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January 11, 2019

New York State Department of Financial Services
One State Street, 20th Floor
New York, New York 10004-1511
Attn: Camielle Barclay, Office of General Counsel

Re: **Proposed Ninth Amendment to Regulation 68**
New York State Register, ID No. DFS-46-18-00014-P

Dear Ms. Barclay,

Please accept the following as Russell Friedman & Associates' comments to the Proposed Ninth Amendment to Regulation 68 ("Proposed Amendment"), published by the Department of Financial Services ("DFS") in the New York State Register on November 14, 2018, under ID No. DFS-46-18-00014-P. [1]

Introduction

On November 14, 2018, the New York State Department of Financial Services ("DFS") published the Proposed Ninth Amendment to Regulation 68 ("Proposed Amendment"). If adopted, the Proposed Amendment would give the no-fault insurer the option to void the assignment of benefits ("AOB") when the insurer issues a denial for the patient's failure to attend either an independent medical examination ("IME") or an examination under oath ("EUO") (collectively "No-Show Denials").[2]

The Firm vehemently opposes the enactment of the Proposed Amendment on three different, but equally important, bases. First, the DFS' rationale with respect to need for the Proposed Amendment is fundamentally flawed as it is based upon three false presumptions: (a) the majority of persons injured in automobile accidents, the healthcare providers treating them (with the exception of hospitals), and the attorneys representing them both, are all engaged in a fraudulent scheme against the no-fault insurers, which they are not; (b) all No-Show Denials are valid when, in reality, certain no-fault insurers are actively abusing the verification process by issuing untimely

[1] See, The Proposed Ninth Amendment to Regulation 68, the New York State Register, Rule Making Activities, November 14, 2018, p. 9-11 https://docs.dos.ny.gov/info/register/2018/november14/rulemaking.pdf

[2] Currently, the no-fault insurer may not opt to void the AOB between the patient and the hospital. Rather, the AOB is voidable at the option of the healthcare provider, an actual party to the agreement, "based on the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor." See NYS Form NF-AOB (Rev 1/2004), https://www.dfs.ny.gov/insurance/r68/nf3.pdf

scheduling notices and refusing valid adjournment requests made by the patients; and (c) no-fault insurers are merely utilizing IME and EUOs to protect themselves from the costs associated with the "staged loss" when in fact no-fault insurers have weaponized IMEs and EUOs to justify their non-payment of otherwise valid no-fault claims.

Second, the Proposed Amendment is not needed to achieve its stated purpose—to reduce fraud and the number of court/arbitration filings dealing with No-Show Denials; no-fault insurers already have a remedy for reducing the number of court/arbitration cases that they have to defend—*collateral estoppel* and the Declaratory Judgment action.

Third, the extremely detrimental, albeit unintended, consequences of the Proposed Amendment outweigh any potential benefit gained therefrom. Allowing the no-fault insurer to void the AOB at its own discretion upon the issuance of a No-Show Denial will upend the current no-fault system, which utilizes the AOB to facilitate the prompt payment of medical expenses and wage loss for those parties injured as a result of an automobile accident. It will also lead to a shortage of medical providers, particularly in low-income areas, willing to accept no-fault patients. Lastly, it will have a disproportionately negative impact on three classes of patients—the unrepresented, the non-English speaking, and those living in economically depressed regions of NYS.

I. The DFS' Presumption that Most No-Fault Insurers Are Utilizing IMEs/EUO Notices Merely as a Tool to Shield Themselves Against Pervasive Fraud Within the No-Fault Industry and that Most No-Show Denials Are Valid, is a Fallacy

With the Proposed Amendment, the DFS issued a Regulatory Impact Statement ("the Impact Statement") setting forth the perceived need for the proposed legislation. The Impact Statement reveals that it is rife with false presumptions regarding the prevalence of fraud within the NYS no-fault industry and the no-fault insurers' level of adherence to claims practice principles and procedures when processing claims.

