ORIGINAL

IN THE SUPREME COURT OF OHIO

ProMedica Health System and The Toledo Hospital,	:	Case No. 2010-1236
Appellants,	:	On Appeal From The Lucas County Court of Appeals Sixth Appellate District
v.	:	
Virginia King Appellee.	:	Court of Appeals Case No. L-09-1282

MEMORANDUM OF AMICI CURIAE, OHIO HOSPITAL ASSOCIATION, OHIO STATE MEDICAL ASSOCIATION, AND OHIO OSTEOPATHIC ASSOCIATION, IN SUPPORT OF PROMEDICA HEALTH SYSTEM, INC.'S MEMORANDUM IN SUPPORT OF JURISDICTION

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STATEMENT OF INTEREST OF AMICI CURIAE

The Ohio Hospital Association (OHA), Ohio State Medical Association (OSMA) and Ohio Osteopathic Association (OOA) (collectively "Amici") urge this Court to accept the discretionary appeal of ProMedica Health System and The Toledo Hospital. Amici's members are deeply concerned that, if the Court does not accept this discretionary appeal Ohio's health care providers[1] (1) no longer will be governed by established, uniform, billing and reimbursement laws and practices, but instead will be subject to inconsistent legal obligations imposed by Ohio's lower courts, and (2) no longer will be able to obtain reimbursement for medical services from all potential third-party payors. While either of these outcomes alone would adversely affect the finances of Ohio's health care providers, combined they strike a serious blow by increasing costs and simultaneously eliminating a significant source of reimbursement. Subjecting heath care providers to inconsistent lower court rulings regarding billing and collection practices creates a myriad of administrative challenges, deprives some health care providers of an important source of reimbursement, and is unfair and unreasonable. This Court should accept this discretionary appeal and provide a clear rule so that Ohio's hospitals, doctors, and patients know their rights and obligations.

The OHA is a private nonprofit trade association established in 1915 as the first state-level hospital association in the United States. For decades, the OHA has provided a mechanism for Ohio's hospitals to come together and develop health care legislation and policy in the best interest of hospitals and their communities. The OHA is comprised of one hundred sixty-nine (169) private, state and federal government hospitals and more than eighteen (18) health systems, all located within the state of Ohio. The OHA's mission is to be a membership-driven

[1] When used herein, "health care providers" refers to hospitals, doctors, and others who provide health care services.

organization that provides proactive leadership to create an environment in which Ohio hospitals are successful in serving their communities.

The OSMA is a non-profit professional association of approximately 20,000 physicians, medical residents, and medical students in the state of Ohio. OSMA's membership includes most Ohio physicians engaged in the private practice of medicine, in all specialties. OSMA's purposes are to improve public health through education, encourage interchange of ideas among members, and maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

The OOA is a non-profit professional association, founded in 1898, that represents Ohio's 3,400 licensed DOs, 18 health-care facilities accredited by the American Osteopathic Association, and the Ohio University College of Osteopathic Medicine in Athens, Ohio. Osteopathic physicians make up eleven percent of all licensed physicians in Ohio and twenty-six percent of the family physicians in the state. OOA's objectives include the promotion of Ohio's public health and maintenance of high standards at all osteopathic institutions within the state.

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

The Sixth District's decision, which precludes Ohio's health care providers from seeking payment from all potentially liable payors, reaches far beyond the parties. At a minimum the Sixth District's decision impacts health care providers who treat patients enrolled with health insuring corporations, and will significantly impact how they manage potential reimbursement and subrogation matters. Of course, the decision also impacts patients enrolled with health insuring corporations, especially those who may end up incurring more out-of-pocket expenses for medical treatment in light of the Sixth District's decision.

A. The Issue of Whether Health Care Providers Are Permitted to Seek Reimbursement From All Applicable Third-Party Payors is Important To All Health Care Providers and Patients.

