

IN THE SUPREME COURT OF OHIO

10-1236

ProMedica Health System and
The Toledo Hospital,

Appellants,

v.

Virginia King,

Appellee.

On Appeal From The
Lucas County Court of Appeals
Sixth Appellate District

Court of Appeals
Case No. L-09-1282

**MEMORANDUM IN SUPPORT OF JURISDICTION OF APPELLANTS
PROMEDICA HEALTH SYSTEM AND THE TOLEDO HOSPITAL**

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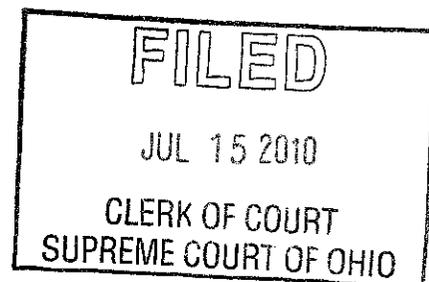


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I. EXPLANATION OF WHY THIS IS A CASE OF PUBLIC OR GREAT GENERAL INTEREST.

This case is of public and great general interest because it presents a matter of first impression for this Court, the construction of R.C. §1751.60(A), and because the construction of R.C. §1751.60(A) by the Court of Appeals is fundamentally inconsistent with Ohio's law on the coordination of insurance benefits, R.C. §3902.11, *et seq.*, and Ohio Adm. Code §3901-8-1, *et seq.*, and with generally accepted industry billing and payment practices based thereon.

Ohio's law on the coordination of benefits sets forth specific rules whereby insurance companies covering an insured patient's medical expenses can determine for themselves who has the primary payment obligation, and whose payment obligation is secondary. R.C. §3902.13(A). The primary plan is required to pay its benefits first, without regard to coverage provided by the secondary plan. R.C. §3902.12; Ohio Adm. Code §3901-8-01(F)(3). The secondary plan is required to pay benefits only after the benefits paid or payable by the primary plan have been determined and deducted from the benefits payable by the secondary plan. R.C. §§3902.12, 3902.13(B), (C), and (E); Ohio Adm. Code §3901-8-01(F)(6) and (H). These coordination of benefits rules apply to insurance coverage provided by Health Insuring Corporations, the insurance companies that are the subject of R.C. §1751.60. R.C. §3902.11(B)(2); see also Ohio Adm. Code §3901-8-01(C)(11)(c)(iii). They also apply to automobile insurance companies providing medical payment benefits for insureds who are injured in automobile accidents. R.C. §3902.11(B)(3); see also Ohio Adm. Code §3901-8-01(C)(11)(c)(vi).

Historically automobile insurance companies providing coverage for the cost of accident related medical care have determined that their coverage is primary, and they have paid hospital billings accordingly. The insurance coverage provided by other insurance companies for such care, including that provided by Health Insuring Corporations, has historically been secondary,

and those other companies have paid their benefits after deducting amounts paid or payable by the automobile insurance companies.

The members of the medical care industry have generally followed the coordination of benefits process laid out in these statutes and regulations in their billing and payment practices. Indeed, insurance companies that elect to coordinate their benefits with other plans are required by regulation to include mandatory language describing and incorporating the statutory coordination of benefits process in each contract and certificate of insurance that they issue. Ohio Adm. Code §3901-8-01(D)(3) and (4); see also Appendix A thereto. Industry members have not viewed R.C. §1751.60(A) as modifying the statutory coordination of benefits process. Rather they viewed the statute simply as insulating patients from personal liability for the cost of medical services when those services are covered by insurance provided by a Health Insuring Corporation.

The Court of Appeals construed R.C. §1751.60(A) as prohibiting Providers and Health Care Facilities from seeking compensation, *i.e.*, sending bills, to any insurance company other than the patient's Health Insuring Corporation. This is so even when the patient's Health Insuring Corporation is only a secondary plan under Ohio's coordination of benefits law. Such a prohibition is wholly inconsistent with the coordination of benefits process. For that process to work, Providers and Health Care Facilities must be able to submit their bills to all of their patient's plans of health coverage, so those plans can determine for themselves their order of priority and make payments accordingly. Any other construction leads to absurd results.

If R.C. §1751.60(A) is construed simply as requiring Providers and Health Care Facilities to submit their bills to the Health Insuring Corporations of their patients, the Health Insuring Corporations themselves would still be free to apply the coordination of benefits rules. Thus, if

the Health Insuring Corporations are secondary plans under the coordination of benefits rules, they would be free to deduct amounts payable by primary plans when they determine their own coverage. Since Providers or Health Care Facilities would not be permitted to submit their bills to the primary plans if those plans are not Health Insuring Corporations, the amount deducted by the secondary Health Insuring Corporations would remain unpaid.

Alternatively, if Providers and Health Care Facilities are prohibited from submitting bills to primary plans that are not Health Insuring Corporations, there would be no payments from primary plans that the secondary Health Insuring Corporations would be able to offset against their own payment obligations. It is possible to argue that the Health Insuring Corporations should then be required to pay the patients bills without being able to offset benefits payable by primary plans because those benefit payments will never be made. Thus, the Court of Appeals construction of R.C. §1751.60(A) would effectively repeal the statutory and regulatory coordination of benefits process, at least insofar as Health Insuring Corporations are concerned, because it makes the Health Insuring Corporation the primary plan in every case.

Furthermore, as a result of the inconsistency between the generally accepted industry practice and the construction of R.C. §1751.60(A) by the Court of Appeals, it may ultimately prove necessary to revisit literally years of transactions involving payments by automobile insurance companies on behalf of patients who also had insurance coverage with Health Insuring Corporations. This will create an administrative nightmare. It will also create a substantial risk that Providers and Health Care Facilities will ultimately go unpaid for services rendered because contracts between the Providers, Health Care Facilities, and Health Insuring Corporations often have time limits governing the submission of claims, frequently twelve months. If a Provider or Health Care Facility is required to refund a payment made by an automobile insurer more than a

year before the date of the refund, that Provider or Health Care Facility will probably be unable to submit a new billing to the insured's Health Insuring Corporation because the time for submission of the billing has expired. Thus, Providers and Health Care Facilities could go completely unpaid for services rendered.

