

IN THE SUPREME COURT OF OHIO

RICHARD JACQUES

Plaintiff-Appellee,

v.

PATRICIA A. MANTON

Defendant-Appellant.

CASE NO 09-0820

On Appeal from the
Lucas County Court of Appeals
Sixth Appellate District
Case No. L-08-1096

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STATEMENT OF FACTS

The Merit Brief of appellant Patricia A. Manton adequately sets forth the facts and procedural history of this case. While Amicus endorses both propositions of law set forth in the appellant's brief, this brief deals only with Proposition of Law No. I.

ARGUMENT

PROPOSITION OF LAW NO. I:

IN A PERSONAL INJURY CASE, THE AMOUNT THAT A MEDICAL CARE PROVIDER ACCEPTS AS FULL PAYMENT FOR MEDICAL CARE CONSTITUTES FULL PAYMENT FOR SERVICES RENDERED AND IS THE ONLY EVIDENCE ADMISSIBLE TO PROVE THE REASONABLE VALUE OF MEDICAL SERVICES CAUSED BY THE INJURY IN CASES COVERED BY R.C. 1751.60

Once a medical provider or health care facility agrees to accept payment for its services to an insured of a health insuring corporation, the provider is prohibited by statute from seeking additional compensation for covered services from the subscriber or enrollee of that health insuring corporation, except for approved copayments and/or deductibles. The subscriber or enrollee is not liable to any contracting provider or health care facility for the cost of any covered health care services beyond the payments made by the health insuring corporation.

Revised Code 1751.60 Provider or facility to seek compensation for covered services only from HIC

(A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insured corporation to provide health care services to the health insuring corporations' enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles.

(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of

any covered health care services, if the subscriber or enrollee has acted in accordance with the evidence of coverage.

(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved copayments and deductibles.

* * *

(As amended, effective September 23, 2008)¹. (emphasis added)

Thus, where a third-party payor is a health insuring corporation, a plaintiff is never liable for anything more than the co-payment or deductible portion of a medical bill or hospital bill. The provider never writes off any amount; it is simply paid whatever was agreed to in the contract between the provider and the health insuring corporation. It would be dishonest for a plaintiff to claim or represent to a jury that he was liable or has paid or is liable to pay in the future any other amount to the provider.

Under these circumstances, it is imperative for the Ohio Supreme Court to address this issue and reflect upon its prior holding in *Robinson v. Bates*, 112 Ohio St.3d 17, 2006-Ohio-6362.

At issue in *Robinson v. Bates, supra*, was whether the amount accepted by a medical provider as payment in full was admissible to prove the reasonable value of the provider's medical services. On that point, this court held in paragraph 1 of its syllabus that:

"Both an original medical bill rendered and the amount accepted as full payment are admissible to prove the reasonableness and the necessity of charges rendered for medical and hospital care." (*Wagner v. McDaniels* (1984), 9 Ohio St.3d 184, followed)

¹ The 2008 amendment dealt with subsection (E) of this statute, which is unrelated to the issue at hand.

Under the holding of the *Robinson* decision, the plaintiff may still introduce the total amount of the bill into evidence, but the Supreme Court's decision allows the jury to find that the amount actually paid and accepted was the "reasonable value of the service provided".

Footnote 1 in the *Robinson* decision states:

"We note that, effective April 7, 2005, the general assembly passed R.C. §2315.20, which is a statute entitled "Introduction of Collateral Benefits in Tort Actions". The purpose of this statute was to set forth Ohio's statement of the law on collateral source rule. This new collateral benefits statute does not apply to this case, however, because it became effective after the cause of action accrued and after the complaint was filed." *Robinson*, at ¶10, note 1.

As noted above, the issue in *Robinson* was whether evidence of what a health care provider accepts as payment in full is admissible on the issue of the "reasonableness of the bill". Nowhere in footnote 1 or elsewhere, does the *Robinson* decision suggest that its holding would be different if R.C. §2315.20 were applicable or that it would not apply to cases arising after the enactment of §2315.20.

