommendations each proposed an appropriation of 6.0 FTEs and \$499,300 in restricted funding for its operations and administration. The cost of criminal history background checks under the bill would be assumed as part of the standard cost of operations of the Department of State Police's Criminal Justice Information Systems budget. Other existing entities that could work toward the objectives of the anti-fraud unit could include the Consumer Protection Practice Bureau, the Department of Attorney General's Health Care Fraud Division and the Department of State Police's Fraud Investigation Unit.

Department of Corrections

The bill specifies that a physician, hospital, clinic, or other person or institution that knowingly submitted false or misleading records or other information to an insurer, the MCCA, or the Department would commit a fraudulent insurance act. A person who commits a fraudulent insurance act is guilty of a felony punishable by imprisonment for up to four years, a maximum fine of \$50,000, or both.

This proposed offense would have a negative, but likely minor, fiscal impact on the State and local government. More felony arrests and convictions could increase resource demands on law enforcement, court systems, community supervision, jails, and correctional facilities. The average cost to State government for felony probation supervision is approximately \$3,024 per probationer per year. For any increase in prison intakes, in the short term, the marginal cost to the State is approximately \$3,764 per prisoner per year. Any associated increase in fine revenue would increase funding to public libraries.

Date Completed: 5-28-19

Fiscal Analyst: Steve Angelotti
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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.

**STATE OF MICHIGAN
100TH LEGISLATURE
REGULAR SESSION OF 2019**

Introduced by Senators Nesbitt, Theis, LaSata, Horn, McBroom, Barrett, Lauwers and VanderWall

ENROLLED SENATE BILL No. 1

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 150, 224, 1244, 2038, 2040, 2069, 2105, 2106, 2108, 2111, 2118, 2120, 2151, 3009, 3101, 3101a, 3104, 3107, 3109a, 3111, 3112, 3113, 3114, 3115, 3135, 3142, 3145, 3148, 3151, 3157, 3163, 3172, 3173a, 3174, 3175, and 3177 (MCL 500.150, 500.224, 500.1244, 500.2038, 500.2040, 500.2069, 500.2105, 500.2106, 500.2108, 500.2111, 500.2118, 500.2120, 500.2151, 500.3009, 500.3101, 500.3101a, 500.3104, 500.3107, 500.3109a, 500.3111, 500.3112, 500.3113, 500.3114, 500.3115, 500.3135, 500.3142, 500.3145, 500.3148, 500.3151, 500.3157, 500.3163, 500.3172, 500.3173a, 500.3174, 500.3175, and 500.3177), section 150 as amended by 1992 PA 182, section 224 as amended by 2007 PA 187, section 1244 as amended by 2001 PA 228, section 2069 as amended by 1989 PA 306, section 2108 as amended by 2015 PA 141, section 2111 as amended by 2012 PA 441, sections 2118 and 2120 as amended by 2007 PA 35, section 2151 as added by 2012 PA 165, sections 3009 and 3113 as amended by 2016 PA 346, section 3101 as amended by 2017 PA 140, section 3101a as amended by 2018 PA 510, section 3104 as amended by 2002

PA 662, section 3107 as amended by 2012 PA 542, section 3109a as amended by 2012 PA 454, section 3114 as amended by 2016 PA 347, section 3135 as amended by 2012 PA 158, section 3163 as amended by 2002 PA 697, sections 3172, 3173a, 3174, and 3175 as amended by 2012 PA 204, and section 3177 as amended by 1984 PA 426, and by adding sections 261, 271, 2013a, 2111f, 2116b, 2162, 3107c, 3107d, 3107e, 3157a, and 3157b and chapters 31A and 63.

The People of the State of Michigan enact:

Sec. 150. (1) Any person who violates any provision of this act for which a specific penalty is not provided under any other provision of this act or of other laws applicable to the violation must be afforded an opportunity for a hearing before the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. If the director finds that a violation has occurred, the director shall reduce the findings and decision to writing and issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than \$1,000.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this act, the director may order the payment of a civil fine of not more than \$5,000.00 for each violation. With respect to filings made under chapters 21, 22, 23, 24, and 26, "violation" means a filing not in compliance with those chapters and does not include an action with respect to an individual policy based on a noncomplying filing. An order of the director under this subdivision must not require the payment of civil fines exceeding \$50,000.00. A fine collected under this subdivision must be turned over to the state treasurer and credited to the general fund.

(b) The suspension, limitation, or revocation of the person's license or certificate of authority.

(2) After notice and opportunity for hearing, the director may by order reopen and alter, modify, or set aside, in whole or in part, an order issued under this section if, in the director's opinion, conditions of fact or law have changed to require that action or the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this section and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of \$20,000.00 for each violation, or a suspension, limitation, or revocation of the person's license, or both. A fine collected under this subsection must be turned over to the state treasurer and credited to the general fund.

(4) The director may apply to the court of claims for an order of the court enjoining a violation of this act.

Sec. 224. (1) All actual and necessary expenses incurred in connection with the examination or other investigation of an insurer or other person regulated under the director's authority must be certified by the director, together with a statement of the work performed including the number of days spent by the director and each of the director's deputies, assistants, employees, and others acting under the director's authority. If correct, the expenses must be paid to the persons by whom they were incurred, on the warrant of the state treasurer payable from appropriations made by the legislature for this purpose.

(2) Except as otherwise provided in subsection (4), the director shall prepare and present to the insurer or other person examined or investigated a statement of the expenses and reasonable cost incurred for each person engaged on the examination or investigation, including amounts necessary to cover the pay and allowances granted to the persons by the Michigan civil service commission, and the administration and supervisory expense including an amount necessary to cover fringe benefits in conjunction with the examination or investigation. Except as otherwise provided in subsection (4), the insurer or other person, on receiving the statement, shall pay to the director the stated amount. The director shall deposit the money with the state treasurer as provided in section 225.

(3) The director may employ attorneys, actuaries, accountants, investment advisers, and other expert personnel not otherwise employees of this state reasonably necessary to assist in the conduct of the examination or investigation or proceeding with respect to an insurer or other person regulated under the director's authority at the insurer's or other person's expense except as otherwise provided in subsection (4). Except as otherwise provided in subsection (4), on certification by the director of the reasonable expenses incurred under this section, the insurer or other person examined or investigated shall pay those expenses directly to the person or firm rendering assistance to the director. Expenses paid directly to such person or firm and the regulatory fees imposed by this section are examination expenses under section 22e of the former single business tax act, 1975 PA 228, or under section 239(1) of the Michigan business tax act, 2007 PA 36, MCL 208.1239.

(4) An insurer is subject to a regulatory fee instead of the costs and expenses provided for in subsections (2) and (3). By June 30 of each year or within 30 days after the enactment into law of any appropriation for the department's operation, the director shall impose on all insurers authorized to do business in this state a regulatory fee calculated as follows:

(a) As used in this subsection:

(i) "A" means total annuity considerations written in this state in the preceding year.

(ii) "B" means base assessment rate. The base assessment rate must not exceed .00038 and must be a fraction, the numerator of which is the total regulatory fee and the denominator of which is the total amount of direct underwritten premiums written in this state by all insurers for the preceding calendar year, as reported to the director on the insurer's annual statements filed with the director.

(iii) "I" means all direct underwritten premiums other than life insurance premiums and annuity considerations written in this state in the preceding year by all insurers.

(iv) "L" means all direct underwritten life insurance premiums written in this state in the preceding year by all life insurers.

(v) Total regulatory fee must not exceed 80% of the gross appropriations for the department's operation for a fiscal year and must be the difference between the gross appropriations for the department's operation for that current fiscal year and any restricted revenues, other than the regulatory fee itself, as identified in the gross appropriation for the department's operation.

(vi) Direct premiums written in this state do not include any amounts that represent claims payments that are made on behalf of, or administrative fees that are paid in connection with, any administrative service contract, cost-plus arrangement, or any other noninsured or self-insured business.

(b) Two actual assessment rates must be calculated so as to distribute 75% of the burden of the regulatory fee shortfall created by the exclusion of annuity considerations from the assessment base to life insurance and 25% to all other insurance. The 2 actual assessment rates must be determined as follows:

$$(i) \frac{L \times B + .75 \times B \times A}{L} = \text{assessment rate for life insurance.}$$

$$(ii) \frac{I \times B + .25 \times B \times A}{I} = \text{assessment rate for insurance other than life insurance.}$$

(c) Each insurer's regulatory fee must be a minimum fee of \$250.00 and must be determined by multiplying the actual assessment rate by the assessment base of that insurer as determined by the director from the insurer's annual statement for the immediately preceding calendar year filed with the director.

(5) Not less than 55% of the revenue derived from the regulatory fee under subsection (4) may be used for the regulation of financial conduct of persons regulated under the director's authority and for the regulation of persons regulated under the director's authority engaged in the business of health care and health insurance in this state.

(6) The amount, if any, by which amounts credited to the director under section 225 exceed actual expenditures under appropriations for the department's operation for a fiscal year must be credited toward the appropriation for the department in the next fiscal year.

(7) All money paid into the state treasury by an insurer under this section must be credited as provided under section 225.

(8) An insurer shall not treat a regulatory fee under this section as a levy or excise on premium but as a regulatory burden that is apportioned in relation to insurance activity in this state. A regulatory fee under this section reflects the insurance regulatory burden on this state as a result of this insurance activity. A foreign or alien insurer authorized to do business in this state may consider the liability required under this section as a burden imposed by this state in the calculation of the insurer's liability required under section 476a.

(9) An insurer may file with the director a protest to the regulatory fee imposed not later than 15 days after receipt of the regulatory fee. The director shall review the grounds for the protest and hold a conference with the insurer at the insurer's request. The director shall transmit his or her findings to the insurer with a restatement of the regulatory fee based on the findings. Statements of regulatory fees to which protests have not been made and restatements of regulatory fees are due and must be paid not later than 30 days after their receipt. Regulatory fees that are not paid when due bear interest on the unpaid fee, which must be calculated at 6-month intervals from the date the fee was due at a rate of interest equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months preceding July 1 and January 1, as certified by the state treasurer, and compounded annually, until the assessment is paid in full. An insurer who fails to pay its regulatory fee within the prescribed time limits may have its certificate of authority or license suspended, limited, or revoked as the director considers warranted until the regulatory fee is paid. If the director determines that a regulatory fee or a part of a regulatory fee paid by an insurer is in excess of the amount legally due and payable, the amount of the excess must be refunded or, at the insurer's option, be applied as a credit against the regulatory fee for the next fiscal year. An overpayment of \$100.00 or less must be applied as a credit against the insurer's regulatory fee for the next fiscal year unless the insurer had a \$100.00 or less overpayment in the immediately preceding fiscal year. If the insurer had a \$100.00 or less overpayment in the immediately preceding fiscal year, at the insurer's option, the current fiscal year overpayment of \$100.00 or less must be refunded.

(10) Any amounts stated and presented to or certified, assessed, or imposed on an insurer as provided in subsections (2), (3), and (4) that are unpaid as of the date that the insurer is subjected to a delinquency proceeding under chapter 81 are regarded as an expense of administering the delinquency proceeding and are payable as such from the general assets of the insurer.

(11) In addition to the regulatory fee provided in subsection (4), each insurer that locates records or personnel knowledgeable about those records outside this state under section 476a(3) or section 5256 shall reimburse the department for expenses and reasonable costs incurred by the department as a result of travel and other costs related to examinations or investigations of those records or personnel. The reimbursement must not include any costs that the department would have incurred if the examination had taken place in this state.

(12) As used in this section:

(a) "Annuity considerations" means receipts on the sale of annuities as used in section 22a of the former single business tax act, 1975 PA 228, or in section 235 of the Michigan business tax act, 2007 PA 36, MCL 208.1235.

(b) "Insurer" means an insurer authorized to do business in this state and includes nonprofit health care corporations, dental care corporations, and health maintenance organizations.

Sec. 261. (1) The department shall maintain on its internet website a page that does all of the following:

(a) Advises that the department may be able to assist a person who believes that an automobile insurer is not paying benefits, not making timely payments, or otherwise not performing as it is obligated to do under an insurance policy.

(b) Advises the person of selected important rights that the person has under chapter 20 that specifically relate to automobile insurers and the payment of benefits by automobile insurers.

(c) Allows the person to submit an explanation of the facts of the person's problems with the automobile insurer.

(d) Allows the person to submit electronically, or instructs the person how to provide paper copies of, any documentation to support the facts submitted under subdivision (c).

(e) Explains to the person the steps that the department will take and that may be taken after information is submitted under this section.

(2) The department shall maintain on its internet website a page that advises consumers about the changes to automobile insurance in this state that were made by the amendatory act that added this section, including, among any other information that the director determines to be important, ways to shop for insurance.

(3) The department shall maintain on its internet website a page or pages that allow a person to report fraud and unfair settlement and claims practices.

Sec. 271. By December 31 of 2022 and every year afterward through 2030, the department shall review the effect of changes made to section 3157 by the amendatory act that added this section and provide a report to the legislature on the department's findings.

Sec. 1244. (1) If the director finds that a person has violated this chapter, after an opportunity for a hearing under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director shall reduce the findings and decision to writing and shall issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the director may order any of the following:

(a) Payment of a civil fine of not more than \$1,000.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this chapter, the director may order the payment of a civil fine of not more than \$5,000.00 for each violation. An order of the director under this subsection must not require the payment of civil fines exceeding \$50,000.00. A fine collected under this subdivision must be turned over to the state treasurer and credited to the general fund of this state.

(b) A refund of any overcharges.

(c) That restitution be made to the insured or other claimant to cover incurred losses, damages, or other harm attributable to the acts of the person found to be in violation of this chapter.

(d) The suspension or revocation of the person's license.

(2) The director may by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the opinion of the director conditions of fact or of law have changed to require that action, or if the public interest requires that action.

(3) If a person knowingly violates a cease and desist order under this chapter and has been given notice and an opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director may order a civil fine of not more than \$20,000.00 for each violation, a suspension or revocation of the person's license, or both. An order issued by the director under this subsection must not require the payment of civil fines exceeding \$100,000.00. A fine collected under this subsection must be turned over to the state treasurer and credited to the general fund of this state.

(4) The director may apply to the court of claims for an order of the court enjoining a violation of this chapter.

Sec. 2013a. (1) The failure of an insurer to materially comply with section 3107e is an unfair method of competition and an unfair or deceptive act or practice in the business of insurance.

(2) This section does not affect any other right of a person under this chapter.

