IN THE SUPREME COURT OF OHIO

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

MERIT BRIEF OF APPELLANTS PROMEDICA HEALTH SYSTEM AND THE TOLEDO HOSPITAL

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TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

INTRODUCTION 1

STATEMENT OF FACTS 4

A. Because King Sustained Her Injuries In An Automobile Accident, Two Separate Insurers—King's Health Insurer And Her Auto Insurer—Had Potential Payment Obligations 4

B. King Sued, Alleging That The Hospital Violated R.C. 1751.60(A) By Following Settled Industry Practices And Billing The Automobile Insurer 4

C. The Trial Court Dismissed King's Claims, Finding That R.C. 1751.60(A) Did Not Prevent The Hospital From Billing Potentially Responsible Insurers, But Rather Only Prevented The Health Care Provider From Seeking Compensation From *The Insured* 5

D. The Sixth District Court Of Appeals Reversed, Focusing Exclusively On The Word "Solely," And Failing To Address The Question Of Statutory Scope 6

E. Since The Appeals Court Decision, The Ohio Department Of Insurance Has Issued Statutory Guidance Stating That R.C. 1751.60(A) Applies Only To Payments By *Insureds*, And Does Not Apply To Relationships Among Multiple *Insurers* 7

STANDARD OF REVIEW 8

ARGUMENT 8

PROPOSITION OF LAW: R.C. 1751.60(A) APPLIES ONLY WHEN AN INSURED PATIENT'S HEALTH INSURING COVERAGE PROVIDES THE ONLY COVERAGE AVAILABLE TO THE INSURED PATIENT; THE STATUTE DOES NOT SUPERSEDE OHIO'S COORDINATION OF BENEFITS LAW, NOR PREVENT A PROVIDER FROM SEEKING COMPENSATION FROM OTHER RESPONSIBLE INSURERS 8

A. Statutory Commands Apply Only Within A Statute's Proper Scope 9

B. The Scope Of R.C. 1751.60(A) Is Ambiguous 11

C. Settled Rules Of Statutory Construction Confirm That R.C. 1751.60(A) Applies Only To Compensation Issues As Among A Health Care Provider, Health Insuring Corporation, And Patient, And Does Not Prevent A Health Care Provider From Seeking Reimbursement From Other Potentially Responsible Insurers 13

1. The Language Of R.C. 1751.60(A), When Read In Its Entirety And In The Context Of Section 1751.60, Indicates That Its Application Is Limited To The Single-Insurer Setting. 14

TABLE OF CONTENTS
(cont'd.)

2. The Legislative History Surrounding R.C. 1751.60(A) And The Title Of The Section Confirm That The Provision Is Intended To Insulate Insureds From Liability, Not To Prevent Providers From Billing Other Insurers 17

3. The Appeals Court's Interpretation Puts R.C. 1751.60(A) In Direct Conflict With Ohio's Coordination Of Benefits Law 19

4. The Appeals Court's Construction Of R.C. 1751.60(A) Would Harm Ohio's Health Care Industry 24

5. The Ohio Department Of Insurance's Statutory Guidance Confirms That R.C. 1751.60(A) Does Not Prevent A Health Care Provider From Seeking Reimbursement From Other Insurers 26

CONCLUSION 28

CERTIFICATE OF SERVICE

APPENDIX

Notice of Appeal of Appellants ProMedica Health System and The Toledo Hospital in Case No. 10-1236 (Ohio Supreme Court), filed July 15, 2010 ..... A.2

Judgment Entry and Opinion in Case No. L-09-1282 (6th Dist), Released and Journalized June 4, 2010 ..... A.5

Judgment Entry and Order Granting ProMedica Health System and The Toledo Hospital's Motion to Dismiss in Case No. CI 200903599 (Lucas Cty. Common Pleas), Released October 1, 2009; Journalized October 6, 2009 ..... A.10

Ohio Department of Insurance, Bulletin 2010-06, *Guidance Governing Interpretation of R.C. 1751.60* A.17

R.C. 1751.01 ..... A.19

R.C. 1751.60 ..... A.25

R.C. 3902.11 ..... A.27

R.C. 3902.12 ..... A.28

R.C. 3902.13 ..... A.29

Ohio Adm. Code 3901-8-01 ..... A.32

TABLE OF AUTHORITIES

Page

CASES

Beneficial Ohio, Inc. v. Ellis,
121 Ohio St. 3d 89, 2009-Ohio-311 10

Boley v. Goodyear Tire & Rubber Co.,
125 Ohio St. 3d 510, 2010-Ohio-2550 15

Clark v. Scarpelli,
(2001), 91 Ohio St. 3d 271 12

D.A.B.E., Inc. v. Toledo-Lucas Cty. Bd. Of Health,
96 Ohio St. 3d 250, 2002-Ohio-4172 ..... 14, 15, 19

Hayberg v. Physicians Emergency Servs. Inc.,
(Ohio App. 11th Dist. Nov. 28, 2008), No. 2008-P-0010,
2008 WL 5052744, 2008-Ohio-6180 ..... 6, 7, 22, 23

Hayberg v. Robinson Mem'l Hosp. Foundation,
Portage County C.P. No. 2010-CV-00647 5

Perrysburg Twp. v. Rossford,
103 Ohio St.3d 79, 2004-Ohio-4362 8

San Diego Cty. v. Elavsky,
(1979), 58 Ohio St. 2d 81 23

Sheet Metal Workers' Int'l Ass'n v. Gene's Refrigeration, Heating & Air Conditioning, Inc.,
122 Ohio St. 3d 248, 2009-Ohio-2747 ..... passim

State ex rel. Myers v. Bd. Of Educ. Of Rural Sch. Dist. Of Spencer Twp.,
(1917), 95 Ohio St. 367 15

State v. Consilio,
114 Ohio St. 3d 295, 2007-Ohio-4163 8

State ex rel. Ross v. Crawford Cty. Bd. Of Elections,
125 Ohio St. 3d 438, 2010-Ohio-2167 25

State v. Hall,
(4th Dist. 2001), 141 Ohio App. 3d 561 ..... 10, 11

State v. Jordan,
(2000), 89 Ohio St. 3d 488 ..... 11, 12

TABLE OF AUTHORITIES
(cont'd.)

Page

State v. Kiser,
(1968), 13 Ohio St. 2d 126 18

Streeter v. Mercy Health,
Lucas County C.P. No. CI-200903601 5

Weiss v. Pub. Util. Comm.,
(2000), 90 Ohio St. 3d 15 27

STATUTES AND ADMINISTRATIVE PROVISIONS

R.C. 1.49 ..... 13, 14, 17

R.C. 1.49(D) 19

R.C. 1.49(E) 24

R.C. 1345.01 4

R.C. 1751 ..... passim

R.C. 1751.01(P) 15, 27

R.C. 1751.32 18

R.C. 1751.60 ..... 7, 14, 16, 18

R.C. 1751.60(A) ..... passim

R.C. 1751.60(B) 16

R.C. 1751.60(E) 16

R.C. 3202.11(b)(2) 19

R.C. 3202.11(b)(3) 20

R.C. 3901.011 27

R.C. 3902.11(B) 22, 23

R.C. 3902.12 ..... 20, 21

R.C. 3902.13 19

R.C. 3902.13(A) 20, 21, 22

TABLE OF AUTHORITIES
(cont'd.)

Page

R.C. 3902.13(E) 20

R.C. 3902.13(F) 20

R.C. 4115.05 ..... passim

R.C. 5122.31 ..... 10, 11

Ohio Adm. Code 3901-8-01 ..... 19, 20

Ohio Adm. Code 3901-8-01(C)(11)(c) 23

Ohio Adm. Code 3901-8-01(C)(11)(c)(vi) 20

Ohio Adm. Code 3901-8-01(C)(11)(d) 23

Ohio Adm. Code 3901-8-01(F)(3) 20

Ohio Adm. Code 3901-8-01(F)(6) 20

Ohio Adm. Code 3901-8-01(H) 20

RULES

Ohio Rule of Civil Procedure 12(B)(6) 8

OTHER

66 Ohio Report No. 97, *Gongwer News Serv.* (May 21, 1997) 17

Am. Sub. S.B. No. 67 (1997)... 17

Darrel Rowland, *Insurance Department Pushes Laws on Health Care*, The Columbus Dispatch, April 25, 1996 17

Legislative Service Commission Bill Analysis, Am. Sub. S.B. No. 67, 122nd General Assembly 18

Ohio Department of Insurance, Bulletin 2010-06, *Guidance Governing Interpretation of O.R.C. 1751.60* 7, 27

Ohio Department of Insurance, *Insurance Companies Authorized to Transact Business in the State of Ohio*, at 3–4, (Oct. 11, 2010), available at http://www.insurance.ohio.gov/reports/authlist.pdf 16

INTRODUCTION

This case illustrates the dangers that arise when courts apply a statute outside its intended context. The General Assembly enacted the statute at issue here, R.C. 1751.60(A), as part of an extensive health insurer regulatory reform in the late 1990s. The regulatory overhaul was designed to rectify perceived shortcomings in health insurer oversight that came to light as a result of health insurer insolvencies. R.C. 1751.60(A) reflects the General Assembly's decision that if a health insuring corporation does not pay a provider's bills, insureds should not be left holding the bag. The statute provides (with key language in italics):

> 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.*

In the correct context, the statutory command is unambiguous—a health care provider must look only to the health insuring corporation, not to the insured, for reimbursement.

The problem arises, however, when parties (or courts) apply this statutory command outside its proper scope. In particular, the plaintiff here, Virginia King ("King"), was injured in an automobile accident and received medical care from the appellants ProMedica Health System and The Toledo Hospital (collectively, "the Hospital"). Because the injury arose from an automobile accident, King had two different policies that provided coverage for her health care costs—her health insurance and her automobile insurance medical expense coverage. In this multi-insurer context, Ohio has a comprehensive set of statutory and administrative rules designed to address what is referred to as the "coordination of benefits" process. These

provisions govern how the benefits from an insured's separate policies work together, by specifying, for example, which policy will be "primary" (i.e., which insurer has the first obligation to pay) and which will be "secondary." King does not argue that the Hospital violated the coordination of benefits provisions. Rather, she asserts that, by complying with these settled rules and billing her automobile insurer, the Hospital violated R.C. 1751.60(A), which, she contends, required the Hospital to bill only her health insurer, even if other insurers have also contracted to cover the risk.

Resolving King's claim requires consideration of two related, but distinct, questions: (1) what is the scope of R.C. 1751.60(A)?; and (2) what is the substance of the statute's command? The trial court correctly started with the first of these questions, rejecting King's claim as a matter of law because "[t]he statute does not contemplate situations in which there are other responsible payors." (Appx. at 13.) In other words, the statute does not apply in the multi-insurer context, and thus it did not prevent the Hospital from billing the auto insurer here.