In the Impact Statement, the DFS posits that the rights conveyed by the AOB are being abused wholesale by no-fault healthcare providers, who often obtain patients from accident "runners" who are paid to steer patients to their offices, whether these patients are actually injured or are part of a staged accident ring.[3] Then, according to the DFS, these unscrupulous healthcare providers or "mills", armed with their AOBs, file multiple court and/or arbitration proceedings in an attempt to force the no-fault insurers to settle claims even though they have issued "valid" No-Show Denials. Thus, to thwart these "unscrupulous" healthcare providers and to prevent them from extorting monies from innocent no-fault insurers, the DFS proposes to make the AOB voidable at the discretion of the no-fault insurer upon its issuance of a No-Show Denial.

The rationale that the DFS, as protector of the public, is using to rationalize the Proposed Amendment is disturbing because it is based on three false presumptions: (a) the majority of persons injured in automobile accidents, the healthcare providers treating them (with the exception of hospitals), and the attorneys representing them both, are all engaged in a fraudulent scheme against the no-fault insurers, which they are not; (b) all No-Show Denials are valid when, in reality,

[3] See, Regulatory Impact Statement, §3, Needs and Benefits, p. 9 https://docs.dos.ny.gov/info/register/2018/november14/rulemaking.pdf

certain no-fault insurers are actively abusing the verification process by issuing defective scheduling notices and No-Show Denials; and (c) that no-fault insurers are merely utilizing IME and EUOs to protect themselves from the costs associated with the "staged loss" when, in fact, they have weaponized IMEs and EUOs to justify their non-payment of otherwise valid no-fault claims.

The Firm questions the statistical data upon which the DFS has relied in making the statements contained within the Impact Statement. Prior to enacting the Proposed Amendment, the Firm challenges the DFS to verify said information by seeking the following data from all NYS no-fault insurers:

Annually, over the last 5 years:

1. What percentage of the no-fault claims received by no-fault insurers are ultimately denied because they germinated from a staged loss?
2. What percentage of the IMEs requested were prompted by a suspicion that the underlying accident was staged?
3. What percentage of the EUOs requested were prompted by a suspicion that the underlying accident was staged?
4. What percentage of denials were based on the patient's failure to appear for an examination?
5. Of the no-fault claims denied based on the patient's failure to appear for an examination, how many of those were also connected to a stage loss?
6. Of the claims denied based on the patient's failure to appear for an examination, how many of those patients were represented by legal counsel?
7. Of the claims denied based on the patient's failure to appear for an examination, how many of those patients were non-English speaking?
8. What percentage of the No-Show Denials that are challenged in court and arbitration, are eventually overturned by the judge or arbitrator?

The Firm posits that, after reviewing the data provided by NYS no-fault insurers, the DFS will conclude that the perceived fraud it is striving to curb through the Proposed Amendment—the "staged loss"—is nowhere near as pervasive as it currently believes it to be. Furthermore, the low frequency of this type of fraud does not require the DFS to step in with such a sweepingly destructive remedial measure as that which is currently being proposed. The DFS should not consider the no-fault insurers' complaints of widespread fraud without understanding what may be a partial motivation on their part—having the No-Show Denial as pretext to avoid issuance payment of otherwise valid no-fault claims.

The no-fault insurer is not using IME and EUO requests merely to investigate suspected cases of fraud. Rather, the no-fault insurer, with ever increasing frequency, is issuing IME and EUO notices in the hopes of securing a policy breach, having nothing whatsoever to do with the validity of the claim, but in anticipation that the patient will not understand the ramifications for not cooperating. A No-Show Denial, regardless of the validity of the underlying request, allows the no-fault insurer to file a declaratory judgment action to void all coverage. The large percentage of

No-Show denials that have been successfully overturned by healthcare providers in both arbitration and litigation, will demonstrate to the DFS that certain no-fault insurers are actively abusing the verification process by issuing untimely and defective scheduling notices and ultimately, defective No-Show Denials. [4]

