

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

**MOTION OF APPELLANTS PROMEDICA HEALTH SYSTEM AND
THE TOLEDO HOSPITAL FOR STAY OF COURT OF APPEALS JUDGMENT**

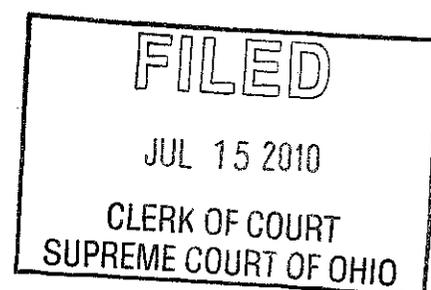
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**Motion of Appellants ProMedica Health System and The Toledo Hospital
For Stay of Court of Appeals Judgment**

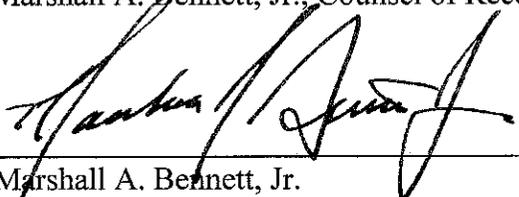
Appellants ProMedica Health System and The Toledo Hospital respectfully move this Court for an Order staying the Judgment of the Court of Appeals. The Court of Appeals incorrectly determined that R.C. §1751.60(A) was unambiguous, hence it did not undertake to construe the statute in light of applicable rules of construction. As a result it interpreted the statute in a manner that is fundamentally inconsistent with Ohio's statutes and regulations dealing with the coordination of insurance benefits, R.C. §3902.11, *et seq.*, and Ohio Adm. Code §3901-8-1, *et seq.*, and with industry practices based thereon.

This interpretation, which appellants believe is likely to be overturned on appeal, adversely impacts insurers, hospitals, physicians, and other health care providers throughout the 6th Appellate District because it fundamentally changes generally accepted billing and payment practices that are based upon Ohio's coordination of benefits statutes and regulations. Since this appeal presents a matter of first impression for this Court, the construction of R.C. §1751.60(A), it would be inappropriate to require these industry members to modify their long followed billing and payment practices until such time as this Court has had an opportunity to review the decision of the Court of Appeals. Indeed, if those billing and payment practices are modified to bring them into compliance with the Court of Appeals' interpretation of R.C. §1751.60(A) during the pendency of this appeal, and this Court reverses the judgment of the Court of Appeals, it will be necessary for billing and payment transactions undertaken prior to the ruling of this Court to be reversed, refunded, and rebilled. If Providers and Health Care Facilities start billing only their patients' Health Insuring Corporations, even though they are secondary plans under Ohio's coordination of benefits law, and those Health Insuring Corporations pay those bills in full because there are no payments from plans that would otherwise be primary, the Health Insuring

Corporations would be entitled to demand a refund if the Court of Appeals construction of R.C. §1751.60(A) is overturned by this Court. R.C. §3902.13(G). This process will be highly disruptive and costly to the members of the industry, and, ultimately, to the insured patients that they serve. Since there is a substantial possibility that the judgment of the Court of Appeals will be overturned on appeal, Providers and Health Care Facilities in the 6th Appellate District should not be required to implement new business practices mandated by the judgment of the Court of Appeals before this Court determines this appeal.

Accordingly, the Judgment of the Court of Appeals should be stayed pending disposition of this appeal.

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



Marshall A. Bennett, Jr.
Counsel For Appellants
ProMedica Health System
And The Toledo Hospital

I. STATEMENT OF THE CASE

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's Safeco policy had medical payments coverage for usual and customary charges incurred for reasonable and necessary medical expenses because of bodily injury caused by an accident.) 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), which 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.

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. (A copy of the Judgment of the Court of Common Pleas is attached hereto as Exhibit A.) 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, R.C. §3902.11, *et seq.*, and Ohio Adm. Code §3901-8-1, *et seq.* The Court of Common Pleas construed R.C. §1751.60(A) as applying only to the three party relationship described in the statute, that existing between the Provider or Health Care Facility, the insured patient, and the patient's Health Insuring Corporation. The Court determined that the statute did not apply when there were other responsible payers, such as those subject to Ohio's statutes and regulations on the coordination of insurance benefits. 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.* (11th Dist. 2008), 2008-Ohio-6180, reversed the judgment of the Court of Common Pleas. (A copy of the Decision and Judgment of the Court of Appeals is attached hereto as Exhibit B.) 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 the insured patients.