Finally, the construction of R.C. §1751.60(A) by the Court of Appeals presents an issue of public or great general interest because it denies patients who have purchased automobile insurance with medical payments coverage the benefit of their bargain. If those patients also have insurance coverage with a Health Insuring Corporation, they will not be permitted to use their medical payments benefit to pay for the cost of medical services, and the automobile insurance companies will have sold their insureds a benefit that they will not be able to use.

R.C. §1751.60 was intended to insulate patients having insurance with Health Insuring Corporations from personal liability for the cost of medical services in the event their Health Insuring Corporations become insolvent or denied payment of a covered expense. It was not intended to impose mandatory billing practices that are inconsistent with Ohio's law on the coordination of insurance benefits, and with generally accepted industry practices based thereon. Unless corrected by this Court, the erroneous construction of R.C. §1751.60(A) by the Court of Appeals may cost hospitals, doctors, and other providers of medical care across the state millions of dollars they can ill afford to lose in these financially challenging times. Such losses, and the negative impact that they will have upon the viability of some hospitals, present questions of the greatest public and general concern.

II. STATEMENT OF THE CASE AND FACTS

This case arises from medical services provided by appellant, The Toledo Hospital, to appellee, Ms. Virginia King, in connection with injuries that she received in an automobile

accident. The Toledo Hospital billed Safeco, Ms. King's automobile insurance company, for the cost of the services provided to Ms. King. Ms. King also had health insurance with Aetna. Ms. King alleges that Aetna is a Health Insuring Corporation within the meaning of R.C. §1751.01(P), and that the prohibitions of R.C. §1751.60(A) apply.

Ms. King filed a complaint in the Court of Common Pleas of Lucas County. In her complaint Ms. King asserted claims for breach of contract, breach of public policy, violation of Ohio's Consumers Sales Practices Act, R.C. §1345.01, *et seq.*, and conversion. Each of Ms. King's claims was based on an alleged violation R.C. §1751.60(A). Ms. King asserted that under this statute when a patient has medical insurance with a Health Insuring Corporation, doctors, hospitals, and other health care Providers may only bill the Health Insuring Corporation for services rendered, and no one else. Ms. King asserted that The Toledo Hospital violated this statute by billing her automobile insurance company, Safeco, instead of her Health Insuring Corporation, Aetna, for the cost of covered services that she received.

The Common Pleas Court rejected Ms. King's construction of R.C. §1751.60. That Court determined that Ms. King's construction of the statute would place it in conflict with Ohio's law on the coordination of insurance benefits. The Court of Common Pleas determined that R.C. §1751.60(A) applies only to the three-party relationship described in the statute, and that the statute does not apply where there are other responsible payers, such as those subject to Ohio's statutes and regulations on the coordination of insurance benefits, R.C. §3902.11, *et seq.*, and Ohio Adm. Code §3901-8-1, *et seq.* Having found that all of Ms. King's claims were based upon an incorrect construction of R.C. §1751.60(A), the Court of Common Pleas dismissed Ms. King's complaint.

On June 4, 2010, the Court of Appeals for Lucas County, citing *Annette Hayberg v. Physicians Emergency Service, Inc.* (11 Dist. 2008), 2008-Ohio-6180, reversed the judgment of the Court of Common Pleas. Improperly focusing on the single word “solely” appearing in the statute, the Court of Appeals erroneously determined that R.C. §1751.60(A) unambiguously required Providers and Health Care Facilities having agreements with Health Insuring Corporations to bill only the Health Insuring Corporation, and no one else, for covered services provided to their insured patients.

III. ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW

A. **Proposition of Law No. 1: R.C. §1751.60(A) is properly interpreted using all applicable rules of construction.**

The primary goal of statutory interpretation is to discern the intent of the legislature. *State ex rel. Cordray v. Midway Motor Sales, Inc.* (2009), 122 Ohio St.3d 234, 237, 2009-Ohio-2610, 910 N.E.2d 432. The intent of the legislature is to be sought in all of the language employed in the statute. *State v. Tuomala* (2004), 104 Ohio St.3d 93, 2004-Ohio-6239, 818 N.E.2d 272, at ¶13. A court must examine a statute in its entirety rather than focus on an isolated word or phrase. *Massillon City School Dist. Bd. of Edn. v. Massillon* (2004), 104 Ohio St.3d 518, 2004-Ohio-6775, 820 N.E.2d 874, at ¶37. A court should not “pick out one sentence and disassociate it from the context, but must look to the four corners of the enactment to determine the intent of the enacting body.” *State v. Jackson* (2004), 102 Ohio St.3d 380, 2004-Ohio-3206, 811 N.E.2d 68, at ¶34. None of the language employed in a statute should be disregarded. *Sarmiento v. Grange Mut. Cas. Co.* (2005), 106 Ohio St.3d 403, 2005-Ohio-5410, 835 N.E.2d 692, at ¶25.

The court below erred because the focus of its interpretation of R.C. §1751.60(A) was the meaning of a single word in the statute, “solely.” The court below ignored the remainder of the

statute, and as a result it failed to perceive the ambiguity of the statute or to apply the appropriate rules of construction in order to resolve that ambiguity.