Based on the foregoing, Firm maintains that the ability of the healthcare provider to challenge the validity of No-Show Denials in arbitration and litigation is a necessary check on the no-fault insurer. The DFS will be unable to effectively police the abusive practices of no-fault insurers by simply reviewing a list of claims maintained by each carrier of those claims that have been denied based on the patient's failure to appear for an examination and for which the no-fault insurer voids the AOB. Market Conduct Examinations alone will not provide the patient, whose AOB has been wrongly voided by the no-fault insurer, with sufficient redress. Rather, the claims practices employed by no-fault insurers must also be subject to the scrutiny of no-fault arbitrators and judges. Without this scrutiny, certain unscrupulous no-fault insurers will dramatically increase their use of IME and EUOs as a pretext to avoid issuing payment of otherwise valid no-fault claims.

II. The Proposed Amendment Will Not Achieve Its Stated Purpose—To Curb Fraud Stemming from the "Staged Loss"

The DFS' rationale with respect to the benefit of the Proposed Amendment is fundamentally flawed. The DFS falsely presumes that patients, who are part of a staged accident ring, are less likely than patients, who were innocently injured, to appear for an IME or EUO and also less likely to contest the insurers' denials for failing to appear for an examination. [5] However, this could not be further from the truth.

Contrary to the DFS' belief, it is the unrepresented patient (i.e. the non-litigious patient) and the non-English speaking patient, and not the co-conspirator to a staged loss, who are less likely to either appear for an IME or EUO in the first instance. The unrepresented patient is less likely to understand the necessity of appearing for an IME or EUO, especially since the DFS has not mandated that IME and EUO scheduling notices be issued on a prescribed form designed to ensure that the average layperson will understand same (similar to the way that the DFS has mandated the use of prescribed forms for certain notices to homeowners facing foreclosure).

Similarly, the non-English speaking patient is less likely to understand the necessity of appearing for the IME/EUO since the DFS has not mandated that IME/EUO scheduling notices be written in the patient's native language (if they are aware that he is non-English speaking). From the time that the non-English speaking patient receives the IME/EUO notice until the time that the patient obtains a person to translate same, he may have already missed his opportunity to either appear for the examination or request an adjournment of same.

With respect to the likelihood that a patient will commence an arbitration or lawsuit to contest an improper No-Show Denial, there are three classes of individuals, who are less likely to do so—the

[4] Currently, when the Firm arbitrates the validity of No-Show Denials on behalf of its healthcare providers, it is often successful in overturning said denials based on the no-fault insurer's failure to comply the claims practice procedures prescribed in Regulation 68.
[5] See, Regulatory Impact Statement, §4 Costs, p. 10 https://docs.dos.ny.gov/info/register/2018/november14/rulemaking.pdf

unrepresented patient, the non-English speaking patient, and the low-income patient. Unrepresented and non-English speaking patients are less likely to understand the process for commencing an arbitration or lawsuit. And, low-income patients are less likely to have the means to file an arbitration or lawsuit, or the money to hire an attorney to do so on their behalf.

On the other hand, the co-conspirator to a staged loss, who is probably being coached by a "ringleader" and whose entire goal is to obtain a large monetary payout, would be incentivized to comply with policy preconditions and to challenge the validity of a No-Show denial, which would jeopardize his future payout.

III. The Proposed Amendment is Not Needed to Reduce the Number of Court and Arbitration Filings Dealing Stemming from No-Show Denials.

The DFS posits that forcing the patient to litigate or arbitrate the validity of No-Show Denials would reduce the number of court and arbitration filings dealing with same.[6] The DFS reasons that a patient connected to a staged accident ring or otherwise engaged in fraudulent activities concerning no-fault is unlikely to contest the insurer's denials for IME and EUO no-shows. The DFS also reasons that the disposition of the patient's case would apply to all related claims of the patient arising out of the accident, thus decreasing the number of arbitration/court filings. However, the DFS' reasoning is flawed based on the reasons discussed in the foregoing section as well as for the reasons discussed below.