1. The Meaning of R.C. 1751.60 Has Been and Will Continue to be Litigated Until this Court – as the Final Arbiter of Ohio Law – Resolves the Issue

The primary issue addressed by the Sixth District — whether R.C. 1751.60 allows health care providers to seek payment from automobile insurers — has been and will continue to be litigated in other cases, thereby creating a very real threat of conflicting outcomes. This issue first came to the Court's attention last year in *Hayberg v. Physician's Emergency Service, Inc.*, Supreme Court Case No. 2009-0083. After this Court declined to accept the discretionary appeal, *Hayberg* was remanded to the trial court. Hayberg refiled her suit as a class action and it is currently pending in the Portage County Common Pleas Court. See *Hayberg v. Robinson Memorial Hospital Foundation*, Portage County C.P. Court Case No. 2010-CV-00647. There is also another class action pending in the Lucas County Common Pleas Court involving the same primary issue as in the instant case. See *Streeter v. Mercy Health*, Lucas County C.P. Case No. CI-200903601. Another case involving this issue was filed in the Logan County Common Pleas Court, but was dismissed prior to a decision being rendered. See *Ritter v. Mary Rutan Hospital*, Logan County C.P. Court Case No. CV07-100497. Thus, this issue has been litigated in various geographic locations throughout Ohio and there are at least three pending class actions involving it — *Hayberg, King* and *Streeter*.

Although there is no way to know how many other lawsuits have been filed that involve this issue, there is little doubt that others will be filed (particularly if this Court declines this discretionary appeal). In fact, several hospitals have received threatening letters from attorneys representing patients that instruct the hospitals not to bill the patient's automobile insurer or risk legal recourse (citing R.C. 1751.60). It is only a matter of time before additional lawsuits will be

filed as the alleged wrongful activity is a common practice of health care providers. It is this aspect of the case that makes the issues particularly prone to future litigation. Guidance from this Court in the instant case will be extremely beneficial to the courts and litigants in pending cases, as well as cases in yet to be filed.

2. In the Absence of Resolution by this Court, Health Care Providers Will be Subject to Inconsistent Legal Rights and Obligations Regarding Billing and Collection Practices

The Sixth District's decision, which requires health care providers to *only* seek payment from health insuring corporations, has already garnered a lot of attention with hospital billing departments and medical billing companies because it dismantles a long-standing practice for seeking reimbursement for medical treatment and completely cuts off a well-recognized source of reimbursement — other applicable insurance coverage.

This decision has created confusion and administrative difficulties within hospital billing departments because it is contrary to long-standing Ohio law and industry billing practices that require hospitals to seek payment from multiple potentially liable insurers.[2] In the past, hospitals routinely sought payment from the patient's automobile insurance policy's medical payment coverage when the patient's need for treatment arose from an automobile accident because those insurance companies usually had the primary payment obligation under Ohio's coordination of benefits law. The Sixth District's decision prohibits ProMedica Health System and its hospitals, such as The Toledo Hospital, from continuing to follow this statutorily mandated practice. Hence, the Sixth District's decision precludes some, but not all, hospitals from continuing this long-standing practice, thereby creating conflicting legal obligations between health care providers in the Sixth District and other appellate districts.[3] Although no health care provider

[2] The term "insurer" is used loosely in this Memorandum to refer to other applicable coverage.
[3] Amici support Appellants' Motion for Stay which will alleviate this problem.

should be subjected to more stringent application of a statute merely because of geographic location (being in one appellate district versus another), this problem is compounded when a health care provider operates in more than one geographic location (such as a hospital system with hospitals in multiple geographic locations) and inconsistent lower court rulings apply.

Health care providers required to comply with the Sixth District's decision must alter well established billing and collection practices. The costs of implementing new hospital billing practices, which drastically alter previous billing practices, can be enormous for even a single hospital, let alone all health care providers. Such an undertaking will likely involve new or modified software, system integration, changes in policies and procedures, and training of personnel.

The Sixth District's decision not only requires health care providers to incur the costs of overhauling their established billing practices, at the same time it also eliminates a very important source of reimbursement — the medical payment benefit of their patients' automobile insurance. If health care providers are not permitted to bill their patients' automobile insurance companies when they are primary plans under Ohio's coordination of benefits law, they will lose millions of dollars in revenue. This is something that Ohio's hospitals simply cannot afford in the current economic environment. Ohio hospitals are committed to providing quality health care 24 hours a day, seven days a week to persons in their communities regardless of their ability to pay. But hospitals cannot keep their doors open without adequate reimbursement for their services. If hospitals are cut-off from an essential source of revenue — reimbursement from

other primary plans such as automobile insurance — they will not be able to continue to serve their communities as they have in the past.[4] The same goes for other health care providers.

