DELAY, DENY, DEFEND

Do **AUTOMOBILE INSURANCE** firms operating in Michigan put **PROFITS** ahead of policyholders by **AGGRESSIVELY** challenging no-fault **ACCIDENT CLAIMS** in court or offering **LOW SETTLEMENT** offers, thereby saving millions of dollars in **POTENTIAL PAYOUTS**? Yes, say accident victims, lawyers, and insurance advocacy experts.

BY DAN CALABRESE

PHOTOGRAPHS BY MARTIN VECCHIO

DEVIN KALISZ WAS AN ACTIVE 24-YEAR-OLD MOTHER of twins when she stopped at a red light in Lake Orion. It was 2006. In her rearview mirror, Kalisz saw a Chevrolet S10 pickup coming up very fast behind her and thought, "this girl is not going to stop."

The rear-end collision did minimal damage to Kalisz's Ford F10 pickup, but Kalisz wasn't so fortunate. Her head crashed into the steering wheel, and the sudden pain in her head was unlike anything she had experienced before. "That was the beginning of the end of life as I knew it," Kalisz recalls.

As serious as Kalisz's injuries were, her real ordeal was dealing with the insurance company. Her case and others illustrate what is needed to improve the state's widely lauded no-fault auto insurance system.

As it stands, Michigan is the only state that mandates insurance companies to provide unlimited, lifetime medical benefits to motorists injured in auto accidents. While the no-fault benefits Michigan policyholders receive far outpace benefits available in other states, the operation of the program is often riddled with frustration and impediments to recovery.

Insurers and policy holders routinely face each other in court over benefit

claims that insurers say drive up the cost of premiums, and leave them with no choice but to carefully scrutinize every case.

Plaintiffs' attorneys allege the industry is far more calculating and cunning than it acknowledges.

They say insurers routinely engage in the wholesale and arbitrary denial of claims, understanding that a claimant's only recourse is through the court system, where the insurer's liability can be limited and its chances of outlasting claimants — if not actually winning — are good. Short of a trial, insurance firms have been known to make low-ball settlement offers to unsuspecting victims in hopes they won't pursue legal advice, *say* plaintiff attorneys.

Most disconcerting is that some insurance companies delay paying accident victims in the hopes that they will die. Such practices were featured in John Grisham's 2005 book, *The Rainmaker*, and a subsequent movie by the same name directed by Francis Ford Coppola and starring Matt Damon, Danny DiVito, and Danny Glover.

In other instances, insurers quietly seek the claimant's agreement to a denial of claims, which completely undermines Michigan's well-regarded no-fault system. Dairyland Insurance Co., which has its headquarters in Stevens Point, Wis., will send a release of liability form to its own injured customers that, if signed, extinguishes their legal rights — past, present, and future (often just seven days after a crash) — in exchange for merely paying off the claimant's deductible.

"When the auto insurance firms say they have low profit margins, keep in mind that their (combined) annual profits are in the billions of dollars," says Michael Morse, owner and president of Michael Morse PC in Southfield, the state's largest auto accident plaintiff's firm. "The insurance companies are more than willing to lose 10 percent of the claims (those that are successfully challenged or settled in court) knowing that the other 90 percent are never challenged. Those victims just learn to live with the injuries or wind up on Medicaid, which doesn't come close to matching the medical treatment they would get in the private insurance system."

According to a 2007 analysis of the state's auto insurance market by Jay Angott, director of the Office of Consumer Information and Insurance Oversight at the U.S. Health and Human Services Department, auto insurers operating in Michigan are among the most profitable in the country, and have been for years.

Meanwhile, regulators claim there is no way to specify in law exactly what insurers must pay for, as every case is unique and ultimately comes down to a contract dispute between private parties.

Kalisz knows the game well. After her accident, she was taken to the emergency room at Pontiac Osteopathic Hospital, where Kalisz says the physicians on duty did what they usually do with head or neck pain: They assumed it was whiplash, and treated it as such. In fact, Kalisz had a closed-head injury. Worse, the blow aggravated a condition she did not even know she had — Chiari malformation, which causes brain tissue to protrude into the spinal canal and can cause a range of symptoms including dizziness, muscle weakness, numbness, vision problems, headaches, and trouble with balance and coordination.

