

**IN THE SUPREME COURT OF OHIO**

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

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**MERIT BRIEF OF AMICI CURIAE,  
OHIO HOSPITAL ASSOCIATION, OHIO STATE MEDICAL ASSOCIATION,  
OHIO OSTEOPATHIC ASSOCIATION,  
AND OHIO ASSOCIATION OF HEALTH PLANS  
IN SUPPORT OF APPELLANTS**

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Anne Marie Sferra (0030855)  
 Bridget Purdue Riddell (0082502)  
 BRICKER & ECKLER LLP  
 100 South Third Street  
 Columbus, Ohio 43215  
 Tel: (614) 227-2300  
 Fax: (614) 227-2390 (facsimile)  
 asferra@bricker.com  
 bpurdue@bricker.com

*Attorney for Amici Curiae,  
 Ohio Hospital Association,  
 Ohio State Medical Association,  
 Ohio Osteopathic Association, and  
 Ohio Association of Health Plans*

Patrick F. McCartan (Counsel of Record)  
 Jones Day  
 North Point, 901 Lakeside Avenue  
 Cleveland OH 44114-1190  
 (216) 586-3939/Facsimile (216-579-0212)  
 pmccartan@jonesday.com

Douglas R. Cole  
 Jones Day  
 325 John H. McConnell Boulevard  
 Suite 600  
 Columbus OH 43216-5017  
 (614) 469-3939/Facsimile (614) 461-4198  
 drcole@jonesday.com

Marshall A. Bennett, Jr. (0015845)  
 Jennifer J. Dawson (0033707)  
 Marshall & Melhorn, LLC  
 Four SeaGate, Eighth Floor  
 Toledo, Ohio 43604  
 (419) 249-7100/Facsimile (419) 249-7151  
 bennett@marshall-melhorn.com

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*Counsel for Appellants ProMedica Health System and  
The Toledo Hospital*

John T. Murray, Esq. (008793) (Counsel of Record)  
Leslie O. Murray, Esq. (0081496)  
Murray & Murray Co., L.P.A.  
111 East Shoreline Drive  
Sandusky, OH 44870  
(419) 624-3000/Facsimile: (419) 624-0707  
jotm@murrayandmurray.com

John L. Huffman, Esq. (0039658)  
520 Spitzer Building  
Toledo OH 43604  
(419) 242-8461/Facsimile: (419) 242-6866  
jhuffman@aol.com

*Counsel for Appellee Virginia King*

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## **I. STATEMENT OF INTEREST OF AMICI CURIAE**

The Ohio Hospital Association (“OHA”), Ohio State Medical Association (“OSMA”), Ohio Osteopathic Association (“OOA”), and Ohio Association of Health Plans (“OAHP”) (collectively “Amici”) urge the Court to reverse the decision of the Sixth Appellate District (“Sixth District”) which precludes Ohio’s health care providers<sup>1</sup> from seeking payment for health care services from all available insurers<sup>2</sup> when a patient has multiple insurers, one of which is a health insuring corporation as defined in R.C. 1751.01(P). If such decision is allowed to stand, Ohio’s health care providers no longer will be able to do what they have historically done under Ohio law—obtain reimbursement for medical services from all potentially liable payors. While this alone would strike a serious financial blow to Ohio’s health care providers (during a time when many of them are already struggling to serve their patients and communities), the impact would be compounded because many health care providers would need to implement new billing systems and retrain employees to adhere to the new law restricting reimbursement. Thus, at the same time that they would be losing an important revenue stream, Ohio’s health care providers would also be increasing their costs in order to implement new collection processes. This unreasonable outcome will have an adverse impact on Ohio’s health care providers and the communities they serve.

The OHA is a private nonprofit trade association established in 1915 as the first state-level hospital association in the United States. For decades, the OHA has provided a mechanism for Ohio’s hospitals to come together and develop health care legislation and policy in the best

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<sup>1</sup> When used herein, “health care providers” refers to hospitals, doctors, and others who provide health care services. The statute at issue, R.C. 1751.60, refers to “providers” and “health care facilities.” As used herein, “health care provider” encompasses providers and health care facilities as used in R.C. 1751.60.

<sup>2</sup> The term “insurer” is used loosely in this Memorandum to refer to any entity that provides other applicable coverage for health services rendered.

interest of hospitals and their communities. The OHA is comprised of one hundred sixty-nine private, state and federal government hospitals and more than eighteen health systems, all located within the state of Ohio. The OHA's mission is to be a membership-driven organization that provides proactive leadership to create an environment in which Ohio hospitals are successful in serving their communities.