A statute is ambiguous when its language is subject to more than one reasonable interpretation. *Family Medicine Found., Inc. v. Bright* (2002), 96 Ohio St.3d 183, 2002-Ohio-4034, 772 N.E.2d 1177, at ¶8, citing *State v. Jordan* (2000), 89 Ohio St.3d 488, 492, 733 N.E.2d 601. Where the words of a statute are ambiguous and subject to varying interpretations, further interpretation is necessary. *Bailey v. Republic Engineered Steels, Inc.* (2001), 91 Ohio St.3d 38, 40, 741 N.E.2d 121.

R.C. §1751.60(A) provides as follows,

Except as provided for in divisions (E) and (F) of this section, every Provider or Health Care Facility that contracts with a Health Insuring Corporation to provide health care services to the Health Insuring Corporation's 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.

(Emphasis added.) This statute is ambiguous because it is susceptible to two different reasonable interpretations. On the one hand, when viewed in isolation the language in bold could be construed as imposing an absolute mandate requiring Providers and Health Care Facilities to seek compensation solely from their patient's Health Insuring Corporation, even though the patient has other insurance covering the services provided. Conversely, when the italicized language is construed in conjunction with the language in bold, the statute may reasonably be construed as applying only when the coverage afforded by the Health Insuring Corporation is the only coverage available to the patient. In other words, if there is no other coverage or all other coverage has been exhausted, and the Health Insuring Corporation and the insured patient are the only remaining available payers, the Provider or Health Care Facility may seek compensation only from the Health Insuring Corporation and not from the insured patient.

The latter construction of R.C. §1751.60(A) fully insulates patients having insurance with Health Insuring Corporations from liability to Providers and Health Care Facilities for the cost of services rendered. This construction is consistent with R.C. §1751.60(B), which provides that no patient having insurance with a Health Insuring Corporation shall be liable to any contracting Provider or Health Care Facility for the cost of covered health care services. This construction is also consistent with R.C. §1751.60(E), which permits Ohio's Superintendent of Insurance to waive the requirements of subsections (A) and (B) altogether if the Superintendent is satisfied that the Health Insuring Corporation has given the Provider or Health Care Facility "financial guarantees" covering the cost of services provided to the insured patient. Indeed, R.C. §1751.60(E) brings into focus the true purpose of R.C. §1751.60, which is to insulate patients having insurance with Health Insuring Corporations from personal liability in the event the Health Insuring Corporation becomes insolvent or denies payment for a covered medical expense.

Since R.C. §1751.60(A) is susceptible to two different reasonable interpretations, it is the duty of the reviewing court to construe the statute, using all the rules of construction, in order to determine the true legislative intent. *Vaughn Industries, Inc. v. Dimech Servs.* (6th Dist. 2006), 167 Ohio App.3d 634, 2006-Ohio-3381, 856 N.E.2d 312, at ¶23. The Court of Appeals erred by failing to perform this duty.

Even if this Court were to determine that the language of R.C. §1751.60(A) is not ambiguous, it should still interpret the statute in light of all applicable rules of construction. When a statute has been drafted clearly so as to convey a specific meaning, normally the only proper function of the Court is to effectuate this legislative intent.

This rule is subject to the qualification that if a part of a statute appears to have a clear meaning if considered alone but when given that meaning is inconsistent with other parts

of the same statute or others *in pari materia*, the Court will examine the entire act and those *in pari materia* in order to ascertain the overall legislative intent.

Florida State Racing Commission v. McLaughlin (1958), 102 So.2d 574, 575-576; see also *Florida Dept. of Environmental Protection v. ContractPoint Florida Parks, LLC* (2008), 986 So.2d 1260, 33 Fla. L. Weekly S493.

This exception is applicable in Ohio. In enacting a statute the legislature is presumed to intend a just and reasonable result. R.C. §1.47(C). *Discount Cellular, Inc. v. Pub. Util. Comm.* (2007), 112 Ohio St.3d 360, 859 N.E.2d 957, at ¶26. “It is presumed that the General Assembly does not intend to enact laws producing unreasonable or absurd consequences.” *American Chemical Soc. v. Kinney* (1980), 62 Ohio St.2d 258, 260, 405 N.E.2d 272; see also *In re Petition for Disclosure of Evidence Presented to Franklin County Grand Juries in 1970* (1980), 63 Ohio St.2d 212, 215, 407 N.E.2d 513. “It is a cardinal rule of statutory construction that a statute should not be interpreted to yield an absurd result.” *Mishr v. Poland Bd. of Zoning Appeals* (1996), 76 Ohio St.3d 238, 240, 667 N.E.2d 365.

It is not necessary to refer to precedent to sustain the position that where the literal construction of a statute would lead to gross absurdity, or where, out of several acts touching the same subject matter, there arise collaterally any absurd consequences, manifestly contradictory to common reason, the obvious intention of the law must prevail over a literal interpretation, and it is even said, that provisions leading to collateral consequences of great absurdity or injustice, may be rejected as absolutely void.

Slater v. Cave (1853), 3 Ohio St. 80, 82-83, 1853 WL 134; see also *Mishr v. Poland Bd. of Zoning Appeals* (1996), 76 Ohio St.3d 238, 240, 667 N.E.2d 365.

Even if this Court were to determine that R.C. §1751.60(A) is unambiguous, it should still construe the provisions thereof in light of Ohio’s law on the coordination of benefits, and determine that R.C. §1751.60(A) was not intended to supersede that law. Any other construction

could lead to absurd results that were clearly unintended by the legislature when it adopted the statute.

B. Proposition of Law No. 2: R.C. §1751.60(A) applies only when the insurance coverage provided by an insured patient's Health Insuring Corporation is the only coverage available to an insured patient, and it does not supersede Ohio's law on the coordination of insurance benefits.

The Court of Appeals construed R.C. §1751.60(A) as requiring The Toledo Hospital to bill Ms. King's Health Insuring Corporation, Aetna, and no one else, for the covered medical services that she received. This construction is incorrect. When construed in light of applicable rules of construction it is clear that R.C. §1751.60(A) was not intended to impose a rule superseding Ohio's statutes and regulations on the coordination of insurance benefits. Rather the statute was simply intended to insulate patients from personal liability for the cost of medical care covered by Health Insuring Corporations.