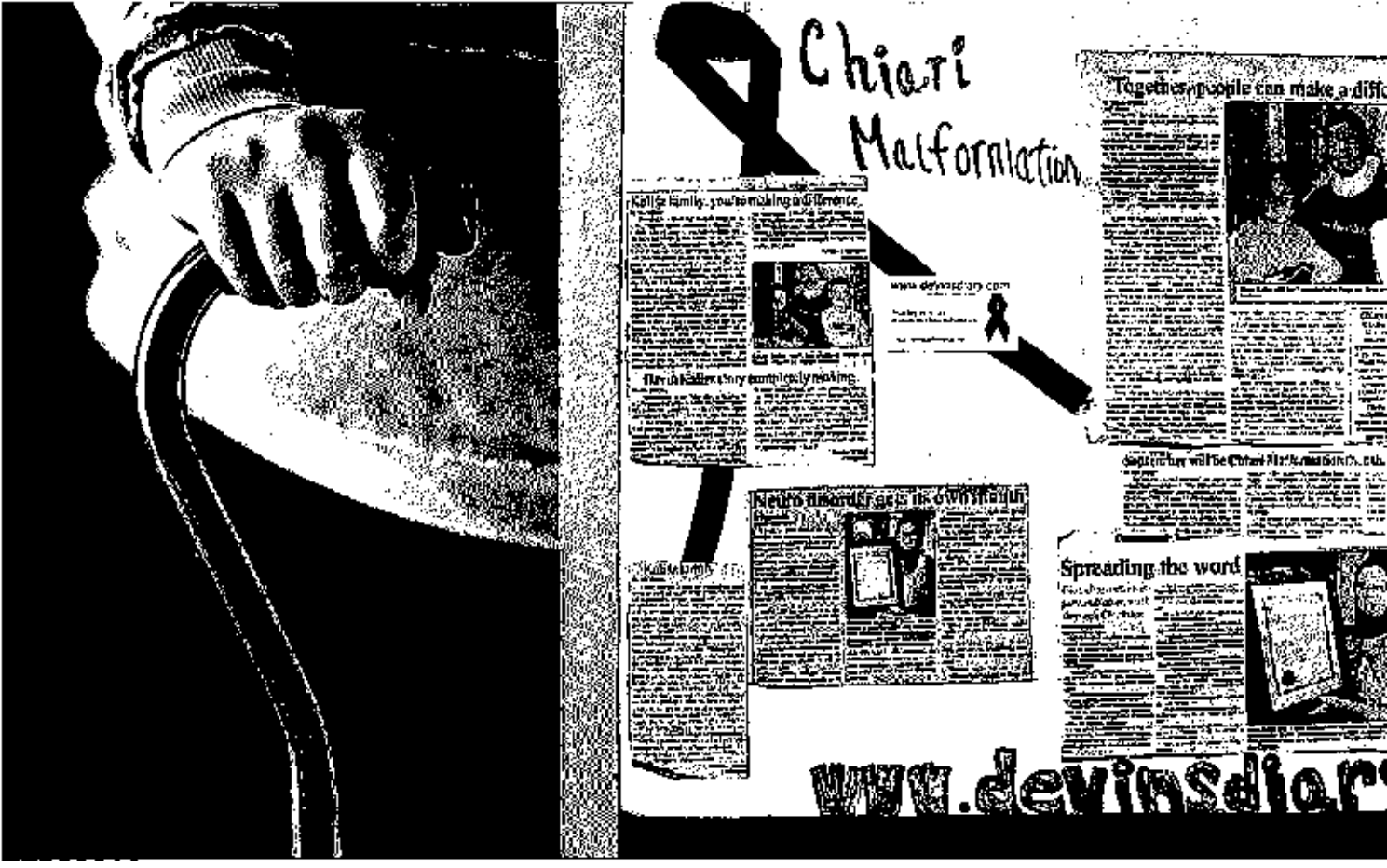
The initial misdiagnosis and subsequent correction run up hefty medical bills as Kalisz began the long process of seeking treatment for her injuries. Fortunately, she initially received excellent service and attention from the adjuster with her auto insurance company, Michigan Education Employees Mutual Insurance Co., or MEEMIC. The insurer was responsible for her medical bills under Michigan's no-fault auto insurance system.

But that changed about six months after the accident. Kalisz says she received a letter from MEEMIC — which did not return repeated phone calls seeking comment for this story — informing her that they would no longer accept the word of Kalisz's doctors about the necessity of her treatment. Instead, she was required to see a doctor working for the insurance company.

"Their doctor saw me for about two minutes, and I remember I thought it went pretty well," Kalisz says. "But he decided that these injuries were not, in fact, what they were, and that the insurance company should not pay me. He said I was able to go to work and live a normal life. And at that point, I knew I had a big problem on my hands — that this was not going to get better, that they were not going to help me."

The so-called "Independent Medical Evaluation (IME)" involves a doctor hired by the insurance company. Many lawyers and insurance experts contend such doctors are highly motivated to recommend that an auto accident victim's claim be denied — or, in other words, that all benefits should be cut off. "It's a multimillion-dollar business where the doctor gets $500 to $750 per examination, and $2,000 to $3,000 if they review records or conduct a deposition, all paid for by an insurance company," Morse says. "These IMEs are anything but independent. They are bought-and-paid-for experts hired by insurance companies.

» TOUGH ROAD Devin Kalisz sued her insurance company to restore [illegible]



"Obviously, a doctor that favors the victims doesn't last long under this system. We've deposed doctors in court who admit to making millions of dollars from the insurance companies for doing this type of work," he adds. "Unfortunately, once a physician hired by the insurance firms recommends a denial of claims, the insurer will send a 'cut-off letter' to all of the doctors and medical personnel treating a victim, saying that payments have been terminated. It puts the victim in an incredibly bad place."