The court of appeals reversed. In a brief opinion, the court concluded that the statute was "unambiguous," and that it precluded any attempt to bill other insurers in the multi-insurer setting. (Appx. at 8–9.) It arrived at that result by focusing exclusively on the ***substance*** of the statute's command and, in particular, on the word "solely," which the court determined meant "to the exclusion of others." (*Id.* at 8.) But the court neglected to address the statute's ***scope***, and thus failed to recognize that "solely" necessarily means "to the exclusion of others ***to whom the statute applies***."

On the scope question, the statute is ambiguous—it neither expressly states that it does, or does not, apply to multiple insurers. In resolving that ambiguity, the proper starting point is the statute's language, which this Court has repeatedly stated must be read in context. An

examination of the language of R.C. 1751.60(A) in its entirety, and in the context of Chapter 1751 (a chapter directed exclusively to "Health Insuring Corporations") as a whole, shows that R.C. 1751.60(A) simply does not apply in the multiple-insurer setting, particularly where, as here, the other insurer is not a health insuring corporation.

Other well-settled tools of statutory construction reinforce that the multi-insurer situation lies outside the statute's scope. For example, this Court has properly noted the importance of harmonizing various statutes directed to a single topic and avoiding absurd results. Here, Appellant's (and the trial court's) proposed reading makes R.C. 1751.60(A) consistent with Ohio's coordination of benefits statutes and administrative rules, while the reading that Appellee advances (and the court below adopted) turns R.C. 1751.60(A) into an implied repeal of that extensive body of well-settled law. Moreover, the available legislative history surrounding its enactment strongly implies that the statute was intended to insulate ***insureds*** from liability, not to provide other ***insurers*** a free pass on their obligations. Indeed, the Ohio Department of Insurance ("ODI"), the agency charged with interpreting and applying Ohio's insurance laws, has expressly confirmed this point.

In short, all of the available sources demonstrate that the purpose of R.C. 1751.60(A) is to insulate ***insureds*** from liability, and that it is not intended to prevent a provider from billing multiple responsible ***insurers***. Accordingly, the Hospital respectfully urges this Court to reverse the decision below and reinstate the trial court's decision dismissing this case.

STATEMENT OF FACTS

A. Because King Sustained Her Injuries In An Automobile Accident, Two Separate Insurers—King's Health Insurer And Her Auto Insurer—Had Potential Payment Obligations.

Appellant The Toledo Hospital treated King for injuries she sustained in an automobile accident.[1] (Compl. ¶ 12–13.) Like many Ohioans, King had two insurance policies that provided coverage for the cost of the treatment she received: an automobile insurance policy with Safeco that included medical expense coverage, and a health insurance policy with Aetna. (*Id.* at ¶ 16.) King alleges that the Hospital billed Safeco. (*Id.*) King does not allege that the Hospital ever billed ***her*** for the care, nor that she has reimbursed either the Hospital or either of her insurers for any part of the costs of the care that she received.

B. King Sued, Alleging That The Hospital Violated R.C. 1751.60(A) By Following Settled Industry Practices And Billing The Automobile Insurer.

Notwithstanding her inability to allege that she was billed for or had paid for any part of her care, King nonetheless filed a putative class action in the Lucas County Court of Common Pleas. The complaint asserted claims for breach of contract, breach of public policy, violation of Ohio's Consumer Sales Practices Act (R.C. 1345.01, et seq.), and conversion. As the trial court noted, and as King's complaint reflects, each of these claims hinges on the Hospital's purported violation of R.C. 1751.60(A). (Appx. at 16; Compl. ¶¶ 15, 42, 44, 49, 52.)

According to King, R.C. 1751.60(A) requires health care providers to seek compensation exclusively from a single health insuring corporation (here, Aetna) and not from any other

[1] This appeal arises from a decision on a motion to dismiss. Other than as expressly noted, the "facts" described above are actually allegations from Ms. King's complaint. For purposes of the motion to dismiss, Appellants accept those facts as true, as they must.

potentially liable insurers (such as Safeco).[2] Thus, King claims that the Hospital violated the statute when it sought reimbursement from the auto insurer for the cost of her care.

King further claims that the Hospital sought payment from Safeco, rather than Aetna, because doing so would allow the Hospital to charge a higher fee. (Compl. ¶ 17.) As noted in the complaint, the Hospital has preferred-payment agreements with Aetna, under which it has agreed to pre-negotiated discounted rates for services. These rates are lower than the "standard, not-preferred, provider rates for the services rendered." (*Id.*) As Safeco and the Hospital do not have a preferred-provider agreement, the Hospital billed Safeco at the Hospital's "standard" rates. King does not allege that these rates were higher than the rates that the Hospital would charge other payors who do not have a preferred-provider agreement.

C. The Trial Court Dismissed King's Claims, Finding That R.C. 1751.60(A) Did Not Prevent The Hospital From Billing Potentially Responsible Insurers, But Rather Only Prevented The Health Care Provider From Seeking Compensation From *The Insured.*

The Hospital moved to dismiss King's complaint, arguing, inter alia, that King was misreading R.C. 1751.60(A). In particular, the Hospital argued that the statute governs only the "three-party relationship that exists between a health insuring corporation, the health insuring corporation's subscriber, and a health care provider . . . ," and that the statute does not "address situations where there are other payors who are responsible for the cost of medical care received by a patient." (Mot. to Dismiss at 3.) Accordingly, R.C. 1751.60(A)'s requirement that the Hospital bill "solely . . . the health insuring corporation, and not, under any circumstances, . . . the enrollees or subscribers," should be understood to apply "only when a health insuring corporation provides the only coverage available to a patient." (*Id.* at 6.)

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[2] At least two other class action suits involving the interpretation of R.C. 1751.60(A) are currently pending. *See Hayberg v. Robinson Mem'l Hosp. Found.*, Portage County C.P. No. 2010-CV-00647; *Streeter v. Mercy Health*, Lucas County C.P. No. CI-200903601.

The trial court agreed with the Hospital. Noting that applying the statute in the multi-insurer setting would "contradict[] Ohio's coordination of insurance benefits laws," (Appx. at 13.), it found that the statute's language is designed to prevent health care providers from seeking payment ***from insured patients***—not ***from other insurers***—and King's complaint "contain[ed] no allegation that [the Hospital] sought compensation from [King], the enrollee."[3] (*Id.* at 15.) Thus, the statute did not apply. Because all of King's claims turned on the alleged violation of R.C. 1751.60(A), the court found that the claims failed as a matter of law. (*Id.* at 16.)

D. The Sixth District Court Of Appeals Reversed, Focusing Exclusively On The Word "Solely," And Failing To Address The Question Of Statutory Scope.

The Sixth District Court of Appeals reversed. Although the Hospital again raised the statutory scope issue, the appeals court did not confront that question. Instead, the court focused exclusively on the substance of the statutory command. In particular, the court zeroed in on the word "solely," which it called "the key, determinative word utilized in R.C. 1751.60(A)." (Appx. at 8.) According to the appeals court, "the term 'solely' clearly and plainly means to the exclusion of others." (*Id.*) It reached this result without addressing the remainder of the phrase in which the word "solely" appears: "and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles."

Having concluded that the word "solely" was unambiguous, the court failed to consider the possibility that the statute may nonetheless be ambiguous ***as to its scope***. The court also relied heavily on the Eleventh District's interpretation of R.C. 1751.60(A) in *Hayberg v.*

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[3] Given King's inability to allege that she paid for any portion of her medical expenses, it is questionable at best whether she has incurred any damages, even if she could show a statutory violation (which, as described below, she cannot).

Physicians Emergency Service Inc., 11th Dist. No. 2008-P-0010, 2008-Ohio-6180, which it characterized as "a strikingly similar case." (*Id.*)

E. Since The Appeals Court Decision, The Ohio Department Of Insurance Has Issued Statutory Guidance Stating That R.C. 1751.60(A) Applies Only To Payments *By Insureds*, And Does Not Apply To Relationships Among Multiple *Insurers*.

The Hospital sought review of the appeals court decision in this Court. (Appx. at 2–4.) After the Hospital filed its jurisdictional memorandum, the ODI issued Bulletin 2010-03, in which it confirmed that R.C. 1751.60(A) "applies to compensation sought from a subscriber"—and not to compensation sought from other responsible payors, such as other insurance companies. (*See* Ohio Department of Insurance, Bulletin 2010-03, *Guidance Governing Interpretation of O.R.C. 1751.60*, available at http://www.insurance.ohio.gov/legal /bulletins/documents/2010-03.pdf.)

The Court granted review on the Hospital's second proposed proposition of law, which addresses the question of R.C. 1751.60(A)'s appropriate scope. The Ohio Department of Insurance then issued Bulletin 2010-06. (Appx. at 17.) Although that bulletin rescinded and replaced Bulletin 2010-03,[4] as applied to the situation here the substance of the ODI's guidance remained unchanged. Like Bulletin 2010-03, Bulletin 2010-06 provides that R.C. 1751.60 applies to compensation "***sought from a subscriber***." (*Id.*) The bulletin further confirms that the statute applies in the context of a health care provider's contract with ***a health insuring corporation***, and thus does not apply to provider billing practices with other insurers, such as the

[4] The Hospital refers to both bulletins here only for sake of completeness. Because the ODI's newer bulletin rescinds and replaces the older bulletin, the Hospital relies exclusively on the new bulletin in its Argument infra.

Safeco policy covering King.[5] (*Id.*) This is the precise interpretation that the Hospital advances in the case at bar.

STANDARD OF REVIEW

This case arises on appeal of the trial court's order granting the Hospital's Civil Rule 12(B)(6) motion to dismiss for failure to state a claim, which was reversed by the Sixth District Court of Appeals. This Court reviews the appellate court's decision de novo, accepting all factual allegations in the complaint as true. *Perrysburg Twp. v. Rossford*, 103 Ohio St. 3d 79, 2004-Ohio-4362, at ¶ 5. Moreover, the sole question presented is the proper interpretation of R.C. 1751.60(A), an issue that King conceded in her brief below is subject to de novo review. (*See* Appellant's Br. at 5.) *See also State v. Consilio*, 114 Ohio St. 3d 295, 2007-Ohio-4163, at ¶ 8.

ARGUMENT

PROPOSITION OF LAW: ***R.C. 1751.60(A) Applies Only When An Insured Patient's Health Insuring Coverage Provides The Only Coverage Available To The Insured Patient; The Statute Does Not Supersede Ohio's Coordination Of Benefits Law, Nor Prevent A Provider From Seeking Compensation From Other Responsible Insurers.***

When applied to payment issues as among a health provider, a health insuring corporation, and an insured patient, the meaning of R.C. 1751.60(A) is clear and unambiguous: health care providers must seek compensation for covered services only from health insuring corporations—not from insureds. But applying R.C. 1751.60(A) outside its intended scope transforms the statute from a provision that insulates ***insureds*** (i.e., patients) from personal

[5] The Guidance further notes that neither R.C. Chapter 1751 nor R.C. 1751.60 references a private right of action. (Appx. at 18.) One of the other arguments that the Hospital advanced as a basis for dismissal in the trial court was that Ohio law does not recognize a private right of action for alleged violations of R.C. 1751.60. The trial court did not reach that issue as it held that R.C. 1751.60 did not prevent the Hospital from billing other insurers.

liability for provider bills into one that insulates ***insurers***, such as Safeco here, from their contractual payment obligations.