It is in the best interest of Ohio's hospitals, doctors, patients, and third-party payors to have clear, definitive rules regarding the duties and liabilities they face in billing, collecting, and paying for medical services provided to patients. And, the instant appeal provides this Court the opportunity to provide those rules.

B. Ohio's Health Care Providers Need Clear Guidance Regarding Obtaining Reimbursement When A Health Insuring Corporation is Involved.

Members of the OHA, OSMA, and OOA provide health care services to millions of people throughout Ohio. Generally speaking, Ohio's hospitals and doctors charge patients for the services they render and receive payment from the patients or the patients' insurers (including Medicare and Medicaid).[5]

Every single day, Ohio's 171 hospitals and 20,000+ doctors are affected by, and required to comply with, the numerous state and federal laws governing the billing and payment of health care services. In order for Ohio's hospitals and doctors to comply with these laws, they need to know or be able to ascertain, with reasonable certainty, their duties and obligations.

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[4] A survey performed last fall shows that many of Ohio's hospitals are already under significant financial stress. Of the 51 hospitals that responded, almost 50% have enacted layoffs and 67% have not filled vacancies. And the economic environment has forced hospitals to cut vital services, such as obstetrics, cardiology units, and home health care. Based on the recent survey, 37.5% of responding hospitals have reduced or eliminated services and nearly 39% are planning to reduce or eliminate services. See http://www.ohanet.org/SiteObjects/57AEE3CFB2585F16682EF98E1BBE3B48/State%20Budget%20Survey%20Report.pdf.

[5] While cumulative statistics are not available for all health care services rendered in Ohio in a given year, the OHA compiles statistics for patients treated at hospitals. In 2008 (the last year for which the compilation has been completed), there were more than 32,000,000 outpatient visits and more than 1,500,000 admissions in Ohio hospitals. Patients often receive multiple services at each of these visits/admissions, all of which ultimately are billed. In 2008, Ohio hospitals received 40% of their payments from private insurers, 42% from Medicare, and 12% from Medicaid.

Consistent with these laws, industry practices have developed to make the billing and payment for health care services standardized and more efficient. One common practice is that at the time services are rendered, health care providers usually obtain information from patients regarding (1) the medical issue for which they are seeking services,[6] and (2) potentially applicable insurance coverage for the services.[7] And another common industry practice is that when it is time to bill for such services, the health care provider may seek payment from one or more of the potentially applicable insurance coverages. This practice makes sense because when a patient has more than one insurance coverage that may be applicable, hospitals and doctors are not required to determine which coverage should pay first or how much each should pay. In fact this would be virtually impossible for them to do since they usually have only limited, general information pertaining to potential coverage such as the name and address of the patient's employer, insurer, etc. Although hospitals and doctors are not required to determine who pays first, when Medicare is involved they are precluded from billing Medicare until they have exhausted all other sources of potential payment. See 42 U.S.C. 1395y and 1395w-22.

While a health care provider is allowed to seek payment from more than one potentially liable source if a patient has more than one insurance coverage that may be applicable, the health care provider is only allowed to be paid the full amount charged for the services rendered (and not more).

When a patient has only one potential coverage for the services rendered and such coverage is from a "health insuring corporation," as defined in R.C. 1751.01(P), Ohio law

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[6] For instance, when patients present at a hospital or doctor's office they are usually asked (verbally or in writing) why they are seeking treatment, whether their medical condition is related to a workplace injury or automobile accident, etc.

