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CPAN'S PROACTIVE AUTO NO-FAULT REFORM AGENDA

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INTRODUCTORY COMMENT

As a staunch defender of the Michigan Auto No-Fault Insurance Act (MCL 500.3101, *et seq*) and the innovative reparations systems it enacted, CPAN welcomes the opportunity to work with interested constituencies in an effort to strengthen the law and make it more affordable for Michigan citizens. Accordingly, in the pending legislative session, CPAN is ready to negotiate a fair, balanced, and comprehensive package of legislative reforms that would accomplish two major objectives: (1) promote cost savings and premium reductions for consumers; and (2) provide needed protection to seriously injured auto accident victims who are frequently treated unfairly in the claim handling process. These reforms are briefly summarized in Section I., entitled "*Promoting Premium Reduction and Cost Savings,*" and in Section II., entitled "*Promoting Fairness to Claimants.*"

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SECTION I: PROMOTING PREMIUM REDUCTION AND COST SAVINGS

A. Adopt Reasonable Fee Schedules for Virtually All Medical Providers Treating Auto Accident Patients.

Comment: Historically, CPAN has opposed fee schedules for a number of reasons. First, fee schedules are contrary to the flexible charge concepts that have been a part of the Michigan No-Fault Act since its adoption in 1972. Under the current statute, fee schedules are not utilized. Rather, insurers have a statutory obligation to *"pay all reasonable charges."* This standard allows a flexible, individualized approach to reimbursable charges that can take into consideration the unique circumstances of each case. In addition, fee schedules can be arbitrary and often times result in underpayment to providers treating a particular class of patients, thereby rendering those patients "*second-class citizens*" in comparison to other patients whose treatment is not encumbered with unrealistic reimbursement schedules. However, in recent years, and as referenced in Section II., insurers are engaging in practices resulting in frequent payment delays and frequent underpayment of charges. Therefore, fair and flexible fee schedules may be an effective way to counter these unfair practices. Accordingly, CPAN supports a no-fault fee schedule for all medical providers, with the exception of Level 1 trauma hospitals, that would be based upon 185% of the workers' compensation fee schedules, with cost-of-living adjustments. The adoption of these schedules would be accompanied by legislation that would require prompt payment at the scheduled amount with significant sanctions for insurers who do not comply.

B. Adopt Reasonable Hourly Rate Schedules for Family-Provided Attendant Care.

Comment: CPAN has historically opposed fee schedules for family-provided attendant care, primarily because past proposals for the implementation of such attendant care reforms undercompensated caregivers who were willing to render attendant care to catastrophically injured family members. Under such previous proposals, in-home care of severely injured auto accident victims would have been disincentivized, thereby resulting in an increase in the institutionalization of such patients. Going forward, CPAN would support legislation that adopts reasonable hourly rate fee schedules for family-provided attendant care, as long as those rate schedules are reasonably related to the nature and extent of the patient's disability and the specific needs of that patient.

C. *Limit the Open-Ended Financial Liability of No-Fault Insurers to the Amount of the Applicable MCCA Claim Threshold Requirement, Currently $555,000.*

Comment: Under current law, insurers retain financial liability for all medical expenses incurred by a catastrophically injured person if, for some reason, the MCCA is not financially able to pay those expenses after the insurer has paid its minimum threshold obligation of $555,000. This means that insurers are required to treat this potential exposure as a possible liability which, many insurers contend, limits their financial and credit status. In an effort to avoid this problem, CPAN would support legislation that limits the financial exposure of auto no-fault insurers to the threshold amount the insurer must pay in order for the claim to qualify for MCCA handling. However, such a major rewrite of the catastrophic claim provision of the No-Fault Statute would require the corresponding enactment of very strict and specific rules to ensure that the MCCA always remains financially solvent and that it be continually subject to close administrative and legislative oversight.

D. *Adopt Meaningful and Balanced Fraud Prevention Legislation.*

Comment: CPAN vigorously opposes all forms of fraud and claim handling abuse as being very harmful to the viability of the Michigan no-fault system. Therefore, new and effective methodologies must be adopted by the Legislature to identify fraud and claim handling abuse and to formulate effective strategies to eradicate these harmful practices. However, such legislation must be based upon the reality that fraud by claimants is only part of the problem. Insurers who engage in abusive claim handling practices also damage the no-fault system by violating its basic promise to take care of patients without fostering unnecessary litigation that drives up costs. Accordingly, comprehensive fraud legislation must address both aspects of this significant problem—fraud by claimants and abuse by insurers.