Once one the no-fault insurer obtains a court or arbitration decision upholding the validity of the No-Show Denial, then the doctrine of *collateral estoppel* operates to preclude other no-fault healthcare providers from successfully re-litigating or re-arbitrating the same issue as they are mere assignees of the patient.

Furthermore, the no-fault insurer already has a remedy for reducing the number of court/arbitration cases that it has to defend, which it uses actively for this very purpose—the Declaratory Judgment action. A sampling of the Firm's data reveals that a single no-fault healthcare provider can receive upwards of 20 new Declaratory Judgment Actions per month seeking to void all no-fault benefits (often for multiple patients) based on No-Show Denials.

IV. The Extremely Detrimental, Albeit Unintended, Consequences of the Proposed Amendment Outweigh Any Potential Benefit Gained Therefrom.

The AOB is the foundation of the entire no-fault system and, as such, it is sacrosanct. If the no-fault insurer is given the option to void *ab initio* the AOB between the patient and his treating healthcare provider, to which it is not even a party[7], it would create a climate of extreme

[6] See, Regulatory Impact Statement, §3, Needs and Benefits, p. 10 https://docs.dos.ny.gov/info/register/2018/november14/rulemaking.pdf

[7] Making a contract voidable at the option of a non-party is contrary to basic principles of contract law, which only permits a party to the contract to exercise the option to void same. See, Restatement (First) of Contracts §13 (1932), October 2018 Update, §13, Voidable Contracts, which states that "a voidable contract is one where one or more parties thereto have the power, by a manifestation of election to do so, to avoid the legal relations created by the contract, or by ratification of the contract to extinguish the power of avoidance" [*emphasis added*]. The Comment to this section further states, "[u]sually the power to avoid is confined to one party to the contract, but where, for instance, both parties are infants, or where both

uncertainty that will detrimentally impact the patient, the no-fault healthcare provider, and the liability portion of the automobile insurance policy, in ways not yet perceived by DFS. The extremely detrimental, albeit unintended, consequences outlined below far outweigh any potential benefit gained from the Proposed Amendment. Below are some of the harmful consequences of the Proposed Amendment perceived by the Firm, as it relates to the patient, the healthcare provider, and liability portion of the automobile policy.

The Patient:

1. Only the patient, and not the treating healthcare provider, would be permitted to litigate or arbitrate No-Show Denials.

2. To protect himself from mounting medical bills, once his billing is switched to "self-pay" by his treating healthcare provider(s) after receipt of the No-Show Denial, the patient would be forced to litigate or arbitrate the denial of his no-fault benefits. Thus, the financial burden of litigating/arbitrating the denial of a no-fault claim (e.g. laying out attorneys' fees and filing fees) would be passed from the healthcare provider, who is able to bear said expense, to the patient, who may be unable to shoulder same. The DFS posits that the Proposed Amendment "should have no cost impact on EIPs, [as it] does not require an EIP to be represented in court or arbitration by an attorney." However, the conclusion drawn by the DFS is erroneous. No-Fault is highly regulated and an extremely nuanced area of the law and, without the assistance of legal counsel (particularly an attorney specializing in No-Fault), the patient's chances of success in overturning a No-Show Denial are nil. Overturning a No-Show Denial requires knowledge of the claims practice principals and procedures set forth in Regulation 68, the DFS's Opinion and Circular Letters, and a multitude decisional law interpreting same. This is knowledge that a lay person simply does not and cannot be expected to possess. [8] As such, if the patient has any hope of overturning the No-Show Denial, he will be forced to hire legal counsel and bear the resulting expense.