Sec. 2038. (1) If, after opportunity for a hearing held under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the director determines that the person complained of has engaged in methods of competition or unfair or deceptive acts or practices prohibited by sections 2001 to 2050, the director shall reduce his or her findings and decision to writing and shall issue and cause to be served on the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from engaging in that method of competition, act, or practice. The director may also order any of the following:

(a) Payment of a monetary penalty of not more than \$1,000.00 for each violation but not to exceed an aggregate penalty of \$10,000.00, unless the person knew or reasonably should have known he was in violation of this chapter, in which case the penalty must not be more than \$5,000.00 for each violation and must not exceed an aggregate penalty of \$50,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the person's license or certificate of authority if the person knowingly and persistently violated a provision of this chapter.

(c) Refund of any overcharges.

(2) The filing of a petition for review does not stay enforcement of action under this section, but the director may grant, or the appropriate court may order, a stay on appropriate terms.

(3) If a petition for review has not been filed within the time allowed under section 244, until the time for filing the petition expires or, if a petition for review has been filed within that time, until the transcript of the record in the proceeding has been filed in the circuit court, as provided in this chapter, the director, on notice and in a manner as he or she considers proper, may modify or set aside in whole or in part an order issued under this section.

(4) After the expiration of the time allowed for filing a petition for review, if a petition has not been filed within that time, the director may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued under this section, if in the director's opinion conditions of fact or of law have so changed as to require that action or if required by the public interest.

Sec. 2040. (1) A person who violates a cease and desist order of the director under this chapter while the order is in effect, after notice and an opportunity for a hearing and on order of the director, may be subject to any of the following:

(a) A monetary penalty of not more than \$20,000.00 for each violation.

(b) Suspension or revocation of the person's license or certificate of authority.

(2) The filing of a petition for review does not stay enforcement under this section, but the director may grant, or the appropriate court may order, a stay on appropriate terms.

(3) A cease and desist order issued by the director under section 2043 must not contain fines or other penalties applicable to acts or omissions that occur before the date of the cease and desist order.

Sec. 2069. An insurer, agent, solicitor, or other person that violates section 2064 or 2066 is guilty of a misdemeanor. On conviction of violating section 2066, the offender must be sentenced to pay a fine of not more than \$100.00 for each violation, or in the discretion of the court, to imprisonment in the county jail of the county in which the offense is committed. On conviction of violating section 2064, the offender must be sentenced to pay a fine of not more than \$2,000.00 for each violation, or in the discretion of the court, to imprisonment in the county jail of the county in which the offense is committed.

Sec. 2105. (1) A policy of automobile insurance or home insurance must not be offered, bound, made, issued, delivered or renewed in this state unless the policy conforms to this chapter.

(2) Except as otherwise expressly provided in subsection (4) and this chapter, this chapter does not apply to insurance written on a group, franchise, blanket policy, or similar basis that offers home insurance or automobile insurance to all members of the group, franchise plan, or blanket coverage who are eligible persons.

(3) For purposes of this section, a group plan includes a franchise plan, and, except as provided in subsection (4), is exempt from this chapter if the group meets all of the following criteria:

(a) Individuals in the group share a common enterprise or an economic or social affinity or relationship.

(b) The group was not created for the purposes of obtaining insurance.

(c) Membership in the group is not conditioned on the purchase of insurance.

(d) The individual members of the group can be specifically identified.

(e) Any other criteria as prescribed by a rule promulgated by the director under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(4) An insurer, including, but not limited to, an insurer that writes insurance as described in subsection (2), shall not establish or maintain rates or rating classifications for automobile insurance based on a factor that is not allowed, or that is prohibited, under section 2111. This subsection does not prohibit a group discount offered to a group based on the losses or expenses, or both, of the group but does prohibit group membership based on home ownership or postal zone.

(5) The amendments to this chapter made by the amendatory act that added this subsection apply to an insurer exempted from any of the requirements of this chapter under section 2129.

(6) The amendments to this chapter made by the amendatory act that added this subsection apply beginning July 1, 2020.

Sec. 2106. (1) Except as specifically provided in this chapter, chapter 24 and chapter 26 do not apply to automobile insurance and home insurance.

(2) Subject to section 2108(6), an insurer shall file rates with the department for approval in compliance with this act.

(3) An insurer may use rates for home insurance as soon as those rates are filed.

(4) To the extent that other provisions of this act are inconsistent with this chapter, this chapter governs with respect to automobile insurance and home insurance.

Sec. 2108. (1) On the effective date of a manual of classification, manual of rules and rates, rating plan, or modification of a manual of classification, manual of rules and rates, or rating plan that an insurer proposes to use for home insurance, the insurer shall file the manual or plan with the director. For automobile insurance, an insurer shall file a manual or plan described in this subsection in accordance with subsection (6). Each filing under this subsection must state the character and extent of the coverage contemplated. An insurer that is subject to this chapter and that maintains rates in any part of this state shall at all times maintain rates in effect for all eligible persons meeting the underwriting criteria of the insurer.

(2) An insurer may satisfy its obligation to make filings under subsection (1) by becoming a member of, or a subscriber to, a rating organization licensed under chapter 24 or chapter 26 that makes the filings, and by filing with the director a copy of its authorization of the rating organization to make the filings on its behalf. This chapter does not require an insurer to become a member of or a subscriber to a rating organization. An insurer may file and use deviations from filings made on its behalf. The deviations are subject to this chapter.

(3) A filing under this section must be accompanied by a certification by or on behalf of the insurer that, to the best of the insurer's information and belief, the filing conforms to the requirements of this chapter.

(4) A filing under this section must include information that supports the filing with respect to the requirements of section 2109. The information may include 1 or more of the following:

- (a) The experience or judgment of the insurer or rating organization making the filing.
- (b) The interpretation of the insurer or rating organization of any statistical data it relies on.
- (c) The experience of other insurers or rating organizations.
- (d) Any other relevant information.

(5) Except as otherwise provided in this subsection, the department shall make a filing under this section and any accompanying information open to public inspection on filing. An insurer or a rating organization filing on the insurer's behalf may designate information included in the filing or any accompanying information as a trade secret. The insurer or the rating organization filing on behalf of the insurer shall demonstrate to the director that the designated information is a trade secret. If the director determines that the information is a trade secret, the information is not subject to public inspection and is exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. As used in this subsection, "trade secret" means that term as defined in section 2 of the uniform trade secrets act, 1998 PA 448, MCL 445.1902. However, trade secret does not include filings and information accompanying filings under this section that were subject to public inspection before January 11, 2016.

(6) For automobile insurance, an insurer shall file a manual or plan in accordance with chapter 24, except that the manual or plan must remain on file for a waiting period of 90 days before it becomes effective, which period may not be extended by the director, and the waiting period applies regardless of whether supporting information is required by the director under section 2406(1). Upon written application by the insurer, the director may authorize a filing that he or she has reviewed to become effective before expiration of the waiting period.

(7) An insurer shall not make, issue, or renew a contract or policy except in accordance with filings that are in effect for the insurer under this chapter.

(8) A filing under this chapter must specify that the insurer will not refuse to insure, refuse to continue to insure, or limit the amount of coverage available because of the location of the risk, and that the insurer recognizes those practices to constitute redlining. An insurer shall not engage in redlining as described in this subsection.

Sec. 2111. (1) Notwithstanding any provision of this act or this chapter to the contrary, classifications and territorial base rates used by an insurer in this state with respect to automobile insurance or home insurance must conform to the applicable requirements of this section.

(2) Classifications established under this section for automobile insurance must be based only on 1 or more of the following factors, which must be applied by an insurer on a uniform basis throughout this state:

(a) With respect to all automobile insurance coverages:

(i) Either the age of the driver; the length of driving experience; or the number of years licensed to operate a motor vehicle.

(ii) Driver primacy, based on the proportionate use of each vehicle insured under the policy by individual drivers insured or to be insured under the policy.

(iii) Average miles driven weekly, annually, or both.

(iv) Type of use, such as business, farm, or pleasure use.

(v) Vehicle characteristics, features, and options, such as engine displacement, ability of the vehicle and its equipment to protect passengers from injury, and other similar items, including vehicle make and model.

(vi) Daily or weekly commuting mileage.

(vii) Number of cars insured by the insurer or number of licensed operators in the household. However, number of licensed operators must not be used as an indirect measure of marital status.

(viii) Amount of insurance.

(b) In addition to the factors prescribed in subdivision (a), with respect to personal protection insurance coverage:

(i) Earned income.

(ii) Number of dependents of income earners insured under the policy.

(iii) Coordination of benefits.

(iv) Use of a safety belt.

(c) In addition to the factors prescribed in subdivision (a), with respect to collision and comprehensive coverages:

(i) The anticipated cost of vehicle repairs or replacement, which may be measured by age, price, cost new, or value of the insured automobile, and other factors directly relating to that anticipated cost.

(ii) Vehicle make and model.

(iii) Vehicle design characteristics related to vehicle damageability.

(iv) Vehicle characteristics relating to automobile theft prevention devices.

(d) With respect to all automobile insurance coverage other than comprehensive, successful completion by the individual driver or drivers insured under the policy of an accident prevention education course that meets the following criteria:

(i) The course must include a minimum of 8 hours of classroom instruction.

(ii) The course must include, but not be limited to, a review of all of the following:

(A) The effects of aging on driving behavior.

(B) The shapes, colors, and types of road signs.

(C) The effects of alcohol and medication on driving.

(D) The laws relating to the proper use of a motor vehicle.

(E) Accident prevention measures.

(F) The benefits of safety belts and child restraints.

(G) Major driving hazards.

(H) Interaction with other highway users, such as motorcyclists, bicyclists, and pedestrians.

(3) Each insurer shall establish a secondary or merit rating plan for automobile insurance, other than comprehensive coverage. A secondary or merit rating plan required under this subsection must provide for premium surcharges for all coverages for automobile insurance, other than comprehensive coverage, based on any of the following, when that information becomes available to the insurer:

(a) Substantially at-fault accidents.

(b) Convictions for, determinations of responsibility for civil infractions for, or findings of responsibility in probate court for civil infractions for violations under chapter VI of the Michigan vehicle code, 1949 PA 300, MCL 257.601 to 257.750. However, an insured must not be merit rated for a civil infraction under chapter VI of the Michigan vehicle code, 1949 PA 300, MCL 257.601 to 257.750, for a period of time longer than that which the secretary of state's office carries points for that infraction on the insured's motor vehicle record.

(4) An insurer shall not establish or maintain rates or rating classifications for automobile insurance based on any of the following:

- (a) Sex.
- (b) Marital status.
- (c) Home ownership.
- (d) Educational level attained.
- (e) Occupation.
- (f) The postal zone in which the insured resides.
- (g) Credit score as provided in section 2162.

(5) Notwithstanding other provisions of this chapter, automobile insurance risks may be grouped by territory.

(6) This section does not limit insurers or rating organizations from establishing and maintaining statistical reporting territories. This section does not prohibit an insurer from establishing or maintaining, for automobile insurance, a premium discount plan for senior citizens in this state who are 65 years of age or older, if the plan is uniformly applied by the insurer throughout this state. If an insurer has not established and maintained a premium discount plan for senior citizens, the insurer shall offer reduced premium rates to senior citizens in this state who are 65 years of age or older and who drive less than 3,000 miles per year, regardless of statistical data.

(7) Classifications established under this section for home insurance other than inland marine insurance provided by policy floaters or endorsements must be based only on 1 or more of the following factors:

- (a) Amount and types of coverage.
 - (b) Security and safety devices, including locks, smoke detectors, and similar, related devices.
 - (c) Repairable structural defects reasonably related to risk.
 - (d) Fire protection class.
 - (e) Construction of structure, based on structure size, building material components, and number of units.
 - (f) Loss experience of the insured, based on prior claims attributable to factors under the control of the insured that have been paid by an insurer. An insured's failure, after written notice from the insurer, to correct a physical condition that presents a risk of repeated loss is a factor under the control of the insured for purposes of this subdivision.
 - (g) Use of smoking materials within the structure.
 - (h) Distance of the structure from a fire hydrant.
 - (i) Availability of law enforcement or crime prevention services.
- (8) Notwithstanding other provisions of this chapter, home insurance risks may be grouped by territory.
- (9) An insurer may use factors in addition to those permitted by this section for insurance if the plan is consistent with the purposes of this act and reflects reasonably anticipated reductions or increases in losses or expenses.

Sec. 2111f. (1) Before July 1, 2020, an insurer that offers automobile insurance in this state shall file premium rates for personal protection insurance coverage for automobile insurance policies effective after July 1, 2020.

(2) Subject to subsections (6) and (7), the premium rates filed as required by subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage under automobile insurance policies effective before July 1, 2028, must result, as nearly as practicable, in an average reduction per vehicle from the premium rates for personal protection insurance coverage that were in effect for the insurer on May 1, 2019 as follows:

- (a) For policies subject to the coverage limits under section 3107c(1)(a), an average 45% or greater reduction per vehicle.
- (b) For policies subject to the coverage limits under section 3107c(1)(b), an average 35% or greater reduction per vehicle.
- (c) For policies subject to the coverage limits under section 3107c(1)(c), an average 20% or greater reduction per vehicle.
- (d) For policies not subject to any coverage limit under section 3107c(1)(d), an average 10% or greater reduction per vehicle.

(3) For a policy under which an election under section 3107d has been made to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a), or for a policy to which an exclusion under section 3109a(2)

applies, the premium rates filed under subsection (1), and any subsequent premium rates filed by the insurer for personal protection insurance coverage must result in no premium charge for coverage for personal protection insurance benefits payable under section 3107(1)(a).

(4) The director shall review a filing submitted by an insurer under subsections (1) to (3) for compliance with this section. Subject to subsection (7), the director shall disapprove a filing if after review the director determines that the filing does not result in the premium reductions required by subsections (2) and (3).

(5) If the director disapproves a premium rate filing under subsection (4), the insurer shall submit a revised premium rate filing to the director within 15 days after the disapproval. The premium rate filing is subject to review in the same manner as an original premium rate filing under subsection (4).

(6) For policies issued or renewed in the year beginning July 1, 2024 and for the year beginning July 1, 2026, an automobile insurer that offers automobile insurance in this state shall make filings demonstrating its compliance with this section.

(7) At any time, an insurer may apply to the director for approval to file rates that result in a lower premium reduction level or an exemption from the requirements of subsection (2) and the director shall approve the application if the rates otherwise comply with this act and compliance with the premium reductions required by subsection (2) will result in any of the following:

(a) The insurer reaching the company action level risk-based capital.

(b) A violation of the Fourteenth Amendment of the United States Constitution as to the insurer. This subdivision does not apply after July 1, 2023.

(c) A violation of section 17 of article I of the state constitution of 1963, as to deprivation of property without due process. This subdivision does not apply after July 1, 2023.

