

COST-SHIFTING OF MEDICAL COSTS IN AUTOMOBILE CRASHES STUDY - BACKGROUND MEMORANDUM

The Legislative Council chairman directed the Transportation Committee to study cost-shifting of medical costs of individuals injured in automobile crashes.

The end result of any automobile crash is that some person pays or is liable to pay for medical costs that result from the automobile crash. Depending on the fact scenario, and the insurance and drivers involved in the accident, that person may be:

1. An automobile no-fault or medical payments insurance company.
2. An automobile liability insurance company.
3. An automobile uninsured insurance company.
4. An automobile underinsured insurance company.
5. A health care insurance company.
6. The at-fault driver.
7. The driver not at fault.
8. A health care provider.
9. A medical assistance program.

Any change in mandated coverages should be reviewed to determine the change's effect on which person pays or is liable to pay. In addition, any change in mandated coverages should be reviewed to determine if any efficiency in payment is gained and if there is any change in the certainty of payment.

This memorandum will review recent bill changing law relating to who pays medical costs in automobile crashes. Because no-fault automobile insurance has the primary obligation for economic loss from bodily injury in an automobile crash, the bills relate to no-fault insurance.

NO-FAULT INSURANCE

Generally, the term "no-fault automobile insurance" refers to a type of automobile insurance under which claims for personal injury are made against the claimant's own insurance company rather than against the insurer of the party at fault. *Black's Law Dictionary*, 411-412 (Abridged 5th Ed. 1983).

In 1975 the North Dakota Legislative Assembly enacted the North Dakota Auto Accident Reparations Act, which provides for a no-fault automobile insurance system. This no-fault automobile insurance law became effective on January 1, 1976, and remains in effect, with amendments, today. North Dakota Century Code (NDCC) Chapter 26.1-41 is entitled "Auto Accident Reparations," and this chapter comprises most of the state's no-fault automobile insurance law. Under this system, the owner of an insured motor vehicle (secured person and secured

motor vehicle) is required to have insurance coverage for the payment of basic no-fault benefits and liabilities covered under motor vehicle liability insurance.

Under a no-fault system there are limitations on the right of a victim to sue if injured in a motor vehicle accident. North Dakota Century Code Chapter 26.1-41 precludes tort actions by injured parties for damages covered by no-fault insurance. Chapter 26.1-41 prohibits all tort actions for the bodily injury unless there is a serious injury. A serious injury means an accidental bodily injury that results in death, dismemberment, serious and permanent disfigurement, or disability beyond 60 days, or which results in medical expenses in excess of \$2,500.

WHAT POLICY PAYS?

Under NDCC Section 26.1-41-13, a basic no-fault insurer has the primary obligation for economic loss from bodily injury unless there is workers' compensation coverage. Under Section 26.1-41-13(3), the basic no-fault insurer pays for the first \$10,000 of medical expenses and the health care insurer pays the remainder. This coordination of benefits is designed to ensure that there is not a double payment.

COORDINATION OF BENEFITS

The coordination of benefits provisions in this state's no-fault automobile insurance law provides for cost-shifting among automobile and health care insurers as it relates to medical costs for automobile crashes. The following is a history of the changes to this state's coordination of benefits provisions:

"North Dakota Auto Accident Reparations Act--North Dakota's No-Fault Insurance Law," Thomas O. Smith, *North Dakota Law Review*, Vol. 52, No. 1 1975 (fall), discusses the coordination of benefits provisions in the 1975 law. The article states:

It is the primary obligation of the insurance company providing no-fault coverage to make payment for economic loss . . . [T]he insurance company may not coordinate no-fault benefits with benefits the victim receives or is entitled to receive under a hospitalization policy or an accident and sickness policy. If the victim has both types of coverage, he may recover duplicate benefits. However, the act does permit an insurance company . . . other than an insurance company providing no-fault benefits to coordinate benefits paid under its hospitalization policies or accident and sickness policies

with those paid under the no-fault act. The result is that such insurers would be obligated to cover economic loss only to the extent it exceeds an insured's no-fault benefits. Any insurance company offering this type of coverage must provide a reduction or savings in the premiums charged on these policies, and its plan to coordinate benefits must be approved by the Commissioner of Insurance. Thus, in the future insurance companies which write hospitalization or accident and sickness insurance may coordinate benefits paid under these contracts with no-fault benefits received by the injured party.

In such cases, the insured will receive a reduction or savings in the premiums charged on those contracts.

