

IN THE SUPREME COURT OF OHIO

MEDICAL MUTUAL OF OHIO, :
 :
 Appellant, :
 :
 vs. :
 : On Appeal from the Cuyahoga County
 Court of Appeals, Eighth Appellate District
 :
 WILLIAM SCHLOTTERER, D.O., :
 :
 Appellee. :
 :

**BRIEF OF AMICI CURIAE OHIO ASSOCIATION OF HEALTH
PLANS AND THE OHIO INSURANCE INSTITUTE
IN SUPPORT OF APPELLANT, URGING REVERSAL**

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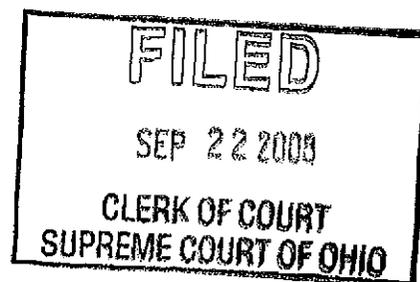
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STATEMENT OF INTEREST OF AMICI CURIAE

I. OHIO ASSOCIATION OF HEALTH PLANS

The Ohio Association of Health Plans (“OAHP”) is a state trade association representing 20 health insurance plans which provide coverage to more than seven million Ohioans. OAHP’s members offer a broad range of products in the commercial marketplace, including health, dental, vision, disability, and other supplemental coverage. OAHP’s members also have a strong track record of participation in Medicare, Medicaid, and other public programs.

II. THE OHIO INSURANCE INSTITUTE

The Ohio Insurance Institute (“OII”) is Ohio’s property and casualty insurance trade association. OII provides a wide range of services to Ohio insurers, consumers, media, and legislators. OII public information and education programs include publications, television programs, seminars, workshops, and industry issue campaigns that play a vital role in increasing consumer understanding of insurance issues. OII serves as a liaison between its members and Ohio’s legislative, judicial, and regulatory bodies by providing insurance-related information and answers to insurance questions to state lawmakers, governmental and regulatory officials, courts, and state agencies. OII is uniquely qualified to provide the Court with both a broad perspective and practical insight into questions of insurance law.

This case is of significant concern to OAHP and OII (the “Insurance Amici Curiae”) and their members because they have a significant role and interest in preventing, investigating, and detecting insurance fraud.

STATEMENT OF FACTS / STATEMENT OF THE CASE

The Insurance Amici Curiae adopt and incorporate by reference the Statement of Facts and Statement of the Case included in Appellant Medical Mutual of Ohio’s Merit Brief.

ARGUMENT

Proposition of Law No. 1: Revised Code Sections 3999.42 and 2913.47 do not restrict insurers' ability to investigate insurance fraud. As recognized by the Ohio General Assembly in Revised Code Section 3999.41, insurers are important and necessary participants in the insurance fraud investigation process.

The Court of Appeals was asked to consider whether William Schlotterer, D.O. was properly compelled to produce non-party patient information to Medical Mutual of Ohio ("MMO") in the context of MMO's insurance fraud investigation. Instead of confining its decision to this issue, the Court of Appeals opined on what it believes to be the proper allocation of insurance fraud investigation responsibilities as between insurers and the State of Ohio. Citing Revised Code Sections 3999.42 and 2913.47, the Court of Appeals stated:

The legislature thus has indicated a preference for such matters [insurance fraud investigation] to be handled by the state, rather than by a private party.

Court of Appeals' Journal Entry and Opinion No. 89388 at p.10 (Appellant's Appendix at 15).

The Court of Appeals' opinion on this issue is incorrect, without foundation, and inconsistent with the practical realities of insurance fraud investigation in the State of Ohio for at least four reasons.

First, contrary to the Court of Appeals' opinion, the Ohio Legislature mandates that insurers investigate insurance fraud. Revised Code Section 3999.41(A) provides that "every insurer ... shall adopt an antifraud program and shall specify in a written plan the procedures it will follow when instances of insurance fraud or suspected insurance fraud are brought to its attention." The Ohio Legislature recognizes the valuable and necessary function served by insurers in the investigation of insurance fraud, and in fact requires insurers to establish antifraud programs to detect and investigate insurance fraud.