The trial court and the Ohio Department of Insurance directly confronted this question of statutory scope and both concluded that R.C. 1751.60(A) applies only in the former context—the single-insurer setting. The appeals court, on the other hand, failed to address the scope issue. Instead, mechanistically applying the statute to the multi-insurer setting, the court found that R.C. 1751.60(A) barred a health provider from seeking compensation from anyone other than a health insuring corporation, including other responsible insurers.

The appeals court's myopic focus on the statute's use of the word "solely" resulted in a reading that missed the forest for the trees. "Solely" undoubtedly means "to the exclusion of others," but only "to the exclusion of others ***to whom the statute applies***." If the court had considered that scope issue, it would have recognized that the statute is ambiguous; it lacks language that either expressly limits the statute to the single-insurer context or expressly expands it to include the multi-insurer setting.

The first step in resolving that ambiguity, of course, is to read the statutory language in the context of the statute as a whole. Reading the statute in context shows that the provision at issue applies only in the single-insurer setting. And this Court's well-settled rules of statutory construction confirm that result. Indeed, extending R.C. 1751.60(A) to the multi-insurer context, as the appellate court did, results in the statute sub silentio overruling Ohio's coordination of benefits law. As both the trial court and the ODI have recognized, there is no reason to believe that the General Assembly intended that incongruous result in enacting R.C. 1751.60(A).

A. Statutory Commands Apply Only Within A Statute's Proper Scope.

The first step in any case involving statutory interpretation—a step that the trial court took, but the appeals court did not—is to determine whether the statute applies to the facts at

hand. *See, e.g.*, *Beneficial Ohio, Inc. v. Ellis*, 121 Ohio St. 3d 89, 2009-Ohio-311, at ¶ 27 (O'Donnell, J., concurring) (discussing lis pendens statute and noting that "[t]he issue in this case is whether the statute applies in multiple-defendant situations . . . .").

Indeed, this Court recently reaffirmed the importance of this step in *Sheet Metal Workers' International Association v. Gene's Refrigeration, Heating & Air Conditioning, Inc.*, 122 Ohio St. 3d 248, 2009-Ohio-2747. There, the statute at issue, R.C. 4115.05, required employers to pay the "prevailing rate of wages . . . upon any material to be used in or in connection with a public work":

> The prevailing rate of wages to be paid for a legal day's work, to laborers, workers, or mechanics, *upon any material to be used in or in connection with a public work*, shall be not less than the prevailing rate of wages payable for a day's work in the same trade or occupation in the locality within the state where such public work is being performed and where the material in its final or completed form is to be situated, erected, or used.

R.C. 4115.05 (emphasis added). Although the substance of the statutory command was unambiguous—pay "the prevailing rate of wages"—the Court separately had to consider whether this statutory command ***applied*** to the facts at hand, which involved work performed off-site on materials to be used in a public project. Concluding that the statute's scope was ambiguous, the Court used normal tools of statutory construction to determine that the statute extended only to on-site work. *Sheet Metal Workers*, 2009-Ohio-2747, at ¶¶ 29–43. The Court thus held that the union could not rely on the statute to claim an entitlement to prevailing wages for work performed off-site. *Id.* at ¶ 44.

In *State v. Hall* (4th Dist. 2001), 141 Ohio App. 3d 561, a party relied on R.C. 5122.31, which imposes a blanket confidentiality requirement for certain patient records: "reports . . . shall be kept confidential and shall not be disclosed." Before interpreting the content of this statutory

confidentiality command, however, the court, as in *Sheet Metal Workers*, first asked whether the command even applied on the facts presented in the case:

> To begin, it is not entirely clear whether this statute applies to the case *sub judice*. R.C. Chapter 5122 deals with psychiatric hospitals and other similar institutions. We find nothing in the statute generally, or in R.C. 5122.31 in particular, which suggests that the statute is meant to govern trial courts and to require courts to keep competency evaluations confidential.

Id. at 569.

In that regard, the court specifically noted that applying the statute in the trial court setting would create conflicts with other laws (in that case, they were public records laws, which require court records to be open). According to the court:

> In the absence of some clearer indication that R.C. 5122.31 overrides common law and statutory mandates that court records be open to the public, we decline to construe the statute in that manner.

Id. Thus, the court found that the statute did not apply.[6]

Unfortunately, the appeals court here neglected this vitally important initial step. The court erred in doing so.

B. The Scope Of R.C. 1751.60(A) Is Ambiguous.

If the appeals court had considered the statutory scope issue, it necessarily would have concluded that R.C. 1751.60(A) is ambiguous. Ambiguity arises whenever a statute's language is susceptible to more than one reasonable interpretation. *State v. Jordan* (2000), 89 Ohio St. 3d 488, 492. Ambiguity can infect either the statute's substantive command, or the statute's appropriate scope. That is, in some instances, the statute's scope is clear, while its substantive

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[6] While the court went on to consider the substantive content of the confidentiality command, it did so only as an alternative basis supporting its holding. *See Hall*, 141 Ohio App. 3d at 569–70.

command is ambiguous. In other instances, as here, the reverse is true: the statute's substantive command is clear, but its scope of operation is ambiguous.

This Court's recent opinion in *Sheet Metal Workers* is again instructive. Faced with the question of whether work on "any material to be used in or in connection with a public work" included only work performed on the project site or also extended to off-site work performed on materials used in or in connection with the project, the Court concluded that the statute's scope was ambiguous. *Sheet Metal Workers*, 2009-Ohio-2747, at ¶ 29. According to the Court, that ambiguity arose from statutory silence: "There is no reference in R.C. 4115.05 to where the work must be performed, i.e., whether it must be directly on the project site or be performed off-site." *Id.* Given this silence, the Court needed to resolve the resulting ambiguity by reference to the traditional tools of statutory interpretation.

The scope of 1751.60(A) is likewise ambiguous. Just as in *Sheet Metal Workers*, R.C. 1751.60(A) states neither that it applies only in the single-insurer setting, nor that it applies to multiple insurers. The statutory provision is thus susceptible to "more than one reasonable interpretation." *Jordan*, 89 Ohio St. 3d at 492. Like the use of "any material" in the statute at issue in *Sheet Metal Workers*, which could be read as including only on-site materials, or both on-site and off-site materials, here, some (e.g., the trial court and the ODI) could read R.C. 1751.60(A) as applying only to the parties actually identified in the statute (the health care provider, the health insuring corporation, and the insured). Others (e.g., the appellate court), given the absence of specific cabining language, might read the statute to apply more broadly. These conflicting interpretations evince the statute's ambiguity. *Clark v. Scarpelli* (2001), 91 Ohio St. 3d 271, 274 ("conflicting interpretations by various trial and appellate courts" supported statute's ambiguity).

Depending upon which scope is selected, the effect of R.C. 1751.60(A) varies dramatically. "Solely" admittedly means "to the exclusion of others to whom the statute applies." But, if the statute applies only in the single-insurer context, "solely" means that the health provider must seek compensation from the health insuring corporation "to the exclusion ***of the insured***." By contrast, if the statute's scope extends beyond this single-insurer context to the multi-insurer setting, "solely" means "to the exclusion of ***other responsible insurers*** as well as the insured." This ambiguity in scope must be resolved by turning to settled rules of statutory construction.

C. Settled Rules Of Statutory Construction Confirm That R.C. 1751.60(A) Applies Only To Compensation Issues As Among A Health Care Provider, Health Insuring Corporation, And Patient, And Does Not Prevent A Health Care Provider From Seeking Reimbursement From Other Potentially Responsible Insurers.

Ambiguities regarding statutory scope, just like any other statutory ambiguity, should be resolved "in a manner that carries out the intent of the General Assembly." *Sheet Metal Workers*, 2009-Ohio-2747, at ¶ 29. When determining legislative intent, this Court "look[s] to the language of the statute" and a host of factors set forth in R.C. 1.49, including the object sought to be attained by the legislature, "the circumstances under which the statute was enacted, legislative history, laws upon the same or similar subjects, and the consequences of a particular construction . . . ." *Id.* (citing R.C. 1.49). So, for example, in *Sheet Metal*, after determining that the prevailing wage statute's silence on the issue of whether it applied to off-site work rendered the statutory scope ambiguous, the Court carefully examined the history of the prevailing wage statute. *Id.* at ¶¶ 30–32. The Court also considered administrative regulations that the Department of Commerce had adopted pursuant to the prevailing wage statutes, and practices within the construction industry, all of which reflected an understanding that the prevailing wage law applied only to on-site work. *Id.* at ¶¶ 37–39. It then analyzed the practical

consequences of the competing understandings of the statute's scope, noting that applying the statute to off-site work would "interject[] uncertainty into a process by creating a new standard," and observing that "departure from current prevailing-wage law, custom, and practice properly belong[s] in the legislative domain as a matter of public policy." *Id.* at ¶ 42. Applying these settled tools of statutory construction, the Court concluded that the statute should not be understood to apply to off-site work, even though the statute did not expressly exclude such application.

Here, the same considerations that drove the Court's decision in *Sheet Metal* require a finding that R.C. 1751.60(A) does not apply in the multi-insurer context. Indeed, the statute's language and the factors set forth in R.C. 1.49 all point to the same result—that the legislative intent underlying R.C. 1751.60(A) is to insulate ***insureds*** from liability, not to insulate multiple responsible ***insurers*** from their payment obligations.

1. The Language Of R.C. 1751.60(A), When Read In Its Entirety And In The Context Of Section 1751.60, Indicates That Its Application Is Limited To The Single-Insurer Setting.

The interpretive process begins with the statute's language, which "must be construed as a whole and given such interpretation as will give effect to every word and clause in it." *D.A.B.E., Inc. v. Toledo-Lucas Cty. Bd. of Health*, 96 Ohio St. 3d 250, 2002-Ohio-4172, at ¶ 26 (internal quotation marks and citation omitted). In addition to examining the language of the specific statute at issue, this Court also looks to "language elsewhere in the [] statutory scheme" to gain "insight into the scope of the law." *Sheet Metal Workers*, 2009-Ohio-2747, at ¶ 34. Reading R.C. 1751.60(A) in its entirety, and in conjunction with the rest of R.C. 1751.60 and the health-insuring corporation statutory scheme, reveals that R.C. 1751.60(A) is limited, as the trial court found, to those situations involving a single insurer.

