

CASE SUMMARY

Samsel v. Allstate Insurance Company
201 Ariz. 1, 59 P.3d 281 (2002)
decided December 12, 2002

In a precedent setting ruling, the Arizona Supreme Court held that an insured may recover from both the health insurer and the medical payments provision of an automobile policy, regardless of the fact that the health insurer already paid the medical expenses incurred by the insured. This topic is important to insurers that include a medical coverage payment provision in their policies. This decision indicates that, notwithstanding a specific provision in the policy restricting or limiting coverage to or for expenses actually paid and not reimbursed, an insured is permitted to collect from a collateral source providing additional coverage.¹ This article summarizes the Court's ruling and emphasizes the importance of including a restrictive clause in the medical coverage provision of a policy in order to avoid paying the insured more than is necessary.

BACKGROUND

In August 1995, Ms. Lisa Samsel was injured in a Tucson automobile accident. She was taken by ambulance to University Medical Center ("UMC") for emergency treatment. The next day Ms. Samsel signed a UMC "Conditions of Admission" form, agreeing to "pay all of her hospital charges as and when billed." At the time of the accident Ms. Samsel was insured under an Allstate automobile policy issued to her parents in 1993. The Allstate policy included medical payments coverage with a limit of \$10,000, for which her parents paid an additional annual premium of \$300. Beginning in April 1995 Ms. Samsel was also enrolled in Partners Health Plan ("Partners"), an HMO regulated health care services organization pursuant to A.R.S. §§ 20-1051 *et seq.*

UMC's charges for treatment of Ms. Samsel's injuries totaled \$16,413 in medical services and \$2,494 in physicians' services. Upon her discharge, UMC billed Ms. Samsel as a guarantor. Partners paid the total amount, notwithstanding \$315.55 of Ms. Samsel's expenses. She subsequently filed a claim with Allstate under the Samsels' medical payment coverage. Allstate paid the \$315.55 that was not covered by Partners.

Allstate denied coverage on the remaining charges, claiming that because Partners was obligated to and did pay the charges, Ms. Samsel did not actually incur those expenses as required by the medical payments provision of its policy. The Samsels sued Allstate for breach of contract and bad faith. Allstate argued that Ms. Samsel did not actually

¹ It is important to note that the Court's opinion does not directly address the issue of ambiguity and reasonable expectation. However, it is reasonable to infer from this opinion that the Court is relying on its "ambiguity approach" established in previous cases. In fact, in this case the Court states "in determining whether there is an ambiguity that should be construed against the insurer, the language should be examined from the viewpoint of one not trained in law or the insurance business."

incur the hospital and physician expenses that Partners paid.² Allstate argued that *Coconino County v. Fund Administrators Ass'n.*, 149 Ariz. 427, 719 P.2d 693 (App. 1986) does not require that Ms. Samsel be liable for such payments. Further, under A.R.S. § 20-172(A) to (C), Ms. Samsel was not liable for medical expenses covered by Partners and thus could only have actually incurred those expenses not covered by Partners.

THE COURT'S ANALYSIS

Definition of "Actually Incurred"

The *Samsel* Court relied on *Coconino County* and a line of other cases³ in defining the meaning of "actually incurred." According to the Court, the primary definition of the word "incur" is "to become liable for." The Court maintains that Ms. Samsel became liable for her medical expenses when she accepted medical treatment. The fact she contracted with a health insurance company to compensate her for her medical expenses, or to pay directly the health care provider on her behalf, **does not** alter the fact that she was obligated to pay those expenses. The *Samsel* Court extracts a narrow rule from these cases concluding that "incurred" or "actually incurred" language does not bar an insured who became liable for expenses from recovery simply because "of the availability of collateral means of discharging liability, thereby eliminating the need to pay the charges personally."

Court's Interpretation of A.R.S. § 20-1072

Despite the Court's reliance on this rule, it does not address the issue of whether the insured is **immunized from legal liability by a statute** that transfers liability for covered expenses to the collateral source of payment. The Court resolved this issue by applying the basic principles outlined in *Andrews v. Samaritan Health Systems*, 201 Ariz. 379, 384, 36 P.3d 57, 62 (App. 2001)⁴ to the facts in the present case. The

² The medical payments provision of Allstate's automobile policy reads in pertinent part: "Allstate will pay *to or on behalf of* an insured person all reasonable expenses *actually incurred by an insured person* . . ." (Emphasis added). Importantly, the Court stated that Allstate's medical payments provision does not define the words "actually incurred" for these purposes or any other.

