CHAPTER 11: MEDICAL PAYMENTS BENEFITS

Medical payments coverage is not mandatory in Arizona. For the most part, the insurer is free to define coverage as it sees fit. Med pay coverage, however, is not fault-based. The insurer need only pay for reasonable medical expenses. The coverage is generally very broad (vast number of people in an array of situations).

WHAT IS COVERED BY MEDICAL PAYMENTS BENEFITS

Med pay coverage applies only to reasonable and necessary medical expenses, and does not include expenses charged by untrained or unlicensed health care providers. ***Sanfilippo v. State Farm Mut. Auto. Ins. Co.***, 24 Ariz. App. 10 (1975). The definition of untrained or unlicensed healthcare provider is subject to interpretation. For example, osteopathic and chiropractic assistants may administer therapy because they are supervised by licensed healthcare professionals. ***State Farm Mut. Auto Ins. Co. v. Arizona Bd. of Chiropractic Examiners***, 187 Ariz. 526 (App. 1996). In *State Farm*, the court noted that "[t]he statutory landscape has changed dramatically since *Sanfilippo*" and "undercut its rationale." Specifically, "the legislature has shifted from a posture where health care services, such as physical therapy, could be provided only by licensed individuals to one where such services can be provided by licensed individuals and supervised assistants of those individuals who are themselves subject to regulation by licensing boards."

WHO IS COVERED FOR MEDICAL PAYMENTS BENEFITS

Who is covered for med pay benefits largely depends on the policy's definition of an insured, but most policies typically cover the named insured and members of the named insured's family when they are:

- In their own car named in policy;
- Driving a non-owned car;
- Riding as a passenger in any other car;
- Walking as a pedestrian and struck by another vehicle; or
- Riding a bicycle and struck by another vehicle.

Other individuals are typically covered when:

- Riding as passengers in car of named insured designated under the policy; and
- Riding in non-owned car driven by named insured or member of named insured's family.

CREDIT FOR MEDICAL PAYMENTS BENEFITS AGAINST LIABILITY COVERAGE

In a third-party claim situation, where there is no privity of contract between the third-party claimant and the liability insurer, med pay benefits may be credited against any liability benefits to be paid to the third-party claimant. This must, however, be clearly stated within the med pay policy provision.

An unambiguous policy provision crediting medical expense payments toward a recovery against the liability coverage is valid and effective. Credit for med pay benefits against liability proceeds is not against public policy because med pay coverage is not mandatory; thus, the third-party claimant is entitled to collect his medical expenses only one time from a liability insurer, regardless of whether those medical expenses are paid under liability coverage or med pay coverage. ***Caballero v. Farmers Ins. Group***, 10 Ariz. App. 61 (1969).

A tortfeasor's insurer is not a collateral source. Consequently, when medical expenses are paid in advance by the tortfeasor's insurer, there may be no right to recovery under the insured's own med pay coverage if it would lead to double recovery. ***Sahadi v. Mid-Century Ins. Co.***, 132 Ariz. 422 (App. 1982).

In a first-party claim situation, such as a claim under UM or UIM coverage, med pay benefits may be credited against liability benefits only where there is a non-duplication endorsement and the insured is fully compensated. Where there is no non-duplication endorsement or the insured would not be fully compensated, there is no right to offset med pay benefits from liability coverage. Thus, where medical expenses are paid by a tortfeasor's insurer, excess coverage under an injured party's own insurance policy will be denied even if judgment against the tortfeasor was reduced by the amount of medical expenses paid with med pay benefits., since those medical expenses could not be recovered from the tortfeasor, having been previously paid by the tortfeasor's insurer. *Id*.

In ***Schultz v. Farmers Ins. Group of Co.***, 167 Ariz. 148 (1991), the court found a non- duplication endorsement valid so long as it does not deprive the insured of full recovery for her loss. Here, the insured made a claim under her uninsured motorist (UM) and med pay coverages. The med pay coverage contained a provision for an offset against other coverage applicable to the loss. After paying medical expenses, Farmer's notified its insured it would apply the non-duplication endorsement to offset this amount against the UM benefits otherwise payable. The court held this was valid, so long as the coverage provided fully compensated the claimant. The test, therefore, is whether applying the endorsement denies full recovery for the insured's loss. To the extent applying such an endorsement deprives an insured of full recovery, it is unenforceable. However, a non-duplication endorsement is enforceable if it does not interfere with the insured's right to full recovery for her loss. This is true whether the endorsement is stated as a reduction of a required coverage or a reduction of an optional coverage.