The title of R.C. §1751.60 is properly considered in connection with any construction of the statute. *State ex rel. Murphy v. Athens County Board of Elections* (1941), 138 Ohio St. 432, 435, 35 N.E.2d 574; see also *State v. Kiser* (1968), 13 Ohio St.2d 126, 128, 235 N.E.2d 126. The title of R.C. §1751.60, "Enrollees and subscribers not liable to Providers or Facilities," strongly suggests that the purpose of the statute was to insulate insured patients from personal liability for the cost of medical care covered by their Health Insuring Corporations.

Such a construction is also consistent with Ohio's statutes and regulations governing the coordination of insurance benefits, R. C. §3902.11, *et seq.*, and Ohio Adm. Code §3901-8-1, *et seq.* The courts of Ohio attempt to construe statutes harmoniously whenever possible. *General Motors Corp. v. McAvoy* (1980), 63 Ohio St.2d 232, 235, 407 N.E.2d 527. "It is a primary rule of statutory construction that courts should not construe one statute in a way that would abrogate, defeat, or nullify another statute, where a reasonable construction of both is possible." *San*

Diego County v. Elavsky (1979), 58 Ohio St.2d 81, 86, 388 N.E.2d 1229. Consistency in statutes is important; hence, if possible, statutes should be construed so as to reconcile their provisions. *State ex rel. Phillips v. Andrews* (1977), 50 Ohio St.2d 341, 344, 364 N.E.2d 281. Ohio courts must harmonize and give full application to all related and coexisting statutes unless they are irreconcilable and in hopeless conflict. *Couts v. Rose* (1950), 152 Ohio St. 458, 460, 90 N.E.2d 139.

R.C. §1751.60(A), R.C. §3902.11, *et seq.*, and Ohio Adm. Code §3901-8-1, *et seq.*, all relate to the same subject matter, *i.e.*, the responsibility to pay for covered medical services provided to insured patients. As such they are *in pari materia* and must be read together to ascertain and effectuate the legislative intent. *State ex rel. Pratt v. Weygandt* (1956), 164 Ohio St. 463, 132 N.E.2d 191, paragraph two of the syllabus. Statutes relating to the same or similar subject matter should be read together as if they were a single statute. *Bosher v. Euclid Income Tax Bd. of Rev.*, 99 Ohio St. 3d 330, 2003-Ohio-3886, 792 N.E.2d 181, at ¶14. The rule of *in pari materia* reflects the fact that the General Assembly is presumed to have legislated with full knowledge and in the light of all statutory provisions concerning the same subject matter. *State v. Conyers* (1999), 87 Ohio St. 3d 246, 719 N.E.2d 535, at ¶14.

It is also appropriate to give deference to the construction of R.C. §1751.60(A) by the Ohio Department of Insurance. *Northwestern Ohio Bldg. & Constr. Trades Council v. Conrad* (2001), 92 Ohio St.3d 282, 750 N.E.2d 130. This court can and should rely upon the expertise of state agencies dealing with issues that are highly specialized. *Elyria Foundry Co. v. Pub. Util. Comm.* (2008), 118 Ohio St.3d 269, 2008-Ohio-2230, 888 N.E.2d 1055. A long standing administrative construction of a statute should not be set aside unless judicial construction makes it imperative do to so. *UBS Financial Servs., Inc. v. Levin* (2008), 119 Ohio St.3d 286, 893

N.E.2d 811. Thus, the fact that the coordination of benefits regulations promulgated by the Department of Insurance since the adoption of R.C. Chap. 1751 specifically provide that Health Insuring Corporations are included within the statutory coordination of benefits framework is properly given substantial weight by this Court. Indeed, the adoption of these regulations can only be viewed as a rejection of the Court of Appeals interpretation of R.C. §1751.60(A).

The Court of Appeals' construction of R.C. §1751.60(A) as imposing a new, mandatory billing practice is incorrect because it is fundamentally inconsistent with Ohio's statutes on coordination of insurance benefits, R.C. §3902.11, *et seq.*, and the regulatory framework based thereon, Ohio Adm. Code §3901-8-1, *et seq.* The statutes and regulations apply when an insured patient has coverage for medical expenses through more than one policy. One frequently encountered example of such a circumstance involves a patient who is injured in an automobile accident. The medical care provided to such a patient is often covered by the patient's health insurance and the medical payments benefit of the patient's automobile insurance.

Both of these kinds of insurance are subject to Ohio's coordination of benefits statutes and regulations because both are "plan[s] of health coverage" subject to coordination of benefits. The term "plan of health coverage" includes insurance provided by Health Insuring Corporations. R.C. §3902.11(B)(2); see also Ohio Adm. Code §3901-8-01(C)(11)(c)(iii). It also includes automobile insurance that provides coverage for hospital, dental, surgical, or medical services. R.C. §3902.11(B)(3); see also Ohio Adm. Code §3901-8-01(C)(11)(c)(vi). Thus, both Ms. King's automobile insurance with Safeco and her health insurance with Aetna are subject to the statutory coordination of benefits process.

Ohio's coordination of benefit statute provides that plans of health coverage determine for themselves the order in which they are obliged to pay their benefits. R.C. §3902.13(A). A

plan is not required to make a payment of benefits until it has determined for itself whether it is the primary plan or the secondary plan and, if it is the secondary plan, the benefits that have been paid or are payable under the primary plan. R.C. §3902.12; see also R.C. §3902.13(B), (C), and (E). In order to facilitate this determination, plans have the right to obtain any facts and information necessary to permit them to determine their order of benefits. R.C. §3902.13(F). An insured claiming benefits under a plan is also required to provide any information that the plan requires in order to make its order of benefits determination. R.C. §3902.13(F).