³ Citing *American Indemnity Co. v. Olesjuk*, which held that an insured injured on active military duty, whose hospital expenses were paid by the United States Navy, as required by statute, incurred expenses for purposes of recovery under his automobile policy's medical payments provisions. 353 S.W. 2d 71,72 (Tex.Civ.App.1961); see also *Hollister v. Government Employees Ins. Co.*, 192 Neb. 687, 224 N.W.2d 164, 166-67 (1974). In the above cases, both courts concluded that when the serviceman was treated in the hospital, an implied contract for payment was created, and later payment or reimbursement by the government did not relieve the insurer. In *Dutta v. State Farm Insurance Co.*, the court stated that an insured whose HMO paid her accident-related medical expense was permitted to recover on her own automobile policy's personal injury protection provision. 363 Md. 540, 769 A.2d 948, 961 (App. 2001).

⁴ *Andrews* involved filing medical liens pursuant to A.R.S. § 33-931. The *Andrews* court held that an actual "non-recourse debt" exists and is subject to the medical lien . . . the hospitals are not bringing legal

Samsel Court stated that a debt to the provider is incurred when covered services are provided to the enrollee. Further, the insured's property interest in his or her tort claim and eventual recovery is affected when and if the debt is eventually satisfied from the insured's property.

Allstate argued that Partners under A.R.S. § 20-1072 was responsible for payment of Ms. Samsel's expenses. Further, under subsections (A) and (C) Ms. Samsel had no personal liability for the medical services covered under her HMO plan and therefore, no debt was actually incurred for such services. The Court rejected this argument emphasizing the fact that A.R.S. § 20-1072 does not confer **complete immunity** from the enrollee's personal liability to the provider. Relying on *Andrews*, the Court stated "despite the provisions of A.R.S. § 20-1072 (A) to (C), an enrollee's property is or may be liable for repayment of the charges covered by the HCSO provider plus the remaining portion or the provider's usual fee or charge, plus the items covered in subsection (D)."

In answering the question of whether an insured becomes legally liable when he or she is immunized from legal liability by statute, the court also looks to the legislative intent behind A.R.S. § 20-1072. The Court held that proper interpretation of the statute is that the enrollee is immunized from actions by the provider for recovery of charges for services provided and covered by the enrollee's agreement with the HMO.⁵ By the remaining subsections, however, especially subsection (E), the enrollee remains liable for co-insurance, co-payments, non-covered services, services of a non-contracting provider, and similar costs. As stated previously in *Andrews*, the insured's property remains subject to a lien for recovery of the provider's full charges. Importantly, the Court maintained that it is their belief that the legislature clearly intended that the provider, not the enrollee, would run the risk of HMO non-payment for covered services and also that the enrollee was immunized from direct action for the difference between the provider's usual fees or charges and the lesser amount payable pursuant to the contract between the provider and the HMO. However, the Court found that A.R.S. § 20-1072 (E) permits the provider to obtain the enrollee's enforceable promise to pay for all amounts and services not covered, including co-payments, services different from or in excess of those permitted by the HMO contract, and similar types of liabilities.

action against the HCSO enrollees, as prohibited by A.R.S. § 20-1072, they are only asserting a statutory lien against the enrollee's tort claim." *Id* at 383, 36 P.3d at 61.

⁵ The *Samsel* Court rejects the court of appeals affirmation of Allstate's argument that subsection (E) 's express language allows an HMO enrollee to accept financial responsibility for services provided by either contracting or non-contracting providers. The Court points out that A.R.S. § 20-1072 was enacted in 1988 as part of a bill addressing HMO insolvency, capitation, and regulatory issues. Subsections (A) to (C) are important components of Arizona's HMO regulatory scheme and very similar to the "hold harmless" provisions of the Health Maintenance Organization Model Act, promulgated by the National Association of Insurance Commissioners ("NAIC") following a 1988 NAIC advisory report on HMO regulation and insolvency issues. At least thirty-five states have some type of hold-harmless provision. However, no states appear to have a provision such as Arizona's subsection (E).