When R.C. 1751.60(A) is applied only to the three-party relationship among a health provider, a health insuring corporation, and a patient, "every word and clause" in R.C. 1751.60(A) is accorded significance and effect. *D.A.B.E.*, 2002-Ohio-4172, at ¶ 26 (internal quotation marks and citation omitted). Applying R.C. 1751.60(A) to a multi-insurer setting, however, contradicts the fundamental proposition that "'[n]o part [of a statute] should be treated as superfluous unless that is manifestly required.'" *See Boley v. Goodyear Tire & Rubber Co.*, 125 Ohio St. 3d 510, 2010-Ohio-2550, at ¶ 21 (quoting *State ex rel. Myers v. Bd. of Educ. of Rural Sch. Dist. of Spencer Twp.* (1917), 95 Ohio St. 367, 373). In particular, the appeals court's understanding of "solely" in the phrase "solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers," renders the latter half of the statutory phrase nugatory. If "solely" means "to the exclusion of all others in the world," then there is no need to say "and not, under any circumstances, from the enrollees or subscribers." If, on the other hand, "solely" means, as it must, "to the exclusion of all others ***to whom this statute applies***," then the remainder of the phrase provides important information regarding who is in the excluded group ("enrollees and subscribers") and in delineating the extent of the exclusion for that group ("except for approved copayments and deductibles").

The statutory context in which R.C. 1751.60(A) arises further confirms this reading. Chapter 1751 is not in the portion of the Revised Code directed to insurers generally, which resides in Title 39. Rather, Chapter 1751 is part of Title 17, Ohio's corporate code. Chapter 1751 does not purport to address insurers generally, but instead is directed solely toward a particular kind of corporation: a "health insuring corporation." Indeed, the Chapter is entitled "Health Insuring Corporations." Safeco, the auto insurer here, is not a "health insuring corporation" under Chapter 1751. *See* R.C. 1751.01(P) (defining "health insuring corporation");

see also Ohio Department of Insurance, *Insurance Companies Authorized to Transact Business In the State of Ohio*, at 3–4, (Oct. 11, 2010), available at http://www.insurance.ohio.gov/reports /authlist.pdf (listing health insuring corporations authorized to transact business in Ohio).

Consistent with the Chapter's exclusive focus on regulating health insuring corporations, the language of R.C. 1751.60(A) identifies only three parties: "a health care provider or health care facility," "a health insuring corporation," and "enrollees or subscribers." Nowhere does R.C. 1751.60(A), or any other portion of R.C. 1751.60 for that matter, refer to other insurers. This is strong contextual evidence that the provision addresses reimbursement obligations as among those three parties, and not payment issues as among multiple insurers, like the health insuring corporation (Aetna) and non-health insuring corporation (Safeco) here.

Other subsections of R.C. 1751.60 reinforce that R.C. 1751.60(A) is focused on the relationship among a health insuring corporation, a provider, and an insured, and, in particular, on insulating insureds from personal liability for covered expenses in that setting. For example, R.C. 1751.60(B) 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 any covered health care services" if the patient provides sufficient evidence of coverage. "Other insurers" again receive no mention. In addition, R.C. 1751.60(E), permits Ohio's Superintendent of Insurance to waive the requirement of subsection (A) if the health insuring corporation gives the provider "financial guarantees" covering the cost of services provided to the insured patient.

Giving effect to all words and phrases of R.C. 1751.60(A) and reading it in conjunction with the other subsections, the statute simply does not speak to the multi-insurer context. Instead, it applies to payment issues as among a health care provider, a health insuring corporation, and an insured patient. Because the scope of R.C. 1751.60(A) does not extend to

the multi-insurer context, the statute does not bar the Hospital from billing other insurers such as Safeco.

2. The Legislative History Surrounding R.C. 1751.60(A) And The Title Of The Section Confirm That The Provision Is Intended To Insulate Insureds From Liability, Not To Prevent Providers From Billing Other Insurers.

In addition to the statute's language, R.C. 1.49 provides a list of other factors that courts may consider when interpreting ambiguous statutes. The first three criteria that the statute lists all relate to the available information regarding the circumstances under which the statutory provision was enacted. *See* R.C. 1.49 ("If a statute is ambiguous, the court may consider, among other matters, (A) The object sought to be attained; (B) The circumstances under which the statute was enacted; (C) The legislative history."); *see also Sheet Metal Workers*, 2009-Ohio-2747, at ¶¶ 30–32 (considering statutory history in resolving ambiguity regarding appropriate scope of R.C. 4115.05). Here, that information confirms what the language of R.C. 1751.60(A) suggests, namely, that the provision was enacted to protect ***insureds*** from personal liability in the event that a health insuring corporation becomes insolvent or otherwise fails to pay for covered services.

In 1991, after a string of HMO insolvencies adversely affected 125,000 Ohioans, the General Assembly enacted laws imposing financial stability requirements on HMOs. Darrel Rowland, *Insurance Department Pushes Laws on Health Care*, The Columbus Dispatch, April 25, 1996. Several years later, the emergence of a new type of managed care entity prompted the legislature to pass Am. Sub. S.B. No. 67 (1997) (the "Act") in order to uniformly regulate the different types of providers of managed health care. 66 Ohio Report No. 97, *Gongwer News Serv.* (May 21, 1997). Of particular concern to the legislature was the fact that these new entities were operating outside of the previously-enacted solvency standards,

potentially making consumers vulnerable in the event that the managed care entity became insolvent. *Id.*

The Act broadly amended Chapter 1751 ("Health Insuring Corporations") to address these concerns. For example, some of the Act's statutory requirements sought to enhance the stability of health insuring corporations. *See, e.g.*, R.C. 1751.32. Other provisions, such as R.C. 1751.60(A), "focus[ed] on protections for ***subscribers*** and ***enrollees***, including . . . restricting the authority of providers and health care facilities to seek compensation for covered services from ***enrollees***." Legislative Service Commission Bill Analysis, Am. Sub. S.B. No. 67, 122nd General Assembly. Thus, concerns about insulating ***insureds***, not other ***insurers***, from health care billing led to the statute's passage.

This Court has also noted that a statute's title, while not subject to a legislative vote, can nonetheless add valuable information in resolving questions regarding its meaning. *State v. Kiser* (1968), 13 Ohio St. 2d 126, 128 (title deserves some deference when determining a statute's purpose). Here, the title provided for R.C. 1751.60 in the Final Bill Analysis—"Enrollees and subscribers liable only for deductibles and copayments and for noncovered services"—corroborates that the statute is directed at insulating ***insureds***, not other ***insurers***.[7] Legislative Service Commission Bill Analysis, Am. Sub. S.B. No. 67, 122nd General Assembly. In sum, the available legislative history surrounding the statute's enactment shows that the trial court correctly identified the statute's proper scope, and the court of appeals erred in failing to consider the issue.

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[7] The title given R.C. 1751.60 by Baldwin's makes the same point: "Enrollees and subscribers not liable to providers and facilities." The title in Page's simply tracks the statutory language and thus sheds no light one way or the other: "Provider or facility to seek compensation for covered services solely from HIC."

3. The Appeals Court's Interpretation Puts R.C. 1751.60(A) In Direct Conflict With Ohio's Coordination Of Benefits Law.

Perhaps an even more important tool in resolving statutory ambiguity is the principle, codified in R.C. 1.49(D), that statutes relating to a similar subject matter, even if passed at different times and making no reference to one another, should be read together. *D.A.B.E.*, 2002-Ohio-4172, at ¶ 20. "Further, in reading such statutes and construing them together, [the court] must arrive at a reasonable construction giving the proper force and effect, if possible, to each statute." *Id.* Courts typically refer to this doctrine by the label in pari materia. "Statutes and regulations that relate to the same general subject matter may be read in pari materia in order to discover and carry out legislative intent." *Sheet Metal Workers*, 2009-Ohio-2747, at ¶ 38.

Both R.C. 1751.60(A) and Ohio's coordination of benefits law, R.C. 3902.13 & Ohio Adm. Code 3901-8-01, et seq., assign responsibility for payment obligations relating to covered medical services. The appeals court's construction of R.C. 1751.60(A) renders the statutory section in conflict with Ohio's coordination of benefits law, nullifying those provisions in certain circumstances. When properly limited to health care providers, health insuring corporations, and insureds, however, R.C. 1751.60(A) says nothing about payments as between multiple insurers, allowing the coordination of benefits statutes and regulations to govern those interactions.

Ohio's law on coordination of benefits applies when a person is insured under multiple "plans of health coverage" that provide coverage for the same expense. *See* R.C. 3902.13; Ohio Adm. Code 3901-8-01, et seq. The multiple plans could include "plans of health coverage" offered by health insuring corporations, like Aetna,[8] or medical benefits coverage offered by a

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[8] *See* R.C. 3202.11(b)(2) ("plan of health coverage" includes "any individual or group contract of a health insuring corporation, which contract provides for hospital, dental, surgical, or medical services").

third-party payor, like Safeco,[9] or any combination of the two. This case thus illustrates one circumstance in which these rules come into play. King suffered injuries from a car accident, and she had two separate "plans of health coverage"—Aetna health insurance and Safeco auto insurance medical expense coverage—that provided coverage for her medical costs.

Ohio's coordination of benefits rules permit each insurance company to determine its respective payment obligation. R.C. 3902.13(A); Ohio Adm. Code 3901-8-01. The rules require ***insurers***—the entities possessing the necessary information—to determine for themselves which of them is primary or secondary. R.C. 3902.13(A). Pursuant to the rules, a plan concluding that it has the primary payment obligation must pay its benefits as if the secondary plan does not exist. R.C. 3902.12; Ohio Adm. Code 3901-8-01(F)(3). Conversely, the secondary plan may consider the primary plan's payment obligation when calculating the amount owed. R.C. 3902.12; Ohio Adm. Code 3901-8-01(F)(6);(H). A plan need not pay the provider until it determines whether it is the primary or secondary plan and what benefits are payable under the primary plan. R.C. 3902.13(E). To facilitate communication between insurers regarding the amount owed, R.C. 3902.13(F) enables each plan to "obtain any facts and information necessary . . . or supply this information to any other third-party payer or provider . . . to determine priority of payments."

R.C. 3902.13(A) enumerates six specific rules for plans of health coverage to apply when determining the order of benefits. R.C. 3902.13(A)(1) provides that "[a] plan that does not coordinate with other plans is always the primary plan." (Auto insurer medical expense benefits typically do not coordinate, and thus are primary under this rule.) R.C. 3902.13(A)(2)–(5)

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[9] *See* R.C. 3202.11(b)(3) ("plan of health coverage" includes "any [] individual or group policy or agreement under which a third-party payer provides for hospital, dental, surgical, or medical services"); Ohio Adm. Code 3901-8-01(C)(11)(c)(vi) ("plan" includes "[m]edical benefits coverage under automobile 'no fault' and traditional 'fault' type contract").

concern coverage of employees and/or dependents. And R.C. 3902.13(A)(6), the catch-all provision, provides that if none of the previous rules apply, the plan providing coverage for the longest amount of time is the primary plan.