(8) An insurer shall pass on, in filings to which this section applies, savings realized from the application of section 3157(2) to (12) to treatment, products, services, accommodations, or training rendered to individuals who suffered accidental bodily injury from motor vehicle accidents that occurred before the effective date of the amendatory act that added this section. An insurer shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to evaluate the insurer's compliance with this subsection. After July 1, 2022, the director shall review all rate filings to which this section applies for compliance with this subsection.

(9) This section does not prohibit an increase for any individual insurance policy premium if the increase results from applying rating factors as approved under this chapter, including the requirements of this section.

(10) After July 1, 2020 and before July 1, 2028, an insurer shall not issue or renew an automobile insurance policy in this state unless the premium rates filed by the insurer for personal protection insurance coverage are approved under this section.

(11) For purposes of calculating a personal protection insurance premium or premium rate under this section, the premium must include the catastrophic claims assessment imposed under section 3104.

(12) If subsection (2) or the application of subsection (2) to any insurer is found to be invalid by a court, the remaining portions of the amendatory act that added this section are not severable and shall be deemed invalid and inoperable.

(13) As used in this section:

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC report, including risk-based capital instructions adopted by the National Association of Insurance Commissioners and the director.

(b) "Company action level risk-based capital" means 2 times the insurer's authorized control level RBC.

(c) "RBC report" means the report of the insurer's RBC levels as required by the annual statement instructions.

Sec. 2116b. (1) Subject to subsection (2), an automobile insurer shall not refuse to insure, refuse to continue to insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance for an eligible person solely because the person previously failed to maintain insurance required by section 3101 for a vehicle owned by the person.

(2) This section only applies to an eligible person that applies for automobile insurance before January 1, 2022.

Sec. 2118. (1) As a condition of maintaining its certificate of authority, an insurer shall not refuse to insure, refuse to continue to insure, or limit coverage available to an eligible person for automobile insurance, except in accordance with underwriting rules established as provided in this section and sections 2119 and 2120.

(2) The underwriting rules that an insurer may establish for automobile insurance must be based only on the following:

(a) Criteria identical to the standards set forth in section 2103(1).

(b) The insurance eligibility point accumulation in excess of the amounts established by section 2103(1) of a member of the household of the eligible person insured or to be insured, if the member of the household usually accounts for 10% or more of the use of a vehicle insured or to be insured. For purposes of this subdivision, a person who is the principal driver for 1 automobile insurance policy is rebuttably presumed not to usually account for more than 10% of the use of other vehicles of the household not insured under the policy of that person.

(c) With respect to a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(d) Except as otherwise provided in section 2116a or 2116b, failure by the person to provide proof that insurance required by section 3101 was maintained in force with respect to any vehicle that was both owned by the person and driven or moved by the person or by a member of the household of the person during the 6-month period immediately preceding application. The proof must take the form of a certification by the person on a form provided by the insurer that the vehicle was not driven or moved without maintaining the insurance required by section 3101 during the 6-month period immediately preceding application.

(e) Type of vehicle insured or to be insured, based on 1 of the following, without regard to the age of the vehicle:

(i) The vehicle is of limited production or of custom manufacture.

(ii) The insurer does not have a rate lawfully in effect for the type of vehicle.

(iii) The vehicle represents exposure to extraordinary expense for repair or replacement under comprehensive or collision coverage.

(f) Use of a vehicle insured or to be insured for transportation of passengers for hire, for rental purposes, or for commercial purposes. Rules under this subdivision must not be based on the use of a vehicle for volunteer or charitable purposes or for which reimbursement for normal operating expenses is received.

(g) Payment of a minimum deposit at the time of application or renewal, not to exceed the smallest deposit required under an extended payment or premium finance plan customarily used by the insurer.

(h) For purposes of requiring comprehensive deductibles of not more than \$150.00, or of refusing to insure if the person refuses to accept a required deductible, the claim experience of the person with respect to comprehensive coverage.

(i) Total abstinence from the consumption of alcoholic beverages except if such beverages are consumed as part of a religious ceremony. However, an insurer shall not use an underwriting rule based on this subdivision unless the insurer was authorized to transact automobile insurance in this state before January 1, 1981, and has consistently used such an underwriting rule as part of the insurer's automobile insurance underwriting since being authorized to transact automobile insurance in this state.

(j) One or more incidents involving a threat, harassment, or physical assault by the insured or applicant for insurance on an insurer employee, agent, or agent employee while acting within the scope of his or her employment, if a report of the incident was filed with an appropriate law enforcement agency.

Sec. 2120. (1) Affiliated insurers may establish underwriting rules so that each affiliate will provide automobile insurance only to certain eligible persons. This subsection applies only if an eligible person can obtain automobile insurance from 1 of the affiliates. The underwriting rules must be in compliance with this section and sections 2118 and 2119.

(2) An insurer may establish separate rating plans so that certain eligible persons are provided automobile insurance under 1 rating plan and other eligible persons are provided automobile insurance under another rating plan. This subsection applies only if all eligible persons can obtain automobile insurance under a rating plan of the insurer. Underwriting rules consistent with this section and sections 2118 and 2119 must be established to define the rating plan applicable to each eligible person.

(3) Underwriting rules under this section must be based only on the following:

(a) With respect to a vehicle insured or to be insured, substantial modifications from the vehicle's original manufactured state for purposes of increasing the speed or acceleration capabilities of the vehicle.

(b) Except as otherwise provided in section 2116a or 2116b, failure of the person to provide proof that insurance required by section 3101 was maintained in force with respect to any vehicle owned and operated by the person or by a member of the household of the person during the 6-month period immediately preceding application or renewal of the policy. The proof must take the form of a certification by the person that the required insurance was maintained in force for the 6-month period with respect to the vehicle.

(c) For purposes of insuring persons who have refused a deductible lawfully required under section 2118(2)(h), the claim experience of the person with respect to comprehensive coverage.

(d) Refusal of the person to pay a minimum deposit required under section 2118(2)(g).

(e) A person's insurance eligibility point accumulation under section 2103(1)(h), or the total insurance eligibility point accumulation of all persons who account for 10% or more of the use of 1 or more vehicles insured or to be insured under the policy.

(f) The type of vehicle insured or to be insured as provided in section 2118(2)(e).

Sec. 2151. As used in this chapter:

(a) "Adverse action" means an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any personal insurance, existing or applied for.

(b) "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(c) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related must not be considered credit information, regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(d) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in the rating of personal insurance.

(e) "Credit score" means the numerical score ranging from 300 to 850 assigned by a consumer reporting agency to measure credit risk and includes FICO credit score.

(f) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

(g) "Personal insurance" means property/casualty insurance written for personal, family, or household use, including automobile, home, motorcycle, mobile home, noncommercial dwelling fire, boat, personal watercraft, snowmobile, and recreational vehicle, whether written on an individual, group, franchise, blanket policy, or similar basis.

Sec. 2162. An insurer shall not use an individual's credit score to establish or maintain rates or rating classifications for automobile insurance. *but not*

Sec. 3009. (1) Subject to subsections (5) to (8), an automobile liability or motor vehicle liability policy that insures against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle must not be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless the liability coverage is subject to all of the following limits:

(a) A limit, exclusive of interest and costs, of not less than \$250,000.00 because of bodily injury to or death of 1 person in any 1 accident.

(b) Subject to the limit for 1 person in subdivision (a), a limit of not less than \$500,000.00 because of bodily injury to or death of 2 or more persons in any 1 accident.

(c) A limit of not less than \$10,000.00 because of injury to or destruction of property of others in any accident.

(2) If authorized by the insured, automobile liability or motor vehicle liability coverage may be excluded when a vehicle is operated by a named person. An exclusion under this subsection is not valid unless the following notice is on the face of the policy or the declaration page or certificate of the policy and on the certificate of insurance:

Warning—when a named excluded person operates a vehicle all liability coverage is void—no one is insured. Owners of the vehicle and others legally responsible for the acts of the named excluded person remain fully personally liable.

(3) A liability policy described in subsection (1) may exclude coverage for liability as provided in section 3017.

(4) If an insurer deletes coverages from an automobile insurance policy under section 3101, the insurer shall send documentary evidence of the deletion to the insured.

(5) An applicant for or named insured in the automobile liability or motor vehicle liability policy described in subsection (1) may choose to purchase lower limits than required under subsection (1)(a) and (b), but not lower than \$50,000.00 under subsection (1)(a) and \$100,000.00 under subsection (1)(b). To exercise an option under this subsection, the person shall complete a form issued by the director and provided as required by section 3107e, that meets the requirements of subsection (7).

(6) On application for the issuance of a new policy or renewal of an existing policy, an insurer shall do all of the following:

(a) Provide the applicant or named insured the liability options available under this section.

(b) Provide the applicant or named insured a price for each option available under this section.

(c) Offer the applicant or named insured the option and form under this subsection.

(7) The form required under subsection (5) must do all of the following:

(a) State, in a conspicuous manner, the risks of choosing liability limits lower than those required by subsection (1)(a) and (b).

(b) Provide a way for the person to mark the form to acknowledge that he or she has received a list of the liability options available under this section and the price for each option.

(c) Provide a way for the person to mark the form to acknowledge that he or she has read the form and understands the risks of choosing the lower liability limits.

(d) Allow the person to sign the form.

(8) If an insurance policy is issued or renewed as described in subsection (1) and the person named in the policy has not made an effective choice under subsection (5), the limits under subsection (1)(a) and (b) apply to the policy.

Sec. 3101. (1) Except as provided in sections 3107d and 3109a, the owner or registrant of a motor vehicle required to be registered in this state shall maintain security for payment of benefits under personal protection insurance and property protection insurance as required under this chapter, and residual liability insurance. Security is only required to be in effect during the period the motor vehicle is driven or moved on a highway.

(2) Except as provided in section 3107d, all automobile insurance policies offered in this state must include benefits under personal protection insurance, and property protection insurance as provided in this chapter, and residual liability insurance. Notwithstanding any other provision in this act, an insurer that has issued an automobile insurance policy may only delete portions of the coverages under the policy and maintain the comprehensive coverage portion on a motor vehicle that is not driven or moved on a highway in accordance with section 3009(4).

(3) As used in this chapter:

(a) "Automobile insurance" means that term as defined in section 2102.

(b) "Commercial quadricycle" means a vehicle to which all of the following apply:

(i) The vehicle has fully operative pedals for propulsion entirely by human power.

(ii) The vehicle has at least 4 wheels and is operated in a manner similar to a bicycle.

(iii) The vehicle has at least 6 seats for passengers.

(iv) The vehicle is designed to be occupied by a driver and powered either by passengers providing pedal power to the drive train of the vehicle or by a motor capable of propelling the vehicle in the absence of human power.

(v) The vehicle is used for commercial purposes.

(vi) The vehicle is operated by the owner of the vehicle or an employee of the owner of the vehicle.

(c) "Electric bicycle" means that term as defined in section 13e of the Michigan vehicle code, 1949 PA 300, MCL 257.13e.

(d) "Golf cart" means a vehicle designed for transportation while playing the game of golf.

(e) "Highway" means highway or street as that term is defined in section 20 of the Michigan vehicle code, 1949 PA 300, MCL 257.20.

(f) "Moped" means that term as defined in section 32b of the Michigan vehicle code, 1949 PA 300, MCL 257.32b.

(g) "Motorcycle" means a vehicle that has a saddle or seat for the use of the rider, is designed to travel on not more than 3 wheels in contact with the ground, and is equipped with a motor that exceeds 50 cubic centimeters piston displacement. For purposes of this subdivision, the wheels on any attachment to the vehicle are not considered as wheels in contact with the ground. Motorcycle does not include a moped or an ORV.

(h) "Motorcycle accident" means a loss that involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle, but does not involve the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle.

(i) "Motor vehicle" means a vehicle, including a trailer, that is operated or designed for operation on a public highway by power other than muscular power and has more than 2 wheels. Motor vehicle does not include any of the following:

(i) A motorcycle.

(ii) A moped.

(iii) A farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan vehicle code under section 216 of the Michigan vehicle code, 1949 PA 300, MCL 257.216.

(iv) An ORV.

(v) A golf cart.

(vi) A power-driven mobility device.

(vii) A commercial quadricycle.

(viii) An electric bicycle.

(j) "Motor vehicle accident" means a loss that involves the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle regardless of whether the accident also involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle.

(k) "ORV" means a motor-driven recreation vehicle designed for off-road use and capable of cross-country travel without benefit of road or trail, on or immediately over land, snow, ice, marsh, swampland, or other natural terrain. ORV includes, but is not limited to, a multitrack or multiwheel drive vehicle, a motorcycle or related 2-wheel, 3-wheel, or 4-wheel vehicle, an amphibious machine, a ground effect air cushion vehicle, an ATV as defined in section 81101 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.81101, or other means of transportation deriving motive power from a source other than muscle or wind. ORV does not include a vehicle described in this subdivision that is registered for use on a public highway and has the security required under subsection (1) or section 3103 in effect.

(l) "Owner" means any of the following:

(i) A person renting a motor vehicle or having the use of a motor vehicle, under a lease or otherwise, for a period that is greater than 30 days.

(ii) A person renting a motorcycle or having the use of a motorcycle under a lease for a period that is greater than 30 days, or otherwise for a period that is greater than 30 consecutive days. A person who borrows a motorcycle for a period that is less than 30 consecutive days with the consent of the owner is not an owner under this subparagraph.

(iii) A person that holds the legal title to a motor vehicle or motorcycle, other than a person engaged in the business of leasing motor vehicles or motorcycles that is the lessor of a motor vehicle or motorcycle under a lease that provides for the use of the motor vehicle or motorcycle by the lessee for a period that is greater than 30 days.

(iv) A person that has the immediate right of possession of a motor vehicle or motorcycle under an installment sale contract.

(m) "Power-driven mobility device" means a wheelchair or other mobility device powered by a battery, fuel, or other engine and designed to be used by an individual with a mobility disability for the purpose of locomotion.

(n) "Registrant" does not include a person engaged in the business of leasing motor vehicles or motorcycles that is the lessor of a motor vehicle or motorcycle under a lease that provides for the use of the motor vehicle or motorcycle by the lessee for a period that is longer than 30 days.

(4) Security required by subsection (1) may be provided under a policy issued by an authorized insurer that affords insurance for the payment of benefits described in subsection (1). A policy of insurance represented or sold as providing security is considered to provide insurance for the payment of the benefits.

(5) Security required by subsection (1) may be provided by any other method approved by the secretary of state as affording security equivalent to that afforded by a policy of insurance, if proof of the security is filed and continuously maintained with the secretary of state throughout the period the motor vehicle is driven or moved on a highway. The person filing the security has all the obligations and rights of an insurer under this chapter. When the context permits, "insurer" as used in this chapter, includes a person that files the security as provided in this section.