II. ARGUMENT

The Court of Common Pleas correctly determined that Ms. King’s construction of R.C. §1751.60(A), which was ultimately adopted by the Court of Appeals, is fundamentally inconsistent with Ohio’s statutes and regulations dealing with the coordination of insurance benefits, R.C. §3902.11, *et seq.*, and Ohio Adm. Code §3901-8-1, *et seq.* These statutes and regulations create an orderly process whereby insurance companies providing coverage for the cost of medical treatment received by an insured patient can determine for themselves their respective order of priority, and thus their obligation to pay the expenses incurred by their insureds. R.C. §3902.13(A). The Court of Appeals’ construction of R.C. §1751.60(A) disrupts this orderly process by prohibiting Providers and Health Care Facilities from issuing bills to insurance companies that are primary plans under Ohio’s coordination of benefits law if they are not Health Insuring Corporations. This construction inevitably leads to one of two equally absurd results.

First, the Court of Appeals construction of R.C. §1751.60(A) creates a circumstance under which the bills of Providers and Health Care Facilities may go partially unpaid when the

patients' Health Insuring Corporations are secondary plans under Ohio's coordination of benefits statutes and regulations. This is so because under those statutes and regulations, secondary Health Insuring Corporations may deduct the benefits payable by the primary plans from the benefits payable under their own plans. R.C. §§3902.12, 3902.13(B), (C), or (E); Ohio Adm. Code §3901-8-01(F)(6) and (H). Since the Court of Appeals construction of R.C. §1751.60(A) prohibits Providers and Health Care Facilities from issuing bills to any payer other than the patient's Health Insuring Corporation, the primary plan will never receive a bill and will never pay the amount deducted by the secondary Health Insuring Corporation. Thus, the amount deducted will never be paid.

Second, as construed by the Court of Appeals, R.C. §1751.60(A) could be viewed as effectively repealing Ohio's law on the coordination of benefits, at least insofar as Health Insuring Corporations are concerned. Under the Court of Appeals' interpretation of R.C. §1751.60(A), Providers and Health Care Facilities are not permitted to bill primary plans. This means that there will be no payments from primary plans that secondary Health Insuring Corporations can deduct from their own payment obligations. This being so, it is possible to argue that the Health Insuring Corporations are obliged to pay the full amount of the patient's bill, even when they are secondary plans under Ohio's coordination of benefits law. Such a result effectively repeals Ohio's statutes and regulations on the coordination of benefits, at least insofar as Health Insuring Corporations are concerned, because it makes the Health Insuring Corporations the primary plan whenever the insured patient receives medical care.

These inappropriate results flow from a single failure by the Court of Appeals. Instead of construing R.C. §1751.60(A) as a whole, the Court focused on a single word in the statute, "solely." The Court concluded that this word was easily defined by reference to a dictionary,

hence it concluded that the statute was not ambiguous and did not require construction. Such a narrow focus is improper. 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.

Unfortunately, as a result of its inappropriately narrow focus, the Court of Appeals denied itself the ability to appreciate the true ambiguity of the statute, which lay in the relationship between the clause containing the word “solely” and the clause following it. 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 bold language 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 with plans that are primary under Ohio's coordination of benefits statutes and regulations. This is the construction adopted by the Court of Appeals. 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.

Because R.C. §1751.60(A) is susceptible to two different reasonable constructions, it is ambiguous. *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. Indeed, 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.

Furthermore, 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. 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 should 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. Thus, even if this Court were to determine that the R.C. §1751.60(A) is unambiguous, it should still apply all appropriate rules of construction because of the fundamental inconsistency between the billing practices specified in the statute and Ohio’s statutes and regulations governing the coordination of benefits.

Having concluded that the word “solely” was unambiguous, the Court of Appeals did not apply the accepted rules of construction in order to determine the true intent of the legislature when it adopted R.C. §1751.60(A). As a result, unlike the Court of Common Pleas, the Court of Appeals failed to appreciate the fundamental inconsistency between its interpretation of R.C. §1751.60(A) and Ohio’s statutes and regulations dealing with the coordination of benefits. (The court in *Annette Hayberg v. Physicians Emergency Service, Inc.* (11th Dist. 2008), 2008-Ohio-

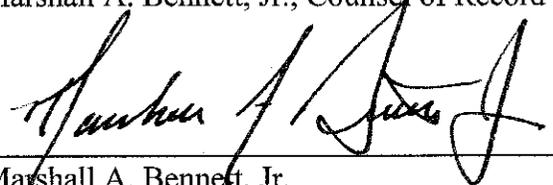
6180, similarly failed to consider the inconsistency between its construction of R.C. §1751.60(A) and Ohio's law on the coordination of benefits.) As a result of this fundamental failure, there is a substantial possibility that the judgment of the Court of Appeals will be overturned on appeal. This being so, it is appropriate for this Court to stay that judgment pending disposition of this appeal because of the adverse impact it will have upon all the members of the medical care industry doing business and providing services in the 6th Appellate District.