What the Supreme Court did do in *Robinson* was to reject the plaintiff's argument that the write-offs by medical providers fell within the traditional collateral source rule:

"The collateral source rule excludes only 'evidence of benefits paid by a collateral source' (citations omitted). Because no one pays the write off, it cannot possibly constitute payment of any benefit from a collateral source (citation omitted). Because no one pays the negotiated reduction, admitting evidence of write offs does not violate the purpose behind the collateral source rule (emphasis added). *Id.* at ¶16.

This view is all the more significant in light of R.C. 2315.18 which is the same chapter of the Revised Code where the collateral source provision appears which took effect on the same date and in R.C. 2307.011, which also was effective that date, too. These sections define the economic loss

component of compensatory damages. Specifically, when it comes to care and treatment, economic damages are limited to:

All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations incurred as a result of an injury, death, or loss to person that is a subject of a tort action, including expenditures for those purposes that were incurred as of the date of a judgment and expenditures for those purposes that, in the determination of the trier of fact, will be incurred in the future because of the injury, whether paid by the injury person or by another person on behalf of the insured person R.C. 2307.011(C)(2).

All expenditures for medical care or treatment, rehabilitation services, or other care, treatment, services, products, or accommodations as a result of an injury or loss to person or property that is subject of a tort action. R.C. 2315.18(A)(2)(b).

That same statute requires a jury in a general interrogatory to specify:

The portion of the total compensatory damages that represents damages for economic loss. R.C. 2315.18(D)(2).

Accordingly, only "expenditures" for care and treatment are economic loss. Since "write-offs" or "adjustments" are not "expenditures", so evidence of amounts greater than those actually expended for care and treatment of the plaintiff may not be included in the computation of the compensatory damages for economic loss.

Thus, only the amounts expended for care and treatment should be allowed as evidence of economic loss. The import of *Robinson* is that even before these statutory changes, there was a clear and specific holding that a defendant may introduce evidence of the amount a health care provider accepted as payment in full on the issue of reasonableness of the charges for services. R.C. 2315.20 did not redefine what constitutes collateral source evidence, nor does it touch on the criteria for what makes a medical or hospital bill reasonable in the first place. Above all, R.C. 2315.20 does not affect the holding in *Robinson* and does not provide a basis for excluding evidence of a write-off by

plaintiff's health care providers in this case. Because the Ohio Supreme Court held in *Robinson* that write-offs are not collateral benefits, §2315.20 is simply not relevant to the current controversy.

The *Robinson v. Bates* decision was controversial and many trial judges appear to have misunderstood its purposes. They have not properly applied the holding in *Robinson* in their courtrooms. In that process, however, trial judges have unwittingly encouraged plaintiffs to mislead the courts and to misrepresent the actual amounts of their economic loss damages for their injuries. While the trial judge certainly has the right and authority to interpret legal issues of first impression in his or her court as he or she sees fit, trial judges may and should give some thought to how the Ohio Supreme Court might ultimately resolve the issue. Given the language in *Robinson*, amicus respectfully submits that the Ohio Supreme Court, should and will follow its own precedent and uphold Proposition of Law No. 1 holding that this evidence is admissible and further extend its holding to state that this evidence is the only proper evidence of medical or hospital expense admissible.

Moreover, in view of the statute now quoted above as R.C. 1751.60, R.C. 2307.011 and R.C. 2315.18, the Supreme Court should extend the ruling further and hold that evidence of payment by a "health care insuring corporation" is the only evidence of the reasonable value of services rendered and no other evidence is permitted except for approved copayments and deductibles. This should be the case, at least, when a provider signs a contract with a health care facility that requires it to bill the health insuring corporation only and prohibits the provider from billing the subscriber or the enrollee any amount aside from, the approved copayments or deductibles pursuant to R.C. 1751.60.

To allow the plaintiffs to introduce evidence of an amount which neither the health insuring corporation nor the subscriber or enrollee were ever liable, and will never be liable, only confuses the record and the jury, and allows the recovery of nonexistent, phantom damages.