In 1977, House Bill No. 1510 created the amount of no-fault medical expenses a no-fault insurer may coordinate with a health care insurer in an amount of \$5,000. As introduced, the bill would have repealed the coordination of benefits provisions. Before the passage of House Bill No. 1510, if an individual had medical expenses in excess of \$15,000, depending on the coordination of benefits, the first \$15,000 might be paid by the no-fault insurer and the excess paid by the health care insurer. However, this did not leave any money left under the no-fault benefits for work loss, replacement services, or death benefits. Testimony states that the amendment allowed the no-fault carrier to subrogate against the health care insurer after the first \$5,000 of no-fault benefits are paid, thereby leaving more benefits for items other than medical expenses.

In 1981, Senate Bill No. 2061 included health maintenance organizations as health care insurers in the coordination of benefits provision.

In 1987, Senate Bill No. 2413 provided that a basic no-fault insurer may coordinate any benefits it is obligated to pay for medical expenses as a result of accidental bodily injury in excess of \$5,000. The bill clarified the coordination of benefits happened after the first \$5,000 in medical expenses.

In 1991, Senate Bill No. 2089 clarified the exclusion of basic no-fault insurers from the prohibition from coordinating benefits without providing the purchaser with an equitable reduction or savings in cost. In addition, the bill allows a basic no-fault insurer to recover all no-fault benefits, not solely basic no-fault benefits, from another no-fault insurer when tort law would require recovery.

In 1999 the Legislative Assembly considered, but did not pass, Senate Bill No. 2378. This bill would have increased the coordination of benefits from \$5,000 to \$10,000.

In 2003, Senate Bill No. 2275 increased the amount of no-fault medical expenses a no-fault insurer may coordinate with a health care insurer from in excess of \$5,000 to \$10,000. In short, the no-fault

insurer pays the first \$10,000 of medical expenses and the health care insurer pays medical expenses after \$10,000.

There was testimony for and against the increase. Generally, health care insurers were for the increase because inflation had increased the cost of medical procedures. Because the threshold was at \$5,000 for 18 years, health care insurers had to pay more medical expenses as inflation caused more expenses to exceed the threshold.

Generally, no-fault insurers were against the increase. They argued that health care insurers are more efficient at administering insurance for medical expenses. One example showed that health care insurers had over a 30 percent lower expense ratio than no-fault insurers. Health care insurers have the experience, expertise, and size to more efficiently administer medical insurance. In addition, the increase lowers the amount of no-fault benefits available for benefits that are not medical expenses, including work loss and replacement services benefits.

CHANGING MANDATED COVERAGES

Another means by which there is a cost shift is by changing the requirements of mandated coverage. The most extreme change would be to remove a mandated coverage, e.g., repealing a no-fault law.

In the 1970s, no-fault laws were enacted in 16 states. Since that time, five of those states repealed no-fault laws--Colorado, Connecticut, Georgia, Nevada, and Pennsylvania. Although Pennsylvania repealed its law in 1984, it adopted a new law in 1990.

Twenty-nine states are tort liability states. An individual injured in a motor vehicle accident must collect payment from the at-fault driver, if any, and must be able to prove negligence. However, some vehicle owners purchase medical payments coverage to provide personal injury protection (PIP).

A recent state to convert to a tort system, after being in a no-fault system, is Colorado. In a memorandum dated August 18, 2003, drafted by the Colorado Legislative Council staff, the question "Will There be Lower Auto Insurance Rates for Consumers Under a Tort System?" is examined. The memorandum states:

Yes. In December 2002, there was an actuarial study completed under the direction of the Colorado Auto Insurance Working Group. The study included findings on the cost implications of a complete repeal of Colorado's no-fault insurance statutes and the consequent conversion to a tort system of insurance. A major premise of the study was that personal injury protection coverage (PIP) would no longer be required.

The study concluded that there will be a net reduction in overall insurance premiums of approximately 36 percent on average for policyholders

selecting state-mandated liability only coverage and 17 percent on average for full coverage policyholders.

A few cautionary notes need to be included regarding the aforementioned estimates of savings. Spokespersons for both Farmers Insurance and State Farm indicated that there will be an increase in the rates charged for bodily injury and property damage (i.e. the liability coverage component) due in part to the increased exposure of insurance companies to lawsuits under a tort system of insurance. A small increase in premiums for optional uninsured/underinsured motorist coverage is also expected. Those increases will be more than offset by the elimination of PIP coverage which, on average, amounts to approximately 25 percent of the total premium under no-fault insurance. In some instances, PIP insurance can account for up to 50 percent of the no-fault premium.

