



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

House Insurance Committee
April 24, 2013
Testimony on House Bill 4612
MHA Position: Oppose

Mr. Chairman and members of the committee, I am Dave Finkbeiner, senior vice president for Advocacy at the Michigan Health & Hospital Association. I am here today on behalf of more than 130 Michigan hospitals.

House Bill 4612 reduces benefits to people injured in auto accidents. There are small and temporary savings for consumers, while the new limits on benefits are drastic and permanent. This bill limits the personal injury protection benefit to \$1 million which is inadequate for catastrophic injuries, will require Michigan to supplant private insurance coverage with Medicaid, and will invite costly time-consuming lawsuits.

The reduction of the personal injury protection benefits as a means for reducing premiums is puzzling. Recently you may have read a comment attributed to Mike Duggan, the former CEO of Detroit Medical Center. He said the biggest change when he moved to Detroit was that his auto insurance premiums doubled from \$3000 to \$6000. I'm sure that's true. I am equally sure that his auto insurer paid the same amount, \$175 per car, for the catastrophic benefits beyond \$500,000. Whatever caused Mr. Duggan's insurance to increase so dramatically, it wasn't the personal injury protection benefits above \$500,000. In fact, the benefits covered by the MCCA went from being 20 percent of his premium to 10 percent of the total premium. If this effort is about reducing premiums for consumers, the bill is taking aim at the wrong part of the policy.

House Bill 4612 continues to promote the idea that rates paid to hospitals and other providers by auto insurers must be set artificially by government intervention and legislation. Unfortunately, the data used to promote such misguided proposals are incomplete and misleading. Comparing hospital charges to cover the care of catastrophic accident victims to hospital charges for workers compensation and Medicare is comparing apples to oranges. Furthermore, the use of Medicare data in such politically motivated messaging is inaccurate because it doesn't include supplemental payments that most large tertiary care centers receive for medical education, bad debt and outlier payments. Even when those considerations are added, the reimbursement from these government fee schedules is below what is paid by auto insurers. That is because government-set reimbursement rates from Medicaid and Medicare do not cover the cost

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of providing services. For some hospitals, workers compensation fees are marginally better, but provide little if any margin above cost. The fact that hospitals are forced to accept inadequate reimbursement from some payers is not a rationale for imposing yet *another* system that pays inadequate rates.

Hospitals regularly negotiate payment rates with insurers and those rates are dependent upon a number of factors. These rates are not transferable from payer to payer because the volume, type and frequency of services differ depending upon the group of people covered by the contract. Hospitals do recognize economies of scale. For this reason the language related to payments “customarily” received is not appropriate. This raises an important point: by federal law, hospitals are required to bill every insurer or patient the same amount. Let me repeat that: by federal law, hospitals are required to bill every insurer or patient the same amount. Allegations that hospitals charge more for care in the cases of no-fault covered patients is baseless and misleading. What is *accepted* as payment is different by insurer and patient, including total write-offs of the cost of care for patients that qualify for charity care — for the reasons I have just mentioned.

There is no evidence that auto insurers need a fee schedule to control costs. The existing law does not place a limit on the ability of auto insurers to negotiate rates with health care providers. In fact, many providers, including hospitals, have contracts with networks that establish rates for services rendered. Some hospitals are currently paid for auto no-fault claims under their Cofinity contract. Auto insurers also use many services to review and pay bills, and challenge bills they question as “excessive.” Auto insurers do not need legislative action to negotiate private contracts with health care providers. Nowhere else does such a government imposition between two private parties currently exist — and this is because the free market is able to operate, unencumbered by government intervention.

While the number of people seriously injured in auto accidents is small in comparison to the number of drivers and the total number of patients admitted to hospitals each year, people who are seriously injured in accidents represent costly cases. The intensity of the service needed is great. Trauma services require on-call physicians and large numbers of other professionals, technical equipment, and extra capacity for operating rooms and critical care beds. Care for a severely injured patient starts with the special critical care transportation vehicle staffed with specially trained paramedics, continues in the intensive care unit and may even move to an inpatient rehabilitation unit or facility where a recovering patient receives at least three hours of physical and occupational therapy daily. Many patients continue to require assistance in daily living, outpatient care in a variety of settings and home and vehicle modifications to accommodate their injuries. It is not clear whether the work comp fee schedule can adequately be adjusted to recognize these types of services and accommodations.

The cost of investing in and maintaining critical care, trauma and rehabilitation facilities and staff is expensive. Auto no-fault reimbursement must recognize the cost of providing these resources. That is the purpose of using a no-fault, first-party payment system. The state of Michigan recognized that accidents will occur and that drivers should maintain the ability to pay for the cost of care, rehabilitation and accommodation through our system of auto insurance. Artificially reducing reimbursement will lead to inadequate margins for providers, which means less capital investment for equipment upgrades and

technologies, fewer resources for paying staff and fewer physicians willing to serve on call.

Earlier this year the MHA made a proposal to rollback hospital rates to 2012 and freeze those rates in place through 2015. Hospitals would also agree to control rates going forward by the health care inflation rate in Michigan. This would allow each hospital to preserve its rate-setting mechanisms that are already in place, but would give auto insurers the certainty and rate ceiling they have requested.

The MHA has previously advocated for reasonable reforms to the system using these principles: cost containment applied to all provider services, a coverage cap that covers most people who are catastrophically injured; increased efforts to reduce fraudulent auto no-fault insurance claims; and new efforts to identify appropriate care/best practices for the catastrophically injured.

We hope elected officials consider such reasonable changes in the place of those being proposed in House Bill 4612.