This description of Ohio's coordination of benefits law exposes the unavoidable conflict that the appellate court's construction of R.C. 1751.60(A) creates. When both a health insuring corporation and another qualifying health plan provide coverage for the same expenses, R.C. 1751.60(A)—if construed in the way the appeals court did—will obstruct the statutorily-mandated coordination process. In particular, under such a construction, the Hospital may seek reimbursement only from Aetna, King's health insuring corporation, and may not seek compensation from Safeco.

Consider the consequences. If Safeco is the primary insurer and the benefits available under the Safeco policy surpass or equal the bill's amount, Aetna should have no payment obligation under the coordination of benefits rules. Yet, Chapter 1751 and Ohio's coordination of benefits laws neither direct Aetna to pay the Hospital's bill and then seek compensation from Safeco, nor require it to forward the Hospital's bill to Safeco. Thus, under the appeals court's interpretation of R.C. 1751.60(A), pursuant to which the Hospital cannot bill Safeco, there is no path for the responsible insurer (i.e., Safeco) even to receive the provider's bill. Alternatively, if Safeco's primary medical benefit does not cover the bill in its entirety, the coordination of benefits rules still allow Aetna to consider in determining its own payment the amount that Safeco paid under its primary obligation. R.C. 3902.12. But because the Hospital is barred from submitting bills to anyone other than the health insuring corporation (under the appeal court's decision), again the primary insurer would not even receive the bill, meaning there would be no payment from the primary insurer (Safeco) for the secondary insurer (Aetna) to deduct.

Ultimately, both scenarios result in either an unpaid provider bill, or in the health insuring corporation, which should be secondary under the coordination of benefits rules, instead assuming the primary payment obligation.

Other undesirable consequences abound. Recall that the appeals court interpreted R.C. 1751.60(A) to mean that a provider may seek compensation "solely from ***the*** health insuring corporation"—and from no one else. What happens when a dependent is insured under ***both*** of his or her parents' health insuring corporation plans? The coordination of benefits statutes, and in particular R.C. 3902.13(A)(3), provides rules for determining which parent's plan is primary and which is secondary, ensuring that the patient receives all of the coverage to which he or she is entitled. And, again, that determination is one that the ***insurers*** (not the providers) are supposed to make. Under the appellate court's construction of R.C. 1751.60(A), though, a provider can seek compensation solely from a ***single*** health insuring corporation—not multiple health insuring corporation***s***. Requiring the hospital to bill a single health insuring corporation (rather than billing both) would again thwart the coordination of benefits process, both by creating the prospect that the insured will not receive the full benefits of having multiple policies, and by forcing ***the provider*** in essence to determine which of the two insurers should act as the primary (indeed, ***sole***) reimbursement source.

It cannot be emphasized too strongly that the tension that exists between the appeals court's interpretation of R.C. 1751.60(A) and the coordination of benefits laws was entirely absent from *Hayberg*, the case the court below found "strikingly similar." In fact, *Hayberg* did not implicate Ohio's coordination of benefits laws ***at all***. Coordination of benefits issues arise only where there are multiple "health plans," which, as noted above, includes medical expense coverage under a policy issued to the insured. *See* R.C. 3902.11(B). Here, King was an insured

under multiple insurance policies that qualified as "health plans" and covered the same medical expenses, thus, directly implicating coordination of benefits concerns. *Hayberg*, by contrast, involved coverage issues as between a health insurance policy on which the plaintiff was a named insured and a ***different insured's*** automobile insurance plan (against which the plaintiff was making a claim for liability coverage). *Hayberg*, 2008-Ohio-6180, at ¶¶ 2, 51. Because liability coverage under a different insured's liability plan is not a "health plan," *see* R.C. 3902.11(B); Ohio Adm. Code 3901-8-01(C)(11)(c)–(d), coordination of benefits issues did not arise. Thus, the court in *Hayberg* was free to analyze R.C. 1751.60(A) without considering Ohio's coordination of benefits law. Whatever one may think of *Hayberg*'s result on the facts there (and many of the reasons discussed above strongly suggest that the case was incorrectly decided),[10] the court below was wrong to simply transplant *Hayberg*'s holding to the vastly different situation here.

In contrast to the appellate court's holding, which places R.C. 1751.60(A) in direct conflict with Ohio's coordination of benefits law, the construction that the Hospital advanced—and which the trial court adopted, and the ODI confirmed—gives proper force and effect to both R.C. 1751.60(A) and the coordination of benefits process. *See San Diego Cty. v. Elavsky* (1979), 58 Ohio St. 2d 81, 86 ("[C]ourts should not construe one statute in a way that would abrogate, defeat, or nullify another statute, where a reasonable construction of both is possible."). Under that interpretation, the statute prevents the Hospital from billing ***the insured***, thereby ensuring that the insured receives the full protection that the General Assembly provided. But the Hospital and the various potentially responsible ***insurers*** remain free to adjust the costs and expenses among themselves according to the settled rules and practices reflected in the

[10] The analysis in *Hayberg* was by one judge. A second judge concurred in judgment only; the third member of the panel dissented.

coordination of benefits statutes and regulations. The Court should read R.C. 1751.60(A) and Ohio's coordination of benefits law together to effectuate the legislature's intent.

4. The Appeals Court's Construction Of R.C. 1751.60(A) Would Harm Ohio's Health Care Industry.

In resolving ambiguities, courts also look to the practical consequences of the competing interpretations. *See* R.C. 1.49(E). Here, the appellate court's interpretation of R.C. 1751.60(A), if not corrected by this Court, will open a Pandora's Box of coverage quandaries: insurers and providers will no longer know when the coordination of benefits process applies and how they may interact with one another; and patients will no longer know if, when, and how they will receive the insurance coverage to which they are entitled. Certainly, the abrupt change to long-settled billing practices threatens to visit mass confusion on the health care industry. And even if the confusion fades, in its place will be left serious logistical and financial problems.

Providers, accustomed to seeking compensation from all potentially responsible payors, will be hamstrung—able to seek compensation for a patient's care from a single health insuring corporation and no one else. In order to adapt, they will scramble to restructure billing practices—and do so at a significant cost. Health insuring corporations—the only entities health providers would be able to bill—will be confronted with uncertain payment obligations and the prospect of shouldering primary payment obligations as secondary insurers. Non-health insuring corporations, such as automobile insurance carriers, will likewise confront uncertain payment obligations when they find themselves without a bill for the medical services for which their policy makes them responsible, and for which Ohio's coordination of benefits law makes them the primary insurer.

There is no evidence anywhere that the legislature intended R.C. 1751.60(A) to impose these consequences. The Court should not interpret the statute to do so here. Using the trial

court's interpretation—under which the statute applies only in the single-insurer context—Pandora's Box remains tightly shut.

King will no doubt try to counter these practical concerns by reference to her claim, urged below, that the Hospital's construction will enable providers to "hunt[] for potentially more lucrative payment sources" (i.e., to bill insurers that do not have preferred-provider agreements with the Hospital) and "deprive[] their patients of the full benefit of their automobile policies." (Appellant's Br. in Ct. App. at 5). But such arguments are unavailing for at least three reasons. First, this is the wrong forum for any such argument. As noted above, the statutory language, read in context, shows that the General Assembly did not intend to prevent a provider from billing other responsible insurers. To the extent that King or others wish to challenge that policy decision, the correct venue is the General Assembly, not Ohio's courts. *See State ex rel. Ross v. Crawford Cty. Bd. Of Elections*, 125 Ohio St. 3d 438, 2010-Ohio-2167, at ¶ 31 ("'[J]udicial policy preferences may not be used to override valid legislative enactments, for the General Assembly should be the final arbiter of public policy.'" (quoting *State v. Smorgala* (1990), 50 Ohio St. 3d 222, 223)).

Second, the argument is wrong on the facts. The Hospital is not "hunting for potentially more lucrative payment sources." It is the automobile insurers themselves that historically have determined that they have the primary payment obligation. The Hospital issues billing statements to the companies that have historically been primary merely as a means of expediting the payment process. It is true that one consequence is that those bills may reflect higher rates than the pre-negotiated contract rates with health insuring corporations, but the Hospital's billing practices are a result of the terms of the auto insurance contract (which typically pays "usual and customary rates"), and the coordination of benefits rules (which typically make auto insurer

medical expense coverage the primary coverage), not a result of some effort to target higher reimbursement.

Finally, King's arguments are wrong as a matter of policy. King basically asserts that health care providers should be forced to collect only the preferred-provider rates, rather than charging the standard rates that they typically charge to insurers with whom they have not negotiated pre-arranged fees. But there is no basis for requiring a provider to extend its preferred rate structure to insurers with whom it has not negotiated preferred-provider rates. There is likewise no reason to twist the language of R.C. 1751.60(A) to force the Hospital to bill only the insurer with whom it has a preferred-provider agreement, rather than billing the insurer that Ohio law designates as "primary" for a given claim. Yet, under the appeals court's construction, that is exactly what happens—not only does the auto insurer, which is the "primary" insurer under Ohio law in most cases, avoid paying the "usual and customary rate" that its policy specifies, but ***the auto insurer does not pay at all.***

This unwarranted windfall for auto insurers would have severe consequences for health care providers. Limiting the provider to collecting the preferred-provider rate for services that should have been billed at the higher standard and customary rate necessarily will result in hospitals receiving less total recovery of their costs, which in turn impacts their ability, for example, to continue meeting their commitment to provide low-cost and no-cost care to indigent patients. There is no reason to believe that the General Assembly intended any such result and, as noted above, overwhelming reasons to believe that it did not.

5. The Ohio Department Of Insurance's Statutory Guidance Confirms That R.C. 1751.60(A) Does Not Prevent A Health Care Provider From Seeking Reimbursement From Other Insurers.

In resolving statutory ambiguity, agency interpretation carries significant weight. This Court has held that when interpreting statutes, courts must give "[d]ue deference . . . to statutory

interpretations by an agency that has accumulated substantial expertise and to which agency the legislative body has delegated enforcement responsibility." *Weiss v. Pub. Util. Comm.* (2000), 90 Ohio St. 3d 15, 17–18; *accord Sheet Metal Workers*, 2009-Ohio-2747, at ¶ 37–38 (citing regulations that the director of the Department of Commerce issued as a factor to consider in resolving issue regarding scope of R.C. 4115.05). The Ohio Department of Insurance has the responsibility of "execut[ing] and enforc[ing]" insurance law. R.C. 3901.011. Accordingly, this Court should give the agency's interpretation of R.C. 1751.60(A) due deference.