Second, despite the references by the Court of Appeals, Revised Code Sections 3999.42(A) and 2913.47 do not indicate a preference by the Ohio General Assembly that insurance fraud investigation be handled by the State of Ohio as opposed to insurers. Revised Code Section 3999.42(A) provides, in pertinent part: “If an insurer ... has reasonable belief that a person is perpetuating or facilitating an insurance fraud, ... or has done so, *the insurer shall notify the department of insurance.*” R.C. 3999.42(A) (emphasis added.) While this statute requires an insurer to notify the Department of Insurance (the “Department”) of suspected insurance fraud (after the insurer has done sufficient investigation to formulate a “reasonable belief” that insurance fraud has occurred), it does not state that the Department shall have exclusive responsibility for insurance fraud investigation, or that insurers must cease all insurance fraud investigation once they have disclosed suspected insurance fraud to the Department. The statute does not preclude insurers from conducting their own investigations into allegations of fraud.

Nor does Revised Code Section 2913.47¹ require insurers to terminate their own investigations when and if a case is referred for criminal prosecution. It does not address in

¹ Revised Code Section 2913.47 provides, in pertinent part:

(B) No person, with purpose to defraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Present to, or cause to be presented to, an insurer any written or oral statement that is part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive;

(2) Assist, aid, abet, solicit, procure, or conspire with another to prepare or make any written or oral statement that is intended to be presented to an insurer as part of, or in support of, an application for insurance, a claim for payment pursuant to a policy, or a claim for any other benefit pursuant to a policy, knowing that the statement, or any part of the statement, is false or deceptive.

anyway who conducts the investigation. Instead, Revised Code Section 2913.47 simply defines the crime of “insurance fraud” and identifies various criminal penalties – e.g., “If the amount of the claim that is false or deceptive is five hundred dollars or more and is less than five thousand, insurance fraud is a felony of the fifth degree.” *See* R.C. 2913.47(C).

Third, the Court of Appeals ignores reliance by the Department and county prosecutors on insurers to identify and assist with insurance fraud matters. Detection, investigation, prevention, and prosecution of insurance fraud is a collaborative effort between the Department, insurers, and prosecutors. Insurers are the first line of defense against insurance fraud, as they review and process insurance reimbursement requests submitted by medical providers and are in the best position to initially detect fraud. Having insurers investigate insurance fraud is a natural extension of reviewing medical providers’ practices, including abusive billing and breaches of contract.

Fourth, the Court of Appeals’ opinion ignores the realities of the Department’s financial situation and labor force. The estimated costs of insurance fraud in the United States is staggering. For example, the National Health Care Anti-Fraud Association estimates the annual cost of health care fraud to be \$51 billion annually, the Coalition Against Insurance Fraud estimates the figure to be \$54 billion annually, and the Insurance Information Institute believes the cost of fraud to be \$95 billion a year. *See* OII website, <<http://ohioinsurance.org/factbook/2006/chapter5/chapter5_d.asp>> last visited August 28, 2008. The FBI believes this number to

(C) Whoever violates this section is guilty of insurance fraud. Except as otherwise provided in this division, insurance fraud is a misdemeanor of the first degree. If the amount of the claim that is false or deceptive is five hundred dollars or more and is less than five thousand, insurance fraud is a felony of the fifth degree. If the amount of the claim that is false or deceptive is five thousand dollars or more and is less than one hundred thousand dollars, insurance fraud is a felony in the fourth degree. If the amount of the claim that is false or deceptive is one hundred thousand dollars or more, insurance fraud is a felony in the third degree.

be even higher, estimating that health care fraud cost the American public between \$68 billion and \$226 billion in the year 2007 alone. *See* Brief of *Amici Curiae* National Health Care Anti-Fraud Association, National Insurance Crime Bureau, Coalition Against Insurance Fraud, and America's Health Insurance Plans in Support of Medical Mutual of Ohio, filed August 29, 2008, p. 4. This high cost can be attributed to the increasing complexity and variety of external fraud cases. These cases, committed by insurance applicants, policyholders, third-party claimants and medical providers, can be categorized as "soft" or "hard." "Soft" cases are those in which otherwise legitimate claims are exaggerated, whereas "hard" cases refer to deliberate attempts to stage losses.

