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No-Fault's Effect in New York

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Much has been written, litigated, and discussed about auto insurance rates in New York state and the role of no-fault insurance in pushing in into the realm of luxury for the average consumer.

Several news services have been consistent in covering the indictments and investigations conducted in the fight against perpetrators of fraud. Emphasis has been placed on certain medical providers, who have become the faces of no-fault fraud, the villains in this scheme to defraud the public. Although most people familiar with the current situation would agree that, on the whole, the medical providers have been the single most influential group in moving the system toward its present state, they have not been alone in their culpability.

New York State's automobile insurance laws are among the most comprehensive in the country, providing relief for insureds, innocent third parties, and all other classes of claimants. The regulation governing no-fault benefits is just as encompassing, to the extent that benefits are provided, in certain circumstances, for family members who were injured while in vehicles other than the ones owned by the households (e.g., passengers on a bus). It is this very comprehensive nature, the emphasis on making sure that eligible injured parties can obtain relief, that makes no-fault susceptible to the type of fraud being perpetrated today.

The no-fault system is viewed by opportunistic claimants as a kind of macabre, modern day lottery: get into a fender bender, go to a doctor for a few months, get paid. Any insurance company doing business in New York -- non-standard, standard, high risk, whatever the criteria -- has to be cognizant of this influx of fraudulent claims, a large number of which can be attributed to public perception of the insurance industry.

From the individual who initiates a claim for minor injuries, seeing it as easy money and not a crime because, "It's the insurance company's money," to the highly organized rings that may include street runners, medical clinics, law enforcement personnel, and attorneys, insurance fraud is a major industry. These rings may stage accidents, inflate treatment, and falsify diagnoses and official reports to get as much as possible out of the $50,000 per claimant allotted for medical treatment or to achieve a higher payout on the inevitable third party claim.

Fraud Adds Up

The mathematics of this problem are straightforward enough: an insured gets into an accident with another vehicle. The insured has four passengers; the other vehicle has three, including the driver. In vehicle number one, all of the occupants are claiming soft tissue-injuries and seeing medical providers in their neighborhood. That is five claims with a ceiling of $50,000 each.

The medical provider initiates a regimen of treatment that includes visits to chiropractors, neurologists, acupuncturists, orthopedists, physical therapists, and psychiatrists. The claimant also undergoes a series of tests: multiple MRIs, X-rays, and nerve conduction tests. This does not include the medical supplies and transportation provided to each claimant.

Whether all this is necessary is moot. It may be necessary for some but, when it occurs on 97 percent of the claims coming in, even the most sanguine person would have to concede that this could not be legitimate.

On these five claims, let's suppose that each of the claimants seeks treatment for three months, just enough to meet the legal threshold. Their medical bills can average $15,000 each. That is $75,000, and we have not factored in the costs to the carrier for IMEs, peer reviews, investigations, and, if it goes that far, defending no-fault lawsuits or arbitration. And let us not forget the occupants of the other vehicle and their third party claims.

One of the big obstacles is that the regulations are so tilted toward claimants that insurers can only react to the deluge of paperwork generated by each claim. Insurance companies have 30 days to deny or pay submitted bills. Claimants have 90 days to submit first notices of no-fault claims. Beyond the obvious silliness of needing three months to inform the insurance company that injuries have occurred, the company is now playing catch-up, as most of that 97 percent mentioned before have been having treatments since the accident.

In such an environment, when a company has a loss ratio of 20, 30, or even 50 percent, that company is not going to survive. It is a scary thought, but is it happening? Absolutely. Don't take my word. The rolls of the New York State Liquidation Bureau show the shells of the companies who have buckled under the onslaught.

We are now poised on the brink of a two-tier system. One tier comprises those few companies large enough to weather this climate, while the second is those companies who modify their underwriting policies to only collision/comprehensive coverage or, if they write liability and PIP, leave the non-standard market alone, refusing to renew any drivers involved in accidents. This hurts everyone, but especially legitimate consumers who are forced to pay higher premiums with large carriers or to forego insurance coverage.

Finding Answers

The solution to the problems faced by the insurance industry is not readily evident. Eliminate no-fault and create another system? In its defense, the no-fault system helps cover the costs of medical care to those who are truly injured and need extended medical treatment. A serious motor vehicle accident can be devastating for the entire family. The expenses can be incredible, in some instances quickly exhausting the $50,000 limit, leaving the patient to apply for some type of government aid to offset the continued costs of medical care. This is by no means the norm, but it happens too frequently to make anyone feel comfortable claiming that no-fault should be eliminated.

Another more extreme, but workable, answer is to eliminate or modify the threshold requirement for presenting third party claims. No-fault is a means to an end, not an end in itself. When the trial lawyer association and claimants are complaining about the system and fighting against restructuring no-fault, they are not trying to make sure that doctors are fully paid and injuries are treated adequately. They are fighting because of that clause in the threshold requirement, the one loophole through which about 97 percent of the claims pass, the one that states that a personal injury action meets the legal standard if the claimant needs medical treatment for at least 90 of the first 180 days.

That solution is straightforward, but it is not popular. Take away the incentive to pad medical treatment, and a lot of what is happening now would be eliminated. On the other hand, taking away the threshold requirement or adjusting it so that a monetary or time limit for treatment is not the standard, would cause a majority of the claims being represented by the plaintiff bar to disappear. It is an idea that not many have proposed, but one that should be given serious consideration.

What next? Insurance companies in general and claim personnel in particular have to be more aggressive in their approaches to suspicious claims. To their credit, a few are. More often than not, however, carriers are not actively investigating claims as they are reported and, when they do get around to looking closely, it is too late to do the basic investigation that could help them. That most likely has more to do with the fact that the volume of mail coming in for each claimant/patient is more than claim staff can handle.

The intention is not to create an adversarial relationship with insureds, claimants, or other involved parties. The intention is to gather as much information as possible so that legitimate claims can be handled quickly and suspicious claims can be investigated. This can be done within the regulations by requiring insureds and all other parties to comply with requests for statements, photographs, records, or examinations.

Amending Regulation 68 by reducing the time for notice of claim is a great idea, but whether it is 30 days, 90 days, or one week, if a suspicious claim is not addressed quickly, it does not matter when the company receives notice. The onslaught of bills and phone calls is right around the corner and the clock to deny or pay starts ticking.

Until a decision is made and finalized, the only viable option for insurers is to work within the present system to identify and mitigate their exposures on claims that are deemed suspicious. Statements, examinations under oath, and peer reviews are methods that carriers and TPAs use, some more than others and some with more success than others. I have conducted examinations under oath on behalf of insurance carriers and had claimants say, "No, I don't like needles. I never did acupuncture," when the no-fault rep is looking at a stack of acupuncture bills, or, "Yeah, I treated with all of these guys on the same day for 15 minutes each," although the doctor has spread out the visits over several days, so as not to have them denied for concurrent care. In many instances, claimants give such ridiculous testimony that their attorneys drop the cases.

I do not propose to have the answer to solving the present problem with the no-fault system, but I think that the questions and suggestions raised here should be explored. Changes are needed, and a happy medium must be reached. The system can work if enough people calling the shots decide to go after the problems in a consistent manner, and make the idea of filing frivolous claims not worth it to the people presently taking the system for a ride.

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