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

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

The OAHP is the statewide trade association for the health insurance industry. The OAHP represents twenty member health plans providing health insurance coverage to more than 7.5 million Ohioans. The OAHP actively promotes and advocates for quality health care for Ohioans and access to affordable health care benefits for all consumers in Ohio. By promoting the use of best medical practices and improving the delivery of appropriate medical care, the

OAHP's members are working toward the goal of a healthier Ohio, both physically – with better health outcomes and health management for enrollees—and fiscally—by controlling costs and contributing substantially to Ohio's economy.

Amici urge the Court to reverse the decision of the Sixth District as it is contrary to Ohio law and, if allowed to stand, will have a severe negative impact on the finances of health care providers, many of which are already struggling in these difficult economic times to provide health care services to the Ohioans they serve. At the same time, the Sixth District's decision provides no meaningful benefit to patients enrolled in health insuring corporations as, under existing law, health care providers are not permitted to collect any amount from such patients for covered health care services, except for deductibles and copayments. In fact, the Sixth District's decision may require some patients to come out of pocket to reimburse health care providers for deductibles and copayments that usually are paid by other available insurance coverage.

## **II. STATEMENT OF FACTS**

Amici defer to the Appellants' Statement of Facts, but highlight the limited facts set forth below.

King sought and received medical services at The Toledo Hospital ("Hospital") for injuries she sustained in an automobile accident in December 2007. Compl. ¶13. King informed the Hospital that she had health insurance with Aetna and automobile insurance with Safeco. See Reply in Supp. of Defs.' Mot. to Dismiss (July 9, 2009), Ex. AA (Hospital Admission Record). King later informed the Hospital that it was to bill Safeco directly for the medical treatment she received as Safeco was the "primary" insurer for the medical treatment she received. See Reply in Supp. of Defs.' Mot. to Dismiss (July 9, 2009), Ex. AB (December 4, 2007 Letter to King from Safeco). The Hospital followed these instructions and received payment from Safeco.

Months later, King filed a class action lawsuit against the Hospital, alleging that it violated Ohio law by seeking compensation from her automobile carrier—the very automobile carrier that indicated it had primary coverage for her accident-related medical bills—as opposed to her health insurer. There is no allegation in the Complaint that the Hospital sought reimbursement directly from King or collected any amount from her. *King v. Promedica Health System, Inc.* (Oct. 1, 2009), Lucas C.P. No. CI-200903599, at 6, fn. 6. Nor is there any allegation that the Hospital collected more than the amount it billed for the health care services rendered.

### **III. INTRODUCTION**

At the outset, it may be helpful to put the statute at issue—R.C. 1751.60—and the narrow legal issue based on this statute, in general perspective in the overall scheme of providing and collecting payment for health care services to insured patients.

The statute at issue, R.C. 1751.60, is included in R.C. Chapter 1751 which governs the licensure and operation of health insuring corporations. R.C. 1751.60 only applies to “health insuring corporations” (sometimes referred to as HMOs) as defined in R.C. 1751.01(P). There are many other types of insurers that provide coverage for health care services to which R.C. 1751.60 does not apply. For instance, R.C. 1751.60 does not apply 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. See Ohio Dept. of Ins., Bulletin 2010-06, Guidance Governing Interpretation of R.C. 1751.60 (Nov. 9, 2010), at 1, attached hereto as Exhibit A.

Members of the OHA, OSMA, and OOA provide health care services, and members of the OAHP provide health insurance, to millions of people throughout Ohio. Generally speaking, Ohio’s hospitals and doctors charge patients for the services they render and receive payment from the patients or the patients’ insurers. Various types of private and government insurance

are available to cover health care services, including, but not limited to, per diem health insurance policies, indemnity policies, workers' compensation coverage, Medicare, Medicaid, ERISA plans, medical payment coverage in automobile liability policies, and so on. While a given hospital or doctor typically bills all patients and insurers the same charge (sometimes referred to as a uniform or standard charge) for a particular service, government insurers (Medicare and Medicaid) and some private insurers are able to negotiate and pay lower rates for services. Such an agreement with one or more insurers does not bind the health care provider to give the same discount to all other insurers or payors.