In Ohio, though dedicated to the investigation and prevention of insurance fraud, the Department is already spread thin investigating the numerous insurance fraud and agent misconduct complaints it receives each year. According to information provided by the Department:

- In 2008, to date, 120 insurance fraud cases were opened by the Department, and 92 cases were referred for prosecution.
- In 2007, 194 insurance fraud cases were opened by the Department, and 81 cases were referred for prosecution.
- In 2006, 149 insurance fraud cases were opened by the Department, and 95 cases were referred for prosecution.
- In 2005, 139 insurance fraud cases were opened by the Department, and 56 cases were referred for prosecution.

Given the number of insurance fraud cases in Ohio, the financial and human resources needed to investigate those claims would be overwhelming for one agency. By way of example only, one OII member, Motorists Mutual Insurance Company ("Motorists") has four investigators, one investigative technician and one supervisor dedicated to investigating fraud,

primarily in Ohio and its neighboring states. Each investigator has a company car and the collective salary of these six employees is close to \$400,000.00 plus benefits. Last year, Motorists investigated 831 fraud cases in Ohio alone; this year, Motorists has already handled 584 fraud cases in Ohio. Motorists is of course, only one of hundreds of insurance companies that write business in Ohio.

The Department does not have the financial resources or manpower to shoulder the burden of insurance fraud investigation alone. Motorists' budget for investigating fraud is almost half of the Department's entire allocation for its Fraud & Enforcement Division, and in 2008, the Department only has 15 personnel (just nine more than Motorists) devoted to investigating fraud. The Department depends on insurers to assist with insurance fraud detection, investigation and prevention. The general public would not be served by restricting or limiting an insurers' ability to investigate insurance fraud because: (1) insurance fraud investigation efforts would slow dramatically; (2) the instances of insurance fraud would likely increase because medical providers would know there was only one overwhelmed watch dog (the Department) as opposed to multiple watch dogs (the Department and insurers); and (3) consumer premiums would increase as insurers sustained additional losses attributable to fraud.

The bottom line is that the Court of Appeals' opinion that the Ohio Legislature has expressed a preference that insurance fraud investigation be handled by the State of Ohio and not by insurers has no basis and does not comport with the realities of how insurance fraud is investigated in the State of Ohio. In addition, placing the burden of insurance fraud investigation exclusively on the Department would put the Department in a position that it would not have the resources to handle. The public is better served by the collaborative insurance fraud investigation efforts that currently exist between the Department, prosecutors, and insurers.

The Court of Appeals' opinion undercuts the cooperative balance between the Department, prosecutors and insurers, and should therefore be reversed.

Proposition of Law No. 2: The investigation of insurance fraud constitutes a special situation in which the interests of the public, third-party insurance providers, and the Ohio Department of Insurance outweigh the interests of non-party patients in absolute confidentiality of personal health information. Limited disclosure of patients' privileged information is to entities who have a legitimate need for the information to investigate fraud is necessary to facilitate and aid in the investigation of insurance fraud.

While the physician-patient privilege codified in Revised Code Section 2317.02 serves a laudable purpose and goal, the privilege is not absolute and may not be invoked in all circumstances. *State Medical Board of Ohio v. Miller* (1989), 44 Ohio St. 3d 136, 140, 541 N.E.2d 602, 605.