E. *Adopt Meaningful Reforms to the Assigned Claims Plan to Ensure More Efficient Operation and to Assist in the Identification of Improper Claims.*

Comment: Many victims who sustain serious injury in automobile accidents are *"legally uninsured."* In other words, they are non-drivers, minors, senior citizens, and others who are not required to purchase auto no-fault insurance. Frequently, those victims must draw no-fault benefits from the Michigan Assigned Claims Plan (ACP). The ACP contends that it is experiencing significant problems in handling many of these claims. CPAN recognizes that certain reforms to the ACP could be enacted that

would increase the efficiency and fairness of the claim handling process, and, therefore, CPAN is willing to support such reforms.

F. Require Full Transparency of the MCCA.

Comment: CPAN is involved in litigation against the MCCA in an effort to subject that entity to the Michigan Freedom of Information Act (FOIA). That case is currently pending in the Michigan Supreme Court. The main thrust of this litigation is to require the MCCA, through the auspices of FOIA, to disclose certain information which it currently keeps hidden from the public—primarily *"rate-making data"* (RMD). This is the critical information that the MCCA uses to do two things: (a) determine the annual assessment amount that Michigan drivers must pay; and (b) measure the future financial viability of the MCCA. If the RMD is inaccurate or otherwise not properly applied, both the annual assessments and the projections for future sustainability could be seriously inaccurate. Therefore, transparency legislation should be enacted in order to require the production of information such as RMD, as well as other information pertinent to the operation of the MCCA.

G. Require Auto No-Fault Insurers to Obtain Prior Approval for Future Insurance Premium Rate Increases.

Comment: In Michigan, owners or registrants of motor vehicles required to be registered, are compelled to purchase auto no-fault insurance. The failure to purchase this insurance subjects the offender to criminal prosecution and imprisonment. Unfortunately, however, insurers are virtually free to charge consumers whatever they want because auto insurance premium rates do not require prior approval by the Department of Insurance and Financial Services (DIFS), as is required in many states. On the contrary, Michigan has a *"file and use"* system, where the insurer simply files its rates and then proceeds to charge customers the new rate unless the Insurance Commissioner objects to the rate. In the 44 year history of the Michigan No-Fault Act, the Michigan Insurance Commissioner has never declared any rate to be excessive. On the contrary, the definition of *"excessive,"* as used in the Insurance Code, makes it virtually impossible for a rate to be disqualified on that basis. Therefore, new standards should be promulgated to require all rate increases to be approved by the Michigan Insurance Commissioner and to set forth more realistic definitions to measure the fairness and appropriateness of the rate. This type of legislation is even more necessary in light of the fact that in the early years of the Michigan no-fault experience, the Michigan Supreme Court, in its landmark decision in ***Shavers v Attorney General*, 402 Mich 554 (1978)**, ruled that there is a constitutional right to have compulsory no-fault

insurance *"available to Michigan motorists at fair and equitable rates."* CPAN believes it is now time to give the *Shavers* decision true meaning.

H. Eliminate Non-Driving Rating Factors in Determining Insurance Policy Rates.

Comment: One of the factors that significantly drives up the cost of auto no-fault insurance is the utilization of various rating factors that have nothing whatsoever to do with a person's driving record. These include things such as credit scoring, previously lapses in coverage, etc. CPAN believes that these rating practices are fundamentally unfair, particularly to those with limited incomes. Rather, a person's insurance rates should depend solely on whether that person is a safe driver. Those who are should not be penalized by the rating factors currently used by most insurance companies.

I. Encourage the Purchase of Coordinated No-Fault Policies by Providing Lien Protection.

Comment: The current No-Fault Statute, in Section 3109a, gives consumers the opportunity to lower insurance rates by purchasing *"coordinated coverage"* that elevates health insurance plans into the primary pay position and moves a no-fault insurer into the secondary pay position with responsibility to only pay those charges not covered by health insurance. Coordinating coverages in this manner also allows no-fault insurance companies to realize a substantial savings by cost-shifting to health insurance. Unfortunately, however, there currently exists a real disincentive for people to coordinate their coverages because certain health plans have provisions stating that if the health plan pays medical expenses, it is entitled to be reimbursed out of a patient's liability settlement, even though that settlement does not include any compensation for medical expenses. In order to eliminate this disincentive from purchasing coordinated coverages, CPAN believes that legislation should be enacted that prohibits health insurance plans from having lien rights that are any greater than lien rights enjoyed by auto no-fault insurers who pay medical expenses. This would encourage more people to purchase coordinated no-fault which would result in more savings to no-fault insurers.