Cundiff v. State Farm Mut. Auto. Ins. Co., 217 Ariz. 358 (2008), came to the opposite conclusion where the insurer tried to offset the insured's worker's compensation benefits from an underinsured motorist (UIM) coverage arbitration award. The UIM statute allows only liability insurance benefits to offset UIM coverage, and worker's compensation is not liability insurance. In reaching its conclusion,

Cundiff distinguished ***Schultz v. Farmers Ins. Group***, 167 Ariz. 148 (1991). Specifically, in *Schultz,* the court held that an insurer may offset UM benefits by the amount paid under medical payments coverage in order to prevent double recovery, so long as the insured receives full compensation for damages incurred. *Cundiff* declined to follow *Schultz,* however, for the reason that it involved an offset to UM, not UIM, benefits. The court explained that the statutory definition of UM coverage expressly provides that such coverage is "**subject to the terms and conditions of that coverage**," *see* A.R.S. § 20–259.01(E), while the UIM statutory provision does not contain a similar limitation, *see* A.R.S. § 20–259.01(G). *See also* A.R.S. § 20–259.01.H ("Uninsured and underinsured motorist coverages are separate and distinct"). Instead, the UIM statutory provision specifically states that the total applicable liability limits are the only amounts that may be deducted from the insured's total damages when calculating UIM coverage. *Id*. Thus, the court held that Schultz's reasoning did not apply in the UIM context. *See also* ***Miller v. American Standard Ins. Co. of Wisconsin***, 759 F.Supp.2d 1144 (D. Ariz. 2010) (holding that because the med pay endorsement provision is not "liability" coverage, it cannot be used to offset UIM payments).

NOTE: The collateral source rule may prevent credit where the third-party claimant is also a named insured, i.e., wife suing husband over automobile accident.

While the courts in the above cases gave insurance companies wide latitude in determining what provisions governed the payment of medical expense benefits, the court in ***Salerno v. Atl. Mut. Ins. Co.***, 198 Ariz. 54 (App. 2000), limited this principle when addressing a policy provision mandating that claims be brought within one year. The court held that absent actual prejudice, filing a late notice of claim will not bar recovery.

LIENS FOR AMOUNTS IN EXCESS OF $5,000 – A.R.S. § 20-259.01(J)

An automobile insurer that makes a payment under the medical payments coverage of the policy on behalf of an insured for an accident occurring after December 31, 1998 may assert a lien against any amount paid to the insured in excess of $5,000. In order to perfect the lien, the insurer must, within 60 days of making payment, record the lien in the office of the county recorder in the county in which the accident occurred. Within five days of recording the lien, the insurer must also mail a copy of the lien to the insured and to each person, firm, and corporation and their insurance carriers alleged to be liable for the damages. This provision of A.R.S. § 20- 259.01(J) does not give an insurer making payments under medical payments coverage a right of subrogation independent of the filing of the lien.

Healthcare Provider Lien Enforcement Against Med Pay Benefits

A.R.S. § 33-931(A) provides that:

> Every individual, partnership, firm, association, corporation or institution or any governmental unit that maintains and operates a health care institution or provides health care services in this state and that has been duly licensed by this state, or any political subdivision or private entity with ambulances operated, licensed or registered

> pursuant to title 36, chapter 21.1, is entitled to a lien for the care and treatment or transportation of an injured person. The lien shall be for the claimant's customary charges for care and treatment or transportation of an injured person. **A lien pursuant to this section extends to all claims of liability or indemnity, except health insurance and underinsured and uninsured motorist coverage** as defined in section 20-259.01, for damages accruing to the person to whom the services are rendered, or to that person's legal representative, on account of the injuries that gave rise to the claims and that required the services. (emphasis added).

In ***Ansley v Banner Health Network,* 248 Ariz. 143 (2020)**, the Arizona Supreme Court held A.R.S. § 33-931(A) unconstitutional to the extent it allowed the hospitals to secure payment from third-party tortfeasors for the difference between Medicaid's reimbursement and the hospitals' actual costs. The court reasoned that the federal Medicaid provisions prohibiting balance billing preempted the application of this Arizona statute. *Id.* at 152 ("42 C.F.R. § 447.15 expressly provides that '[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.' As we noted in *Abbott*, this amounts to a categorical prohibition against balance billing.").

Citing *Ansley,* plaintiffs in *Grunwald v. Scottsdale Healthcare Hospitals*, 252 Ariz. 141 (App. 2021), argued that a hospital's lien for amounts in excess of the hospital contract amount with their insurer was also void. The appellate court upheld the hospital liens, however, because there the hospital was effectively an HMO which is not subject to A.R.S. § 33-931(A).

Prior to *Ansley*, the court of appeals held that med pay benefits are subject to a healthcare provider's lien because the term "health insurance" does not include med pay benefits under an auto policy. ***Dignity Health v. Farmers Insurance Company of Ariz***., 247 Ariz. 39 (App. 2019).