There are six specific rules to be applied by plans of health coverage when they determine their order of benefits. R.C. §3902.13(A); see also Ohio Adm. Code §3901-8-01 (G). A plan that does not coordinate with other plans is always the primary plan. R.C. §3902.13(A)(1). (This provision is important because historically automobile insurance companies have not coordinated their medical payments benefit with other plans, except for other automobile insurance companies providing medical payments coverage. Thus, under R.C. §3902.13(A)(1), auto insurers have historically been the primary plan in the order of benefits.) R.C. §3902.13(A)(2), (3), (4), and (5) cover various circumstances involving coverage of employees and/or dependents. If none of the other rules apply, the plan that has covered the employee, member, insured, or subscriber for the longest is the primary plan. R.C. §3902.13(A)(6).

When a plan of health coverage is primary, its benefits are paid without regard to the benefits of another plan. R.C. §3902.12; see also Ohio Adm. Code §3901-8-01(F)(3). Conversely, when a plan of health coverage is secondary, its benefits are determined by taking into consideration the benefits paid or payable by the primary plan. See R.C. §3902.12, R.C. §3902.13(B), (C), and (E), and Ohio Adm. Code §3901-8-01(F)(6) and (H). Indeed, a secondary

plan may require a beneficiary to file a claim with the primary plan before it determines the amount of its payment obligation, if any, with regard to that claim. R.C. §3902.13(D).

When R.C. §1751.60(A) is read *in pari materia* with Ohio's coordination of benefits statutes and regulations it is clear that the Court of Appeals' construction of the statute simply makes no sense. Under the Court of Appeals' construction of R.C. §1751.60(A), The Toledo Hospital would be required to seek compensation only from Ms. King's Health Insuring Corporation, Aetna. It would not be permitted to seek compensation from any other payer, including Ms. King's automobile insurance company Safeco, even if the other payer is the primary plan under Ohio's coordination of benefits law. Such a limitation is fundamentally inconsistent with Ohio's law on the coordination of benefits. It leads to a circumstance in which substantial portions of billings issued by Providers and Health Care Facilities will go unpaid. Alternatively, it imposes the primary payment obligation upon Health Insuring Corporations whenever their insureds receive covered medical treatment, effectively repealing Ohio's coordination of benefits law, at least insofar as Health Insuring Corporations are concerned. In Ohio, such repeals by implication are disfavored as a matter of judicial policy. *State ex rel. Kelley v. Board of Educ. of Clearcreek Local School Dist.* (1990), 52 Ohio St.3d 93, 556 N.E.2d 173. They will not be found unless the subsequent legislation clearly requires that holding. *State v. Volpe* (1988), 38 Ohio St.3d 191, 527 N.E.2d 818.

Only where the provisions of the two statutes are irreconcilable by any means of interpretation ... or are so repugnant to or contradictory with each other as to evidence an intent on the part of the General Assembly to change the statutory law will this court conclude that the earlier statute has been superseded by the later statute, and therefore of no force and effect.

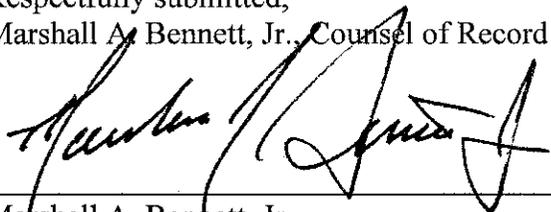
(Citations omitted.) *State ex rel. Specht v. Painesville Tp. Local School Dist. Bd. of Ed.* (1980), 63 Ohio St.2d 146, 149, 407 N.E.2d 20, quoting *State v. Ruppert* (1978), 54 Ohio St.2d 263, 268, 375 N.E.2d 1250.

When properly construed R.C. §1751.60(A) applies only when a Health Insuring Corporation provides the only insurance coverage available to a patient. This may occur when the patient's only medical insurance is that provided by the Health Insuring Corporation. It may also occur when all benefits payable by the patient's primary plan have been exhausted, and the coverage provided by a secondary Health Insuring Corporation is the only coverage remaining available to the patient. In both of these situations the Provider and Health Insuring Corporation would be permitted to seek compensation for amounts due only from the Health Insuring Corporation, and not the insured patient. The statute should not be construed as applying in any other circumstance.

IV. CONCLUSION

For the reason discussed above, this case involves matters of first impression for this Court and of public and great general interest. Accordingly, appellants request that this Court accept jurisdiction in this case so that the important issues presented will be reviewed on the merits.

Respectfully submitted,
Marshall A. Bennett, Jr., Counsel of Record



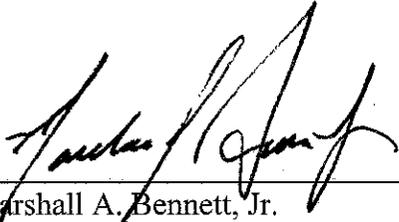
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V. PROOF OF SERVICE

I certify that on July 14, 2010, a copy of the foregoing was sent by ordinary U.S. mail to counsel for appellee at the addresses listed below.

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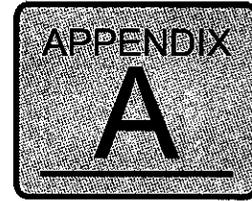
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And The Toledo Hospital

APPENDIX

- A. June 4, 2010, Lucas County Court of Appeals Decision and Judgment
- B. October 1, 2009, Lucas County Court of Common Pleas Judgment Entry

FILED
COURT OF APPEALS
2010 JUN -4 A 8:00

COMMON PLEAS COURT
BERNIE QUILTER
CLERK OF COURTS



IN THE COURT OF APPEALS OF OHIO
SIXTH APPELLATE DISTRICT
LUCAS COUNTY

Virginia King

Court of Appeals No. L-09-1282

Appellant

Trial Court No. CI 200903599

v.