3. If the no-fault insurer opts to void the AOB *ab initio*, an action sanctioned by the Proposed Amendment, it would not only make the patient personally responsible for billing related to any future medical treatment, but it would also make the patient personally responsible for all prior billing, whether previously paid or denied by the no-fault insurer (even if denied for reasons other than IME/EUO no-show).

parties enter into the contract under such a mutual mistake as affords ground for rescission by a court of equity, the contract may be voidable by either one of the parties." See also, *Matter of Rothko's Estate*, 43 N.Y.2d 305, 324 (1977) (explaining that a voidable contract is one where one or more of the parties to the contract has the power to avoid the legal obligations created by same).

[8] For example, there is currently a split in the Judicial Departments (albeit one that is narrowing) as to whether the patient's failure to appear for an IME/EUO is a defense that must be preserved in a timely denial or whether it is a precludable defense. In the First Department, an IME or EUO no-show is deemed to be a non-precludable defense. In the Second and Fourth Departments, an IME or EUO no-show defense is subject to the preclusion remedy if not asserted in a timely. See, *Unitrin Advantage Ins. Co. v. Bayshore Physical Therapy, PLLC*, 82 A.D.3d 559, 918 N.Y.S.2d 4731 (1st Dept. 2011); Compare, *Westchester Medical Center v. Lincoln General Ins. Co.*, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2d Dept. 2009); see also *Nationwide Affinity Insurance Company of America v. Jamaica Wellness Medical, P.C.*, 2018 WL 6007455, 2018 N.Y. Slip Op. 07850 (4th Dept. 2018).

a. If the AOB is voided *ab initio* by the no-fault insurer, then the no-fault insurer would be permitted to seek recovery of benefits previously paid to the healthcare provider, who would in-turn seek restitution from the patient.

b. Alternatively, if billing was originally denied by the no-fault insurer, for reasons other than IME/EUO no-show, and then the no-fault insurer opts to void the AOB *ab initio* based on a purported IME/EUO no-show, then the healthcare provider would be precluded from seeking reimbursement from the no-fault insurer either through arbitration or litigation. As such, the healthcare provider would be forced to switch these unpaid claims to self-pay, making the patient responsible for all previously denied billing.

Allowing the no-fault insurer to void the AOB *ab initio* is a draconian penalty that runs counter to the position of the DFS, as espoused by the Office of General Counsel, in its Opinion published on February 11, 2003 (hereinafter "the Opinion Letter"). Pursuant to the Opinion letter, the no-fault insurer has no right of recovery for previously paid claims after the patient fails to appear for a reasonable request for an IME. The Opinion Letter provides, in relevant part:

> *When a No-Fault insurer has made payment for claims for health services provided to the eligible injured person, the failure of the eligible injured person to comply with a reasonable request for a medical examination made to verify the medical necessity of claims for subsequent health services performed (arising from the same accident) does create a right of recovery for the insurer for benefits previously paid under the New York Insurance Law.* See, the Opinion Letter https://www.dfs.ny.gov/insurance/ogco2003/rg030212.htm.

In part, this Opinion Letter also served as a basis for a trial balloon floated by the DFS in 2010/2011 for a regulatory change designed to correct the injustices created by the Second Department's holding in *Fogel v. Progressive Cas. Ins. Co,* where the Second Department held that the no-fault insurer may deny a claim retroactively to the date of loss for the claimant's failure to attend an IME that the no-fault insurer reasonably requires. *Fogel v. Progressive Cas. Ins. Co.*, 35 A.D.3d 720, 827 N.Y.S.2d 217 (2d Dept 2006).

4. If the patient is unable to bear the added cost of litigating/arbitrating the validity of a global denial of his no-fault benefits based on an IME or EUO No-Show and also is unable to pay the healthcare provider for any billing subsequently switched to self-pay, then his outstanding medical debt would eventually be referred by the healthcare provider to a debt collector.

5. The unrepresented patient (i.e. the patient without a personal injury attorney) and the non-English speaking patient are two classes of patients that would be most adversely affected by the Proposed Amendment. Said patients are more likely to default in appearing for an IME/EUO in the first instance as they would not understand the significance of appearing for same. Furthermore, if said patients were to receive an improper No-Show Denial (i.e. after requesting an adjournment, etc.), then they would be less likely to commence an arbitration or

lawsuit to contest the validity of said denial. Thus, both the unrepresented (i.e. non-litigious) and the non-English speaking patient would be most vulnerable to having their policies voided *ab initio*, making them personally responsible for all medical bills related to the automobile accident.