Premium savings for a policyholder could be very small if the policyholder chooses to buy high levels of optional medical payments and uninsured/underinsured motorist coverage. The medical payments benefit packages that will be offered by Farmers Insurance range from \$2,500 to \$25,000 while the State Farm medical payments package has a range of \$1,000 to \$25,000. Very similar thresholds of coverage will be offered by other auto insurers to Colorado policyholders. In deciding whether to purchase medical payments coverage, the individual policyholder must evaluate the adequacy of his or her health insurance policies, which would be primary coverage if the insured is at fault in an accident and he or she has either a small amount of medical payments coverage or has waived such coverage. The selection of a high threshold of medical payments coverage could include benefits such as chiropractic services and massage therapy. It is unlikely that the policyholder's health insurance coverage includes those services.

In *A History and Overview of Colorado Law for Automobile Insurance Coverage*, by Paul D. Godec, September 2003, Mr. Godec lists a number of other consequences of the change to a tort system. These consequences include:

1. Health insurance benefits will increase because health insurance will cover more of the medical expenses following accidents.
2. Medical facilities will more likely aggressively pursue liens and reimbursements for services through tort litigation. In addition, emergency facilities experiencing financial difficulties will face more difficulties because of the lower certainty of reimbursement.
3. Individuals who suffer injury as a result of an at-fault driver will have to pay for medical expenses with the hopes of recovering in

later litigation. This may result in an injured party not obtaining certain medical services until the resolution of the litigation.

4. At-fault drivers will be left to pay for their own medical expenses and the change will make it more likely the injured driver will become a defendant in a tort action.

OTHER MAJOR LEGISLATION

In 1985, House Bill No. 1528 increased the maximum level for basic no-fault benefits from \$15,000 to \$30,000 and optional excess no-fault benefits for motor vehicle insurance from \$40,000 to \$80,000. The bill increased the threshold amount defining serious injury from \$1,000 to \$2,500 of medical expenses. The stated reason for the bill was that \$15,000 was not large enough to cover serious accidents. In those accidents, if an individual does not have medical insurance, the individual must pay the balance above the no-fault limits. The reason for the increase in the medical expenses threshold was to balance the increased benefit with the removal of more of the right to sue.

In 1989, House Bill No. 1467 increased the time for filing a no-fault insurance claim in an action to recover further benefits for a loss in which the basic or optional excess no-fault benefits have been paid from two to four years after the last payment of benefits. The time for filing was increased in an action for benefits for survivors' income loss and replacement services loss and funeral expenses for one to two years after the death or from four to six years after the accident from which the death results, whichever is earlier. The time for filing was increased in an action to recover further survivors' income loss or replacement services loss benefits from two to six years after the last payment for benefits. The bill increased the time for filing if basic or optional excess no-fault benefits have been paid for loss suffered by an injured person before death and action to recover survivors' income loss or replacement services loss benefits from one to two years after death or from four to six years after the last benefits are paid, whichever is earlier.

In 1991, Senate Bill No. 2555 increased the funeral expense benefit from \$1,000 to \$3,500. The increased benefit was expected to cost approximately 22 cents per vehicle per year.

In 2005, Senate Bill No. 2047 made modifications to mandatory no-fault automobile insurance. Basically, no-fault insurance pays for medical expenses for accidental bodily injury from a car crash while occupying the car. The bill removed from the definition of "accidental bodily injury" injury resulting from entering or alighting from a stopped motor vehicle and not caused by another motor vehicle. The bill changed the definition of "medical expenses" so that the charges must be usual and customary instead of merely reasonable. The bill expressly included diagnostic services as medical expenses and excluded

charges for drugs sold without a prescription, experimental treatments, and medically unproven treatments. The bill changed the definition of "occupying" to exclude getting into or out of a motor vehicle. The bill provides for a court to order the insured to reimburse the insurer for an independent medical examination that the insured failed to appear for without good cause.

Senate Bill No. 2047 also repealed NDCC Section 26.1-41-17, which provided for equitable allocation of losses among insurers. This section provided for an insurer to recover no-fault benefits paid to an injured person from the motor vehicle liability insurer of a secured person based upon tort law principles. In other words, if an individual drives a car and causes an accident with another car, the individual in the other car goes to that individual's insurance company to collect no-fault benefits; after that the insurance company can proceed against the first individual's insurance company for equitable allocation. The

legislative history reveals that under this procedure, insurance companies recover as much as they pay over time. As such, this reimbursement system drives up the cost of administration with no benefit to insurers.

SUGGESTED STUDY APPROACH

The committee may receive testimony from the Insurance Department, automobile insurers, and health care insurers on the recent changes in the law and any shifts in cost. The committee may desire to determine to which insurer the cost should be shifted. Issues that may be considered in determining where to shift the cost include:

1. Cost and benefit to the consumer.
2. Cost of administration.
3. Speed of administration.
4. Certainty of payment.
5. Ability of entity with the cost to manage the risk.