J. Vigorously Enforce Existing Law Requiring that Premiums for Coordinated Coverages be Appropriately Reduced.

Comment: The current No-Fault Act, in Section 3109a, provides that auto insurance companies who sell coordinated no-fault policies to consumers must offer those policies *"at appropriately reduced premium rates."* Moreover, this section states that these rates

"are subject to prior approval by the Commissioner." Unfortunately, however, recent litigation has disclosed that the Insurance Commissioner does not have any standards that are utilized to determine whether premiums for coordinated no-fault coverages have been *"appropriately reduced."* [See *Darmer v Citizens Insurance Company*, Ingham County Circuit Court Docket No. 03-1881-NI-C30.] In light of the fact that the majority of Michigan citizens purchase coordinated no-fault coverages, it is unconscionable that the Insurance Bureau has not adopted standards to guarantee that the rate paid for those coverages has been *"appropriately reduced,"* as required by existing law. CPAN believes that Section 3109a should either be amended to strengthen the existing mandate or that the Bureau be charged with the responsibility of developing real standards to ensure that citizens receive the protection they are entitled to receive under the current law.

K. Discourage Unnecessary Litigation by Requiring Insurers to Promptly Pay Claims.

Comment: The harsh reality is that insurers routinely pay claims late and frequently do not pay the full amount of the bill submitted. The current No-Fault Statute requires that an insurer pay a claim *"within 30 days of receiving reasonable proof of the fact and the amount of the loss"* (Section 3142). In reality, however, insurance companies rarely pay claims within 30 days. Often they pay months late. For many providers, particularly smaller ones, these payment delays cause significant cash flow problems that interfere with the operation of the provider's business and sometimes leads to the termination of medical care. As an aside, it should be noted that insurance companies never tolerate any *"payment delay"* when it comes to paying auto insurance premiums. A premium is either paid on time or coverage is terminated. In reality, paying bills on time should be a two-way street, not simply an obligation that consumers owe to insurance companies.

In addition, insurance companies routinely send medical provider charges to auditing companies who are hired by no-fault insurers and who are completely unregulated by law. These auditing companies typically *"write down"* the provider's charges on the basis of what the auditor believes is *"reasonable."* The insurer then only pays the discounted audited charge. Therefore, by utilizing this self-help, insurers frequently avoid paying the full amount of the charge. All of this has created an unpredictable and disruptive reimbursement practice that ultimately is deleterious to the patients. Therefore, CPAN believes that, along with the adoption of fair, reasonable, and flexible fee schedules as stated earlier in this document, the Legislature should enact much stricter, prompt payment requirements that subject insurers to significant penalties and liability for legal expenses whenever fee scheduled charges are not promptly paid.

L. Discourage Unnecessary Litigation by Requiring Insurers to Deal Fairly and in Good Faith with Patients and to Subject Insurers to Sanctions When that Duty is Breached.

Comment: Unnecessary litigation drives up costs for everyone. In the last several years, patients have been forced to file an increasing number of lawsuits against insurance companies who simply refuse to honor their statutory obligations to pay claims. One of the reasons that this happens is because the Michigan No-Fault Act does not contain adequate penalties and sanctions that can be imposed against insurance companies who do not honor their legal obligations. There are only two penalties under the current statute: (1) 12% interest for an overdue benefit; and (2) reasonable attorney fees, but only if a benefit is overdue and if a judge determines that the denial or delay was *"unreasonable."* Michigan appellate case law has recognized a number of reasons that frequently permit insurers to escape paying the attorney fee penalty by convincing judges that an insurer's conduct, although legally wrong, was not *"unreasonable."* The reality is that for many, the Michigan No-Fault Act has become a *"toothless tiger,"* containing woefully inadequate sanctions that create no real incentive for insurers to *"play by the rules."* Because of these inadequate sanctions, claim denials are commonplace and litigation is becoming more and more prevalent. All of this runs completely contrary to the goals and objectives of the Michigan Auto No-Fault Insurance system. Therefore, legislation is needed to require insurers to deal with claimants *"fairly and in good faith"* and when that duty is breached, insurers should be subjected to significant penalties and liability for the legal expenses that were incurred by the patient in getting the insurer to fulfill its legal obligation.