ProMedica Health System, Inc., et al.

DECISION AND JUDGMENT

Appellees

Decided:

JUN 04 2010

* * * * *

John Murray, Leslie Murray, Michael Stewart, and John Huffman,
for appellant.

Marshall Bennett, Jr., Jennifer Dawson, and John Borell, Jr., for
appellees.

* * * * *

OSOWIK, P.J.

{¶ 1} This is an appeal from a judgment of the Lucas County Court of Common Pleas which granted appellees' motion to dismiss appellant's complaint pursuant to Civ.R. 12(B)(6). For the reasons set forth below, this court reverses the judgment of the trial court.

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1.

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{¶ 2} Appellant, Virginia King, sets forth the following sole assignment of error:

{¶ 3} "I. The trial court erred by dismissing a patient's complaint against a health care provider that circumvented its contractual and statutory obligation to seek compensation for covered services solely from the patient's health insurer by directly billing her automobile insurer for an inflated amount."

{¶ 4} The following undisputed facts are relevant to the issues raised on appeal. Following injuries sustained in a motor vehicle accident, appellant received medical treatment at the Toledo Hospital. Appellant was covered by an Aetna health insurance plan pursuant to which appellee was a preferred provider.

{¶ 5} Given the preferred provider contract in place between appellant's healthcare insurer and the healthcare provider from whom treatment was received, the billing activities in connection to the treatment were subject to the statutory limitations established by R.C. 1751.60(A). The crux of R.C. 1751.60(A) is that in preferred provider scenarios, compensation, and therefore billing, may solely be pursued from the contracting health insurer.

{¶ 6} Despite the contractual arrangement between the parties and its statutory implications pertaining to billing exclusivity, appellees directly billed appellant's motor vehicle insurer rather than the contracting healthcare insurer with whom appellant was a subscriber. We note that although there is much discussion regarding the pecuniary motivations potentially underlying this billing strategy, that issue is not relevant to the statutory interpretation nature of this appeal.

{¶ 7} On November 5, 2008, appellant filed a complaint in the United States District Court. On March 24, 2009, appellant voluntarily dismissed the federal action. On April 13, 2009, appellant refiled the matter in state court. On June 10, 2009, appellees filed for dismissal of the matter pursuant to Civ.R. 12(B)(6). On October 1, 2009, the motion to dismiss was granted. The instant appeal ensued.

{¶ 8} In her sole assignment of error, appellant asserts that the trial court erred in granting the Civ.R. 12(B)(6) dismissal. In support, appellant determinatively relies upon the notion that the disputed trial court judgment was premised upon a flawed interpretation of R.C. 1751.60(A). In essence, appellant maintains that R.C. 1751.60(A) prohibits appellees from billing anyone other than her health insurer for the treatment rendered to her, while appellees conversely contend that the statute only prohibits billing appellant herself, but does not prohibit invoicing potential third-party payors, such as the motor vehicle insurer.

{¶ 9} It is well-established that appellate review of a disputed Civ.R. 12(B)(6) judgment is conducted pursuant to an independent, de novo standard of review.

Perrysburg Twp. v. Rossford, 103 Ohio St.3d 79, 2004-Ohio-4362, ¶ 5.

{¶ 10} R.C. 1751.60(A) establishes in pertinent part, "every provider or health care facility that contracts with a health insurance corporation to provide health care services to the health insurance corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insurance corporation and not, under any

circumstances, from the enrollees or subscribers, except for approved copayments and deductibles."

{¶ 11} In a strikingly similar case assessing this precise issue, the Eleventh District Court of Appeals held in relevant part, "Here, appellee billed and accepted \$2,566.06 more than it was entitled to from Nationwide in violation of R.C. 1751.60. Under the statute, appellee was required to seek compensation for covered services solely from Anthem and was only permitted to seek approved co-payments and deductibles from Nationwide." *Hayberg v. Physicians Emergency Serv. Inc.*, 11th Dist. No. 08-P-0010, 2008-Ohio-6180, ¶ 26.

{¶ 12} Likewise, the present case is rooted in the existence of a preferred provider agreement. In this case, the underlying agreement was between Aetna and ProMedica. The key, determinative word utilized in R.C. 1751.60(A) is "solely." The commonly understood meaning of the term is reflected in the definition set forth in Black's Law Dictionary (6 Ed. 1991) which defines sole as, "Without another or others." In applying that unambiguous term to the instant case, we find that the term "solely" clearly and plainly means to the exclusion of others.

{¶ 13} Based upon the foregoing, the plain and unambiguous meaning of R.C. 1751.60(A) is that health care providers and facilities who execute preferred provider agreements with health insurance corporations can solely bill the health insurance corporation subject to the agreement for covered services furnished to enrollees or subscribers covered by the agreement to the exclusion of any and all other potential

payors. As such, we interpret R.C. 1751.60(A) consistent with *Hayberg* and contrary to the mistaken, non-exclusive payor interpretation proffered by appellees.

{¶ 14} We have carefully reviewed and considered the record of evidence in this matter. We find that appellees were statutorily prohibited from billing appellant's motor vehicle insurer for the medical treatment rendered to her at the Toledo Hospital pursuant to the plain and unambiguous meaning of R.C. 1751.60(A). Wherefore, we find appellant's sole assignment of error well- taken.

{¶ 15} On consideration whereof, the judgment of the Lucas County Court of Common Pleas is reversed. Appellees are ordered to pay the cost of this appeal pursuant to App.R. 24.

JUDGMENT REVERSED.

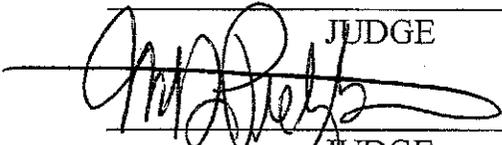
A certified copy of this entry shall constitute the mandate pursuant to App.R. 27. See, also, 6th Dist.Loc.App.R. 4.