Kalisz's next move was to engage Romanzi Atnip, a law firm in Waterford Township that specializes in personal injury claims. The law firm sued MEEMIC on Kalisz's behalf, winning the initial case and surviving an appeal, so that today her full benefits have been restored and her treatment is back on schedule.

An unbelievable story? Not really, say critics of the insurance industry.

They claim that Kalisz's experience is all too typical — especially in Michigan, where they say insurance companies routinely seek ways to avoid paying claims. The tactic is described by industry critics as "Delay, Deny, Defend," meaning delay your claim, deny you were hurt, and defend aggressively.

In a nutshell, critics allege insurers delay by declaring a claim is "under investigation" — a process that can drag on indefinitely, even though under Michigan law an insurance company must make a decision on whether or not to pay a claim within 30 days after receiving reasonable proof of a loss.

After the investigation, they say, insurers issue wholesale denials of claims, then defend their denials in court, figuring many customers do not have the resources to litigate. While the insurance companies do lose or settle numerous court cases, like Kalisz's, the strategy makes money overall because few people challenge an insurer's denial of claims in court.

Why would an industry that's all about customer service treat its customers this way? Industry critics assert that with the current structure of Michigan law, and given certain anomalies applicable only to the insurance industry, the logic of the strategy starts to come together:

• Under Michigan's mandatory no-fault law, everyone who owns a car must purchase auto insurance. The insurers have a captive market.

• Judgments against auto insurers in Michigan are limited to the value of the disputed claim. In most other states, there is a provision that allows the courts to find insurers have acted in "bad faith" (i.e., they knowingly denied a legitimate claim) and to impose punitive damages as a result. Insurers in Michigan are on the hook for their legal costs, but as far as judgments are concerned, they can't be made to pay more than if they had just paid the claim in the first place. Michigan law does allow for punitive fines to be levied by the state insurance commissioner if the official finds a company

IN A NUTSHELL, CRITICS ALLEGE INSURERS **DELAY BY DECLARING A CLAIM IS "UNDER** INVESTIGATION" — A PROCESS THAT **CAN DRAG ON ALMOST INDEFINITELY.**

engaged in a pattern of bad faith practices, but fines are limited to $2,500 per case and cannot be applied when only one case is involved. (However, a judge can award attorney fees and interest to law firms that successfully challenge a denial of claims.)

• Since 1979, nearly 26,000 catastrophic claims have been reported to the Michigan Catastrophic Claims Association, which reimburses no-fault auto insurers for benefits that exceed $500,000. Based on current estimates, 13,103 claims remain active, resulting in future lifetime payments in excess of $71 billion, according to MCCA data. The figure assumes inflating costs for products, services, and accommodations necessary for the care, recovery, and rehabilitation of injured persons throughout their lives. The MCCA estimates that an additional 850 drivers in Michigan will be catastrophically injured in auto accidents next year.

• Insurance companies' favorite customers are those that never file a

« PUBLIC NOTICE Devin Kniss' website [illegible] raises awareness about her medical condition. [illegible]

claim. A customer can pay premiums to an insurance company for his or her entire life, never receive a benefit in return, and be satisfied. By contrast, a driver might pay premiums for 10 years, and then file a claim — only to have it denied. The result is an often expensive and stressful legal challenge. As for those drivers who sign a release extinguishing all of their legal rights following an accident, the insurer collects 10 years of payments and offers nothing in return.

Craig S. Romanzi, a partner at Romanzi Atnip, says the phenomenon is aided by the complicated nature of insurance products.

"I cannot think of a product that is more complicated and comprehensive in what it does than an auto no-fault policy," Romanzi says. "You have a health care policy built into it. You have property damage built into it. You have income replacement built into it. All kinds of things are built into it. But at the time of the sale, you have none of that explained to you. And I would say very few, if any, consumers understand the breadth and scope of the benefits that are available, because there is no requirement for an explanation of what the policy is. You walk in and say, 'This is my car.' They ask you three questions, and then they say, 'This is your premium.'"

Adding to the mix and cost are the nearly 20 percent of drivers on the road in Michigan who lack insurance — up from 11 percent in 1989, according to the Insurance Research Council, an independent, nonprofit research organization supported by leading property and casualty insurance companies and associations. The actual cost of Michigan's uninsured drivers is picked up by other insurance programs or hospitals, which ultimately pass along the costs to their customers.

James Mathis, a Nevada-based consultant who is certified as an expert witness in insurance cases, and previously worked for Allstate Insurance Co. and State Farm Mutual Automobile Insurance Co., says the industry did not always embrace these practices. It started, he says, after major hurricane-related losses put several insurers out of business in the early 1990s, prompting the industry to look for new ways to enhance profits.