M. Discourage Unnecessary Litigation by Prohibiting the MCCA from Meddling in the Adjustment of Auto No-Fault Claims.

Comment: In the last several years, the Michigan Catastrophic Claims Association (MCCA), which was statutorily created solely for the purpose of being an indemnitor that reimburses no-fault insurers in cases of expensive catastrophic loss, has now become a *"super adjuster"* that is directly controlling the payment of products, services, and accommodations required by the most severely injured patients in the no-fault system. This interference by the MCCA is not specifically authorized by the No-Fault Statute (see Section 3104). Rather, this power was created by the Michigan Supreme Court in its decision in *USF&G v MCCA*, 482 Mich 414 (2008), which resulted in the MCCA promulgating wide-sweeping rules that give it virtually unlimited power in the claim payment process. The result has been a classic situation of *"interference with contract."* In that regard, it should be kept in mind that an auto insurance policy is a private contract that is voluntarily entered into between a consumer and a no-fault insurance company. Presumably, the consumer decides what no-fault insurance

company to *"hire"* by considering its conduct, practices, and behavior in the marketplace. If that consumer is then injured in a catastrophic automobile accident, the consumer should have a right to deal with his or her own no-fault insurance company, without any interference by any outsider. Unfortunately, that is not what is happening today. The MCCA, which is a governmentally created body, is being permitted to interfere with these private contractual relationships. The sanctity of private contract is one of the cornerstones of the marketplace, yet our legal system tolerates the MCCA continually and regularly interfering with the private contractual relationships that exist between insurance consumers and their auto insurance companies. Moreover, insurers are frequently uncertain over what the MCCA will or will not reimburse, thus resulting in non-payment or prolonged delay in the payment of PIP benefits. Frequently, this precipitates litigation, which again is contrary to the spirit of the no-fault system. Michigan needs to return to the original model of the No-Fault Act, which was to restrict the MCCA to its role as an indemnitor—not an adjuster. Therefore, CPAN believes that legislation should be enacted that clearly provides that once a no-fault insurance company has discharged its legal duty to pay for a particular product, service, or accommodation because the insurance company has determined that the charge is reasonable and otherwise owing under the Act, the MCCA should be legally required to reimburse that insurer without any objection or delay. That is how the system was originally designed to work. However, that is not how the system is currently working.

N. Discourage Unnecessary Litigation by Establishing Fair Standards and Qualifications Regulating the Conduct of "Independent Medical Examinations" by Insurance Companies.

Comment: Under the current No-Fault Statute, an insurer has the right to send a patient for an independent medical examination (IME) by any physician the insurance company designates. Unfortunately, however, there are absolutely no rules or regulations regarding who can perform these examinations, the proper qualifications and credentials the examiner must possess, and whether the examiner is, indeed, *"independent."* As a consequence, insurance companies routinely hire *"cut-off doctors"* to examine patients for the sole purpose of terminating medical care. Once the insurer receives such an IME report, benefits are usually terminated. Moreover, a recent decision by the Michigan Supreme Court has made it easier for insurers to ignore the fact that there are other physicians who have expressed conflicting medical opinions—typically the patient's treating physician. Therefore, once the insurer receives an IME cut-off report, the insurer can effectively deny medical care to the patient. The physicians who typically work as *"insurer IME examiners"* frequently do that kind of work almost exclusively, often times earning hundreds of thousands of dollars every year keeping their insurance company clients satisfied. CPAN believes it has become painfully evident that legislation must be enacted to provide stringent IME rules,

regulations, and procedures that must be followed by insurance companies with respect to the practice of requesting IMEs.

O. Discourage Unnecessary Litigation by Relieving Patients and Providers of the Obligation to Contest Health Insurance Denials in Coordinated No-Fault Situations.

Comment: The majority of Michigan auto insurance consumers purchase coordinated no-fault coverage which elevates their health insurance company into the primary pay position, thereby relieving the auto no-fault insurer from payment obligations except to the extent that an expense is not covered by health insurance. Unfortunately, however, health insurance companies frequently deny payment of all or part of a claim. In this situation, CPAN believes that the patient or provider should be entitled to submit the claim to the auto no-fault insurer for payment, rather than being burdened with the costly and time-consuming obligation of challenging the health insurer denial. This is unfair to patients and providers, drives up costs, invites litigation, and, more importantly, serves as a further disincentive for people to purchase coordinated no-fault coverage, which saves money for all concerned.