Peter M. Handwork, J.

Mark L. Pietrykowski, J.

Thomas J. Osowik, P.J.
CONCUR.



JUDGE


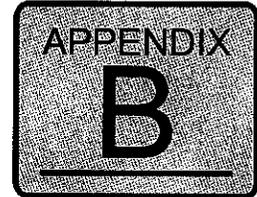
JUDGE


JUDGE

This decision is subject to further editing by the Supreme Court of Ohio's Reporter of Decisions. Parties interested in viewing the final reported version are advised to visit the Ohio Supreme Court's web site at:
<http://www.sconet.state.oh.us/rod/newpdf/?source=6>.

FILED
LUCAS COUNTY

2009 OCT -1 P 4: 36



COMMON PLEAS COURT
**THIS IS A FINAL
APPEALABLE ORDER**

IN THE COURT OF COMMON PLEAS OF LUCAS COUNTY, OHIO

Virginia King,

Plaintiff,

-vs-

ProMedica Health System, Inc. et al.,

Defendants.

* Case No. CI 200903599
* Judge Ruth Ann Franks
* JUDGMENT ENTRY
*
*
*

This cause is before the Court upon Defendants ProMedica Health Systems, Inc., and Toledo Hospital's Motion to Dismiss. Upon consideration of the pleadings, competent evidence, and applicable law, the Court grants the motion.

I. Facts

Virginia King ("Plaintiff") filed a "Complaint with Class Action Allegations" individually and "on behalf of others similarly situated," against ProMedica Health System and The Toledo Hospital ("Defendants"). She states that the action is brought on behalf of all patients who have

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received healthcare services from Defendants¹ and were covered under a health policy by a health insuring corporation. The complaint is a class action seeking redress for damages resulting from Defendants' refusal to submit claims for health care services to the health insuring corporations.

Specifically, Plaintiff alleges that she sought treatment from Defendants for injuries sustained in an automobile accident.² At the time of treatment, she informed Defendants that she had health insurance through Aetna Insurance Company, and provided them with the appropriate information to make a claim. Plaintiff further alleges that, pursuant to R.C. 1751.60, Defendants were required to submit her treatment claims to Aetna, but refused to do so. According to the complaint, Defendants avoid submitting claims to health insurance companies because they have preferred payment agreements with the insurers that contractually require the Defendants to accept less compensation than their standard (non-preferred) provider rates for service. Hence, by refusing to submit claims to the insurer, Defendants can force patients to pay them more than they are contractually entitled to be paid. Essentially, Defendants are collecting monies directly from insured persons such as Plaintiff in an effort to collect more than they are allowed to recover in law and in contract. Plaintiff alleges breach of contract, violation of public policy, violation of the Ohio Consumer Sales Practices Act ("OCSPA"), and conversion.

Defendants have filed a motion to dismiss Plaintiff's complaint on several different grounds. Plaintiff opposed the motion, and Defendants replied. The motion is decisional.

¹ Plaintiff alleges that Defendants are medical facilities, and that the Toledo Hospital is a part of the ProMedica Health Care System. For ease of discussion, the Court will refer to them collectively as "Defendants."

² Paragraph 12 of Plaintiff's Complaint identifies Dorothy Streeter as the Plaintiff. Based on the remainder of the allegations in the Complaint, the Court assumes this to be an erroneous identification and construes the remaining allegations as if alleged on Virginia King's behalf.

II. Standard

When ruling on a motion to dismiss, the complaint is to be construed in a light most favorable to the plaintiff, and material allegations are taken as admitted. Mitchell v. Lawson Milk Co. (1988), 40 Ohio St.3d 190, 192, 532 N.E.2d 753. To sustain a motion to dismiss it must appear beyond doubt from the complaint that no set of facts exists which may entitle the plaintiff to the relief requested. See O'Brien v. Univ. Community Tenants Union (1975), 42 Ohio St.2d 242, 327 N.E.2d 753.

A motion to dismiss for failure to state a claim upon which relief can be granted pursuant to Civ.R. 12(B)(6) is procedural and tests the sufficiency of the complaint. Bratton v. Couch, Morgan App. No. CA02-012, 2003-Ohio-3743, at ¶8, citing State ex rel. Hanson v. Guernsey Cty. Bd. of Commrs. (1992), 65 Ohio St.3d 545, 605 N.E.2d 378. The Court is required to examine only the four corners of the complaint. Ferraro v. B.F. Goodrich Co., (2002) 149 Ohio App.3d 301, 777 N.E.2d 282, citing Thompson v. Cent. Ohio Cellular (1994), 93 Ohio App.3d 530, 538, 639 N.E.2d 462.

III. Discussion

Defendants have moved to dismiss Plaintiff's complaint on several grounds. Defendants argue that Plaintiff has failed to plead facts establishing a breach of contract, a violation of the OCSPA, or conversion. Additionally, Plaintiff has failed to join necessary parties, including Aetna and Safeco.³

Plaintiff's causes of action are all based on Defendants' alleged violation of R.C. 1751.60, which states:

³ Aetna is Plaintiff's health insurer, and Safeco is her auto insurer.

1751.60. Provider or facility to seek compensation for covered services solely from HIC [Health Insuring Corporation]

(A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's 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

Plaintiff asserts that this statute requires Defendants to bill *only* Aetna for the services she received from Defendants. Defendants disagree, arguing that R.C. 1751.60 only addresses the financial relationship between a health insuring corporation, the corporation's subscriber, and the health care provider. The statute does not contemplate situations in which there are other responsible payors. If the Court were to adopt Plaintiff's construction of the statute, Defendants would not, under any circumstances, be allowed to seek compensation from Safeco, thereby contradicting Ohio's coordination of insurance benefits laws.