That's when Mathis says top insurers sought the advice of two major consulting firms — McKinsey Group and Accenture (formerly part of Arthur Andersen) — on how to cut costs and improve their profit margins.

"What they wanted them to do was go over and review their operations and claims, and give them an outline and guidance on how to increase profits in the claims department," Mathis says. "Of course, there are multiple departments in an insurance company, but the claims department has always been the department that spent the money. They paid the claims. That's the business of insurance."

So if a department's entire purpose was to spend money, how could it add to profits? Given the numbers the industry started with, it wouldn't be easy. Currently, insurers pay, on average, 65 cents per premium dollar on claims (with expenses of 30 percent). "The overall ratio in the early '90s was costs of 104 cents per premium dollar, so if it hadn't been for their investment strategies, they would have been losing money," Mathis says.

In other words, with the average claim occurring between three to seven years after the issuance of the policy, the insurers had to wisely invest the premium dollars they collected in advance of paying any claims.

According to the documents Allstate released after years of refusing to do so — the same ones cited by Mathis — McKinsey recommended a strategy through which the insurer would avoid paying claims wherever possible. Armed with resources to outlast frustrated policyholders, the strategy was said to offer a path to greater profitability, even if some customers successfully litigated to get their claims paid.

"The initiatives were very subtle," Mathis says. "The basic philosophy was the three Ds in the handling of claims — delay, deny, defend. But there is also what I call invisible barriers to fair claim handling, and these are the incremental and almost insignificant dollar savings, or even less than a dollar savings, on a large number of claims."

As an example, Mathis cites a situation in which a female accident victim requires an X-ray. Any woman who is potentially pregnant (admittedly having had sex with a man after her last period) must have a pregnancy test before X-rays are taken as a safety precaution. But because an auto accident obviously does not cause pregnancy, Mathis says, the insurers started refusing to pay for the tests.

"Potentially pregnant females represent occupancy in about 30 percent of all accidents," Mathis says. "You're talking about a $22 test, so it's not a significant cost factor in an individual accident. And yet the risk is huge, if it's not done. Would you give up the life of one child so you didn't have to pay $22 on an accident? Well, no. But the insurance company has decided it's an affordable risk, so they don't pay it. When you start multiplying out the cost factor, 30 percent of 15,000 claims at $22 each (per day), you're talking about a huge number ($36.1 million annually for one insurer)."

For individuals caught in the middle while an insurer investigates or questions a claim, the result can be months of uneven care. Health care providers are asked to accept the risk of not getting paid while a claimant waits for an insurer's decision; some providers are willing to accept the risk, but many others are not.

That becomes an especially big problem for a person like Larry Dodson,

AUTO INSURANCE **REFORM**

According to a 2007 report, *An Analysis of the Profitability and Performance of the Michigan Auto Insurance Act* by insurance advocate Jay Angoff, director of the Office of Consumer Information and Insurance Oversight at the U.S. Health and Human Services Department, various changes to Michigan law could be enacted which would bring Michigan auto insurance rates down. They include:

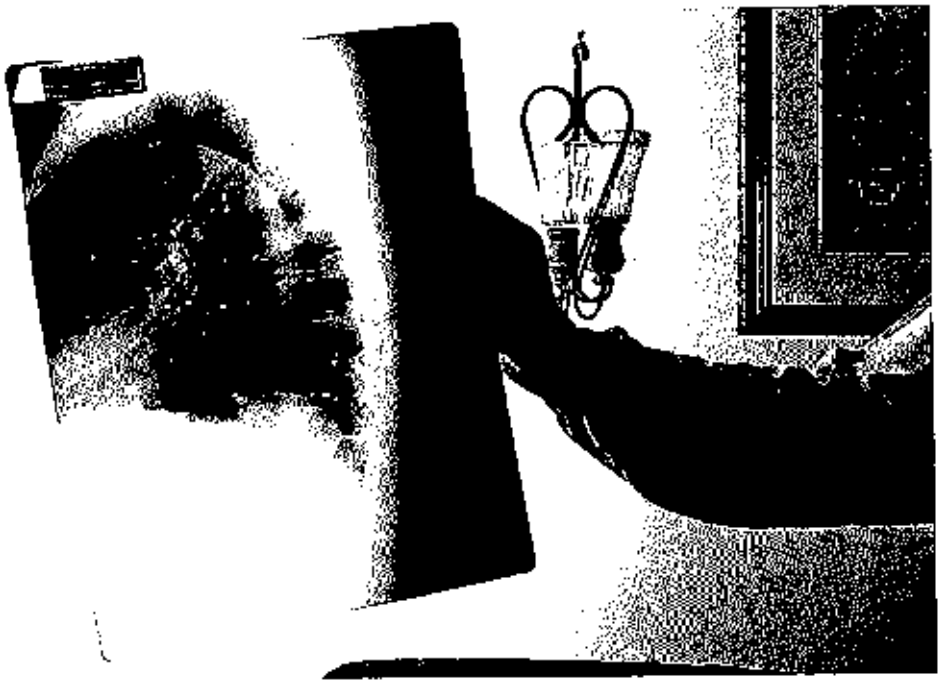
1 Authorizing the commissioner to find rates excessive, and to disapprove of excessive rates.