The currently operative ODI Bulletin 2010-06 clearly articulates the ODI's view that R.C. 1751.60(A) "only applies to provider contracts involving health insuring corporations." (Appx. at 17.) As noted above, Safeco is ***not*** a "health insuring corporation." *See* R.C. 1751.01(P). Likewise, the Bulletin states that R.C. 1751.60(A) "applies to compensation sought ***from a subscriber***." (Appx. at 17.) Lest there be any confusion regarding the statute's limited scope of operation, the Bulletin reemphasizes that point, stating that the statute "prohibits a health care provider or health care facility from balance billing, or seeking compensation from, ***a subscriber***, except for approved copayments and deductibles." (*Id.*) As also noted above, King (the subscriber) has ***not*** alleged that anyone sought compensation from her here. The ODI Bulletin thus confirms the inapplicability of the statute to the case at bar.

Indeed, the ODI's understanding of R.C. 1751.60(A) was clear long before it issued this statutory guidance. In developing coordination-of-benefits regulations that explicitly govern plans offered by health insuring corporations, the ODI necessarily interpreted R.C. 1751.60(A) as applying only to the three-party relationship between a health care provider, a health insuring corporation, and an insured. After all, an interpretation of R.C. 1751.60(A) that prohibits a provider from billing any entity other than a single health insuring corporation (such as the

appellate court's interpretation below) would render health insuring corporations ineligible to coordinate with ***anyone***—a result that contradicts the very premise of the regulatory scheme.

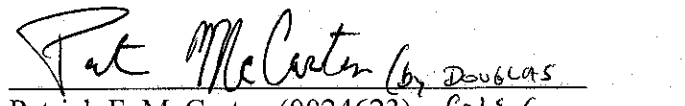
The ODI, both explicitly and implicitly, has confirmed what every other indicium of meaning shows—R.C. 1751.60(A) applies only as among a health care provider, a health insuring corporation, and an insured.

CONCLUSION

In sum, the court below erred in failing to consider the statute's proper scope. Within its proper scope, the statute unambiguously requires the provider to bill only the health insuring corporation and not the insured. The statute simply does not apply, however, as between multiple responsible insurers. Properly understood, the statute says nothing as to whether the Hospital could bill Safeco. Accordingly, King's claims, all of which rest on a purported "violation" of R.C. 1751.60(A), fail as a matter of law, and the trial court was correct to dismiss her complaint. For the above-stated reasons, the Hospital respectfully urges this Court to overturn the appeals court's decision and reinstate that dismissal.

Dated: January 3, 2011

Respectfully submitted,



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I certify that a copy of this Merit Brief was sent by ordinary U.S. mail on this 3rd day of January, 2011, to:

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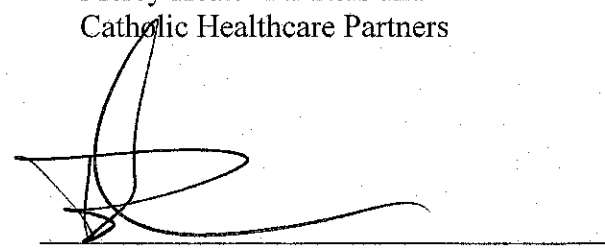

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ProMedica Health System and
The Toledo Hospital

IN THE SUPREME COURT OF OHIO

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

APPENDIX TO THE MERIT BRIEF OF APPELLANTS PROMEDICA HEALTH SYSTEM AND THE TOLEDO HOSPITAL

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ProMedica Health System and The Toledo Hospital v. King
Case No. 2010-1236
Index to Appendix

Notice of Appeal of Appellants ProMedica Health System and The Toledo Hospital in Case No. 10-1236 (Ohio Supreme Court), filed July 15, 2010 ..... A.2

Judgment Entry and Opinion in Case No. L-09-1282 (6th Dist), Released and Journalized June 4, 2010 ..... A.5

Judgment Entry and Order Granting ProMedica Health System and The Toledo Hospital's Motion to Dismiss in Case No. CI 200903599 (Lucas Cty. Common Pleas), Released October 1, 2009; Journalized October 6, 2009 ..... A.10

Ohio Department of Insurance, Bulletin 2010-06, *Guidance Governing Interpretation of R.C. 1751.60* A.17

R.C. 1751.01 ..... A.19

R.C. 1751.60 ..... A.25

R.C. 3902.11 ..... A.27

R.C. 3902.12 ..... A.28

R.C. 3902.13 ..... A.29

Ohio Adm. Code 3901-8-01 ..... A.32

ORIGINAL

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

NOTICE OF APPEAL OF APPELLANTS PROMEDICA HEALTH SYSTEM AND THE TOLEDO HOSPITAL

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FILED
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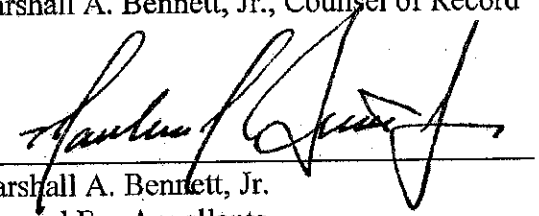
SUPREME COURT OF OHIO

Notice of Appeal of Appellants
ProMedica Health System and The Toledo Hospital

Appellants ProMedica Health System and The Toledo Hospital hereby give notice of appeal to the Supreme Court of Ohio from the judgment of the Lucas County Court of Appeals, Sixth Appellate District, entered in the Court of Appeals Case No. L-09-1282 on June 4, 2010.

This case is one of public or great general interest.

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 this Notice of Appeal was sent by ordinary U.S. mail to counsel for appellee at the addresses listed below.

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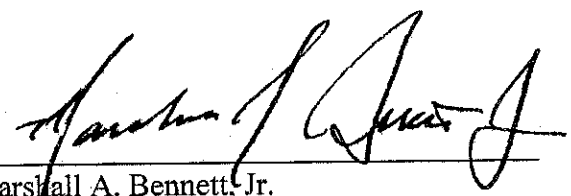

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BERNIE QUILTER
CLERK OF COURTS

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

Virginia King

Appellant

v.

ProMedica Health System, Inc., et al.

Appellees

Court of Appeals No. L-09-1282

Trial Court No. CI 200903599

DECISION AND JUDGMENT

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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{¶ 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. JUDGE

Mark L. Pietrykowski, J. JUDGE

Thomas J. Osowik, P.J. JUDGE
CONCUR.

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.

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LUCAS COUNTY

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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
	*	Judge Ruth Ann Franks
Plaintiff,	*	JUDGMENT ENTRY
-vs-	*	
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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OCT 06 2009

received healthcare services from Defendants[1] 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.

OHIO DEPARTMENT OF INSURANCE
STATE OF OHIO

BULLETIN 2010-06

GUIDANCE GOVERNING INTERPRETATION OF R.C. 1751.60
Effective November 9, 2010

Bulletin 2010-06 (hereafter, "this Bulletin") is being issued to rescind and replace Bulletin 2010-03. This Bulletin supersedes Bulletin 2010-03. This Bulletin is not intended to promote or encourage any practice involving a health care provider or health care facility seeking payment directly from a property & casualty liability insurer, and is not intended to overturn any court decisions. The purpose of this Bulletin is to clarify the Department's authority and provide guidance to insurance companies, health insuring corporations (sometimes called HMOs), health care providers and health care facilities regarding interpretation of Section 1751.60 of the Revised Code ("R.C."), which reads in pertinent part:

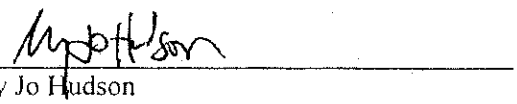
> **1751.60. Provider or facility to seek compensation for covered services solely from HIC.**
> (A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health 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.

The Department is seeking to clarify the meaning of the statute in the context of R.C. Chapter 1751 in order to avoid confusion regarding the statute and the Department's authority. R.C. Chapter 1751 governs the licensure and operation of health insuring corporations, including contracting between health insuring corporations and health care providers. The term "health insuring corporation" is specifically defined in R.C. 1751.01 (P). R.C. 1751.60 only applies to provider contracts involving health insuring corporations. It does not apply to providers in relation to coverage offered by sickness and accident insurers licensed under R.C. Title 39, self-insured health benefit plans, or third party administrators or carriers that administer self-insured plans on an "administrative services only" basis.

R.C. 1751.60 requires that a contract between a health insuring corporation and a health care provider or health care facility include a provision that holds harmless the health insuring corporation's subscriber from provider or facility charges for covered services, except for approved copays and deductibles. This statute prohibits a health care provider or health care facility from balance billing, or seeking compensation from, a subscriber, except for approved copayments and deductibles.

R.C. 1751.60 applies to compensation sought from a subscriber and provides the Department with authority to take action if a violation with respect to a subscriber occurs.

Neither R.C. Chapter 1751 nor R.C. 1751.60 reference a private right of action.



Mary Jo Hudson
Superintendent of Insurance

Baldwin's Ohio Revised Code Annotated Currentness
Title XVII. Corporations--Partnerships (Refs & Annos)
Chapter 1751. Health Insuring Corporations
1751.01 Definitions

As used in this chapter:

(A)(1) "Basic health care services" means the following services when medically necessary:

(a) Physician's services, except when such services are supplemental under division (B) of this section;

(b) Inpatient hospital services;

(c) Outpatient medical services;

(d) Emergency health services;

(e) Urgent care services;

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;

(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;

(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.

"Basic health care services" does not include experimental procedures.

Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in medicare pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of medicaid recipients, or to the coverage of participants of the children's buy-in program, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may

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offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.

(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply:

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section:

(i) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(a) Services of facilities for intermediate or long-term care, or both;

(b) Dental care services;

(c) Vision care and optometric services including lenses and frames;

(d) Podiatric care or foot care services;

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;

(f) Short-term outpatient evaluative and crisis-intervention mental health services;

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

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(h) Home health services;

(i) Prescription drug services;

(j) Nursing services;

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(l) Physical therapy services;

(m) Chiropractic services;

(n) Any other category of services approved by the superintendent of insurance.

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(E) "Children's buy-in program" has the same meaning as in section 5101.5211 of the Revised Code.

(F) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

(G) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

(H) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

(I) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

(J) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

(K) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

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(L) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

(M) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.

(N) "Health care services" means basic, supplemental, and specialty health care services.

(O) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

(P) "Health insuring corporation" means a corporation, as defined in division (I) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

(Q) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

(R) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

(S) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code.

(T) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

(U) "Medicare" means the program established under Title XVIII of the "Social Security Act" 49 Stat. 620 (1935), 42 U.S.C. 1395, as amended.

(V)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers

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and that also allows enrollees to use providers that are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

(W) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

(X) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

(Y) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

(Z) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

(AA) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse midwives, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

(BB) "Provider sponsored organization" means a corporation, as defined in division (I) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division.