Numerous state and federal laws govern the billing and payment of health care services. Consistent with these laws, industry practices have developed to make the billing and payment for health care services standardized and more efficient. One common practice is that at the time health care services are rendered, health care providers usually obtain information from patients regarding the medical issue for which they are seeking services,<sup>3</sup> and whether there is any potentially applicable insurance coverage for the services.<sup>4</sup>

Another common industry practice is that when it is time to bill for such services, the health care provider may seek payment from one or more of the potentially applicable insurance coverages. See Ohio Adm. Code 3901-8-01, Appx. A (setting forth the order of benefit payment rules applicable [w]hen a person is covered by two or more "Plans"). This practice makes sense because when a patient has more than one insurance coverage that may be applicable, hospitals and doctors are not required to determine which coverage should pay first or how much each

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<sup>3</sup> For instance, when patients present at a hospital or doctor's office they are usually asked (verbally or in writing) why they are seeking treatment, whether their medical condition is related to a workplace injury or automobile accident, etc.

<sup>4</sup> For instance, patients are asked whether they have health insurance, whether their spouse has health insurance, whether they have automobile insurance that may be applicable, etc.

should pay. In fact this would be virtually impossible for them to do since they usually have only limited, general information pertaining to potential coverage such as the name and address of the patient's and/or patient's spouse's employer, health insurer, automobile carrier (if the injuries were sustained in an automobile accident), etc.

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

When a patient has only one potential coverage for the services rendered and such coverage is from a "health insuring corporation," as defined in R.C. 1751.01(P), Ohio law precludes hospitals and doctors from seeking payment from the patient for covered services, except for copayments and deductibles.<sup>5</sup> See R.C. 1751.60(A). Under R.C. 1751.60, if a health insuring corporation becomes insolvent or for some other reason does not pay the medical provider for covered services, the medical provider cannot seek payment from the enrollee. This statutory protection is only necessary when the health insuring corporation has not met its obligations to the enrollee and, hence, it should only be invoked under that circumstance.

When a patient has multiple coverages available for health care services, Ohio's coordination of benefits laws come into play. See R.C. 3902.11 *et seq.*, and Ohio Adm. Code 3901-8-01 *et seq.* Ohio's coordination of benefits laws provide detailed rules for insurers to use to determine priority (whose obligation is primary and whose is secondary, etc.) and payment

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<sup>5</sup> Just because a patient has health insurance does not mean that a "health insuring corporation" is involved. Health insuring corporations are only one type of entity that is permitted to offer health care and medical payment benefits. R.C. 1751.60 only applies to health insuring corporations; it does not apply 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. See Ohio Dept. of Ins., Bulletin 2010-06, Guidance Governing Interpretation of R.C. 1751.60 (Nov. 9, 2010), at 1.

amount when multiple coverages are available for a patient. Conversely, when there is only one insurance coverage available to pay for health care expenses, Ohio's coordination of benefits laws are not invoked.

When a patient has multiple coverages for health care services and one of them is through a health insuring corporation (such as in the instant case), health care providers follow the laws and industry practices that apply when multiple coverages are available. More specifically, when there are multiple coverages available and one of them is from a health insuring corporation, health care providers usually will seek payment from more than one available coverage and let the insurers determine who is liable and in what amount under the statutes and rules governing coordination of benefits.

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

In the instant case, the Sixth District determined that the health care provider could only seek reimbursement from King's health insuring corporation and not from any other coverage, including the medical payment ("med pay") coverage in her automobile liability policy. In doing so, it essentially relieved all other liable insurers from their contractual obligations. This decision is contrary to Ohio's coordination of benefits law and Ohio contract law which requires insurers to comply with their contractual obligations to provide payment on behalf of their insureds.

For example, in the instant case, the med pay coverage in King's automobile policy is at issue. By way of background, med pay coverage is designed to pay for medical expenses incurred for immediate and short-term medical care required as a result of an automobile accident. Although not required in Ohio, med pay coverage is typically included in personal automobile liability policies and the most common amount of med pay coverage in Ohio is \$5000 (per person, per accident).<sup>6</sup>

Here, King's automobile insurer determined that her med pay coverage was primary coverage for all reasonable and necessary accident-related medical bills up to her policy limits of \$5,000. See Reply in Supp. of Defs' Mot. to Dismiss (July 9, 2009), Ex. AB (December 4, 2007 Letter to King from Safeco). Under Ohio's coordination of benefits laws, primary coverage applies first to pay for health care services received. Ohio Adm. Code 3901-8-01(I)(2)(a) ("if the complying plan is the primary plan, it shall pay or provide its benefits first"). Under contract law, Safeco is obligated to make this payment on behalf of its insured. The Sixth District's decision is contrary to these laws and essentially relieves Safeco of its obligation.