(6) An insurer that issues a policy that provides the security required under subsection (1) may exclude coverage under the policy as provided in section 3017.

Sec. 3101a. (1) An insurer, in conjunction with the issuance of an automobile insurance policy, shall provide to the insured 1 certificate of insurance for each insured vehicle and for private passenger nonfleet automobiles listed on the policy shall supply to the secretary of state the automobile insurer's name, the name of the named insured, the named insured's address, the vehicle identification number for each vehicle listed on the policy, and the policy number. The insurer shall transmit the information required under this subsection in a format as required by the secretary of state. The secretary of state shall not require the information to be transmitted more frequently than every 14 days.

(2) The secretary of state shall provide policy information received under subsection (1) to the Michigan automobile insurance placement facility as required for the Michigan automobile insurance placement facility to comply with this act. Information received by the Michigan automobile insurance placement facility under this subsection is confidential and is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. The Michigan automobile insurance placement facility shall only use the information for purposes of administering the assigned claims plan under this chapter and shall not disclose the information to any person unless it is for the purpose of administering the assigned claims plan or in compliance with an order by a court of competent jurisdiction in connection with a fraud investigation or prosecution.

(3) The secretary of state shall provide policy information received under subsection (1) to the department of health and human services as required for the department of health and human services to comply with 2006 PA 593, MCL 550.281 to 550.289.

(4) The secretary of state shall accept as proof of vehicle insurance a transmission of the insured vehicle's vehicle identification number. Policy information submitted by an insurer and received by the secretary of state under this section is confidential, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and must not be disclosed to any person except the department of health and human services for purposes of 2006 PA 593, MCL 550.281 to 550.289, or pursuant to an order by a court of competent jurisdiction in connection with a claim or fraud investigation or prosecution. The transmission to the secretary of state of a vehicle identification number is proof of insurance to the secretary of state for motor vehicle registration purposes only and is not evidence that a policy of insurance actually exists between an insurer and an individual.

(5) A person who supplies false information to the secretary of state under this section or who issues or uses an altered, fraudulent, or counterfeit certificate of insurance is guilty of a misdemeanor punishable by imprisonment for not more than 1 year or a fine of not more than \$1,000.00, or both.

(6) The department of health and human services shall report to the senate and house of representatives appropriations committees and standing committees concerning insurance issues on the number of claims and total dollar amount recovered from automobile insurers under 2006 PA 593, MCL 550.281 to 550.289. The reports required by this subsection must be given to the appropriations committees and standing committees concerning insurance issues by December 30 of each year and must cover the preceding 12-month period.

(7) As used in this section:

(a) "Automobile insurance" means that term as defined in section 3303.

(b) "Private passenger nonfleet automobile" means that term as defined in section 3303.

Sec. 3104. (1) The catastrophic claims association is created as an unincorporated, nonprofit association. Each insurer engaged in writing insurance coverages that provide the security required by section 3101(1) in this state, as a condition of its authority to transact insurance in this state, shall be a member of the association and is bound by the plan of operation of the association. An insurer engaged in writing insurance coverages that provide the security required by section 3103(1) in this state, as a condition of its authority to transact insurance in this state, is considered to be a member of the association, but only for purposes of premiums under subsection (7)(d). Except as expressly provided in this section, the association is not subject to any laws of this state with respect to insurers, but in all other respects the association is subject to the laws of this state to the extent that the association would be if it were an insurer organized and subsisting under chapter 50.

(2) For all motor vehicle accident policies issued or renewed before July 2, 2020 and for a motor vehicle accident policy issued or renewed after July 1, 2020 to which section 3107c(1)(d) applies, the association shall provide and each member shall accept indemnification for 100% of the amount of ultimate loss sustained under personal protection insurance coverages in excess of the following amounts in each loss occurrence:

(a) For a motor vehicle accident policy issued or renewed before July 1, 2002, \$250,000.00.

(b) For a motor vehicle accident policy issued or renewed during the period July 1, 2002 to June 30, 2003, \$300,000.00.

(c) For a motor vehicle accident policy issued or renewed during the period July 1, 2003 to June 30, 2004, \$325,000.00.

(d) For a motor vehicle accident policy issued or renewed during the period July 1, 2004 to June 30, 2005, \$350,000.00.

(e) For a motor vehicle accident policy issued or renewed during the period July 1, 2005 to June 30, 2006, \$375,000.00.

(f) For a motor vehicle accident policy issued or renewed during the period July 1, 2006 to June 30, 2007, \$400,000.00.

(g) For a motor vehicle accident policy issued or renewed during the period July 1, 2007 to June 30, 2008, \$420,000.00.

(h) For a motor vehicle accident policy issued or renewed during the period July 1, 2008 to June 30, 2009, \$440,000.00.

(i) For a motor vehicle accident policy issued or renewed during the period July 1, 2009 to June 30, 2010, \$460,000.00.

(j) For a motor vehicle accident policy issued or renewed during the period July 1, 2010 to June 30, 2011, \$480,000.00.

(k) For a motor vehicle accident policy issued or renewed during the period July 1, 2011 to June 30, 2013, \$500,000.00.

(l) For a motor vehicle accident policy issued or renewed during the period July 1, 2013 to June 30, 2015, \$530,000.00.

(m) For a motor vehicle accident policy issued or renewed during the period July 1, 2015 to June 30, 2017, \$545,000.00.

(n) For a motor vehicle accident policy issued or renewed during the period July 1, 2017 to June 30, 2019, \$555,000.00.

(o) For a motor vehicle accident policy issued or renewed during the period July 1, 2019 to June 30, 2021, \$580,000.00. Beginning July 1, 2021, this \$580,000.00 amount must be increased biennially on July 1 of each odd-numbered year, for policies issued or renewed before July 1 of the following odd-numbered year, by the lesser of 6% or the Consumer Price Index, and rounded to the nearest \$5,000.00. The association shall calculate this biennial adjustment by January 1 of the year of its July 1 effective date.

(3) An insurer may withdraw from the association only on ceasing to write insurance that provides the security required by section 3101(1) in this state.

(4) An insurer whose membership in the association has been terminated by withdrawal continues to be bound by the plan of operation, and on withdrawal, all unpaid premiums that have been charged to the withdrawing member are payable as of the effective date of the withdrawal.

(5) An unsatisfied net liability to the association of an insolvent member must be assumed by and apportioned among the remaining members of the association as provided in the plan of operation. The association has all rights allowed by law on behalf of the remaining members against the estate or funds of the insolvent member for money due the association.

(6) If a member has been merged or consolidated into another insurer or another insurer has reinsured a member's entire business that provides the security required by section 3101(1) in this state, the member and successors in interest of the member remain liable for the member's obligations.

(7) The association shall do all of the following on behalf of the members of the association:

(a) Assume 100% of all liability as provided in subsection (2).

(b) Establish procedures by which members must promptly report to the association each claim that, on the basis of the injuries or damages sustained, may reasonably be anticipated to involve the association if the member is ultimately held legally liable for the injuries or damages. Solely for the purpose of reporting claims, the member shall in all instances consider itself legally liable for the injuries or damages. The member shall also advise the association of subsequent developments likely to materially affect the interest of the association in the claim.

(c) Maintain relevant loss and expense data relating to all liabilities of the association and require each member to furnish statistics, in connection with liabilities of the association, at the times and in the form and detail as required by the plan of operation.

(d) In a manner provided for in the plan of operation, calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association that the association will likely incur during the period for which the premium is applicable. The total premium must include an amount to cover incurred but not reported losses for the period and must be adjusted for any excess or deficient premiums from previous periods. Excesses or deficiencies from previous periods must either be fully adjusted in a single period or be adjusted over several periods in a manner provided for in the plan of operation. Each member must be charged an amount equal to that member's total written car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state during the period to which the premium applies, with the total written car years of insurance multiplied by the applicable average premium per car. The average premium per car is the total premium, as adjusted for any excesses or deficiencies, divided by the total written car years of insurance providing the security required by section 3101(1) or 3103(1), or both, written in this state of all members during the period to which the premium applies, excluding cars insured under a policy with a coverage limit under section 3107c(1)(a), (b), or (c), cars as to which an election to not maintain personal protection insurance benefits has been made under section 3107d, or as to which an exclusion under section 3109a(2) applies, except for any portion of total premium that is an adjustment for a deficiency in a previous period. A member may not be charged a premium for a car insured under a policy with a coverage limit under section 3107c(1)(a), (b), or (c), as to which an election to not maintain personal protection insurance benefits has been made under section 3107d, or as to which an exclusion under section 3109a(2) applies, other than for the portion of the total premium attributable to an adjustment for a deficiency in a previous period. A member must be charged a premium for a historic vehicle that is insured with the member of 20% of the premium charged for a car insured with the member.

(e) Require and accept the payment of premiums from members of the association as provided for in the plan of operation. The association shall do either of the following:

(i) Require payment of the premium in full within 45 days after the premium charge.

(ii) Require payment of the premiums to be made periodically to cover the actual cash obligations of the association.

(f) Receive and distribute all money required by the operation of the association.

(g) Establish procedures for reviewing claims procedures and practices of members of the association. If the claims procedures or practices of a member are considered inadequate to properly service the liabilities of the association, the association may undertake or may contract with another person, including another member, to adjust or assist in the adjustment of claims for the member on claims that create a potential liability to the association and may charge the cost of the adjustment to the member.

(h) Provide any records necessary or requested by the director for the actuarial examination under subsection (21).

(i) Subject to subsection (23), obey an order of the director for a refund under subsection (22).

(8) In addition to other powers granted to it by this section, the association may do all of the following:

(a) Sue and be sued in the name of the association. A judgment against the association does not create any direct liability against the individual members of the association. The association may provide for the indemnification of its

members, members of the board of directors of the association, and officers, employees, and other persons lawfully acting on behalf of the association.

(b) Reinsure all or any portion of its potential liability with reinsurers licensed to transact insurance in this state or approved by the director.

(c) Provide for appropriate housing, equipment, and personnel as necessary to assure the efficient operation of the association.

(d) Pursuant to the plan of operation, adopt reasonable rules for the administration of the association, enforce those rules, and delegate authority, as the board considers necessary to assure the proper administration and operation of the association consistent with the plan of operation.

(e) Contract for goods and services, including independent claims management, actuarial, investment, and legal services, from others in or outside of this state to assure the efficient operation of the association.

(f) Hear and determine complaints of a company or other interested party concerning the operation of the association.

(g) Perform other acts not specifically enumerated in this section that are necessary or proper to accomplish the purposes of the association and that are not inconsistent with this section or the plan of operation.

(9) A board of directors is created and shall operate the association consistent with the plan of operation and this section.

(10) The plan of operation must provide for all of the following:

(a) The establishment of necessary facilities.

(b) The management and operation of the association.

(c) Procedures to be utilized in charging premiums, including adjustments from excess or deficient premiums from prior periods. The plan must require that any deficiency from a prior period be amortized over not fewer than 15 years.

(d) Procedures for a refund to members of the association, for distribution to insureds as provided in subsection (24), as ordered by the director under subsection (22). The procedures must provide for a distribution of a refund attributable to a historic vehicle equal to 20% of the refund for a car that is not a historic vehicle.

(e) Procedures governing the actual payment of premiums to the association.

(f) Reimbursement of each member of the board by the association for actual and necessary expenses incurred on association business.

(g) The investment policy of the association.

(h) Any other matters required by or necessary to effectively implement this section.

(11) The board must include members that would contribute a total of not less than 40% of the total premium calculated under subsection (7)(d). Each board member is entitled to 1 vote. The initial term of office of a board member is 2 years.

(12) As part of the plan of operation, the board shall adopt rules providing for the composition of the board and the terms of board members, consistent with the membership composition requirements in subsections (11) and (13). Terms of the board members must be staggered so that the terms of all the board members do not expire at the same time and so that a board member does not serve a term of more than 4 years.

(13) The board must consist of 5 board members and the director, who shall serve as an ex officio member of the board without vote.

(14) The director shall appoint the board members. A board member shall serve until his or her successor is selected and qualified. The board shall elect the chairperson of the board. The director shall fill any vacancy on the board as provided in the plan of operation.

(15) The board shall meet as often as the chairperson, the director, or the plan of operation requires, or at the request of any 3 board members. The chairperson may vote on all issues. Four board members constitute a quorum.

(16) The board shall furnish to each member of the association an annual report of the operations of the association in a form and detail as determined by the board.

(17) Any amendments to the plan of operation are subject to majority approval by the board, ratification by a majority of the membership of the association having a vote, with voting rights being apportioned according to the premiums charged in subsection (7)(d), and approval by the director.

(18) An insurer authorized to write insurance providing the security required by section 3101(1) in this state, as provided in this section, is bound by and shall formally subscribe to and participate in the plan of operation as a condition of maintaining its authority to transact insurance in this state.

(19) The association is subject to all the reporting, loss reserve, and investment requirements of the director to the same extent as is a member of the association.

(20) Premiums charged members by the association must be recognized in the rate-making procedures for insurance rates in the same manner that expenses and premium taxes are recognized. If a member of the association passes on any portion of the premium payable under this section to an insured, the amount passed on must equal the portion of the premium payable by the member under this section attributable to the car or historic vehicle insured, including any adjustments for excesses or deficiencies from a previous period.

(21) The director or an authorized representative of the director may visit the association at any time and examine any and all of the association's affairs. Beginning July 1, 2022, and every third year after 2022, the director shall engage 1 or more independent actuaries to examine the affairs and records of the association for the previous 3 years. The actuarial examination must be conducted using sound actuarial principles consistent with the applicable statements of principles and the code of professional conduct adopted by the Casualty Actuarial Society. By September 1, 2022 and by September 1 of every third year after 2022, the director shall provide a report to the legislature on the results of the audit conducted under this subsection.

(22) If the actuarial examination under subsection (21) shows that the assets of the association exceed 120% of its liabilities, including incurred but not reported liabilities, and if the refund will not threaten the association's ongoing ability to provide reimbursements for personal protection insurance benefits based on sound actuarial principles consistent with the applicable statements of principles and the code of professional conduct adopted by the Casualty Actuarial Society, the director shall order the association to refund an amount equal to the difference between the total excess and 120% of the liabilities of the association, including incurred but not reported liabilities, under subsection (10)(d) and order the members of the association to distribute the refunds under subsection (24).