[7] For instance, patients are asked whether they have health insurance, whether their spouse has health insurance, whether they have automobile insurance that may be applicable, etc.

precludes hospitals and doctors from seeking payment from the patient, except for copayments and deductibles.[8] See R.C. 1751.60(A). Ohio law creating health insuring corporations was enacted after several health maintenance organizations (HMOs) in Ohio collapsed, adversely affecting more than 125,000 Ohioans and leaving millions of dollars in unpaid medical bills. In light of the problems created by the insolvent HMOs, the General Assembly set out to protect Ohio consumers who are enrollees of health insuring corporations from being held liable for medical bills that should be paid by their health insuring corporations. Now, under R.C. 1751.60, if a health insuring corporation becomes insolvent or for some other reason does not pay the medical provider for covered services, the medical provider cannot seek payment from the enrollee. This statutory protection is only necessary when the health insuring corporation has not met its obligations to the enrollee and, hence, it should only be invoked under that circumstance.

When a patient has multiple coverages, one of which is a health insuring corporation (such as in the instant case), health care providers are not restricted by R.C. 1751.60. Rather, they follow the same laws and industry practices that apply when multiple coverages are available. More specifically, when there are multiple coverages available and one of them is from a health insuring corporation, health care providers usually will seek payment from more than one available coverage and let the insurers determine who is liable and in what amount. This process is governed by Ohio's coordination of benefits laws. See R.C. 3902.11 et seq., and Ohio Adm. Code 3901-8-01 et seq. Ohio's coordination of benefits laws provide detailed rules

[8] Just because a patient has health insurance does not mean that a "health insuring corporation" is involved. Health insuring corporations are only one type of entity that is permitted to offer health care and medical payment benefits.

for insurers to use to determine priority (whose obligation is primary and whose is secondary, etc.) and payment amount when multiple coverages are available for a patient.

Under Ohio's statutory coordination of benefits scheme, there is no law that requires a health care provider to bill only a health insuring corporation and not the patient's automobile insurance company (when the medical treatment sought was related to an automobile accident). Nor is there any Ohio law that prohibits a health care provider from collecting more than the discounted contractual rate the health care provider agreed to accept from one insurer if there is another insurer also liable for payment that does not have a contractual discount.

In addition to affecting health care providers and insurers, the Sixth District's decision also affects patients. And, the decision may impact patients adversely. Health insuring corporations require health care providers to collect copayments and deductibles from patients. These amounts can be thousands of dollars for a critically injured patient. Prior to the Sixth District's decision, health care providers could seek copayments and deductibles from a patient's other insurers, such as the patient's automobile insurer. Thus, the patient did not have to come out of pocket to pay these amounts. But, under the Sixth District's interpretation of R.C. 1751.60, the burden shifts to the injured patient to incur increased out of pocket expenses and/or to attempt to collect reimbursement from their automobile insurer since the health care provider will not be able to seek payment from anyone other than the health insuring corporation.

In addition to the inconsistency, confusion, and harm caused by the Sixth District's decision, conceivably every other lower court addressing any of the statutory issues presented in this appeal can reach a different conclusion, thereby creating contradictory legal rights, duties, and liabilities of health care providers, patients, and others. This undesirable outcome would leave Ohio's hospitals and doctors with no clear direction regarding the proper method for

obtaining reimbursement and no clear guidance as to their potential liability for accepting payment for patient treatment services from an automobile insurance company or other third-party payor when a health insuring corporation is involved.

STATEMENT OF THE CASE AND FACTS

Amici defer to the Statement of the Case and Facts provided by ProMedica Health System and The Toledo Hospital.

LAW AND ARGUMENT

Proposition of Law No. 1: R.C. 1751.60 is properly interpreted using all applicable rules of construction.

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 benefits.

The decision of the Sixth District, which precludes a health care provider from seeking payment from any third-party payor other than the patient's health insuring corporation, is wrong. In short, the Sixth District's myopic focus on a single word — solely — in a single statute — R.C. 1751.60 — resulted in a decision that

- is contrary to the intent of the statute itself;
- disregards and obliterates other applicable law; and
- wreaks havoc on Ohio's health care providers by dismantling established industry-wide billing practices and eliminating a critical source of reimbursement.[9]

The General Assembly revised Ohio's HMO statutes in the aftermath of several HMO insolvencies. One objective of the revisions was to provide consumer protection to enrollees.

[9] In the interest of brevity, Amici refer the Court to Appellants' Memorandum in Support of Jurisdiction, pp. 6-10, for a thorough discussion regarding why the Sixth District's focus on the word "solely" was wrong and to this Memorandum, pp. 4-6 regarding the third bullet point.