In addition to affecting health care providers and insurers, the Sixth District's decision also affects patients, and may impact them adversely. Health insuring corporations require health care providers to collect copayments and deductibles from patients. Prior to the Sixth District's decision, health care providers could seek copayments and deductibles from a patient's other insurers so that a patient did not have to come out of pocket to pay these amounts. But, under the Sixth District's interpretation of R.C. 1751.60(A), if the health insuring corporation has primary coverage, the burden shifts to the injured patient to incur increased out of pocket expenses and/or to attempt to collect reimbursement from their other insurance coverage since

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<sup>6</sup> See AllState Insurance Co., Ohio Auto Insurance Coverages, Coverage Scale, at <http://www.allstate.com/auto-insurance/Ohio-auto-insurance-coverages.aspx>.

the health care provider will not be able to seek payment from anyone other than the health insuring corporation.

#### IV. LAW AND ARGUMENT

**Proposition of Law: R.C. 1751.60(A) applies only when the insurance coverage provided by an insured patient's Health Insuring Corporation is the only coverage available to an insured patient, and it does not supersede Ohio's law on the coordination of insurance benefits.**

The decision of the Sixth District, which precludes a health care provider from seeking payment from any insurer other than the patient's health insuring corporation, is wrong. In short, the Sixth District's focus on a single word—solely<sup>7</sup>—in a single subdivision of a statute—R.C. 1751.60(A)—resulted in a decision that:

- (1) is contrary to the purpose and intent of the statute;
- (2) ignores other applicable law, namely Ohio's coordination of benefits law; and
- (3) wrecks havoc on Ohio's health care providers by eliminating a critical source of reimbursement for health care providers and dismantling established industry-wide billing practices.

##### A. The Sixth District's Decision is Contrary to the Purpose and Intent of R.C. 1751.60.

##### 1. **R.C. 1751.60 is Not Applicable to Insurers Other than Health Insuring Corporations.**

To glean the intent of a statute, it is helpful to understand its purpose and the context in which it was enacted. *Bovi v. Pacific Indem. Co.* (1999), 85 Ohio St. 3d 343, 344, 708 N.E.2d 693 ("In determining legislative intent, the court first looks to the language in the statute and the purpose to be accomplished.").

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<sup>7</sup> In the interest of brevity, Amici refer the Court to Appellants' Merit Brief, pp. 8-13, for a thorough discussion regarding why the Sixth District's focus on the word "solely" is contrary to Ohio law.

The statute at issue—R.C. 1751.60—was enacted in the aftermath of several health maintenance organization (“HMO”) insolvencies in Ohio. The collapse of these HMOs adversely affected more than 125,000 Ohioans and left millions of dollars in unpaid medical bills.<sup>8</sup> In light of the problems created by the insolvent HMOs, the General Assembly repealed the laws that governed HMOs and replaced them with laws providing for the establishment, operation, and regulation of “health insuring corporations” “to provide uniform regulation of providers of managed health care.” See Legislative Service Commission Final Bill Analysis, Am.Sub.S.B. No. 67, 122nd General Assembly (the “Act”). The Act created existing R.C. Chapter 1751, which governs the licensure and operation of health insuring corporations, including contracting between health insuring corporations and health care providers. See Ohio Dept. of Ins., Bulletin 2010-06, Guidance Governing Interpretation of R.C. 1751.60 (Nov. 9, 2010), at 1. The Act expanded the Ohio Department of Insurance’s regulatory responsibilities by bringing formerly unregulated managed care entities under its authority. See Fiscal Note & Local Impact Statement, Am.Sub.S.B. No. 67, 122nd General Assembly (May 21, 1997), p.3.

Among other things, the Act imposed requirements to ensure the financial stability of health insuring corporations and “contain[ed] several provisions focusing on protections for subscribers and enrollees, including \* \* \* restricting the authority of providers and health care facilities to seek compensation for covered services from enrollees.” Legislative Service Commission Final Bill Analysis, Am.Sub.S.B. No. 67, 122nd General Assembly. Plainly, an

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<sup>8</sup> See Center for Health Affairs, The Evolution of Medicaid Managed Care in Ohio, Sept. 2007, at 4, available at [http://www.chanet.org/NR/rdonlyres/E8B41E66-9FCF-4BF5-A092-AA7912FD7E6A/404/FinalIB14\\_MedicaidManagedCare.pdf](http://www.chanet.org/NR/rdonlyres/E8B41E66-9FCF-4BF5-A092-AA7912FD7E6A/404/FinalIB14_MedicaidManagedCare.pdf) (discussing the fact that in the mid-1990s, “\* \* \* providers’ worst fears were realized as many managed care plans’ financial footing deteriorated beyond repair, leaving hospitals and doctors with millions in unpaid bills. Losses from claims left unpaid by just one managed care plan, Personal Physician Care, were estimated to cost area hospitals a staggering \$15 million in unpaid claims.”).

important objective of the revised law was to protect Ohio consumers who are enrollees of health insuring corporations from being held liable for medical bills for covered services that their health insuring corporation refused to pay.