(23) Within 30 days after receiving an order from the director under subsection (22), the association may request a hearing to review the order by filing a written request with the director. The department shall conduct the review as a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(24) A member of the association shall distribute any refund it receives under subsection (10)(d) to the persons that it insures under policies that provide the security required under section 3101(1) or 3103(1), or both, and that are subject to a premium under this section on a uniform basis per car and historic vehicle in a manner and on the date or dates provided by the director in accordance with an order issued by the director. A refund attributable to a historic vehicle must be equal to 20% of the refund for a car that is not a historic vehicle.

(25) By September 1 of each year, the association shall prepare, submit to the committees of the senate and house of representatives with jurisdiction over insurance matters, and post on the association website an annual consumer statement, written in a manner intended for the general public. The statement must include all of the following:

(a) The number of claims opened during the preceding 12 months, the amount expended on the claims, and the future anticipated costs of the claims.

(b) For each of the preceding 10 years, the total number of open claims, the amount expended on the claims, and the anticipated future costs of the claims.

(c) For each of the preceding 10 years, the total number of claims closed and the amount expended on the claims.

(d) For each of the preceding 10 years, the ratio of claims opened to claims closed.

(e) For each of the preceding 10 years, the average length of open claims.

(f) A statement of the current financial condition of the association and the reasons for any deficit or surplus in collected assessments compared to losses.

(g) A statement of the assumptions, methodology, and data used to make revenue projections. As used in this subdivision, "revenue" means return on investments.

(h) A statement of the assumptions, methodology, and data used to make cost projections.

(i) A list of the association's assets, sorted by category or type of asset, such as stocks, bonds, or mutual funds, and the expected return on each asset.

(j) The total amount of the association's discounted and undiscounted liabilities and a description and explanation of the liabilities, including an explanation of the association's definition of the terms discounted and undiscounted.

(k) Measures taken by the association to contain costs.

(l) A statement explaining what portion of the assessment to insureds as recognized in rates under subsection (20) is attributable to claims occurring in the previous 12 months, administrative costs, and the amount, if any, to adjust for past deficits.

(m) A statement explaining any qualifications identified by the independent auditors in the most recent audit report prepared under subsection (21).

(n) A loss payment summary for each of the preceding years by category.

(o) For each of the preceding 10 years, an injury type summary, categorizing the injuries suffered by claimants the payment of whose claims are being reimbursed by the association, by brain injuries, injuries resulting in quadriplegia, injuries resulting in paraplegia, burn injuries, and other injuries.

(p) A summary of investment returns over the preceding 10 years showing the investment balance, the investment gain, and the percentage return on the investment balance.

(q) A summary of the mortality assumptions used in making cost projections.

(r) A summary of any financial practices that differ from those found in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

(26) By September 1 of each year, the association shall prepare and provide to the committees of the senate and house of representatives with jurisdiction over insurance matters an annual report of the association. The report must contain all of the following:

(a) An executive summary.

(b) A discussion of the mortality assumptions used by the association in making cost projections.

(c) An evaluation of the accuracy of the association's actuarial assumptions over the preceding 5 years.

(d) The annual consumer statement prepared under subsection (25).

(e) Anything else the association determines is necessary to advise the legislature about the operations of the association.

(27) The association does not have liability for losses occurring before July 1, 1978. After July 1, 2020, the association does not have liability for an ultimate loss under personal protection insurance coverage for a motor vehicle accident policy to which a limit under section 3107c(1)(a), (b), or (c) is applicable.

(28) As used in this section:

(a) "Association" means the catastrophic claims association created in subsection (1).

(b) "Board" means the board of directors of the association created in subsection (9).

(c) "Car" includes a motorcycle but does not include a historic vehicle.

(d) "Consumer Price Index" means the percentage of change in the Consumer Price Index for all urban consumers in the United States city average for all items for the 24 months before October 1 of the year before the July 1 effective date of the biennial adjustment under subsection (2)(o) as reported by the United States Department of Labor, Bureau of Labor Statistics, and as certified by the director.

(e) "Historic vehicle" means a vehicle that is a registered historic vehicle under section 803a or 803p of the Michigan vehicle code, 1949 PA 300, MCL 257.803a and 257.803p.

(f) "Motor vehicle accident policy" means a policy providing the coverages required under section 3101(1).

(g) "Ultimate loss" means the actual loss amounts that a member is obligated to pay and that are paid or payable by the member, and do not include claim expenses. An ultimate loss is incurred by the association on the date that the loss occurs.

Sec. 3107. (1) Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses do not include either of the following:

(i) Charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations, unless the injured person requires special or intensive care.

(ii) Funeral and burial expenses in excess of the amount set forth in the policy, which must not be less than \$1,750.00 or more than \$5,000.00.

(b) Work loss consisting of loss of income from work an injured person would have performed during the first 3 years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date on which the injured person dies. Because the benefits received from personal protection insurance for loss of income are not taxable income, the benefits payable for the loss of income must be reduced 15% unless the claimant presents to the insurer in support of his or her claim reasonable proof of a lower value of the income tax advantage in his or her case, in which case the lower value must be applied. For the period beginning October 1, 2012 through September 30, 2013, the benefits payable for work loss sustained in a single 30-day period and the income earned by an injured person for work during the same period together must not exceed \$5,189.00, which maximum must be applied pro rata to any lesser period of work loss. Beginning October 1, 2013, the maximum must be adjusted annually to reflect changes in the cost of living under rules prescribed by the director, but any change in the maximum must be applied only to benefits arising out of accidents occurring after the date of change in the maximum.

(c) Expenses not exceeding \$20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first 3 years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.

(2) Both of the following apply to personal protection insurance benefits payable under subsection (1):

(a) A person who is 60 years of age or older and in the event of an accidental bodily injury would not be eligible to receive work loss benefits under subsection (1)(b) may waive coverage for work loss benefits by signing a waiver on a form provided by the insurer. An insurer shall offer a reduced premium rate to a person who waives coverage under this subdivision for work loss benefits. Waiver of coverage for work loss benefits applies only to work loss benefits payable to the person or persons who have signed the waiver form.

(b) An insurer is not required to provide coverage for the medical use of marihuana or for expenses related to the medical use of marihuana.

Sec. 3107c. (1) Except as provided in sections 3107d and 3109a, and subject to subsection (5), for an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured shall, in a way required under section 3107e and on a form approved by the director, select 1 of the following coverage levels for personal protection insurance benefits under section 3107(1)(a):

(a) A limit of \$50,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a). The selection of a limit under this subdivision is only available to an applicant or named insured if both of the following apply:

(i) The applicant or named insured is enrolled in Medicaid, as that term is defined in section 3157.

(ii) The applicant's or named insured's spouse and any relative of either who resides in the same household has qualified health coverage, as that term is defined in section 3107d, is enrolled in Medicaid, or has coverage for the payment of benefits under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(b) A limit of \$250,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(c) A limit of \$500,000.00 per individual per loss occurrence for any personal protection insurance benefits under section 3107(1)(a).

(d) No limit for personal protection insurance benefits under section 3107(1)(a).

(2) The form required under subsection (1) must do all of the following:

(a) State, in a conspicuous manner, the benefits and risks associated with each coverage option.

(b) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands the options available.

(c) Allow the applicant or named insured to mark the form to make the selection of coverage level under subsection (1).

(d) Require the applicant or named insured to sign the form.

(3) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective selection under subsection (1) but a premium or premium installment has been paid, there is a rebuttable presumption that the amount of the premium or installment paid accurately reflects the level of coverage applicable to the policy under subsection (1).

(4) If an insurance policy is issued or renewed as described in subsection (1), the applicant or named insured has not made an effective selection under subsection (1), and a presumption under subsection (3) does not apply, subsection (1)(d) applies to the policy.

(5) The coverage level selected under subsection (1) applies to the named insured, the named insured's spouse, and a relative of either domiciled in the same household, and any other person with a right to claim personal protection insurance benefits under the policy.

(6) If benefits are payable under section 3107(1)(a) under 2 or more insurance policies, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any 1 of the policies.

(7) This section applies for a transportation network company vehicle, but an applicant or named insured that is a transportation network company shall only select limits under either subsection (1)(b), (c), or (d). As used in this subsection:

(a) "Transportation network company" means that term as defined in section 2 of the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2102.

(b) "Transportation network company vehicle" means that term as defined in section 3114.

(8) This section also applies to security required under section 3101(1) that is provided by a rental car company certified by the director as a self-insurer under section 3101d. The director shall provide a form for the rental car company to provide to allow a customer to make the selection of a coverage level under subsection (1)(b), (c), or (d).

(9) An insurer shall offer, for a policy that provides the security required under section 3101(1) to which a limit under subsection (1)(a) to (c) applies, a rider that will provide coverage for attendant care in excess of the applicable limit.

Sec. 3107d. (1) For an insurance policy that provides the security required under section 3101(1) and is issued or renewed after July 1, 2020, the applicant or named insured may, in a way required under section 3107e and on a form approved by the director, elect to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a) if the applicant or named insured is a qualified person, and if the applicant's or named insured's spouse and any relative of either that resides in the same household have qualified health coverage or have coverage for benefits payable under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).

(2) An applicant or named insured shall, when requesting issuance or renewal of a policy under subsection (1), provide to the insurer a document from the person that provides the qualified health coverage stating the names of all persons covered under the qualified health coverage.

(3) The form required under subsection (1) must do all of the following:

(a) Require the applicant or named insured to mark the form to certify whether all persons required to be qualified persons under subsection (1) are qualified persons.

(b) Disclose in a conspicuous manner that qualified persons are not obligated to but may purchase coverage for personal protection insurance coverage benefits payable under section 3107(1)(a).

(c) State, in a conspicuous manner, the coverage levels available under section 3107c.

(d) State, in a conspicuous manner, the benefits and risks associated with not maintaining the coverage.

(e) State, in a conspicuous manner, that if during the term of the policy the qualified health coverage ceases, the person has 30 days after the effective date of the termination of qualified health coverage to obtain insurance that provides coverage under section 3107(1)(a) or the person will be excluded from all personal protection insurance coverage benefits under section 3107(1)(a) during the period in which coverage under this section was not maintained.

(f) Provide a way for the applicant or named insured to mark the form to acknowledge that he or she has read the form and understands it and that he or she understands the options available to him or her.

(g) If all persons required to be qualified persons under subsection (1) are qualified persons, provide the person a way to mark the form to elect to not maintain the coverage.

(h) Require the applicant or named insured to sign the form.

(4) If an insurance policy is issued or renewed as described in subsection (1) and the applicant or named insured has not made an effective election under subsection (1), the policy is considered to provide personal protection benefits under section 3107c(1)(d).

(5) An election under this section applies to the applicant or named insured, the applicant or named insured's spouse, a relative of either domiciled in the same household, and any other person who would have had a right to claim personal protection insurance benefits under the policy but for the election.

(6) If, during the term of an insurance policy under which coverage for personal protection insurance benefits payable under section 3107(1)(a) are not maintained under this section, the persons required to have qualified health coverage under subsection (1) cease to have qualified health coverage, all of the following apply under this subsection:

(a) Within 30 days after the effective date of the termination of qualified health coverage, the named insured shall obtain insurance that includes coverage under section 3107(1)(a).

(b) An insurer that issues policies that provide the security required by section 3101(1) shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee to, or increase the insurance premiums for a person who is an eligible person, as that term is defined in section 2103, solely because the person previously failed to obtain insurance that provides coverage for benefits under section 3107(1)(a) in the time required under subdivision (a).

(c) If the applicant or named insured does not obtain insurance as required under subdivision (a) and a person to whom the election under this section applies as described in subsection (6) suffers accidental bodily injury arising from a motor vehicle accident, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury but is entitled to claim benefits under the assigned claims plan.

(8) As used in this section:

(a) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(b) "Qualified health coverage" means either of the following:

(i) Other health or accident coverage to which both of the following apply:

(A) The coverage does not exclude or limit coverage for injuries related to motor vehicle accidents.

(B) Any annual deductible for the coverage is \$6,000.00 or less per individual. The director shall adjust the amount in this sub-subparagraph on July 1 of each year by the percentage change in the medical component of the Consumer Price Index for the preceding calendar year. However, the director shall not make the adjustment unless the adjustment, or the total of the adjustment and previous unadded adjustments, is \$500.00 or more.

(ii) Coverage under parts A and B of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll.

(c) "Qualified person" means a person who has qualified health coverage under subdivision (b)(i).

Sec. 3107e. (1) A form under section 3009, 3107c, or 3107d must be delivered to the applicant or named insured using 1 of the following methods:

- (a) Personal delivery.
- (b) First-class mail, postage prepaid.
- (c) Electronic means in accordance with section 2266.

(2) A person must make a selection under section 3009 or 3107c, or an election under section 3107d in 1 of the following ways:

- (a) Marking and signing a paper form.
- (b) Giving verbal instructions, in person or telephonically, that the form be marked and signed on behalf of the person. To be an effective selection or election, the verbal instructions must be recorded and the recording maintained by the person to whom the instructions were given. If there is a dispute over the effectiveness of a selection or election under this subdivision, there is a presumption that the selection or election was not effective and the insurer has the burden of rebutting the presumption with the recording.
- (c) Electronically marking the form and providing an electronic signature as provided in the uniform electronic transactions act, 2000 PA 305, MCL 450.831 to 450.849.

Sec. 3109a. (1) An insurer that provides personal protection insurance benefits under this chapter may offer deductibles and exclusions reasonably related to other health and accident coverage on the insured. Any deductibles and exclusions offered under this section must be offered at a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both, are subject to prior approval by the director, and must apply only to benefits payable to the person named in the policy, the spouse of the insured, and any relative of either domiciled in the same household.

(2) An insurer shall offer to an applicant or named insured that selects a personal protection benefit limit under section 3107c(1)(b) an exclusion related to other health or accident coverage. All of the following apply to that exclusion:

(a) If the named insured, his or her spouse, and all relatives domiciled in the same household have accident and health coverage that will cover injuries that occur as the result of a motor vehicle accident, the premium for the personal protection insurance benefits payable under section 3107(1)(a) under the policy must be reduced by 100%.

(b) If a member, but not all members, of the household covered by the insurance policy has health or accident coverage that will cover injuries that occur as the result of a motor vehicle accident, the insurer shall offer a reduced premium that reflects reasonably anticipated reductions in losses, expenses, or both. The reduction must be in addition to the rate rollback required by section 2111f and the share of the premium reduction for the policy attributable to any person with accident and health coverage must be 100%.

(c) Subject to subdivision (d), a person subject to an exclusion under this subsection is not eligible for personal protection benefits under the insurance policy.

(d) If a person subject to an exclusion under this subsection is no longer covered by the health coverage, the named insured shall notify the insurer that the named insured or resident relative is no longer eligible for an exclusion. All of the following apply under this subdivision:

(i) The named insured shall, within 30 days after the effective date of the termination of the health coverage, obtain insurance that provides the security required under section 3101(1) that includes coverage that was excluded under this subsection.