Recovery under Medical Payment Provisions Does not Constitute a Windfall

The Court rejected the argument that recovery under the Samsels' medical payments provisions for the amount of medical expenses covered by their HMO constituted a duplicate, windfall recovery. The Court pointed out that Allstate failed to provide any evidence that its premiums for medical payments coverage were reduced so as to account for the expectation that the insurer would be relieved of coverage for expenses paid by HMOs for their enrollees. Therefore, there cannot be a windfall when insureds that paid for a separate coverage collected just what they paid for. The Court emphasized this point by asserting that notwithstanding "other insurance" provisions, the insured is entitled to medical payment reimbursement regardless of duplicate recovery from a second source.

Excluding or Limiting Medical Coverage to Expenses Actually Paid By the Insured Must be Clearly Stated in the Policy Provisions to be Enforceable

The Court made it very clear that, unlike other policy forms, Allstate's policy failed to contain a **clause restricting medical payment coverage to or for expenses actually paid and not reimbursed to the insured**. Allstate could have provided for reduction of medical payments benefits by a coordination of benefits or other clause limiting medical payments coverage to expenses actually paid by an insured. The *Samsel* Court embraced the court's reasoning employed in *Feit v. St. Paul Fire & Marine Ins.*, 209 Cal.App.2d Supp. 825, 827, 27 Cal.Rptr. 870, 872 (1962). The *Fiet* court noted ". . . If an insurer does not wish to honor claims of the type involved here it should exclude them specifically so that an insured with additional medical or hospital coverage would know that he is receiving less coverage for his premium dollar than some other insured who is without outside benefits." The Court suggested that this particular medical payment coverage issue could be resolved with more certainty if there was a **specific exclusion, other insurance, or a coordination of benefits clause in the policy**, instead of relying on litigating the meaning of the undefined term "actually incurred by the insured" contained in Allstate's policy.

In addition, the Court addressed the issue of consumer expectation with respect to the language contained in a policy similar to that of Allstate's. The fact that Allstate did not include any language indicating its **intent to exclude coverage** in situations in which expenses were paid by an insured's HCSO it is unreasonable to expect that such a limitation could be called to the insured's attention. Hence, it is completely reasonable to assume that Allstate did not intend to exclude coverage in this situation. If it wanted to it should have included it in the policy. Moreover, evidence demonstrating that the underwriting department intended this exclusion, given the premium it charged, is a telling indication that was the insurers' intention. Evidence demonstrating that the insureds were given a choice for restricted coverage for a lesser premium also indicates an intention to exclude coverage in situations in which expenses were paid by an insured's HCSO. Thus, a consumer should be able to reasonably expect, **notwithstanding any provision to the contrary**, medical payments coverage to apply

to all expenses incurred for treatment of his or her injuries, regardless of what collateral benefits the insured may have purchased or paid. The policy reason behind this centers on the fact that HMO coverage is protection that the enrollee earned and paid for by his or her labor, payroll deductions and employer contributions.

The Court held that the benefits Ms. Samsel received from her HMO coverage should be treated the same as benefits received from any other collateral source acquired by an insured. Further, the undefined phrase “actually incurred by the insured” is interpreted to mean actually incurred for treatment of the insured rather than actually incurred for treatment for which the insured is directly legally liable.

IMPLICATIONS OF *SAMSEL v. ALLSTATE INSURANCE COMPANY*

The holding in this case is particularly significant to the issue of including a restrictive clause in the medical payment provision of a policy which limits or excludes coverage to expenses actually paid. The Arizona Supreme Court’s decision allows an insured to recover under their automobile policy’s medical payment coverage provisions despite the fact that the insured’s medical expenses were fully compensated by their health insurer. More importantly, the Court’s opinion suggests that an insurer can avoid this particular scenario by incorporating restrictive clauses into the policy.

It is highly advisable to include language in the medical payment coverage provisions of the policy that clearly and unambiguously indicates to consumers that medical payment benefits are limited or exclude to expenses actually paid and not reimbursed to the insured. The Court’s opinion conveys the notion that had Allstate included a provision of this nature then it would be enforceable because it put the insured on notice as to what he or she paid for. A restrictive clause of this nature will eliminate any uncertainty as to when an insured “incurred” or “actually incurred” medical expenses. Hence, eliminating the possibility of the insurer paying out more than what is actually necessary to cover the actual expenses incurred by the insured. This also demonstrates an intent by the insurer to exclude coverage in a situation where expenses were paid by the insured’s health insurance company. Finally, a premium reflecting this limitation or exclusion is also evidence that the insured received exactly what he or she paid for.

If you have any questions about this case or want to read a copy of the actual opinion, please contact [David Bell](#) or [Jalana Dixon](#).