The problems inherent in the application of the rules contained in *Robinson* are evidentiary ones. This is particularly true when, as in this case, the subrogated insurance providers have not been joined as parties. As argued above, while the amount of any contractual write-off is not a collateral source and should not be admissible as economic loss, quite often the exhibits used to prove the amount of economic loss contain evidence of those write-offs. They come from the provider or medical facility's bills or payment summaries issued by insurance companies. Both types of documents often contain not only the amount of the contractual write-off but also evidence as to the identity of the insurance carrier and the amount of payments made under the policy. Identifying that a portion of the bill was paid by an insurer is viewed as offending the collateral source rule and is the reason most often offered by the conflicting trial court for not following *Robinson*.

Even if this court does not adopt the view that R.C. 1751.60, R.C. 2307.011 and R.C. 2315.18 limit the economic loss evidence for medical care or treatment, rehabilitation services, or other care, treatment, services, products or accommodations to the amounts actually expended, then it is submitted that stipulations, discovery requests, or requests for admissions properly utilized can establish the amount of the contractual write-off, so that the evidence of the write-off is presented in a way that does not offend the collateral source rule.

Furthermore, Civil Rule 19 (A) permits the joinder of a party that claims a subrogated interest. Ohio law is clear that such a subrogated party, and not the plaintiff, is the real party in interest with regard to the bills that the subrogated party has paid.

When, as here, a person who claims injuries as a result of a tortious act submits a claim for medical treatment received as a result of those claimed injuries to an insurance carrier and in exchange for the payment of those medical expenses assigns his/her right to recover those bills to

that insurance company, the insurance company receiving the assignment becomes the real party in interest with regard to those payments and is the party entitled to recover for the benefits paid, *Smith v. The Travelers Insurance Co.* (1977) 50 Ohio St. 2d 43. Therefore, it is inappropriate to permit the injured party to present those bills in evidence to a jury as though they were part of his/her own damages, because the injured party is not the real party in interest and the medical expenses are not part of his/her damages, *Bartram V. Edmonds*, No. CCA1873, Court of Appeals, Fifth Appellate District, Richland County, Ohio, Ohio App. LEXIS 11740 (1981); *Bowers v. Johns* 1986 Ohio App. LEXIS 6533.

As the court in *Bowers v. Johns* so succinctly stated:

... The sole issue concerned whether appellant was entitled to damages for injuries which she suffered. Appellant having not paid the medical bills suffered no injury and was not entitled to receive an award for the medical bills paid by the medical plan. The medical plan had the right to recover the costs of the medical bills which were paid out of the medical plan's fund. The trial court did not err when it did not join the medical plan as a party to the action, nor did the court err when it refused to submit the costs of the medical bills to the jury for an award of damages. *Id.* pg.4.

When subrogated carriers are joined then neither the collateral source rule nor the rules contained in *Robinson* apply, at least as to the subrogated bills. At that point, the subrogated carriers present the bills as part of their case, not the plaintiff, and the subrogated carriers cannot claim more than they paid. Then, it is not considered a violation of the collateral source rule. The same should be true whether or not a subrogated carrier is joined as a party in the case.

Ohio law is clear. The measure of damages in a tort action is that which will compensate and make the plaintiff whole. *Pryor v. Weber* (1970), 23 Ohio St.2d 104, 263 N.E.2d 235, at ¶1 of the syllabus. The rule in a personal injury action is that a "plaintiff may recover for the necessary and

reasonable expenses caused by the injury. (*Bagyi v. Miller* (1965), 3 Ohio App. 2d 371, see also *Wagner v. McDaniels* (1984), 9 Ohio St.3d 184; 459 N.E.2d 561).

The Sixth District Court of Appeals decision holding conflicts with these well established principles by allowing the plaintiff to recover more than would make him whole by precluding the defendant from submitting relevant evidence tending to establish the reasonable value of medical services incurred as a result of the injury where the reasonable value is less than the actual stated medical bills submitted by the plaintiff. The Amicus submits that the Sixth District holding is an and unreasonable expansion of the collateral source rule beyond its intended purpose.