(ii) During the period described in subparagraph (i), if any person excluded suffers accidental bodily injury arising from a motor vehicle accident, the person is entitled to claim benefits under the assigned claims plan.

(e) If the named insured does not obtain insurance that provides the security required under section 3101(1) that includes the coverage excluded under this subsection during the period described in subdivision (d)(i) and the named insured or any person excluded under the policy suffers accidental bodily injury arising from a motor vehicle accident, unless the injured person is entitled to coverage under some other policy, the injured person is not entitled to be paid personal protection insurance benefits under section 3107(1)(a) for the injury that occurred during the period in which coverage under this section was excluded.

(3) An automobile insurer shall not refuse to prospectively insure, limit coverage available to, charge a reinstatement fee for, or increase the premiums for automobile insurance for an eligible person solely because the person previously failed to obtain insurance that provides the security required under section 3101(1) in the time period provided under subsection (2)(d)(i).

(4) The amount of a premium reduction under subsection (1) must appear in a conspicuous manner in the declarations for the policy, and be expressed as a dollar amount or a percentage.

Sec. 3111. Personal protection insurance benefits are payable for accidental bodily injury suffered in an accident occurring out of this state, if the accident occurs within the United States, its territories and possessions, or Canada, and the person whose injury is the basis of the claim was at the time of the accident a named insured under a personal protection insurance policy, the spouse of a named insured, a relative of either domiciled in the same household, or an occupant of a vehicle involved in the accident, if the occupant was a resident of this state or if the owner or registrant of the vehicle was insured under a personal protection insurance policy or provided security approved by the secretary of state under section 3101(4).

Sec. 3112. Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his or her death, to or for the benefit of his or her dependents. 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 sections 3171 to 3175, to recover overdue benefits payable for charges for products, services, or accommodations provided to an injured person. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled to the benefits, the insurer, the claimant, or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:

(a) To the dependents of the injured person, the personal protection insurance benefits accrued before his or her death without appointment of an administrator or executor.

(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

Sec. 3113. A person is not entitled to be paid personal protection insurance benefits for accidental bodily injury if at the time of the accident any of the following circumstances existed:

(a) The person was willingly operating or willingly using a motor vehicle or motorcycle that was taken unlawfully, and the person knew or should have known that the motor vehicle or motorcycle was taken unlawfully.

(b) The person was the owner or registrant of a motor vehicle or motorcycle involved in the accident with respect to which the security required by section 3101 or 3103 was not in effect.

(c) The person was not a resident of this state, unless the person owned a motor vehicle that was registered and insured in this state.

(d) The person was operating a motor vehicle or motorcycle as to which he or she was named as an excluded operator as allowed under section 3009(2).

(e) The person was the owner or operator of a motor vehicle for which coverage was excluded under a policy exclusion authorized under section 3017.

Sec. 3114. (1) Except as provided in subsections (2), (3), and (5), a personal protection insurance policy described in section 3101(1) applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, if the injury arises from a motor vehicle accident. A personal injury insurance policy described in section 3103(2) applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, if the injury arises from a motorcycle accident. If personal protection insurance benefits or personal injury benefits described in section 3103(2) are payable to or for the benefit of an injured person under his or her own policy and would also be payable under the policy of his or her spouse, relative, or relative's spouse, the injured person's insurer shall pay all of the benefits up to the coverage level applicable under section 3107c to the injured person's policy, and is not entitled to recoupment from the other insurer.

(2) A person who suffers accidental bodily injury while an operator or a passenger of a motor vehicle operated in the business of transporting passengers shall receive the personal protection insurance benefits to which the person is entitled from the insurer of the motor vehicle. This subsection does not apply to a passenger in any of the following, unless the passenger is not entitled to personal protection insurance benefits under any other policy:

(a) A school bus, as defined by the department of education, providing transportation not prohibited by law.

(b) A bus operated by a common carrier of passengers certified by the department of transportation.

(c) A bus operating under a government sponsored transportation program.

(d) A bus operated by or providing service to a nonprofit organization.

- (e) A taxicab insured as prescribed in section 3101 or 3102.
- (f) A bus operated by a canoe or other watercraft, bicycle, or horse livery used only to transport passengers to or from a destination point.
- (g) A transportation network company vehicle.
- (h) A motor vehicle insured under a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d or as to which an exclusion under section 3109a(2) applies.

(3) An employee, his or her spouse, or a relative of either domiciled in the same household, who suffers accidental bodily injury while an occupant of a motor vehicle owned or registered by the employer, shall receive personal protection insurance benefits to which the employee is entitled from the insurer of the furnished vehicle.

(4) Except as provided in subsections (2) and (3), a person who suffers accidental bodily injury arising from a motor vehicle accident while an occupant of a motor vehicle who is not covered under a personal protection insurance policy as provided in subsection (1) shall claim personal protection insurance benefits under the assigned claims plan under sections 3171 to 3175. This subsection does not apply to a person insured under a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d or as to which an exclusion under section 3109(2) applies, or who is not entitled to be paid personal protection benefits under section 3107d(6)(c) or 3109a(2)(d)(ii).

(5) Subject to subsections (6) and (7), a person who suffers accidental bodily injury arising from a motor vehicle accident that shows evidence of the involvement of a motor vehicle while an operator or passenger of a motorcycle shall claim personal protection insurance benefits from insurers in the following order of priority:

- (a) The insurer of the owner or registrant of the motor vehicle involved in the accident.
- (b) The insurer of the operator of the motor vehicle involved in the accident.
- (c) The motor vehicle insurer of the operator of the motorcycle involved in the accident.
- (d) The motor vehicle insurer of the owner or registrant of the motorcycle involved in the accident.

(6) If an applicable insurance policy in an order of priority under subsection (5) is a policy for which the person named in the policy has elected to not maintain coverage for personal protection insurance benefits under section 3107d, or as to which an exclusion under section 3109(2) applies, the injured person shall claim benefits only under other policies, subject to subsection (7), in the same order of priority for which no such election has been made. If there are no other policies for which no such election has been made, the injured person shall claim benefits under the next order of priority or, if there is not a next order of priority, under the assigned claims plan under sections 3171 to 3175.

(7) If personal protection insurance benefits are payable under subsection (5) under 2 or more insurance policies in the same order of priority, the benefits are only payable up to an aggregate coverage limit that equals the highest available coverage limit under any 1 of the policies.

(8) Subject to subsections (6) and (7), if 2 or more insurers are in the same order of priority to provide personal protection insurance benefits under subsection (5), an insurer that pays benefits due is entitled to partial recoupment from the other insurers in the same order of priority, and a reasonable amount of partial recoupment of the expense of processing the claim, in order to accomplish equitable distribution of the loss among all of the insurers.

(9) As used in this section:

(a) "Personal vehicle", "transportation network company digital network", and "transportation network company prearranged ride" mean those terms as defined in section 2 of the limousine, taxicab, and transportation network company act, 2016 PA 345, MCL 257.2102.

(b) "Transportation network company vehicle" means a personal vehicle while the driver is logged on to the transportation network company digital network or while the driver is engaged in a transportation network company prearranged ride.

Sec. 3115. Except as provided in section 3114(1), a person who suffers accidental bodily injury while not an occupant of a motor vehicle shall claim personal protection insurance benefits under the assigned claims plan under sections 3171 to 3175.

Sec. 3135. (1) A person remains subject to tort liability for noneconomic loss caused by his or her ownership, maintenance, or use of a motor vehicle only if the injured person has suffered death, serious impairment of body function, or permanent serious disfigurement.

(2) For a cause of action for damages under subsection (1) or (3)(d), all of the following apply:

(a) The issues of whether the injured person has suffered serious impairment of body function or permanent serious disfigurement are questions of law for the court if the court finds either of the following:

(i) There is no factual dispute concerning the nature and extent of the person's injuries.

(i) There is a factual dispute concerning the nature and extent of the person's injuries, but the dispute is not material to the determination whether the person has suffered a serious impairment of body function or permanent serious disfigurement. However, for a closed-head injury, a question of fact for the jury is created if a licensed allopathic or osteopathic physician who regularly diagnoses or treats closed-head injuries testifies under oath that there may be a serious neurological injury.

(b) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(c) Damages must not be assessed in favor of a party who was operating his or her own vehicle at the time the injury occurred and did not have in effect for that motor vehicle the security required by section 3101(1) at the time the injury occurred.

(3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:

(a) Intentionally caused harm to persons or property. Even though a person knows that harm to persons or property is substantially certain to be caused by his or her act or omission, the person does not cause or suffer that harm intentionally if he or she acts or refrains from acting for the purpose of averting injury to any person, including himself or herself, or for the purpose of averting damage to tangible property.

(b) Damages for noneconomic loss as provided and limited in subsections (1) and (2).

(c) 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 exclusion under section 3109a(2) applies. The party liable for damages is entitled to an exemption reducing his or her liability by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

(d) Damages for economic loss by a nonresident. However, to recover under this subdivision, the nonresident must have suffered death, serious impairment of body function, or permanent serious disfigurement.

(e) Damages up to \$3,000.00 to a motor vehicle, to the extent that the damages are not covered by insurance. An action for damages under this subdivision must be conducted as provided in subsection (4).

(4) All of the following apply to an action for damages under subsection (3)(e):

(a) Damages must be assessed on the basis of comparative fault, except that damages must not be assessed in favor of a party who is more than 50% at fault.

(b) Liability is not a component of residual liability, as prescribed in section 3131, for which maintenance of security is required by this act.

(c) The action must be commenced, whenever legally possible, in the small claims division of the district court or the municipal court. If the defendant or plaintiff removes the action to a higher court and does not prevail, the judge may assess costs.

(d) A decision of the court is not res judicata in any proceeding to determine any other liability arising from the same circumstances that gave rise to the action.

(e) Damages must not be assessed if the damaged motor vehicle was being operated at the time of the damage without the security required by section 3101(1).

(5) As used in this section, "serious impairment of body function" means an impairment that satisfies all of the following requirements:

(a) It is objectively manifested, meaning it is observable or perceivable from actual symptoms or conditions by someone other than the injured person.

(b) It is an impairment of an important body function, which is a body function of great value, significance, or consequence to the injured person.

(c) It affects the injured person's general ability to lead his or her normal life, meaning it has had an influence on some of the person's capacity to live in his or her normal manner of living. Although temporal considerations may be relevant, there is no temporal requirement for how long an impairment must last. This examination is inherently fact and circumstance specific to each injured person, must be conducted on a case-by-case basis, and requires comparison of the injured person's life before and after the incident.

Sec. 3142. (1) Personal protection insurance benefits are payable as loss accrues.

(2) Subject to subsection (3), personal protection insurance benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained. Subject to subsection (3), if reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within

30 days after the proof is received by the insurer. Subject to subsection (3), any part of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within 30 days after the proof is received by the insurer. For the purpose of calculating the extent to which benefits are overdue, payment must be treated as made on the date a draft or other valid instrument was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(3) For personal protection insurance benefits under section 3107(1)(a), if a bill for the product, service, accommodations, or training is not provided to the insurer within 90 days after the product, service, accommodations, or training is provided, the insurer has 60 days in addition to 30 days provided under subsection (2) to pay before the benefits are overdue.

(4) An overdue payment bears simple interest at the rate of 12% per annum.

Sec. 3145. (1) An action for recovery of personal protection insurance benefits payable under this chapter for an accidental bodily injury may not be commenced later than 1 year after the date of the accident that caused the injury unless written notice of injury as provided in subsection (4) has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.

(2) Subject to subsection (3), if the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss, or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

(3) A period of limitations applicable under subsection (2) to the commencement of an action and the recovery of benefits is tolled from the date of a specific claim for payment of the benefits until the date the insurer formally denies the claim. This subsection does not apply if the person claiming the benefits fails to pursue the claim with reasonable diligence.

(4) The notice of injury required by subsection (1) may be given to the insurer or any of its authorized agents by a person claiming to be entitled to benefits for the injury, or by someone in the person's behalf. The notice must give the name and address of the claimant and indicate in ordinary language the name of the person injured and the time, place, and nature of the person's injury.

(5) An action for recovery of property protection insurance benefits may not be commenced later than 1 year after the accident.

Sec. 3148. (1) Subject to subsections (4) and (5), an attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits that are overdue. The attorney's fee is a charge against the insurer in addition to the benefits recovered, if the court finds that the insurer unreasonably refused to pay the claim or unreasonably delayed in making proper payment. 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.

(b) A payment for the claim is overdue under this chapter.

(2) A court may award an insurer a reasonable amount against a claimant as an attorney fee for the insurer's attorney in defending against a claim that was in some respect fraudulent or so excessive as to have no reasonable foundation. 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.

(3) To the extent that personal or property protection insurance benefits are then due or thereafter come due to the claimant because of loss resulting from the injury on which the claim is based, an attorney fee awarded in favor of the insurer may be taken as an offset against the benefits. Judgment may also be entered against the claimant for any amount of an attorney fee awarded that is not offset against benefits or otherwise paid.

(4) For a dispute over payment for allowable expenses under section 3107(1)(a) for attendant care or nursing services, attorney fees must not be awarded in relation to future payments ordered more than 3 years after the trial court judgment or order is entered. If attendant care or nursing services are subsequently suspended or terminated, attorney fees on future payments may be again awarded for not more than 3 years after a new trial court judgment or order is entered.

(5) A court shall not award a fee to an attorney for advising or representing an injured person in an action for personal or property protection insurance benefits for a treatment, product, service, rehabilitative occupational training, or accommodation provided to the injured person if the attorney or a related person of the attorney has, or had at the time the treatment, product, service, rehabilitative occupational training, or accommodation was provided, a direct or indirect financial interest in the person that provided the treatment, product, service, rehabilitative occupational training, or accommodation. For purposes of this subsection, circumstances in which an attorney has a direct or indirect

financial interest include, but are 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.

Sec. 3151. (1) If the mental or physical condition of a person is material to a claim that has been or may be made for past or future personal protection insurance benefits, at the request of an insurer the person shall submit to mental or physical examination by physicians. A personal protection insurer may include reasonable provisions that are in accord with this section in a personal protection insurance policy for mental and physical examination of persons claiming personal protection insurance benefits.

(2) A physician who conducts a mental or physical examination under this section must be licensed as a physician in this state or another state and meet the following criteria, as applicable:

(a) The examining physician is a licensed, board certified, or board eligible physician qualified to practice in the area of medicine appropriate to treat the person's condition.

(b) During the year immediately preceding the examination, the examining physician must have devoted a majority of his or her professional time to either or both of the following:

(i) The active clinical practice of medicine and, if subdivision (a) applies, the active clinical practice relevant to the specialty.