(CC) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

(DD) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

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(EE) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

CREDIT(S)

(2009 S 79, eff. 10-6-09; 2008 H 562, eff. 9-23-08; 2008 S 186, eff. 8-5-08; 2006 S 116, eff. 3-30-07; 2006 S 154, eff. 5-17-06; 1999 H 471, eff. 7-1-00; 1998 H 698, eff. 3-22-99; 1997 S 67, eff. 6-4-97)

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Baldwin's Ohio Revised Code Annotated Currentness
Title XVII. Corporations--Partnerships (Refs & Annos)
Chapter 1751. Health Insuring Corporations
1751.60 Enrollees and subscribers not liable to providers or facilities

(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.

(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of any covered health care services, if the subscriber or enrollee has acted in accordance with the evidence of coverage.

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

(D) Nothing in this section shall be construed as preventing a provider or health care facility from billing the enrollee or subscriber of a health insuring corporation for noncovered services.

(E) Upon application by a health insuring corporation and a provider or health care facility, the superintendent may waive the requirements of divisions (A) and (C) of this section when, in addition to the reserve requirements contained in section 1751.28 of the Revised Code, the health insuring corporation provides sufficient assurances to the superintendent that the provider or health care facility has been provided with financial guarantees. No waiver of the requirements of divisions (A) and (C) of this section is effective as to enrollees or subscribers for whom the health insuring corporation is compensated under a provider agreement or risk contract entered into pursuant to Chapter 5111. or 5115. of the Revised Code or under the children's buy-in program.

(F) The requirements of divisions (A) to (C) of this section apply only to health care services provided to an enrollee or subscriber prior to the effective date of a termination of a contract between the health insuring corporation and the provider or health care facility.

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CREDIT(S)

(2008 H 562, eff. 9-23-08; 2003 H 95, eff. 9-26-03; 1998 H 698, eff. 3-22-99; 1997 S 67, eff. 6-4-97)

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C
Baldwin's Ohio Revised Code Annotated Currentness
Title XXXIX. Insurance
Chapter 3902. Insurance Policies and Contracts (Refs & Annos)
Health Coverage Plans
→ **3902.11 Definitions**

As used in sections 3902.11 to 3902.14 of the Revised Code:

(A) "Beneficiary" and "third-party payer" have the same meanings as in section 3901.38 of the Revised Code.

(B) "Plan of health coverage" means any of the following if the policy, contract, or agreement contains a coordination of benefits provision:

(1) An individual or group sickness and accident insurance policy, which policy provides for hospital, dental, surgical, or medical services;

(2) Any individual or group contract of a health insuring corporation, which contract provides for hospital, dental, surgical, or medical services;

(3) Any other individual or group policy or agreement under which a third-party payer provides for hospital, dental, surgical, or medical services.

(C) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other licensed health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.

CREDIT(S)

(2001 S 4, eff. 7-24-02; 1997 S 67, eff. 6-4-97; 1992 H 478, eff. 1-14-93; 1990 H 544; 1988 S 169)

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Baldwin's Ohio Revised Code Annotated Currentness
Title XXXIX. Insurance
Chapter 3902. Insurance Policies and Contracts (Refs & Annos)
Health Coverage Plans
→ 3902.12 Primary and secondary health coverage plans

When a plan of health coverage is primary, its benefits are paid without regard to the benefits of another plan. When a plan of health coverage is secondary, its benefits are determined by taking into consideration the payments made or to be made by another plan. When there are more than two plans, a plan may be primary as to one and may be secondary as to another.

CREDIT(S)

(1988 S 169, eff. 6-29-88)

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C
Baldwin's Ohio Revised Code Annotated Currentness
Title XXXIX. Insurance
Chapter 3902. Insurance Policies and Contracts (Refs & Annos)
Health Coverage Plans
→ **3902.13 Order of benefits; procedure for payment of benefits**

(A) A plan of health coverage determines its order of benefits using the first of the following that applies:

(1) A plan that does not coordinate with other plans is always the primary plan.

(2) The benefits of the plan that covers a person as an employee, member, insured, or subscriber, other than a dependent, is the primary plan. The plan that covers the person as a dependent is the secondary plan.

(3) When more than one plan covers the same child as a dependent of different parents who are not divorced or separated, the primary plan is the plan of the parent whose birthday falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan that covered the parent the longer is the primary plan. The plan that covered the parent the shorter time is the secondary plan. If the other plan's provision for coordination of benefits does not include the rule contained in this division because it is not subject to regulation under this division, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

(4)(a) Except as provided in division (A)(4)(b) of this section, if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:

(i) The plan of the parent who is the residential parent and legal custodian of the child;

(ii) The plan of the spouse of the parent who is the residential parent and legal custodian of the child;

(iii) The plan of the parent who is not the residential parent and legal custodian of the child.

(b) If the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is the primary plan. A parent responsible for the health care pursuant to a court decree must notify the insurer or health insuring corporation of the terms of the decree.

(5) The primary plan is the plan that covers a person as an employee who is neither laid off or retired, or that employee's dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or that employee's dependent.

(6) If none of the rules in divisions (A)(1), (2), (3), (4), and (5) of this section determines the order of benefits, the primary plan is the plan that covered an employee, member, insured, or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

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(B) When a plan of health coverage is determined to be a secondary plan it acts to provide benefits in excess of those provided by the primary plan.

(C) The secondary plan shall not be required to make payment in an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of expenses allowable under the provisions of the applicable policies and contracts.

(D) A third-party payer 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.

(E) Nothing in this section shall be construed to require a plan to make a payment until it determines whether it is the primary plan or the secondary plan and what benefits are payable under the primary plan.

(F) A plan may obtain any facts and information necessary to apply the provisions of this section, or supply this information to any other third-party payer or provider, or any agent of such third-party payer or provider, without the consent of the beneficiary. Each person claiming benefits under the plan shall provide any information necessary to apply the provisions of this section.

(G) If the amount of payments made by any plan is more than should have been paid, the plan may recover the excess from whichever party received the excess payment.

(H) No third-party payer shall administer a plan of health coverage delivered, issued for delivery, or renewed on or after June 29, 1988, unless such plan complies with this section.

(I)(1) A third-party payer that is subject to this section and has reason to believe payment has been made by another third-party payer for the same service may request from that third-party payer, and shall be provided by the third-party payer, such data as necessary to determine whether duplicate payment has been made.

(2) A third-party payer that meets the criteria of a secondary payer in accordance with this section may seek repayment of any duplicate payment that may have been made from the person to whom it made payment. If the person who received the duplicate payment is a provider, absent a finding of a court of competent jurisdiction that the provider has engaged in civil or criminal fraudulent activities, the request for the return of any duplicate payment shall be made within three years after the close of the provider's fiscal year in which the duplicate payment has been made.

(J) Nothing in this section shall be construed to affect the prohibition of section 3923.37 of the Revised Code.

(K)(1) No third-party payer shall knowingly fail to comply with the order of benefits as set forth in division (A) of this section.

(2) No primary plan shall direct or encourage an insured to use the benefits of a secondary plan that results in a reduction of payment by such primary plan.

(L) Whoever violates division (K) of this section is deemed to have engaged in an unfair and deceptive insurance act or practice under sections 3901.19 to 3901.26 of the Revised Code, and is subject to proceedings pursuant to those sections.

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(1997 S 67, eff. 6-4-97; 1990 S 3, eff. 4-11-91; 1988 S 169)

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Ohio Admin. Code § 3901-8-01

Baldwin's Ohio Administrative Code Annotated Currentness
3901 Insurance Department (Refs & Annos)
Chapter 3901-8. Health Insurance Plans (Refs & Annos)
3901-8-01 Coordination of benefits

(A) Authority

This rule is promulgated pursuant to section 3901.041 of the Revised Code, providing that the superintendent of insurance shall adopt, amend and rescind rules and make adjudications necessary to discharge his duties and exercise his powers under Title 39 of the Revised Code; and section 3902.14 of the Revised Code, providing that the superintendent may adopt rules to carry out the purposes of sections 3902.11 to 3902.14 of the Revised Code.

(B) Purpose

The purpose of this rule is to:

(1) Permit plans to include a coordination of benefits "(COB)" provision;

(2) Provide the authority for the orderly transfer of information needed to pay claims promptly;

(3) Eliminate duplication of benefits by permitting a plan to reduce benefits paid when, pursuant to this rule, it is not required to pay its benefits first;

(4) Reduce claim payment delays; and

(5) Further define the "COB" statute.

(C) Definitions

As used in this rule:

(1)

(a) "Allowable expense" means, except as set forth below or otherwise defined by statute, any health care expense, including coinsurance or co-payments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

(b) If a plan is advised by the covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

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(c) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(d) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

(e) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of "COB" to certain coverages or benefits may limit the definition of allowable expenses in its contract to expenses that are similar to the expenses that it provides. When "COB" is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which "COB" applies.

(f) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(g) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

(i) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions for services; or

(ii) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

(2) "Birthday" means the month and day in a calendar year and does not include the year in which an individual is born.

(3) "Claim" means a request that plan benefits be provided or paid. This term includes a request for:

(a) Services, including supplies;

(b) Payment for all or a portion of expenses incurred;

(c) A combination of paragraphs (C)(3)(a) and (C)(3)(b) of this rule; or

(d) Indemnification.

(4) "Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(5) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation pursuant to federal law.

(6) "Coordination of benefits" or "COB" means a procedure establishing the order in which plans shall pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(7) "Custodial parent" means:

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(a) The parent awarded custody of a child by a court decree; or

(b) In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(8) "Group-type contract" means a contract not available to the general public which is obtained and maintained only because of membership in, or in connection with, a particular organization or group, including blanket coverage. This term shall not include an individually underwritten and issued, guaranteed renewable policy even if purchased through payroll deduction at a premium savings to the insured since the insured would have a right to maintain or renew the policy independently of continued employment with the employer.

(9) "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(10) "Hospital indemnity benefits" means benefits which are not related to actual expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(11)

(a) "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no "COB" among the separate parts of the plan.

(b) The definition of plan in a contract shall state the types of coverage which will be considered in applying the "COB" provision of that contract. Whether the contract uses the term "plan" or some other term such as "program", the contractual definition may be no broader than the definition of "plan" in paragraph (C)(11) of this rule.

(c) Plan includes:

(i) Group and non-group insurance and subscriber contracts;

(ii) An uninsured arrangement of group or group-type coverage;

(iii) Group or group-type and non-group coverage through a health insuring corporation, closed panel plan or other prepayment, group practice or individual practice plan;

(iv) Group-type contracts;

(v) The medical care components of long term care contracts, such as skilled nursing care;

(vi) Medical benefits coverage under automobile "no fault" and traditional "fault" type contract; and

(vii) Medicare or other governmental benefits, as permitted by law, except as provided in paragraph (C)(11)(d)(x) of this rule. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

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(d) The term "plan" shall not include:

(i) Hospital indemnity benefits or other fixed indemnity coverage;

(ii) Accident only coverage or specified accident coverage;

(iii) A supplemental sickness and accident policy excluded from coordination of benefits pursuant to sections 3923.37 and/or 1751.56 of the Revised Code;

(iv) School accident-type coverage;

(v) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(vi) Medicare supplement policies; or

(vii) A state plan under medicaid, or other governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

(12) "Primary plan" means a plan whose benefits for a person's health care coverage shall be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following conditions is true:

(a) A plan either does not contain order of benefit rules, or it has rules which differ from those permitted by this rule; or

(b) All plans which cover the person use the order of benefits determination required by this rule, and under this rule that plan determines its benefits first.

