



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.



December 7, 2011

The Honorable Dick Posthumus
Senior Legislative Advisor
Office of Governor Rick Snyder
Romney Building
Lansing, MI 48933

Dear Mr. Posthumus:

Thank you for the invitation last week to discuss House Bill 4936, the auto no-fault legislation pending in the House. There was significant value in having Sen. Hune, Rep. Lund, Majority Leader Richardville, Commissioner Clinton and the Governor in the room to discuss areas of agreement and potential obstacles to an agreement.

As you know, the MHA Board of Trustees has consistently taken a position that they cannot support or negotiate additional government intervention in price setting between health care providers and insurers. Medicare, Medicaid and the workers' compensation system all involve government rate-setting, and each one results in inadequate payment to some or all health care providers.

The proposal outlined on Nov. 30 again includes a fee schedule based on the workers' compensation fee schedule. The MHA cannot agree to any legislation that includes a government-mandated fee schedule for services, products and accommodations for people injured in auto accidents. For this reason it is difficult to evaluate the remainder of the proposal.

However, the MHA also wishes to continue the conversation on HB 4936. Below we have outlined our responses to each area under discussion, which are all offered in, and predicated on, the context of achieving legislation that does not include government price setting for claims paid under the auto no-fault law.

Proposal: A personal injury protection (PIP) cap of \$1 million with no other PIP choices.

MHA Response: The MHA is willing to break with its historical position opposing a maximum on the personal injury protection benefit and discuss the concept of appropriate limits governed by medical necessity. The \$1 million limit in the proposal is an improvement on the proposed \$250,000 and \$500,000 limits, however does not yet reflect the necessary level to adequately care for Michigan citizens.

SPENCER JOHNSON, PRESIDENT

During the Nov. 30 meeting, the Commissioner's office reported that at least 6,400 people are currently reserved for \$1 million or more for their injury costs. Additionally, at least 13,000 Michigan citizens are currently reserved for \$14.7 billion. Given these facts, the \$1 million proposal seems to be substantially inadequate to address the needs of people injured in auto accidents.

While we are concerned about sustainability of the system in general, and the MCCA in particular, the MHA also believes the decision to cap the no-fault personal injury protection has significant implications for Michigan citizens, our tort system, the Medicaid program and the families of injured people. Therefore, lawmakers and representatives from the insurance and health care communities must have an open, data-driven discussion to evaluate the cost of the existing cases and to determine how a cap on the benefit will shift cost to other sectors of the health care system and to state government. Only then will lawmakers, insurers and health care providers be able to defend the ultimate decision for a cap on PIP benefits.

**Proposal:** *A fee schedule at 125% of work comp fees starting on October 1, 2013, going down 5% per year for 5 years to 100% of work comp.*

**MHA Response:**

This portion of the proposal is outside of the parameters of what the MHA can negotiate as explained above.

**Proposal:** *A language change in the MCCA fund allowing for \$10/premium of fund to go to match federal Medicaid funds providing an additional \$200,000,000 in Medicaid funds to hospitals.*

**MHA Response:** While the MHA is appreciative of the recognition that rates of payments from Medicaid are inadequate, this offer of funding support is tied to the establishment of a fee schedule, which is outside of the parameters of what the MHA can negotiate.

There is clearly a need to improve the sustainability of the Medicaid system, but that cannot be accomplished by a one-time infusion of cash that has an unknown distribution. Those hospitals and providers that stand to lose under the proposed no-fault fee schedule may be a different list than those who would stand to gain under this proposed addition of Medicaid funds.

Medicaid funding cannot be protected from changes made by subsequent legislatures. It is also not clear how the MCCA assessment would become public funds. This concern is especially salient, given the position of the auto insurers that MCCA funds are, have always been and must always be, private funds upon which the insurers solvency is based.

**Proposal:** *A cap on attendant care at 56 hours per week, with \$15 per hour for basic care and \$20 per hour for skilled care.*

**MHA Response:** Like the earlier proposal related to a workers' compensation fee schedule, these limits on attendant care are a different version of a fee schedule. The MHA-member hospitals and health systems that provide home care for physical therapy, occupational therapy, medical needs and activities of daily living could not offer these services at these prices and remain solvent. The arbitrary weekly limit on the number of hours of care ignores the needs of catastrophically injured people who will bear the ultimate cost of such a change. Those licensed and/or accredited entities providing this care are already highly regulated and must comply with reasonable and necessary requirements of providing services.

The MHA understands the need to address the growth in the cost of family-provided attendant care. Therefore, in consultation with those who are more expert in the long-term post-acute provision of services, we propose establishing requirements that family caregivers obtain a Care Review Plan from the treating physician that includes the following:

1. Specifies the delivery of attendant care services needed, including the amounts of skilled vs. non-skilled care.
2. Specifies a specific length of time the attendant care services will be required, establishing a recognized period of time after which the Care Review Plan expires.
3. Requires a timeframe in which the Care Review Plan will be reevaluated as medically necessary, but not more than once a year after the first year of care.
4. If ongoing care is deemed necessary after the first year of care, allow the Care Review Plan to remain in effect for longer periods of time, including "lifetime" for circumstances that are not expected to see medical change.
5. Requires submission of a form that legally attests to the delivery of services and includes appropriate documentation such as receipt of services (e.g. Flexible Spending Account).

The MHA understands that most licensed or accredited providers are already covered by requirements for such plans, unlike families.

**Proposal:** *Language on fraud and abuse to be developed.*

**MHA Response:** The MHA Board of Trustees, the association and its members have a zero tolerance policy for fraud. All Michigan hospitals are required to provide access to medically appropriate care, while maintaining standards of patient safety and quality. In addition, there are substantial anti-fraud requirements in place through state and federal programs. We understand some auto insurers have shared language to create a fraud prevention authority with the House and Senate Insurance Committees. The MHA will provide feedback when the language is considered.

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The MHA recognizes the importance of sustainability and cost containment strategies regarding auto no-fault coverage and agrees that the Michigan auto insurance no-fault system must be protected from insolvency and cost growth — so that it may continue serving Michigan patients who need it most.

Thank you for the opportunity to respond to the most recent alternative to HB 4396. The MHA remains committed to finding solutions that benefit all stakeholders in this critically important public policy debate and looks forward to further discussion with you.

Sincerely,

A handwritten signature in black ink, appearing to read "Dave", with a large, stylized initial "D" that loops around the first few letters.

Dave Finkbeiner  
Senior Vice President, Advocacy

cc Dennis Muchmore  
Senate Majority Leader Randy Richardville  
Senator Joe Hune  
Speaker of the House Jase Bolger  
Representative Peter Lund  
OFIR Commissioner Kevin Clinton