The written off portion of the medical bill is quite different from a collateral benefit. First of all, the written off portion of the medical bill does not constitute monetary compensation or services received by the plaintiff. Rather, the written off portion of the bill represents a sum which the plaintiff will never be held liable to pay to his or her medical provider or any subrogated party. It is a pure windfall to the plaintiff.

Juries commonly take the amount of medical expenses into account when calculating an award for pain and suffering, and, therefore, the potential for multiple windfalls is great. As such, allowing the plaintiff to recover the full value of the initial bills allows the plaintiff to recover far more than would actually make him or her whole. This is well beyond the law of damages recoverable in a tort action under Ohio law.

Secondly, the amount agreed upon to resolve the medical bills of Richard Jacques is extremely relevant when determining the reasonable amount of damages caused by the defendant. Relevant evidence is defined by Evidence Rule 401 of the Ohio Rules of Evidence, as evidence “having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence”. As noted

above, the general rule of damages in a personal injury action is that the plaintiff may recover for the "necessary and reasonable expenses caused by the injury". *Bagyi v. Miller, supra*. Therefore, the amount that a medical provider has agreed to accept or is required by statute to accept as payment in full for a service rendered clearly tends to establish the reasonable value of such service and is clearly relevant under the Ohio Rules of Evidence.

Both the Ohio legislature and Ohio case law recognize that a tortfeasor should be permitted to challenge the reasonableness of a medical bill. Ohio Revised Code §2317.421 expressly provides:

In an action for damages arising from personal injury or wrongful death, a written bill or statement . . . shall, if otherwise admissible², be prima-facie evidence of the reasonableness of any charges and fees stated therein. . . provided, that such bill or statement shall be prima-facie evidence of reasonableness only, if the party offering it delivers a copy of it, or the relevant portion thereof, to the attorney of record for each adverse party not less than five days before trial. (emphasis added)

Ohio case law construing the statute recognizes that properly submitted medical bills are merely rebuttable evidence of reasonableness, and that the statute permits opposing counsel to challenge their reasonableness with contrary evidence. See *Stiver v. Miami Valley Cable Council* (1995), 105 Ohio App.3d 313; *Coleman v. Drayton* (March 24, 1994), 10th Dist. No. 93 APE 10-1402; *Holmeyer-McGee v. Hood*, 8th Dist, No, 799552, 2002-Ohio-1410; and *Wood v. Elzoheary* (1983), 11 Ohio App.3d 27, 462 N.E. 2d 1243.

The Sixth District's holding effectively precludes a defendant tortfeasor from challenging the reasonableness of a submitted medical bill despite the Ohio legislature's clear intent that a defendant shall be permitted to rebut the presumption of reasonableness in a given medical bill. Furthermore,

²R.C. 1751.60, R.C. 2307.011 and R.C. 2315.118 lead to the conclusion that when a health insuring corporation has paid medical expenses, evidence beyond the contractually agreed amount, including co-payments and deductibles, if any, would be inadmissible.

the Sixth District decision totally disregards the explicit holding in the *Robinson v. Bates* decision cited above. Accordingly, it should be reversed.

CONCLUSION

The Ohio Supreme Court should state once and for all, that under no circumstances may the court preclude a defendant from admitting evidence of the actual amounts paid to the medical or healthcare provider where those are the only bills incurred and the remainder has been written off.

Further, in those cases where the plaintiff is a "subscriber" or "enrollee" of a "health insuring corporation" within the meaning of R.C. 1751.60, cited above, this court should order that the amount paid by the "health insuring corporation" is the only evidence that may be submitted in evidence as proof of damages, except for "deductibles" and/or "non covered services". Any other resolution of the issue fails to give effect to Ohio statutory law and creates confusion in the mind of a jury and/or encourages the plaintiff to misrepresent their actual damages to the jury.

If plaintiffs are permitted to collect the windfall of phantom damages, the result is not only a perversion of the law of damages and subversion of the jury's deliberations, but it imposes the burden upon the premium paying public. That is not sound public policy when society is already struggling to pay the costs of medical and health insurance premiums.

Respectfully submitted,



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