Am. Sub. S.B. 67 (122nd General Assembly) (the "Act") repealed the laws that governed HMOs and replaced them with laws providing for the establishment, operation, and regulation of "health insuring corporations" "to provide uniform regulation of providers of managed health care." See Legislative Service Commission 122nd Final Bill Analysis for Am. Sub. S.B. 67. Among other things, the Act imposed requirements to ensure the financial stability of health insuring corporations and "contain[ed] several provisions focusing on protections for subscribers and enrollees, including . . . restricting the authority of providers and health care facilities to seek compensation for covered services from enrollees." Id.

The restrictions imposed on health care providers from seeking compensation from enrollees were set forth in R.C. 1751.60. In relevant part, this statute provides:

> [E]very 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.

R.C. 1751.60(A). Regardless of whether this statute is determined to be ambiguous or unambiguous, the result is a construction that permits health care providers to seek payment from third-party payors, but not from enrollees.

In construing this statute, the Sixth District erroneously relied on *Hayberg* which was incorrectly decided. Further, *Hayberg* did not invoke the coordination of benefits issue that was squarely presented and applicable in *King*.

Hayberg was incorrectly decided for a number of reasons, but most notably because the court's interpretation of R.C. 1751.60, was, as the dissenting opinion stated, "completely inapplicable in the present situation" because the health care provider never sought payment from Hayberg. *Hayberg*, 2008-Ohio-6180, at ¶ 59 (Grendell, J., dissenting). The same is true

here. Properly construed, R.C. 1751.60 prohibits health care providers from seeking compensation from King; it does not prevent them from receiving payment from a third-party payor who has assumed liability for the payment (such as an automobile insurance company under its medical payment coverage). See id. at ¶ 61.

Hayberg was also wrong in holding that a health care provider could only be reimbursed from all third-party payors the discounted amount it contractually agreed to accept from a health insuring corporation. The fact that health care providers may have a contract with some insurers for a discounted rate does not mean that they cannot collect the full amount of their standard charge from third-party payors with whom they do not have a contract for a discounted rate. See id. at ¶ 62.

Significantly, *Hayberg* did not involve Ohio's coordination of benefits law. In addition to erroneously relying on *Hayberg*, the Sixth District ignored Ohio's coordination of benefits law, even though such law is critical to properly deciding *King*. Under Ohio's coordination of benefits law, insurers — not health care providers — are required to determine priority of coverage and how much each third-party payor shall pay. R.C. 3902. 13(A). If the Sixth Circuit had utilized Ohio's coordination of benefits law, it would have seen that the patient's medical benefits under her automobile insurance policy were available to reimburse the health care provider.

The Sixth District's construction of R.C. 1751.60, which allows health care providers to seek reimbursement *only* from a patient's health insuring corporation, completely obliterates Ohio's coordination of benefits laws and leaves health care providers without any recourse for seeking payment if the health insuring corporation is not the primary insurer. See *King v. ProMedica Health System*, Judgment Entry (C.P. Lucas County October 6, 2009) ("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 benefits laws."). Plainly, R.C. 1751.60 was not intended to deprive health care providers of reimbursement when insurance coverage is available, and any interpretation of the statute that allows this is unreasonable and unlawful.

CONCLUSION

The Sixth District's decision reaches well beyond the parties to this litigation. If allowed to stand, the Sixth District's decision will have a dramatic impact on Ohio's health care system by, at a minimum, increasing health care providers' costs while at the same time decreasing their revenue. Amici urge the Court to accept this discretionary appeal and decide this important legal issue favorably to Appellants.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing MEMORANDUM OF AMICUS CURIAE, OHIO HOSPITAL ASSOCIATION, OHIO STATE MEDICAL ASSOCIATION, AND OHIO OSTEOPATHIC ASSOCIATION, IN SUPPORT OF PROMEDICA HEALTH SYSTEM, INC.'S MEMORANDUM IN SUPPORT OF JURISDICTION was sent via regular U.S. mail, postage prepaid this 16 th day of July 2010, to the following:

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