CREDIT FOR MEDICAL PAYMENTS COVERAGE AGAINST JUDGMENTS

A.R.S. § 12-2302(B) provides as follows:

> If judgment is entered against a defendant by whom or on whose behalf an advance payment has been made and in favor of a plaintiff to whom or for whose benefit an advance payment has been made, such defendant shall be entitled to a reduction of the amount of damages awarded to such plaintiff equal to the amount or value of such advance payments as may be found by the court to have been made. However, in no event shall a person who has made such advance payments be entitled to reimbursement for amount paid in excess of the damages awarded to such plaintiff or in the event such plaintiff fails to recover judgment in his favor.

In ***Bustos v. W.M. Grace Dev.***, 192 Ariz. 396 (App. 1997), the court of appeals held that A.R.S. § 12-2302 applies to payments that a defendant's insurer makes to a plaintiff pursuant to a no-fault

medical payment provision of defendant's policy. The plaintiff in *Bustos* argued that the defendant was not entitled to a credit because the defendant's insurance policy had no provision for offsetting no-fault medical payments against liability payments. The court disagreed, reasoning that while the plaintiff was a beneficiary under the defendant's insurance contract, the payment was made voluntarily on behalf of defendant because she had purchased a policy that provided no-fault coverage. The statute does not distinguish between liability payments and no-fault medical payments. Instead, A.R.S. § 12–2301(1) defines "advance payment" as "*any* money or other thing of value voluntarily paid or provided before trial, as compensation" By the statute's plain language, the defendant was entitled to a credit for the advance payment made to the plaintiff pursuant to the no-fault medical payment provision of the defendant's insurance policy. This holding furthers the purpose of A.R.S. § 12-2302 to encourage potential defendants to advance payments to assist plaintiffs in meeting their immediate needs, without having to either admit liability or pay twice for the same injury.

"OTHER INSURANCE" CLAUSES

Two Arizona cases have addressed "other insurance" clauses in the med pay context and reached different conclusions. The crux of each court's analysis was the "ambiguity" of the clause, and not whether the clause violated public policy.

In ***Aetna Cas. & Sur. Co. v. Scott*****,** 107 Ariz. 609 (1971), the Supreme Court held that an "other insurance" clause was ambiguous and unenforceable. This meant the "other insurance" clause was ineffective to make Aetna's medical payments coverage excess over other collectible insurance. Consequently, the claimant was permitted to collect the full amount of his medical expenses under two separate insurance policies issued by two separate insurance carriers. In essence, the claimant was allowed to "aggregate" medical pay benefits.

In ***Almagro v. Allstate Ins. Co.***, 129 Ariz. 163 (App. 1981), the court of appeals held that an "other insurance" clause was unambiguous, valid and enforceable. As a result, the "other insurance" clause was effective to make Allstate's medical payments coverage excess over other collectible insurance. Consequently, pursuant to Allstate's "other insurance" clause, the court held that Allstate's med pay coverage would apply only after the primary insurance was exhausted.

COORDINATION OF BENEFITS

In ***Samsel v. Allstate Ins. Co***., 204 Ariz. 1 (2002), the Supreme Court held that an insured was entitled to reimbursement from his/her medical payments coverage even if this resulted in duplicate recovery from another source such as health insurance. There, the plaintiff incurred medical bills from an automobile accident. Plaintiff's HMO paid all but a small portion of the bills. Allstate denied coverage under the medical payments coverage of those expenses already paid by the insured's HMO. The Allstate policy provided that it would pay "all reasonable expenses actually incurred by an insured person." The court held that even though the plaintiff was insured under an HMO, she incurred the charges as defined by the Allstate policy and should be able to collect. Moreover, the medical payments section of the policy did not contain a coordination of benefits provision. The court did not

conclude that such coordination of benefits provisions are unlawful. Rather, the court stated that "Allstate could have, but did not, specifically provide for reduction of medical payments benefits by a coordination of benefits or other clause limiting medical payments coverage" and therefore, the plaintiff could collect from both sources.

PORTABILITY AND STACKING OF MEDICAL PAY BENEFITS

Generally, by definition and broad scope of policy language, med pay benefits are portable, i.e., they follow the insured.

No Arizona cases have directly addressed the issue of stacking med-pay benefits. However, in ***Schultz v. Farmers Ins. Group of Cos.***, 167 Ariz. 148 (1991), the Supreme Court held that a non-duplication endorsement is valid if the insured is not deprived of full recovery for medical expenses. In reaching its decision, the court noted that although A.R.S. § 20-259.01(H) was not directly applicable, the stacking preclusion contained in that statute demonstrates Arizona public policy to permit an insurer to preclude double recovery on multiple coverages.

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