(ii) The instruction of students in an accredited medical school or in an accredited residency or clinical research program for physicians and, if subdivision (a) applies, the instruction of students is in the specialty.

Sec. 3157. (1) Subject to subsections (2) to (14), a physician, hospital, clinic, or other person that lawfully renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, or a person that provides rehabilitative occupational training following the injury, may charge a reasonable amount for the treatment or training. The charge must not exceed the amount the person customarily charges for like treatment or training in cases that do not involve insurance.

(2) Subject to subsections (3) to (14), 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 for payment or reimbursement under this chapter for more than the following:

(a) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 200% of the amount payable to the person for the treatment or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 195% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 190% of the amount payable to the person for the treatment or training under Medicare.

(3) Subject to subsections (5) to (14), a physician, hospital, clinic, or other person identified in subsection (4) that renders treatment or rehabilitative occupational training to an injured person for an accidental bodily injury covered by personal protection insurance is eligible for payment or reimbursement under this chapter of not more than the following:

(a) 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 or training under Medicare.

(b) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 225% of the amount payable to the person for the treatment or training under Medicare.

(c) For treatment or training rendered after July 1, 2023, 220% of the amount payable to the person for the treatment or training under Medicare.

(4) Subject to subsection (5), subsection (3) only applies to a physician, hospital, clinic, or other person if either of the following applies to the person rendering the treatment or training:

(a) On July 1 of the year in which the person renders the treatment or training, the person has 20% or more, but less than 30%, indigent volume determined pursuant to the methodology used by the department of health and human services in determining inpatient medical/surgical factors used in measuring eligibility for Medicaid disproportionate share payments.

(b) The person is a freestanding rehabilitation facility. Each year the director shall designate not more than 2 freestanding rehabilitation facilities to qualify for payments under subsection (3) for that year. As used in this subdivision, "freestanding rehabilitation facility" means an acute care hospital to which all of the following apply:

(i) The hospital has staff with specialized and demonstrated rehabilitation medicine expertise.

- (ii) The hospital possesses sophisticated technology and specialized facilities.
- (iii) The hospital participates in rehabilitation research and clinical education.
- (iv) The hospital assists patients to achieve excellent rehabilitation outcomes.
- (v) The hospital coordinates necessary post-discharge services.
- (vi) The hospital is accredited by 1 or more third-party, independent organizations focused on quality.
- (vii) The hospital serves the rehabilitation needs of catastrophically injured patients in this state.
- (viii) The hospital was in existence on May 1, 2019.

(5) To qualify for a payment under subsection (4)(a), a physician, hospital, clinic, or other person shall provide the director with all documents and information requested by the director that the director determines are necessary to allow the director to determine whether the person qualifies. The director shall annually review documents and information provided under this subsection and, if the person qualifies under subsection (4)(a), shall certify the person as qualifying and provide a list of qualifying persons to insurers and other persons that provide the security required under section 3101(1). A physician, hospital, clinic, or other person that provides 30% or more of its total treatment or training as described under subsection (4)(a) is entitled to receive, instead of an applicable percentage under subsection (3), 250% of the amount payable to the person for the treatment or training under Medicare.

(6) Subject to subsections (7) to (14), a hospital that is a level I or level II trauma center that renders treatment to an injured person for an accidental bodily injury covered by personal protection insurance, if the treatment is for an emergency medical condition and rendered before the patient is stabilized and transferred, is not eligible for payment or reimbursement under this chapter of more than the following:

- (a) 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.
- (b) 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.
- (c) For treatment rendered after July 1, 2023, 230% of the amount payable to the hospital for the treatment under Medicare.

(7) If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under subsection (2), (3), (5), or (6), the physician, hospital, clinic, or other person that renders the treatment or training is not eligible for payment or reimbursement under this chapter of more than the following, as applicable:

(a) For a person to which subsection (2) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

- (i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 55%.
- (ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 54%.
- (iii) For treatment or training rendered after July 1, 2023, 52.5%.

(b) For a person to which subsection (3) applies, the applicable following percentage of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment or training on January 1, 2019:

- (i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 70%.
- (ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 68%.
- (iii) For treatment or training rendered after July 1, 2023, 66.5%.

(c) For a person to which subsection (5) applies, 78% of the amount payable for the treatment or training under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, 78% of the average amount the person charged for the treatment on January 1, 2019.

(d) For a person to which subsection (6) applies, the applicable following percentage of the amount payable for the treatment under the person's charge description master in effect on January 1, 2019 or, if the person did not have a charge description master on that date, the applicable following percentage of the average amount the person charged for the treatment on January 1, 2019:

- (i) For treatment or training rendered after July 1, 2021 and before July 2, 2022, 75%.
- (ii) For treatment or training rendered after July 1, 2022 and before July 2, 2023, 73%.
- (iii) For treatment or training rendered after July 1, 2023, 71%.

(8) For any change to an amount payable under Medicare as provided in subsection (2), (3), (5), or (6) that occurs after the effective date of the amendatory act that added this subsection, the change must be applied to the amount

allowed for payment or reimbursement under that subsection. However, an amount allowed for payment or reimbursement under subsection (2), (3), (5), or (6) must not exceed the average amount charged by the physician, hospital, clinic, or other person for the treatment or training on January 1, 2019.

(9) An amount that is to be applied under subsection (7) or (8), that was in effect on January 1, 2019, including any prior adjustments to the amount made under this subsection, must be adjusted annually by the percentage change in the medical care component of the Consumer Price Index for the year preceding the adjustment.

(10) For attendant care rendered in the injured person's home, an insurer is only required to pay benefits for attendant care up to the hourly limitation in section 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.315. This subsection only applies if the attendant care is provided directly, or indirectly through another person, by any of the following:

- (a) An individual who is related to the injured person.
- (b) An individual who is domiciled in the household of the injured person.
- (c) An individual with whom the injured person had a business or social relationship before the injury.

(11) An insurer may contract to pay benefits for attendant care for more than the hourly limitation under subsection (10).

(12) A neurological rehabilitation clinic is not entitled to payment or reimbursement for a treatment, training, product, service, or accommodation unless the neurological rehabilitation clinic 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. This subsection does not apply to a neurological rehabilitation clinic that is in the process of becoming accredited as required under this subsection on July 1, 2021, unless 3 years have passed since the beginning of that process and the neurological rehabilitation clinic is still not accredited.

(13) Subsections (2) to (12) do not apply to emergency medical services rendered by an ambulance operation. As used in this subsection:

(a) "Ambulance operation" means that term as defined in section 20902 of the public health code, 1978 PA 368, MCL 333.20902.

(b) "Emergency medical services" means that term as defined in section 20904 of the public health code, 1978 PA 368, MCL 333.20904.

(14) Subsections (2) to (13) apply to treatment or rehabilitative occupational training rendered after July 1, 2021.

(15) As used in this section:

(a) "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.

(b) "Consumer Price Index" means the most comprehensive index of consumer prices available for this state from the United States Department of Labor, Bureau of Labor Statistics.

(c) "Emergency medical condition" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(d) "Level I or level II trauma center" means a hospital that is verified as a level I or level II trauma center by the American College of Surgeons Committee on Trauma.

(e) "Medicaid" means a program for medical assistance established under subchapter XIX of the social security act, 42 USC 1396 to 1396w-5.

(f) "Medicare" means fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395fff, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration.

(g) "Neurological rehabilitation clinic" means a person that provides post-acute brain and spinal rehabilitation care.

(h) "Person", as provided in section 114, includes, but is not limited to, an institution.

(i) "Stabilized" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(j) "Transfer" means that term as defined in section 1395dd of the social security act, 42 USC 1395dd.

(k) "Treatment" includes, but is not limited to, products, services, and accommodations.

Sec. 3157a. (1) By rendering any treatment, products, services, or accommodations to 1 or more injured persons for an accidental bodily injury covered by personal protection insurance under this chapter after July 1, 2020, a physician, hospital, clinic, or other person is considered to have agreed to do both of the following:

(a) Submit necessary records and other information concerning treatment, products, services, or accommodations provided for utilization review under this section.

(b) Comply with any decision of the department under this section.

(2) A physician, hospital, clinic, or other person or institution that knowingly submits under this section false or misleading records or other information to an insurer, the association created under section 3104, or the department commits a fraudulent insurance act under section 4503.

(3) The department shall promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to do both of the following:

(a) Establish criteria or standards for utilization review that identify utilization of treatment, products, services, or accommodations under this chapter above the usual range of utilization for the treatment, products, services, or accommodations based on medically accepted standards.

(b) Provide procedures related to utilization review, including procedures for all of the following:

(i) Acquiring necessary records, medical bills, and other information concerning the treatment, products, services, or accommodations provided.

(ii) Allowing an insurer to request an explanation for and requiring a physician, hospital, clinic, or other person to explain the necessity or indication for treatment, products, services, or accommodations provided.

(iii) Appealing determinations.

(4) If a physician, hospital, clinic, or other person provides treatment, products, services, or accommodations under this chapter 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 for the diagnosis or condition for which the patient is being treated, the insurer or the association created under section 3104 may require the physician, hospital, clinic, or other person to explain the necessity or indication for the treatment, products, services, or accommodations in writing under the procedures provided under subsection (3).

(5) If an insurer or the association created under section 3104 determines that a physician, hospital, clinic, or other person overutilized or otherwise rendered or ordered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under this chapter, the physician, hospital, clinic, or other person may appeal the determination to the department under the procedures provided under subsection (3).

(6) As used in this section, "utilization review" means 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.

Sec. 3157b. Any proprietary information or sensitive personally identifiable information regarding a patient that is submitted to the department under section 3157a is exempt from disclosure under section 13(d) of the freedom of information act, 1976 PA 442, MCL 15.243, and the department shall exempt any such information from disclosure under any other applicable exemptions under section 13 of the freedom of information act, 1976 PA 442, MCL 15.243.

Sec. 3163. An insurer authorized to transact automobile liability insurance and personal and property protection insurance in this state is not required to provide personal protection insurance or property protection insurance benefits under this chapter for accidental bodily injury or property damage occurring in this state arising from the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle by an out-of-state resident who is insured under the insurer's automobile liability insurance policies, unless the out-of-state resident is the owner of a motor vehicle that is registered and insured in this state.

Sec. 3172. (1) A person entitled to claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may claim personal protection insurance benefits through the assigned claims plan if any of the following apply:

(a) No personal protection insurance is applicable to the injury.

(b) No personal protection insurance applicable to the injury can be identified.

(c) No personal protection insurance applicable to the injury can be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss.

(d) The only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

(2) Unpaid benefits due or coming due as described in subsection (1) may be collected under the assigned claims plan, and the insurer to which the claim is assigned is entitled to reimbursement from the defaulting insurers to the extent of their financial responsibility.

(3) A person entitled to claim personal protection insurance benefits through the assigned claims plan under subsection (1) shall file a completed application on a claim form provided by the Michigan automobile insurance placement facility and provide reasonable proof of loss to the Michigan automobile insurance placement facility. The Michigan automobile insurance placement facility or an insurer assigned to administer a claim on behalf of the Michigan automobile

insurance placement facility under the assigned claims plan shall specify in writing the materials that constitute a reasonable proof of loss within 60 days after receipt by the Michigan automobile insurance placement facility of an application that complies with this subsection.

(4) The Michigan automobile insurance placement facility or an insurer assigned to administer a claim on behalf of the Michigan automobile insurance placement facility under the assigned claims plan is not required to pay interest in connection with a claim for any period of time during which the claim is reasonably in dispute.

(5) Except as otherwise provided in this subsection, personal protection insurance benefits, including benefits arising from accidents occurring before March 29, 1985, payable through the assigned claims plan must be reduced to the extent that benefits covering the same loss are available from other sources, regardless of the nature or number of benefit sources available and regardless of the nature or form of the benefits, to a person claiming personal protection insurance benefits through the assigned claims plan. This subsection only applies if the personal protection insurance benefits are payable through the assigned claims plan under subsection (1)(a), (b), or (d). As used in this subsection, "sources" and "benefit sources" do not include the program for medical assistance for the medically indigent under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, or health insurance for the aged and disabled under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll.

(6) If the obligation to provide personal protection insurance benefits cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss, and if a method of voluntary payment of benefits cannot be agreed upon among or between the disputing insurers, all of the following apply:

(a) The insurers who are parties to the dispute shall, or the claimant may, immediately notify the Michigan automobile insurance placement facility of their inability to determine their statutory obligations.

(b) The Michigan automobile insurance placement facility shall assign the claim to an insurer and the insurer shall immediately provide personal protection insurance benefits to the claimant or claimants entitled to benefits.

(c) The insurer assigned the claim by the Michigan automobile insurance placement facility shall immediately commence an action on behalf of the Michigan automobile insurance placement facility in circuit court to declare the rights and duties of any interested party.

(d) The insurer to whom the claim is assigned shall join as parties defendant to the action commenced under subdivision (c) each insurer disputing either the obligation to provide personal protection insurance benefits or the equitable distribution of the loss among the insurers.

(e) The circuit court shall declare the rights and duties of any interested party whether or not other relief is sought or could be granted.

(f) After hearing the action, the circuit court shall determine the insurer or insurers, if any, obligated to provide the applicable personal protection insurance benefits and the equitable distribution, if any, among the insurers obligated, and shall order reimbursement to the Michigan automobile insurance placement facility from the insurer or insurers to the extent of the responsibility as determined by the court. The reimbursement ordered under this subdivision must include all benefits and costs paid or incurred by the Michigan automobile insurance placement facility and all benefits and costs paid or incurred by insurers determined not to be obligated to provide applicable personal protection insurance benefits, including incurred attorney fees and interest at the rate prescribed in section 3175 applicable on December 31 of the year preceding the determination of the circuit court.

(7) The Michigan automobile insurance placement facility and the insurer to whom a claim is assigned by the Michigan automobile insurance placement facility are only required to provide personal protection insurance benefits under section 3107(1)(a) up to whichever of the following is applicable:

(a) Unless subdivision (b) applies, the limit provided in section 3107c(1)(b).

(b) If the person is entitled to claim benefits under the assigned claims plan under section 3107d(6)(c) or 3109a(2)(d)(ii), \$2,000,000.00.