6. The patient would have to pay upfront and out-of-pocket for any future medical treatment (i.e. surgeries, injections, physical therapy). If the patient could not afford to do so, then he would have to forego necessary medical treatment until he was able to obtain a decision overturning the No-Show Denial, which could take upwards of one-year in both arbitration and in court.

7. The low-income patient would be the third class of patients most adversely affected by the Proposed Amendment. A low-income patient, who is injured in a motor vehicle accident, may lose access to necessary medical care. If the healthcare provider determines that accepting a low-income no-fault patient is too risky financially, since the healthcare provider would be unable to obtain reimbursement from said patient directly in the event that the no-fault insurer opts to void the AOB, then the healthcare provider may opt not to provide services to no-fault patients within certain geographical regions. Thus, the Proposed Amendment would detrimentally and disproportionally impact the patient living in a low-income neighborhood, who would lose access to medical care.

The Healthcare Provider:

1. The healthcare provider's only means of obtaining reimbursement for medical services previously rendered would be to switch the underlying billing to "self-pay" and attempt to collect same directly from the patient, who may or may not have a pending personal injury action.

2. If the patient has a pending personal injury action, then the treating healthcare provider would be forced to file a lien against said action. Depending on the duration of the personal injury action, it could take the healthcare provider years to obtain reimbursement, if ever.

3. If the patient does not have a personal injury action pending and the patient does not have the means to tender payment, then the healthcare provider would have to pursue collection efforts, utilizing debt collection agencies and attorneys.

4. Due to the financial risk involved with accepting a no-fault patient, the healthcare provider may be forced to limit its acceptance of new no-fault patients to only those patients with the financial means to cover their medical expenses should the no-fault insurer issue a No-Show Denial (i.e. those patients with a certain level of income or those patients with a pending personal injury action).

5. Alternatively, healthcare providers, particularly those that do not generally treat no-fault patients and thus, are already unnerved by no-fault's nuanced paper-based retrospective claim review process, may conclude that it is simply too financially risky to accept no-fault patients due to the risk of a claw-back from the no-fault insurer. Thus, these healthcare providers would

only agree to accept a patient that was injured in an automobile accident if said patient would be willing to pay upfront for his treatment on a self-pay basis. As the DFS clearly bemoans the existence of no-fault medical mills, it is baffling that it would propose the instant legislation, which will only further dissuade non-no-fault healthcare providers from accepting patients with auto-related injuries.

The Liability Portion of the Automobile Insurance Policy

1. If the patient has a personal injury action pending, then the patient's personal injury attorney (rather than the healthcare provider's no-fault attorney) would be forced to arbitrate the denial of the patient's no-fault benefits to protect the potential proceeds of the personal injury action from extensive liens that could exceed the limits of the bodily injury liability portion of the automobile policy. NYS law requires that motorists carry a minimum amount of liability insurance of $25,000.00 for bodily injury and a minimum amount of no-fault coverage of $50,000.00.[9] Thus, if the patient only maintains the minimum amount of coverage, the liability portion of the policy may very well be insufficient to absorb the medical liens resulting from the no-fault insurers' decision to void the AOB.[10]

2. Unlike the no-fault attorney that represents the healthcare provider, the personal injury attorney that represents the patient would be prohibited from charging his client a contingency fee for arbitrating/litigating the denial of his no-fault benefits and thus, would be loath to take said case.[11] The personal injury attorney would be forced to charge his client an hourly rate (which may be too costly for the patient), or be limited to the statutory rate set forth in 11 N.Y.C.R.R. 65-4.6(c)—$70.00 per hour up to a maximum $1,400.00, in addition to $80.00 per hour for each appearance before the arbitration forum or court—a rate that is well below the prevailing hourly rate for lawyers in NYS, and a rate that only applies should the attorney prevail in overturning the No-Show Denial.[12]