The restrictions imposed on health care providers regarding seeking compensation from enrollees<sup>9</sup> are set forth in R.C. 1751.60. In relevant part, this statute provides:

(A) \* \* \* [E]very provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles.

(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) \* \* \* [E]very 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.

\* \* \*

R.C. 1751.60(A), (B) & (C).

When read together, these provisions make it clear that this statute addresses the financial relationship between a health insuring corporation, the corporation's enrollees, and a health care provider who provided services to an enrollee. Equally as clear is the legislative intent to protect enrollees from paying more than copayments and deductibles for covered services. The statute does not address the financial relationship between health care providers and any insurers other than health insuring corporations. Simply put, "R.C. 1751.60 applies to compensation sought

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<sup>9</sup> Hereafter, the term "enrollee" is used to include subscribers and enrollees.

from a subscriber [enrollee] and provides the Department with authority to take action if a violation with respect to a subscriber occurs.” Ohio Dept. of Ins., Bulletin 2010-06, Guidance Governing Interpretation of R.C. 1751.60 (Nov. 9, 2010), at 1.<sup>10</sup> As such, the only reasonable construction of R.C. 1751.60(A) is one that permits health care providers to seek payment from a health insuring corporation, but not from enrollees, for covered services.

Stated another way, R.C. 1751.60 governs who is responsible for payments for health care services when the only two potential sources of payment are the health insuring corporation or the enrollee. This statute does not, by its express terms or implication, govern payments by anyone else and is silent with respect to collecting payments from other insurers. Hence, R.C. 1751.60 is not applicable to and certainly does not control a health care provider’s ability to seek payment from all potential insurance coverage for health care services rendered.

Properly construed, R.C. 1751.60(A) prohibits a health care provider from seeking compensation from King, even if King’s health insuring corporation becomes insolvent or refuses to pay for covered services. It does not, however, prevent a health care provider from seeking payment from another payor who has assumed liability for the payment (such as an automobile insurance company under its med pay coverage).

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<sup>10</sup> Plaintiff’s claim should further be barred because no private right of action exists either explicitly or implicitly under R.C. 1751.60. As to an explicit right, Bulletin 2010-06 explains that “[n]either R.C. Chapter 1751 nor R.C. 1751.60 reference a private right of action.” Ohio Dept. of Ins., Bulletin 2010-06, Guidance Governing Interpretation of R.C. 1751.60 (Nov. 9, 2010), at 1. As to an implicit right of action, Plaintiff, an enrollee from whom no health care provider has sought compensation for a covered service, has suffered no actual injury and is not in the class for whose special benefit R.C. 1751.60 was enacted. *Wilson v. Burt* (Dec. 7, 1994), 2d Dist. No. 13096, 1994 Ohio App. LEXIS 6003, at \*6, discretionary appeal not allowed in *Wilson v. Burt* (1995), 72 Ohio St. 3d 1527, 1527 (where a statute does not explicitly provide for a private cause of action, Ohio courts consider the following factors in determining whether an implied right exists: (a) whether the plaintiff is in a class for whose special benefit the statute was enacted, (b) the statute’s legislative intent, and (c) whether an implied private right of action is consistent with the underlying purposes of the legislative scheme).

Because there is no allegation in King's Complaint that a health care provider sought compensation from her for covered health care services, the trial court properly dismissed the Complaint. See *King v. ProMedica Health System, Inc.* (Oct. 1, 2009), Lucas C.P. No. CI-200903599, at 6, fn. 6 .

**2. R.C. 1751.60 Must be Interpreted to Effect a Just and Reasonable Result.**

In reaching its conclusion that health care providers are only allowed to collect from a patient's health insuring corporation even when other coverage is available, the Sixth District not only ignored the purpose of the statute and the context in which it was enacted, it also blatantly disregarded the express terms of the statute except for the word "solely" as used in R.C. 1751.60. Such a narrow construction of the statute is unsupportable not only because it ignores established principles of statutory construction which require a court to examine a statute in its entirety,<sup>11</sup> but also because it leads to an unjust and unreasonable result. See R.C. 1.47(C); see, also, *Discount Cellular, Inc. v. PUCO*, 112 Ohio St.3d 360, 2007-Ohio-53, ¶26 (holding that in enacting legislation, the General Assembly is presumed to intend a just and reasonable result).

