UNDUE INFLUENCE

When An Insurance Organization Makes Its Own Rules, Accident Survivors and Their Families Are the Ones Who Pay the Price

By: MAJ Secretary Nick Andrews and Meagan O'Donnell, Liss, Seder & Andrews, Bloomfield Hills

The Michigan Catastrophic Claims Association (MCCA) has gone rogue.

It uses fear and intimidation to achieve improper goals that harm Michigan families and their injured loved ones who are losing money, homes, and even their lives.

As the entity that reimburses No-Fault insurance companies for many personal injury protection (PIP) medical claims resulting from auto accidents, the MCCA is at the forefront of an egregious money grab—an effort based on legally dubious and morally outrageous notions—that is hurting Michigan's most vulnerable residents and causing significant financial hardship for struggling families and many of the state's most important healthcare providers.

The MCCA has been making suspicious financial and legal assertions for some time now, misrepresenting the statutory landscape and not only its own obligations under the revisions to the No-Fault law (that was first passed by the Michigan Legislature in 2019 and went fully into effect in July of 2021), but also the obligations of insurance companies and the families of injured accident victims.

None of this is particularly new. It's all part of a slow-moving catastrophe that has been unfolding for years and is only now starting to bear rotten fruit. What's new is the scale of the deception. The MCCA is now actively, and seemingly purposefully, misreading a clear opinion issued by the Supreme Court of Michigan.

We'll explain. But first, to understand just how misleading the MCCA's claims are, it's important to understand how we got to this point.

When Michigan's one-of-a-kind No-Fault automobile insurance law was first passed in 1973, the prospect of paying lifetime benefits to seriously injured auto accident victims was daunting for smaller insurance companies. To protect them, and to insulate all insurers from the highest costs, the MCCA was created. The MCCA manages a huge fund of money intended for motor vehicle accident survivors. The MCCA's job is to manage that fund and use it to make any insurance payments to accident victims that are higher than a set dollar amount. By capping the amount that any individual insurance company was required to pay, this arrangement also limited insurance companies' risk and exposure, allowing them to set rates accordingly and compete in a more stable marketplace. Currently, the MCCA controls more than $26 billion intended to pay for the care and treatment of the catastrophically injured both many years ago and today for those who elect unlimited coverage. The fund is sourced by a relatively small addition to everyone's insurance premium who elects unlimited coverage (currently $86.00 per vehicle per year). Presently, your automobile insurance company is paid back dollar for dollar for every payment above $600,000 per claim, enabling them to make obscene profits.

Fundamentally, the way the system worked was insurance companies managed and adjusted insurance claims, and then submitted those claims to the MCCA for reimbursement whenever those claims exceeded the cap. The MCCA has a legal obligation to pay that sum, referred to as the "ultimate loss." Even though this process has generally worked well, and the fund had swelled to an eye-popping $26 billion as of July 2021, the MCCA has used the passage of the No-Fault law revisions to not only duck its obligations, but use its substantial leverage to pressure insurance companies, accident victims, and their families to accept lower payments, thereby jeopardizing their access to life-sustaining care.

The MCCA created internal rules and procedures that, in practice, are unlawful. Under this new scheme, certain agreed-upon payments between insurance companies and accident victims are now deemed "unreasonable" by the MCCA. In many cases, the MCCA illegally refuses to provide "pre-approval" on clearly reasonable payouts for critical care that they have already been paying and that accident victims have been receiving for years—and still desperately need. This stance essentially makes the MCCA a kind of super claims adjuster, pre-approving (or, in many cases, pre-denying) reasonable claims. In conjunction with misleading statements to families about what is permitted under the revised No-Fault statute, the result is that rates for critical care reimbursement have plummeted—in some cases to less than minimum wage. Families who provide the around-the-clock critical care that some catastrophically injured accident victims need to stay alive are now placed in the impossible position of either continuing to provide that care themselves at an unsustainable wage, or trying to find outside help from a shrinking pool of providers who refuse to provide care at these offensively low rates.

Fortunately, a clear opinion issued by the Michigan Supreme Court in the case of *United States Fidelity Insurance & Guaranty Company v. Michigan Catastrophic Claims Association* addresses this issue, confirming that the MCCA's role is to pay the ultimate loss and that they do not have the ability to say what is and isn't reasonable.

The specific language in the opinion is unequivocal:

> "...the powers granted to the MCCA in § 3104(7) are limited to adjusting the 'practices and procedures' of the member insurers and do not encompass adjustment to the payment amount agreed to between claimants and member insurers. Moreover, we hold that the power granted to the MCCA under MCL 500.3104(8)(g) is limited to furthering the purposes of the MCCA and that ***determining reasonableness is not one of its purposes.***"

Unfortunately, that opinion has not dissuaded the MCCA from providing contradictory information to its member insurers. The MCCA is claiming that the consequences for failing to ***seek*** pre-approval are the same as failing to obtain pre-approval. In other words, the MCCA is functionally making determinations of reasonableness, something the Michigan Supreme Court ruled it cannot do. In practice, insurance company adjusters and managers believe that denials of a request for pre-approval of reasonable payments will lead to a denial of requests for reimbursement, putting the MCCA in charge of determining what is reasonable, again, in violation of the law. The MCCA board has authorized a plan of operation that outlines this policy and clarifies that failing to seek pre-approval only gives the MCCA the right to either deny the claim or hire an independent adjuster and take over the adjustment process. Of course, the MCCA has never followed through on that threat. **It's much easier to control the claims process indirectly through the improper and illegal implied threat of non-payment**.

The organization has seized on what it apparently views as a loophole, claiming that subsequent language in the opinion stating that the MCCA does have the right to implement "safeguards against negligent actions of member insurers" gives the MCCA the right to take these steps.

To be clear about what is taking place here: the MCCA is acting in outright defiance of a State Supreme Court ruling, ignoring the statute and claiming they are doing so in accordance with rules they themselves wrote (and that insurance companies must agree to abide by to sell insurance in Michigan). But the fact remains that there is no statutory authority to deny payment, regardless of the shape that denial takes. Denial of payment through thinly veiled threats or institutional strong-arming is still denial of payment.

And in case there was any remaining doubt about whether the MCCA knows exactly what it's doing, consider this: the insurance log notes in claim files obtained in litigation are now heavily redacted, in some cases, by MCCA lawyers. Those log notes contain records of conversations between insurance company adjusters and the MCCA, and the MCCA is using false claims of privilege and protected work product to hide those conversations. In submitting requests for pre-approval (and all communications) the MCCA requires insurance companies use the MCCA's internal email system—the MMS—that insurance adjusters later claim they cannot access for production of documents, thereby insulating the MCCA from typical discovery. The MCCA, through this process, is hiding the damning evidence about the extent to which the organization is coercing insurance companies to deny payment.

Beyond the MCCA's regulatory misdirection, the underlying logic—that these measures are a financial necessity—doesn't remotely hold water. Even as the fund has grown dramatically over the years, the MCCA has continued to make noise about potential insolvency or unsustainable price structures. But not only is the money there, there is actually more of it than ever. This is a fund collected from policyholders specifically designed to pay accident survivors—not to enrich the MCCA. The money was accumulated years ago to pay for the very services insurance companies are now cutting. The MCCA is legally and morally required to use this fund to reimburse legitimate claims and to stop playing games with the lives and livelihoods of accident survivors and their families.