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Testimony to House and Senate insurance committees regarding CRC auto no-fault report

The report released by the CRC is riddled with misinterpretations and inaccuracies regarding the Michigan auto no-fault code. In order to keep this testimony somewhat brief, this testimony is only going to detail some of the problems contained within this report. As an auto no-fault injury survivor of almost 20 years, I have had the opportunity to see how the system functions from a very unique perspective.

This report misinterprets the use of the language written in MCL 500.3107 (1) (A) "allowable expenses consisting of all reasonable charges incurred for reasonable and necessary products, services and accommodations for it injured persons care, recovery or rehabilitation." Their report claims that auto insurers pay higher rates because they're unable to negotiate discounts on the rates they're charged, and that the charge shall not exceed the amount the person or institution customarily charges were like products, services and accommodations. They claim that this language is held to me that auto insurers must pay the amount customarily charged and not the amount customarily received.

When in fact, this is the exact opposite of the way the law currently functions. Insurers are only required to pay what they deem to be a reasonable and necessary charge, for the product or service incurred by the patient, regardless of what was billed. This practice is used at a regular basis. When a provider submits a bill to the auto insurer, the auto insurer is only going to pay what their computer program tells him is a reasonable charge for that product or service based on providers in the geographical area. Additionally, if they can delay payment for one year, then they are no longer responsible to pay that charge.

The way this works: Example: provider bills the insurer $100 for a product or service incurred by the patient. The insurer will send payment for $40 with a CPC code on the bottom of the receipt informing the provider that this is what they're going to receive, based on information they have constituting a reasonable, necessary charge for providers in their area. Case law has upheld that the reasonableness and necessity of the charge is solely determined by the insurer, not the provider. Case law has also upheld that providers are unable to sue for unpaid balances. When you are able to name your own price, how can you ever overpay?

This report claims that Michigan's unique and relatively generous medical coverage has resulted in expansive, and nearly Unlimited coverage for those who need or want medical services. To use the learn unlimited coverage, is very deceiving. Benefits are paid out for the lifetime of the catastrophically injured patient, not for their unlimited usage. Benefits are only paid for necessary products, services and accommodations related directly to the auto injury. The insurance industry claims they do not have any cost-containment measures in place to regulate the necessity and reasonableness of charges.

When in fact the insurance industry has an elaborate cost-containment program through the use of independent case managers and case management firms. Each patient is assigned a case manager, which reviews the necessity of a physician's prescription, and then the reasonableness of the charge from the provider to the insurer. Case managers will often attend appointments directly with the patient's to know firsthand how the claim is being handled.