The statute provides that health care providers who contract with a health insuring corporation to provide health care services to enrollees of the health insuring corporation "shall seek compensation for covered services **solely** from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved copayments and deductibles." R.C. 1751.60(A) (emphasis added). The Sixth District interpreted this to mean that the health care provider could seek compensation from the health insuring corporation and

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<sup>11</sup> See *Massillon City School Dist. Bd. of Edn. v. City of Massillon*, 104 Ohio St.3d 518, 2004-Ohio-6775, ¶37 (holding that a court must examine a statute in its entirety rather than focus on a word or phrase); *Sarmiento v. Grange Mut. Cas. Co.*, 106 Ohio St.3d 403, 2005-Ohio-5410, ¶25 (holding that when interpreting a statute, none of the language in the statute should be disregarded).

no one else, as opposed to construing it to mean that the health care provider could seek compensation from the health insuring corporation, but not from the enrollee. This result is neither just nor reasonable as it will deprive health care providers from billing for their services if primary coverage is not the obligation of a health insuring corporation.

**B. The Sixth District Erroneously Relied on *Hayberg* and Ignored Ohio's Coordination of Benefits Law.**

In construing R.C. 1751.60, the Sixth District erroneously relied on *Hayberg v. Robinson Emergency Serv.*, 11th Dist. No. 2008-P-0010, 2008-Ohio-6180, discretionary appeal denied 121 Ohio St.3d 1442, 2009-Ohio-1638. Reliance on *Hayberg* was misplaced because *Hayberg* was incorrectly decided and did not involve Ohio's coordination of benefits laws, which are invoked in the instant case.

*Hayberg* was incorrectly decided for a number of reasons, most notably because R.C. 1751.60(A) was, as the dissenting opinion stated, "completely inapplicable in the present situation" because the health care provider never sought payment from Hayberg. *Hayberg*, 2008-Ohio-6180, at ¶59 (Grendell, J., dissenting). In other words, for R.C. 1751.60(A) to be applicable, a health care provider must seek compensation directly from an enrollee in a health insuring corporation for a covered service; in the absence of this situation, the statute is completely inapplicable. As stated above, the same is true here—R.C. 1751.60(A) is not applicable because the health care provider never sought payment from King. See Amici Brief, at 4, 12-13.

*Hayberg* was also wrong in holding that a health care provider could only be reimbursed from all third-party payors (in the aggregate) the discounted amount it contractually agreed to accept from a health insuring corporation. The fact that health care providers may have a contract with some insurers for a discounted rate does not mean that they cannot collect the full

amount of their standard charge from other liable third-party payors with whom they do not have a contract for a discounted rate. See *id.* at ¶62 (Grendell, J., dissenting). Simply put, there is nothing unlawful about a health care provider collecting the standard amount charged from persons liable for such payment.

*Hayberg* was also wrongly decided because the court ignored the fact that the plaintiff approved the payment made to the hospital-defendant by her husband's automobile carrier in a settlement agreement. *Hayberg*, 2008-Ohio-6180, ¶¶2, 63. *Hayberg*'s claim should have been barred as a result of agreeing to this payment to the hospital. *Id.* at ¶63 (Grendell, J., dissenting) (stating "there is precedent for the proposition that *Hayberg* waived her rights under the statute, whatever those may be, by acquiescing to Nationwide's payment of her medical expenses \* \* \*").

In addition to being wrongly decided, the Sixth District's reliance on *Hayberg* is misplaced because *Hayberg* did not address Ohio's coordination of benefits laws which are critical to properly deciding the instant case. Under Ohio's coordination of benefits laws, insurers—not health care providers—are required to determine priority of coverage and how much each payor shall pay. R.C. 3902.13(A). If Ohio's coordination of benefits laws were properly applied here, King's medical benefits under her automobile insurance policy would be available to reimburse the Hospital. See Merit Brief of Appellants, at 19-21.

The Sixth District's construction of R.C. 1751.60(A), which allows health care providers to seek reimbursement **only** from a patient's health insuring corporation, completely ignores Ohio's coordination of benefits laws and leaves health care providers without any recourse for seeking payment if the health insuring corporation is not the primary insurer. See *King v. Promedica Health System, Inc.* (Oct. 1, 2009), Lucas C.P. No. CI-200903599, at 4 ("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."). Plainly, R.C. 1751.60 was not intended to deprive health care providers of reimbursement when insurance coverage is available, and any interpretation of the statute that allows this result is unreasonable and unlawful.