3. If the no-fault insurer is permitted to void the AOB, settlements in personal actions would screech to a halt, forcing most lawsuits to proceed to trial. Currently, a personal injury attorney may not settle a client's lawsuit without first ascertaining the existence and value of all pending medical liens (liens from plaintiff's health care providers and health insurers) and governmental liens[13] (liens from Medicare and Medicaid). However, if the Proposed Amendment allows the no-fault insurer to void the AOB *ab initio*, based on a purported No-Show Denial, then the personal injury attorney would also be forced to consider any and all potential medical liens (i.e. all amounts the no-fault insurer either previously paid or denied), when settling his client's personal injury lawsuit. The level of uncertainty involved would prevent most actions from settling, and force more personal injury actions to go forward to trial, further clogging the court system.

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[9] See, Car Insurance in New York, The Department of Motor Vehicles, https://www.dmv.org/ny-new-york/car-insurance.php .

[10] If the Proposed Amendment is enacted the DFS would also have to raise the minimum amount of liability insurance required to match the no-fault coverage, such that it could absorb the medical liens resulting from the no-fault insurer's decision to void the AOB.

[11] See, *Matter of Hausen*, 108 A.D.2d 206, 488 N.Y.S.2d 742, 22 N.Y.C.R.R. 303.7(e)(7), 691.209(e)(7), 806.13(f).

[12] It is important to note that the DFS has not increased the statutory attorney fee in more than one decade.

[13] Medical liens are liens from plaintiff's health care providers and health insurers. Governmental liens are liens from Medicare and Medicaid.

Conclusion

In sum, the Firm vehemently objects to the enactment of the Proposed Amendment on three different, but equally important, bases. First, the DFS' rationale with respect to need for the Proposed Amendment is fundamentally flawed as it based on three false presumptions—(a) the majority of persons injured in automobile accidents, the healthcare providers treating them (with the exception of hospitals), and the attorneys representing them both, are all engaged in a fraudulent scheme against the no-fault insurers, which they are not; [14] (b) all No-Show Denials are valid when, in reality, certain no-fault insurers are actively abusing the verification process by issuing defective scheduling notices and No-Show Denials; and (c) the no-fault insurers are merely utilizing IME and EUOs to protect themselves from the costs associated with the "staged loss" when, if fact, they have weaponized IMEs and EUOs to justify their non-payment of otherwise valid no-fault claims. Second, the Proposed Amendment is not needed to achieve its stated purpose—to reduce the number of court/arbitration filings dealing with No-Show Denials—as no-fault insurers already have two remedies for reducing the number of court/arbitration cases that they have to defend—*collateral estoppel* and the Declaratory Judgment action. Third, the extremely detrimental, albeit unintended, consequences of the Proposed Amendment outweigh any potential benefit gained therefrom. Allowing the no-fault insurer to void the AOB at its own discretion upon the issuance of a No-Show Denial will upend the current no-fault system, which utilizes the AOB to facilitate the prompt payment of medical expenses and wage loss for those parties injured as a result of an automobile accident. It will lead to a shortage of medical providers, particularly in low-income areas, willing to accept no-fault patients. And, it will have a disproportionately negative impact on three classes of patients—the unrepresented, the non-English speaking, and those living in economically depressed regions of NYS.

Thank you for your attention to this matter. If you have any questions or require additional information, please do not hesitate to contact the undersigned at the above-listed number.

Sincerely,

RUSSELL FRIEDMAN & ASSOCIATES

_____/s/_____
Erin S. Stamper

[14] The Firm is incensed by the DFS' negative characterization of persons injured in automobile accidents, the healthcare providers with whom they treat, and *implicitly* the lawyers that represent them. The DFS's position in the Impact Statement diminishes the public's view of these parties.