Ohio courts have recognized exceptions to the physician-patient privilege and have allowed the disclosure of otherwise privileged information, absent a patient's consent, when the interests of the public or third-parties outweigh the patient's interest in absolute confidentiality. *Miller*, 44 Ohio St. 3d at 140-141, 541 N.E.2d at 605-606 (allowing disclosure of privileged patient information during a state medical board investigation of physician conduct); *Biddle v. Warren General Hospital* (1999), 86 Ohio St. 3d 395, 402, 715 N.E.2d 518, 524 (recognizing that special situations exist when the interest of the public, the patient, the physician, or a third person are of sufficient importance to justify the creation of a conditional or qualified privilege to disclose); *Soehlen v. Aultman Hospital* (May 4, 2007), N.D. Ohio No. 5:06 CV 1594, 2007 U.S. Dist. LEXIS 33064, at *16 (allowing production of privileged patient information in negligence case); *Varghese v. Royal Maccabesse Life Ins. Co.* (S.D. Ohio 1998), 181 F.R.D. 359, 362 (ordering the production of privileged patient information in disability case); *Alcorn v.*

Franciscan Hospital Mt. Airy Compus (Nov. 9, 2006), 1st App. No. C-060061, 2006 Ohio App. LEXIS 5840, 2006-Ohio-5896, at ¶13 (allowing production of privileged patient information in negligence case); *Richards v. Kerlakian* (2005), 162 Ohio App. 3d 823, 826, 2005-Ohio-4414, ¶8, 835 N.E.2d 768, 770 (allowing the production of privileged patient information in medical malpractice and negligent credentialing case); *Fair v. St. Elizabeth Medical Center* (2000), 136 Ohio App. 3d 522, 527, 737 N.E.2d 106, 109 (allowing production of privileged patient information in negligence case).

Likewise, the Ohio Legislature has codified an exception to the physician-patient privilege to allow insurers to share information when necessary to investigate fraud and other wrongdoing. *See* R.C. 3904.13(C) (allowing the disclosure of privileged information from one insurer to another to detect and prevent criminal activity, fraud, material misrepresentations or material nondisclosures).

In *Biddle*, this Court held that “[i]n the absence of prior authorization, a physician or hospital is privileged to disclose otherwise confidential medical information in those special situations where disclosure ... is necessary to protect or further a countervailing interest that outweighs the patient’s interest in confidentiality. *Biddle*, 86 Ohio St. 3d at 402, 715 N.E.2d at 524.

The need to thoroughly and accurately detect, investigate and prosecute insurance fraud is a “countervailing interest” that outweighs the patient’s interest in absolute confidentiality. These investigations do not amount to “fishing expeditions” when there is a reasonable basis to suspect fraud. Medical providers cannot be permitted to shield fraudulent conduct behind the physician-patient privilege. Insurers, the Department, and prosecutors must be able to obtain patient medical records and information (redacted as appropriate or pursuant to a protective

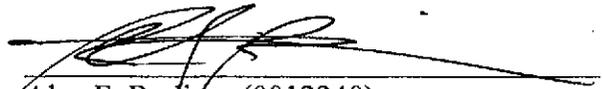
order) so that they can investigate suspected and alleged insurance fraud. The public and insurers will suffer if the key documents that evidence insurance fraud – i.e., patient medical records and information – are not discoverable absent patient consent.

The Court of Appeals' decision impedes the ability of the Department, insurers, and prosecutors to investigate and prosecute insurance fraud, and therefore must be reversed.

CONCLUSION

For the foregoing reasons, the Amici Curiae Ohio Association of Health Plans and Ohio Insurance Institute respectfully ask the Court to reverse the decision and judgment entered by the Court of Appeals.

Respectfully submitted,



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CERTIFICATE OF SERVICE

The undersigned certifies that a true copy of the *Brief of Amici Curiae Ohio Association of Health Plans and The Ohio Insurance Institute in Support of Appellant, Urging Reversal* was served upon the following by regular U.S. Mail, postage pre-paid, on September 22, 2008:

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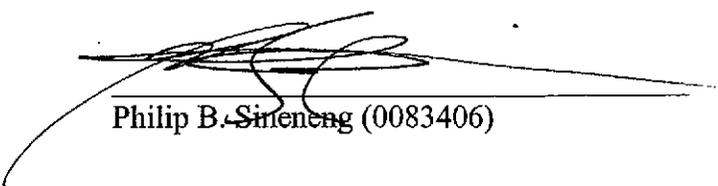
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