2 Strengthening the law prohibiting insurers from surcharging people based on credit history, lack of prior coverage, and other factors that drive up rates for low-income people.

3 Authorizing the commissioner to order refunds when insurers unlawfully overcharge policyholders.

4 Establishing a private right of action to enable policyholders to recover illegal overcharges.

5 Enabling the public to have access to the Michigan Catastrophic Claims Association's records, and authorizing the commissioner to disapprove excessive MCCA assessments. The profitability of no-fault coverage depends to a large extent on what the ultimate liabilities of the MCCA are, and under current law the ultimate liabilities of the MCCA are whatever the MCCA says they are. Allowing the legislature and the public to have access to the MCCA's data and projections will enable the public to have a truer picture of the profitability of no-fault insurance than is available today.



whose injuries were so serious that he is in need of constant care.

Dodson, a Virginia native who came to Michigan a decade ago seeking employment opportunities, was working as a tow-truck operator when, one day in 2006, he was underneath a disabled vehicle preparing to connect it to his tow truck. Unfortunately, the vehicle accidentally bounced out of the lift hinges and fell on Dodson's head, leaving him a paraplegic.

Dodson's subsequent battle for no-fault benefits dealt with myriad issues affecting his eligibility for benefits, including the distinction between whether he was "loading" or "hitching," and whether he was using a "sling bed" truck.

"We had two insurance companies — State Farm and Progressive — battling it out, each saying they were not responsible," says Deborah Johnson, CEO of Southfield-based CareForward, the attendant care company that manages Dodson's care. "When you have insurance companies battling over who is going to pay, basically nothing gets done, and (reaching any type of settlement or decision) can take years."

And, in Dodson's case, it did. During that time, Johnson says, CareForward continued to manage Dodson's care without knowing when, or if, it would be paid. When Dodson needed various forms of treatment, CareForward had to find providers who understood the risk of nonpayment, which often eliminated the better-qualified providers.

It was ultimately decided that Progressive was responsible for Dodson's care, and while Progressive did eventually pay his benefits, Johnson says the payment was delayed for months while Progressive declared the case "under investigation." In the meantime, Dodson's condition deteriorated to the point where, today, he is wheelchair-bound.

Progressive spokeswoman Leah Knapp declined to comment on Dodson's case. "What I can tell you is that our goal is to settle all claims quickly, accurately, and fairly," Knapp says. "In some instances, when complex claims are overlaid with intricate state laws, it takes time."

Peter Kuhnmuench, executive director of the Insurance Industry of Michigan in Lansing, disputes the notion that delays and disagreements equate to insurer wrongdoing. They are, he says, the nature of contract relationships.

"There will be circumstances, obviously, where somebody's not happy with the results of their claim," Kuhnmuench says. What's more, he emphasizes that the industry must look at claims carefully in a system that confers unlimited lifetime benefits.

While Kuhnmuench and others in the insurance industry point to Michigan's unlimited no-fault benefits as a significant burden on insurers, the liability of insurers is actually capped.

The statute that created Michigan's no-fault system in 1973 also mandated the creation of a private nonprofit reinsurer, the Michigan Catastrophic Claims Association. When an insurer's liability to a claimant reaches a certain point — $500,000, under state law — MCCA reimburses 100 percent of any future payouts.

MCCA, whose board consists of representatives from AAA, Auto Owners Insurance, Progressive, State Farm, and Farmers Insurance, obtains revenue from two sources: a state-mandated assessment on every insured driver (currently $145 per year) and investment income.

During fiscal year 2010, MCCA says it paid out $816 million in claim reimbursements on 1,348 cases, while taking in $827 million in assessment income and $526.5 million in investment income.

Critics of MCCA point to its asset reserve of $12.9 billion and question whether some of that money should be returned to taxpayers, or should be used to reduce auto insurance premiums, as it was in 1998, when MCCA returned $1.2 billion from the reserve to policyholders following pressure from the Michigan Legislature and then-Gov. John Engler.

But MCCA officials say the purpose of the reserve fund is to keep assets on hand so that, if a change in the law were to terminate MCCA's assessment and shut it off from responsibility for any new claimants, it would have the resources to pay lifetime benefits for its existing claimants.

"We're not a pay-as-you-go system," says Gloria Freeland, MCCA's executive director. "What we've collected (from insured drivers) is what — if MCCA were abolished tomorrow — should be sufficient to pay all the current claims that we have." According to its actuarial estimates, MCCA officials say they are currently $1.6 billion short of the money needed to do this.