Sec. 3173a. (1) The Michigan automobile insurance placement facility shall review a claim for personal protection insurance benefits under the assigned claims plan, shall make an initial determination of the eligibility for benefits under this chapter and the assigned claims plan, and shall deny a claim that the Michigan automobile insurance placement facility determines is ineligible under this chapter or the assigned claims plan. If a claimant or person making a claim through or on behalf of a claimant fails to cooperate with the Michigan automobile insurance placement facility as required by subsection (2), the Michigan automobile insurance placement facility shall suspend benefits to the claimant under the assigned claims plan. A suspension under this subsection is not an irrevocable denial of benefits, and must continue only until the Michigan automobile insurance placement facility determines that the claimant or person making a claim through or on behalf of a claimant cooperates or resumes cooperation with the Michigan automobile insurance placement facility. The Michigan automobile insurance placement facility shall promptly notify in writing the claimant and any person that submitted a claim through or on behalf of a claimant of a denial and the reasons for the denial.

(2) A claimant or a person making a claim through or on behalf of a claimant shall cooperate with the Michigan automobile insurance placement facility in its determination of eligibility and the settlement or defense of any claim or

suit, including, but not limited to, submitting to an examination under oath and compliance with sections 3151 to 3153. There is a rebuttable presumption that a person has satisfied the duty to cooperate under this section if all of the following apply:

(a) The person submitted a claim for personal protection insurance benefits under the assigned claims plan by submitting to the Michigan automobile insurance placement facility a complete application on a form provided by the Michigan automobile insurance placement facility in accordance with the assigned claims plan.

(b) The person provided reasonable proof of loss under the assigned claims plan as described in section 3172.

(c) If required under this subsection to submit to an examination under oath, the person submitted to the examination, subject to all of the following:

(i) The person was provided at least 21 days' notice of the examination.

(ii) The examination was conducted in a location reasonably convenient for the person.

(iii) Any reasonable request by the person to reschedule the date, time, or location of the examination was accommodated.

(3) The Michigan automobile insurance placement facility may perform its functions and responsibilities under this section and the assigned claims plan directly or through an insurer assigned by the Michigan automobile insurance placement facility to administer the claim on behalf of the Michigan automobile insurance placement facility. The assignment of a claim by the Michigan automobile insurance placement facility to an insurer is not a determination of eligibility under this chapter or the assigned claims plan, and a claim assigned to an insurer by the Michigan automobile insurance placement facility may later be denied if the claim is not eligible under this chapter or the assigned claims plan.

(4) A person who presents or causes to be presented an oral or written statement, including computer-generated information, as part of or in support of a claim to the Michigan automobile insurance placement facility, or to an insurer to which the claim is assigned under the assigned claims plan, for payment or another benefit knowing that the statement contains false information concerning a fact or thing material to the claim commits a fraudulent insurance act under section 4503 that is subject to the penalties imposed under section 4511. A claim that contains or is supported by a fraudulent insurance act as described in this subsection is ineligible for payment of personal protection insurance benefits under the assigned claims plan.

(5) The Michigan automobile insurance placement facility may contract with other persons for all or a portion of the goods and services necessary for operating and maintaining the assigned claims plan.

Sec. 3174. A person claiming through the assigned claims plan shall notify the Michigan automobile insurance placement facility of his or her claim within 1 year after the date of the accident. On an initial determination of a claimant's eligibility for benefits through the assigned claims plan, the Michigan automobile insurance placement facility shall promptly assign the claim in accordance with the plan and notify the claimant of the identity and address of the insurer to which the claim is assigned. An action by a claimant must be commenced as provided in section 3145.

Sec. 3175. (1) The assignment of claims under the assigned claims plan must be made according to procedures established in the assigned claims plan that assure fair allocation of the burden of assigned claims among insurers doing business in this state on a basis reasonably related to the volume of automobile liability and personal protection insurance they write on motor vehicles or the number of self-insured motor vehicles. An insurer to whom claims have been assigned shall make prompt payment of loss in accordance with this act. An insurer is entitled to reimbursement by the Michigan automobile insurance placement facility for the payments, the established loss adjustment cost, and an amount determined by use of the average annual 90-day United States treasury bill yield rate, as reported by the Council of Economic Advisers as of December 31 of the year for which reimbursement is sought, as follows:

(a) For the calendar year in which claims are paid by the insurer, the amount must be determined by applying the specified annual yield rate specified in this subsection to 1/2 of the total claims payments and loss adjustment costs.

(b) For the period from the end of the calendar year in which claims are paid by the insurer to the date payments for the operation of the assigned claims plan are due, the amount must be determined by applying the annual yield rate specified in this subsection to the total claims payments and loss adjustment costs multiplied by a fraction, the denominator of which is 365 and the numerator of which is equal to the number of days that have elapsed between the end of the calendar year and the date payments for the operation of the assigned claims plan are due.

(2) An insurer assigned a claim by the Michigan automobile insurance placement facility under the assigned claims plan or a person authorized to act on behalf of the plan may bring an action for reimbursement and indemnification of the claim on behalf of the Michigan automobile insurance placement facility. The insurer to which the claim has been assigned shall preserve and enforce rights to indemnity or reimbursement against third parties and account to the Michigan automobile insurance placement facility for the rights and shall assign the rights to the Michigan automobile insurance placement facility on reimbursement by the Michigan automobile insurance placement facility. This section does not preclude an insurer from entering into reasonable compromises and settlements with third parties against

whom rights to indemnity or reimbursement exist. The insurer shall account to the Michigan automobile insurance placement facility for any compromises and settlements. The procedures established under the assigned claims plan of operation must establish reasonable standards for enforcing rights to indemnity or reimbursement against third parties, including a standard establishing an amount below which actions to preserve and enforce the rights need not be pursued.

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

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

(4) Payments for the operation of the assigned claims plan not paid by the due date bear interest at the rate of 20% per annum.

(5) The Michigan automobile insurance placement facility may enter into a written agreement with the debtor permitting the payment of the judgment or acknowledgment of debt in installments payable to the Michigan automobile insurance placement facility. A default in payment of installments under a judgment as agreed subjects the debtor to suspension or revocation of his or her motor vehicle license or registration in the same manner as for the failure by an uninsured motorist to pay a judgment by installments under section 3177, including responsibility for expenses as provided in section 3177(4).

Sec. 3177. (1) The insurer obligated to pay personal protection insurance benefits for accidental bodily injury to a person arising out of the ownership, maintenance, or use of an uninsured motor vehicle as a motor vehicle may recover all benefits paid, incurred loss adjustment costs and expenses, and incurred attorney fees from the owner or registrant of the uninsured motor vehicle or from his or her estate. Failure of the owner or registrant to make payment within 30 days after a judgment is entered in an action for recovery under this subsection is a ground for suspension or revocation of his or her motor vehicle registration and license as defined in section 25 of the Michigan vehicle code, 1949 PA 300, MCL 257.25. For purposes of this section, an uninsured motor vehicle is a motor vehicle with respect to which security as required by sections 3101(1) and 3102 is not in effect at the time of the accident.

(2) The Michigan automobile insurance placement facility may make a written agreement with the owner or registrant of an uninsured vehicle or his or her estate permitting the payment of a judgment described in subsection (1) in installments payable to the Michigan automobile insurance placement facility. The motor vehicle registration and license of an owner or registrant who makes a written agreement under this subsection must not be suspended or revoked and, if already suspended or revoked under subsection (1), must be restored if the payment of any installments is not in default.

(3) The secretary of state, on receipt of a certified abstract of court record of a judgment described in subsection (1) or notice from an insurer or the Michigan automobile insurance placement facility or its designee of an acknowledgment of a debt described in subsection (1), shall notify the owner or registrant of the provisions of subsection (1) at the owner or registrant's last address recorded with the secretary of state and inform the owner or registrant of the right to enter into a written agreement under this section with the Michigan automobile insurance placement facility or its designee for the payment of the judgment or debt in installments.

(4) Expenses for the suspension, revocation, or reinstatement of a motor vehicle registration or license under this section are the responsibility of the owner or registrant or of his or her estate. An owner or registrant whose registration or license is suspended under this section shall pay any reinstatement fee as required under section 320e of the Michigan vehicle code, 1949 PA 300, MCL 257.320e.

CHAPTER 31A MANAGED CARE

Sec. 3181. As used in this chapter, "managed care option" means an optional coverage selected by an insured at the time a policy is issued that 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.

Sec. 3182. This chapter applies to all automobile insurance whether written on an individual or group basis.

Sec. 3183. An automobile insurer may offer a managed care option that provides for allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation. This managed care option is subject to all of the following:

- (a) It must be uniformly offered in all areas where the managed care option is available.
- (b) It must provide a discount that reflects reasonably anticipated reductions in losses or expenses or both.

(c) It must not apply to emergency care. Emergency care includes, but is 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.

Sec. 3184. An automobile insurer that offers a managed care option under this chapter shall also offer personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option.

Sec. 3185. The managed care option must apply 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 personal protection insurance benefits under the policy with the managed care option.

Sec. 3186. A managed care option may provide for deductibles, co-pays, or both deductibles and co-pays.

Sec. 3187. A managed care option must provide for all of the following:

(a) That personal protection insurance benefits are primary and will not be coordinated with other health and accident coverage on the individual claiming personal protection insurance benefits under the policy with the managed care option.

(b) That personal protection insurance benefits must be exhausted by the individual claiming those benefits under the policy with the managed care option before the individual may seek benefits from another health or accident coverage provider.

(c) That deductibles, co-pays, or other similar sanctions will not be assessed or collected from other health and accident coverage providers for the individual claiming personal protection insurance benefits under the policy with the managed care option.

Sec. 3188. At the time of the initial selection of the managed care option by the insured, an automobile insurer shall obtain a signed acknowledgment that the insured received a written disclosure statement approved by the director or a written disclosure statement that includes all of the following:

(a) A summary of the provisions of the managed care option.

(b) The estimated range of the percentage of the discount provided by the managed care option.

(c) A general description of the differences between a managed care option under this chapter and personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option, including any procedural differences in seeking treatment and filing a claim.

(d) The consequences for violating any provisions of the managed care option, including the possibility of a claim denial, the payment of a deductible and the amount of that deductible, and any additional out-of-pocket expenses that may be incurred.

(e) An explanation of whether the insurer offers an opt-out provision that would enable the insured to change his or her policy from a managed care option to personal protection insurance benefits under section 3107(1)(a) that are not subject to the managed care option and any restrictions placed upon the insured in regard to opting out of the managed care option.

Sec. 3189. The disclosure statement under section 3188 must include a postal mailing address and either a toll-free telephone number or an internet website address that insureds or applicants for insurance may write, call, or otherwise access for information on the managed care option.

CHAPTER 63 ANTI-FRAUD UNIT

Sec. 6301. (1) An anti-fraud unit is established as a criminal justice agency in the department, dedicated to prevention and investigation of criminal and fraudulent activities in the insurance market.

(2) The anti-fraud unit is a criminal justice agency with full access to criminal justice information and criminal justice information systems. 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 anti-fraud unit may investigate criminal and fraudulent activity related to any matter under the jurisdiction and authority of the department under Executive Reorganization Order No. 2013-1, MCL 550.991.

(3) The anti-fraud unit may do any of the following:

(a) Conduct criminal background checks on applicants for licenses and current licensees in accordance with state and federal law.

- (b) Collect and maintain claims of criminal and fraudulent activities in the insurance industry.
- (c) Investigate claims of criminal and fraudulent activity in the insurance market that, if true, would constitute a violation of applicable state or federal law, including, but not limited to, the Michigan penal code, 1931 PA 328, MCL 750.1 to 750.568, and this act.
- (d) Maintain records of criminal investigations.
- (e) Share records of its investigations with other criminal justice agencies.
- (f) Review information from other criminal justice agencies to assist in the enforcement and investigation of all matters under the authority of the director.
- (g) Conduct outreach and coordination efforts with local, state, and federal law enforcement and regulatory agencies to promote investigation and prosecution of criminal and fraudulent activities in the insurance market.

Sec. 6302. (1) A document, material, or information related to an investigation of the anti-fraud unit is confidential by law and privileged, is not subject to the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the director may use the documents, materials, or information in the furtherance of any supervisory activity or legal action brought as part of the director's duties.

(2) The director, or any person that received documents, materials, or information while 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 information described in subsection (1).

(3) To assist in the performance of the anti-fraud unit's duties, the director may do any of the following:

(a) Share documents, materials, or information, including the confidential and privileged documents, materials, or information that is subject to subsection (1), with any of the following:

- (i) Other state, federal, and international regulatory agencies.
- (ii) Other state, federal, and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or information.
- (iii) Any other person as the director considers necessary to discharge the anti-fraud unit's duties under section 6301 or other applicable law.

(b) Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from any of the following:

- (i) Other state, federal, and international regulatory agencies.
- (ii) Other state, federal, and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, or information.
- (iii) Any other person as the director considers necessary to discharge his or her duties under this act or any other applicable act.

(c) Enter into agreements governing the sharing and use of information that are consistent with this section.

(4) The director shall maintain as confidential and privileged any documents, materials, or information received under subsection (3)(b) with notice or the understanding that the documents, materials, or information is confidential and privileged under the laws of the jurisdiction that is the source of the documents, materials, or information.

(5) The disclosure of any documents, materials, or information to the director, or the sharing of documents, materials, or information under subsection (3), is not a waiver of, and must not be construed as a waiver of, any privilege applicable to or claim of confidentiality in those documents, materials, or information.

Sec. 6303. (1) Beginning July 1 of the year after the effective date of the amendatory act that added this section, the anti-fraud unit shall prepare and publish an annual report to the legislature on the anti-fraud unit's efforts to prevent automobile insurance fraud.

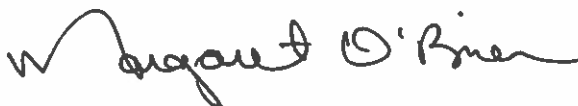
(2) The anti-fraud unit shall submit the annual report to the legislature required by this section to the standing committees of the senate and house of representatives with primary jurisdiction over insurance issues and the director.

Sec. 6304. This chapter does not limit the power of the anti-fraud unit to conduct activities under Executive Order No. 2018-9 with respect to the financial services industry or markets.

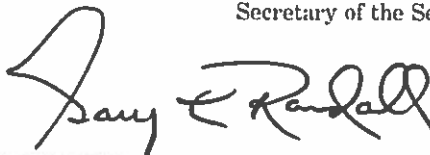
Enacting section 1. Section 3112 of the insurance code of 1956, 1956 PA 218, MCL 500.3112, as amended by this amendatory act, applies to products, services, or accommodations provided after the effective date of this amendatory act.

Enacting section 2. Section 3135 of the insurance code of 1956, 1956 PA 218, MCL 500.3135, as amended by this amendatory act, is intended to codify and give full effect to the opinion of the Michigan supreme court in *McCormick v Carrier*, 487 Mich 180 (2010).

This act is ordered to take immediate effect.



Secretary of the Senate



Clerk of the House of Representatives

Approved

.....
Governor