**C. Public Policy Favors an Interpretation of the Statute That Allows Health Care Providers to Seek Compensation from All Potentially Liable Insurers.**

Ohio courts have recognized that public policy can provide ancillary support to a particular statutory interpretation. "After all, statutes are merely declarations of public policy" and it is the function of the court to interpret them "and determine what public policy requires." See *Milo v. Milo Co.* (June 17, 1992), 9th. Dist. No. 15251, 1992 Ohio App. LEXIS 3143, at \*5; *Motorists Mut. Ins. Co. v. Andrews*, 65 Ohio St. 3d 362, 365, 1992-Ohio-21 (noting that the Court "must interpret [a] statute in light of the public policy responsible for its adoption").<sup>12</sup>

Here, public policy supports an interpretation that does not put health care providers in a position where they are denied the opportunity to seek reimbursement from insurers having the primary payment obligation under Ohio law.

The Sixth District's decision, which requires health care providers to **only** seek payment from health insuring corporations, is contrary to long-standing Ohio law and industry billing practices that permit hospitals to seek payment from multiple potentially liable insurers. If allowed to stand, the Sixth District's decision will not only dismantle the long-standing industry billing practice of seeking reimbursement for medical treatment from all potentially liable

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<sup>12</sup> *Andrews* was superseded by statute on other grounds by R.C. 3937.18 as explained in *Pearson v. Motorists Ins. Cos.* (Sept. 1, 2000), 8th Dist. No. 99-A-0009, 2000 Ohio App. LEXIS 3973, at \*7.

payors, it will also completely cut off a well-recognized, and critical, source of reimbursement to Ohio's hospitals and doctors—other applicable insurance coverage.

Health care providers have routinely sought payment from a patient's automobile insurance policy's med pay coverage when the patient's need for treatment arose from an automobile accident. The reason for doing so is that under Ohio's coordination of benefits laws, such coverage is to be considered in determining which coverage has the primary payment obligation for medical treatment for injuries sustained in an automobile accident and in what amount. See Ohio Adm. Code 3901-8-01(C)(11)(c)(vi) (defining "Plan" for purposes of coordination of benefits to include "medical benefits coverage under automobile 'no fault' and traditional 'fault' type contract[s]"). But, med pay coverage is limited to the specific amount set forth in the automobile insurance policy (in Ohio, commonly \$5000 per person, per accident). So, if other insurance coverage is available, it too may be invoked to reimburse the health care provider for the services rendered, depending on the amount charged for the health care services. The Sixth District's decision prohibits hospitals and doctors from continuing to follow this statutorily mandated practice.

If this Court affirms the Sixth District's decision, health care providers will need to alter established billing and collection practices to ensure that when the patient is an enrollee in a health insuring corporation, reimbursement is only sought from such entity and not from any other insurer. The costs of implementing these new billing practices, which drastically alter previous billing practices, will undoubtedly be substantial. Such an undertaking will likely involve new or modified software, system integration, changes in policies and procedures, and training of personnel.

At the same time that health care providers will be forced to incur the costs of overhauling their established billing practices so as to collect only from health insuring corporations when a patient is enrolled in one, they also will be forced to give up an important source of reimbursement—other insurance coverage, such as the med pay benefits of their patients' automobile insurance. Carried to its logical extreme, the Sixth District's decision may result in no payment at all to health care providers. More specifically, if, as the Sixth District held, health care providers are not permitted to seek reimbursement from anyone other than the health insuring corporation, and if the health insuring corporation does not have the primary payment obligation, then the health insuring corporation (the secondary plan) will not be required to pay for the health care services. See Ohio Adm. Code 3901-8-01, Appx. A (secondary plan "determines its benefits after those of [the primary] Plan").

Since the health care providers are precluded from seeking reimbursement from anyone else, they will have provided treatment without any payment. This is hardly a fair or just outcome, especially when the patient has multiple insurance coverages to pay for the health care services rendered.

In short, health care providers will lose millions of dollars in revenue if they are not permitted to seek reimbursement from payors other than the patient's health insuring corporation. If health care providers are not permitted to bill their patient's automobile insurance companies when they are primary plans under Ohio's coordination of benefits laws, they will lose millions of dollars in revenue.

This is something that Ohio's hospitals simply cannot afford in the current economic environment. Ohio hospitals are committed to providing quality health care twenty-four hours a day, seven days a week to persons in their communities regardless of their ability to pay. As part

of their charitable mission, hospitals provide a significant amount of “charity care” to those who cannot afford health care. “Charity care” is health care provided at no charge or at a substantial discount to patients unable to pay. In 2008, Ohio hospitals provided nearly \$2 billion in charity care and other uncompensated care to uninsured and medically indigent patients, including those on Medicaid. See Ohio Hospital Association 2010 Community Benefit Report, at <http://www.ohanet.org/community-benefits/>.