The decision of the Court of Appeals is inconsistent not only with Ohio's statutes and regulations dealing with the coordination of benefits, but also with the generally accepted business practices followed by insurers, hospitals, physicians, and other health care providers doing business and providing services in the 6th Appellate District. Nonetheless, the Court of Appeals interpretation of R.C. §1751.60(A) is now binding in that District, despite the fact that it is likely to be overturned on appeal. In order to bring themselves into compliance with the Court of Appeals construction of R.C. §1751.60(A), members of the industry will need to start billing their patients' Health Insuring Corporations, and only their patients' Health Insuring Corporations, regardless of their order of priority under Ohio's coordination of benefits law. As discussed above, this will result either in a portion of their billings going unpaid, or in the Health Insuring Corporations being required to assume the role of the primary plan, even though they would normally be secondary plans under Ohio's coordination of benefits law. Because this is a matter of first impression for this Court, and because there is a substantial possibility that the judgment of the Court of Appeals will be overturned, the members of the health care industry should not be required to suffer these consequences until such time as this Court has had an opportunity to determine for itself how R.C. §1751.60(A) should be construed.

A stay is also appropriate because if this Court reverses the judgment of the Court of Appeals, billing and payment transactions engaged in by industry members in the 6th Appellate District after the judgment of the Court of Appeals and before the final judgment of this Court would need to be reversed, refunded, and rebilled if the Health Insuring Corporation paying the patient's bills is only a secondary plan. This refund and rebilling process will impose very significant financial and administrative burdens upon Providers and Health Care Facilities in the 6th Appellate District, burdens that they should not be forced to bear until this Court construes R.C. §1751.60(A).

Accordingly, for the reasons set forth hereinabove and in the Memorandum in Support of Jurisdiction of Appellants ProMedica Health System and the Toledo Hospital, appellants ProMedica Health System and the Toledo Hospital respectfully move this Court for an order staying the judgment of the Court of Appeals. Since there has been no monetary judgment entered in this action, no bond should be required in connection with the requested stay.

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



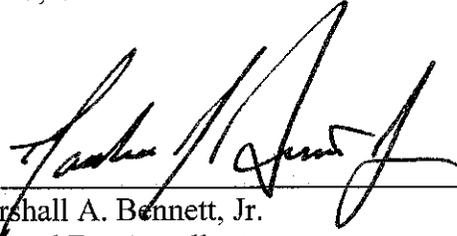
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Certificate of Service

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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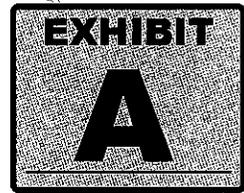
Marshall A. Bennett, Jr.
Counsel For Appellants
ProMedica Health System
And The Toledo Hospital

Exhibit A

October 1, 2009, Lucas County Court of Common Pleas Judgment Entry

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,

*

Case No. CI 200903599

Plaintiff,

*

Judge Ruth Ann Franks

-vs-

*

JUDGMENT ENTRY

ProMedica Health System, Inc. et al.,

*

Defendants.

*

*

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.

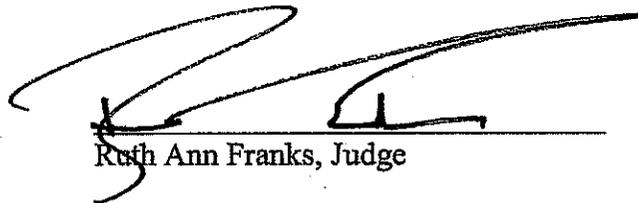
⁶ At ¶¶ 17 and 18 of her complaint, Plaintiff alleges that Defendants systematically refuse to submit claims to health insuring corporations in order to force members of the plaintiff class to pay the Defendants more than they are entitled to receive, and that Defendants collect directly from the insured 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.

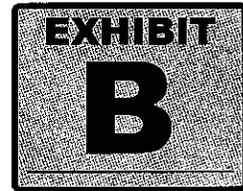
⁷ It is worth noting that the parties have raised additional arguments, as very briefly referenced herein, relative to the viability of Plaintiff's claims. The Court finds it need not analyze the arguments, however, because Plaintiff has not alleged that *she* was billed for covered services in violation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

Exhibit B

June 4, 2010, Lucas County Court of Appeals Decision and Judgment

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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JUN -4 2010

{¶ 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.

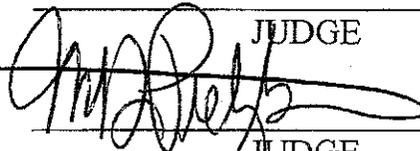
Peter M. Handwork, J.

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>.