

Task Force on No-Fault Insurance Issues

Meeting Notes – **DRAFT**

NOTE: Meeting notes are not a transcript or “official” documentation of task force meetings. They are intended to track the key themes of the discussion. They do not reflect agreement with or the accuracy of any statements, comments, or presentations. *Please contact Demian Moore (MAD) with any requested edits, additions, revisions, or overall questions/comments. (651) 259-3831 (direct), or demian.moore@state.mn.us*

Meeting Details

Date: November 5, 2015

Start/End Time: 8:30 a.m. to 12 noon

Location: Minnesota County Attorneys Association, 100 Empire Drive, St. Paul, MN

Present: Marty Fleischhacker, Rep. Joe Atkins, Rep. Bob Loonan, Sen. Vicki Jensen, Douglas Broman, Bob Johnson, Vicky Rizzolo, Joel Carlson, Eric Dick, Charles J. Lloyd, Brad L. Plowman, Dan Wolfe, Dr. Timothy Johnson, Donald Bechtle, Mark Engdahl, Tammy Reno, JoAnn Aiken, Charlie Petersen and Demian Moore (MAD)

The Task Force is charged with submitting a report to the legislature with recommendations for changes to no-fault auto insurance, regarding:

- (1) no-fault arbitration process;
- (2) independent medical exam (IME) process; and
- (3) treatment standards and fee schedules.

Task Force information is available at the Department of Commerce website. <https://mn.gov/commerce/insurance/ins-companies/information-resources/task-force-no-fault-auto.jsp>

Activities

- Introductions and review of outstanding issues from 10-26 meeting
- Review of 10-26 meeting notes
- Discussion of definition of “abuse”
- Commerce: No-fault information from other states
- Other issues

Introductions, Review, and Miscellaneous

- Commerce Dept. expects to present Worker’s Compensation (WC) data and information at the 11-5 meeting; the data is aggregated, and comparable auto-related only data is difficult to pull out.
- Insurance industry indicated also that the data they have was difficult to process in a meaningful way as well; it is likely possible, but it would take time

- Question: is there a way to compare the “front end” of how WC cases are handled compared to how NF cases are handled upon entry into “the system”?
- Response: In many NF states the two systems are very closely intertwined. Hard to know without more research what sort of comparisons may be made
- Follow-up question: Do medical providers handle WC cases differently than NF cases?
- Response: DoLI does include in their insurance claim information indications of the type of accident/claim. They may be able to pull out specific information about WC and NF claim. Commerce will check.
- Mention was made of a concurrent legislative task force that is working on medical cost data; an All Payer Claims Database (APCD) is maintained by the office of Health Economics – there may be some relevant information there. Commerce staff will follow-up.
- Comment: WC has fee schedule and standards, but that hasn’t eliminated the issues that can result in IMEs, arbitration, or fraud concerns

10-26 Meeting Notes

- Points were raised about the accuracy of some of the points/comments made and recorded in the notes. Also, a comment regarding the differences between the intent of No-Fault compared to Worker’s Compensation was reported incorrectly in the notes. The incorrectly reported item was changed in the notes.
- Duluth attorney presenting at the 10-26 meeting raised some important and interesting issues, but most are outside the scope of this task force.
- Comment: there’s really no argument among those in the field that more than 90% of IME cases result in benefit termination [MAD Question: Is this the correct way to state this?]
- (Marty): his experience is that in more than 90% of case reviewed the result was either treatment termination or a change of services provided.
- Comment: This raises the point that the task force really needs a larger discussion about data, and availability of data.
- Response: Someone (presumably Commerce) would need to be given the authority by the Legislature to require reporting of data that isn’t currently reported (or isn’t reported in a way that is useful)
- Comment: Data reporting requirements could be part of the recommendations of this task force.
- Comment: For IME data, you’re already looking at a very small pool of people/claims out of the entire number of claims.
- Comment: The NF data may already exist, but it would take a lot of case-by-case work to extract.