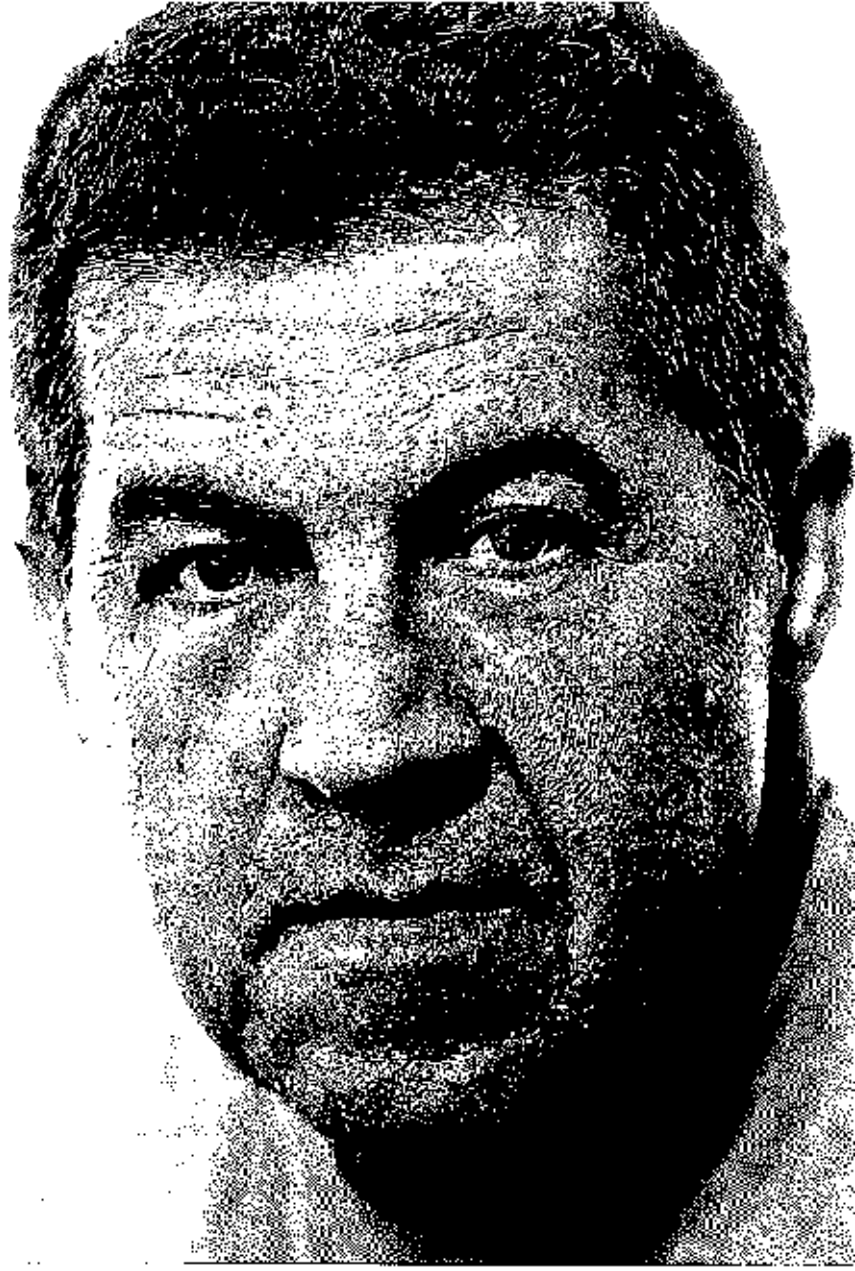
> OTHERS IN THE INSURANCE INDUSTRY **POINT TO MICHIGAN'S UNLIMITED** NO-FAULT BENEFITS AS A SIGNIFICANT **BURDEN ON INSURERS. THE LIABILITY** OF INSURERS IS ACTUALLY CAPPED.

But is MCCA required to maintain a reserve fund that could pay the lifetime claims of all existing claimants?

State Rep. Ellen Lipton (D-Huntington Woods), a member of the House Insurance Committee, says the MCCA may well have the discretion to maintain such a large reserve fund, and she recognizes the benefits of such a practice for claimants and for MCCA's investing power, but there is no state statute that requires it to do so.

"There's nothing in 3104 (the statute that creates and governs the MCCA) that says this is what they must do, or this is what their obligations might be in the event of a dissolution or if they cease to exist," Lipton says.

Some plaintiff attorneys say MCCA plays a role in the delay or denial of benefits by insurers, to the detriment of claimants. This stems from the 2009 outcome of litigation between MCCA and the insurer USF&G, which agreed to a settlement with a claimant and then sought MCCA reimbursements when the costs of the settlement exceeded the cap at the time.



» GET BACK Henry Telesz is suing his insurance company after it cut off some of his benefits not stemming from a 2008 car accident.