Plaintiff offers the Eleventh District case of Hayberg v Physicians Emergency Service, Inc., 2008 Ohio 6180, Portage App. No. 2008-P-0010, to support her cause of action.⁴ The Hayberg court considered an action in which a hospital forwarded a patient's hospital bills to both the patient's health insurer and to the auto insurer that settled a claim the patient made against an insured. The health insurer paid the bills at a discounted rate, commensurate with a contract between it and the hospital. The auto insurer likewise paid the bills, albeit at the regularly charged rate. The appellate court found that the hospital billed and accepted more than it was entitled to from the auto insurer in violation of R.C. 1751.60 because under the statute, the

⁴ For purposes of argument only, the Court assumes that R.C. 1751.60 provides a private cause of action.

hospital was required to seek compensation for covered services only from the health insurer, and co-payments and deductibles from the auto insurer. Thus, the court found a question of fact relative to whether the hospital defrauded the auto insurer (who was not a party to the action), and whether it engaged in the conversion of the patient's "money" by accepting payments from both insurers and refunding to the health insurer the lesser amount paid by it, thereby reducing amounts available to the patient under her auto policy. In reaching these opinions, the appellate court stated:

The clear legislative purpose of R.C. 1751.60 is to make sure that individuals who are covered under health plans realize the benefit of those plans and are not forced to pay any amounts in excess of the co-payments and deductibles they are required to pay under the contracts between health care facilities and the health insuring corporations who negotiate the discounts and write-offs on their behalf. In addition, R.C. 1751.60 protects the health insuring corporations who negotiate the adjustments and discounts through third party administrators like Anthem in the instant matter. Id. at ¶ 25.

First noting that the Eleventh District decision is not binding on this Court, it respectfully disagrees with the majority in the Hayberg decision. The court cites to, but then ignores, the statutory definitions listed in R.C. 1751.01 for purposes of applying 1751.60. Additionally, the court attributes a far-reaching and unsupported "clear legislative purpose" to the statute with which this Court disagrees. In this respect, the Hayberg decision is likewise unpersuasive. As astutely pointed out in the dissent, the statute should not have been applied in the Hayberg case because the hospital never sought payment from Hayberg, who was the "enrollee," and therefore

the protected party under the statute.⁵ The dissent opined that, "properly construed," R.C. 1751.60 prohibited the hospital from seeking compensation from the patient, but it did not prevent it from receiving payments from a third party willing to assume liability for the debt. *Id.* at ¶61. Moreover:

Without citing any authority, the majority concludes that R.C. 1751.60 is meant to protect 'the health insuring corporations who negotiate the adjustments and discounts through third party administrators like Anthem.' The majority concludes, illogically, that [the hospital] was 'required to seek compensation for covered services solely from Anthem and was only permitted to seek approved co-payments and deductibles (which in this case was nothing) from Nationwide.' Nationwide represents a third party's interests in these proceedings and does not, as the majority suggests, stand in the shoes of Hayberg. *Id.* at ¶ 60.

Likewise, the complaint subjudice contains no allegation that Defendants sought compensation from Plaintiff, the enrollee.⁶ Instead, it alleges that they billed the auto insurer. By way of argument, Plaintiff asserts that she is an intended beneficiary of the contract between Defendant and Aetna, and therefore has standing to sue under that contract as a third party beneficiary. Despite this argument, Plaintiff's complaint contains no allegations from which it could reasonably be inferred that she was an intended third- party beneficiary to any contract between Defendants and Aetna. See, Sony Elecs v Grass Valley Group, 2002 Ohio 1614, Hamilton App. Nos. C-010133, C-010423. In these respects, and otherwise taking all allegations as true for purposes of the motion to dismiss, Plaintiff has failed to state a cause of action based

⁵ The majority specifically referenced the statute's definition of "enrollee" as a "natural person who is entitled to receive health care benefits provided by a HIC." The majority proceeded, however, to apply the protection of the statute to *Nationwide*, which is clearly not a natural person.

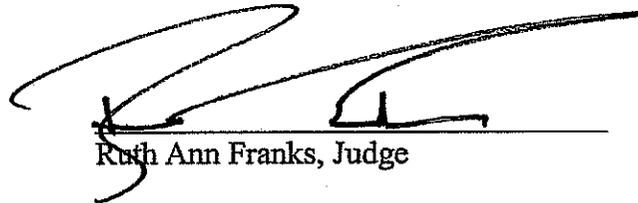
⁶ At ¶¶ 17 and 18 of her complaint, Plaintiff alleges that Defendants systematically refuse to submit claims to health insuring corporations in order to force members of the plaintiff class to pay the Defendants more than they are entitled to receive, and that Defendants collect directly from the insured persons. There is no allegation that payment was ever sought from Plaintiff.

on the statute. All of Plaintiff's claims: breach of contract, violation of public policy, violation of the Ohio Consumer Sales Practices Act, and conversion are based on the hospital's alleged improper billing of Plaintiff's auto insurer, Safeco. Consequently, all of the claims fail as a matter of law.⁷

JUDGMENT ENTRY

It is therefore ORDERED, ADJUDGED, and DECREED that Defendants ProMedica Health Systems, Inc., and Toledo Hospital's Motion to Dismiss is well taken and granted.

October 1, 2009



Ruth Ann Franks, Judge

cc: John T. Murray, Esq.
Leslie O. Murray, Esq.
John L. Huffman, Esq.
Marshall A. Bennett, Esq.
Jennifer A. Dawson, Esq.

⁷ It is worth noting that the parties have raised additional arguments, as very briefly referenced herein, relative to the viability of Plaintiff's claims. The Court finds it need not analyze the arguments, however, because Plaintiff has not alleged that *she* was billed for covered services in violation of the statute.