P. Discourage Unnecessary Litigation by Extending the One-Year-Back Rule Applicable to Claims for No-Fault PIP Benefits to a Three-Year-Back Rule.

Comment: Under the current No-Fault Statute (Section 3145), a claim for no-fault PIP benefits becomes unenforceable unless a lawsuit is filed against the insurance company within one year of the date the expense in question was incurred. For many years, the Courts interpreted this requirement to allow the one year period (referred to as the *"one-year-back rule"*) to be suspended from the date the claim was submitted to the insurance company until the date the insurance company formally denied payment of the claim. This elongated the one-year-back rule so as to give the claimant and insurer more time to resolve the issues. This rule has now been repealed by the Michigan Supreme Court and replaced with a *"no exceptions"* one-year-back rule. Such a short enforcement period frequently causes the filing of unnecessary lawsuits, simply for the purpose of preventing the claim from becoming unenforceable because it is more than one year old. CPAN believes this is a classic example of legal rules and principles that encourage litigation rather than avoiding it. Accordingly, CPAN believes the one-year-back rule should be extended to a three-year-back rule which is the typical time limitation for traditional liability claims.

SECTION II: PROMOTING FAIRNESS TO CLAIMANTS

A. Require Insurers to Pre-Authorize Payment of Benefits Without First Requiring the Patient to Incur the Financial Expense of Care.

Comment: Under the current No-Fault Statute, a no-fault insurance company is never obligated to (1) pre-authorize any form of medical treatment, surgery, prescriptions, etc.; or (2) pay for any medical treatment, surgery, prescriptions, etc. that the patient has not actually *"incurred."* Most patients cannot afford to incur such expenses and medical providers understandably will not provide the services or the products without insurance company pre-authorization. The result is that patients frequently go without. CPAN believes that legislation should be enacted that clearly provides that an expense is incurred when the patient submits documentation from the medical provider establishing that the service for which the expense is to be incurred is reasonably necessary for the patient's care, recovery, or rehabilitation.

B. Eliminate the Confusion and Unfairness Regarding Causation Issues Created by Recent Supreme Court Decisions Causing Considerable Unfairness for Catastrophically Injured Patient.

Comment: Due to the Supreme Court's decisions in *Griffith v State Farm*, 472 Mich 521 (2005) and *Admire v Auto-Owners*, 494 Mich 10 (2013), catastrophically injured people who no longer can live in their homes and no longer operate their traditional motor vehicles are having terrible problems getting insurance companies to construct necessary barrier-free accommodations and to provide effective transportation prescribed by the patient's medical and rehabilitation team. This confusion and unfairness has occurred because these court decisions provide that no-fault benefits are not payable for *"every day ordinary expenses,"* even though a catastrophically injured person's need for incurring such expenses has been substantially affected by the auto accident disability. CPAN believes that clarifying legislation should be enacted requiring that benefits be paid if it is shown that the injured person's need for the claimed product, service, or accommodation has been affected or altered by the accidental bodily injury that gives rise to the claim. Once such a showing has been made, the insurer should not be permitted to reduce or diminish payment by any amount that allegedly represents expenses that the injured person would have incurred for similar products, services, or accommodations had the accidental bodily injury not occurred.

C. *Increase the Minimum Residual Bodily Injury Insurance Limit Requirement From the 1967 Limit to an Equivalent Limit Adjusted for Cost-of-Living.*

Comment: For the last 50 years, Michigan's antiquated bodily injury limits law has required drivers to only purchase $20,000 of liability insurance. This $20,000 limit went into effect in 1967 and has never been changed. Since that time, the Michigan No-Fault Act was adopted in 1972 which allows liability claims only when the victim has sustained a *"serious impairment of body function."* Therefore, the minimum bodily injury liability law should have been increased in recognition of the fact that it is only serious injury that is now compensated under the no-fault system. Unfortunately, no such change has been made. CPAN believes that the minimum bodily injury law should be adjusted by a cost-of-living factor so as to make the current standard the present day equivalent of the old $20,000 standard, had it been adjusted by the cost-of-living over the last 50 years. This will treat the liability limit requirement in exactly the same way as the no-fault wage loss benefit, which is adjusted every year to keep pace with the cost-of-living. The same mechanism should apply to the bodily injury requirement.