MCCA believed that USF&G unreasonably agreed to the terms of the settlement, and refused reimbursement. When the court ruled that MCCA did not have the authority to refuse reimbursement because it disagreed with an insurer's adjustment practices, MCCA issued a claim bulletin informing insurers that it would demand the right to give prior approval to settlements that may ultimately require MCCA reimbursements.

"When the carrier recognizes a claim is likely to involve MCCA at some point in the future, it has a duty to report that claim to the MCCA," says Joseph Epstein, corporate counsel for MCCA. "And any time there's a material development subsequent to the claim arising in the first place, the carrier has to advise the MCCA of that development."

According to Marc Lipton, a Southfield-based personal injury attorney who specializes in auto no-fault cases (and is the husband of Ellen Lipton), insurance adjusters exercise extreme caution to avoid a rebuke from MCCA.

"If you're an adjuster on a claim, you have no incentive to resolve a claim short of litigation," he says. "An adjuster who's handling more than 100 files is overworked, and the adjuster can't do anything without the MCCA's blessing."

But MCCA executive director Freeland believes the organization's new policy actually has the opposite effect, because adjusters who check with MCCA in advance know what kind of leeway they have.

"If anything, this practice is the safeguard for the company," Freeland says. "Because now, instead of making the payment, they're reaching out and getting that pre-approval, and they know immediately that they're getting that reimbursement. There's nothing left to question."

Romanzi says the requirement causes snags in the process, citing the example of Henry Telesz of Clinton Township.

In July 2008, Telesz, then 47, was going through an intersection in Roseville when another driver ran a red light and T-boned his car. Minutes later, a witness on the scene found Telesz bloody and unresponsive, and called 911. Roseville emergency responders used the "Jaws of Life" equipment to remove Telesz from his car.

Telesz's injuries affected his brain, ribs, lungs, aorta, spleen, spine, and diaphragm, among other areas. His medical expenses and loss of wages were well in excess of $100,000. Released from the hospital after a month, Telesz began following an intense rehabilitation regimen ordered by his primary care physician, Dr. Erwin Feldman.

Telesz filed a claim with Titan, which proceeded to pay no-fault benefits including medical expenses and loss-of-wage benefits, although he says they were less than 10 percent of what he had been earning. But in 2010, after ordering Telesz to see two of their own physicians — one of whom declared him fit for "return to work efforts," while the other wanted to see more information — Titan cut off Telesz's benefits with respect to his spinal injuries, as well as his loss-of-wage benefits.

"In Henry's situation, his no-fault benefits were approaching the cap, so the insurance company, Titan, indicated they were unable to resolve his case with MCCA approval," Romanzi says. "Henry has an aortic stent, and you have to have a thoracic CT performed every six months to make sure the stent is not becoming dislodged. This type of preventive measure is clearly related to the accident. But the insurance company has terminated all of his benefits."

In response, Telesz hired Romanzi Atnip to proceed with litigation against Titan. Meantime, Telesz lost his trailer, and many of his bills went unpaid. He is still receiving medical treatment, but his doctors are not getting paid — and will not, unless Telesz is able to win the resumption of his benefits.

Telesz says Titan hired a doctor to conduct an "independent medical examination," but he wasn't impressed.

"They looked at me," Telesz says. "They told the insurance company I was fit, fine — but I wasn't. Their doctors' offices are spic-and-span and clean, and don't even look like they're used. They didn't examine me. They talked to me more than they examined me. They didn't give me a physical examination. They didn't take any X-rays."

According to Steven M. Gursten of Farmington Hills-based Michigan Auto Law, he also sees a pattern where insurers regularly send claimants to "cut-off doctors" who are paid by the insurers, and understand their job is to come up with justifications for ending benefits.

"The public would be shocked if they knew of the industry that exists in Michigan, of doctors who make enormous amounts of money cutting people off left and right," Gursten says. "A lot of these doctors don't practice anymore. They don't treat people anymore. And they're making vast amounts of money doing 15-minute examinations and then writing reports saying people don't need benefits."

To whatever extent Gursten's charge may be accurate, there appears to be

little that regulators can do about it short of making changes in the law. Teri Morante, senior deputy commissioner of Michigan's Office of Financial and Insurance Regulation, says disagreements among doctors are common.

"If we noticed a particular company had an extraordinary number of complaints like this, we definitely could go in and do a market conduct exam and look for a pattern of this sort of thing," Morante says. "I don't know that this has ever been done because a lot of these are just individual situations."

Indeed, OFIR can only do what Michigan law empowers it to do, and insurance statutes permit regulators to take action only if they can show a pattern of questionable conduct on the part of an insurer. It cannot act against an insurer based on an individual case.

What's more, Morante notes, out of more than 700,000 personal injury claims filed with no-fault auto insurers in Michigan in 2010, just over 700 resulted in complaints to OFIR — less than one-tenth of 1 percent. That number makes her skeptical of plaintiff attorney complaints about "delay, deny, and defend."

"I do not see delay, deny, defend as a practice that is happening in the industry," Morante says.