(13) "School accident-type coverage" means a contract covering elementary, junior high, high school and or college students for accidents only, including athletic injuries, on a twenty-four hour basis or on a "to and from school" basis.

(14) "Secondary plan" means any plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this rule shall determine the order in which their benefits are determined in relationship to each other.

(15) "This plan" means, in a "COB" provision, the part of a contract providing health care benefits to which the "COB" provision applies and which may be reduced because of the benefits of other plans.

(D) Solicitation, certificate and contract provisions

(1) The following language shall be included as a separate and distinct paragraph on the first page in at least one solicitation, marketing, advertising or enrollment document which shall be provided to potential subscribers of a plan subject to this rule and shall be printed in twelve point type:

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"WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."

(2) The following language shall be included as a separate and distinct paragraph on the first page in every contract, policy, certificate/evidence of coverage and summary plan description issued to a beneficiary under a plan subject to this rule, and shall be printed in twelve-point type:

"NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."

(3) A contract which utilizes "COB" shall contain the "COB" provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No substantive changes are permitted.

(4) Each certificate issued under a group contract which utilizes "COB" shall contain the "COB" provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the group certificate or to reflect the difference among plans which provide services, which pay benefits for expenses incurred and which indemnify. No substantive changes are permitted.

If a group policyholder or contractholder distributes its own solicitation, marketing, advertising or enrollment documents to its members who are potential subscribers of a plan subject to this rule, then the plan shall make the foregoing language available for use by the group.

(E) Prohibited coordination and benefit design

(1) A contract shall not reduce benefits on the basis that:

(a) Another plan exists and the covered person did not enroll in that plan;

(b) A person is or could have been covered under another plan, except with respect to part B of medicare; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

(2) No contract, certificate or policy shall contain a provision that its benefits are "always excess" or "always secondary" to any other plan, except as otherwise provided in this rule.

(3) Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services

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of a closed panel plan provider. In most instances, "COB" does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, "COB" may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of paragraph (H) of this rule to determine the amount it should pay for the benefit.

(4) No plan may use a "COB" provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under paragraph (C)(11) of this rule.

(F) Requirements

(1) Allowable expense

(a) When plans have differing allowable expenses, the larger allowable expense shall be used for the purpose of division (C) of section 3902.13 of the Revised Code. When benefits paid by a primary plan are less than the allowable expenses, the secondary plan shall pay or provide its benefits toward any remaining balance otherwise payable by the insured or the certificate holder. A secondary plan shall not be required to make a payment of an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of the larger of the expenses allowable under the provisions of the applicable policies and contracts.

(b) When a plan provides benefits in the form of services, the reasonable cash value of each service shall be both an allowable expense and a benefit paid.

(c) When a contract restricts "COB" to specific coverage, allowable expense shall include the expenses or services to which "COB" applies under the contract.

(2) A secondary plan shall not be required to pay for services unless such services are received in accordance with the rules and provisions outlined in its policy, contract or certificate.

(3) A primary plan shall pay or provide its benefits as if the secondary plan does not exist. A plan that does not contain a coordination of benefits provision shall not take into account benefits of other plans. However, a contract holder's coverage which is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by that contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits. A plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of paragraph (F)(3) of this rule, state that the complying plan is primary.

(4) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(5) When multiple contracts providing coordinated coverage are treated as a single plan under this rule, this paragraph applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as

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primary within the plan shall be responsible for the plan's compliance with this rule.

(6) A secondary plan may take the benefits of another plan into account when, under this rule, it is secondary to the other plan.

(7) Nothing in this rule shall be construed to prevent a third party payer and a provider from entering into an agreement under which the provider agrees to accept, as payment in full from any or all plans providing benefits to a beneficiary, an amount which is less than the provider's regular charges.

(G) Order of benefit determination

Order of benefits shall be determined by the first applicable provision set forth in this paragraph:

(1) Non-dependent or dependent. The benefits of a plan covering the person as an employee, member, insured, subscriber or retiree, other than as a dependent, shall be determined before those of a plan which covers the person as a dependent. However, the benefits of a plan covering the person as a dependent shall be determined before the benefits of a plan covering the person as other than a dependent if the person is a medicare beneficiary, and as a result of Title XVIII of the Social Security Act and its implementing regulations:

(a) Medicare is secondary to the plan covering the person as a dependent; and

(b) Medicare is primary to the plan covering the person as other than a dependent (e.g. a retired employee).

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married (not separated or divorced) or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan;

(ii) If both parents have the same birthday, the plan which has covered the parent for a longer period of time is the primary plan;

(iii) If one plan does not have the rule described in paragraphs (G)(2)(a)(i) and (G)(2)(a)(ii) of this rule because that plan is not subject to the "COB" statutes, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the plan containing the rule based upon the gender of the parent shall determine the order of benefits.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If the specific terms of the court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

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(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (G)(2)(a) of this rule shall determine the order of benefits.

(iii) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the plans covering the child shall be subject to the order of benefit determination contained in paragraph (G)(2)(a) of this rule.

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The plan covering the custodial parent;

(b) The plan covering the custodial parent's spouse;

(c) The plan covering the non-custodial parent; and then

(d) The plan covering the non-custodial parent's spouse.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraph (G)(2)(a) or (G)(2)(b) of this rule as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The benefits of a plan which covers a person as an active employee who is neither laid off nor retired, or as that active employee's dependent, is the primary plan. If the other plan does not have this provision, and if, as a result, the plans do not agree on the order of benefits, this provision shall be ignored.

This paragraph does not supersede paragraph (G)(1) of this rule. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under paragraph (G)(1) of this rule. Paragraph (G)(3) of this rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies.

(4) "COBRA" or state continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(a) The plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is the primary plan;

(b) The continuation coverage provided pursuant to federal or state law is the secondary plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This provision does not apply if the order of benefits can be determined under paragraph (G)(1) of this rule.

(5) Longer or shorter length of coverage. If none of the preceding provisions determines the order of benefits, the

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plan which has covered the person for the longer period of time is the primary plan and the plan which covered that person for the shorter period of time is the secondary plan. For the purposes of this provision:

(a) The time covered under a plan is measured from the claimant's first date of coverage under that plan, or, if that date is not readily available for a group plan, the date the claimant first became a member of the group covered by that plan shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force;

(b) Two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended;

(c) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another, such as, from a single plan to a multiple employer plan.

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

(H) Procedure to be followed by secondary plan to calculate benefits and pay a claim.

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred per cent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(I) Miscellaneous provisions

(1) A secondary plan which provides benefits in the form of services may recover the reasonable cash value of the services from a primary plan, to the extent that benefits for the services are covered by, and have not already been paid or provided by the primary plan. Nothing in this paragraph shall be interpreted to require a plan to reimburse a covered person in cash for value of services provided by a plan that provides benefits in the form of services.

(2) A plan with order of benefit determination rules which comply with this rule (complying plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with this rule (non-complying plan) as follows:

(a) If the complying plan is the primary plan, it shall pay or provide its benefits first;

(b) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. Such payment shall be the limit of the complying plan's liability;

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(c) If a non-complying plan does not provide the information needed by a complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. However, if the complying plan receives information within two years of payment as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

(d) If a non-complying plan which paid or provided benefits as a primary plan reduces its benefits so that a claimant receives less in benefits than he would have received had the complying plan paid or provided its benefits as the secondary plan, the complying plan shall advance to, or on behalf of, the claimant an amount equal to such difference. The amount advanced, combined with other amounts previously paid by the complying plan, shall not exceed the liability of the complying plan as calculated as if the complying plan were the primary plan.

In consideration of the advance, the complying plan shall be subrogated to all rights of the claimant against the non-complying plan. The advance by the complying plan shall be without prejudice to any claim it may have against the non-complying plan in the absence of subrogation.

(3) A term such as "medical care" or "dental care" may be substituted for the term "health care" in describing the coverages to which the "COB" provisions of a contract apply.

(4) Provisions regarding either "COB" or subrogation may be included in a health care benefits contract without compelling the inclusion or exclusion of the other in that contract.

(5) If the plans cannot agree on the order of benefits within thirty calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

(J) This rule is applicable to every contract which provides health care benefits and which was issued on or after the effective date of this rule. A contract which provides health care benefits and was issued before the effective date of this rule shall comply with this rule by:

(1) The later of:

(a) The next anniversary date or renewal date of the contract, whichever is sooner; or

(b) Three hundred sixty-five days following the effective date of the rule; or

(2) The expiration of any applicable collectively bargained contract pursuant to which the contract was written.

For the transition period between the adoption of this rule and the timeframe for which plans are to be in compliance pursuant to paragraph (K)(1) of this rule, a plan that is subject to the prior "COB" requirements shall not be considered a non-complying plan by a plan subject to the new "COB" requirements and if there is a conflict between the prior "COB" requirements under the prior rule and the new "COB" requirements under the new rule, the prior "COB" requirements shall apply.

(K) Penalties

Whoever violates this rule or any paragraph thereof shall be deemed to have engaged in an unfair and deceptive in-

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surance act or practice under sections 3901.19 to 3901.26 of the Revised Code, and is subject to proceedings pursuant to those sections.

(L) Severability

If any section, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other section, term or provision of this rule, but the remaining sections, terms and provisions shall be and continue in full force and effect.

HISTORY: 2008-09 OMR pam. #5 (E), eff. 11-14-08

RC 119.032 rule review date(s): 8-29-13

HISTORICAL AND STATUTORY NOTES

Ed. Note: Effective 11-14-08, 3901-8-01 contains provisions of former 3901-1-56.

Ed. Note: The appendix to this rule is referenced only. Appendices are generally available on Westlaw and/or CD-ROM. Subscribers who wish to obtain a copy may request one from the publisher, the Legislative Service Commission, or the issuing agency.

CROSS REFERENCES

RC 3901.041, Rulemaking and adjudicating powers of superintendent
RC 3902.11, Definitions
RC 3902.12, Primary and secondary health coverage plans
RC 3902.13, Order of benefits; procedure for payment of benefits
RC 3902.14, Rulemaking powers

OAC 3901-8-01, OH ADC 3901-8-01

Rules are complete through Sept. 19, 2010; Appendices are current to February 28, 2010

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