In addition to providing medical treatment, hospitals are employers, business drivers, and partners to local schools and other community organizations and, with more than 170 hospitals in Ohio, nearly every community in the state includes a hospital. Hospitals and physicians support and sustain their local communities in many different ways. For instance, in 2008, Ohio hospitals invested almost \$1.2 billion in community activities, such as partnering with local schools to keep kids safe and healthy, and offering free preventive screenings and health services in the community. *Id.*

But health care providers cannot keep their doors open without adequate reimbursement for their services. If health care providers are cut off from an essential source of revenue—reimbursement from primary insurance coverage that is not provided by a patient’s health insuring corporation, such as automobile insurance med pay coverage—they will not be able to continue to serve their communities as they have in the past.<sup>13</sup>

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<sup>13</sup> A survey performed in 2009 shows that many of Ohio’s hospitals are already under significant financial stress. Of the 51 hospitals that responded, almost 50% have enacted layoffs and 67% have not filled vacancies. And the economic environment has forced hospitals to cut vital services, such as obstetrics, cardiology units, and home health care. Based on the recent survey, 37.5% of responding hospitals have reduced or eliminated services and nearly thirty-nine percent are planning to reduce or eliminate services. See Ohio Hospital Association, *New State Hospital Tax: Extra Burden in a Failing Economy* (Nov. 2009), at <http://www.ohanet.org/SiteObjects/57AEE3CFB2585F16682EF98E1BBE3B48/State%20Budget%20Survey%20Report.pdf>.

V. CONCLUSION

If the Sixth District's decision is permitted to stand, Ohio's hospitals, doctors, and other health care providers will only be allowed to seek reimbursement from a patient's health insuring corporation regardless of whether other insurance coverage exists and regardless of whether another insurer has the primary coverage obligation. Such a result is contrary to the legislative intent underlying R.C. 1751.60, principles of statutory construction that call for statutes to be interpreted to effect a just and reasonable result, and Ohio's coordination of benefits laws. Moreover, there is no applicable case law that supports this result, and such result is contrary to public policy. Amici ask the Court to reverse the Sixth District's decision.

Respectfully submitted,



Anne Marie Sferra (0030855)  
Bridget Purdue Riddell (0082502)  
BRICKER & ECKLER LLP  
100 South Third Street  
Columbus, Ohio 43215  
(614) 227-2300  
(614) 227-2390 (facsimile)  
Email: [asferra@bricker.com](mailto:asferra@bricker.com)

*Counsel for Amici Curiae,  
Ohio Hospital Association, Ohio State Medical  
Association, Ohio Osteopathic Association, and  
Ohio Association of Health Plans*

**CERTIFICATE OF SERVICE**

I hereby certify that a true copy of the foregoing MERIT BRIEF OF AMICUS CURIAE, OHIO HOSPITAL ASSOCIATION, OHIO STATE MEDICAL ASSOCIATION, OHIO OSTEOPATHIC ASSOCIATION, AND OHIO ASSOCIATION OF HEALTH PLANS IN SUPPORT OF APPELLANTS was sent via regular U.S. mail, postage prepaid this 3rd day of January 2010, to the following:

Patrick F. McCartan  
Jones Day  
North Point, 901 Lakeside Avenue  
Cleveland, OH 44114-1190

Douglas R. Cole  
Jones Day  
325 John H. McConnell Boulevard  
Suite 600  
Columbus, OH 43216-5017

Marshall A. Bennett, Jr.  
Jennifer J. Dawson  
Marshall & Melhorn, LLC  
Four SeaGate, Eighth Floor  
Toledo, OH 43604

*Counsel for Appellants ProMedica Health System  
and The Toledo Hospital*

John T. Murray  
Leslie O. Murray  
Murray & Murray Co., L.P.A.  
111 East Shoreline Drive  
Sandusky, OH 44870

John L. Huffman  
520 Spitzer Building  
Toledo, OH 43604

*Counsel for Appellee Virginia King*

  
Bridget Purdue Riddell (0082502)

OHIO DEPARTMENT OF INSURANCE  
STATE OF OHIO

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BULLETIN 2010-06

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

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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.

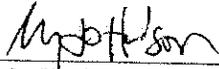
50 W. Town Street, 3<sup>rd</sup> Floor, Suite 300  
Columbus, Ohio 43215

**EXHIBIT**

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



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Mary Jo Hudson  
Superintendent of Insurance