D. *Protect the Right of Policyholders Who Buy Underinsured Motorist Coverage to Pursue Such Claims Whenever the At-Fault Driver's Insurance Company Offers Policy Limits, Without Requiring the Policyholder to Obtain Consent From His or Her Insurer.*

Comment: In recognition of the fact that many drivers do not purchase adequate amounts of liability coverage, many Michigan insurance consumers are doing the wise thing and are purchasing underinsured motorist coverage that will provide additional liability compensation to the victim if the at-fault driver does not have enough liability insurance to adequately compensate the victim for the damages sustained. For example, if the at-fault driver has the minimum $20,000 liability insurance policy and the victim sustains permanently disabling injuries, the victim would be entitled to seek additional compensation under his or her underinsured motorist policy up to the limits purchased under that policy. Unfortunately, however, many underinsured motorist policies contain language that prohibits the policyholder from tapping into the underinsured motorist coverage if the insurer refuses to give consent to the victim to settle for the policy limits of the at-fault driver. Such provisions completely frustrate the purpose of purchasing underinsured motorist coverage and further require unnecessary litigation. CPAN considers this practice to be outrageous. Therefore, CPAN believes legislation should be passed that would allow a victim who purchases underinsured motorist coverage to tap into that coverage whenever the victim recovers a policy limits settlement from the at-fault driver's insurance company, without requiring the victim to obtain the consent of the underinsured motorist insurer and

without having the victim's underinsured motorist coverage reduced by the amount recovered from the at-fault driver.

E. Prohibit Innocent Third-Parties from Losing Auto No-Fault PIP Benefits if Insurers Rescind the Policy Because of the Wrongful Acts of Another.

Comment: For many years, Michigan adhered to the *"innocent party rule"* which says that if an insurer has a basis to rescind a policy because it was fraudulently obtained, the insurer may not rescind coverage for innocent third parties who are entitled to claim under that policy and who did not participate in the fraudulent act. This doctrine is now under attack in the courts and, if that attack is successful, many accident victims will lose the right to recover benefits if the policy, through no fault of their own, was obtained by the fraudulent act of another. CPAN believes that the innocent third-party rule should be codified by the Legislature to prevent this inequity.

F. Codify the Right of Medical Providers to Bring Direct Legal Enforcement Action Against Insurers Who Fail to Pay for Services.

Comment: For more than 20 years, the Michigan Courts have recognized that medical providers who render services to auto accident victims have a legal right to pursue a direct cause of action against a no-fault insurance company who does not pay for the services rendered to the patient. Our courts have recognized that this independent right of action by providers is important in the overall enforcement of the No-Fault Act. Unfortunately, insurance companies are attacking that principle in the courts, seeking a ruling that providers do not have the right to sue a no-fault insurance company for non-payment of medical expenses and that the provider's sole remedy is to sue the patient. Such a concept is completely antithetical to the objectives of the No-Fault Statute, which is to see that patients have their bills paid promptly without getting involved in litigation. Therefore, CPAN believes that the right of medical providers to bring a direct action against no-fault insurers who do not pay expenses should be codified.

G. Allow Patients Whose Claims are Being Processed by the MCCA to Negotiate Monetary Redemptions of Their Claims, With Safeguards.

Comment: For many catastrophically injured patients, the MCCA has become a living nightmare. Because of the MCCA's constant meddling in the payment of claims, patients are experiencing prolonged delays, frustration, anxiety, and often times the unnecessary expense of litigation. Rather than compelling catastrophically injured

patients to remain in such a poisonous relationship, CPAN believes the No-Fault Statute should be amended so as to require the MCCA to engage in good faith negotiations with those patients who wish to redeem their claims and be free of MCCA control. However, such legislation must include stringent safeguards to make sure that any redemptions are approved and supervised by a court with appropriate jurisdiction.

H. Adopt Standards that Prohibit the Current Tort Threshold From Being Judicially Interpreted in a Way that Disqualifies More Innocent Victims from Compensation.

Comment: Ever since the Michigan No-Fault Statute went into effect, victims have been precluded from pursuing tort claims for noneconomic loss, unless the victim has sustained a "*threshold injury.*" Under the statute, there are three (3) threshold injuries: death, permanent serious disfigurement, and serious impairment of body function. The last of these threshold phrases has been the subject of intense litigation activity in the Michigan Supreme Court. Over the last 40 years, the Supreme Court has altered the definition of this phrase at least four times. CPAN believes that this instability is injurious to the no-fault system and threatens the necessary balance that must be maintained in order for the system to survive politically. Therefore, CPAN believes that the current judicial standards applicable to the threshold requirement of serious impairment of body function should be codified.