Definitions of Abuse Discussion

[Double-sided page of definitions submitted by various task force member organizations was distributed at the 10-26 meeting]

- Primary theme was that “abuse” is when medical care that is not necessary is provided, and/or, is not provided at a reasonable cost

- Secondly, abuse is also the denial of necessary care; i.e. a patient's coverage being terminated before the patient's medical "need" has ceased
 - Some comments raised returned to the discussion of what level of post-accident recovery no-fault is intended to provide to the patient; comparisons between intent of WC and NF discussed again, i.e. what is "making whole" in the context of each?
- Question/Comment: Is there a recognized definition of "abuse" at the federal level? What about among major medical insurers – what is their definition of "medically necessary"? Is this a legally enforceable definition? Is it statutorily or only contractually defined (i.e. on a company by company basis), if at all?
- Comment: Task force may be entering the area of intruding on coverage decisions, standards of care decisions, patient/doctor decisions, etc.
- Comment: Could we define appropriate treatment methods?
- Charlie Question: Are there any definition of abuse that people DO NOT like?
 - Definition that includes "benefits of the providers and/or attorney," (referring to the "attorney" portion)
 - Response: attorneys can have a hand in defining the scope of an arbitration case, or, which can be part of what creates real or perceived examples of abuse. For example, as part of the pre-trial decisions, attorneys select which bills to arbitrate. [Q: does this sound accurate?]
- "Abuse" is often actual fraud that isn't identified or caught, e.g. intentionally using incorrect billing codes, improper billing

Summary of Abuse Discussion

- How/if to define "medically necessary" and "reasonable cost"
 - Medical "need" must be a direct result of the accident under NF
- Consumer side – at what point is denial of benefits abusive?
 - Examples: legal intimidation, or being discouraged from pursuing care for fear of ultimately not being covered or compensated for treatment
 - ER example: there are lots of tests, procedures, etc. that may not appear "necessary" in hindsight
- What are the next steps once "abuse" has been found?
- Retrospectively, if a treatment, procedure, etc. is determined to have been "abusive," who compensates for that treatment/care that has already been undertaken? Can't be the patient, insurer, care-giver, etc. How is that cost distributed and compensated for?

Review of Other States' No-Fault Fee Schedules

- Refer to the handouts distributed at meeting
- Commerce/MAD will provide a simplified matrix of the various state's schedules at the 11/5 meeting
- New Jersey is a good example of an extensively designed system
- Number of states tie NF system directly to their WC system and its rates
- Treatment guidelines/reimbursement rates are often tied to Medicare rates and standards

Follow-up/Closing Discussion

- Is there any objective measure of whether these other states' systems work, save money, reduce fraud, etc.?
- Is there any correlation between having a fee schedule and lower premium rates? How effective are fee schedules at controlling costs (re: medical in NF)?
- What percentage of premium cost goes to PIP?
- PIP reforms don't affect the liability portion of premium costs.
- Comment: really need to identify how much of the premium cost we can affect by getting savings from NF reforms. In the end, is it worth it? Will fee schedules lower premium costs?
- Comment: PIP costs really are not an effective way to affect premium cost drivers.
- Comment: If the PIP benefit had been adjusted for inflation from its implementation it would currently be around \$95,000.
- IME decision are based only on the evidence provided. Can't be faulted for what drives the decision if the evidence is properly assessed.
- Response: But, insurance companies choose the IME doctors. They aren't truly "independent."
- Comment: Fee schedules "are a wash, or worse"
- Comment: If you base fees on 1X0% (either 110 or 150), then a lot of ERs will close, and a lot of ambulance services as well, particularly those serving rural areas.
 - Some states exempt ER costs from counting against NF limits
- Comment: Fee schedule discussion is not unique to NF. Pervasive topic in health care cost discussions. Also politically charged.
- Comment: Can't compare NF to normal health insurance. All those costs/fees are negotiated (Medicare too).
- Question: Does Medicare have a standard for chiropractic costs/treatment?

Charlie - Concluding

- Of the two, what should the task force focus on, fee schedules, or treatment guidelines?
 - Response: treatment guidelines (overwhelmingly agreed upon)
 - No "bang for buck" in a fee schedule; also, very sensitive issue
- Can we define the line between "reasonable" and "excessive"?

Next Steps

- **Homework:** What is your organization's definition of "medically necessary"?
LANGUAGE TO CHARLIE BY 11/16
- Small group formed to work on "medically necessary" and "abuse" definitions [MAD: I believe that was their charge.]: Joel Carlson, Bob Johnson, Doug Broman, Dan Wolfe
- The 11-17 meeting will include a discussion on the medical side of arbitration.
- There will be two meetings in December.

Meeting notes prepared by Demian Moore, MAD. Please direct revisions, additions, or questions to demian.moore@state.mn.us.

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