On the other hand, plaintiff attorneys note that most accident victims complain directly to insurance companies, not the OFIR. They may not know the OFIR exists, or that the organization even handles complaints.

Michigan insurance statutes require insurers to pay legitimate claims within 30 days, and impose interest penalties on insurers who don't comply. But the state's no-fault law offers few specific definitions of what constitutes a legitimate claim, and OFIR regulators have little power to act when claimants and insurers disagree over the legitimacy of a claim.

"There's nothing in the code that says you have to pay for this, this, and this," Morante says. "Every situation is fact-dependent, so reasonable people can disagree on facts of a given situation. Regardless of what you might think of a doctor that a company might send somebody to, doctors disagree, and it's going to happen. We have the highest level of benefits in the country, so it shouldn't surprise anyone that there are going to be disagreements. But it's a contract between the individual and the insurance company. So (the insurers) have to behave in a certain way, but the law doesn't tell them what they have to pay for."

As a result, disputes between claimants and insurers inevitably end up in litigation. According to plaintiff attorneys, this is where Michigan law stacks the deck in favor of the insurers. Because Michigan law does not make a provision for punitive damages for a finding of "bad faith" by insurance companies, insurers who lose in court only have to pay the value of the original claim plus interest (and, likely, attorney fees).

"What we've had here is an explosion of litigation forced by the insurance companies by these wholesale denial of claims — forcing people into court," Romanzi says. "Insurance companies look at things at a very high level. Any one claim doesn't matter to them. They know a certain number of people will just give up. They know others will drop their claim. It's ridiculous how they are treated."

In 2009 Lipton attempted to introduce reforms to the state's no-fault system that would have given OFIR regulators more power to intervene.

"You have to prove bad faith, and then there are enhanced damages — the theory being that if the insurance company is going to have to pay more for acting in bad faith, then they won't."

Lipton sought to act on recommendations offered by Butch Hollowell, who was serving at the time as the state's automobile and home insurance consumer advocate. But her bill died in the Michigan Senate, and she sees little interest in reviving such reforms at present.

Today, legislators are considering a number of reforms to no-fault, some of which would allow consumers to buy lower levels of coverage in exchange for lower premiums. One proposal of personal injury protect, or PIP, would offer a tiered system in which the lowest level of coverage would be $50,000.

SAFETY **FIRST**

1 Review your policy and be truthful with the insurance agent. Make sure all potential drivers are listed, including spouse, children, nannies, babysitters, etc. Make sure the address where the vehicle(s) is/are kept is accurate and truthful.

2 Make sure you have at least $250,000 of both Uninsured Motorist Protection (UM) and Underinsured Motorist Protection (UIM). UM protects you from drivers who may cause an accident (including a hit and run) and lack insurance. UIM protects you from negligent drivers who may not have enough insurance to cover your injuries.

3 Understand the difference between a coordinated policy and an uncoordinated policy. You have a choice, but most insurance agents will give you a coordinated benefits policy unless you ask for uncoordinated coverage. Uncoordinated is better from the standpoint that you can be treated by any type of medical provider, regardless of whether your health policy covers it. In other words, you are not limited to your health plan. It is very good for people with an HMO or limited health insurance options.

4 Not all insurance companies are equal. Ask friends and family to discern the level of service provided by their carriers following an accident (loss). Some carriers do not offer all benefits. Shop around for the best prices.

5 If price is a big concern, look to raise your deductible or consider the different types of collision coverage. This will lower your premiums. But don't skimp on UM or UIM coverage.

6 Make sure you have enough bodily injury coverage in case you cause an accident and injure someone. You need to be insured at a high enough amount so that, if you get sued, your assets will be protected. At least $250,000 is recommended. If you are a "high-net worth individual, consider insuring yourself for $1 million or more. Consider an umbrella policy on top of that.

Source: Michael Morse PC, Southfield

Attorney Gursten sees the measures as a money grab by auto insurers. In a recent study by Anderson Economic Group in Lansing, the proposed changes, if enacted, would mean "the auto insurance industry in Michigan stands to pay out between $91 million and $109 million less in claims each year."

Gursten fears such an option may entice many consumers to accept the lower levels of coverage, not understanding that a catastrophic accident would likely lead to medical bills well in excess of such a number. He hopes the Legislature will look to regulatory tweaks that can maintain unlimited lifetime benefits while controlling costs and protecting consumers from arbitrary denials.

"If you have the misfortune of being catastrophically injured, I hate to say it, but the state where you want that to happen is Michigan, because Michigan has unlimited medical," Gursten says. "What that means for those with catastrophic spinal cord injuries and traumatic brain injuries is that they receive a much higher level of medical care than states without no-fault.

"So, yes, there are tons of games, and (some) people are treated terribly by insurance companies. But that still doesn't mean the alternative — which is not having no-fault, or being in a state like Florida, where because no-fault doesn't exist people get pushed to Medicaid and receive terrible medical treatment — would be better." db